LOUISIANA DEPARTMENT OF HEALTH

STATE OF LOUISIANA

FINANCIAL AUDIT SERVICES
MANAGEMENT LETTER
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Introduction

As a part of our audit of the State of Louisiana's Comprehensive Annual Financial Report and our work related to the Single Audit of the State of Louisiana (Single Audit) for the fiscal year ended June 30, 2020, we performed procedures at the Louisiana Department of Health (LDH), including the Office of Public Health (OPH), to provide assurances on financial information that was significant to the state's Comprehensive Annual Financial Report; evaluate the effectiveness of LDH's internal controls over financial reporting and compliance; and determine whether LDH complied with applicable laws and regulations. In addition, we determined whether management has taken actions to correct the findings reported in the prior year.

Results of Our Procedures

Follow-up on Prior-year Findings

Our auditors reviewed the status of the prior-year findings reported in the LDH management letter dated February 26, 2020. We determined that management has resolved the prior-year findings related to Noncompliance on Managed Care Premium Payments, Inadequate Controls over Quarterly Federal Expenditure Reporting, Inadequate Controls Over Healthy Louisiana Premium Payments, Inadequate Controls over Medicare Buy-In, and Noncompliance with Review of Redeemed Food Instruments and Cash-Value Vouchers. In addition, the finding related to Inadequate Internal Control over Modified Adjusted Gross Income (MAGI) Eligibility Determinations is considered resolved based on changes to the 2020 Compliance Supplement.

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

Current-year Findings

Inadequate Internal Control over Eligibility Determinations

The Louisiana Department of Health (LDH) lacked adequate internal control over eligibility determinations in the Medical Assistance Program (Medicaid - CFDA 93.778) and Children's Health Insurance Program (CHIP - CFDA 93.767) during fiscal year 2020. Federal regulations require that in order to be considered eligible, a recipient must meet all eligibility factors and the recipient case record must include facts to support agency eligibility decision. Proper eligibility determinations are critical to ensuring appropriate service eligibility, appropriate premium payments, and appropriate federal match rate on expenditures.

In a sample of 60 recipients determined eligible during fiscal year 2020, deficiencies were found in case record documentation for six recipients (10%), with one recipient's case record containing more than one error. LDH paid $20,372 ($18,143 federal funds and $2,229 state funds) for these recipients for periods during fiscal year 2020 in which case records do not support eligibility decisions. We consider these costs to be questioned costs. Eligibility determinations include consideration of categorical, non-financial, and financial requirements.

Our test noted the following:

- For three of 60 (5%) recipients, case records did not support financial requirements for eligibility based on income. In these instances, self-employment income was not verified, income reported was not counted correctly, and updated wage information was obtained in LaMEDS but not considered.

- For one of 60 (2%) recipients, the case record did not support categorical requirements for the eligibility group assigned. In this instance, a pregnant recipient was included in the adult group rather than the pregnant woman group.

- For two of 60 (3%) recipients, case records did not support non-financial requirements for the eligibility group assigned. In one instance, LDH did not obtain a Social Security number (SSN) or proof of application for a SSN at application or renewal. In another instance, the case record does not support the continuity of stay requirement for long-term care eligibility.

- For one of 60 (2%) recipients, the case record did not support retroactive eligibility as applied. According to LDH policy for pregnant woman eligibility, retroactive eligibility cannot begin before the first month of pregnancy. However, retroactive eligibility was applied for three months prior to the first month of pregnancy.

LDH should ensure its employees follow procedures over eligibility determinations in the Medicaid and CHIP programs to make sure case records support eligibility decisions. Management partially concurred with the finding and provided a corrective action plan. (See Appendix A, pages 1-2)

Noncompliance with Managed Care Provider Enrollment Requirement

For the third consecutive year, LDH did not enroll and screen Healthy Louisiana managed care providers and dental managed care providers as required by federal regulations. Currently, the managed care plans continue to enroll and screen all managed care providers, in violation of federal regulations. As a result, LDH cannot ensure the accuracy of provider information obtained from the Louisiana Medicaid managed care plans and cannot ensure compliance with enrollment requirements defined by law and the Medicaid and CHIP state plan. LDH accepted 90.7 million Healthy Louisiana encounter claims totaling $5.9 billion and 3.8 million dental encounter claims totaling $132 million in fiscal year 2020 from the managed care plans and paid $8.3 billion in Healthy Louisiana premiums and $174 million in dental premiums.

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

LDH was required to enroll and screen all Healthy Louisiana managed care providers by January 2018 and dental managed care providers by July 2018. LDH failed to do this and therefore is in violation of federal law. LDH noted that the enrollment and screening of managed care providers was to be performed as part of a new provider management system. The contract for the new system was terminated in April 2020.

LDH should ensure all providers are screened, enrolled, and monitored as required by federal regulations. Management concurred with the finding and provided a corrective action plan. (See Appendix A, pages 3-4)

Noncompliance with Provider Revalidation and Screening Requirements

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

Based on information provided by LDH, approximately 80% of providers with claims activity in fiscal year 2020 have not had a risk-based screening with a majority of those providers enrolled more than five years ago.

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

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

In response to the prior-year finding, LDH noted that performance of all required revalidations, screenings, and monthly checks would be implemented in a new provider management system. The contract for the new system was terminated in April 2020. LDH now plans to use the current provider enrollment contractor for revalidations, monthly SAM database checks, and risk-based screening for all provider types.

LDH should ensure all providers are screened based on categorical risk level upon initial enrollment, re-enrollment, and revalidation of enrollment as required by federal regulations. Also, LDH should perform revalidation of enrollment on all providers at least every five years. In addition, LDH should ensure all required databases are checked at least monthly. Management concurred with the finding and provided a corrective action plan. (See Appendix A, pages 5-6)

Inadequate Controls over Consideration of Lottery Winnings for Medicaid Eligibility

LDH did not have adequate controls to ensure compliance with the federal requirement over consideration of lottery winnings in MAGI-based eligibility determinations for the Medicaid program.

In February 2018, Congress passed *Public Law 115-123* that amended the Social Security Act for the treatment of qualified lottery winnings and other qualified lump sum income, including winnings from any gaming activities, for the purposes of income eligibility under Medicaid. Under the new regulation, qualified lottery or other lump sum winnings of $80,000 and greater occurring on or after January 1, 2018, are now counted as income, for MAGI-based determinations, over a period of months instead of just in the month received. For amounts greater than or equal to $80,000 but less than $90,000, the winnings would be counted as income over a period of two months. For amounts greater than or equal to $90,000 but less than $100,000, the winnings would be counted as income over a period of three months. For amounts $100,000 and over, an additional month would be added for each increment of $10,000 for the purposes of income counting for a maximum of 120 months for winnings or income of $1,260,000 or more. The regulation stipulates that the income and winnings are only counted for the recipient of winnings and cannot be counted for any other members of the household, including a spouse.

The state is required to notify the recipient of the loss of eligibility, of opportunities to enroll in a qualified health plan through the Federal Healthcare Marketplace (Exchange), and the date on which the recipient would no longer be ineligible for Medicaid due to lottery winnings or qualified lump-sum income.

In Louisiana, winnings that exceed $80,000 from Louisiana Lottery Corporation drawings and scratch-off games, as well as multi-state lottery drawings are considered countable lump sum income under the new regulations. Based on data obtained from the Louisiana Lottery Corporation and Medicaid recipient data, auditors identified 38 recipients each with Louisiana lottery prizes over $80,000 claimed from February 2018 through March 2020 for which LDH did not count lottery winnings as income as required by federal regulation. As a result, the individuals obtained and/or maintained Medicaid eligibility during months in which their winnings made them ineligible while Medicaid payments were made on their behalf. Payments associated with these individuals total of $120,372 (108,299 federal and 12,073 state funds) through June 30, 2020.

Louisiana accepted a temporary increase in federal match for certain Medicaid expenditures under the Families First Coronavirus Response Act (FFCRA) 6008, which was enacted due to the March 2020 national public health emergency (PHE) due to COVID-19 pandemic. As a condition of the temporary increase, FFCRA prohibits the agency from terminating Medicaid coverage unless a recipient "requests a voluntary termination of eligibility" or "ceases to be a resident of the state". Also, as a result of the PHE, LDH submitted to CMS modifications to its' Eligibility Verification Plan to allow for the processing of eligibility determinations based on self-attested income amounts. The Eligibility Verification Plan addendum allows the agency to temporarily accept self-attested income for eligibility determinations. Through the conclusion of the emergency, the agency is not required to verify income including lottery winnings and is not permitted to remove recipients from Medicaid for income discrepancies. Once the COVID-19 emergency is concluded, the agency is required to return to its thorough post-enrollment verification process to ensure eligibility.

Of the 38 Medicaid recipients auditors identified as Lottery winners in the period February 2018 through March 2020, a total of six recipients had $6,969 in payments made on their behalf during the PHE period from March 2020 through June 2020. Questioned costs are considered to be $113,403 (102,628 federal and 10,775 state funds).

LDH updated its policy for the new income counting requirements in April 2020 but still relies on applicants and recipients to self-report winnings. LDH is currently in the process of negotiating an agreement with the Louisiana Lottery Corporation to obtain data on a regular basis for the purposes of eligibility determinations.

LDH should ensure that lottery and all other qualified lump sum incomes are considered as part of MAGI-based eligibility determinations as required by federal regulations. Management concurred with the finding and provided a corrective action plan. (See Appendix A, pages 7-9)

Inadequate Controls over Billing for Behavioral Health Services

For the second consecutive year, LDH, the MCOs, and Magellan Health Services (Magellan) did not have adequate controls in place to ensure that behavioral health services in the Medicaid and CHIP programs were properly billed and that improper encounters were denied. For fiscal year 2020, we identified approximately $10.5 million in encounters for services between July 1, 2019, and June 30, 2020, that were paid by the MCOs and Magellan even though encounters did not comply with the LDH coding requirements and fee schedule. The billing errors could be avoided by LDH, the MCOs, and Magellan applying system edits that would deny encounters when billing and fee schedule requirements are not followed. Our analysis identified the following instances of billing errors:

- Providers were paid $9,088,625 for 147,183 encounters that were billed using incorrect procedure and modifier codes. LDH's fee schedule outlines procedure codes for services and the applicable billing rates. Some services require that procedure codes also contain modifier codes which indicate information such as the age of the recipient, location where the service was provided, the educational background of the person providing the service, and the license(s) they have obtained. Without the required modifiers, the encounter does not contain enough information to determine that the billing was appropriate.

- Providers were paid $1,425,875 more than indicated on the LDH fee schedule for 32,703 encounters for behavioral health services. The LDH fee schedule outlines different rates depending on the procedure code and modifier codes. The MCOs can optionally pay more than the minimum LDH fee schedule. However, LDH does not currently maintain a list of these providers and therefore cannot determine if an encounter paid at an excessive rate was improperly billed. For the amount noted above, the MCOs confirmed that they did not have alternative fee schedules.

- Providers were paid $1,722 for 45 encounters for improperly billed add-on behavioral health services. According to MCO guidance to providers, add-on services are reimbursable when provided in addition to the appropriate primary service performed by the same provider and cannot be billed as standalone services. For the amount noted above, add-on services were paid without the required primary service.

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

LDH management should implement adequate internal controls to ensure that encounters are coded correctly, which could include edit checks to deny improper billings. Management did not concur with the auditor's recommendation regarding implementing encounter edits but did detail other procedures currently in place and to be implemented. (See Appendix A, pages 10-14)

Additional Comments: Incomplete encounter data submission by the MCOs limits LDH's ability to fulfill its role as the contract monitor of the MCOs. Although LDH noted it holds the MCOs accountable for implementing necessary claim system edits, if LDH does not require the proper coding of procedure codes and modifiers, it would have to implement the multiple system evaluations and verifications employed by the MCOs in order to ensure that the encounter data submitted was complete and accurate.

LLA is not recommending that LDH limit encounter acceptance to only those encounters that are in alignment with the Medicaid fee schedule, but instead is recommending that LDH establish edits that flag, but do not deny, instances where providers are paid rates that are outside of the fee schedule. This would allow LDH to easily identify and review these encounters and confirm with each MCO that the rates at which each provider was paid are correct. LLA removed those providers with special, negotiated rates from the analysis and only analyzed those providers that the MCOs indicated should have been paid at the rate listed on LDH's fee schedule.

LDH's Specialized Behavioral Health fee schedule outlines which primary and add-on codes are supposed to be used in conjunction with one another. The primary procedure codes that LDH identified as being provided for the add-on services identified by the LLA's analysis are not the proper primary codes listed on the fee schedule for the identified add-on services. Rather, the primary procedure codes identified by LDH are procedure codes for established patient office visits that, in many cases, allow the provider to bill at a rate higher than the primary procedure code identified on LDH's fee schedule allows.

Weaknesses in Controls over LaMEDS

For the second consecutive year, LDH had weaknesses in controls over its Medicaid and CHIP eligibility and enrollment system, LaMEDS. LaMEDS was implemented in November 2018. All recipient eligibility records are stored in LaMEDS.

LDH is the single state agency responsible for the administration of the Medicaid and CHIP programs. As such, LDH is responsible for adequate internal control over any system used in administration of the program. In addition, LDH is considered a covered entity under the Health Insurance Portability and Accountability Act (HIPAA). According to the HIPAA Security Rule, a covered entity must implement and maintain documented procedures to determine, assign, and revoke access to electronic protected health information appropriately, and review system activity regularly.

We evaluated system controls based on best practices, as defined by *Control Objectives for Information and Related Technology*, a framework developed by the Information Systems Audit and Control Association. As a result, we determined during fiscal year 2020, LDH lacked documented procedures for disabling user accounts upon separation and documented procedures for identifying contractors who no longer need access to LaMEDS. In addition, LDH failed to complete user access reviews during fiscal year 2020, which should be done at least annually.

A lack of documented procedures and proper monitoring over user access may lead to inappropriate access that may violate HIPAA Security Rules because users may retain access to protected health information after they no longer need access.

Management should establish procedures for: immediately disabling separated employee access; monitoring contractors and terminating their access when no longer needed; performing user access reviews at least annually; and making appropriate changes as a result of the user access reviews. Management concurred in part with the finding and provided a corrective action plan. LDH provided that Medicaid has a procedure to perform annual user access reviews and noted the November 2019 ransomware attack and the COVID-19 public health emergency in March 2020 delayed timely completion of the annual user access review. LDH also noted that a new review is currently in progress that should be completed in February 2021. (See Appendix A, pages 15-17)

Inadequate Controls Over Service Providers with Closed Enrollment

LDH paid $287,617 ($190,302 in federal funds and $97,315 in state funds) in fiscal years 2016 through 2020 for claims with service dates occurring after the service providers were no longer enrolled. LDH lacked adequate procedures to ensure claims are only paid for service dates in which the service provider is enrolled in Medicaid. Payments made for services that fall on dates that service providers are not enrolled in the program increases the risk that payments were made to providers that should not be providing services to Medicaid and CHIP recipients.

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

In an analysis of 23,389 service providers with activity during fiscal year 2020, we noted 235 providers with enrollment end dates during the fiscal year or prior. Of the 235 providers, we noted 27 providers with claims paid for service dates after the providers' enrollment end date. After reviewing the information with LDH, errors were noted for 16 providers as detailed below.

- Thirteen providers with Medicare crossover claims totaling $85,264, in which LDH did not ensure the service providers were enrolled in Medicaid on the service dates being billed. Even if a provider is enrolled with the Centers for Medicare and Medicaid Services (CMS) as a Medicare provider, the provider must be enrolled as a Medicaid provider to perform and be paid for services in the Medicaid and CHIP programs.

- Three providers with claims totaling $202,353, in which enrollment end dates were applied retroactively by LDH; however, LDH had already paid for services dates during that period. LDH did not consider if those payments needed to be recouped from the provider.

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

any claims already paid during that retroactive closure period. Management concurred with the finding and provided a corrective action plan. (See Appendix A, pages 18-20)

Lack of Internal Controls over and Noncompliance with Subrecipient Monitoring Requirements

LDH, Office of Public Health (OPH) did not have adequate controls in place to monitor subrecipients of the HIV Prevention Activities Health Department Based program (CFDA 93.940).

- OPH did not evaluate any subrecipient's risk of noncompliance for purposes of determining the appropriate subrecipient monitoring related to the award as required by federal regulations.

- From a population of 25 contracts, we selected a sample of six contracts for testing with expenditures totaling $662,893. In addition, we tested three individually important contracts with expenditures totaling $3,594,770. Although OPH documented site visits for the subrecipients randomly selected for testing, OPH could not provide documentation of site visits for the subrecipients related to the individually important contracts.

Federal regulations require pass-through entities to evaluate each subrecipient's risk of noncompliance with federal statutes, regulations, and the terms and conditions of the subaward for purposes of determining the appropriate monitoring. In addition, all pass-through entities must monitor the activities of the subrecipient as necessary to ensure that the subaward is used for authorized purposes and is in compliance with all requirements and conditions of the subaward as well as meeting performance goals. Failure to properly monitor subrecipients results in noncompliance with federal regulations and increases the likelihood of disallowed costs that may have to be returned to the federal grantor.

OPH should ensure that risk evaluations are performed for all subrecipients to determine the appropriate monitoring. In addition, OPH should establish a plan based on risk, such as a rotation schedule, to ensure that all subrecipients are monitored periodically. Management did not concur with the finding and asserts that its risk evaluation methodology meets the requirements of 2 CFR 200.332(b). Management acknowledged that site visit meetings were not documented and provided a corrective action plan to ensure that all site visits are documented with agendas and written summary reports. (See Appendix A, pages 21-25)

Additional comments: LDH asserts that all OPH subrecipients undergo yearly financial and compliance audits and referred to a checklist documenting the factors that OPH considered in evaluating each subrecipients' risk of noncompliance with federal regulations. The purpose of the checklist is to determine if the subrecipient or contractor requires an annual audit, a requirement of 2 CFR 200.332(d)(4) and (f). However, the checklist does not address the risk of noncompliance with federal regulations in accordance with 2 CFR 200.332(b). Management did not provide documentation of conclusions reached as to the assessed risk of noncompliance that determined the appropriate monitoring of each subrecipient.

Lack of Internal Controls over Program Expenditures

LDH OPH lacked internal controls to ensure compliance with regulations over the HIV Prevention Activities Health Department Based program related to the activities allowed or unallowed, allowable costs/cost principles, and period of performance compliance requirements.

In a sample of 49 payments made to subrecipients and vendors in fiscal year 2020 who provided services related to the HIV Prevention Activities Health Department Based program, we noted 21 (43%) payments with exceptions as follows:

- Nine (18%) payments were not approved by an appropriate supervisor and eight of those payments did not include enough information to determine if the account coding was accurate.

- Twelve payments (24%) did not include enough information to determine if the account coding was accurate.

Federal regulations require that records documenting compliance with federal statutes must be sufficient to establish that funds have been used in accordance with the terms and conditions of the federal award. Failure to adequately maintain supporting documentation and approve program expenditures increases the risk of unallowable costs requiring reimbursement to the federal grantor.

OPH should ensure that adequate internal controls are established and followed to ensure all expenditures of federal awards are adequately supported and approved by an appropriate supervisor. Management did not concur with the finding noting that the invoices were reviewed but the supervisors did not document their approval and based on its review, the coding agreed to the purchase order and was applicable to the grant. Management provided a corrective action plan to ensure evidence of approval of all payments. (See Appendix A, pages 26-28)

Additional Comments: Documentation provided by OPH did not indicate how each portion used to code expenditures to the different grants or projects within the HIV Prevention Activities Health Department Based program was determined to enable the auditor to conclude that the expenditure coding was correct.

Inadequate Controls over Waiver Services Providers

For the ninth consecutive year, LDH paid Medicaid Home and Community Based Services (HCBS) claims for the New Opportunities Waiver (NOW), Residential Options Waiver (ROW), and Community Choices Waiver (CCW) for waiver services that were not documented in accordance with provider manuals. NOW and ROW are administered by the LDH, Office for Citizens with Developmental Disabilities (OCDD). CCW is administered by the LDH, Office for Aging and Adult Services (OAAS). Waiver services are accessed through support coordinators who assist with development and monitoring of the recipient's plan of care (POC). The errors noted occurred because LDH failed to ensure that NOW, ROW, and CCW providers follow the provider manuals' requirements, which includes review of documentation to support services billed for accuracy and documenting deviations from the POC.

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

Our testing of waiver services included 126 claims paid in fiscal year 2020 totaling $33,255 paid to two providers for seven recipients. The recipients received services from three waivers: NOW, ROW, and CCW. Auditors used LDH's provider manuals to identify required documentation. Provider manuals are intended to give a provider the information needed to fulfill its vendor agreement with the state of Louisiana, and is the basis for federal and state reviews of the program. Our test identified errors for 57 claims, some claims having multiple errors.

For the NOW and ROW waivers administered by OCDD, the following were noted:

- For 38 claims for three recipients, the waiver services provider did not provide documentation to support deviations from the approved POC.

- For five claims for one recipient, auditors were unable to determine if a deviation from the POC occurred because timesheets/EVV documentation and units billed were not consistent. Provider could not provide explanation or documentation to explain why EVV documentation did not match units billed.

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

For the CCW waiver administered by OAAS, the following were noted:

- For two claims for one recipient, the waiver services provider did not provide adequate documentation to support billed services. These claims total $1,035 ($756 in federal funds and $279 in state funds) and are considered questioned costs.

- For 14 claims for two recipients, the waiver services provider did not provide documentation to support deviations from the approved POC. According to the CCW provider manual, significant deviations must be documented. Significant is not defined. Errors noted were deviations of thirty minutes or more.

Without adequate supporting documentation and compliance with LDH provider manuals there is increased risk that services billed and paid may not actually have been performed, recipients may not receive needed services as required by their POC, and limited resources may not be allocated appropriately to best meet recipient needs.

LDH should ensure all provider manuals for waiver services are enforced, including documentation to support claims and evidence deviations from the approved POC meet the needs of the recipient. LDH should also consider additional provider training regarding documentation requirements. Management concurred in part and provided a corrective action plan. (See Appendix A, pages 29-33)

Inadequate Controls over Payroll

LDH OPH did not ensure payroll expenditures were timely approved for the Public Health Emergency Preparedness program (CFDA 93.069), the HIV Prevention Activities Health Department Based program, and the Coronavirus Relief Fund program (CFDA 21.019). In addition, expenditures were not adequately supported for the HIV Prevention Activities Health Department Based program, which resulted in noncompliance. Exceptions for each federal program are as follows:

- For the Public Health Emergency Preparedness program, six (18%) of 34 payroll transactions were not approved by the employees' supervisors.

- For the HIV Prevention Activities Health Department Based program, four (36%) of 11 payroll transactions were not approved by the employees' supervisors and three (27%) did not include documentation, such as a time statement to support expenditures totaling $3,151.

- For the Coronavirus Relief Fund program, 11 (17%) of 63 payroll transactions were not approved by the employees' supervisors.

As a result of the high exception rate of payroll transactions that were not approved by the employees' supervisors noted above, we performed additional audit procedures to determine the exception rate of time statements that were not approved for all OPH employees during the entire fiscal year. OPH uses electronic time statements which allows for an electronic determination of supervisor approval. Based on audit procedures conducted on all payroll transactions in fiscal year 2020, we identified 3,672 (10%) of 35,301 time statements that were not approved by the employees' supervisors.

Federal regulations require records to be supported by a system of internal control which provides reasonable assurance that the charges are accurate, allowable, and properly allocated. OPH lacked sufficient controls to ensure electronic time statements were properly supported and approved prior to the posting date in accordance with federal and state regulations. Failure to adequately maintain supporting documentation and approve program expenditures increases the risk that unallowable costs could be reimbursed by the federal grantor.

OPH should ensure employees comply with existing policies and procedures, including properly approving electronic time statements in a timely manner and maintaining adequate documentation to support all expenditures of federal awards. Management concurred with the finding and provided a corrective action plan. (See Appendix A, pages 34-36)

Noncompliance with Third-Party Liability Assignment

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

Prior to the new eligibility system, LaMEDS, implemented in calendar year 2018, TPL assignment language was not included as part of electronic application summaries in all recipient case records. LDH planned corrective action in conjunction with the launch of LaMEDS, but LDH's corrective action was prospective in nature and did not attempt to remedy cases in which recipients with case files lacking TPL assignment notification do not complete a new application in LaMEDS. In response to the fiscal year 2019 finding, LDH planned to include the notification in Decision Letters for all approvals and renewals which each recipient would receive at least annually. However, LDH did not implement any corrective action in fiscal year 2020.

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

LDH should ensure notification of TPL assignment is included in each Medicaid and CHIP recipient case record as part of required documentation to support the eligibility decision. Management concurred with the finding and provided a corrective action plan. (See Appendix A, pages 37-38)

Noncompliance with Prenatal Service Third-Party Liability Requirements

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

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

to eliminate the cost avoidance exception for prenatal services and pregnancy-related services effective in February 2018.

During fiscal year 2020, LDH did not update the managed care contracts to require compliance with the revised regulation and did not monitor plan compliance with the revised regulation. Managed care claims payments are sent to LDH as encounters which are used by LDH's actuary for future rate setting.

LDH should ensure that Medicaid and CHIP programs are the payers of last resort by ensuring that cost avoidance measures are applied by the managed care health plans for prenatal services and pregnancy related services as required by federal regulations. Management concurred with the finding and provided a corrective action plan. (See Appendix A, pages 39-40)

Inadequate Controls over Monitoring of Abortion Claims

For the second consecutive year, LDH did not have adequate controls to ensure compliance with federal regulations prohibiting the use of federal funding for abortion claims. As a result, the managed care health plans may have paid for abortion services that did not meet exceptions noted in federal regulations, and LDH may have accepted those claims as encounters. Encounters are considered in future premium rate setting and are used for reporting and monitoring of the Medicaid and CHIP programs.

LDH included provisions in the Healthy Louisiana managed care contracts requiring the health plans to comply with the federal regulations, but LDH did not have procedures in place to monitor the health plans' compliance with the contract requirement until May 2020. The health plans started submitting monthly reporting for April 2020 in May 2020. In addition, LDH started a claims review for encounters with dates of service from January 2018 through June 30, 2020. As of January 2021, LDH was still reviewing documentation from the health plans to complete the claims review.

Federal requirements prohibit Medicaid and CHIP funding for abortion services except in instances where an abortion is necessary to save the mother's life or if the pregnancy is the result of an act of rape or incest. Under managed care, LDH pays the health plans monthly premiums for enrolled recipients. The health plans pay provider claims for services provided to enrolled recipients and submit the claims to LDH as encounter claims.

LDH should complete its current claims review and continue on-going monitoring of encounter claims for Medicaid and CHIP recipients to ensure compliance with federal regulations regarding funding of prohibited abortion claims. Management did not concur with the finding but did concur with the recommendation. In its response dated February 10, 2021, LDH noted it is nearing completion of the claims review mentioned above. (See Appendix A, pages 41-42)

Comprehensive Annual Financial Report – State of Louisiana

As a part of our audit of the Comprehensive Annual Financial Report for the year ended June 30, 2020, we considered internal control over financial reporting and examined evidence supporting LDH's Medical Vendor Payments (Agency 306) non-payroll expenditures, federal revenue, Medicaid current and non-current accruals, and critical information systems and related user controls.

The account balances and classes of transactions tested, as adjusted, were materially correct.

Federal Compliance - Single Audit of the State of Louisiana

As a part of the Single Audit for the year ended June 30, 2020, we performed internal control and compliance testing as required by Title 2 U.S. Code of Federal Regulations Part 200, Uniform *Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) on LDH's major federal programs, as follows:

- Commodity Supplemental Food Program (part of the Food Distribution Cluster, CFDA 10.565)
- Coronavirus Relief Fund (CFDA 21.019)
- Public Health Emergency Preparedness (CFDA 93.069)
- Children's Health Insurance Program (CFDA 93.767)
- Medicaid Cluster (CFDA 93.775, 93.777, and 93.778)
- HIV Prevention Activities Health Department Based (CFDA 93.940)

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

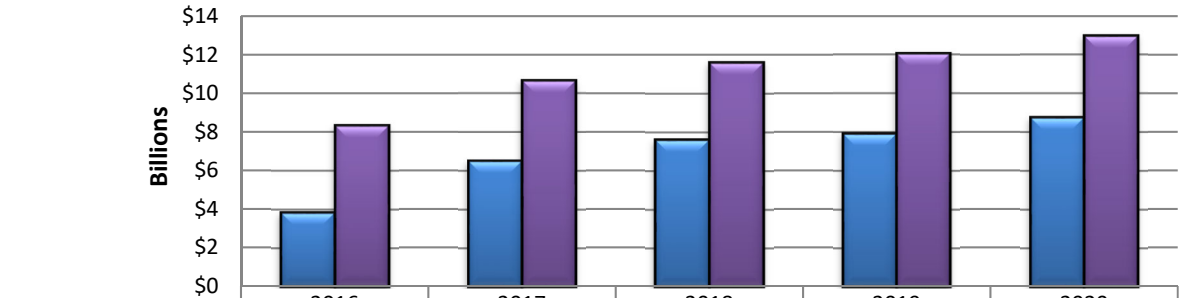
Based on the results of these Single Audit procedures, we reported the findings located in the Current-year Findings section. These findings will also be included in the Single Audit for the year ended June 30, 2020. In addition, LDH's information submitted for the preparation of the state's SEFA and the state's Summary Schedule of Prior Audit Findings, as adjusted, is materially correct.

Trend Analysis

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

Exhibit 1 provides an analysis of LDH's Medicaid Healthy Louisiana expenditures over the past five years which accounted for more than 67% of LDH's expenditures in Medical Vendor Payments in fiscal year 2020. Implementation of the Managed Care Incentive Payment Program accounts for almost half of the increase in Healthy Louisiana expenditures. LDH has established the opportunity for Medicaid MCOs to participate in incentive arrangements collectively known as the Managed Care Incentive Payment Program. The program makes incentive payments to the MCOs for achieving quality objectives designed to increase access to health care, improve the quality of care and/or enhance the health of the Medicaid managed care population.

Exhibit 1
Healthy Louisiana Medicaid Managed Care Expenditures
Compared to Total Program
Five-Year Trend

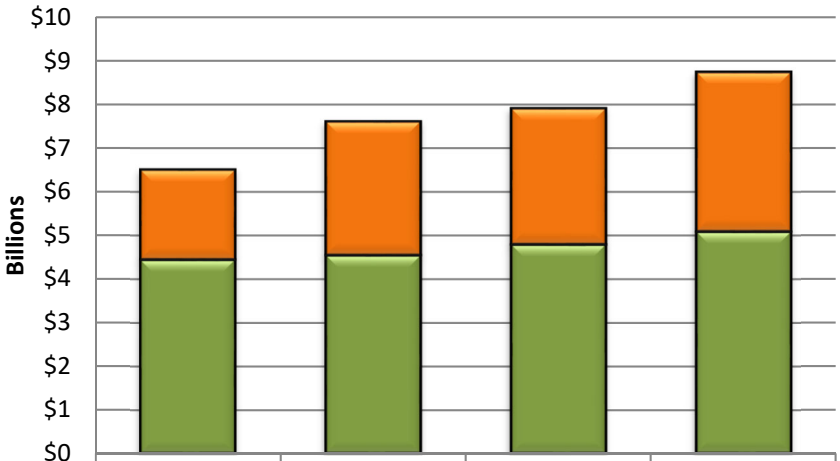


	2016	2017	2018	2019	2020
HEALTHY LOUISIANA	$3,825,909,416	$6,498,739,297	$7,604,277,019	$7,903,544,878	$8,736,973,527
TOTAL PROGRAM	$8,317,394,056	$10,636,119,498	$11,596,329,818	$12,043,735,432	$12,950,115,160

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

Exhibit 2 provides a breakdown of Healthy Louisiana Medicaid expenditures by eligibility and non-expansion eligibility for state fiscal years 2017 (first year of implementation) through 2020.

Exhibit 2
Healthy Louisiana
Expansion vs Non-Expansion Expenditures



	2017	2018	2019	2020
Expansion	$2,061,005,124	$3,065,597,933	$3,119,368,834	$3,659,143,006
Regular	$4,437,734,173	$4,538,679,086	$4,784,176,044	$5,077,830,521

Source: LDH Medicaid Year End Financial Reporting

Other Reports

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

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

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

Respectfully submitted,

Thomas H. Cole, CPA, CGMA
Temporary Legislative Auditor

KW:AHC:BH:EFS:aa

LDH2020

APPENDIX A: MANAGEMENT'S RESPONSES

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA E-MAIL ONLY

February 25, 2021

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

Re: Inadequate Internal Control over Eligibility Determinations

Dear Mr. Purpera:

The Louisiana Department of Health (LDH) acknowledges receipt of your correspondence dated February 8, 2021, wherein the Louisiana Legislative Auditor (LLA) notified LDH of a reportable finding related to inadequate internal control over eligibility determinations. LDH appreciates the opportunity to provide this response to your findings. Along those lines, please allow this correspondence to serve as the LDH official response thereto.

Finding - The Louisiana Department of Health (LDH) lacked adequate internal control over the eligibility determinations in the Medicaid Assistance Program and Children's Health Insurance Program during fiscal year 2020.

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

LDH Response - LDH partially concurs with this finding and recommendation. Medicaid agrees with the findings of the six cases in the audit. However, the agency is operating in compliance with its CMS approved Verification Plan and does not concur that it does not have controls in place to ensure accurate eligibility decisions. LDH continuously works to strengthen its eligibility determination processes. To that end, LDH has implemented corrective actions to ensure continued compliance with state and federal regulations as follows:

- LDH will continue to reinforce caseworker training on agency policy requiring eligibility re-determination when information is received that may affect eligibility of a recipient, consistent with federal law.

- LDH will continue to reinforce caseworker training on agency policy requiring documentation of information used to make eligibility decisions.
- LDH will continue to pursue interfaces and data sources to aid in strengthening its eligibility determination process.

Additionally, LDH has implemented controls and put corrective measures in place to identify errors through an improved case review process. LDH rectifies errors when identified to ensure accurate eligibility determinations. In the past, supervisors pulled a sampling of cases each month from their subordinates to review from specific programs only, and remedial training was limited to the individual that made the error. The new case review process pulls a sampling of random cases across all Medicaid programs for each Medicaid Analyst Supervisor to perform the case reviews. A report is generated that indicates how many cases were reviewed, the type of case, and if errors are identified. The case review report is shared with the training team who uses it to develop remedial training topics for the entire eligibility field staff in the following month.

Rebecca Harris, Interim Medicaid Deputy Director for Eligibility, serves as the lead on this matter. If you have any questions or concerns regarding the department's response and/ or corrective action plan, please contact Ms. Harris by emails at Rebecca.Harris@la.gov or by telephone at (225) 342-2907.

Sincerely,

Dr. Courtney N. Phillips

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA E-MAIL ONLY

November 6, 2020

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

Re: Noncompliance with Managed Care Provider Enrollment Requirement

Dear Mr. Purpera:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor (LLA) dated October 23, 2020, regarding a reportable audit finding related to Managed Care Provider Enrollment. LDH appreciates the opportunity to provide this response to your office's findings.

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

Response:
LDH concurs with your finding that LDH has not enrolled and screened providers contracted with the Healthy Louisiana managed care organizations and dental managed care organizations as required by federal regulations. Louisiana began working on becoming compliant and achieving Provider Management System modularity when it executed a Provider Management contract with Verisys after a successful competitive procurement process. This contract was executed on April 25, 2019. Verisys was expected to bring Louisiana into compliance by the end of Calendar Year 2019. However, Louisiana canceled the Verisys contract effective April 3, 2020, after multiple deadlines on the project were missed. LDH is proceeding with an alternate approach to become fully compliant by mid-year of 2021, assuming there is little impact to the timeline due to the COVID-19 crisis.

LDH plans to amend the current Gainwell (formerly DXC) contract to accomplish enrollment and screening of managed care providers. CMS has approved enhanced funding for this project. The Legislative Joint Health & Welfare Committee has approved the contract amendment, which is now pending final approval by the Louisiana Office of State Procurement. LDH anticipates that work will begin near December 1, 2020. Implementation is estimated to take approximately three (3) months, during which an online application portal will be built by Gainwell and prepopulated with provider data. Following the implementation period, managed care providers will be invited to submit their online enrollment application through the portal and Gainwell will screen them according to federal regulations. This application period will last approximately six (6) months. Following that six-month period, LDH will prohibit managed care plans from paying or contracting with a provider that has not yet been approved by the state through this online application process, unless LDH determines that this needs to be delayed. During this time, Gainwell will also make further enhancements to the portal and invite new managed care providers to submit an online application in the portal.

LDH currently collects provider information from the MCOs including name, specialty, date of birth, social security number, and state license or certification number on all providers enrolled with the MCOs. This data is compared to the USDHHS-OIG List of Excluded Individuals/Entities (LEIE) on a monthly basis to ensure that excluded individuals/entities are not enrolled with the Managed Care Providers. Encounter data from the managed care organizations is compared to the System for Award Management (SAM) database for excluded companies or individuals on a quarterly basis.

You may contact Virginia Brandt, Compliance Officer by telephone at (225) 219-3454 or by e-mail at Virginia.Brandt@al.gov with any questions concerning this matter.

Sincerely,

Dr. Courtney N. Phillips

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA E-MAIL ONLY

December 23, 2020

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

Re: Noncompliance with Provider Revalidation and Screening Requirements

Dear Mr. Purpera:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor (LLA) dated December 11, 2020, regarding a reportable audit finding related to Provider Revalidation and Screening Requirements. LDH appreciates the opportunity to provide this response to your office's findings.

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

Response:
LDH concurs with your finding that LDH has not revalidated providers. Louisiana began working on becoming compliant with this requirement when it executed a Provider Management contract with Verisys after a successful competitive procurement process. This contract was executed on April 25, 2019. Verisys was expected to bring Louisiana into compliance by the end of 2019. LDH cancelled the contract with Verisys Corporation to provide a Provider Management solution effective April 3, 2020. LDH is proceeding with an alternate approach to become fully compliant by the end of 2021, assuming there is little impact to the timeline due to the COVID-19 crisis.

LDH has amended the current Gainwell contract to accomplish provider revalidations, with CMS-approved enhanced funding. LDH anticipates that work will begin near January 4, 2021. Implementation is estimated to take approximately three (3) months, during which an online application portal will be built by Gainwell and prepopulated with provider data. Following the implementation period, current fee-for-service (FFS) and MCO only providers will be able to submit their online enrollment application through the portal and Gainwell will revalidate them according to federal regulations. This application period will last approximately six (6) months. Following that six-month period, LDH will prohibit managed care plans from paying or contracting with a provider that has not yet been approved by the state and fee-for-service (FFS) claims will no longer be paid for non-revalidated providers. At the end of the 6 months all providers will be required to enroll with the state prior to contracting with FFS or the MCOs.

LDH currently performs risk-based screening for newly enrolling and reenrolling FFS providers. Monthly screening of all providers is also being performed through the OIG List of Excluded Individuals/Entities, and the System for Award Management (SAM) database is screened quarterly. As part of the Gainwell portal, risk-based screening will be expanded to include MCO-only providers and the remaining monthly database queries.

Michael Boutte serves as the lead on this matter. If you have any questions or concerns, please contact Mr. Boutte by email at Michael.Boutte@la.gov or by telephone at (225) 342-0327.

Sincerely,

Dr. Courtney N. Phillips

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

VIA E-MAIL ONLY

December 10, 2020

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

Re: Inadequate Controls over Consideration of Lottery Winnings for Medicaid Eligibility

Dear Mr. Purpera:

Thank you for the opportunity to respond to the audit finding that will also be subsequently included in the Single State Audit. The Bureau of Health Services Financing, which is responsible for the administration of the Medicaid program in Louisiana, is committed to ensuring the integrity of the Medicaid eligibility determination process through appropriate management controls.

We reviewed the finding and provide the following response to the recommendation documented in the report.

Finding: LDH did not have adequate controls to ensure compliance with federal requirement over consideration of lottery winnings in [Modified Adjusted Gross Income] MAGI-based eligibility determinations for the Medicaid program.

***Recommendation*:** LDH should ensure that lottery and all other qualified lump sum incomes are considered as part of MAGI-based eligibility determinations as required by federal regulations.

LDH Response: LDH concurs with the finding and recommendation. LDH continuously works to strengthen its eligibility determination processes and has implemented the following corrective action plan to ensure compliance with federal regulations:

- In December 2019, LDH enhanced the Louisiana Medicaid Eligibility Determination System (LaMEDS) to (1) capture lottery winnings or qualified lump sum income via the online Medicaid application, (2) update MAGI-based income counting

methodologies, (3) calculate periods of Medicaid ineligibility for recipients who are qualified lottery and/or other lump sum payments prizewinners, and (4) provide the required decision notice language.

- In April 2020, LDH updated its Medicaid Eligibility Manual policy to include the income counting requirements for qualified lottery and other lump sum payments.

- In June 2020, LDH developed training related to qualified lottery and qualified lump sum winnings for its Medicaid field staff.

- In August 2020, LDH entered into a Data Sharing Agreement with the Louisiana Lottery Corporation for the sharing of lottery prizewinner information for the purposes of eligibility determinations.

- In late September 2020, LDH resumed income verification checks at application and renewal, no longer accepting self-attestation.

- In October 2020, LDH received a list of lottery prizewinners with winnings of $80,000 or greater claimed between the dates of January 1, 2020 and September 30, 2020. The Medicaid Recipient Fraud Investigations Unit has developed procedures and begun review of lottery prizewinner data.

- Beginning December 2020, LDH's Program Integrity Section, Eligibility Program Operations Section, and Eligibility Field Operations Section will coordinate in developing and finalizing processes for the receiving, reviewing, and tracking of lottery prizewinner data. Additionally, LDH will finalize processes to identify Medicaid recipient prizewinners, compare lottery data to the recipient's self-attested information, and update MAGI-based income data collection in the LaMEDS system.

- During the COVID-19 public health emergency period, LDH will continue to track Medicaid recipient prizewinners. Once the public health emergency ends, LDH will conduct re-determinations of eligibility for those recipients, and, if necessary, will take appropriate actions. LDH anticipates that its corrective action plan will be completed six months after the designated end date of the public health emergency period.

Rebecca Harris, Interim Medicaid Deputy Director for Eligibility, serves as the lead on this matter. If you have any questions or concerns regarding the Department's response and/or corrective action plan, please contact Ms. Harris by email at Rebecca.Harris@la.gov or by telephone at 225-342-2907.

Sincerely,

Dr. Courtney N. Phillips

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of the Secretary

February 5, 2021

VIA E-MAIL ONLY

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

Re: Inadequate Controls over Billing for Behavioral Health Services

Dear Mr. Purpera:

On behalf of the Louisiana Department of Health (LDH), I acknowledge receipt of your correspondence dated January 26, 2021, in regards to your office's findings and recommendations related to Inadequate Controls over Billing for Behavioral Health Services. The LDH also appreciates the opportunity to address each separate finding and recommendation presented in your report. Along those lines, please allow this correspondence to serve as the LDH official response thereto.

The Louisiana Department of Health's (LDH) response to the Louisiana Legislative Auditor's finding is shown below and delineated along the three "sub-findings" detailed in your office's report.

Sub-finding 1 - Use of incorrect procedure and modifier codes
Sub-finding 2 - Payments not made in accordance with the SBHS fee schedule
Sub-finding 3 - Add-on services paid without required primary service

Recommendation - LDH management should implement adequate internal controls to ensure that encounters are coded correctly, which could include edit checks to deny improper billings

LDH Response:
LDH does not concur with this recommendation.

<u>Use of incorrect procedure and modifier codes</u>

LDH holds the Managed Care Organizations (MCOs) accountable for implementing necessary claim system edits, as identified in Section 17.2.7. of the current contracts between Bureau of Health Services Financing (BHSF) and each individual MCO, and between Office of Behavioral Health (OBH) and Magellan Complete Care of Louisiana. Required edits include:

- Confirming eligibility on each member
- Validating member names
- Validating unique member identification numbers
- Assuring that dates of services are valid
- Evaluating claims for medical necessity
- System determination as to whether a covered service required prior authorization and if so, whether the MCO granted such approval
- Identification of claims that are exact duplicates of a claim previously submitted to the same MCO
- Ensuring that the system verifies that a service is a covered
- Ensuring the patient is eligible
- Ensuring the provider is eligible to render the service and has not been excluded from receiving Medicaid payments
- Ensuring that the System shall evaluate claims for services provided to members to ensure that any applicable benefit limits are applied.

Further the MCOs must incorporate all National Correct Coding Initiative (NCCI) edits to applicable claims, as well as have the ability to update national standard code sets such as Current Procedural Terminology(CPT)/ Healthcare Common Procedure Coding System (CPT/HCPCS), International Classification of Diseases Codes (ICD-10-CMS), and move to future versions as required by CMS or LDH. In order to meet these requirements, the MCOs implement a variety of edits that are not dependent on the use of modifiers, including the use of information readily available through interfaces with their provider enrollment and service authorization data. The MCOs are also required to perform internal audit reviews to confirm claim edits are functioning properly.

Additionally, the MCOs have multiple systems that interface with their claims processing systems in order to validate claims based on information such as the provider's specialty, which is validated during credentialing, and the member's age on the date of service. This is the most effective way for the MCO to adjudicate the claims while reducing administrative burden and preventing provider abrasion. This results in the MCO not being dependent upon modifiers, which may or may not be valid, to process and pay these claims as clean, rather than denying and requiring unnecessary resubmission.

Payments not made in accordance with the SBHS fee schedule

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

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

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

Medicaid's Managed Care model places emphasis on efficacy and efficiency, which may not necessarily align with hard coded claims logic across multiple populations, providers and patients' varying medical needs. However, LDH will continue to review best practices related to the independent claims processing systems of MCOs, and ensure compliance with and, as needed, development of, contract language to ensure due diligence on their part.

It would be inappropriate for LDH to limit encounter acceptance to only those encounters that are in alignment with the Medicaid fee schedule. While the MCOs are required to provide all of the services listed on the Medicaid fee schedule, they are neither limited to the services listed, nor the rates. Section 9.2 of the current MCO contract requires MCOs to provide reimbursement for defined core benefits and services provided by an in-network provider at a rate of reimbursement that is no less than the published Medicaid fee-for-service rate in effect on the date of service or its equivalent, unless mutually agreed to by both the plan and the provider in the provider contract. Therefore, the fee schedule does list the minimum reimbursement rates, as well as the minimum array of services, but LDH cannot implement edits to account for all instances of an MCO operating outside of these basic requirements.

MCOs may offer additional benefits and rates that are outside the scope and fee of core State Plan benefits and services to individual members on a case-by-case basis, based on medical necessity, cost-effectiveness, the wishes of the member and/or member's family, the potential for improved health status of the member, and functional necessity. In fact, MCOs are required to have Value Based Purchasing Strategic Plans based on the national Health Care Payment Learning and Action Network (HCP-LAN) Alternative Payment Method Framework. The development, maintenance and implementation of this plan is incentivized via a 1 percent withhold by LDH of the MCO's capitation payments as a further effort toward the improvement of quality, health outcomes and the implementation of value-based payments, versus a traditional fee-for-service model. Medicaid programs that are operated under a Managed Care model uniquely afford MCOs the ability, and responsibility to negotiate

rates with providers in order to ensure that contractual requirements related to access and quality are met. In addition to offering incentivized rates to increase access, MCOs also have the ability to cover services and rates not included on the fee schedule in order to implement sub-capitation provider payment models, provide physician incentive payment plans, incentivize utilization of certain interventions and adjust payment levels based on outcomes and performance. Per their contracts, MCOs are further specifically instructed to develop capacity for enhanced rates or incentives to behavioral health clinics to employ primary care providers in a psychiatric specialty setting in an effort to monitor the physical health of patients and improve the integration of behavioral and physical healthcare.

All of the above listed payment methodology options are also taken into consideration in the rate development process. In Louisiana, MCOs are paid under a risk based arrangement using an actuarially sound per member per month (PMPM) rate. These PMPM payments are subject to the federal rules in 42 CFR 438 which do not require the use of FFS limits, nor a direct correlation between the rates and encounter data or MCO reporting. Rather, these resources are all analyzed in consideration of the expectation that the MCOs manage utilization and cost while ensuring an effective and efficient service delivery system. Utilization trends and the expected impact of managed care on utilization of the various types of services, is applied to these varying sources of data, including consideration of managed care savings assumptions and managed care efficiency adjustments, third party liability payments and the MCOs' administration and overhead costs.

Add-on services paid without required primary service

LDH did a preliminary review of the 47 encounters for add-on therapy services that did not appear to be accompanied by an encounter for the primary office visit. In consulting with one MCO, as a sample, they were able to confirm that the primary visits were billed and paid. We will be addressing the remaining encounters with the other managed care entities to ensure that the office visit did occur and was billed. In the event that the MCOs cannot confirm, the additional service will need to be billed and paid out to the provider, or the stand alone service will need to be billed instead. As only a few providers are involved, OBH will work closely with the MCOs to remedy any errors within this category over the next 15 business days and to ensure provider education is offered, if warranted.

Corrective Action Plan

While LDH will not be implementing a CAP to include implementing encounter edits, as recommended by the LLA, LDH is cognizant of the fact that post-payment reviews are a critical component of this payment model. Numerous reviews of behavioral health claims and encounters have been and continue to be conducted by the

Surveillance and Utilization Review Subsystem Unit (SURS), the Unified Program Integrity Contractor (UPIC) and the MCOs to ensure that claims are paid appropriately. These reviews are far more in-depth than what can be accomplished by data analytics alone and allow for consideration of the flexibility necessary for successful implementation of a managed care program. Additionally, LDH provides the MCOs with the records identified by the LLA via this, as well as other audits, so they can research the claims in order to validate whether or not they were paid appropriately. While Program Integrity has already begun to receive feedback, it is still under review by the MCOs and by the Department. Once we have isolated the portion of the claims identified in the finding that were, in fact, processed inappropriately, we will work with the MCOs to identify any areas in their claims review and monitoring process that can be improved upon. In order to accomplish this, OBH will also be establishing and leading a recurring workgroup with the MCOs and Magellan as an ongoing preventative effort relative to these types of issues.

Outside of the specific edits that LDH is able to implement appropriately, we have also elected to contract with a third party for the provision of CMS's optional External Quality Review (EQR) Protocol 4 - Validation of Encounter Data Reported by the MCO or PIHP. Though not required, we've tasked our contractor with reviewing the MCO's Information Systems Capabilities Assessments and analyzing encounter data validity.

Finally, we have two additional safeguards in place that are intended to prevent payment of excessive PMPM rates to the MCOs. The first being the ability of LDH, per the contract, to adjust rates when there are changes to core benefits, services or Medicaid populations, as well as based on Legislative appropriations or budgetary constraints. Secondly, the MCOs are held to a minimum Medical Loss Ratio (MLR) on an annual basis. This MLR requires that their costs for health care benefits and services must account for at least eighty-five percent (85 percent) of their total PMPM revenue. If the MCO does not meet this threshold, they must refund LDH the difference.

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

Sincerely,

Dr. Courtney N. Phillips

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA E-MAIL ONLY

January 26, 2021

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

Re: Weaknesses in Controls over LaMEDS

Dear Mr. Purpera:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor (LLA) dated January 12, 2021, regarding a reportable audit finding for the Single Audit of Louisiana related to Weaknesses in Controls over LaMEDS. LDH appreciates the opportunity to provide this response to your office's findings.

Recommendation: Management should establish procedures for immediately disabling separated employee access.

LDH Response to Finding and Recommendation: LDH concurs with the finding and recommendation. In an attempt to achieve more standardization across the agency, LDH created Policy #134.1 "LDH Policy and Procedures for Ending or Suspending Employee System Access" on December 2, 2020, which includes the process for supervisors to request termination of systems access upon separation. Policy #134.1 is posted on the LDH Policy Website at https://ldh.la.gov/assets/docs/hr/Policies/HumanResources/Policies/LDHEmployeeOffboardingPolicyDEC20.pdf. The corrective action plan to resolve this audit finding is completed.

Recommendation: Management should establish procedures for monitoring contractors and terminating their access when no longer needed.

LDH Response to Finding and Recommendation: LDH concurs with the finding and recommendation. All access to LaMEDS is granted and removed via the Identity Access Management (IAM) Portal. This process was outlined by LDH and has not changed. A procedure document was created by LDH when

LaMEDS first went live on 11/13/2018 titled Managing Access with LaMEDS Users. Managing Access with LaMEDS Users relates to the process LDH created to manage access for all users/contractors. As a corrective action, an attribute (i.e., a "contractor" flag) was developed and added in the Active Directory (AD) to identify users as contractors. On January 12, 2021, a compiled list of contractors was submitted to InfoSEC with OTS to review and add into the AD with a "contractor" flag for identification. These have been completed. Going forward, identification of contractors for monitoring and termination will be completed using this "contractor" flag. This has been added to the Managing Access with LaMEDS Users procedure. The corrective action plan to resolve this audit finding is completed.

Recommendation: Management should establish procedures for performing user access reviews at least annually and making appropriate changes as a result of the user access reviews.

LDH Response to Finding and Recommendation: LDH partially concurs with the finding and recommendation. Medicaid has a procedure to perform annual user access reviews. A review of LaMEDS was timely scheduled for the annual user access review in November 2019 when the state was impacted by the ransomware attack. As a result, the review was delayed and subsequently started in February 2020. During this review, a notification including lists of their employees with access to LaMEDS was sent to every supervisor instructing them to update and respond if their employees still needed access. Supervisors were responding and updating items. However, the final step to actually remove individuals was delayed due to the COVID-19 public health emergency in March 2020 as resources were diverted.

A new review of LaMEDS access is currently in progress pursuant to the timeline referenced below. This is a manually intensive process. However, enhancements to automate the review process have been documented and are being evaluated in an attempt to streamline this process and eliminate manual workload. Below is the progress and timeline of the current review:

- 8/17/20 - Pre-review transmitted to supervisors; due date 8/24/20 - COMPLETE
- 9/14/20 - Review transmitted to supervisors; due date 10/2/20 - COMPLETE
- 11/14/20 - Second review transmitted to supervisors who had not previously responded; due date 11/30/20 - COMPLETE
- 12/1/20 - Begin process of manually removing non-responders based on supervisor review – IN PROGRESS
- 1/14/21 – Notification of Removal sent directly to users from list of non-responders - COMPLETE

- 1/29/21 – Due date of direct user final review before removal - PENDING
- 2/15/21 – User access removals complete - PENDING

This timeline will be compressed prior to the next annual user access review as efficiencies and lessons learned are incorporated.

Mitzi Hochheiser serves as the lead on this matter. If you have any questions or concerns, please contact Ms. Hochheiser by telephone at (225) 342-8935 or email at Mitzi.Hochheiser@la.gov.

Sincerely,

Dr. Courtney N. Phillips

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA E-MAIL ONLY

March 3, 2021

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

Re: Inadequate Controls Over Service Providers with Closed Enrollment

Dear Mr. Purpera:

The Louisiana Department of Health (LDH) acknowledges receipt of your correspondence dated February 11, 2021, wherein the Louisiana Legislative Auditor (LLA) notified LDH of a reportable finding related to inadequate controls over service providers with closed enrollment. LDH appreciates the opportunity to provide this response to your findings. Along those lines, please allow this correspondence to serve as the LDH official response thereto.

The Louisiana Department of Health's (LDH) response to the Louisiana Legislative Auditor's finding is shown below and is delineated along the two "sub-findings" detailed in your office's report.

Sub-finding 1 – Subfinding Related to Medicare Crossovers
Sub-finding 2 – Subfinding Related to Licensing Retroactive Closures

Finding - The Louisiana Department of Health (LDH) paid $287,617 (190,302 federal funds and 97,315 state funds) in fiscal years 2016 through 2020 for claims with service dates occurring after the service providers were no longer enrolled. LDH lacked adequate procedures to ensure claims are only paid for service dates in which the service provider is enrolled in Medicaid.

Recommendation -
LDH should develop and implement procedures to ensure claims are only paid for dates of service during time periods in which the provider was enrolled in the program. In the cases of retroactive closures, LDH should

develop and implement procedures to consider and address, as necessary, any claims already paid during that retroactive closure period.

LDH Response -

LDH concurs with the finding and recommendation and offers the following responses relative to each sub-finding under this recommendation.

Medicare crossovers

Under this finding, there was an identified sub-finding relative to Medicare crossover claims where the auditor identified that the rendering and/or ordering provider on a paid Medicaid claim was not enrolled in Medicaid on the date of service. When Medicare crossover claims are adjudicated, the billing provider's Medicaid enrollment is confirmed as part of claims editing but the rendering and/or ordering providers on the claim are not checked for enrollment. The providers noted in the audit finding were actively enrolled in Medicare on the service dates noted by the audit; however, LDH concurs the rendering and/or ordering providers were not checked for enrollment in Medicaid on the service dates being billed.

Licensing retroactive closures

LDH concurs that the providers noted in the audit finding had enrollment end dates applied retroactively by LDH; however, this was a result of licensing appeals with retroactive terminations and is outside the control of LDH. Licensing boards will make effective dates of their terminations retroactive. Once a provider's appeals have exhausted with the licensing board and the appeal is upheld, the licensing board will issue the final decision with a retroactive effective date of the termination based on when the appeal began. LDH is not notified until the appeal is upheld and final but recognizes the retroactive date of the license termination. The provider is then disenrolled with the corresponding retroactive closure date by LDH as provided by the licensing board. As a result of the retroactive termination by the licensing board, LDH had already paid for services dates during the appeal period.

Corrective Action Plan -

Medicare crossovers

LDH will update the claims and encounter editing protocols to check that the ordering, rendering, and prescribing providers are enrolled in Medicaid and eligible for Medicaid payment prior to adjudication. This update will take approximately six months to complete, targeting end of August 2021. LDH

will also review the Medicare crossover claims on the list provided by LLA for possible recoupment based on what is permitted by the Surveillance and Utilization Review Subsytem (SURS) rule.

Licensing retroactive closures

LDH will perform quarterly data analysis to identify paid claims and encounters with dates of service after an enrollment closure date. Identified claims and encounters will be reviewed to determine if recoupment should be pursued. This process will be implemented by the end of March 2021 with the next quarterly data run performed in April 2021. LDH will also review the list provided by LLA with a licensing issue for possible recoupment based on what is permitted by the SURS rule.

You may contact Jarrod Coniglio, Medicaid Program Integrity Section Chief by telephone at (225) 219-4150 or by e-mail at jarrod.coniglio@la.gov with any questions concerning this matter.

Sincerely,

Dr. Courtney N. Phillips

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Public Health

March 3, 2021

VIA E-MAIL ONLY

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

Re: Lack of Internal Controls over and Noncompliance with Subrecipient Monitoring Requirements

Dear Mr. Purpera,

On behalf of the Louisiana Department of Health (LDH), I acknowledge receipt of your correspondence dated February 4, 2021, in regards to your office's findings and recommendations related to noncompliance with subrecipient monitoring requirements of the Louisiana Department of Health, Office of Public Health (LDH OPH), STD/HIV/Hepatitis Program's (SHHP) HIV Prevention Grants (CDFA #93.940).

LDH appreciates the opportunity to address each separate finding and recommendation presented in your report. Along those lines, please allow this correspondence to serve as the LDH official response(s) thereto.

The Louisiana Department of Health's (LDH) response to the Louisiana Legislative Auditor's finding is shown below and delineated along the two "sub-findings" detailed in your office's report.

- Sub-finding 1- OPH did not evaluate any subrecipient's risk of noncompliance for purposes of determining the appropriate subrecipient monitoring related to the award as required by federal regulations.

- Sub-finding 2 - From a population of 25 contracts with expenditures totaling $2,281,253, we selected a non-statistical sample of six contracts for testing with expenditures totaling $662,893. In addition, we tested three individually important contracts with expenditures totaling $3,594,770. Although OPH documented site visits for the subrecipients randomly selected for testing, OPH could not provide documentation of site visits for the subrecipients related to the individually important contracts.

Recommendation -

OPH should ensure that risk evaluations are performed for all subrecipients to determine the appropriate monitoring. In addition, OPH should establish a plan based on risk, such as a rotation schedule, to ensure that all subrecipients are monitored periodically.

Response to Recommendation-

As detailed below, LDH\OPH does not concur with the two sub-findings.

With respect to Sub-finding 1, LDH does not believe that a corrective action plan is required due to its compliance with federal regulations at 2 CFR 200.332(b). Nevertheless, LDH will review its current practices to determine if improvements are necessary as provided in the recommendation.

With respect to Sub-finding 2, a corrective action plan is detailed below.

Sub-finding 1 - Evaluation of subrecipient's risk of noncompliance –

Background

OPH evaluates sub-recipient risk in accordance with the Louisiana Department of Health (LDH) Policy 13.3. This policy details specific requirements for conducting audit reviews, which include risk assessments, as well as yearly management evaluations of said reviews and assessments. A sub-recipient audit check list is completed for each agency to determine if it is a sub-recipient or vendor. The OPH fiscal office generates a SUB19 PMTS report of sub-recipients for each agency which includes confirmation of audit submittal by the sub-recipient and a record of any finding. The report utilizes the Federal Audit Clearinghouse for Single Audits to verify that the sub-recipient has an audit on file for the period of certification. The Contract Specialist reviews the SUB19 PMT list to confirm that payments are on record. The Contract Specialist also reviews the audit findings and the responses and routes it to the proper managers for review and to make a determination on whether or not the responses are adequate or whether there will be any programmatic decisions to continue or not continue using the sub-recipient as a vendor based on the audit findings, regardless of whether or not the audit findings relate to specific contract deliverables. The certifications are then signed and are submitted back to Fiscal.

In communicating the above described process for assessing subrecipients' risk during the course of this audit, OPH received the following additional communication/recommendation from LLA:

> "Regarding the response to the first issue, these are all adequate procedures but they do not address the requirements of 2 CFR 200.332(b), which require evaluating each subrecipient's risk of noncompliance with federal statutes and regulations. These may include consideration of such factors as (1) the subrecipient's prior experience with the same or similar subawards; (2) the results of previous audits; (3) whether the subrecipient has new personnel or new or substantially changed systems, and (4) the extent and results of Federal awarding agency monitoring." (LLA email communication 1/29/2021)

Response

Notwithstanding the above-quoted input provided by the LLA, LDH does not concur with this sub-finding as written. 2 CFR 200.332(b) reads (emphasis added):

> (b) Evaluate each subrecipient's risk of noncompliance with Federal statutes, regulations, and the terms and conditions of the subaward for purposes of determining the appropriate subrecipient monitoring described in paragraphs (d) and (e) of this section, **which *may* include consideration of such factors as**:
> (1) The subrecipient's prior experience with the same or similar subawards;
> (2) The results of previous audits including whether or not the subrecipient receives a Single Audit in accordance with Subpart F of this part, and the extent to which the same or similar subaward has been audited as a major program;
> (3) Whether the subrecipient has new personnel or new or substantially changed systems; and
> (4) The extent and results of Federal awarding agency monitoring (e.g., if the subrecipient also receives Federal awards directly from a Federal awarding agency).

LDH asserts that the emphasized language makes it clear that no particular listed factor, or combination thereof, is required to evaluate the risk of noncompliance. All of the OPH\SHHP subrecipients at issue undergo yearly financial and compliance audits, and the SHHP reviews same pursuant to the aforementioned LDH Policy 13.3 in order to evaluate the risk of noncompliance. That risk evaluation methodology meets the requirements of 2 CFR 200.332(b).

Because LDH believes that its current practices conform to the requirements of 2 CFR 200.332(b), LDH believes that no corrective action plan is necessary with respect to this sub-finding.

Sub-finding 2 - Documentation of site visits for the subrecipients related to the individually important contracts –

Background

The specific contracts that are the focus of this finding are for the provision of personnel that staff the OPH STD/HIV/Hepatitis Program. The STD/HIV/Hepatitis Program consists of approximately 130 staff, of which only 14 are State employees, while the rest are employed through the individual critical contracts referenced in this finding.

These contracts are not for the provision of services but for the day-to-day staffing of the program and are monitored as follows:

- The SHHP Director meets with senior management staff on the personnel contracts at least monthly.
- The SHHP Director meets with the Executive Director of each of the personnel contracts at least twice per year, or more often if needed.
- The SHHP Director meets with all contract staff (not just the senior leadership staff) on the personnel contracts at least twice per year to review performance of the program staff to ensure grant deliverables are communicated and are being met.
- The SHHP Management Team conducts regular meetings with all staff (including the contracted staff) to ensure appropriate performance is being realized.
- SHHP ensures individual annual performance evaluations are completed for each of the contract staff assigned to SHHP via the personnel contracts as part of the monitoring to ensure the goals and deliverables of these subrecipients are met.

Site visit meetings with the personnel contractors generally occur at the main SHHP Central Office located in Benson Tower, as that is where most of the contract staff are also located. Virtual meetings have been employed since the onset of the COVID-19 pandemic. Progress toward achieving the contracted deliverables and stated objectives are reviewed at these meetings and plans for performance improvement are also developed during these meetings when there are any identified deficiencies in performance. OPH contends that the daily supervision, regular recurring staff meetings, annual performance evaluations of contract staff, site visit meetings with the contractors and the overall performance of the program toward accomplishing stated federal grant deliverables and objectives are evidence that appropriate monitoring of these important personnel contracts occurred.

Response

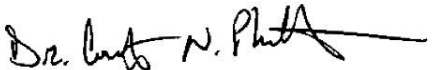
LDH partially concurs with this sub-finding as written. LDH believes that it possessed (and provided to the LLA) sufficient documentation to demonstrate that the site visits at issue occurred. Nevertheless, LDH does agree that site visit meetings were not documented with the designated authorities of each personnel contract and this documentation would have provided "best" evidence of appropriate monitoring of these important subrecipients.

Sub-finding 2 - Corrective Action Plan –

OPH SHHP will begin creating written agendas and meeting summary reports for the semiannual site visit meetings that are held with each of the personnel contractors and these site visit meeting agendas and summary reports will be stored according to LDH records retention policy. For each of the personnel contracts, one of the semiannual site visit meetings will occur in the first six months of each fiscal year and the other site visit meeting will occur in the last six months of each fiscal year. Site visit meetings may be conducted virtually but will be documented with agendas and written summary reports.

You may contact Samuel Burgess, OPH STD/HIV/Hepatitis Program Director by telephone at 504-568-7474 or by e-mail at samuel.burgess@la.gov with any questions concerning this matter.

Sincerely,



Dr. Courtney N. Phillips, Secretary

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of the Secretary

March 3, 2021

VIA E-MAIL ONLY

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

Re: Lack of Internal Controls over Program Expenditures

Dear Mr. Purpera:

On behalf of the Louisiana Department of Health (LDH), I acknowledge receipt of your correspondence dated February 10, 2021, in regards to your office's findings and recommendations related to controls over non-payroll program expenditures of the Louisiana Department of Health Office of Public Health (LDH OPH) STD/HIV/Hepatitis Program. LDH also appreciates the opportunity to address each separate finding and recommendation presented in your report. Along those lines, please allow this correspondence to serve as the LDH official response thereto.

The Louisiana Department of Health's (LDH) response to the Louisiana Legislative Auditor's finding is shown below and delineated along the two "sub-findings" detailed in your office's report. The numbers shown below in the sub-findings were derived from a sample of transactions selected by the auditor.

- Sub-finding 1 - Nine (18%) payments were not approved by an appropriate supervisor and eight of those payments did not include enough information to determine if the account coding was accurate.

- Sub-finding 2 - Twelve payments (24%) did not include enough information to determine if the account coding was accurate.

Recommendation -

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

Response -

LDH / OPH does not concur with these two sub-findings and concurs with the recommendation.

Sub-finding 1 - Approval of expenditures –

LDH / OPH does not concur with this sub-finding as to the type of documentation requested by the auditors. The wording of this sub-finding implies that the appropriate program supervisor did not review the nine payments in question at all before the invoices were submitted for payment processing. On the contrary, the invoices were reviewed before they were paid, but the supervisor did not sign the invoices to document their approval. Therefore, we acknowledge that the payments noted did not include enough information to show approval by an appropriate supervisor before payment was processed. LDH asserts that payments were made with a review and with proper authority to make such purchases. Payment information is uploaded into SharePoint by the agency upon their receipt of the invoice and that serves as Fiscal's confirmation to proceed with payment processing. Invoices are reviewed and approved at the agency level before they are sent to LDH Fiscal for payment.

Sub-finding 1 - Corrective Action Plan –

LDH / OPH will be sure to submit the annual Request for Expenditure Form for the full contract amount with all invoices to ensure there's evidence of preapproval of all payments.

Sub-finding 2 – Account Coding –

LDH / OPH does not concur with this sub-finding. Based on our review of the payments noted, the account coding used agrees to the coding that was approved on the purchase order and the description of each account coding element shows that the coding used was applicable to the grant.

Sub-finding 2 - Corrective Action Plan –

Regarding the cost allocation to the Reporting Categories used on each payment, the SHHP Expense Allocation Policy supports the cost allocation practices. Program staff should sign off on their review and we agree that this should be implemented in their steps.

You may contact Samuel Burgess, OPH STD/HIV/Hepatitis Program Director by telephone at 504-568-7474 or by e-mail at samuel.burgess@la.gov with any questions concerning this matter.

Sincerely,

Dr. Courtney N. Phillips

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of the Secretary

March 1, 2021

VIA E-MAIL ONLY

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

Re: Waiver Services Providers

Dear Mr. Purpera:

On behalf of the Louisiana Department of Health (LDH), Office for Citizens with Developmental Disabilities (OCDD) and Office of Aging and Adult Services (OAAS), I acknowledge receipt of your correspondence dated February 1, 2021, in regards to your office's findings and the recommendation related to Inadequate Controls over Waiver Services Providers. LDH, OCDD and OAAS also appreciate the opportunity to address the findings and the recommendation presented in your report. Along those lines, please allow this correspondence to serve as the LDH official response thereto.

Finding - For the ninth consecutive year, the LDH paid Medical Assistance Program (CFDA 93.778, Medicaid) Home and Community-Based Services (HCBS) claims for the New Opportunities Waiver (NOW), Residential Options Waiver (ROW), and Community Choices Waiver (CCW) for waiver services that were not documented in accordance with provider manuals.

The LDH response to the Louisiana Legislative Auditor's finding is shown below and delineated along the four "sub-findings" (two sub-findings for OCDD and two sub-findings for OAAS) detailed in your office's report.

OCDD -

Sub-finding 1 - For 38 claims for three recipients, the waiver services provider did not provide documentation to support deviations from the approved plan of care (POC).

LDH/OCDD Response to Sub-finding 1 – LDH/OCDD concurs schedules were not followed exactly as written in the POC. However, LDH/OCDD does not agree with the LLA's assessment that providers cannot substantiate, and auditors cannot verify, the deviations were recipient-driven and person-centered as required.

Sub-finding 2 - For five claims for one recipient, auditors were unable to determine if a deviation from the POC occurred because timesheets/EVV documentation and units billed were not consistent. Provider could not provide explanation or documentation to explain why EVV documentation did not match units billed.

LDH/OCDD Response to Sub-finding 2 – LDH/OCDD concurs with this sub-finding that the auditor found some inconsistencies with the manual time sheets the staff completed and the Electronic Visit Verification System (EVV) clock ins/clock outs for the provider referenced in this sub-finding. OCDD Management contacted the provider and determined the provider only billed for the EVV time, and when asked about the difference between the manual entries and EVV time, the provider informed OCDD they are very cautious about only billing time for which they can account. The provider asserted if an individual staff person manually signs in and either forgets to sign in, or is unable to sign in with EVV, the provider will not count the manual sign in when billing unless the staff person is able to explain and document to administrative staff the reason they did not sign in with EVV. OCDD stressed to the individual receiving services, as well as the individual's caretaker and provider staff, the importance of accurate documentation.

OAAS -

Sub-finding 3 - For two claims for one recipient, the waiver services provider did not provide adequate documentation to support billed services. These claims total $1,035 ($756 federal funds and $279 state funds) and are considered questioned costs.

LDH/OAAS Response to Sub-finding 3 – LDH/OAAS concurs that documentation in progress notes was insufficient. LDH/OAAS reviewed the two claims and found that though services were authorized and billed correctly for hours worked, documentation in progress notes of tasks performed was insufficient. There was no negative impact on the health and welfare of the participant and no negative financial impact on the state.

Sub-finding 4 - For 14 claims for two recipients, the waiver services provider did not provide documentation to support deviations from the approved POC. According to the CCW provider manual, significant deviations must be documented. Significant is not defined. Errors noted were deviations of thirty minutes or more.

LDH/OAAS Response to Sub-finding 4 – LDH/OAAS concurs that deviations from the POC were not documented according to policy. LDH/OAAS notes that this sub-finding did not result in any negative financial impact to the State. Our review of the cited claims confirmed all services billed and paid were appropriately authorized and delivered and documentation did confirm service delivery. Furthermore, though the reasons for deviations from the POC were not documented according to policy, the deviations did not have a negative impact on service delivery or the health or welfare of the participants.

LDH/OAAS will update the CCW provider manual regarding documentation requirements when there is significant deviation from the Plan of Care (POC). LDH/OAAS will also implement a risk-based quality assurance process using data from the Electronic Visit Verification (EVV) system.

LDH Response to finding - Inadequate Controls over Waiver Services Providers **-**

LDH/OCDD/OAAS partially concurs with the finding of inadequate controls over waiver service providers.

LDH/OCDD/OAAS asserts that there are sufficient controls over waiver service providers to prevent financial harm to the state and harm to the health and welfare of participants. LDH has implemented the geo-coded Electronic Visit Verification (EVV) system, which only allows providers to bill for time that is actually worked. Through EVV, the LDH data contractor, Statistical Resources, Inc. (SRI), captures both the location and time when a worker clocks in and clocks out. SRI also uses algorithms that block overlapping services and prevent two workers from billing on a single individual at the same time or one worker for billing for two individuals at different locations at the same time. SRI programming also identifies worker on the Louisiana Adverse Action List and blocks billing for that worker if there is a finding. Also, for individuals in the OCDD NOW program, the system ensures the NOW rules are followed for individuals attending the Employment/Day Care programs, and blocks staff from working over 16 hours in a 24-hour period.

Additional checks and balances to ensure sufficient financial and safety controls include:

- Support coordinators contact participants at least monthly to check on participants and ask questions regarding service delivery and care;

- Waiver services are subject to both prior and post authorization by Statistical Resources, Inc. (SRI) before claims can be filed and payments made to providers;
- The LDH Program Integrity Section investigates instances of possible fraud;
- Gainwell Technologies (formerly DXC/Molina) runs random audits on provider agency services as well as audits on agencies where there may be a problem; and
- The Attorney General's Office Medicaid Fraud Control Unit (MFCU), investigates complaints of fraud, waste, and abuse.

As outlined above, LDH/OCDD/OAAS works cooperatively with all of the above mentioned departments/agencies in making sure the participants receive necessary services in a safe manner.

LDH does partially concur with LLA findings regarding insufficient progress note documentation by direct support workers. In instances cited by the LLA, provider agency workers failed to fully document tasks performed and failed to document deviations from the flexible schedule outlined in the Plan of Care.

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

LDH Response – LDH concurs with this recommendation.

Corrective Action Plan

LDH will continue to work with providers to review all regulatory and program requirements for their respective programs. LDH/OCDD/OAAS will also review and update waiver provider manuals as pertains to documentation requirements and deviations from Plan of Care.

LDH/OCDD/OAAS will furthermore implement a new, risk-based quality assurance process using EVV data to target training, technical assistance, and remediation where it is most needed. This process will utilize data from the EVV system to identify areas of provider noncompliance with POC as well as other areas deemed important for further review by program staff.

As regards these specific findings, OCDD has already taken action to explain to the providers cited in sub-finding 1 and sub-finding 2 to make sure that the CPOC clearly explains the rotating schedules, and advised them to continue to provide training to all staff concerning documentation requirements.

OAAS has also already taken steps to explain documentation requirements to this provider cited in sub-finding 3 and sub-finding 4. This provider was advised of the following: 1) ensure that all workers are aware of the documentation requirements when participants have significant changes in their schedules; 2) for new worker orientation, incorporate a training that focuses on appropriate documentation when there is a deviation to a participant's schedule; 3) consider conducting a quality check system for documentation purposes; and 4) remember to contact the Support Coordination Agency when there is a long term change for the participant so the POC can be revised.

LDH/OCDD/OAAS appreciates the opportunity to respond to this audit. For OCDD, you may contact Paul Rhorer, OCDD Program Manager 3, by telephone at (225) 342-8804 or by e-mail at paul.rhorer@la.gov. For OAAS, you may contact Kirsten Clebert, OAAS Policy Division Director by telephone at (225) 955-8214 or by email at Kirsten.Clebert@la.gov at with any questions concerning this matter.

Sincerely,

Dr. Courtney N. Phillips

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Public Health

March 15, 2021

VIA E-MAIL ONLY

Thomas H. Cole, CPA, CGMA
Temporary Legislative Auditor
P.O. Box 94397
Baton Rouge, LA 70804-9397

Re: Inadequate Controls over Payroll

Dear Mr. Cole:

On behalf of the Louisiana Department of Health (LDH), I acknowledge receipt of your correspondence dated March 3, 2021, in regards to your office's findings and recommendations related to controls over payroll related program expenditures of the Louisiana Department of Health Office of Public Health, and the Public Health Emergency Preparedness program (CFDA 93.069), the HIV Prevention Activities Health Department Based program (CFDA 93.940), and the Coronavirus Relief Fund program (CFDA 21.019). LDH also appreciates the opportunity to address each separate finding and recommendation presented in your report. Along those lines, please allow this correspondence to serve as the LDH official response thereto.

The Louisiana Department of Health's (LDH) response to the Louisiana Legislative Auditor's finding is shown below and delineated along the four "sub-findings" detailed in your office's report. The numbers shown below in the sub-findings were derived from a sample of transactions selected by the auditor.

- Sub-finding 1 - For the Public Health Emergency Preparedness program, six (18%) of 34 payroll transactions were not approved by the employees' supervisors.

- Sub-finding 2 - For the HIV Prevention Activities Health Department Based program, four (36%) of 11 payroll transactions were not approved by the employees' supervisors and three (27%) did not include documentation, such as a time statement to support expenditures totaling $3,151.

- Sub-finding 3 - For the Coronavirus Relief Fund program, 11 (17%) of 63 payroll transactions were not approved by the employees' supervisors.

- Sub-finding 4 - Based on audit procedures conducted on all payroll transactions in fiscal year 2020, we identified 3,672 (10%) of 35,301 time statements that were not approved by the employees' supervisors.

Recommendation -

OPH should ensure employees comply with existing policies and procedures, including properly approving electronic time statements in a timely manner and maintaining adequate documentation to support all expenditures of federal awards.

Response -

LDH/OPH concurs with these sub-findings and concurs with the recommendation.

Sub-finding 1 - Public Health Emergency Preparedness program –

The LDH/OPH Public Health Emergency Preparedness (PHEP) program concurs with this sub-finding as to the level of supervisory approval of certain timesheets reviewed by the auditor.

Sub-finding 1 - Corrective Action Plan –

The Public Health Emergency Preparedness Program will begin running reports after each pay period to check for missing supervisor approvals for all staff and to ensure any missing timesheet approvals are addressed/corrected in a timely manner. We will start this process with the pay period that just ended.

In addition, any further corrective action to address this finding will be based on an overall agency-wide plan outlined in the response to sub-finding 4 below.

Sub-finding 2 – STD/HIV/Hepatitis Program –

LDH/OPH STD/HIV/Hepatitis Program concurs with this sub-finding as to the level of supervisory approval of certain timesheets reviewed by the auditor.

Sub-finding 2 - Corrective Action Plan –

The STD/HIV/Hepatitis Program will begin running reports after each pay period to check for missing supervisor approvals for all staff and to ensure any missing timesheet approvals are addressed/corrected in a timely manner. We will start this process with the pay period that just ended.

In addition, any further corrective action to address this finding will be based on an overall agency-wide plan outlined in the response to sub-finding 4 below.

Sub-finding 3 - Coronavirus Relief Fund program –

The LDH/OPH Coronavirus Relief Fund program concurs with this sub-finding as to the level of supervisory approval of certain timesheets reviewed by the auditor.

Sub-finding 3 - Corrective Action Plan –

The LDH/OPH Coronavirus Relief Fund program will develop a corrective action to address this finding based on an overall agency-wide plan outlined in the response to sub-finding 4 below.

Sub-finding 4 – OPH Timesheets –

LDH/OPH concurs with this sub-finding as to the level of supervisory approval of certain timesheets reviewed by the auditor.

Sub-finding 4 - Corrective Action Plan –

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

You may contact Samuel Burgess, OPH STD/HIV/Hepatitis Program Director by telephone at 504-568-7474 or by e-mail at samuel.burgess@la.gov or Dr. Sundee Winder, Interim Deputy Director, Bureau of Community Preparedness at (225) 354-3524 or by e-mail at sundee.winder@la.gov with any questions concerning this matter.

Sincerely,

Dr. Courtney N. Phillips

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of the Secretary

VIA E-MAIL ONLY

January 6, 2021

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

Re: Noncompliance with Third-Party Liability (TPL) Assignment

Dear Mr. Purpera:

Thank you for the opportunity to respond to the audit finding that will be included in the Single State Audit. The Bureau of Health Services Financing, which is responsible for the administration of the Medicaid program in Louisiana, is committed to ensuring the integrity of the Medicaid eligibility determination process through appropriate management controls. We have reviewed the finding and provide the following response to the recommendation documented in the report.

Recommendation: The Louisiana Department of Health (LDH) should ensure notification of TPL assignment is included in each Medicaid and LaCHIP recipient case record as a part of required documentation to support the eligibility decision.

While the LDH is compliant with federal regulations at 42 CFR 433.146 regarding notification of TPL assignment, it concurs with the recommendation to include documentation in the recipient case record. LDH continuously works to strengthen its eligibility processes and has completed the following corrective action plan in response:

In March 2018, Medicaid Eligibility staff were instructed to confirm the TPL assignment notification is contained on paper applications received for processing. If not, a notification of the assignment must be sent to the applicant if found eligible for Medicaid and the notification document uploaded into the Electronic Case record. In November 2018, the new eligibility system, LaMEDS, was implemented and TPL assignment notification was included in the electronic application summary going forward. Immediately following this, in December 2018, the Medicaid Procedures

Manual was updated with instructions for staff to confirm the TPL assignment notification is contained on paper applications received for processing. If not, a notification of the assignment must be sent to the applicant if found eligible for Medicaid and the notification document uploaded in to the new Electronic Document Management System used in conjunction with LaMEDS. This corrective action resolved documentation requirements for all prospective cases.

In regards to cases that existed prior to the launch of LaMEDS, in July 2020, LDH finalized the TPL notification language for application and renewal letters and logged a LaMEDS system enhancement request for the following TPL language to be included in the notices:

> *By enrolling in Medicaid, you understand that you give Louisiana Medicaid the rights to any money owed to you by any other health insurance, legal settlement, spouse or parent, or other their party. Reference: La. R.S. 46:153E.*

LDH Medicaid completed the development, design and testing of the enhancement to the system. In October 2020, this was placed into production to include TPL notification language on both application approval letters and renewal letters and copies of these letters are maintained in the Electronic Document Management System for the recipient's case record.

Fiscal year 2020 presented unique challenges to LDH with the November 2019 ransomware attack followed shortly thereafter by the COVID-19 public health emergency (PHE) in March 2020. Although the Plan of Correction (POC) was not implemented in fiscal year 2020 as originally planned due to system resources becoming stalled or diverted in order to respond to these emergencies, LDH has completed the POC effective October 2020.

Ms. Tara LeBlanc serves as the lead on this matter. If you have any questions or concerns regarding LDH's response and/or corrective action plan, please contact Ms. LeBlanc by email at tara.leblanc@la.gov or by telephone at 225-342-8908.

Sincerely,

Dr. Courtney N. Phillips

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA E-MAIL ONLY

February 18, 2021

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

Re: Noncompliance with Prenatal Service Third-Party Liability Requirements

Dear Mr. Purpera:

The Louisiana Department of Health (LDH) acknowledges receipt of your correspondence dated February 5, 2021, wherein the Louisiana Legislative Auditor (LLA) notified LDH of a reportable finding related to prenatal service third-party liability requirements. LDH appreciates the opportunity to provide this response to your findings.

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

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

LDH Response -

LDH concurs with the finding and recommendation.

Corrective Action Plan -

For its corrective action plan, LDH amended the relevant State Plan provisions and CMS approved this SPA on October 8, 2020, retroactive to July 1,2020. LDH also drafted a change order to implement the technical

changes for compliance. The change order directs the LDH fiscal intermediary to make the following adjudication changes:

1. Move prenatal services from pay and chase to cost avoidance. This means that in the presence of third party liability (TPL) on file, these services will now deny.

2. Implement a wait and see period for Child Support Enforcement claims. Wait and see is defined as payment of a claim only after 100 days since the date of service has passed and documentation has been submitted that demonstrates the provider first tried to bill the third party and has not received payment.

LDH staff and contractors were focused on implementation of COVID-specific changes and needed additional time to complete testing and programming for this change after we received approval in October, in addition to making the necessary MCO contract and system changes. This corrective action plan will be completed by April 1, 2021.

It should be noted that LDH's existing coding cost avoids in fee for service and no corrective action is necessary.

You may contact Michael Boutte, Medicaid Deputy Director by telephone at (225) 342-0327 or by e-mail at michael.boutte@la.gov with any questions concerning this matter.

Sincerely,

Dr. Courtney N. Phillips

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA E-MAIL ONLY

February 10, 2021

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

Re: Inadequate Controls over Monitoring of Abortion Claims

Dear Mr. Purpera:

The Louisiana Department of Health (LDH) acknowledges receipt of your correspondence dated January 28, 2021, wherein the Louisiana Legislative Auditor (LLA) notified LDH of a reportable finding related to monitoring of abortion claims. LDH appreciates the opportunity to provide this response to your findings.

Finding: For the second consecutive year, the Louisiana Department of Health (LDH) did not have adequate controls to ensure compliance with federal regulations prohibiting the use of federal funding for abortion claims.

Recommendation - LDH should complete its current claims review and continue on-going monitoring of encounter claims for Medicaid and CHIP recipients to ensure compliance with federal regulations regarding funding of prohibited abortions claims.

LDH Response:
LDH does not concur with the finding LDH did not have adequate controls to ensure compliance with federal regulations prohibiting the use of federal funding for abortion claims.

However, LDH does concur with the recommendation provided. LDH will complete the current review of claims, and will continue on-going monitoring as mentioned in the recommendation.

LDH asserts its controls to ensure compliance with federal regulations prohibiting the use of federal funding for abortion claims are in place and

effective. Furthermore, LDH does not have any evidence abortion claims did not meet the exception criteria were paid within managed care and fee for service (FFS) based on federal requirements.

As part of its monitoring controls, LDH obtains a report entitled "End of Pregnancy" from the managed care organizations (MCOs) as a mandatory reporting requirement. This report provides documentation on the number of pregnancy terminations and also provides specifics on the procedure/event that led to the termination.LDH uses this report as part of its plan to improve the handling of these claims.

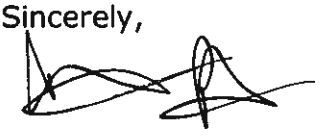
Additionally, the department has implemented a post payment review process using FFS and MCO reporting, which includes the time period in question. The post payment review has become part of the monthly Compliance Monitoring Procedures for Limitations on Abortions. The majority of payments in question have been reviewed and no prohibited abortions are identified at this time.

LDH has completed the FFS review using the No. MW-M-48 Monthly Report On Abortions By Race And Gender from this year and last year, including all of fiscal year 2020 (July 2019 to June 2020), for induced abortions.

All MCOs are required to submit information related to claims paid for induced abortions on the monthly 137 report, Elective Abortion Report tabs. The information on these reports is reviewed monthly for compliance and will continue to be reviewed. Additionally, LDH is nearing completion of the review for MCO reported payments made prior to the information being captured on the monthy 137 report. To finalize its review, LDH has requested MCO records by Friday, February 12, 2021, for claims pending review and expects to have the review completed by March 5, 2021.

You may contact Michael Boutte, Medicaid Deputy Director by telephone at (225) 342-0327 or by e-mail at michael.boutte@la.gov with any questions concerning this matter.

Sincerely,



Dr. Courtney N. Phillips

APPENDIX B: SCOPE AND METHODOLOGY

We performed certain procedures at the Louisiana Department of Health (LDH) for the period from July 1, 2019, through June 30, 2020, to provide assurances on financial information significant to the State of Louisiana's Comprehensive Annual Financial Report, and to evaluate relevant systems of internal control in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States. Our procedures, summarized below, were a part of the audit of the Comprehensive Annual Financial Report and our work related to the Single Audit of the State of Louisiana (Single Audit) for the year ended June 30, 2020.

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

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

- We performed procedures on the Commodity Supplemental Food Program (part of the Food Distribution Cluster, CFDA 10.565), Coronavirus Relief Fund (CFDA 21.019), Public Health Emergency Preparedness (CFDA 93.069), Children's Health Insurance Program (CFDA 93.767), Medicaid Cluster (CFDA 93.775, 93.777, and 93.778), and HIV Prevention Activities Health Department Based (CFDA 93.940) for the year ended June 30, 2020, as a part of the 2020 Single Audit.

- We performed procedures on information for the preparation of the state's Schedule of Expenditures of Federal Awards and on the status of prior-year findings for the preparation of the state's Summary Schedule of Prior Audit Findings for the year ended June 30, 2020, as a part of the 2020 Single Audit.

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

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

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