LOUISIANA DEPARTMENT OF HEALTH

STATE OF LOUISIANA

FINANCIAL AUDIT SERVICES
MANAGEMENT LETTER
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Louisiana Legislative Auditor

Daryl G. Purpera, CPA, CFE

Louisiana Department of Health

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Audit Control # 80190076

Introduction

As a part of our audit of the State of Louisiana's Comprehensive Annual Financial Report (CAFR) and the Single Audit of the State of Louisiana (Single Audit) for the fiscal year ended June 30, 2019, we performed procedures at the Louisiana Department of Health (LDH), including the Office of Public Health (OPH), to provide assurances on financial information that is significant to the state's CAFR; 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 March 18, 2019. We determined that management has resolved the prior-year findings related to Inadequate Controls over Required Reporting on the Schedule of Expenditures of Federal Awards and Improper Charges to Federal Programs. The prior-year findings related to Inadequate Internal Control over Modified Adjusted Gross Income (MAGI) Eligibility Determinations, Noncompliance with Managed Care Provider Enrollment Requirement, Improper Payments to Waiver Services Providers, Inadequate Controls over Quarterly Federal Expenditure Reporting, Noncompliance with Third-Party Liability Assignment, Noncompliance with Provider Revalidation and Screening Requirements, and Noncompliance with Review of Redeemed Food Instruments and Cash-Value Vouchers have not been resolved and are addressed again in this letter.

Current-year Findings

Inadequate Internal Control over Modified Adjusted Gross Income (MAGI) Eligibility Determinations

For the second consecutive year, LDH failed to design and maintain adequate internal control over MAGI-based eligibility determinations in the Medical Assistance Program (Medicaid - CFDA 93.778) and Children's Health Insurance Program (LaCHIP - CFDA 93.767). In 2014,

through the Affordable Care Act, federal regulations changed the requirements for Medicaid eligibility determinations to a new methodology using federal income tax information (FTI) known as MAGI. The new MAGI determination process significantly changed the way Medicaid eligibility is determined for a large percentage of the Louisiana Medicaid program. While the new methodology was designed around federal tax data, LDH did not use federal tax information to verify critical Medicaid eligibility factors, resulting in a lack of internal control and increased risk that applicants could be determined eligible when they are not.

In fiscal year 2019, LDH Medicaid and LaCHIP program expenditures totaled $12 billion. As of June 30, 2019, there were approximately 1.6 million recipients in Louisiana Medicaid. Of these recipients, approximately 1.4 million (89%) were determined eligible in a MAGI eligibility group by LDH and had Healthy Louisiana managed care premium payments made to the managed care organizations (MCO) on their behalf. The MCOs are responsible for payment of provider claims for Medicaid services. LDH paid approximately $7.9 billion in Healthy Louisiana managed care premiums, with $5.5 billion dollars in premiums paid on behalf MAGI-based recipients.

In a previous Medicaid Audit Unit (MAU) report, *Medicaid Eligibility: MAGI Determination Process*, issued in December 2018, we noted that LDH did not use federal and/or state tax information to verify certain self-attested eligibility factors, including tax filer status, household size, self-employment income, and other types of income. This other income could include retirement and annuities, interest and dividends, and rentals and royalties. We determined this lack of verification to be a weakness in internal control, because tax information was the only trusted source for these critical Medicaid MAGI eligibility factors. LDH noted that FTI would be incorporated into the eligibility system for use in the verification process in May 2019.

In a follow-up MAU report titled *Status on the Use of Federal Tax Information*, issued September 11, 2019, we reported that LDH had not implemented the use of FTI for MAGI-based eligibility determinations. Because LDH has not implemented the use of tax information for MAGI-based determinations, LDH continues to be unable to verify all critical eligibility factors. We determined that the lack of internal control due to not using federal tax information for verifications is applicable to all of the 1.4 million recipients in the MAGI eligibility group with premiums paid on their behalf. Since LDH did not use tax information in fiscal year 2019 and auditors are restricted by law from using tax information in the audit of Medicaid and LaCHIP eligibility, we are unable to obtain sufficient appropriate evidence to adequately test MAGI-based Medicaid eligibility. We consider this a scope limitation for our audit.

LDH should design and implement adequate internal controls to ensure and document accurate MAGI-based eligibility determinations. In addition, LDH should consider using federal tax data to verify critical Medicaid and LaCHIP eligibility factors that cannot be verified by other electronic sources. Management concurred in part and provided a corrective action plan (see Appendix A, pages 1-2). Management asserts that LDH has adequate controls over MAGI-based eligibility determinations due to the new eligibility system, LaMEDS, using multiple electronic data sources for verification.

Additional Comments: For fiscal year 2019, LDH did not use FTI to verify critical eligibility factors that cannot be verified by other electronic sources, which increases risk that applicants could be determined eligible when they are not.

Weaknesses in Controls over LaMEDS

LDH had weaknesses in controls over its new Medicaid and LaCHIP eligibility and enrollment system, LaMEDS. LaMEDS was implemented in November 2018. All recipient eligibility records are stored in LaMEDS.

We evaluated system controls based on best practices, as defined by *Control Objectives for Information and Related Technology*, a framework developed by ISACA. Our procedures identified the following:

- LDH did not follow established procedures for user access control and lacked monitoring procedures for reviewing user access, override logs, audit logs, and underlying database changes.

    - LDH failed to remove access for separated employees.

    - LDH only performed one user access review and failed to make all changes noted as a result of the review.

    - LDH lacked a process for tracking non-LDH contract employee access to LaMEDS.

    - LDH did not review logs tracking manual overrides and audit changes for inappropriate overrides and changes.

  Instances of inappropriate access may have violated HIPAA Security Rules because users retained access to protected health information after they no longer had an allowed need for that access. Management should immediately disable a separating employee's access and hold supervisors responsible for requesting removal; perform user access reviews at least bi-annually and update all changes as a result of the reviews; establish procedures for monitoring non-LDH contract employees, and establish procedures for reviewing user access, override logs, and audit logs.

- LDH lacked a formal process for monitoring and timely resolving logged interface errors. LaMEDS interfaces with multiple state and federal databases to verify eligibility factors. Lack of established procedures can result in inconsistent application and unnoticed interface failures that negatively impact the eligibility determination process. LDH should establish formal procedures for monitoring interface errors.

- The agreement between LDH and the Office of Technology Services (OTS) did not provide for availability monitoring of hardware and software managed and supported by OTS. As a result, OTS may not be accountable for application

downtime resulting from the failure of supporting hardware, software, and infrastructure that it maintains. LDH should update its agreement with OTS to require availability metrics and obtain and monitor achievement of agreed upon availability levels.

LDH is the single state agency responsible for the administration of the Medicaid and LaCHIP programs. As such, LDH is responsible for adequate internal control over any system used in administration of the program. Internal controls, including proper monitoring of user access and logs, monitoring of interface errors, and proper monitoring of hardware and software availability help to mitigate the risk of improper eligibility determinations. LDH should improve controls over LaMEDS as recommended above. Management concurred in part and provided corrective action plans (see Appendix A, pages 3-5).

Additional Comments: LDH did not concur with the finding regarding user access reviews and the monitoring of audit logs, citing that CMS only requires an annual review of user access and does not require monitoring of all audit logs. During our work, we noted a high frequency of user access changes due to employee and contractor turnover. This frequency places LDH at an increased risk of allowing inappropriate access to users who no longer have a business need. The HIPAA Security Rule [(45 CFR §164.308(a)(1)(ii)(B)] provides that covered entities must "implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level." A review of access only once a year does not appear to sufficiently reduce this risk. Also, the absence of CMS guidance regarding specific logs to review does not remove LDH's responsibility for identifying the appropriate logs and monitoring them for unauthorized activity.

LDH concurred in part with our recommendation regarding interface error monitoring but noted it had a detailed design specification document that established "a formal process for error standardization" that provides steps for particular errors. However, based on our review, the detailed design specification document does not negate the need for policies and procedures for staff to reference when handling interface errors during normal operations.

Noncompliance on Managed Care Premium Payments

LDH made premium payments totaling approximately $4.8 billion to the Healthy Louisiana MCOs without first receiving required contract amendment approvals. Also, LDH made payments totaling approximately $868 million for service dates outside of the certification period provided by the actuary's Rate Certification Letter. By paying the MCOs prior to contract amendment approvals, LDH may have made payments without proper authorization that were noncompliant with state procurement regulations. By paying the MCOs with rates outside of the rate certification period, LDH may have violated federal regulations requiring payments using actuarial sound rates.

For fiscal year 2019 (FY19), LDH made Medicaid and LaCHIP payments totaling $7.9 billion to the Healthy Louisiana MCOs. In our review of the Healthy Louisiana premium payments made during the fiscal year, the following were identified:

- LDH made premium payments using rates from the actuary's Rate Certification Letter contained in Contract Amendment Number 14 starting in July 2018 for May 2018. Contract Amendment Number 14 was not signed by the MCOs until late October 2018, not submitted for approval to the Office of State Procurement (OSP) until late October 2018, and not approved by OSP until December 2018. Payments made on Contract Amendment Number 14 prior to OSP approval totaled more than $3.9 billion.

- LDH made premium payments using rates from the actuary's Rate Certification Letter contained in Contract Amendment Number 17 starting in June 2019 for April 2019. Contract Amendment Number 17 was not signed by the managed care plans until late June 2019, not submitted to the Office of State Purchasing until July 2019, and not approved by OSP until August 2019. Payments made on Contract Amendment Number 17 as of June 30, 2019, totaled more than $906 million.

- LDH paid the MCOs for February 2019 in March 2019 using the actuary's Rate Certification Letter from Contract Amendment Number 15. The Rate Certification Letter in Contract Amendment Number 15 was for dates July 2018 through January 2019 and not certified by the actuary for use in February 2019. In June 2019, LDH adjusted rates based on Contract Amendment Number 16 with the accompanying Rate Certification Letter for dates including February 2019. Payments made for February 2019 using the inappropriate rates from Contract Amendment Number 15 totaled more than $629 million.

- LDH paid the MCOs for April 2019 in May 2019 using an actuary's Rate Certification Letter from Contract Amendment Number 16. The Rate Certification Letter in contract Amendment Number 16 was for dates January 2019 through March 2019 and not certified by the actuary for use in April 2019. In June 2019, LDH adjusted April 2019 rates based on Contract Amendment Number 17 and the accompanying Rate Certification Letter for dates including April 2019. Payments made for April 2019 using the inappropriate rates from Contract Amendment Number 16 totaled more than $239 million.

LDH failed to design and maintain adequate controls over the timely submission of contract amendments to OSP to ensure contract amendments were approved prior to any payments under the amendment. LDH also failed to design and maintain adequate controls to ensure Rate Certifications Letters covered the period for which the payment was made.

Louisiana Administrative Code, Title 34, Part V. Procurement, Section 2512, requires that all amendments to contracts for professional, personal, consulting, and social services contracts be submitted to OSP and shall become effective only upon approval. Healthy Louisiana contract amendments, categorized as a social services contract, document changes to the managed care program, including updates and changes in rate certifications when necessary. Each actuary's Rate Certification Letter stipulates the population and time period covered by the accompanying rates along with a statement certifying the rates as actuarial sound in accordance with 42 CFR Section 438. Rate certifications should be determined for a 12-month rating period, but CMS

considers time periods other than 12 months to address unusual circumstances. For FY19, LDH made payments using four contract amendments and six Rate Certification Letters. One rate letter included a 12-month certification period while the other five letters had certification periods varying from three to nine months.

LDH should ensure compliance with state purchasing requirements, including obtaining proper contract amendment approvals prior to implementation. In addition, LDH should only make payments using Rate Certification Letters that have been included in an approved contract amendment and for the period certified in the rate letter. In its response, management did not dispute the facts reported regarding dates of the relevant premium payments, rates used to make the payments, or dates of contract amendment approvals. However, management did not agree that the payments made and rates used were inappropriate or noncompliant, so a corrective action plan was not provided (see Appendix A, pages 6-7).

Additional Comments: LDH acknowledges payments were made using rate certification letters in contract amendments prior to submission to OSP and OSP approval and making payments for service dates using rate certification letters that did not cover the respective service dates. LDH noted that in its opinion these instances should be considered an "inevitable" part of the process in setting managed care per member per month payments. However, LDH should strive to implement processes and/or controls to ensure that state and federal regulations are met. LDH should not continue processes that make noncompliance "inevitable."

Noncompliance with Managed Care Provider Enrollment Requirement

For the second 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 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 LaCHIP state plan. LDH accepted 88.5 million Healthy Louisiana encounter claims totaling $5.3 billion and 4.2 million dental encounter claims totaling $152 million in fiscal year 2019 from the managed care plans and paid $7.9 billion in Healthy Louisiana premiums and $172 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 new federally required process, managed care providers must participate in the same screening and enrollment process as Medicaid and LaCHIP 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 is in violation of federal law. LDH noted that enrollment and screening of managed care providers will not be

performed until the new provider management system is implemented. LDH has not implemented the new system as of November 2019. LDH will continue to be in violation until a new provider enrollment system is implemented and all providers are enrolled in the new system.

LDH should ensure all providers are screened, enrolled, and monitored as required by federal regulations. Management concurred with finding and provided a corrective action plan (see Appendix A, pages 8-9).

Inadequate Controls over Waiver Services Providers

For the eighth 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) totaling $11,949 ($7,767 in federal funds and $4,182 in state funds) for waiver services that were not documented in accordance with established policies. 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 LDH policy, which includes review of documentation to support services billed for accuracy and documenting deviations from the POC.

LDH HCBS waivers implemented electronic visit verification (EVV) in fiscal year 2019. EVV is a web-based system that electronically records and documents the precise date, start time, and end times that services are provided to recipients. Time documented through EVV is 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 306 claims paid in fiscal year 2019 totaling $38,629 paid to two providers for 10 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 103 claims, some claims having multiple errors, totaling $11,949, which is considered questioned costs.

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

- For 13 claims for five recipients, waiver services providers did not provide adequate documentation to support billed services. Time sheets, progress notes, and EVV documentation were not consistent. According to the provider manuals, prior to billing for services, the NOW and ROW service provider must verify that time sheets and progress notes are completed correctly and that the services were delivered in accordance with the POC. According to OCDD, since the implementation of EVV, time sheet documentation is no longer required for

Medicaid supporting documentation, but that information is not reflected in updates to the NOW or ROW manuals.

- For 44 claims for six recipients, the waiver services provider did not provide documentation to support deviations from the approved POC. 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. When a recipient's schedule is altered on a consistent basis, a revision to the approved POC is required indicating the reason for the change. Without documentation a provider cannot substantiate and auditors cannot verify that the deviations were recipient-driven and person-centered as required.

- For eight claims for five recipients, auditors were unable to determine if a deviation from the POC occurred because time sheets, progress notes, and EVV documentation were not consistent.

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

- For one claim for one recipient, the waiver services provider did not provide adequate documentation to support billed services. Progress notes and electronic visit verification documentation were not consistent.

- For 51 claims for two recipients, the waiver services provider did not provide documentation to support deviations from the approved POC. According to the provider manual, significant deviations must be documented. Significant is not defined. Errors noted deviations of 30 minutes or more.

Without adequate supporting documentation and compliance with LDH established policies, there is reduced assurance that recipients are receiving needed services, billed services were actually performed, and limited resources are allocated appropriately. In addition, LDH OCDD did not update provider manuals to reflect potential revised documentation requirements.

LDH should ensure all departmental policies and federal regulations for waiver services are enforced, including documentation to support claims and evidence deviations from the approved POC meet the needs of the recipient. In addition, LDH should ensure all provider manuals are updated timely. Management concurred with the finding and provided a corrective action plan (see Appendix A, pages 10-11).

Inadequate Controls over Quarterly Federal Expenditure Reporting

For the fifth consecutive year, LDH failed to accurately complete the required quarterly reports of federal expenditures resulting in $17,279,582 ($14,683,758 federal) in expenditures for

Substance Use Disorder (SUD) waiver services not identified and reported separately as required by CMS. In fiscal year 2019, LDH paid for services under the SUD waiver while identifying and reporting these expenditures as state plan expenditures. The federal expenditures reported in the quarterly reports are used by CMS to track state Medicaid and LaCHIP expenditures and to ensure proper application of federal participation rates. Errors in federal reporting limit the usefulness of the reports and put the state at risk for improper claiming of federal funds and noncompliance with waiver agreements.

The SUD waiver authorizes Louisiana to receive federal financial participation for the continuum of services to treat addiction to opioids or other substances, including services provided to Medicaid enrollees with substance use disorders residing in certain residential treatment facilities that meet the definition of an Institution for Mental Disease. The approved waiver document requires quarterly reporting of expenditures associated with populations affected by the waiver services. The waiver requires such expenditures to be reported on applicable waiver sections of the federal expenditures report as federal reporting is used to monitor budget neutrality requirements for the waiver. While total expenditures for Medicaid and LaCHIP were not misstated due to the classification error, CMS requires accurate reporting of Medicaid and LaCHIP expenditures.

LDH failed to properly identify expenditures for the SUD waiver in the statewide accounting system for appropriate classification on federal reporting. In addition, LDH has implemented some controls over preparation and review of the quarterly expenditure reports, but did not detect the error until after June 30, 2019. LDH made corrections to the September 2019 reports to report the expenditures as SUD waiver.

LDH should ensure that expenditures are accurately classified in the statewide accounting system and federal expenditures are reported accurately by appropriate category on the required quarterly federal reports. Management concurred with the finding and provided a corrective action plan (see Appendix A, page 12).

Inadequate Controls over Monitoring of Abortion Claims

LDH did not have adequate controls to ensure compliance with federal requirements prohibiting the use of federal funding for abortion claims. LDH did not adequately monitor fee-for-services claims and claims from the Healthy Louisiana managed care health plans for compliance with federal requirements which prohibit Medicaid and LaCHIP funding for abortion services except in instances where abortion is necessary to save the mother’s life or if the pregnancy is the result of an act of rape or incest.

LDH’s fiscal intermediary (FI) performed some monitoring of fee-for-services claims for compliance, but LDH did not monitor or review any reporting from the FI to determine if procedures were properly designed and effective. LDH included a provision in the Healthy Louisiana managed care contracts requiring the managed care health plans to comply with the federal regulation, but LDH did not have any procedures in place to monitor the health plan’s compliance with the contract requirement. LDH provided that monitoring was not performed because identifying applicable claims is difficult and would likely require medical record

reviews. Because LDH did not actively monitor compliance with the requirement, the Medicaid and LaCHIP programs may have paid for abortion services that did not meet exceptions noted in federal regulations.

LDH should monitor all claims for Medicaid and LaCHIP recipients, including those paid by the managed care health plans, for compliance with federal regulations regarding prohibited abortions. Management did not specifically concur or disagree with the finding but provided a corrective action plan (see Appendix A, pages 13-14).

Noncompliance with Prenatal Service Third-Party Liability Requirements

LDH failed to implement controls to ensure compliance with revised third-party liability requirements for prenatal and pregnancy related services. As a result, the Medicaid and LaCHIP programs may have paid full or partial claims that were the responsibility of other payers.

Federal regulations require that the Medicaid and LaCHIP 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. Medicaid and LaCHIP 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 LaCHIP programs, to eliminate the cost avoidance exception for prenatal services and pregnancy related services effective in February 2018.

Louisiana Medicaid managed care plans would be responsible for a majority of the services relevant to the revised requirement. LDH did not update the managed care contracts to require compliance with the revised regulation, did not provide any guidance to the managed care plans regarding implementation of the revised regulations, and did not monitor plan compliance with the revised regulation. LDH has accepted more than two million encounters totaling $145.6 million for prenatal services with dates of service from February 2018 through June 2019. LDH did not provide criteria for identifying prenatal encounters that were processed as pay and chase. Managed care encounters are used by LDH's actuary for future rate setting and as a basis for making supplemental payments, known as kick payments, to the managed care plans for costs associated with pre- and post-partum maternal care, as well as the delivery event itself. LDH paid $512 million in kick payments for dates of service from February 2018 through June 2019.

While a much smaller portion of the Louisiana Medicaid program, LDH also did not implement the revised regulation for fee-for-service prenatal claims. For fee-for-service claims paid in state fiscal year 2019 with dates of service from February 2018 through June 2019, LDH paid $1,692 for prenatal and pregnancy related claims processed as pay and chase.

According to LDH, the revised federal regulation has not been implemented because CMS has not issued clear guidance for implementation. LDH should ensure that cost avoidance measures

are applied for prenatal services as required by the Bipartisan Budget Act of 2018 and the Social Security Act and that the Medicaid and LaCHIP programs are the payers of last resort. Management concurred in part with the finding and provided a corrective action plan (see Appendix A, pages 15-16).

Additional Comments: In its response, management acknowledged that the United States Code was amended but noted that the Code of Federal Regulations provision had not been updated, and CMS had not provided guidance until November 2019. However, this does not change LDH's responsibility to implement controls addressing the revised federal requirement that was effective in February 2018.

Noncompliance with Third-Party Liability Assignment

For the third consecutive year, LDH failed to maintain evidence of notification of third-party liability (TPL) assignment as required for eligibility in the Medicaid and LaCHIP. 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. LDH provides notification to an applicant/enrollee by including assignment language on Medicaid and LaCHIP applications. LDH utilizes both paper and electronic applications.

During state fiscal year 2019, TPL assignment language was not included as part of electronic application summaries in all recipient case records. In a sample of 60 active recipient case records, 18 (30%) recipient case records did not contain evidence of TPL assignment notification.

In response to the prior year finding, LDH planned corrective action in conjunction with the launch of the new eligibility system, LaMEDS, in November 2018, 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.

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 LaCHIP 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, page 17).

Noncompliance with Provider Revalidation and Screening Requirements

For the second consecutive year, LDH did not perform five-year revalidations; screenings based on categorical risk of fraud, waste or abuse; and monthly checks of the federal excluded party database, as required by federal regulations for all Medicaid and LaCHIP fee-for-service providers. LDH submitted and received the Medicaid State Plan approval in 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.

In a sample of 40 providers receiving fee-for-service payments from LDH in fiscal year 2019, we noted that for 34 (85%) providers, LDH did not perform the required five-year revalidation, including screening based on categorical risk. The 34 providers have enrollment dates ranging from three to 44 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 after the provider was initially enrolled. 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. Not performing the required revalidations and screenings increases the risk that providers will continue to perform services for Medicaid recipients when they should be excluded.

LDH has noted that performance of all required revalidations, screenings, and monthly checks would be implemented in the new provider management system. LDH has not implemented the new system as of November 2019.

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 18-19).

Inadequate Controls Over Healthy Louisiana Premium Payments

LDH did not have adequate controls in place to ensure proper coding of all managed care premiums, resulting in Healthy Louisiana premium payments made to the managed care health plans that did not match the correct recipient eligibility type. In November 2019, LDH acknowledged the mismatched premiums and made corrections to 518 Healthy Louisiana premiums paid for service dates July 2016 through September 2019. The correction resulted in a net recoupment of approximately $176,000 from the managed care health plans. Managed care premium payments that are not supported by recipient eligibility are considered improper.

LDH's fiscal intermediary makes monthly premium payments to the Healthy Louisiana managed care health plans based on capitation codes and rates established by LDH's actuary. The capitation codes and rates are specific to a recipient's eligibility type in the Medicaid and LaCHIP programs. Premium payments should be based on a recipient's eligibility for the month of service. When a recipient's eligibility for a month does not correspond to the capitation code and rate paid to the managed care plan for that month, the premium coding is considered mismatched and the payment improper.

In addition to the 518 payments noted above, LDH is working to correct an additional 419 premium payments. Based on discussions with LDH, some of the mismatched premiums occurred due to changes in recipient eligibility. LDH is still researching additional causes but does expect mismatched premium payments to occur. According to LDH, modifications are being made to its monthly adjustment processes to correct the payments. LDH made $7.9 billion dollars in Healthy Louisiana premium payments in fiscal year 2019. While the mismatched premium payments noted above are immaterial in relation to the total amount paid, LDH must ensure premium payments are supported by recipient eligibility.

LDH should identify the causes for all existing mismatched premium payments. LDH should also establish controls to ensure premiums payments are made based on recipient eligibility and ensure timely adjustment when premium payments do not match eligibility due to eligibility changes after the payment. Management concurred with the finding and provided a corrective action plan (see Appendix A, pages 20-21).

Inadequate Controls over Medicare Buy-In

LDH failed to correct errors and update information on recipient eligibility records for variances reported to LDH by CMS, resulting in LDH not paying appropriate Medicare Buy-In (Buy-In) premiums to CMS for Medicare coverage for eligible recipients. In November 2018, LDH implemented a new eligibility system, LaMEDS, and integrated the old Buy-In system into LaMEDS. LDH developed some Buy-In reports in LaMEDS for monitoring of variances, but the reports were not used. The LDH Buy-In section addressed variances when notified on a case-by-case basis, in addition to working with LDH LaMEDS staff to address recurring errors. However, LDH lacked any formal consistent procedures to timely address variances. As a result, LDH did not update recipient records and make monthly Medicare Buy-In payments for all recipients who qualified for the benefit.

LDH recipient data and CMS recipient data for Medicare Buy-In eligible recipients must match in order to ensure appropriate Buy-In premium payments and proper handling of medical service claims. Prior to November 2018, using data from CMS, LDH generated monthly reports to identify variances between the CMS data and LDH data. These variances could include differences in claim numbers and demographic data. LDH also generated reports to identify recipients that CMS added to Part B Buy-In that LDH should also enroll into Part A Buy-In. The LDH Buy-In section reviewed the reports and ensured that necessary corrections and additions were made to recipient records in the Buy-In system which stored Buy-In eligibility data. However, after November 2018, LDH did not continue this process and lacked other procedures to address variances on a consistent and timely basis.

Under the Louisiana Medicaid State Plan, the state enrolls certain Medicare eligible recipients in Medicare and pays the premiums associated with their Medicare coverage under the Medicaid program. The payments are made under the Medicare Buy-In program with payments to CMS occurring monthly for Medicare Part A and/or Part B. Medicare Part A helps to pay for the cost of inpatient hospital care, while Part B covers outpatient medical services. In some cases, recipients are enrolled in both Part A and Part B Buy-In. In calendar year 2019, Part A premiums were $437 per month, with LDH paying for approximately 8,900 recipients each month. Part B premiums were $135 per month, with LDH paying for approximately 207,000 recipients each month.

LDH should develop formal procedures to ensure Buy-In variances are addressed on a consistent and timely basis. Management concurred with the finding and provided a corrective action plan (see Appendix A, page 22).

Noncompliance with Review of Redeemed Food Instruments and Cash-Value Vouchers

For the second consecutive year, the LDH, Office of Public Health (OPH) did not have an adequate process in place to review redeemed food instruments (FIs) and cash-value vouchers (CVVs) for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program during fiscal year 2019. Although OPH generated system reports to monitor redeemed FIs and CVVs, and began performing procedures to meet the federal requirements regarding reviews, the procedures performed did not show clear evidence of when the reviews were actually performed and the reviews only sampled rejected food vouchers that were subsequently paid, not all vouchers paid. Failure to properly review redeemed FIs and CVVs could result in undetected violations and improper payments.

Federal regulations require that OPH have in place a process for reviewing all, or a representative sample of, FIs and CVVs submitted by vendors for redemption. At a minimum, this process must be able to detect: redeemed monetary amounts that exceed the maximum monetary purchase amounts; missing information including purchase price, required signature, and vendor identification; transactions or redemption after the specific time period; and altered purchase price.

OPH management should ensure that reviews of redeemed FIs and CVVs show clear evidence of when the reviews were actually performed and include a sample of all food instruments paid.

Management did not concur with the finding and provided that its WIC banking contractor, Solutran, has adequate measures in place that serve as an audit of their processing controls and a Service Organizational Control (SOC) 2 report meets the standards and/or mandates established by the United States Department of Agriculture (USDA) Food and Nutrition Service (FNS) (see Appendix A, pages 23-24).

Additional Comments: The SOC 2 report did not provide, nor is it intended to provide, assurance that Solutran or OPH reviewed all, or a representative sample of, FIs and CVVs submitted by vendors for redemption in accordance with federal regulations. The intent of the SOC 2 report is to provide assurance as to Solutran's controls according to the American Institute of Certified Public Accountants' (AICPA) *Trust Services Criteria*. According to the AICPA, this criteria is not appropriate for a report on an entity's compliance with laws, regulations, rules, contracts, or grant agreements. Finally, even if the SOC 2 report would have included procedures necessary to specifically address applicable controls over WIC, the report provided by OPH covers October 2017 through September 2018, which is only three months of the fiscal year under audit.

Inadequate Controls over Billing for Behavioral Health Services

LDH, the MCOs, and Magellan Health Services (Magellan) did not have adequate controls in place to ensure that behavioral health services in the Medicaid program were properly billed and that improper encounters and claims were denied. In a Medicaid Audit Unit report, *Improper Billing of Services within the Medicaid Behavioral Services Program*, issued September 4, 2019, we identified approximately $47.5 million in encounters and claims for services between December 2015 and June 2019 that were paid by LDH, the MCOs, and Magellan even though claims 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 claims and encounters when billing and fee schedule requirements are not followed. The report identified the following instances of billing errors:

- Providers were paid $38,533,711 for 646,746 encounters and claims 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 claim or encounter does not contain enough information to determine that the billing was appropriate.

- Providers were paid $9,044,773 more than indicated on the LDH fee schedule for 647,910 encounters and claims 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 a claim 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 $7,800 for 322 encounters and claims 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. While a majority of the errors were MCO encounters, 102,889 of the errors were fee-for-service claims totaling $2,166,422 ($1,429,611 federal funds and $736,811 state funds), which are considered questioned costs.

LDH management should implement adequate internal controls to ensure that claims and encounters are coded correctly, which could include edit checks to deny improper billings. Management did not concur with the recommendation providing that the recommendation is inconsistent with a risk-based managed care model (see Appendix A, pages 25-26).

Additional Comments: According to four of the five MCOs and Magellan, contracted providers are required to follow LDH's fee schedule. In addition, both of the MCOs who were sent examples of the issues identified in the Medicaid Audit Unit report *Improper Billing of Services within the Medicaid Behavioral Services Program* agreed that the examples were errors. If MCO edit checks were working appropriately, these claims should have been denied. Although LDH has procedures to monitor on a post-payment basis, edit checks are important for ensuring encounter data is accurate and for ensuring only valid claims are paid. In addition, LDH has established edit checks which deny claims with invalid or missing modifier codes for other types of services such as physician claims and emergency medical transportation. Therefore, establishing edit checks to deny specialized behavioral health claims with invalid or missing modifiers should be consistent with a risk-based managed care model.

Comprehensive Annual Financial Report (CAFR) – State of Louisiana

As a part of our audit of the CAFR for the year ended June 30, 2019, 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, are materially correct.

Federal Compliance - Single Audit of the State of Louisiana

As a part of the Single Audit for the year ended June 30, 2019, 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)
- Disaster Assistance Projects (CFDA 97.088)
- Medicaid Cluster (CFDA 93.775, 93.777, and 93.778)
- Children's Health Insurance Program (CFDA 93.767)

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

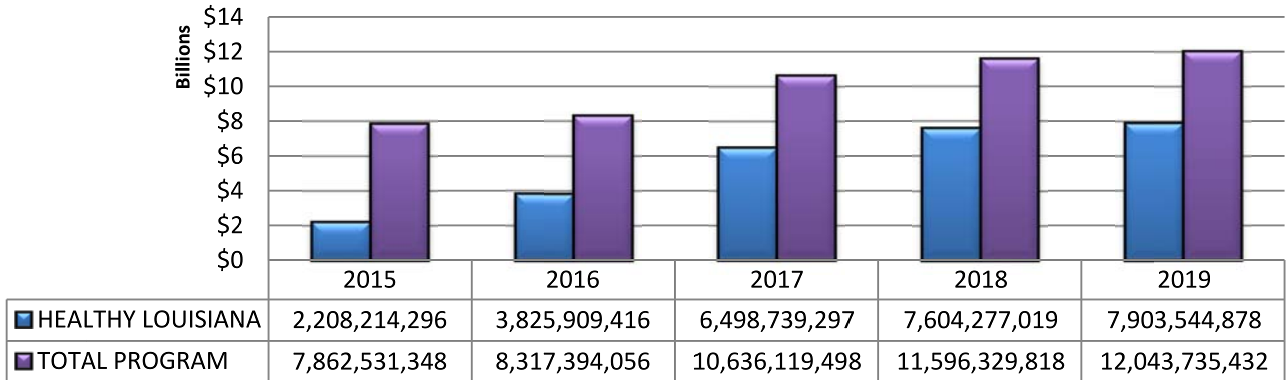
Based on the results of these Single Audit procedures, we reported findings related to Inadequate Internal Control over Modified Adjusted Gross Income Eligibility Determinations, Weaknesses in Controls over LaMEDS, Noncompliance on Managed Care Premium Payments, Noncompliance with Managed Care Provider Enrollment Requirement, Inadequate Controls over Waiver Services Providers, Inadequate Controls over Quarterly Federal Expenditure Reporting, Inadequate Controls over Monitoring of Abortion Claims, Noncompliance with Prenatal Service Third-Party Liability Requirements, Noncompliance with Third-Party Liability Assignment, Noncompliance with Provider Revalidation and Screening Requirements, Inadequate Controls Over Healthy Louisiana Premium Payments, Inadequate Controls over Medicare Buy-In, and Inadequate Controls over Billing for Behavioral Health Services. These findings will also be included in the Single Audit for the year ended June 30, 2019. 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. We also prepared an analysis of LDH's Medicaid Healthy Louisiana expenditures over the past five years which accounted for over 65% of LDH's expenditures in Medicaid Vendor Payments in fiscal year 2019.

Exhibit 1

Healthy Louisiana Medicaid Managed Care Expenditures
Compared to Total Program
Five-year Trend



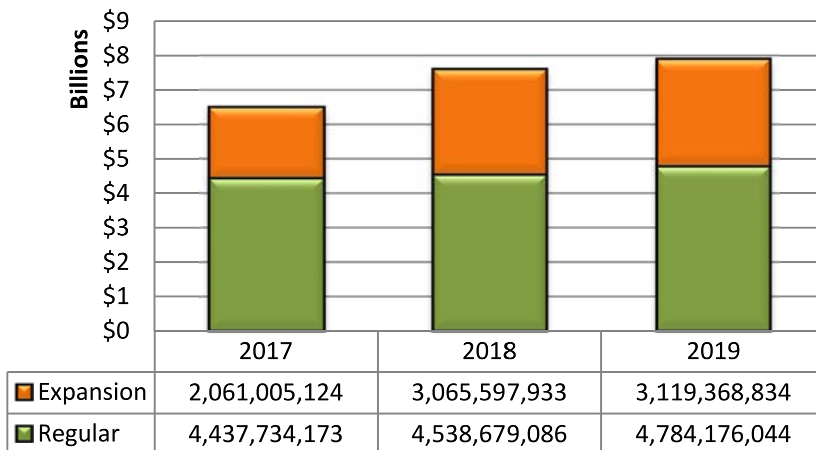
	2015	2016	2017	2018	2019
HEALTHY LOUISIANA	2,208,214,296	3,825,909,416	6,498,739,297	7,604,277,019	7,903,544,878
TOTAL PROGRAM	7,862,531,348	8,317,394,056	10,636,119,498	11,596,329,818	12,043,735,432

Source: Statewide Accounting System Report and LDH Medicaid Year-End Financial Report for FYE 2019

Exhibit 2 provides a breakdown of Healthy Louisiana Medicaid expenditures by regular eligibility and expansion eligibility for state fiscal years 2017, 2018, and 2019.

Exhibit 2

Healthy Louisiana
Expansion vs Regular



	2017	2018	2019
Expansion	2,061,005,124	3,065,597,933	3,119,368,834
Regular	4,437,734,173	4,538,679,086	4,784,176,044

Source: LDH Medicaid Year-End Financial Report for FYE 2019

Other Reports

The Louisiana Legislative Auditor operates a Medicaid Audit Unit (MAU) that focuses audit efforts on fraud, waste, and abuse in Louisiana Medicaid, particularly in managed care. MAU reports are available in the Audit Report Library on the Legislative Auditor's website at www.lla.la.gov.

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,

Daryl G. Purpera, CPA, CFE
Legislative Auditor

KW:AHC:WDG:EFS:aa

LDH2019

APPENDIX A: MANAGEMENT’S RESPONSES

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA ELECTRONIC MAIL ONLY

December 26, 2019

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

Re: Inadquate Internal Control over Modified Adjusted Gross Income (MAGI) Eligibility Determinations

Dear Mr. Purpera:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor (LLA) dated December 16, 2019, regarding a reportable audit finding for the Single State Audit on use of tax data for MAGI-based eligibility decisions. LDH appreciates the opportunity to provide this response to your office's findings.

Recommendation:
LDH should design and implement adequate internal control to ensure and document accurate MAGI-based eligibility determinations. In addition, LDH should consider using federal tax data to verify critical Medciaid and LaCHIP eligibility factors that cannot be verified by other electronic sources.

Response:
LDH concurs in part with this recommendation. LDH has adequate controls over MAGI-based eligibility determinations due to the new eligibility system, LaMEDS, using multiple electronic data sources for verification, which it documents through an extensive audit trail. Additionally, in October 2019, LDH began using federal tax information (FTI) in a post-eligibility review process where there is a significant discrepancy between income reported for eligibility and income reported for federal tax purposes.

Though LDH submitted multiple plans for use of FTI in the eligibility process through LaMEDS to the Internal Revenue Service (IRS) in order to begin use in May 2019, all were rejected for potential security concerns, which delayed implementation. A final solution was approved for use of FTI in a separate secure environment outside LaMEDS, and as of June 23, 2019, LDH began receiving FTI. Due to the lengthy processing of required background checks and installing the building requirements for

the secure workspace in which Medicaid staff can view and work with FTI, actual review of the FTI data actually started in October 2019.

Putting the FTI data into LaMEDS itself w ll not be approved by the IRS without ending the current audit trail on income sources currently built into LaMEDS. This was a major improvement with the new system, which not only helps LDH to better serve our members and make correct eligibility decisions but also assists the auditor in its audit function. Since removing this audit trail in LaMEDS is impractical, LDH commits to working with the auditor on building regular statistical data reports on FTI, which do not violate LDH's IRS agreement and are in compliance with law, that the auditor can use for review. Additionally, LDH has previously provided design documentation on the separate FTI environment and will continue to provide its post-eligibility review process documentation to address concerns over inadequate controls in the MAGI-based eligibility determinations. Going forward, LDH will also investigate procedures in collaboration with the auditor to address its audit scope limitation relative to FTI.

You may contact Tara LeBlanc, Medicaid Deputy Director for Eligibility, at (225) 219-2329 or via e-mail at Tara.Leblanc@la.gov with any questions about this matter.

Sincerely,

Cindy Rives
Undersecretary

CR/jlk

John Bel Edwards
GOVERNOR

Stephen Russo
INTERIM SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA E-MAIL ONLY

February 5, 2020

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

Re: Single State Audit on 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 30, 2020, regarding a reportable audit finding for the Single State Audit on Weaknesses in Controls over LaMEDS. LDH appreciates the opportunity to provide this response to your office's findings.

Finding:
LDH did not follow established procedures for user access control and lacked monitoring procedures for reviewing user access, override logs, audit logs, and underlying database changes.

> **Recommendation**: Management should immediately disable a separating employee's access and hold supervisors responsible for requesting removal; perform user access reviews at least bi-annually and update all changes a result of the reviews; establish procedures for monitoring non-LDH contract employees, and establish procedures for reviewing user access, override, logs, and audit logs.

Response:
LDH partially concurs with these overall findings, as noted below.

- LDH concurs with the finding regarding removal of separated employees. Processes are in place to remove systems access for separated employees. These processes are outlined in the off boarding procedures for all outgoing LDH employees. This is not LaMEDS-specific guidance, but general guidance for access to all LDH systems. Supervisors are required to follow onboarding and off boarding procedures in their annual Performance Evaluation Planning document. To ensure future compliance, LDH will send reminders to all staff and revisit training efforts around off boarding employees by the end of February 2020. Additionally, LDH is exploring processes with the Office of Technology Services (OTS) to automate employee deactivation in LaMEDS with other systems deactivation at separation, as well as a new process whereby LDH generates lists of separated employees on a regular cadence for review and processing.

- LDH does not concur with the finding regarding user access review. CMS requires that LDH conduct an annual review. For LaMEDS, the annual review would be performed in November 2019, one year post go-live, and not in state fiscal year 2019. The annual review is currently in progress, though it was initially delayed due to the recent ransomware attacks in November 2019. However, as an extra measure, LDH also did an informal review in early 2019.

- LDH concurs with the finding that we lacked a process of tracking non-LDH contract employees access to LaMEDS. Currently, LDH employee information is captured in the Active Directory (AD). Supervisors are responsible for updates to the AD at onboarding. Currently, the AD does not capture information to denote who is a contractor. As part of a corrective action measure, LDH is working with the OTS to create an indicator for contractors. Once this is in place, LDH will train supervisory staff to incorporate the contractor indication step into onboarding of new employees.

- LDH concurs with monitoring overrides in LaMEDS. Corrective action will be taken to formalize a process for monitoring by the end of February 2020. This will incorporate a review of 5% of non-appeals overrides, and the maintenance of the records of these findings.

- LDH cannot respond to the finding regarding the monitoring of audit logs and underlying database changes as written without further specificity. CMS guidance does not require review of all audit logs and database changes. Since specific logs were not identified in the audit, LDH is unable to address particular issues. Such broad based monitoring is not standard industry practice in the absence of greater specificity. LDH is committed to working with the auditor to clarify any particular area for improvement.

Finding:
LDH lacked a formal process for monitoring and timely resolving logged interface errors.

> **Recommendation**: LDH should establish formal procedures for monitoring interface errors.

Response:
LDH partially concurs with this finding. There is a formal process for error standardization in the 1.045 Detailed Design Specification Document for LaMEDS at section 4.4. It contains steps for particular errors. As a result, LDH system section staff work all daily batch file exceptions that fall out due to interface errors. This includes but is not limited to Medicaid Management Information System (MMIS) errors, State Data Exchange (SDX) errors, BENDEX errors, etc. OTS, and their contractor Deloitte, are responsible for monitoring and responding to all other real-time interface errors that get logged (e.g., LA Automated Management Information System, TALX – The Work Number, Louisiana Workforce Commission, etc.). However, these procedures will be reviewed for consideration of additional detail that would father mitigate inconsistent application and improve eligibility verification accuracy.

Finding:
The agreement between LDH and OTS did not provide for availability monitoring of hardware and software managed and supported by OTS.

Recommendation: LDH should update its agreement with OTS to require availability metrics and obtain and monitor achievement of agreed upon availability levels.

Response:
LDH concurs in part with this finding. Inclusion of Service Level Agreements (SLA) into the Memorandum of Understanding (MOU) would require these metrics to be included for all systems under LDH, many of which are evolving over time and do not have the same availability and monitoring metrics. Any agreements should be established at an operational level, by system and program. LDH and OTS will review program operational documentation for inclusion of metrics for availability monitoring and establishment of a ready action plan for accountability by March 31, 2020.

You may contact Mitzi Hochheiser, Medicaid Chief Technology Officer, at (225) 342-8935 or via e-mail at Mitzi.Hochheiser@la.gov with any questions about this matter.

Sincerely,

Cindy Rives
Undersecretary

Enclosure [1]

CR/gt

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA E-MAIL ONLY

October 29, 2019

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

Re: Noncompliance on Mangaed Care Premium Payments

Dear Mr. Purpera:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor (LLA) dated October 15, 2019, regarding a reportable audit finding related to Managed Care Premium Payments. LDH appreciates the opportunity to provide this response to your office's findings.

LDH does not dispute the dates of the relevant premium payments, the rates used to make said payments, or the dates of contract amendment approvals; however, LDH does not concur with the characterization that the rates used were inappropriate or any inference that the premium payments were improper or out of compliance. In order to fully understand LDH's position, it will prove useful to provide an overview of the managed care payment process as required by federal regulations.

In pertinent part, federal regulations governing Medicaid managed care can be found in Title 42, Part 438, of the Code of Federal Regulations. In regards to payment, the over-riding principal is that payments to participating Managed Care Organizations (MCOs) must be actuarially sound. As provided for in federal regulation, these rates must be projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the time period specified in the terms of the contract. For all time periods mentioned in the reportable finding, LDH is of the opinion that the per member, per month rates (PMPMs) were rates that were certified as actuarially sound by LDH's contracted actuaries.

In regards to the first finding, it is correct that LDH made premium payments in July 2018, for May 2018. It is also true that Contract Amendment 14 was not signed fully until October 2018, then submitted to the Office of State Procurement (OSP). However, the premium payments that were made were premiums that were certified as actuarially sound rates. If the rates were eventually not approved, LDH represents that it would have adjusted the payments accordingly. At this stage, LDH was simply trying to provide for PMPM payments at the rate that Mercer, its actuary, had certified as sound. This explanation also applies to the second finding.

In regards to the third and fourth bullets, the actions and dates contained therein are accurate. While it is true that the rate certifications in Amendment 15 and 16 were valid through January 2019 and March 2019 respectively, these rates did represent the latest actuarially sound rates in the amendments approved by OSP. Further, pursuant to its contract with the MCOs, LDH had a legal obligation to make a PMPM payment in order to remain in contract compliance. Thus, LDH had a choice of either paying the latest actuarially sound rate that was approved by OSP or paying the latest Mercer-approved rate as above. As detailed in your findings, LDH did in fact adjust the February and April payments based on future approvals. LDH does not agree that the prior payments were inappropriate rates.

In closing, there was no fiscal impact as a result of these actions and it is the position of LDH that we will always be faced with this issue due to the lag between the rate certification period end and OSP/CMS approval of the new certified rates. The situation and lag will intensify in cases of multiple amendments throughout the contract year. Thus, it is the opinion of LDH that this is an inevitable part of the process in setting managed care per member per month payments.

Sincerely,

Cindy Rives
Undersecretary

CR/sr

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA E-MAIL ONLY

December 2, 2019

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 November 15, 2019, 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 did not enroll and screen Healthy Louisiana managed care providers and dental managed care providers as required by federal regulations. LDH has negotiated a contract with Verisys Corporation for the enrollment and screening of all managed care providers, as well as enrollment, re-validation and screening of all fee-for-service providers. We anticipate that the new enrollment system with go live early in FY 21 and that enrollment of providers should be completed well before the end of FY 21. We continue to keep CMS informed of our progress toward implementation of the new system.

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. LDH is exploring other options to ensure that payments for services provided to Medicaid recipients are not made to individuals or entities that are prohibited by law from receiving such payments.

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

You may contact Virginia Brandt, Compliance Officer at (225) 219-3454 or via e-mail at Virginia.brandt@la.gov with any questions about this matter.

Sincerely,

Cindy Rives
Undersecretary

CR/vb

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA ELECTRONIC MAIL ONLY

January 17, 2020

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

RE: Inadequate Controls over Waiver Services Providers

Dear Mr. Purpera:

The Louisiana Department of Health (LDH) acknowledges receipt of a draft correspondence from the Louisiana Legislative Auditor (LLA) dated December 30, 2019 regarding a reportable audit finding related to waiver services that were not documented in accordance with established policies. LDH appreciates the opportunity to provide this response to your office's finding.

LLA Recommendation:
LDH should ensure all departmental policies and federal regulations for waiver services are enforced, including documentation to support claims and evidence deviations from the approved Plan of Care (POC) meet the needs of the recipient. In addition, LDH should ensure all provider manuals are updated timely.

Response:
LDH concurs with the LLA finding and recommendation.

LDH notes that these findings did not result in any negative financial impact to the State. Our review of the cited claims confirmed that all services billed and paid were appropriately authorized and delivered and that 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 negative impact on the health or welfare of the recipient.

Providers are allowed to deviate from the schedule for service delivery outlined in the waiver POC if those deviations are agreed to or at the request of the participant and assure that the needs of the participant are met. The reasons for deviation should be documented and POCs updated if the deviation is ongoing and not temporary in nature. To assure that services are being delivered in accordance with participant needs and preferences, all recipients of New Opportunities Waiver (NOW), Residential Options Waivers (ROW) and Community Choices Waiver (CCW) are contacted monthly, face-to-face or by phone, by their Support Coordination Agency. The participant, their responsible

representative(s) and/or their legal guardian is asked about service delivery; and if they are unhappy about the services being provided or deviations in their schedule, this is reported to their support coordinator, the Local Governing Entity (LGE) or the OAAS Regional Office.

The recent implementation of Electronic Visit Verification (EVV) provides an additional tool for monitoring the timing of service delivery and significantly reduces the risk of incorrect or fraudulent billing.

LDH will provide trainings to providers and Support Coordination Agencies at the quarterly trainings throughout the state by 08/31/2020 in regards to the documentation requirements (e.g. progress notes documentation, documenting when a worker deviates from the recipient's POC, etc.).

LDH will also meet with the providers that were identified in this audit to provide one-on-one training regarding the documentation issues stated in this audit finding.

Recommendation:
LDH should ensure all provider manuals are updated timely.

Response:
LDH concurs with the LLA that the NOW and ROW manuals should be updated timely. The manuals will be updated to reflect the implementation of EVV, and the requirements of the documentation needed. This will be completed by 06/30/2020.

You may contact Julie Foster Hagan, Assistant Secretary OCDD, at (225)-342-8765 or via e-mail at Julie.Hagan@la.gov with any questions about this matter.

Sincerely,

Cindy Rives
Undersecretary

CR/vb/ap

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

December 5, 2019

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

RE: Inadequate Controls over quarterly Federal Expenditure Reporting

Dear Mr. Purpera:

We have reviewed the above referenced audit finding and provide the following response to the recommendation documented in the report.

Recommendation: LDH should ensure that expenditures are accurately classified in the statewide accounting system and federal expenditures are reported accurately by appropriate category on the required quarterly federal reports.

LDH Response: Management concurs that, for fiscal year 2019, LDH failed to accurately capture the SUD waivers on the correct line on the Quarterly Federal Reporting report. However, there are no questionable cost as there was not a misstatement of total expenditures. The error was detected internally by LDH and the correction was made on the September 2019 report.

LDH management recognizes its responsibility of accurately reporting financials and will implement a corrective action plan that will encompass a thorough review and testing of the mapping of expenditures in the statewide accounting system. The anticipated completion date of this corrective action plan is April 30, 2020. Helen Harris, LDH Fiscal Director, is responsible for the execution and implementation of this correction action. You may contact Helen Harris, Fiscal Director, at (225) 342-4160 or via email at Helen.Harris@la.gov with any questions about this matter.

Sincerely,

Cindy Rives
Undersecretary

c: Pam Diez
Helen Harris
Angel Cavaretta

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA E-MAIL ONLY

October 29, 2019

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 October 15, 2019, 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.

For the below mentioned reasons, LDH does not have any evidence that abortion claims that did not meet the exception criteria were paid within managed care and fee for service (FFS) based on federal requirements. However, your report highlighted some places where additional clarity could be beneficial to the process. As such, LDH will take some additional steps, outlined below, to further improve how these claims are handled.

As your office is aware, the vast majority of Medicaid services are provided through managed care contracts with Managed Care Organizations (MCOs). The contracts, specifically in Section 6.17, provide that all abortions must be prior approved before the service is rendered to ensure compliance with federal and state regulations. Further, by operation of contract language, the MCOs are restricted to providing abortions in conformity with the federal "Hyde Amendment" and only in specifically delineated circumstances. As a control in these situations, a physician must certify that these circumstances are currently present and what conditions led to that conclusion. The physician must then obtain full informed consent. The MCO contracts expressly prohibit the provision of any other abortions as an MCO benefit. These requirements are not new, and the provider community is well aware of their responsibilities in this regard.

Currently, as a mandatory reporting requirement, LDH obtains a report entitled "End of Pregnancy" from the MCOs. This report provides documentation on the number of pregnancy terminations and also provides specifics on the procedure/event that led to the termination. While this report has, to date, only been used for eligibility purposes, LDH will begin to use this report as part of its plan to improve the handling of these claims discussed below.

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In managed care and FFS, auditing for compliance in this area is labor intensive. Administrative information on claims is never sufficient to establish whether an abortion was in compliance with relevant federal and state regulations. There are not diagnosis codes that precisely map to the exceptions (endangerment of life, rape, or incest) nor are their conventions on how to code abortions that are necessary due to these exceptions.

To enhance monitoring of abortion claims for compliance with federal and state regulations, LDH will take the following steps.

1. LDH will modify the "End of Pregnancy" monthly report to require the MCOs to include paid claims for abortions that conform with the Hyde Amendment. LDH will also ensure that the form captures member identifying information, the reason for the services, the date of the procedure/event, and the claim type.
2. LDH will also mandate that the MCOs provide each hard copy claim with the required supporting documentation outlined in the Medicaid Professional Services manual with the monthly report mentioned above.
3. LDH will then conduct a review of each claim, including review of the claim and the required supporting documentation. These reviews will be compared to the regular reporting to confirm their validity. If validity is not confirmed and/or it is determined that claims are paid without proper documentation/against policy, the report will be rejected and the MCOs will be directed to void any such claims.
4. With implementation of this process, LDH will conduct a retrospective review using claims/ encounters from this year and last year for induced abortion. However, complexity arises in the claims review as the procedure code does not identify the reason for the induced abortion, i.e., whether it meets Hyde Amendment criteria or not. Therefore, during this review, LDH will refine the process and look for further improvements.
5. LDH will also reach out to other state Medicaid programs to determine their compliance processes. If any "best practices" are identified, LDH will look to integrate them into the process.
6. LDH has recently assigned a Program Manager to focus on Women's Health and be an LDH subject matter expert.
7. Effective October 1, 2019, LDH began implementation of these changes. The person responsible for this process improvement plan is Michael Boutte.

Sincerely,

Cindy Rives
Undersecretary

CR/sr

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA E-MAIL ONLY

December 6, 2019

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:

On behalf of the Louisiana Department of Health (LDH), I hereby acknowledge receipt of your correspondence dated November 25, 2019, related to a reportable audit finding for LDH. Specifically, the reportable finding was related to LDH controls to ensure compliance with CMS Third-party Liability (TPL) requirements for prenatal and pregnancy related services. Further, the finding expressed your office's opinion that, as a result of LDH's alleged lack of controls, Medicaid and LaCHIP programs may have paid full or partial claims that were the responsibility of other payers. LDH appreciates this opportunity to respond to the reportable finding and will address it specifically below.

LDH concurs in part with this finding. While it is true that United States Code was amended in this area to require "cost avoidance" instead of "pay and chase", the implementing Code of Federal Regulations (CFR) provision has not been updated. Further, the Centers for Medicare and Medicaid Services (CMS), LDH's federal regulator, released guidance on November 14, 2019 regarding implementing "cost avoidance" in this area. Finally, the LDH contracts with the Medicaid Managed Care Organizations (MCOs), as well as, the current Medicaid State Plan which is required for LDH to claim federal funds, refers to the CFR provisions, requiring compliance therewith.

In regards to Medicaid managed care, LDH, per contracts with Medicaid MCOs, is required to pay per member, per month capitation payments for Medicaid eligible enrollees. This capitation payment is contractually required regardless of whether the enrollee seeks covered services. Thus, it is the position of LDH that the capitation payments made were proper. Finally, after discussions with LDH's actuary, the possibility of TPL is factored into the calculations of the above-mentioned capitation payments[1].

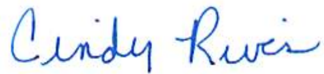
---

[1] While potentially not relevant to the issue at hand, LDH does not consent to the characterization of the maternity "kick" payments as CMS defined "supplemental" payments

LDH does plan to immediately update the relevant State Plan provisions, through the amendment process. LDH will also revise the current fee for service procedures and amend the MCO contracts to be consistent with the guidance provided by our federal regulators. Also, in order to fully close the loop, La. R.S. 46:446.3 would also need to be amended to be consistent with the new federal law, although LDH does not need this statutory change in order to implement the new federal requirement.

You may contact Mitzi Hochheiser, Medicaid Deputy Director, at (225)342-8935 or via e-mail at Mitzi.Hochheiser@la.gov with any questions about this matter.

Sincerely,



Cindy Rives
Undersecretary

CR/vb

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA E-MAIL ONLY

December 5, 2019

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

Re: Noncompliance with Third-Party Liability Assignment

Dear Mr. Purpera:

The Louisiana Department of Health (LDH) acknowledges receipt of your correspondence dated November 21, 2019, to Dr. Rebekah Gee, Secretary of LDH regarding a reportable audit finding. Specifically, this audit finding related to LDH's alleged non-compliance with Third-party liability (TPL) assignment and alleges that this finding has been repeated for three consecutive years. As always, LDH appreciates the opportunity to respond to this reportable finding by your office.

At the outset, LDH wants to make it clear that it is of the opinion that persons who applied for Medicaid electronically under the "pre-LaMeds system" did in fact receive notification of assignment of rights to third party benefits that satisfies the requirements of 42 CFR 433.146. This was accomplished via inclusion of such language in the online application and the applicants' acknowledgement thereof. However, LDH does understand that the LLA is of the opinion that proof of notification must be maintained in each recipient file. LDH CONCURS that this was not done prior to the implementation of the LaMeds electronic application and LDH did not take actions to remedy the lack of documentation in the file retroactively. In order to remedy this and cover the retroactive period, LDH's Plan of Correction (POC) involves including the proper notification language as required by the Code of Federal Regulations in upcoming Decision Letters for all approvals and renewals, which each Medicaid recipient will receive, at least, annually. LDH will then insure that such proof will be placed in the individual eligibility files. This POC will be implemented as soon as the contractual process with our vendor allows. Please be aware that this process will also be followed in the Children's Health Insurance Program (LaCHIP).

Erin Campbell, Interim Medicaid Director, is responsible for the implementation of this corrective action. You may contact her at (225)342-9767 or via email at Erin.Campbell@la.gov with any questions about this matter.

Sincerely,

Cindy Rives
Cindy Rives
Undersecretary

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John Bel Edwards
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Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA E-MAIL ONLY

December 5, 2019

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 November 21, 2019, 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 that 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 did not perform five-year revalidations and has not screened previously enrolled providers based on categorical risk of fraud, waste or abuse. LDH also concurs with your finding that required monthly SAM database checks have not been performed. LDH has negotiated a contract with Verisys Corporation for the enrollment and screening of all fee-for-service providers, as well as the enrollment and screening of all Managed Care Providers. We anticipate that the new enrollment system will go live early in FY 21 and that enrollment of providers should be completed well before the end of FY 21. We continue to keep CMS informed of our progress toward implementation of the new system.

LDH does wish to point out that although SAM database checks have not been performed on a monthly basis for all providers, quarterly SAM database checks have been completed for those providers who have received payments from LDH and/or the Managed Care Organizations. LDH is currently exploring other options to ensure that payments for services provided to Medicaid recipients are not made to individuals or entities that are prohibited by law from receiving such payments.

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You may contact Virginia Brandt, Compliance Officer at (225) 219-3454 or via e-mail at Virginia.brandt@la.gov with any questions about this matter.

Sincerely,

Cindy Rives
Undersecretary

CR/vb

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA ELECTRONIC MAIL ONLY

December 26, 2019

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

Re: Inadquate Internal Control over Healthy Louisiana Premium Payments

Dear Mr. Purpera:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor (LLA) dated December 16, 2019, regarding a reportable audit finding for the Single State Audit on Healthy Louisiana premium payment mismatches with recipient eligibility types. LDH appreciates the opportunity to provide this response to your office's findings.

Recommendation:
LDH should identify the causes for all existing mismatches premium payments. LDH should also establish controls to ensure premium payments are made based on recipient eligibility and ensure timely adjustment when premium payments do not match eligibility due to eligibility changes after the payment.

Response:
LDH concurs with this recommendation. The primary drivers of mismatches occurring between eligibility types and premium payments is due to eligibility changes after the payment is made and overlapping enrollments, or due to changes in eligibility between when the premium payment report is generated and payment actually rendered. There will always be a need to adjust eligibility and claims and adjust reporting due to timing issues of new eligibility information received. The Center for Medicare & Medicaid Services (CMS) allows states to report additional expenditures applicable to a service period up to two years after the date of original service payment.

LDH corrected the payments by November 2019 and also modified the monthly demographic adjustment process to reduce these occurrences resulting from overlapping enrollments and changing eligibilty. When LDH upgraded its eligibility system (LaMEDS), it increased the number and timeliness of eligibility changes being transmitted to the mainframe based payment system. As a result, LDH and its fiscal intermediary, DXC, implemented a corrective action in November 2019 that updated the adjustment process to include a secondary query to identify and address additional mismatches generated from updates passing through the more robust eligibility system.

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Additionally, LDH is exploring options for alignment of premium payment reporting, review and disbursement. Current operations are to generate the premium payment report for review and approval on a Monday and LDH reviews and approves within 48 to 72 hours, after which payment processing occurs. During that period, eligibility can change with retro-adjustments and the payments are generated based on the approved premium report rather than the current eligibility status in LaMEDS. This timing gap sometimes causes a mismatch; however, LDH must also have adequate controls to approve premium disbursal. As a corrective action, LDH will develop a preventative or reconciliation process to ensure that premium payments align with updates in eligibility , while also allowing for some form of continued monitoring controls to be in place.

You may contact Mitzi Hochheiser, Medicaid Chief Technology Officer, at (225) 342-8935 or via e-mail at Mitzi.Hochheiser@la.gov with any questions about this matter.

Sincerely,

Cindy Rives
Undersecretary

CR/jlk

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA E-MAIL ONLY

January 8, 2020

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

Re: Inadequate Controls over Medicare Buy-In

Dear Mr. Purpera:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor (LLA) dated December 26, 2019, regarding a reportable audit finding for the Single State Audit on Medicare Buy-In Variances. LDH appreciates the opportunity to provide this response to your office's findings.

Recommendation:
LDH should develop formal procedures to ensure Buy-In variances are addressed on a consistent and timely basis.

Response:
LDH concurs with this recommendation. The primary drivers of variances occurring between the Center for Medicare & Medicaid Services (CMS) and LDH as it pertains to Buy-In are demographic discprepencies between the two agencies. As a corrective action, LDH maintains a separate table to store this information to crosswalk with CMS data, which allows the Buy-In to start and initiates Medicare premium payments.

LDH implemented the corrective action plan using a separate table on December 13, 2019. LDH also found Buy-In segments that had previously erred out due to the demographic discrepancies and resent the corrections to CMS on December 20, 2019. LDH has received the return file and is analyzing it for any additional corrections.

You may contact Mitzi Hochheiser, Medicaid Chief Technology Officer, at (225) 342-8935 or via e-mail at Mitzi.Hochheiser@la.gov with any questions about this matter.

Sincerely,

Cindy Rives
Cindy Rives
Undersecretary

CR/gt

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Public Health

December 4, 2019

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

RE: Special Supplemental Nutrition Program for Women, Infants, and Children

Dear Mr. Purpera:

In an effort to continue to improve the operations and performance of the State's Bureau of Nutrition Services (BONS) Special Supplemental Nutrition Program for Women, Infants and Children (WIC), the Louisiana Department of Health (LDH) Office of Public Health (OPH) is performing a comprehensive performance evaluation of the program to ensure the highest level of program integrity and quality services. WIC is one of OPH's largest programs and accounts for one-third of the OPH budget and serves an average of 110,000 participants monthly. OPH has reviewed your office's finding and our response is as follows:

Audit Finding & Program Actions:
Finding: Noncompliance with Review of Redeemed Food Instruments and Cash-Value Vouchers
Louisiana Department of Health, Office of Public Health did not have a process in place to review redeemed food instruments (FIs) and cash-value vouchers (CVVs) for Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) (CFDA 10.557) program during fiscal year 2019.

Recommendation: OPH management should ensure that reviews of redeemed FIs and CVVs are performed and appropriate follow-up action is taken. That is, the auditor recommended the provision of a SOC 1 report by the WIC banking contractor, Solutran.

Response: BONS agrees with the assessment that it is the program's responsibility to ensure the review of redeemed FIs/CVVs. BONS contracts with Solutran to provide banking services for the redemption of FIs/CVVs and to review all FIs/CVVs submitted by authorized vendors. This review occurs before BONS approves payments to vendors. On behalf of the state agency, Solutran detects all of the errors as outlined in 7 CFR 246.12(k)(1) which include: purchase price missing; participant, parent/caretaker, or proxy signature missing; vendor identification missing; food instruments or cash-value vouchers transacted or redeemed after the specified time periods; and, as appropriate, altered purchase price. The state agency also enforces maximum allowable reimbursement levels (MARLs) on all FIs/CVVs in accordance with the policy approved by the United States Department of Agriculture (USDA) Food and Nutrition Service (FNS).

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Therefore, we do not agree with the finding that BONS does not have a process in place to review redeemed food instruments. BONs is compliant with 7 CFR 246.12(k) *Retail food delivery systems: Vendor claims* based on the fact that Solutran has adequate measures in place that serve as an audit of their processing controls and that the Service Organization Control (SOC) 2 report meets the standards and/or mandates established by the USDA FNS.

The argument presented by LLA is that *"the services are provided by Solutran, but since they no longer provide a SOC 1 report covering an audit of their processing controls, we cannot rely on Solutran for audit purposes. As a result, we now consider the second level review you all perform as first level... If Solutran starts providing the SOC 1 report again, I believe this finding will go away."* In an immediate follow-up to this preliminary finding, the BONs Director and Finance Manager spoke with Solutran and conducted internal research into the matter. During the conversation the Solutran representative provided the following insight on why Solutran changed from a SOC 1 report to a SOC 2 report:

A SOC 1 report gives BONS assurance that their financial information is being handled safely and securely. However, a SOC 1 report is limited in that it demonstrates that the internal financial controls are properly designed, while a SOC 2 report further demonstrates that the controls operate effectively over a period of time. The SOC 1 defines to an auditor what can be seen as opposed to the SOC 2 report which defines the practices to be followed (i.e., best practices). The SOC 2 Type 2 has been identified as the better reporting mechanism, which is the reason that Solutran transitioned from the SOC 1 to the SOC 2.

Internal research led to a better understanding that the (SOC) 1 reports are to be conducted in accordance with the Statement on Standards for Attestation Engagements (SSAE) No. 16, the American Institute of CPAs (AICPA) "attest" standard. However, changing needs have led many organizations to transition to providing a SOC 2 report as opposed to a SOC 1 report. According to our research, the SOC 2 report meets the standard criteria of the Trust Service Principles (renamed to Trust Services Criteria in 2018) and is a generally accepted practice by both USDA-FNS and other states' WIC program. Solutran's SOC 2 report provides verification on FIs (returned vs. redeemed) by reviewing key factors through the use of a well-defined script to accomplish both determinations.

Louisiana WIC transitioned from paper benefit issuance to electronic benefit issuance in October 2019. Since benefits are issued three months in advance, some FIs/CVVs will be still be available for redemption through February 2020. BONS will continue to monitor the redemption of these FIs/CVVs until they have expired or been redeemed and will continue to randomly review rejected FIs/CVVs and paid FIs/CVVs to ensure all are processed (either redeemed or rejected) correctly by Solutran and will maintain documentation of such reviews.

Sincerely,

Cindy Rives
Undersecretary

cc:
Alexander Billioux, MD, DPhil, Assistant Secretary, Office of Public Health
M. Beth Scalco, Deputy Assistant Secretary Center of Community and Preventive Health, Office of Public Health
Jennifer Nicklas, Interim Director of BONS, Office of Public Health

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA ELECTRONIC MAIL ONLY

January 17, 2020

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:

Thank you for the opportunity to respond to the reportable audit finding in the Single Audit Report for the State of Louisiana on Inadequate Controls over Billing for Behavioral Health Services. The Louisiana Department of Health (LDH) is committed to ensuring the integrity of the Medicaid program, and it appreciates the efforts of the legislative audit team toward that end.

We have reviewed the findings and provide the following response to the recommendations documented in the report.

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

LDH Response: LDH does not agree with this recommendation.

This recommendation is inconsistent with a risk-based managed care model. While federal law mandates that Medicaid MCOs be paid an actuarially sound rate, there is no federal requirement that plans pay their providers in a particular way or at a particular level. Most states elect to take a hands-off approach to provider reimbursement and claims processing by MCOs. Some states set minimum requirements, often benchmarking from fee-for-service, like Louisiana. Additionally, MCOs have the flexibility to pay their providers higher than fee for service. With provider reimbursement being among the most critical factors contributing to provider participation in MCOs, this flexibility enables MCOs to maintain an adequate network, particularly in rural areas and for provider types in short supply.

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LDH holds the MCOs accountable for implementing necessary claims payment system edits, as identified in Section 17.2 of the current contracts. In order to meet these requirements, the MCOs employ a variety of edits that are not dependent on modifiers, including the use of information readily available through interfaces with their provider enrollment and service authorization data. Based on further review of the claims identified by LLA, preliminary feedback from the MCOs indicate that claims were paid correctly because information such as provider qualifications captured during provider enrollment and member's date of birth captured in their member file can be used in place of the modifier to properly pay the claim and reduce administrative burden on providers.

Further, post-payment reviews are a core component of a risk-based managed care 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 preserve flexibility for payment variances while ensuring program integrity with more depth than edit checks can provide.

It would also be inconsistent with a risk-based managed care model, and 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, the fee schedule defines only the minimum services that must be provided and the minimum amount that should be paid for those services. Section 9.2 of the current 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.

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

Sincerely,

Cindy Rives
Undersecretary

CR/vb

APPENDIX B: SCOPE AND METHODOLOGY

We performed certain procedures at LDH for the period from July 1, 2018, through June 30, 2019, to provide assurances on financial information significant to the State of Louisiana's Comprehensive Annual Financial Report (CAFR), and to evaluate relevant systems of internal control in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States. Our procedures, summarized below, are a part of the audit of the CAFR and the Single Audit of the State of Louisiana (Single Audit) for the year ended June 30, 2019.

- 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 CAFR.

- We performed procedures on the Commodity Supplemental Food Program (part of the Food Distribution Cluster - CFDA 10.565), Disaster Assistance Projects (CFDA 97.088), Medicaid Cluster (CFDA 93.775, 93.777, and 93.778), Children's Health Insurance Program (CFDA 93.767) for the year ended June 30, 2019, as a part of the 2019 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, 2019, as a part of the 2019 Single Audit.

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

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 CAFR, upon which the Louisiana Legislative Auditor expresses opinions.