IMPLEMENTATION STATUS OF RECOMMENDATIONS FROM SELECT PERFORMANCE AUDITS ISSUED DURING FISCAL YEARS 2018 THROUGH 2019

PERFORMANCE AUDIT SERVICES
ISSUED DECEMBER 9, 2021

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

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

FOR QUESTIONS RELATED TO THIS PERFORMANCE AUDIT, CONTACT KRISTA BAKER-HERNANDEZ, PERFORMANCE AUDIT MANAGER, AT 225-339-3800.

LOUISIANA LEGISLATIVE AUDITOR
MICHAEL J. "MIKE" WAGUESPACK, CPA

December 9, 2021

The Honorable Patrick Page Cortez,
President of the Senate
The Honorable Clay Schexnayder,
Speaker of the House of Representatives

Dear Senator Cortez and Representative Schexnayder:

This report provides the status of 100 recommendations contained in 11 performance audit reports issued in fiscal year 2019 and 12 recommendations in two performance audit reports issued in fiscal year 2018.

Of the 112 recommendations, 87 (77.6 percent) were implemented, partially implemented, or in the process of being implemented. Twenty-one (18.8 percent) were not implemented, and the status of two (1.8 percent) could not be determined. In addition, two other recommendations (1.8 percent) were not implemented because of circumstances beyond the agencies' control.

We found that implementation of our audit recommendations resulted in the following notable improvements:

- The Louisiana Department of Education (LDE) revised child-to-staff ratios in child care centers to more closely align with best practices. Effective July 1, 2021, all center types have the same child-to-staff ratios. Type I centers' child-to-staff ratios were reduced by at least one child. In addition, effective July 1, 2022, child-to-staff ratios for 2-year-old children in all center types will be reduced to 10:1. While Louisiana still does not meet national best practices regarding child-to-staff ratios, these changes better ensure the safety of children in child care centers.

- LDE now requires both announced and unannounced inspections of family and in-home child care providers. Unannounced inspections are recommended by national best practices and increase the likelihood that LDE can discover serious violations.

- The Louisiana Workforce Commission worked with the Legislature to improve its ability to deter businesses from misclassifying employees as independent contractors. Act 455 of the 2021 Regular Legislative Session removed the

warning letter for first offense worker misclassification and increased penalties for businesses that misclassify workers as independent contractors instead of as employees.

- The Louisiana Department of Veterans Affairs (LDVA) developed a policy for referring elder financial exploitation cases to law enforcement. Any suspicion of theft or loss of a resident's property valued at more than $500 requires a Board of Investigation be appointed to review the incident. LDVA chose the $500 threshold because this is a standard line often drawn in Louisiana's Criminal Code between misdemeanors and felonies.

Our review involved audit reports that focused on the Department of Public Safety and Corrections, the Governor's Office of Elderly Affairs, the Louisiana Department of Education, the Louisiana Department of Health, the Louisiana Department of Justice, the Louisiana Department of Veterans Affairs, the Louisiana State Board of Medical Examiners, the Louisiana Workforce Commission, the Office of Group Benefits, the Office of State Lands, and the State Bond Commission.

The report contains an explanation of the implementation status of each recommendation. I hope this report will benefit you in your legislative decision-making process.

We would like to express our appreciation to the agencies for their assistance during this audit.

Respectfully submitted,

Michael J. "Mike" Waguespack, CPA
Legislative Auditor

MJW/aa

FOLLOWUPREPORT

Louisiana Legislative Auditor

Michael J. "Mike" Waguespack, CPA

Implementation Status of Recommendations from Select Performance Audits Issued During Fiscal Years 2018 through 2019

December 2021

Audit Control # 40210017

Introduction

Recommendations in performance audits are intended to improve agency programs and state government operations, but agencies must either implement these recommendations or address audit findings in some other way to achieve desired improvements. This report provides the implementation status of 100 recommendations contained in 11 performance audit reports issued during fiscal year 2019. We also included two audits issued during fiscal 2018 that contained 12 recommendations.[1] In total, we reviewed 112 recommendations made in 13 performance audits for this report.

Each fiscal year, we ask agencies to attest to their progress in implementing our recommendations from performance audits[2] issued approximately two years earlier, because it can take time to fully implement some of them. We use these attestations as part of our risk assessment to select audits to conduct more comprehensive follow-up audits. The remaining audits are included in this report. Appendix A contains detail on our scope and methodology. The implementation status includes the following categories:

- ***Implemented:*** The agency fully implemented the recommendation.
- ***Implementation in Progress:*** The agency started but has not completed implementing the recommendation.
- ***Partially Implemented:*** The agency implemented a portion of the recommendation but does not intend to implement the recommendation completely.
- ***Not Implemented:*** The agency has not acted to implement the recommendation, or the agency has not implemented the recommendation because legislative action is required.
- ***Cannot Determine:*** Based on agency's response and information provided, we could not determine the implementation status of the recommendation.

[1] Because of changes in leadership in the Department of Education (LDE), we did not include two charter school audits in our fiscal 2018 review and instead included them in this report.

[2] Not including annual statutorily-required audits or audits that do not include recommendations.

- ***Other:*** The agency has not had the opportunity to implement the recommendation.

Exhibit 1 lists the audits selected for this review, the responsible agencies, the date the audit report was issued, and the number of recommendations.

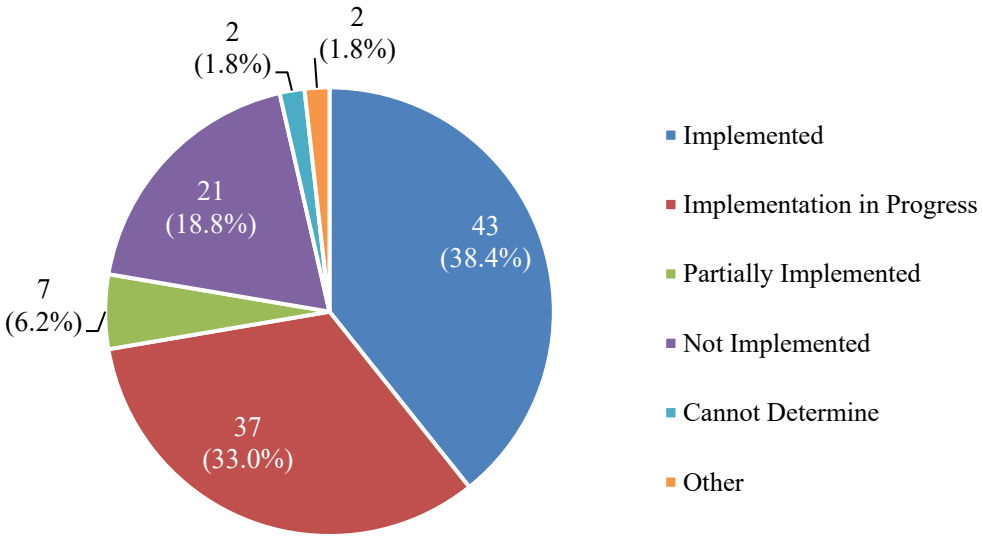
Exhibit 1
Audits Selected for Follow Up

Audit*	Agency	Issue Date	Number of Recommendations	Page
Evaluation of Charter School Monitoring	Louisiana Department of Education	October 4, 2017	10	5
Use of Academic Performance in the Charter School Renewal Process		October 18, 2017	2	9
Local Government Bond Issuance Costs	State Bond Commission	July 11, 2018	3	11
Medical Assistance Programs Fraud Detection Fund	Louisiana Department of Health	July 25, 2018	4	13
	Louisiana Department of Justice		1	
Inventory of State Lands	Office of State Lands, Division of Administration	August 22, 2018	6	16
Management of State Leases & Rights of Way		October 25, 2018	6	19
Regulation of Child Care Providers	Louisiana Department of Education	October 10, 2018	13	21
Oversight of Surveillance and Utilization Review Subsystem (SURS) – Medicaid Program Integrity Activities	Louisiana Department of Health	December 5, 2018	7	26
Evaluation of Louisiana's Framework for Preventing and Addressing Elder Financial Exploitation	Governor's Office of Elderly Affairs	January 23, 2019	7	29
	Louisiana Department of Health		2	
	Louisiana Department of Justice		3	
	Louisiana Department of Veterans Affairs		2	
Oversight of Pharmacy Benefit Manager	Office of Group Benefits	February 6, 2019	12	35
Prison Enterprises – Evaluation of Operations	Department of Public Safety and Corrections	May 1, 2019	15	40
Regulation of the Medical Profession	Louisiana State Board of Medical Examiners	May 15, 2019	12	45
Detection and Prevention of Worker Misclassification	Louisiana Workforce Commission	June 20, 2019	7	52

* Copies of these reports can be found on LLA's website at https://www.lla.la.gov/reports-data/.

Summary of Results: Of the 112 recommendations, 87 (77.6%) were either implemented, partially implemented, or are in the process of being implemented. In addition, 21 (18.8%) of the recommendations have not been implemented, and we could not determine the status for two (1.8%) recommendations. For two (1.8%) other recommendations, agencies have not had a chance to implement the recommendation due to circumstances beyond their control. Exhibit 2 summarizes the implementation status of the recommendations reviewed.

Exhibit 2
Recommendation Status



Source: Prepared by legislative auditor's staff using information provided by agencies.

Notable Changes as a Result of Report Recommendations. Agency implementation of audit recommendations have resulted in the following notable improvements:

- **The Louisiana Department of Education (LDE) has revised child-to-staff ratios in child care centers to more closely align with best practices.** Effective July 1, 2021, all center types have the same child-to-staff ratios. Type I center's child-to-staff ratios were reduced by at least one child. In addition, effective July 1, 2022, child-to-staff ratios for two-year-old children in all center types will be reduced to 10:1. While Louisiana still does not meet national best practices regarding child-to-staff ratios, these changes better ensure the safety of children in child care facilities.

- **LDE now requires both announced and unannounced inspections of family and in-home childcare providers.** Unannounced inspections are recommended by national best practices and increase the likelihood that LDE can discover serious violations.

- **The Louisiana Workforce Commission worked with the legislature to improve its ability to deter businesses from misclassifying employees as independent contractors.** Act 455 of the 2021 Regular Legislative Session

removed the warning letter for first offense worker misclassification and increased penalties to businesses who misclassify workers as independent contractors instead of as employees.

- **The Louisiana Department of Veterans Affairs (LDVA) developed a policy for referring elder financial exploitation cases to law enforcement.** Any suspicion of theft or loss of a resident's property valued at over $500 requires a Board of Investigation be appointed to review the incident and investigate. LDVA chose the $500 breakpoint because this is a standard line often drawn in Louisiana's Criminal Code between misdemeanors and felonies.

The following sections provide a brief description of each report and an explanation of the implementation status of each recommendation.

Evaluation of Charter School Monitoring

Louisiana Department of Education

October 4, 2017

LDE is in the process of implementing nine (90%) of 10 recommendations. One recommendation has not been implemented because of the impact of COVID-19 on the state accountability system, but LDE stated that it plans to implement it in the near future.

The objective of the audit was to evaluate the Louisiana Department of Education's (LDE) monitoring of charter schools authorized by the Board of Elementary and Secondary Education (BESE). We conducted the audit because a 2013 performance audit on LDE's monitoring of charter schools authorized by BESE recommended that LDE implement a more comprehensive process to annually assess charter schools' compliance with legal/contractual obligations. In its response, LDE stated that its new Charter School Performance Compact (CSPC), which was created by LDE and approved by BESE in January 2013, would satisfy this recommendation. In the October 2017 audit, we evaluated LDE's use of the CSPC to monitor BESE-authorized charter schools' organizational performance.

Finding 1: LDE conducted all required annual CSPC reviews from academic years 2013-14 to 2015-16. However, LDE weighs all critical and non-critical organizational performance indicators equally when determining a school's organizational performance rating. Equally weighting all violations does not reflect the severity of critical violations.

Recommendation	Recommendation Status/Summary of Agency's Response
1. LDE should continue to work with BESE on revising the CSPC to give more weight to critical organizational performance areas than non-critical areas during performance reviews.	*Implementation in Progress* In the October 17, 2017 BESE School Innovation and Turnaround committee meeting, LDE proposed changes to BESE Bulletin 126 and the CSPC. These changes were promulgated in February 2018.
2. LDE should work with BESE to consider whether multiple violations identified under one performance indicator should result in multiple deductions from schools' organizational performance ratings.	*Not Implemented* According to LDE, due to the impact of COVID-19 on its state accountability system, the past 18 months caused LDE to reflect on several aspects of how it annually evaluates and renews BESE authorized charter schools. In the near future, LDE plans to engage in a collaborative process with both BESE and charter schools to review, assess, and revise parts of the current CSPC. During that time, this recommendation will be part of the planned discussion.

Finding 2: LDE has not monitored two provisions of the charter school enrollment law, which may have contributed to some schools enrolling fewer at-risk students than they were statutorily and contractually required to enroll. Seven (19%) of the 36 type 2 and 4 charter schools in academic year 2015-16 failed to enroll the required number of at-risk students.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
3. LDE should review the lottery practices of charter schools annually as required by the CSPC.	*Implementation in Progress* In creating a 2021-2022 common reporting calendar for all BESE-authorized charter schools, LDE included a submission of lottery procedures to be reviewed by the Charter Accountability (CA) team. According to LDE, if any charter school does not meet LDE's required enrollment percentages outlined in its current operating agreement, the school would then be required to submit its enrollment recruitment plans for additional review. LDE has considered revisions to the language within the CSPC and Bulletin 126 that specifically speaks to an annual review of each BESE-authorized charter school's lottery policies and processes. Additionally, LDE is considering changes to language related to lottery practices meeting terms of the CSPC and/or Bulletin 126 to also be added to the list of charter school assurances that each charter board signs and submits as one of the required LDE annual submissions.
4. LDE should work with BESE to amend the contract requirement for type 2 and 4 charter schools that states, "…all charter schools must give lottery preference to siblings of students already enrolled in the charter school" to include an exception for schools failing to meet their at-risk enrollment requirement.	*Implementation in Progress* In October 2017, BESE Bulletin 126 was amended to reflect changes to lottery preference. Previously, siblings were exempt from a lottery. Under current BESE policy, siblings can be given preference in enrollment. LDE is in the process of discussion with its legal team to ensure that changing this language would not violate any previous laws and policies. Once that is determined, LDE will need to engage charter school leaders and authorizers across the state to work together to determine how this change impacts all stakeholders before this language can be changed within charter operating agreements.
5. LDE should review whether schools' enrollment processes ensure the schools meet at-risk enrollment requirements annually before allowing sibling preference, as required by the CSPC and state law.	*Implementation in Progress* According to LDE, its staff annually calculates these percentages following the February 1 student enrollment count and send written communication to charter schools who have not met the required percentages. LDE is in the process of revising the language of the CSPC and BESE policy to specifically address sibling preference.

Finding 3: LDE should consider conducting routine unannounced monitoring visits for charter schools in addition to its announced annual review visits.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
6. LDE should consider expanding its practice of conducting unannounced site visits using a random approach to select charter schools.	*Implementation in Progress* The current CSPC states the following: "During the year, LDE staff members visit each charter school at least once and use data to inform the activities that are conducted during the visit(s). Visits may be announced or unannounced." According to LDE, it currently exercises its ability (given the language of the CSPC) to conduct unannounced site visits to charter schools.

Finding 4: LDE should develop specific and consistent procedures on how to address concerns and violations at charter schools. Currently, LDE procedures do not specify when a school should receive a "Notice of Concern" letter and do not require that LDE send a "Return to Good Standing" letter to the school once violations have been corrected.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
7. LDE should develop procedures that identify what types of violations should result in a Notice of Concern so that these violations are adequately tracked and corrected.	*Implementation in Progress* The current CSPC addresses Notices of Concern or Breach in the *Accountability Decisions and Interventions* section. In July 2021, LDE's CA team created a comprehensive tracker for all notices and formal correspondences that are communicated from the CA team to charter schools related to violations of the CSPC, charter operating agreement, BESE policy and/or state and federal law as a means of keeping track of the status of each violation and what steps have been taken by the charter school to rectify any violations.
8. LDE should update its procedures to require that Return to Good Standing letters are sent to all schools that receive a Notice of Concern or Breach to ensure that violations detected are addressed in a timely manner.	*Implementation in Progress* As of July 1, 2021, the CA team has implemented a procedure aligned with issuing a Notice of Concern or Breach to include sending a closure notice (Return to Good Standing letter) to charter schools that have successfully completed the steps to rectify a Notice of Concern or Notice of Breach. This letter is linked and tracked on the same tracker referred to in LDE's response to Recommendation No. 7. In the future, the CA team has plans to update this procedure within the CSPC to ensure the fidelity of use moving forward.

Finding 5: Although LDE has developed a complaint process for charter schools, it needs to better inform parents with students in type 2 or 4 charter schools of this process.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
9. LDE should better inform parents with a child in a type 2 or 4 charter school of its complaint process. For example, LDE could include a page on its website directed to all charter schools, not just type 5 schools.	*Implementation in Progress* As of July 31, 2021, the CA team is revising the webpage where all resources for parents and the general public are listed. Once the revisions to the CA webpage are complete, it will include information for parents at Type 2, 4, and 5 charter schools on the process for having their complaints/concerns resolved at the school and charter board level. This information will also clarify for parents and the general public what types of complaints/concerns are handled by LDE's CA team.
10. LDE should include a field that captures when staff begin investigating complaints and when complaints are resolved.	*Implementation in Progress* As of July 1, 2021, LDE's CA team is instituting a tracking system that captures when staff begin investigating complaints and when those complaints are resolved.

Use of Academic Performance in the Charter School Renewal Process

Louisiana Department of Education

October 18, 2017

LDE is in the process of implementing both recommendations made in the audit.

We evaluated the Louisiana Department of Education's (LDE) use of academic performance in the renewal process for type 2, 4, and 5 charter schools. LDE's process for evaluating charter schools is important because the department is responsible for making a recommendation about each school's renewal to the Board of Elementary and Secondary Education (BESE), which authorizes these types of charter schools. According to state law,[3] in order to be renewed, charter schools must demonstrate improvement in the academic performance of students over the course of the charter school's existence using standardized test scores.

Finding 1: We found that while LDE has some standards for determining whether a charter school should be recommended for renewal, it has not developed specific guidelines that address the primary academic requirement for charter school renewal, as required by state law.

Recommendation	Recommendation Status/Summary of Agency's Response
1. LDE should work with BESE to develop specific rules and regulations that define what constitutes improvement in the academic performance of its students over the term of the charter school's existence, using standardized test scores as an independent metric.	*Implementation in Progress* On October 18, 2017, BESE approved revisions to Bulletin 111 to include, "for purposes of calculating an Elementary/Middle School Progress Index or a High School Progress Index, schools shall be awarded up to 150 points for students scoring Mastery in the current year, but no fewer than 85 points, including for students whose results fall within the 1st to 39th percentiles of the value-added model (VAM)." Standardized test scores are the primary factor in creating an Assessment Index and Progress Index. The Assessment Index (AI) and Progress Index (PI) come together to form the School Performance Score (SPS) which is the measure by which a charter school is renewed. The PI for all schools in Louisiana (including charter schools) considers whether students are growing at a similar rate to their peers. This takes into consideration factors such as students with disability status, discipline, attendance, mobility, and prior year assessment scores. Annually, the PI is monitored (specifically for schools that are due for renewal in the subsequent year) and counts as 25% of the overall SPS score for students in Louisiana schools. The Charter School Performance Compact (CSPC) bases minimum charter renewal terms on the SPS of which 25% is based on the overall student PI.

[3] R.S. 17:3992(A)(2)(a)

Recommendation	Recommendation Status/Summary of Agency's Response
2. LDE should ensure that all charter schools recommended for renewal demonstrate, using standardized test scores, improvement in the academic performance of its students over the term of its existence.	*Implementation in Progress* According to LDE, it has prioritized student progress as the means for measuring a charter school's improvement in academic performance over the course of a charter term. As of July 2020, the current administration has conducted one renewal cycle using BESE Bulletin 126 Policy-outlined renewal standards. Due to the impact of COVID-19, the mandate of annual administration of testing under the Louisiana Education Assessment Program and End of Course examinations, the provisions of La. R.S. 17:10.1 that provide for the School and District Accountability System, and the provisions of La. R.S. 17:391.2, *et seq.*, that provide for public school accountability and assessments was waived for the 2019-2020 school year. October 2020 charter renewal decisions were made using a revised renewal process. As a result, 10 charter schools were renewed during the Fall 2020 renewal cycle, taking into consideration the impact of the COVID-19 mandates. Annually, as part of LDE's charter oversight activities, the agency's accountability team conducts site visits at each charter school that is authorized by BESE. If schools are not meeting the academic standards of the CSPC at that time, the school provides their detailed plans for school improvement to gauge whether the school is "on track" to meeting the academic standards set forth in the renewal standards. According to LDE, the impact of COVID-19 on student's ability to demonstrate progress on standardized assessments in Spring 2021 is still a concern and LDE is actively pursuing alternate means of making renewal decisions that are more "comprehensive" in nature. LDE is in the process of considering revisions to charter renewal that include multiple considerations based on both absolute performance and student growth. Components of this more "comprehensive" approach includes conducting a school-level comparative analysis which includes an analysis of the charter school SPS score, PI, and proficiency levels for student subgroups.

Local Government Bond Issuance Costs

State Bond Commission

July 11, 2018

The Commission has partially implemented or is in the process of implementing two (66.7 %) of three recommendations. One recommendation has not been implemented due to resource limitations but Commission plans to develop a database to track actual bond issuance costs.

We evaluated the State Bond Commission's (Commission) oversight of bond issuance costs for Louisiana local governments. The Louisiana Constitution of 1974 (La. Const. Art. VII § 8) requires that local government entities obtain the Commission's approval before borrowing money for any purpose. The Commission's oversight helps ensure that local governments do not take on more debt than they can afford to repay.

Finding 1: The Commission does not track actual local government issuance costs in an electronic format. Although not required by law or policy, tracking this information would enable Commission staff to more efficiently analyze costs from comparable bond transactions when reviewing a bond issuance application.

Recommendation	Recommendation Status/Summary of Agency's Response
1. The Commission should consider tracking actual bond issuance costs in an electronic format that can be readily analyzed.	*Not Implemented* According to the Commission, it has not been able to implement the recommendation due to resource limitations; however, the Commission does agree that having this could assist local governments. In previous fiscal years, the Commission's budget and cash position have not supported staffing or the replacement of the Commission's database that was created in 1999 to track applications. In fiscal year 2022, the Commission will finally be able to begin Phase 1 of a replacement database. There are multiple phases of the replacement database, with remaining phases incorporating upgrades that anticipate a fully-automated system, including a web-based portal for applicants.
2. The Commission should make information on bond issuance costs available to local governments for their use as a guideline when evaluating proposed fees from bond issuance professionals.	*Partially Implemented* Estimated fees approved by the Commission and actual fees for certain applications requiring amendments have been available on the Commission's website since July 2017. See response for recommendation No. 1.

Finding 2: The Commission could potentially help local governments reduce their borrowing costs by providing resources to help them use competitive bidding to select bond issuance professionals, as recommended by national best practices.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
3. The Commission should consider providing resources for local governments so they can use competitive bidding to select bond issuance professionals, as recommended by national best practices.	*Implementation in Progress* The Commission worked to compile numerous links to local and national organizations and best practices for a Resources section on its website. During the Treasury website conversion, the information was not converted. The Commission is working to have the page available again.

Medical Assistance Programs Fraud Detection Fund

Louisiana Department of Health &
Office of the Louisiana Attorney General
July 25, 2018

LDH has implemented all four recommendations made in the report. The AG is in the process of implementing the one recommendation made in the report.

In 1997, the Louisiana Legislature enacted Louisiana Revised Statute (R.S.) 46:440.1 which established the Medical Assistance Programs Fraud Detection Fund (Medicaid Fraud Fund). The purpose of this fund is to provide financial support to the Louisiana Department of Health (LDH) and the Office of the Louisiana Attorney General (AG) for their efforts related to Medicaid fraud and abuse. Any monies that result from settlements or civil awards related to Medicaid fraud and abuse recovery efforts are required to be deposited into this fund, except for that amount necessary to make Medicaid whole. The audit determined whether LDH and the AG deposited and expended funds from the Medicaid Fraud Fund from fiscal years 2012 through 2017 in accordance with state law.

Louisiana Department of Health

Finding 1: Both LDH and the AG lack an effective process to properly identify and deposit monies into the Medicaid Fraud Fund. As a result, LDH did not deposit approximately $2.8 million, and the AG did not deposit $712,713 into the Medicaid Fraud Fund in fiscal year 2016 in accordance with state law.

Recommendation	Recommendation Status/Summary of Agency's Response
1. LDH should continue to develop and implement clear policies and procedures for the contribution of monies to the Medicaid Fraud Fund.	*Implemented* The Program Integrity section ensured that the proper coding for the Monetary Penalty was included on the memo submitted to Fiscal/Cash Management. Fiscal/Cash Management updated the coding on the Program Integrity voucher form for Monetary Penalty.

Finding 2: LDH incorrectly deposited $323,570 into the Medicaid Fraud Fund in fiscal year 2012 that should have been deposited to the Nursing Home Residents' Trust Fund.

Recommendation	Recommendation Status/Summary of Agency's Response
3. LDH should retroactively transfer the monies from the Medicaid Fraud Fund that should have been designated for the Nursing Home Residents' Trust Fund in fiscal year 2012.	*Implemented* On June 4, 2018, LDH transferred $323,569.56 to the Nursing Home Residents' Trust Fund from the Medicaid Fraud Detection Fund that were posted in error.

Finding 3: LDH spent $477,266 from the Medicaid Fraud Fund in fiscal year 2017 for salaries that do not appear to meet the intended purpose of contributing to the prevention and detection of Medicaid fraud and abuse. In addition, LDH spent $642,593 from the Medicaid Fraud Fund in fiscal year 2012 on software that could not be implemented due to system compatibility issues.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
4. LDH should ensure that job descriptions are current and reflective of the actual work performed by its employees.	*Implemented* LDH reviewed and updated Internal Audit and Legal job descriptions to reflect current job duties.
5. LDH should determine the percentage of each employee's salary that should be funded out of the Medicaid Fraud Fund based on the employee's updated job descriptions.	*Implemented* LDH made determinations of time that staff spent on Medicaid fraud related activities and adjusted the salaries derived from the Medicaid Fraud Fund as appropriate. LDH Legal removed salaries not related to Medicaid fraud, waste, and abuse detection and prevention from the Medicaid Fraud Fund allocation and revised its time allocation form. Internal Audit removed salaries not related to Medicaid fraud, waste, and abuse detection and prevention from the Medicaid Fraud Fund allocation and set up a mechanism to record hours spent on work related to the Medicaid Fraud Fund.

Office of the Louisiana Attorney General

Finding 1: Both LDH and the AG lack an effective process to properly identify and deposit monies into the Medicaid Fraud Fund. As a result, LDH did not deposit approximately $2.8 million, and the AG did not deposit $712,713 into the Medicaid Fraud Fund in fiscal year 2016 in accordance with state law.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
2. The AG should continue to develop a process to ensure that all required funds are properly deposited into the Medicaid Fraud Fund, including the use of case-numbered memos, verification of the accuracy of these memos and the amounts deposited to the Medicaid Fraud Fund, and the development of a database that allows for tracking of state and federal funds.	*Implementation in Progress* The Administrative Services Division implemented and conducts a monthly reconciliation of funds. Memos are provided from the Medicaid Fraud Control Unit (MFCU) to Administrative Services that details how funds are to be deposited and/or forwarded to LDH or other entities where appropriate. Once a month, the MFCU and Administrative Services conduct a review of all deposits to ensure funds were appropriately deposited into the Medicaid Fraud Fund, forwarded to LDH or offset according to federal guidelines. If any discrepancies are noted, entries are completed to correct. Additionally, the MFCU continues to make entries and comments in the case tracking system allowing for more detailed record keeping. These entries assist in identifying funds that were actually received by the MFCU and which funds were received directly by the AG's federal counterparts. A new case tracking system is being implemented and should be live by the end of 2021.

Inventory of State Lands

Office of State Lands, Division of Administration

August 22, 2018

OSL has implemented or is in the process of implementing two (33.3%) of six recommendations. The other four recommendations were not implemented because OSL stated that the cost outweighed the benefit, or they were contingent upon legislation which did not pass or has not yet been introduced.

We evaluated whether the Office of State Lands (OSL) within the Division of Administration (DOA) maintained a current and comprehensive inventory of state lands as required by Louisiana Revised Statute (R.S.) 39:13(A). This law directs the Commissioner of Administration to maintain an inventory of all immovable properties in which the state has an interest, including all lands, water bottoms, and facilities, both owned and leased, and to keep this inventory as "current and comprehensive as is practicable."

Finding 1: OSL's inventory recorded in LaGov and agency records did not match for 58 (45.3%) of the 128 state agency properties we tested due, in part, to agencies not providing accurate information to OSL. In addition, OSL's inventory does not include all types of properties in which the state has an interest.

Recommendation	Recommendation Status/Summary of Agency's Response
1. DOA should implement a process to reconcile each state agency's property records against the inventory of state agency properties recorded in LaGov. In addition, the Commissioner should implement a timetable in which agencies would be required to inform OSL of any changes to properties, such as acquisitions or sales.	*Implemented* OSL prepared a Business Entity/Property Record Reconciliation letter outlining statutory requirements related to the inventory provisions of Title 41 and Title 39 and sent this to all inventoried agencies in April 2019. OSL received a 54% response rate and worked with the responding agencies to update its LaGov inventory records. Going forward, OSL will follow up with agencies who have not responded. With regard to agencies that have many discrepancies, OSL staff held and plan to hold in-person discussions and train agency personnel. OSL stated that while progress has been made on this initiative, it is an ongoing project and plans to send this reconciliation letter annually.
2. OSL should work with the legislature to clarify which type of lands should be included in the official inventory of state lands.	*Not Implemented* OSL stated that it will pursue implementing this recommendation leading up to the 2022 regular session.

Finding 2: OSL does not have an accurate and complete listing of the tax adjudicated properties the state owns; nor is this information easily accessible to stakeholders. This makes it difficult to determine whether the state is receiving all of the mineral royalties on these properties and whether tax adjudicated properties claimed by the state are also being claimed by private individuals.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
3. OSL should ensure that its GIS layer is complete so that the Office of Mineral Resources can use this information to help ensure the state recovers all mineral royalties owed to it from tax adjudicated properties that it sold but to which it retains mineral rights.	*Not Implemented* OSL believes the costs associated with such a project will outweigh the benefits. OSL stated that while it agrees mapping tax adjudicated properties could provide an easily accessible reference tool that could be used to identify potential assets, the office continues to participate in litigation with the Office of Mineral Resources and the Attorney General's office in an effort to identify and assert ownership claims relative to mineral interests owned by the state, which are subject to existing and/or pending exploration activities, which is a more feasible practice in terms of cost/benefit.
4. OSL should work with DOA to create a new GIS layer for tax adjudicated properties that the state possesses so that OMR can use it to help ensure that the state is receiving mineral rights owed to it. As OSL continues to clarify ownership of these properties, it should update this GIS layer based on this information.	*Not Implemented* See response to recommendation No. 3.
5. OSL should work with parish assessor offices and provide them with an electronic listing of the tax adjudicated properties that the state claims in their parishes so that these offices can assist OSL with researching these properties.	*Implementation in Progress* During the COVID-19 pandemic, OSL cross trained and tasked employees in researching tax adjudicated records and contributing efforts to the compilation of a searchable, electronic tax adjudicated properties database so the status of the properties is easily found (i.e., whether redeemed, cancelled, sold, or remain adjudicated to the state). OSL continues to work with localities in reconciling discrepancies through detailed research, followed by issuance of redemption certificates, cancellations of erroneous adjudications and sheriff's auctions of adjudicated properties. Since 2018, OSL has executed 46 cancellations of erroneous adjudications and 22 redemptions.

Finding 3: The state does not have clear title to an estimated 286,467 acres of water bottoms, because private parties also claim ownership of these lands. These "dual-claimed" water bottoms result in restricted public access, negative economic impacts, and reduced revenue generating opportunities.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
6. OSL should work with the legislature and other stakeholders to determine how to best inventory and address issues related to dual-claimed water bottoms.	*Not Implemented* SB 176 and 177 of the 2020 Regular Session and HB 331 and 399 of the 2021 Regular Session attempted to address the issue but none of these passed. OSL worked with the authors of all four bills. OSL has also worked with the Louisiana Sea Grant pursuant to H.R. 178 (2017) and served on the Public Recreation Access Task Force pursuant to S.C.R. 99 (2018), which precipitated the Senate and House legislation attempts.

Management of State Leases & Rights of Way

Office of State Lands, Division of Administration

October 25, 2018

OSL has implemented or is in the process of implementing five (83.3%) of six recommendations. One recommendation has not been implemented because OSL stated that current procedures are adequate but that they are also considering the benefits of new software or a new system.

We evaluated whether the Office of State Lands (OSL) effectively manages leases and rights-of-way on state lands and water bottoms. Louisiana Revised Statute (R.S.) 39:11 directs the Commissioner of Administration to administer and supervise lands and water bottoms owned by the state of Louisiana. OSL, which is within the Division of Administration (DOA), is responsible for the identification, administration, management, and inventorying of public lands and water bottoms. Its mission is to maximize revenues while ensuring continued public utilization of state public lands and water bottoms, and to protect the state's proprietary interests in its lands and water bottoms through the permitting process.

Finding 1: OSL has not established formal rules and regulations on how to issue and manage certain types of leases and rights of way.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
1. OSL should promulgate rules and regulations in the Administrative Code that establishes the criteria for the management of leases and rights of way, including subsurface agreements, rights of way other than for pipelines, and residential water bottom leases.	*Implementation in Progress* While OSL management initially did not agree with this recommendation, OSL stated that it has reassessed and is currently working on drafting rule changes to be promulgated in the Administrative Code addressing agreements such as horizontally-bored oil and gas pipe lines, as well as other types of utilities (underground fiber optic, electric, water, etc.), as well as overhead electric transmission lines, roads/access corridors, etc.
2. OSL should develop criteria in rules and regulations for when fees can be waived for leases and rights of way with a public benefit purpose. In addition, OSL should ensure that lease or right of way agreements specify the public benefit, and ensure there is adequate documentation in its files to support why it issued a lease or right of way without cash compensation.	*Implementation in Progress* OSL is developing criteria regarding when leases and rights of way may be converted to a Cooperative Endeavor Agreement (CEA) in which fees are waived or reduced. In accordance with settled jurisprudence, CEAs are permitted when a public purpose is being served and the state has a reasonable expectation of receiving fair value in return.

Finding 2: OSL does not maintain sufficient and reliable data on properties in its database. As a result, it cannot use data to effectively monitor the state's leases and rights of way.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
3. OSL should develop policies and procedures that guide staff on how information should be recorded in SLIMS.	*Implemented* OSL staff has prepared desk manuals for its leasing, permitting, and right-of-way programs that detail internal guidance policies and procedures on how information should be recorded in the State Land Information Management System (SLIMS), and also presents a comprehensive overview of the responsibilities of these subsections and how to perform them.
4. OSL should work with OTS to address the current limitations of the SLIMS database, including linking necessary tables and adding all necessary fields.	*Not Implemented* Linking tables is not necessary because of current procedures in place within OSL. However, OSL management is looking again at this recommendation, and is considering changes, including the possibility of entirely new software, to identify potential benefits.

Finding 3: OSL has not established sufficient inspection and enforcement processes to identify and address illegally occupied state properties, which can result in lost revenue and increased liabilities to the state.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
5. OSL should determine the cost-effectiveness of hiring more field staff in order to increase inspections of state leases and rights of way that are not renewed or paid on time and to assist in identifying unlawful encroachments on state lands.	*Implemented* OSL has hired two additional engineering technicians for its field crew and converted engineering technician positions to attract better candidates. OSL has completed a mapping initiative relative to active commercial water bottom leases to use in its enforcement initiative to identify unleased encroachments, and to identify current leaseholders encroaching onto space outside of the intended limits of their original leased area. OSL has also increased field inspections to further this initiative.
6. OSL should establish a consistent enforcement process to address issues of noncompliance, including non-payment and continued use of a lease or right of way after it has expired. This process should include establishing timelines on when to cancel a lease, when fines should be implemented, and when cases should be sent to the AG to begin the eviction process.	*Implementation in Progress* OSL is utilizing the enforcement initiatives described in response to recommendation No. 5 to address issues of noncompliance and is working to establish a consistent enforcement process, which is tied to the promulgation of rules and regulations described in response to recommendation No. 1.

Regulation of Child Care Providers

Louisiana Department of Education

October 10, 2018

We evaluated the Department of Education's (LDE) regulation of Louisiana's child care providers. This function was transferred to LDE in October of 2014. We conducted this audit because effective regulation of child care providers is important to ensure the overall safety and well-being of children in Louisiana.

LDE implemented, partially implemented, or is in the process of implementing all 13 recommendations.

Finding 1: Louisiana child care licensing standards do not meet all national best practices related to child-to-staff ratios, group sizes. and oversight of family and in-home providers. For example, Louisiana is one of only eight states that allows family providers to care for more than six children without requiring a license.

Recommendation	Recommendation Status/Summary of Agency's Response
1. LDE should ensure requirements for child-to-staff ratios and group sizes comply with national best practices.	*Partially Implemented* Child-to-Staff Ratios for Centers - Effective July 1, 2021, all center types have the same child-to-staff ratios. Type I centers' child-to-staff ratios were reduced by at least one child. In addition, effective July 1, 2022, child-to-staff ratios for two-year-olds in all center types will be reduced to 10:1. LDOE will continue to monitor the health and safety of children. Child-to-Staff Ratios for Family Home Providers - LDE stated that it continues to follow state statutory law that allows family providers to care for fewer than seven children unrelated to the caregiver without requiring a license. Any revision to this would require a statutory change. Group Sizes - Regulations limiting group sizes became effective in April 2017, but they do not meet the recommended standards of National Association for the Education of Young Children. According to LDE, the COVID-19 Pandemic has brought into focus the importance of child care for the workforce and the economy in Louisiana. Child care providers operate on razor-thin margins. In fact, at the height of the pandemic, 70% of child care centers were closed in Louisiana. Therefore, an additional strain on the business of child care at this time would have negative impacts on child care, the workforce and the economy in Louisiana. Group sizes were reduced per the Louisiana Department of Health and the Office of Public Health mandates during Phase I and II of the COVID-19 public health emergency. LDE stated that it continues to monitor the health and safety of children in care and will recommend changes should the need arise.

Recommendation	Recommendation Status/Summary of Agency's Response
2. LDE should conduct unannounced inspections of family and in-home providers, as recommended by national best practices.	*Implemented* LDE has updated its internal procedures to require at least one announced and one unannounced inspection within a registration year. The Bureau of Licensing Application System (BLAS), the Division of Licensing's data system, was updated to indicate whether an inspection is unannounced or announced.

Finding 2: During fiscal years 2016 through 2017, LDE conducted annual inspections on 91.6% (1,145 of 1250) of licensed providers within 365 days, as required by state law; however, it needs to strengthen its inspection process for family and in-home providers.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
3. LDE should ensure that it conducts required inspections of family and in-home providers.	*Implemented* LDE revised internal procedures to ensure at least one announced and one unannounced inspection is conducted per registration year.
4. LDE should develop policies and procedures regarding if and when employees can cancel inspection requests.	*Implemented* Staff no longer have the option to delete a request from the system, and internal policies have been updated to indicate the actions to take if an error has occurred while generating a request.

Finding 3: LDE does not have an effective process to collect, investigate, and monitor complaints on licensed child care providers, and family and in-home providers. LDE does not centrally track complaints, does not consistently document whether complaints were substantiated, and does not always investigate complaints timely.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
5. LDE should ensure that each complaint is investigated within the timeframe for its assigned priority level.	*Implemented* LDE runs a report from BLAS to ensure all complaints are documented and investigated within the timeframe for its assigned priority.

Recommendation	Recommendation Status/Summary of Agency's Response
6. LDE should follow its policy and investigate complaints using calendar days instead of business days.	*Partially Implemented* LDE changed its procedure *L-502-P, Investigations* to investigate complaints using business days instead of calendar days. **LLA Comment:** While LDE changed its policy to reflect business days rather than calendar days, the change extends the amount of time that agency staff have to investigate priority 1 and priority 2 complaints, and these time frames are higher than what best practices recommend. Prior policy required priority 1 (immediate) complaints to be investigated within five calendar days and priority 2 (urgent) within 10 calendar days. The policy change now potentially extends these timeframes by requiring five business days for priority 1 and 10 business days for priority 2. However, for priority 3 (non-emergencies), LDE adjusted policy from 30 calendar days to 23 business days, which does not extend the time staff has to investigate the complaint. According to LDE, it doesn't have enough staff to investigate all complaints within the timeframes recommended by best practices.
7. LDE should ensure that all complaints are documented and tracked, including when the complaint was received, the time frame for investigating the complaint and outcome of the investigation.	*Implemented* LDE runs a report from BLAS to ensure all complaints are documented and tracked, including when the complaint was received and the timeframe for investigating the complaint. BLAS is updated with the outcome of each investigation.

Finding 4: LDE did not effectively investigate complaints on unlicensed providers that may be operating illegally and did not issue required fines when it found providers operating without a license.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
8. LDE should ensure that all complaints concerning potentially unlicensed providers are investigated timely and in accordance with agency procedures.	*Implemented* LDE created and monitors a spreadsheet with timeframes to ensure all complaints regarding potentially unlicensed providers are investigated timely, according to procedure.

Finding 5: LDE did not always issue enforcement actions to address deficiencies in accordance with state law. We found that 1,702 (99.1%) of 1,718 inspections with at least one deficiency requiring a correction action plan, did not have a formal corrective action plan issued after the inspection.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
9. LDE should ensure deficiencies are addressed in accordance with state law and regulations.	*Implemented* LDE revised Bulletin 137, Section 1105 to change the requirement that corrective actions be issued when certain deficiencies are cited. LDE has discretion to determine when a deficiency warrants a corrective action plan. This change aligns LDE rules with state law (R.S. 17:407.46).
10. LDE should develop more specific corrective action plans for providers with the deficiencies outlined in law that include specific steps providers should take to correct deficiencies.	*Implemented* According to LDE, its process has not changed much since the time of the audit. In some cases, LDE determines that a provider needs a formal corrective action plan and LDE still provides providers with a statement of deficiencies after each inspection. However, providers must now give LDE a response that details how they will prevent that deficiency from happening again. This applies to all deficiencies cited. In addition, 10% of all specialists' work is reviewed to ensure that all deficiencies include a specific action plan.

Finding 6: LDE does not have criteria regarding when to conduct follow-up inspections to verify that deficiencies identified during complaint investigations or inspections have been corrected. As a result, some providers with the same deficiencies had follow-up inspections, while others did not.	
Recommendation	**Recommendations Status/Summary of Agency's Response**
11. LDE should develop procedures that outline what kinds of deficiencies warrant a follow-up inspection.	*Implemented* LDE has revised procedure *L- 701-P, Licensing Inspection Review*, that outlines deficiencies that warrant a follow-up inspection.

Finding 7: LDE did not ensure that its child care provider website contained all information required by law. Incomplete information on inspections and deficiencies prevents parents from making informed decisions when selecting child care providers.	
Recommendation	**Recommendations Status/Summary of Agency's Response**
12. LDE should ensure that information on all inspections with deficiencies are easily accessible for parents.	*Implemented* LDE resolved a system issue. Parents can access all monitoring online at no cost.
13. LDE should ensure that instances of serious injury, death, and substantiated child abuse are clearly indicated on its website and are linked to the associated providers, as required by federal law.	*Implemented* LDE has ensured that instances of serious injuries, deaths, and substantiated child abuse are clearly indicated on the website. Serious injuries and deaths caused by center staff are linked on the appropriate provider's webpage.

Oversight of Surveillance and Utilization Review Subsystem (SURS) – Medicaid Program Integrity Activities

Louisiana Department of Health

December 5, 2018

LDH implemented or is in the process of implementing six (85.7%) of seven recommendations. LDH has not had the opportunity to implement the other recommendation because it has not settled any cases since the audit.

We evaluated the Louisiana Department of Health's (LDH) oversight over the Surveillance and Utilization Review Subsystem's (SURS) program integrity activities. As a result of Act 420 of the 2017 Regular Session that established the Task Force on Medicaid Fraud Detection, we conducted this audit to develop recommendations related to Medicaid program integrity functions within LDH and for optimization of data mining for Medicaid fraud detection and prevention.

Finding 1: The system SURS uses to track improper payments does not contain accurate or complete information on cases. The database does not include the actual amount of the improper payment identified and does not always provide a description of the violation.

Recommendation	Recommendation Status/Summary of Agency's Response
1. LDH should require that Molina/SURS develop a separate field to track settlement amounts and ensure that the SURS case tracking system includes the actual identified amount.	*Implemented* A "settlement field" was added to the SURS Database.
2. LDH should establish more specific categories for "Case Issues" and ensure that Molina/SURS populate the "Case Issue" field, which would provide information that could be used in planning future program integrity activities.	*Implemented* If a case is associated with a project, the project title field is populated in the SURS Database. Additionally, if the case involves a complaint, the hotline number field from the FACTS Complaint Database is populated in the SURS Database. In addition, the complaint number in the SURS Database can be cross-referenced with the FACTS Complaint Database which contains all of the information relating to the case opening. The Program Integrity section is in the process of implementing a new case management system which LDH estimates will be operational by end of fiscal year 2022. LDH stated that once implemented the new system will further establish categories which will be used in planning future program activities.

Finding 2: Since managed care began on February 1, 2012, SURS cases have focused primarily on improper payments in fee for service claims, even though 85.0% of Medicaid recipients and 71.0% of expenditures were for managed care in fiscal year 2017. SURS could strengthen its identification of improper payments in managed care by analyzing data across all Managed Care Organizations (MCOs), such as identifying providers who bill for more than 15 hours a day, which may indicate providers are billing for services not actually provided.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
3. LDH should require that SURS increase its analysis of managed care encounter data.	*Implemented* LDH has created an Internal SURS unit to increase fraud, waste and abuse efforts. For example, Program Integrity and Behavioral Health program staff developed a process where service providers are identified when they bill more than 12 hours of Community Psychiatric Support & Treatment and Psychosocial Rehabilitation services within a 24-hour period. If the service provider hours billed are occurring in a single MCO, Behavioral Health Program sends the data to that MCO for review. If the hours billed by the service provider exceeds the limit and is across multiple MCOs, Program Integrity handles the reviews. The Program Integrity section is in the process of sharing with the MCOs high level data of audits, exclusions, complaints, etc. captured in Tableau software. The information in Tableau will provide the MCOs with a global view of fraud, waste and abuse audits of service providers across Plans. According to LDH, the Program Integrity section has increased MCO provider audits from 31 closed in fiscal year 2016 to an average of 385 closed each of the last four fiscal years. In addition, Program Integrity has implemented a Managed Care Organization-Special Investigations Unit (MCO-SIU) Dashboard using Tableau software where MCO-SIUs can view across all MCO's and Fee-for-Service complaints, open and closed audits and a five-year historical claims/encounter data.

Finding 3: The amount of improper payments identified by SURS has decreased in part due to revisions to the Molina contract that reduced the number of cases SURS is required to close each year, and the loss of the Recovery Audit Contractor.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
4. LDH should prioritize its data analytics activities based on risk and the results of its return on investment analysis. Developing these priorities into a formal plan that outlines who is responsible for what types of analysis may help improve coordination.	*Implementation in Progress* LDH's Program Integrity section develops an Audit Plan for the state fiscal year and has regular meetings with different stakeholders to discuss case issues and data mining efforts. As a part of LDH's Business Initiatives, the Program Integrity section will be meeting with LDH program staff, MCOs, Medicaid Fraud Control Unit, Gainwell-SURS, etc. to develop algorithms for high-risk provider types. These initiatives were started in calendar year 2021. Program Integrity is in the process of obtaining a robust case management and predictive analytics system. The predictive analytics portion of the system will guide Program Integrity in identifying high-risk providers. The implementation date for this initiative is to be determined.

Finding 4: LDH settled with providers in 11 (36.7%) of 30 improper payment cases we reviewed from fiscal year 2012 through 2017 for $321,729 less than the original identified improper payment amounts without documentation justifying the reduction. Of the 11 settled cases, two (18.2%) were settled for less than the Federal Financial Participation (FFP, or federal share), resulting in LDH having to use state funds to pay back the federal government.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
5. LDH should develop criteria to use when settling cases that outline how it will ensure that the settled amount covers the estimated losses to Medicaid.	*Implemented* Program Integrity created a policy for settlements.
6. LDH should develop a standard format to ensure that memos sent to LDH financial includes the actual identified improper payment so the correct FFP can be calculated.	*Implemented* Program Integrity created a policy for settlements and has a field in the SURS Database to track settlements. The policy and new field are used to ensure the correct amount is identified and sent to LDH Fiscal.
7. LDH should review case files to ensure it correctly calculated the FFP on cases involving settlements.	*Other* Program Integrity has not settled any improper payment cases since this audit was completed.

Evaluation of Louisiana's Framework for Preventing and Addressing Elder Financial Exploitation

State of Louisiana

January 23, 2019

DOJ implemented all three recommendations and LDVA implemented both of their recommendations. GOEA has implemented or is in the process of implementing three (42.8%) of seven recommendations. GOEA did not implement two recommendations because they are waiting on a new data system and for two recommendations we were unable to determine because of insufficient documentation submitted. LDH has implemented or is in the process of implementing both recommendations.

We evaluated whether Louisiana has a sufficient framework to prevent and address cases of elder financial exploitation. Elder financial exploitation (EFE) is a form of elder abuse where a person, such as a family member, paid caregiver, financial adviser, or stranger, misuses or takes the assets of an elder for their own personal benefit without the elder's consent. In Louisiana, multiple state agencies receive, investigate, and refer cases of elder financial exploitation, and each agency plays a different role.

Department of Justice (DOJ)

Finding 1: Louisiana's framework for addressing elder financial exploitation is fragmented, and state agencies do not always coordinate their efforts to address elder financial exploitation cases. As a result, elders may have difficulty receiving the help they need.

Recommendation	Recommendation Status/Summary of Agency's Response
1. The DOJ's Consumer Protection Section (CPS) should work with the FTC to develop an electronic process for sharing consumer complaints, including scams, to the FTC's Consumer Sentinel Network.	*Implemented* In November 2018, DOJ's CPS and DOJ IT personnel spoke to FTC's Consumer Sentinel staff and developed an electronic process for sharing consumer complaints. The DOJ used SQL server reporting services to generate a report from DOJ's CPS's consumer dispute database, which was transferred to Consumer Sentinel. CPS staff sends these reports monthly to Consumer Sentinel staff.
2. The DOJ's Consumer Protection Section should work with GOEA's EPS to determine when it would be appropriate to refer scam cases.	*Implemented* In March 2019, DOJ's CPS met with GOEA's Elder Protective Services (EPS) concerning EFE cases. Based on this meeting, CPS refers scam cases to EPS that contain allegations of EFE in a community setting when the elder needs services.

Finding 3: State agencies estimated that they received approximately 1,730 cases of elder financial exploitation during fiscal year 2017 and 2,175 cases in fiscal year 2018. However, some agencies are not collecting sufficient or reliable data which limits the state's ability to accurately determine the extent to which elder financial exploitation exists in Louisiana.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
8. DOJ's CPS should develop and assign consistent categories for the complaints it receives similar to the FTC's product codes and categories, so it can use this data when providing education to the public.	*Implemented* In March 2018, DOJ's CPS initiated the process of making changes to DOJ's CPS's consumer dispute database, which included updating the categories for the complaints it receives to be consistent and similar to the FTC's categories. The categories were updated on November 28, 2018.

Governor's Office of Elderly Affairs (GOEA)

Finding 1: Louisiana's framework for addressing elder financial exploitation is fragmented, and state agencies do not always coordinate their efforts to address elder financial exploitation cases. As a result, elders may have difficulty receiving the help they need.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
3. GOEA's Long-Term Care Ombudsman should refer elder financial exploitation cases to EPS for further investigation when the resident is unable to communicate consent, and the Ombudsman has reasonable cause to believe the resident's health, safety, welfare, or rights may be adversely affected. For other cases, it should offer the residents the option of referring the case to EPS.	*Implemented* The Ombudsman Program and GOEA entered into a Memorandum of Understanding in which the Ombudsman will refer all financial exploitation cases to EPS when a resident is unable to communicate consent. The State Ombudsman also notified regional ombudsmen to document in their case notes that they did offer a resident the option of referring a case to EPS.

Finding 2: Increased coordination with local law enforcement is needed as agencies did not always refer elder financial exploitation cases. As a result, perpetrators may not have been held accountable for criminal activity.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
4. GOEA's EPS should ensure that workers follow existing policies regarding law enforcement referrals of "substantiated" and "unable to locate" cases.	*Cannot Determine* According to GOEA, certain conditions must all be true in order to close a case with a non-finding. GOEA also stated that EPS Regional Supervisors and Management conduct routine case reviews to ensure appropriate referrals to law enforcement are made. **LLA Comment:** Based on the information GOEA provided, we could not determine whether this recommendation was implemented. We are planning to conduct a full follow-up of the EPS program within GOEA.
5. GOEA's EPS should clarify its policies regarding referrals of rejected and deceased cases to ensure that law enforcement is alerted to elder financial exploitation cases when appropriate.	*Cannot Determine* According to GOEA, EPS policies and procedures have been reviewed and are currently being revised in accordance with state and federal guidance. GOEA also stated that EPS regional supervisors and management conduct routine case reviews to ensure appropriate referrals and alerts are made appropriately. **LLA Comment:** Based on the information GOEA provided, we could not determine whether this recommendation was implemented. We are planning to conduct a full follow-up of the EPS program within GOEA.

Finding 3: State agencies estimated that they received approximately 1,730 cases of elder financial exploitation during fiscal year 2017 and 2,175 cases in fiscal year 2018. However, some agencies are not collecting sufficient or reliable data which limits the state's ability to accurately determine the extent to which elder financial exploitation exists in Louisiana.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
9. GOEA's Long-term Care Ombudsman should develop a report that could be pulled to ensure potential elder financial exploitation is referred when appropriate.	*Implemented* In the Louisiana Ombudsman Reporting System, when an Ombudsman refers a case to EPS/APS, it is captured in the case record. A NORS (National Ombudsman Reporting System) Code Summary Report can be extracted to view how many cases were referred to EPS/APS.

Recommendation	Recommendation Status/Summary of Agency's Response
10. GOEA's EPS should collect more detailed data that shows the accurate number of cases involving elder financial exploitation, whether each allegation in a case was substantiated, and whether or not substantiated cases were referred to law enforcement.	*Not Implemented* According to GOEA, the EPS management system is currently being revised by Office of Technology Services (OTS) through grant funding from the Administration for Community Living. Project begin date was April 1, 2021, to be completed by September 30, 2022.

Finding 4: Improved public awareness and increased training for local law enforcement, district attorneys, and parish Councils on Aging could help Louisiana better identify and address elder financial exploitation cases.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
13. GOEA's Elder Protective Services should use its reporter data to determine where to target its training and public awareness efforts.	*Not Implemented* According to GOEA, the EPS management system is currently being revised by OTS through grant funding from the Administration for Community Living. Project begin date was April 1, 2021, to be completed by September 30, 2022.
14. GOEA's Elder Protective Services should develop training for staff at each of the parish COAs to help them recognize elder financial exploitation.	*Implementation in Progress* EPS provides training one elder abuse, including elder financial exploitation. In efforts to improve the referral system for financial exploitation, GOEA/EPS has received grant funding to develop and provide training for EPS staff, financial institutions, law enforcement, court staff and the general public on elder abuse. EPS management has recently provided training, including to Louisiana Council on Aging directors.

Louisiana Department of Health (LDH)

Finding 2: Increased coordination with local law enforcement is needed as agencies did not always refer elder financial exploitation cases. As a result, perpetrators may not have been held accountable for criminal activity.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
7. LDH's Health Standards Section (HSS) should work with law enforcement to develop policies on when it would be appropriate to refer cases to law enforcement.	*Implemented* The LDH SIMS reporting system is available to all law enforcement agencies to review allegations of exploitation. There were multiple law enforcement agencies that had not updated their access to the SIMS system in order to access this data. Staff were dedicated to contact these agencies, explain the need for this process, and ensure they had correct contacts to access this data. HSS policy for referrals was also reviewed, implemented and updated in both 2019 and early 2021.

Finding 3: State agencies estimated that they received approximately 1,730 cases of elder financial exploitation during fiscal year 2017 and 2,175 cases in fiscal year 2018. However, some agencies are not collecting sufficient or reliable data which limits the state's ability to accurately determine the extent to which elder financial exploitation exists in Louisiana.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
11. LDH's Health Standards Section should review Nursing Home Incident data to identify nursing homes that have not reported cases for long periods of time and follow up during its survey process.	*Implementation in Progress* In August 2021, LDH began running monthly reports to identify nursing facilities that haven't reported any suspected incidents of abuse, neglect, misappropriation of property/funds, and suspicious deaths within the last six months. LDH staff send written communication to the identified facilities advising them of the non-reporting. LDH created a policy for this process which became effective November 15, 2021. LDH also stated that it will continue to review non-reporting by nursing facilities during its regular survey/inspection process.

Louisiana Department of Veterans Affairs (LDVA)

Finding 2: Increased coordination with local law enforcement is needed as agencies did not always refer elder financial exploitation cases. As a result, perpetrators may not have been held accountable for criminal activity.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
6. LDVA should work with law enforcement to develop policies on when it would be appropriate to refer cases to law enforcement.	*Implemented* LDVA updated its policy on the Abuse, Neglect, and Misappropriation of Resident Property Prevention Program in July 2018. Any suspicion of theft or loss concerns of a resident's property valued at more than $500 requires a Board of Investigation be appointed to review the incident and investigate. LDVA chose the $500 breakpoint because this is a standard line often drawn in Louisiana's Criminal Code between misdemeanors and felonies. Facility administrators work closely with the residents and families (and law enforcement) in determining whether the family wants to file a police report or not. According to LDVA, this system has worked well in resolving questions of theft/loss.

Finding 3: State agencies estimated that they received approximately 1,730 cases of elder financial exploitation during fiscal year 2017 and 2,175 cases in fiscal year 2018. However, some agencies are not collecting sufficient or reliable data which limits the state's ability to accurately determine the extent to which elder financial exploitation exists in Louisiana.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
12. LDVA should monitor the number of grievances reported by its veteran homes to identify homes that have not reported cases for long periods of time and follow up with the homes.	*Implemented* LDVA's Registered Nurse (RN) Compliance Officer monitors LDVA veterans home grievances reported on a monthly basis. Each grievance is monitored and evaluated for appropriate response to the grievance, documentation, and complete resolution of the grievance that is satisfactory to the resident, and the resident's family or responsible party. The RN Compliance Officer then reviews these reports with the Deputy Assistant Secretary over veteran homes monthly as well. When there are no grievances documented for the month, the facility administrator or assistant administrator is contacted by the RN Compliance Officer to ensure that there are in fact no grievances for that month.

Oversight of Pharmacy Benefit Manager

Office of Group Benefits

February 6, 2019

OGB implemented or is in the process of implementing five (41.6%) of 12 recommendations. The remaining seven recommendations were not implemented because OGB stated these recommendations were not applicable to them. Many of these were based on best practices in the regulation and monitoring of PBMs in order to control costs and improve patient outcomes.

We evaluated whether the Office of Group Benefits (OGB) effectively monitored its Pharmacy Benefit Manager (PBM), MedImpact[4], to ensure compliance with contract requirements. OGB contracts with its PBM to administer the prescription drug benefits associated with its health plans. The PBM is responsible for processing and paying prescription drug claims, negotiating prices and rebates for medications with drug manufacturers, and contracting with pharmacies to fill prescriptions. The PBM also provides additional services to assist OGB in managing the cost of the prescription plan and ensuring quality of care for plan members. According to the contract, OGB is responsible for oversight of the PBM's services to ensure quality, efficiency, and effectiveness in fulfilling the goals and objectives of OGB.

Finding 1: OGB has not ensured that MedImpact remits rebate payments timely, as required by the contract. As a result, OGB did not earn approximately $119,257 in interest revenue and did not assess approximately $85,000 in penalties to MedImpact for late payments for rebates earned during calendar year 2017.

Recommendation	Recommendation Status/Summary of Agency's Response
1. OGB should ensure MedImpact submits rebate payments in accordance with its contract.	*Implementation in Progress* Since February 2019, seven of the nine commercial plan rebates were issued within 180 days following the end of the associated quarter. Commercial plan rebates for the first and second quarters of 2020 were wired to the Division of Administration's Office of Finance and Support Services on October 13, 2020 (196 days after the first quarter close), and December 30, 2020 (183 days after the second quarter close), respectively. To ensure that the timely submissions of rebates are monitored, the contract monitoring procedures for the 2021 MedImpact emergency contract were updated to include monitoring of the submission dates of the Commercial plan rebates.

[4] Effective January 1, 2022, Express Scripts will be OGB's Pharmacy Benefit Manager.

Recommendation	Recommendation Status/Summary of Agency's Response
2. OGB should penalize MedImpact for late rebate payments.	*Implementation in Progress* On August 10, 2021, OGB notified MedImpact of the $65,981 performance guarantee penalty resulting from two Commercial plan rebates not being issued within 180 days following the end of the associated quarter.
3. OGB should develop a process to ensure MedImpact is submitting 100% of rebates received from drug manufacturers.	*Implemented* OGB utilizes its contracted actuarial services vendor to perform annual claims and rebate audits of its PBM services vendor. Audits for plan years 2016 and 2018 were completed, and MedImpact issued payment for errors found in the 2016 audit. OGB has not yet requested payments for errors found in the 2018 audit. OGB stated that audit for the 2019 plan year was started in August 2021, and audits for 2017 and 2020 plan years will be conducted afterwards.

Finding 2: OGB has not ensured that MedImpact complies with contract terms related to mail-order pricing. As a result, OGB overpaid $89,553 for mail-order prescriptions filled from January 2017 through October 2018 because MedImpact charged a minimum price for them, which is prohibited by the contract.

Recommendation	Recommendation Status/Summary of Agency's Response
4. OGB should ensure that MedImpact prices mail-order prescriptions accurately.	*Implemented* OGB stated that MedImpact corrected their internal systems to discontinue the assessment of a minimum charge on mail order prescription drug claims. Additionally, a recently completed audit of OGB's Commercial Plan prescription drug claims for plan year 2018 found that MedImpact achieved a discount rate of 24.3% on mail order brand prescription drugs and 88.1% on mail order generic prescription drugs, which exceeded the 24.0% and 84.3% discount guarantees (respectively) provided for in the MedImpact contract for plan year 2018.
5. OGB should ensure that MedImpact calculated the amount owed to OGB correctly due to charging a minimum for mail-order drugs.	*Implemented* The $89,553.42 in overpayments by OGB as calculated by MedImpact is correct. MedImpact issued a check to OGB for $89,553.42, which was delivered on May 8, 2019.

Finding 3: OGB has not ensured that MedImpact reports accurate adherence rates for specialty medications. According to healthcare literature, adherence to medications helps control healthcare costs and improves patient outcomes. In addition, OGB could expand adherence rate requirements to include additional medical conditions that require specialty drugs to further help control costs and improve patient outcomes.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
6. OGB should monitor whether MedImpact achieves minimum adherence rates for patients who obtain specialty drugs, as required in the contract.	*Not Implemented* OGB disagreed that finding No. 3 and the resulting recommendation No. 6 should have been included in the audit, and indicated the recommendation status as *Not Applicable*. **LLA Comment:** The LLA issued Finding No. 3 and recommendation No. 6 in the 2019 audit because we found that OGB did not monitor or verify the accuracy of minimum adherence rates. Monitoring and verifying adherence rates that the PBM submits is important because patient adherence rates for expensive specialty drugs keeps costs down and achieve positive patient outcomes. While MedImpact did achieve all required adherence rates, this does not relieve OGB of its responsibility to monitor its PBM.
7. OGB should consider expanding adherence requirements to all pharmacies that fill prescriptions for specialty medications for Hepatitis C, Rheumatoid Arthritis, and Multiple Sclerosis, and not just the adherence rates from US BioServices.	*Not Implemented* OGB indicated the recommendation status as *Not Applicable* because the 2019 audit noted no discrepancies between the requirements of the 2017–2020 MedImpact contract (and associated contract amendments) for PBM services and the reporting on specialty drug adherence rates provided to OGB by MedImpact. **LLA Comment:** This recommendation was based on best practices that states can use to control costs and improve patient outcomes.
8. OGB should consider expanding adherence requirements to the other 22 medical conditions that require specialty drugs to help control the costs of specialty drugs.	*Not Implemented* OGB indicated the recommendation status as *Not Applicable* because the 2019 audit report noted no discrepancies between the requirements of the 2017–2020 MedImpact contract (and associated contract amendments) for PBM services and the reporting on specialty drug adherence rates provided to OGB by MedImpact. **LLA Comment:** This recommendation was based on best practices that states can use to control costs and improve patient outcomes.

Finding 4: OGB relies on MedImpact to self-report performance guarantees it does not meet and to pay any associated penalties, but OGB does not verify the accuracy of information reported by MedImpact. As a result, OGB cannot ensure that MedImpact is meeting all performance guarantees and paying all performance penalties.	
Recommendation	**Recommendation Status/ Summary of Agency's Response**
9. As part of its ongoing monitoring, OGB should ensure MedImpact is accurately reporting performance guarantee measures.	*Not Implemented* OGB indicated the status of this recommendation as *Not Applicable* because the LLA's 2019 performance audit report noted no discrepancies between the requirements of the 2017–2020 MedImpact contract (and associated contract amendments) for PBM services and the accuracy of the performance guarantee data being reported to OGB by MedImpact. **LLA Comment:** In the 2019 audit report, the LLA found OGB relied on MedImpact to self-report the performance guarantees it does not meet and pay the associated penalties, and the LLA did identify errors in the performance guarantee reports submitted by MedImpact. Without verifying the accuracy of these reports, OGB cannot effectively monitor MedImpact and ensure that it is meeting performance guarantees and paying any applicable penalties.
10. OGB should ensure that MedImpact remits 100% of recoupments from pharmacy audits it conducts.	*Not Implemented* OGB indicated the status of this recommendation as *Not Applicable* because the LLA's 2019 performance audit report noted no discrepancies between the requirements of the 2017 – 2020 MedImpact contract (and associated contract amendments) for PBM services and the amount of recoupments MedImpact provided to OGB as a result of pharmacy audits. **LLA Comment:** In the 2019 audit report, the LLA found that OGB relied on MedImpact to report the amount of pharmacy audit recoupments it received from pharmacies. OGB cannot effectively monitor MedImpact when it relies solely on self-reporting by the contractor, because there is a risk OGB is not receiving all recoupments.

Finding 5: OGB has not ensured that MedImpact charges OGB the same price it pays the pharmacy for prescription drug claims, as required by the contract, and does not ensure MedImpact complies with the formulary that outlines what drugs are covered.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
11. OGB should monitor MedImpact to ensure that spread pricing does not occur.	*Not Implemented* OGB indicated the status of this recommendation as *Not Applicable* because LLA's 2019 performance audit report noted no discrepancies between the requirements of the 2017–2020 MedImpact contract (and associated contract amendments) for PBM services in relation to the amounts MedImpact reimburses pharmacies for claims and the amounts it charges OGB for the same claims. Neither the 2017–2020 MedImpact contract nor the 2021 MedImpact emergency contract allow for spread pricing. **LLA Comment:** In the 2019 audit report, the LLA found that OGB had not developed a process to ensure it did not overpay for prescriptions and included recommendation No. 11 to address this issue.
12. OGB should monitor to ensure MedImpact only approved medications listed on the formulary.	*Not Implemented* OGB indicated the status of this recommendation as *Not Applicable* because LLA's 2019 performance audit report noted no discrepancies between the requirements of the 2017–2020 MedImpact contract (and associated contract amendments) for PBM services, including the established prescription drug formularies, and the pharmacy claims paid by OGB to MedImpact. **LLA Comment:** In the 2019 audit report, the LLA found that OGB did not test claims data to potentially identify any drugs approved by MedImpact that were not on the formulary, and included recommendation No. 12 to address this issue.

Prison Enterprises – Evaluation of Operations

Department of Public Safety and Corrections

May 1, 2019

PE implemented, partially implemented or is in the process of implementing 14 (93.3%) of 15 recommendations. PE has not implemented one recommendation because it stated it was not directly applicable.

We evaluated Prison Enterprises' (PE) overall operations, including whether it met its statutory purposes. PE is an ancillary agency within the Department of Public Safety and Corrections (DOC). The mission of PE is to lower the costs of incarceration by providing productive job opportunities to offenders while producing quality products and services for sale to state and local governments, non-profit organizations, political subdivisions, and others. PE produces various products, such as garment items, furniture, and license plates, and provides canteen items to state correctional facilities and janitorial services to state buildings.

Finding 3: PE met its third statutory purpose of providing work opportunities for offenders. However, this statutory purpose does not align with other states and best practices that recommend correctional industries teach transferable job skills to help offenders get jobs after release. Currently, 39.2% of offenders in PE are serving life sentences, and 32.5% of PE offenders are working in fields that LWC has projected to have a decrease in future employment.

Recommendation	Recommendation Status/Summary of Agency's Response
1. PE should work with Department of Corrections' Office of Reentry Services to better coordinate work opportunities in PE industries with those in the current job market to enhance offenders' successful reintegration into their communities.	*Implementation in Progress* According to PE, it continues to work in collaboration with DOC's Office of Reentry Services by offering soft skills training learned in the classroom through reentry programming and applying those skills to work performance. Offenders in PE programs continue to acquire valuable and relevant skills relating to the processes of production, manufacturing, assembly line production, warehousing, etc. Additionally, PE has implemented and expanded its apprenticeship programs where offenders can earn nationally recognized certifications in both the welding and cabinet making trades. These transferrable skills demonstrate that offenders participating in PE's programs are attributed to lowering recidivism rates. PE continues to explore opportunities to achieve its mission.
2. PE should continue to actively seek businesses to partner with and to again participate in the PIE program and provide offenders with work opportunities that are relevant to the job market and pay higher wages.	*Implementation in Progress* According to PE, it continues to actively seek businesses to partner with and will participate in a PE program should a viable opportunity become available.

Finding 4: During fiscal years 1996 through 2018, PE's expenses exceeded its revenues, and PE used more cash than it generated in 11 (47.8%) of the 23 fiscal years. In addition, operations such as silk screen, printing, and corn and cotton production were not profitable at all during fiscal years 2016 through 2018. Because best practices recommend that correctional industries be financially sustainable and maintain positive cash flow in order to ensure long-term viability, PE should document its evaluation of the profitability of each operation and limit non-essential expenditures that affect its financial sustainability.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
3. PE should document how its review of forecasts, financial statements, updated product structures, and other financial information impacts management's decisions concerning financial sustainability.	*Implementation in Progress* According to PE, its staff will continue to produce, analyze, and document its financial position to further enhance its overall financial sustainability by reviewing the following on a weekly, monthly and/or quarterly basis: financial statements, producing labor projections, inventory requirements, overhead expenses, cash flow projections and adhering to PE's three-year business plan.
4. PE should consider limiting non-essential spending on food and other items for offenders and staff.	*Implementation in Progress* According to PE, it continues to monitor and limit non-essential expenditures to ensure financial sustainability through the evaluation of performance and productivity.

Finding 5: PE did not comply with its pricing policy for some manufactured items during fiscal years 2016 through 2018. As a result, PE overcharged customers by at least $55,306 and undercharged customers by at least $81,947 for items whose prices should have been fixed based on PE's statewide contract. In addition, unlike other states, both PE and DOC markup wholesale prices for canteen items.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
5. PE should document the reasons for the deviations from the statewide contract prices to ensure that PE charges customers consistent prices. In addition, PE should document the reasons for charging customers prices that deviate from the pricing model as well as who authorized any deviations so that these changes can be monitored and analyzed for reasonableness.	*Partially Implemented* PE documents specified deviations from the pricing model, as reflected in the price of the products it sells. Due to the thousands of items sold throughout a year, it would be difficult to document to the degree that is being recommended since every situation is different and the pricing model is used as a guide and not a unilateral calculation.

Recommendation	Recommendation Status/Summary of Agency's Response
6. PE should require staff to periodically review its statewide contract prices posted on the Office of State Procurement's (OSP) website for accuracy so that it can ensure that customers are charged correct prices.	*Implementation in Progress* PE staff continuously confer with OSP to ensure correct pricing is reflected on the state contract. Also, PE staff continuously verifies the accuracy of pricing both within its internal system, as well as OSP's published state contract.

Finding 6: PE has not developed a comprehensive marketing plan that describes how it will promote its products and services, as recommended by best practices. In addition, PE does not have a process for tracking whether the approximately $117,000 spent on marketing efforts during fiscal years 2016 through 2018 generated a financial benefit that is proportionate to the costs, as required by policy.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
7. PE should develop a comprehensive marketing plan that includes factors such as goals and direction for attainable future marketing efforts; clear, realistic, and measurable targets; deadlines for meeting those targets; and a budget for all marketing activities.	*Implemented* In October 2019, PE revised and developed a new enhanced marketing plan to address and include the recommendations listed.
8. PE should require staff to document customers attending and reasons for attending each conference; track the quantity of promotional items and product samples given away, to whom they are given, and for what purpose; and track whether the public benefit was proportionate to the cost and whether future sales were generated.	*Partially Implemented* According to PE, it will continue to monitor the public benefit of marketing efforts in place and ensure the expenses of those efforts are comparable to the associated benefit. PE continues to document customers attending conferences, where possible, and monitors the quantity of promotional items provided at an event. However, to track these efforts to the degree of this recommendation would not align with industry standards and require substantial investment in staff and resources that could potentially create inefficiency within our marketing department.
9. PE should bill customers for all services and products provided to ensure compliance with R.S. 15:1157 and Article VII, §14 of the Louisiana Constitution.	*Implementation in Progress* According to PE, it continues to bill customers appropriately and comply with all applicable laws.

Finding 7: PE does not ensure that all complaints are logged and resolved timely and has not developed an effective process to ensure that orders are delivered on time. According to best practices, good customer service is important because it directly impacts sales; however, the number of PE complaints increased by 121.2% between fiscal years 2016 and 2018, and late deliveries increased from 30.7% to 40.3%.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
10. PE should ensure its complaints process includes (1) how customers should file complaints, (2) which PE staff are responsible for resolving complaints and within what timeframe, (3) a requirement that all complaints be logged, and (4) how each type of complaint should be resolved.	*Implemented* PE revised its policy, *PE-I-25* relative to "Customer Complaints" on 9/27/2019 to include the recommendations referenced herein.
11. PE should categorize complaints to provide feedback to staff and ensure that staff collects all required information in order to use complaints data to identify and address ongoing performance issues.	*Implemented* PE has developed a customer complaints process, as outlined in the revised policy, *PE-I-25*, "Customer Complaints" to ensure that appropriate staff is collecting suitable data relating to the customer complaint and addressing identified concerns as necessary. The status of each complaint is tracked documenting progress as well as completion.
12. PE should track all costs of complaints, including transportation costs, in order to measure customer service and industry performance as required by PE policy.	*Implemented* According to PE, it tracks all costs of complaints, including transportation costs, where applicable.
13. PE should analyze delivery times based on the actual delivery dates to determine if orders are on time.	*Partially Implemented* According to PE, it continues to analyze the feasibility of implementing systems or processes that will further enhance the tracking of on-time deliveries.
14. PE should develop a formal complaints policy for its wholesale operations to help ensure that it addresses all complaints and resolves all issues.	*Not Implemented* According to PE, it will continue addressing all complaints and resolving issues within its wholesale operation. PE stated that its wholesale operations distribute items that are not directly related to a manufacturing process; therefore, the purpose of the formal complaints process to enhance the manufacturing processes are not directly applicable.

Recommendation	Recommendation Status/Summary of Agency's Response
15. PE should develop and administer a formal survey to assess customer satisfaction with its products and services.	*Implemented* PE developed and implemented a formal customer satisfaction survey via email/website and the analysis is conducted on a quarterly basis. PE stated that feedback is shared with appropriate PE staff and suggestions are addressed as appropriate.

Regulation of the Medical Profession

Louisiana State Board of Medical Examiners

May 15, 2019

LSBME has implemented or is in the process of implementing 10 recommendations, can only partially implement one recommendation, and has been unable to implement one recommendation due to the COVID-19 public health emergency.

We evaluated whether the Louisiana State Board of Medical Examiners (LSBME or Board) effectively regulated the medical profession during fiscal years 2015 through 2017 to ensure compliance with the Louisiana Medical Practice Act and various other healthcare practice acts (Practice Acts). The purpose of Practice Acts is to protect the public against the unprofessional, improper, and unauthorized practice of medicine. Under Title 37 of the Louisiana Revised Statutes, LSBME is required to regulate 14 categories of medical professions, including physicians, clinical lab personnel, respiratory therapists, and occupational therapists.

Finding 1: LSBME has not developed formal guidance, such as an enforcement guide, to help ensure it follows a consistent, objective approach when making enforcement decisions and that these decisions are appropriate and properly protect the public from unprofessional, improper, unauthorized, and unqualified licensees as required by law. In addition, unlike other states, LSBME does not require that anyone review the Director of Investigation's (DOI) recommendations to the Board regarding enforcement cases.

Recommendation	Recommendation Status/Summary of Agency's Response
1. LSBME should develop criteria for determining whether to issue public or non-public actions to licensees to ensure that its enforcement process is consistent, appropriate, and effective; maintain documentation to support such decisions; and promulgate these criteria in rules under the Administrative Procedure Act.	*Implementation in Progress* LSBME promulgated regulations (LAC 46:XLV.9714) that provide such criteria. According to LSBME, the Board anticipates implementing these immediately with the possibility of developing, within the next year, an implementation form to address both these new rules and those regarding criteria for discipline and mitigating circumstances, to complement the rules. Additionally, the Board is in the process of redesigning its electronic database utilized by the investigations department to enable the Board to more easily track violation types and discipline results.

Recommendation	Recommendation Status/Summary of Agency's Response
2. LSBME should develop a process that incorporates an additional level of review of a selection of recommendations made by the Director of Investigations (DOI) to the Board for adequacy and completeness by board members and/or employees who were not involved in the investigations and to ensure that all licensees receive due process. The reviews should include recommendations to close cases as well as recommendations to impose disciplinary actions.	*Implementation in Progress* LSBME is currently using its Compliance Counsel to ensure all licensees receive their due process rights during the investigative process and to ensure there have been no violations. The Compliance Counsel regularly reports findings to the Board and is in the process of developing an investigations policies and procedures document to guide LSBME's investigations staff. LSBME also uses its various practice advisory committees to review pertinent investigation cases, and hired an executive counsel in January 2021 who is implementing a second level of review process for all investigations. LSBME anticipates this process to be fully implemented by Spring 2022.
3. LSBME should develop formal guidance, such as an enforcement guide, that provides a consistent process involving a graduated and equitable system of sanctions that specifies criteria including the type, number, and severity of violations that should trigger each level of sanctions, and promulgate this guidance in rules under the Administrative Procedure Act.	*Implementation in Progress* LSBME promulgated new regulations (LAC 46:XLV.9716) that provide a system of sanctions, including sanctions criteria. The Board anticipates implementing these immediately with the possibility of developing, within the next year, an implementation form to address both these new rules and those regarding criteria for discipline and mitigating circumstances, to complement the rules. Additionally, LSBME is in the process of redesigning its electronic database utilized by the investigations department so as to enable the Board to more easily track violation types and discipline results.

Finding 2: During calendar years 2015 through 2017, LSBME did not report all licensees who violated their Practice Act to the appropriate parties as required by law. We identified 10 licensees who LSBME failed to report to the National Practitioners Data Bank (NPDB) as required by federal law when they were suspended, did not renew, or relinquished their licenses as a result of the Board's investigation. In addition, LSBME did not report all violations substantiated during its investigation process to the prosecuting officer of the state as required by state law.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
4. LSBME should ensure that it reports all Board decisions involving practitioners relinquishing and/or not renewing a license or being suspended from practice to the NPDB as required by federal law. In addition, LSBME should consult with the NPDB regarding the reporting of applicable decisions from closed cases.	*Implementation in Progress* LSBME stated that all decisions which require NPDB reporting are being reported including but not limited to those practitioners who are suspended, and/or allow their license to lapse and/or choose to not renew, while under investigation. Each month, after the Board meets, LSBME staff uploads final board actions to its website and reports summary suspensions and final actions to the NPDB. Eight of the 10 previous licensees determined to have not been reported to the NPDB in the LLA audit were subsequently reported. Of the two remaining practitioners, one passed away and LSBME did not take any disciplinary action. According to LSBME staff, they will examine the NPDB to determine if it would be appropriate, at this point, to report this last practitioner.
5. LSBME should report any violation of the Practice Acts directly to the prosecuting officer(s) of the state as required by state law. In addition, LSBME should consult with the prosecuting officer(s) of the state regarding the reporting of past violations of Practice Acts from closed cases.	*Implementation in Progress* LSBME reported that the Board is required to forward all violations of its Practice Acts and Board Rules to the Office of the Attorney General. The vast majority of discipline is in the form of Consent Orders, which typically do not contain admissions to the alleged violations, and only consent to the discipline. When such a Consent Order admits a violation, it is treated the same as a Final Decision following adjudication. Those licensees who have been disciplined by the Board in a Final Decision following adjudication are reported to the prosecuting officer of the state (Office of the Attorney General). LSBME has not, but stated that it is planning on, contacting the Office of the Attorney General to discuss reporting past violation of Practice Acts from closed cases.

Finding 3: LSBME has not effectively monitored all licensees. While LSBME has a process to monitor licensees on probation, it does not track and monitor licensees who have verbal agreements or other restrictions such as prohibitions from prescribing controlled substances or requiring supervision or chaperones while treating patients. LSBME also did not ensure that individuals with expired licenses did not continue to practice. We reviewed Prescription Monitoring Program (PMP) data and identified licensees who appeared to have prescribed medications in violation of the restrictions imposed by LSBME and despite having expired licenses.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
6. LSBME should develop a process to track and monitor all licensees with suspensions or other practice restrictions, as it does for licensees on probation, to ensure compliance with all terms imposed by the Board.	*Implementation in Progress* LSBME's Director of Investigations implemented a system of quarterly reports listing those physician licenses which are suspended or revoked since 2017 and the results of the LSBME's monitoring of those licensees for prescribing when suspended or revoked. Following the initial report, licensees who have suspended or revoked licenses within the last year will be monitored quarterly up to one-year post discipline. The initial quarterly report was presented to the Board during the June 2021 meeting. In addition, when LSBME licensure staffs checks the NPDB for initial and renewal licensee applicants, they now request a continuous query response so that LSBME is notified of any NPDB reports on that licensee for the next year. According to LSBME, it is in the process of developing a process for tracking future Final Decisions with practice restrictions that heretofore have not been tracked by the Board via traditional practice monitoring and/or probation.
7. LSBME should use the PMP to monitor individuals with expired licenses for prescribing activity and develop a method to monitor expired licensees for other types of unlicensed practice.	*Partially Implemented* According to LSBME, it identified 12 licensees who are prescribers and have allowed their license to lapse while under investigation or surrendered their license while under investigation, within the last year. LSBME stated that it initially planned to monitor all expired licenses for prescribing activity, but encountered issues. First, a large number of licenses expire each year and LSBME is not allowed to use automated software to search the PMP. In addition, LSBME stated that due to state laws and regulations it may not randomly search expired licenses unless they are connected to a prior investigation/adjudication.

Recommendation	Recommendation Status/Summary of Agency's Response
8. LSBME should follow up on the remaining licensees we identified who prescribed controlled substances in violation of Board restrictions or after their licenses expired, discipline active licensees in accordance with Board policy, and report any unlicensed medical practice to the state's prosecuting officer as required by state law.	*Implementation in Progress* According to LSBME, the Director of Investigations (DOI) recommended the Board open preliminary reviews in the July 2021 board meeting 43 of the 44 licensees identified by LLA in its 2019 audit as prescribing in violation of their restrictions or after the licenses expired. The DOI determined that the 44th licensee was identified in error. With regard to licensees on probation and/or expired licensees who prescribe in violation, please see response to recommendation Nos. 6 and 7.
9. LSBME should consistently document meetings held with licensees and verbal agreements made by licensees so that it can track and evaluate any future instances of licensees' noncompliance with agreements and take appropriate action to protect the public when agreements are violated.	*Implementation in Progress* LSBME reported that it no longer enters into verbal agreements with licensees that are not being actively investigated. However, with regard to impaired physicians who are actively being investigated and who are referred for evaluation or participation in the Physicians Health Program, LSBME's DOI *may* permit, during the investigation, a verbal agreement by the licensee to not practice pending an evaluation of that licensee. According to LSBME, it does not allow this in every instance and these verbal agreements are documented in the investigation case notes and actively monitored through the investigation process. According to LSBME, it has entered into verbal agreements with 20 licensees since June 2019 of which seven (35.0%) violated the agreement and LSBME is taking action as a result.

Finding 4: LSBME has not ensured that licensees comply with all licensing requirements. LSBME does not have a formal process for conducting and tracking Continuing Education (CE) audits and does not retain supporting audit documentation in accordance with its records retention schedule. As a result, it cannot ensure that licensees complied with CE requirements during calendar years 2015 through 2017.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
10. LSBME should develop and formalize a process that requires staff to conduct and track CE audits so that management can ensure that audits are complete, accurate, and conducted in a consistent manner.	*Implementation in Progress* LSBME promulgated new regulations (LAC 46:XLV.433, 435, 437, 439, 441, 443. 445, 447, 449) that require each licensee to utilize a free account with the Board's approved electronic education tracker, CE Broker, to provide proof of compliance with the respective continuing medical education (CE) requirements, and that failure to complete the education required will render the licensee ineligible for renewal. LSBME has encouraged its licensees to initiate a free electronic tracking account ahead of finalization of the new process.
11. LSBME should either comply with its rules that require it to suspend the licenses of practitioners who are noncompliant with CE audits or amend such rules to reflect the Board's current practice.	*Other* In December 2020, LSBME ran its audit of CE for the year 2019, but stated that it refrained from suspending licenses and waived the CE requirements for 2020, due to the need to continue medical staffing to address the ongoing COVID-19 pandemic and pursuant to the Governor's monthly Proclamations. These provisions permitted the Executive Director of LSBME to temporarily waive a Board rule that interferes with the licensing of healthcare professionals that are necessary to address the declared public health emergency and prohibited adverse actions against licensees for failure to comply with procedural licensing requirement during the declared public health emergency, provided the licensee made a good faith attempt to comply. According to LSBME, it plans, upon the end of the pandemic, to address the licensees who failed to complete CE based on the 2019 audit. **LLA Comment:** The status of this recommendation is *Other* because LSBME has not had the opportunity to implement this recommendation due to the COVID-19 public health emergency.

Recommendation	Recommendation Status/Summary of Agency's Response
12. LSBME should amend its policy to align with its records retention schedule and ensure that it retains documentation of CE audits in accordance with this approved schedule and state law.	*Implemented* LSBME promulgated new regulations (LAC 46:XLV.439C) that now require licensees to retain copies of CE documentation that confirms completion for a period of four years. Further, the electronic education tracker the Board employs retains records for over five years. These comply with the Board's retention schedule with regard to licensees' files of the active year plus three years.

Detection and Prevention of Worker Misclassification

Louisiana Workforce Commission

June 20, 2019

We evaluated whether the Louisiana Workforce Commission (LWC) developed effective processes to detect and prevent worker misclassification. Worker misclassification occurs when an employer improperly classifies a worker as an independent contractor instead of an employee in order to gain a competitive advantage through reduced labor costs.

LWC has implemented three (42.9%) of seven recommendations. LWC has not implemented three recommendations because it is waiting on programming in its audit workflow software, it had to reassign employees due to COVID-19, and it is still considering the feasibility of one recommendation.

Finding 1: Since calendar year 2012, LWC met federal audit criteria that require it to audit 1% percent of employers and 1% of total employee wages each year. However, LWC could strengthen how it selects employers to audit by determining which audits identified the highest number of misclassified workers. This analysis would enable LWC to focus its audit efforts on industries with the highest risk of worker misclassification. For example, we found that audits initiated based on tips and referrals, as well as audits of construction companies, generated the highest number of misclassified workers.

Recommendation	Recommendation Status/Summary of Agency's Response
1. LWC should require staff to track the number of misclassified workers identified during each audit by the audit selection source and the employer's NAICS code, and use this data as part of its audit selection process.	*Implemented* LWC developed new audit workflow software (AWS). The new system allows management to select audits that should satisfy the four factors of the United States Department of Labor's Effective Audit Measure. Additionally, through metrics monitoring, management is able to select ad hoc audits using additional criteria, including NAICS code. Management is also able to produce reports detailing assigned audits (and results) by NAICS code and results. This is one of several reports that management can use to assign audits most likely to identify misclassified workers.

Finding 2: LWC could further strengthen its audit selection process by using data from other state agencies to compare to its quarterly wage data from employers. For example, we analyzed LDH and DOTD contractor payroll and time sheet data and identified 383 employers that did not report employee wages to LWC for as many as 22,850 workers as required by law, thus potentially misclassifying workers.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
2. LWC should identify and incorporate payroll and time sheet data from state agencies into its audit selection process so that this data may be matched against LWC's quarterly wage data to identify employers that fail to report wages and thus may be misclassifying employees.	*Not Implemented* LWC is currently working with contractors to completely transition from a mainframe system to a web-based system. LWC is still exploring electronic methods to exchange wage information with current and additional state agencies. Audit staff was reassigned to assist with unemployment insurance claims for most of 2020 (due to COVID-19)– causing delay.
3. LWC should incorporate New Hires data into its audit selection process so that it may be matched against LWC's quarterly wage data to identify employers that fail to report new hires to LWC and thus may be misclassifying workers.	*Not Implemented* LWC is still studying feasibility and will assess programming and development costs to affect this "cross-match" process. However, this is not a high priority at this time.

Finding 3: LWC's enforcement process is not effective at deterring employers from misclassifying their workers. Louisiana is the only state that mandates LWC to send warning letters to employers that misclassify workers on their first offense as opposed to assessing penalties. This requires LWC to use its limited resources to conduct follow-up audits in order to impose applicable penalties. If LWC could impose penalties for first-time offenses, we estimated it could have assessed approximately $3.3 million in penalties for the 13,106 misclassified workers it identified during calendar years 2016 to 2018.	
Recommendation	**Recommendation Status/Summary of Agency's Response**
4. LWC should continue to work with the legislature to determine whether the mandatory warning letter for first offense worker misclassification is an effective deterrent to worker misclassification and whether it contributes to an inefficient audit process.	*Implemented* Act 455 of the 2021 Regular Legislative Session removed the warning letter for first offense worker misclassification and increased penalties.
5. LWC should develop policies and procedures to ensure that it consistently conducts follow-up audits as needed and penalizes employers that are found to have misclassified workers on subsequent audits, as required by law.	*Not Implemented* According to LWC, there are current policies and procedures in place to ensure follow-up audits are conducted when appropriate, and these policies and procedures will remain in place until new programming is completed in the AWS that will compare current reported gross and taxable wages with reported gross and taxable wages of original audit. LWC estimates this will be implemented during the first quarter of 2022 and current policies and procedures will remain in place until this new process is implemented. **LLA Comment:** While LWC is working to implement this new process, the status of the recommendation is *Not Implemented* until the new programming is in place and LWC develops applicable policies and procedures.
6. LWC should continue to work with the legislature to determine whether the penalties established in Louisiana law for worker misclassification should be strengthened. Stronger fines may increase the deterrent effect of the penalties.	*Implemented* Act 455 of the 2021 Regular Legislative Session removed the warning letter for first offense worker misclassification and increased penalties.

Recommendation	Recommendation Status/Summary of Agency's Response
7. LWC should develop policies and procedures to ensure that it consistently penalizes employers that do not comply with audit requests.	*Not Implemented* According to LWC, it is developing programming that will allow penalty information, if assessed, to interface with LaWats (LA Wage and Tax System) for appropriate billing and legal actions. In addition, second and subsequent offense penalty bills will automatically be sent to employer based upon follow-up audit findings. LWC estimates the implementation of this programming is the first quarter of 2022. However, LWC cannot create applicable policies and procedures until these are implemented. **LLA Comments:** The status of the recommendation is *Not Implemented* until LWC implements these new processes and develops applicable policies and procedures.

APPENDIX A: SCOPE AND METHODOLOGY

This report provides the implementation status of recommendations contained in 13 performance audit reports issued during fiscal years 2018 through 2019. We conducted this review under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended.

Since this review was not a performance audit, we did not follow generally accepted *Government Auditing Standards* issued by the Comptroller General of the United States. To obtain our conclusions, we performed the following steps:

- Reviewed the 16 performance audit reports issued from July 1, 2018, through June 30, 2019, to determine which reports to include in this review. We excluded three annual statutorily-required audits, one audit that did not have any recommendations, and one audit that we were in the process of conducting a formal follow-up audit with comprehensive audit procedures.[5] As a result, we reviewed 11 audits issued during fiscal year 2019. We also included in this review two audits issued in fiscal year 2018 because we didn't include these audits in our fiscal year 2018 review due to changes in leadership at the agency. In total, we reviewed 112 recommendations made in 13 performance audits for this report.

- Requested feedback on the status of recommendations contained in the selected audits from the 11 relevant state agencies/entities. These 11 agencies/entities included Department of Public Safety and Corrections; Governor's Office of Elderly Affairs; Louisiana Department of Education; Louisiana Department of Health; Louisiana Department of Justice; Louisiana Department of Veterans Affairs; Louisiana State Board of Medical Examiners; Louisiana Workforce Commission; Office of Group Benefits; Office of State Lands, Division of Administration; and State Bond Commission.

- Requested documentation to support the agencies' responses. Based on agencies' responses and/or documentation provided, we requested further documentation in some instances to clarify or verify the agency's responses. If an agency's response and/or documentation provided did not support the recommendation status reported by the agency, we revised the recommendation status.

    - When necessary, we conducted further research to confirm agencies' responses but did not conduct in-depth auditing procedures, such as file reviews or analysis of data, because of the time and resources needed for such work. If we concluded that in-depth audit procedures were necessary to determine whether an agency was fully implementing one or more

[5] Because of time and resource constraints, we cannot conduct comprehensive follow-up audits for all previously issued audit reports. In addition, not all audits require a comprehensive follow-up audit. We use a risk-based assessment to determine which previous audits do require a comprehensive follow up.

recommendations, we indicated that we would complete a comprehensive follow-up of this audit in the future. In addition, we may determine in the future that an audit included in this review requires a comprehensive follow-up because of significant changes to the program.

- Provided draft of report to all agencies for review and revised report, as necessary.