DEPARTMENT OF HEALTH AND HOSPITALS
BATON ROUGE MAIN OFFICE OPERATIONS
STATE OF LOUISIANA

FINANCIAL AUDIT SERVICES
MANAGEMENT LETTER
ISSUED NOVEMBER 26, 2014

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

LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

FIRST ASSISTANT LEGISLATIVE AUDITOR
AND STATE AUDIT SERVICES
PAUL E. PENDAS, CPA

DIRECTOR OF FINANCIAL AUDIT
THOMAS H. COLE, CPA

LOUISIANA LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

November 26, 2014

The Honorable John A. Alario, Jr.,
President of the Senate
The Honorable Charles E. "Chuck" Kleckley,
Speaker of the House of Representatives
Ms. Kathy Kliebert, Secretary
Department of Health and Hospitals

Dear Senator Alario, Representative Kleckley, and Ms. Kliebert:

This report includes the results of the procedures we performed at the Department of Health and Hospitals (DHH) for the period from July 1, 2013 through June 30, 2014 to evaluate its accountability over public funds. These procedures are a part of our audit of the state of Louisiana's financial statements and the Single Audit of the State of Louisiana for the year ended June 30, 2014. I hope the information in this report will assist you in your legislative and operational decision-making processes.

We would like to express our appreciation to the management and staff of DHH for their assistance during our work.

Sincerely,

Daryl G. Purpera, CPA, CFE
Legislative Auditor

WDG:EFS:THC:aa

Louisiana Legislative Auditor

Daryl G. Purpera, CPA, CFE

Department of Health and Hospitals

November 2014

Audit Control # 80140041

Introduction

As a part of our audit of the state of Louisiana's financial statements and the Single Audit of the State of Louisiana (Single Audit) for the year ended June 30, 2014, we performed procedures at the Department of Health and Hospitals (DHH) to provide assurances on financial information that is significant to the state of Louisiana's financial statements; evaluate the effectiveness of DHH's internal controls over financial reporting and compliance; and determine whether DHH complied with applicable laws and regulations. In addition, we determined whether management has taken actions to correct findings reported in the prior year.

DHH is the largest department in Louisiana state government and administers the Medical Assistance Program (Medicaid). The mission of DHH is to protect and promote health and to ensure access to medical, preventive, and rehabilitative services for all citizens of the state of Louisiana.

Results of Our Procedures

Follow-Up on Prior-Year Findings

Our auditors reviewed the status of the prior-year findings reported in a management letter dated December 2, 2013. We determined that management has resolved the prior-year findings related to noncompliance with Medicaid regulations for an external quality review - Louisiana Behavioral Health Partnership contractor, misappropriation of public funds, ineffective internal audit function, noncompliance with Executive Order BJ 2011-05, and inadequate controls over drug rebate collections. The findings relating to improper payments to waiver services provider, improper payments to non-emergency medical transportation services providers, noncompliance with approved consolidated cost allocation plan, and lack of control over federal cash management requirements have not been resolved and are addressed again in this letter.

Current-Year Findings

Noncompliance with Federal and State Regulations over Contract for New Medicaid Dental Program

On July 1, 2014, DHH launched the new Medicaid Dental Benefits Program using a private contractor but did not submit the three-year, $484 million contract for approval to the federal Centers for Medicare and Medicaid Services (CMS), as required by the waiver agreement with CMS. DHH also disclosed protected health information and personal identifiable information prior to having data-sharing agreements in place. In addition, DHH paid the contractor before the contract was approved by the state Office of Contractual Review (OCR). By not meeting waiver terms, DHH may have violated federal regulations and could owe funds back to the federal grantor. By providing information before executing data-sharing agreements, DHH may have exposed itself and individuals to unnecessary risk by not protecting the confidentiality of the data.

In a letter stamped June 23, 2014, CMS approved a 1915(b) waiver submitted by DHH to create the new Dental Benefits Program. The waiver included multiple assurances that DHH would submit the program contract to CMS for approval prior to enrollment of beneficiaries in the new program. As noted previously, the contractor began managing the program on July 1, 2014, but DHH did not submit the contract to CMS for approval until August 20, 2014. CMS has not approved the contract as of September 30, 2014. Once CMS approves a waiver, the terms of the waiver essentially become the federal regulations for the program.

DHH's policy regarding Business Associate Relationships provides that DHH first enters into a written contract, or other written agreement or arrangement, with the Business Associate before disclosing an individual's protected health information to the Business Associate. The new Dental Benefits Program contract, including a data-sharing clause and HIPAA Business Associate Addendum, was signed by the contractor, MCNA Dental Plans (MCNA) on June 20, 2014, and by DHH (signature undated). However, DHH and its fiscal intermediary, Molina, began sending data to MCNA as early as June 4, 2014. On June 10, 2014, DHH provided all Medicaid recipient data and Medicaid dental provider data to MCNA, 10 days before any data-sharing agreements would have been in place, and weeks before the contract was approved by OCR.

On July 23, 2014, DHH paid MCNA $10,835,187 using both state and federal funds while the contract was not approved by OCR. DHH submitted the contract to OCR on June 30, 2014, and received approval on August 13, 2014. Louisiana Revised Statute 39:1502 (A) states that no professional, personal, consulting, or social service contract shall be valid, nor shall the state be bound by the contract, until it has first been executed by the head of the using agency, or his designee, which is party to the contract and the contractor, and has been approved in writing by the director of OCR.

DHH management should ensure that required approvals are obtained and agreements are finalized before new programs are launched, data is shared, and payments are made. Management concurred in part with the finding, noting that federal regulations do not require

DHH to have CMS approval of the Dental Benefits Program contract prior to enrollment. Management concurred with the remainder of the finding and outlined a plan of corrective action (see Appendix A, pages 1-3).

Additional Comments: For any new waiver, CMS considers all assurances outlined in a waiver before approval. Once approved by CMS, as noted previously, the waiver assurances essentially become the federal regulations over that program. The DHH waiver included multiple assurances that the contract would be sent to CMS for approval prior to enrolling program beneficiaries. The dental benefits program began on July 1, 2014, and the contract was not submitted to CMS for approval until August 20, 2014, in violation of DHH's own assurances to CMS.

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

DHH failed to require the Louisiana Behavioral Health Partnership's (LBHP) State Managing Organization, Magellan, to submit details on claims that would allow DHH to monitor compliance with Medicaid requirements for the timely filing and prompt payment of Medicaid claims. As a result, DHH may be reimbursing Magellan for paid claims that do not meet federal regulations. The amount of claims possibly paid in error could not be determined because Magellan did not capture and report the actual date that the original claim was filed. The date of original claim submission is needed to determine whether or not the claim met Medicaid regulations.

Magellan is required to submit claims data to DHH so that DHH can monitor the claims for compliance with Medicaid regulations. In claims data submitted to DHH, Magellan did not include the date the claim was filed. Without the claim receipt date, DHH cannot determine the length of time between service date and submission of the claim, or the length of time between submission of the claim and payment by Magellan.

Additionally, DHH granted approval for Magellan to lift the timely filing edit in the Magellan claims system because of significant system problems during the implementation of the LBHP in the first two years of its operations. Magellan is allowing denied claims to be recycled and new claims filed without consideration of the date of service and the Medicaid period of availability.

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

DHH should ensure that Magellan submits sufficient detail on claims, including the date the claim was filed, so it can determine Medicaid compliance. Management concurred with the finding and outlined a plan of corrective action (see Appendix A, pages 4-5).

Improper Payments of Medicaid Claims

DHH paid claims totaling $1,246,404 ($760,057 in federal funds and a $486,347 state match) that did not meet federal regulations relating to the period of availability of federal funds that require filing of original claims within one year of the date of service. DHH's contractor, Molina, inappropriately applied system changes that allowed claims to bypass the edit controlling the one-year filing requirement.

Medicaid regulations require claims to be filed within one year of the service date with a few exceptions. The exceptions apply only when an original claim is filed within the first year and denied. No exceptions exist for new claims initially filed later than the one-year period of availability.

In a sample of 25 original claims that were submitted to DHH after 365 days from the date of service and paid by DHH, we identified five (20%) errors where the span from the service date to the submission date ranged from 369 days to 536 days. After discussing our results with DHH, DHH acknowledged that other claims with paid dates as early as December 2012 were also affected. Subsequently, DHH and Molina identified 18,171 claims paid to 1,595 providers for services delivered to 9,049 recipients that were paid in error. According to DHH, the edit was corrected on October 1, 2014. We consider the $1,246,404 paid in error to be questioned costs for which the state may be liable.

DHH should strengthen its monitoring controls over its claims processing contractor to ensure that federal regulations, including period of availability requirements, are met prior to making payments on claims. Management concurred with the finding and outlined a plan of corrective action (see Appendix A, pages 6-7).

Improper Payments to Non-Emergency Medical Transportation Services Providers

DHH paid claims totaling $863,480 ($526,550 in federal funds and a $336,930 state match) to providers of Non-Emergency Medical Transportation (NEMT) for services billed to the Medical Assistance Program (Medicaid) that were not provided in accordance with established policies, which we consider questioned costs for which the state may be liable. This is the seventh consecutive year we have reported improper NEMT payments.

NEMT is defined as transportation for Medicaid recipients to and/or from a provider of Medicaid covered services. The NEMT program's *Provider Manual* requires that providers maintain copies of Recipient Verification of Medical Transportation Forms (Form MT-3), Driver Information Forms (Form MT-8), and Vehicle Inspection Forms (Form MT-9), and a daily schedule of transports.

During our testing, we identified that one provider entered into a contractual agreement with a medical services provider to be the exclusive transportation provider for the recipients of that medical provider. This agreement is a possible violation of Medicaid regulations requiring recipient freedom of choice. At least 77% of the NEMT provider's transports for the year under

audit were to the medical provider with which it had contracted, totaling $861,648. While the NEMT provider had some recipients sign freedom of choice statements, the provider was unable to provide all copies, and we do not consider these forms to signify informed choice.

Further, the contracted state dispatcher for NEMT allowed this provider to circumvent the established process where only the Medicaid recipient or family member/caregiver should request the transport. Daily, the NEMT provider submitted a list of transports to the state dispatcher, noting the transports it would make that day to the medical provider with which the NEMT provider contracted. The NEMT *Provider Manual*, page 10, states that the transportation provider should "under no circumstances" contact the state dispatcher to initiate a transport. The dispatch process should be a control to ensure a fair distribution of transportation services that gives all NEMT providers equitable opportunity to provide services, gives recipients a true freedom of choice, and gives the state a fair and competitive program. We consider all payments for transports made under this contract to be questioned costs.

Additionally, a review of 43 claims totaling $19,114 paid to two providers, including the provider mentioned above, for 13 recipients during calendar year 2013 identified the following errors and additional questioned cost of $1,832:

- For 26 (60%) claims tested, the providers did not maintain adequate documentation of the trips provided. The providers could not provide completed copies of the MT-3s to substantiate all trips provided under capitated (monthly) and/or single trip rates, and in some cases documentation included inconsistent signatures. During 2013, DHH changed the *Provider Manual* requiring that providers only retain one MT-3 form per week, documenting the trips for the week on capitated rates. As a result, the medical services provider, recipient, and NEMT driver only sign the form once, even though different drivers and medical staff members may have direct knowledge of only the one trip when they signed the form. This documentation change weakens controls over the NEMT program and results in inadequate documentation to support all transports provided.

- One provider reviewed did not maintain an adequate daily schedule of transports in the records. Without a daily schedule of transports, we were unable to determine the number of vehicles and drivers used and whether the provider was using appropriately-inspected vehicles and licensed drivers.

- One provider was unable to provide adequately completed MT-9 forms to verify drivers and vehicles used.

These conditions occurred because the NEMT providers failed to follow established DHH Bureau of Health Services Financing policies and regulations for providing services and adequately documenting those services, and DHH controls were inadequate in preventing these exceptions.

DHH management should ensure that all NEMT rules and regulations are enforced, and that only appropriate claims are paid to providers. DHH management should reconsider the weakened requirement on documentation of capitated transports and ensure that adequate internal control is

maintained over the NEMT program. DHH should also ensure that the state-contracted dispatcher follows all NEMT regulations to provide a fair and competitive program with true freedom of choice for Medicaid recipients. Management concurred with the finding and outlined a plan of corrective action (see Appendix A, pages 8-9).

Inaccurate Annual Fiscal Reports

DHH submitted inaccurate financial information in the Annual Fiscal Report (AFR) for DHH Medical Vendor Payments for the fiscal year ended June 30, 2014. DHH also submitted inaccurate federal schedules used to prepare the Statement of Federal Expenditures (SEFA), which is required by Office of Management and Budget (OMB) Circular A-133. Failure to properly compile and review information included in the AFRs before submitting them to Division of Administration, Office of Statewide Reporting and Accounting Policy (OSRAP) for inclusion in the state's *Comprehensive Annual Financial Report* (CAFR) or the state's Single Audit report increases the likelihood that errors and omissions, either intentional or unintentional, may occur and remain undetected.

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

- A $52.6 million overdraw of federal funds was not corrected and returned to the federal grantor at fiscal year-end, resulting in a $52.6 million overstatement of *Federal Revenue* and a $52.6 million understatement in *Accounts Payable - Due to the Federal Government.* DHH overdrew $52,574,430 in federal funds for disproportionate share payments to the LSU public/private hospital partners. Since DHH did not have an approved state plan amendment, the payments should have been made with state funds only.

- In *Note FF, Accounts Payable Adjustment*, DHH did not follow the estimation methodology used for determining Medicaid accounts payable and did not maintain adequate documentation to support the accounts payable amounts reported. As a result, we noted the following misstatements:

    - *Due to Federal Government (Full Accrual)* was understated by $3.2 million.

    - *Due to Audits Payable (Modified Accrual)* was overstated by $47.5 million.

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

- In *Note GG, Accounts Receivable Adjustment*, DHH did not follow the estimation methodology used for determining Medicaid accounts receivable and did not maintain adequate documentation to support the accounts receivable amounts reported. As a result, we noted the following misstatements:

- *Due From Federal Government (Full Accrual)* was overstated by $6.1 million.
- *Due From Medical Providers and Third Parties (Full Accrual)* was understated by $16.6 million.
- *Due From Medical Providers and Third Parties (Modified Accrual)* was overstated by $22.6 million.

DHH provided the required federal schedules to OSRAP and the auditors on August 29, 2014. However, since DHH submitted the federal schedules to OSRAP before closing all accounts at fiscal year-end, finalizing expenditure detail, and completing the AFRs on September 12, 2014, all required reconciliations of AFR financial amounts to the federal schedules were inaccurate and/or incomplete. In addition, DHH did not reconcile revenue detail by grant to expenditures to determine if expenditures reported as federal were actually federally funded. During our audit procedures and procedures performed by DHH personnel subsequent to August 29, 2014, errors were identified and corrections were made. These changes resulted in as many as five revisions to the federal schedules until October 21, 2014, when the final versions were provided to the auditors.

Good internal control over financial reporting should include adequate procedures to record, process, and transmit financial data needed to prepare an accurate and complete AFR and a review process that will identify preparation errors and correct those errors before submitting the AFR to OSRAP for inclusion in the state's CAFR or the state's Single Audit report. DHH management did not perform an adequate review of its AFRs and has not adequately trained its staff in reporting requirements.

DHH management should strengthen its internal control over the financial reporting process and ensure that all personnel are adequately trained and supervised. In addition, management should perform a thorough review of its AFRs to identify and correct errors before submission to OSRAP. Management concurred with the finding and outlined a plan of corrective action (see Appendix A, page 10).

Improper Payments to Waiver Services Provider

For the third consecutive year, DHH paid New Opportunities Waiver (NOW) claims under Medicaid totaling $16,559 ($10,098 in federal funds and a $6,461 state match) for waiver services that were not documented and billed in accordance with established policies, which we consider to be questioned costs. The NOW is administered by the DHH Office for Citizens with Developmental Disabilities. Improper payments for waivers services have been reported in 12 of the last 15 audits, totaling $580,924.

In a test including 73 claims totaling $70,959 paid to two providers, we noted errors on 22 claims paid to one provider for three Medicaid clients who receive 24-hour services. According to the NOW services provider manual, day services must not exceed 16 hours and night services must be a minimum of eight hours in a 24-hour period unless an exception is documented in the recipient's comprehensive plan of care. For the three recipients tested, day services were billed

in excess of the 16-hour maximum and conversely, night services were not billed for the minimum eight hours. The provider did not document circumstances around the exceptions and did not request approval for not complying with the 16-hour maximum and the eight-hour minimum. The day service rate per hour is 66% higher than the night service rate per hour.

These conditions occurred because DHH paid waiver services claims even though the waiver services provider failed to follow established DHH policies and federal regulations for providing services. Regulations and requirements for the delivery of services and payment of claims for the waiver program are established through administrative rules and policy manuals developed by DHH.

DHH management should ensure all departmental policies and federal regulations are enforced, and that only appropriate claims for waiver services are paid to providers. Management concurred with the finding and outlined a plan of corrective action (see Appendix A, pages 11-12).

Noncompliance with Approved Consolidated Cost Allocation Plan

DHH did not follow an approved cost allocation plan for administrative expenditures in the current year and could not provide supporting documentation for statistics that were used for the current-year's cost allocation. As a result, federal programs may have been over or undercharged. This is the second consecutive year that we have reported deficiencies in the cost allocation plan.

DHH's current cost allocation plan was approved in April 2014, retroactive to July 2012, via an amendment submitted by DHH in September 2013. The approval noted three required changes or corrections. As of August 2014, DHH has not submitted the changes or corrections noted in the approval memo. Also, DHH made organizational changes for fiscal year 2014 that would require revising the plan, making a retroactive-approved plan incompatible between fiscal year 2013 and fiscal year 2014. DHH's allocated administrative costs for fiscal year 2014 totaled $101,330,793.

DHH serves as the single state Medicaid agency responsible for administering the Medicaid and the Children's Health Insurance (LaChip) programs, and is required to prepare a public assistance cost allocation plan to support claims for administrative expenses. The cost allocation plan is a description of the procedures that DHH will use in identifying, measuring, and allocating all costs incurred in support of all programs administered or supervised by DHH.

DHH management should submit a new cost allocation plan or amendments to the current plan for required approval and should maintain supporting documentation for statistics used for cost allocation. Management should also determine if the unapproved allocations used resulted in overcharging federal programs for administrative expenses. If federal programs were overcharged, management should take corrective action. If undercharged, management should seek to recover the unallocated costs. Management concurred with the finding and outlined a plan of corrective action (see Appendix A, page 13).

Lack of Controls over Federal Cash Management Requirements

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

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

- DHH overdrew $52,574,430 in federal funds for disproportionate share payments to the LSU public/private hospital partners. Since DHH did not have an approved state plan amendment, the payments should have been made with state funds only. However, DHH erroneously drew federal funds between March 2014 and June 2014. DHH returned the funds to the federal government on September 23, 2014, as part of the June 30, 2014 quarterly reconciliation.

- For one of three draws to pay Magellan, the State Managing Organization for Behavioral Health, DHH drew $1,814,839 in federal funds and held the funds for 20 days before making the payment to Magellan. The clearance pattern required payment on the same day the federal funds were received.

- DHH did not comply with the funding technique noted in the agreement for all three administrative/payroll draws tested, resulting in the underdraw of $9,984,196.

- DHH drew federal dollars inappropriately for one administrative/payroll draw where DHH doubled the draw and overdrew $7,921,893.

- DHH did not comply with the clearance pattern noted in the agreement for three of four benefits draws tested, all three Medicare buy-in draws tested, and all three draws requested on a state holiday.

- DHH did not make required adjustments timely to correct inaccurate draws like the ones mentioned above through the quarterly reconciliation process. Also, DHH did not consistently perform the reconciliation of the federal draws made during the quarters to the quarterly federal expenditure report. DHH did not reconcile the quarters ending September 2013, December 2013, and March 2014 until June 2014.

- DHH did not submit properly-completed interest schedules to OSRAP as required. The schedules submitted did not have accurate dates, overdraw/underdrawn details, and accounting of interest. Without accurate and complete interest schedules from state agencies, OSRAP is unable to accurately

calculate the state's interest liability and prepare an annual report to the federal government.

DHH must schedule the draw of federal funds so that funds are received and disbursed by DHH in accordance with methods and timeframes noted in the agreement known as clearance patterns. Draws should also be adequately supported and follow funding techniques noted in the agreement. Noncompliance with clearance patterns and funding techniques puts the state at risk for interest liabilities and disallowances. Based on the errors and overdraws noted above, DHH owed at least $16,716 in interest to the federal government.

DHH should ensure that draws of federal funds are properly calculated, supported, and follow federal cash management requirements, including compliance with the Treasury State Agreement. In addition, DHH should follow OSRAP's guidelines for reporting disbursement and drawdown information. Management concurred in part with the finding and outlined a plan of correction action for those items in which it concurred. However, management noted that while it agreed that adjustments were not done on a quarterly basis, federal regulations only require annual adjustments. Further, management noted that all required information was provided on interest schedules with supporting documentation to OSRAP (see Appendix A, pages 14-15).

Additional Comments: DHH management acknowledged in its response that quarterly reconciliations and adjustments were not performed until the end of the year but stated that federal regulations only require annual adjustments. Each quarter, DHH is required to submit a federal quarterly report documenting federal expenditures that should be matched to federal revenues. The quarterly report includes a signed certification from DHH management that "the expenditures included in this report are based on the state's accounting of actual recorded expenditures, and are not based on estimates." Since some administrative and payroll draws are based on an estimate, a state Medicaid agency could not make a valid certification without quarterly reconciliations and adjustments. Also, DHH is required by the Cash Management Improvement Act (CMIA) to identify any overdraws of federal funds and return those promptly. Without quarterly reconciliations and adjustments, some overdraws may not be identified and returned promptly.

DHH management further noted in its response that all required information was provided on the interest schedules and supporting documentation submitted to OSRAP. DHH management cited Sections 5.3.5 #5 and #9 of OSRAP's policy on CMIA. Section 5.4 of that same policy notes that the agency is responsible for ensuring that OSRAP is aware of all circumstances where an interest liability may exist. The agency's notification is to be made on the data that agencies submit to OSRAP as long as the reason is clearly stated and the dates and times are clearly denoted so that interest may be calculated. Our finding noted multiple errors on interest schedules provided to OSRAP by DHH. In the majority of schedule items we tested, DHH included the wrong check/electronic funds transfer issue date when compared to the Medicaid Management Information System and other sources. In some instances, DHH included the wrong "Actual Receipt Date" or "Date Received" when compared to documentation supporting the federal draw. Also, no additional comments were provided to OSRAP regarding the Magellan funds that were drawn 20 days prior to vendor payment and the payroll draw that was

doubled. In these instances, DHH knew that the draws were CMIA violations, but the detail in the schedules did not inform OSRAP of the violations.

Financial Statements - State of Louisiana

As a part of our audit of the state of Louisiana's financial statements for the year ended June 30, 2014, we considered internal control over financial reporting and examined evidence supporting DHH's non-payroll expenditures, federal revenue, Medicaid current and non-current accruals, and critical information systems and related user controls. Our audit included tests of DHH's compliance with laws and regulations that could have a direct and material effect on the financial statements, as required by *Government Auditing Standards*.

Based on the results of our procedures, we reported a finding related to inaccurate annual fiscal reports that will also be included in the State of Louisiana's Single Audit Report for the year ended June 30, 2014. In addition, the account balances and classes of transactions tested, as adjusted, are materially correct.

Federal Compliance - Single Audit of the State of Louisiana

As a part of the Single Audit of the State of Louisiana (Single Audit) for the year ended June 30, 2014, we performed internal control and compliance testing on DHH's Medicaid Cluster of federal programs (CFDA 93.775, 93.777, 93.778) and the State Children's Insurance Program (LaChip, CFDA 93.767), as required by OMB Circular A-133. Those tests included evaluating the effectiveness of DHH's internal controls designed to prevent or detect material noncompliance with program requirements and tests to determine whether DHH complied with applicable program requirements.

In addition, we performed procedures on DHH's Schedule of Expenditures of Federal Awards (Schedule 8) and Summary Schedule of Prior Federal Audit Findings (Schedule 8-3), as required by OMB Circular A-133.

Based on the results of those procedures, we reported findings related to noncompliance with state and federal regulations over the contract for the new Medicaid dental program, inadequate controls to monitor timely file and prompt payment of Medicaid claims, improper payments of Medicaid claims, improper payments to Non-Emergency Medical Transportation services providers, improper payments to a waiver services provider, noncompliance with an approved consolidated cost allocation plan, and lack of controls over federal cash management requirements that will also be included in the Single Audit for the year ended June 30, 2014. The finding related to inaccurate annual fiscal reports, mentioned in the report section above, includes results from our Schedule 8 procedures. In addition, DHH's Schedule 8 and Schedule 8-3, as adjusted, are materially correct.

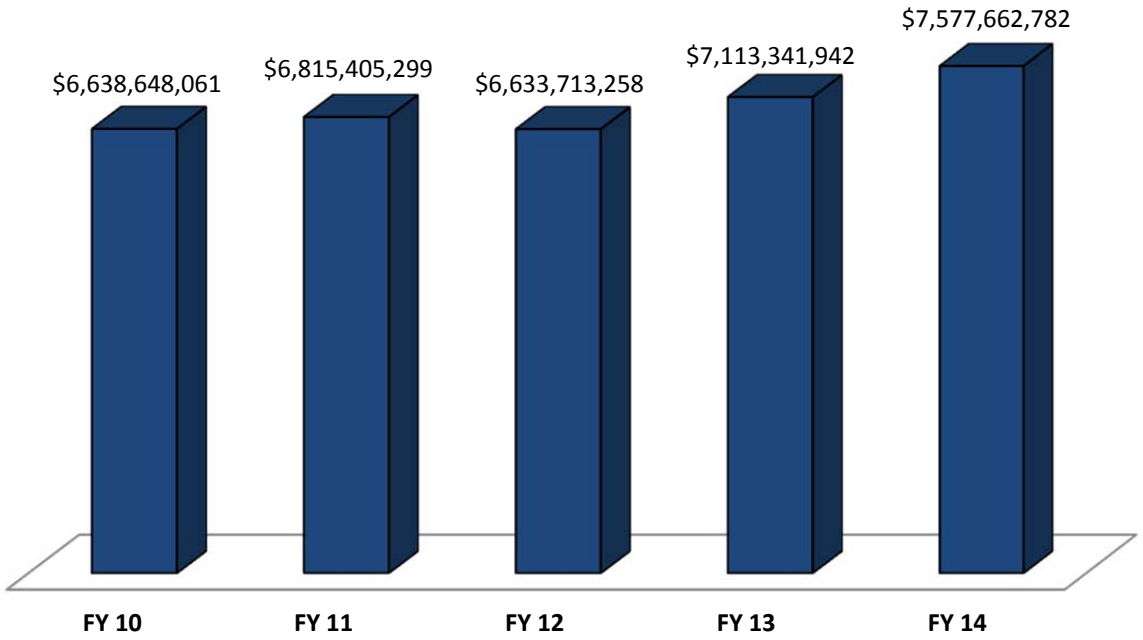
Trend Analysis

We compared the most current- and prior-year financial activity using DHH's annual fiscal reports and/or system-generated reports and obtained explanations from DHH management for any significant variances. We also prepared an analysis of Medicaid program expenditures and a breakdown of Medicaid funding sources over the last five years.

In analyzing financial trends of DHH Medicaid expenditures over the past five years, expenditures remained fairly consistent between 2010 and 2012. However, since 2012, expenditures have increased by more than $900 million, or 14 % (see Exhibit 1). Because of a shift in services for the implementation of Bayou Health (BH) and the Louisiana Behavioral Health Partnership (LBHP), fees for service payments to private and public providers decreased by more than $800 million, while Buy In (per-member, per-month fee) payments for BH and LBHP increased by over $1.4 billion, for an net increase of approximately $600 million. Also, Uncompensated Care payments increased by approximately $350 million due primarily to increased payments to the LSU hospitals' partners. Funding sources for Medicaid expenditures have varied greatly over the past five years, with decreased federal funding and increased state funding through dedicated funds and the general fund (see Exhibit 2). Federal funds are decreasing because of drops in the federal medical assistance percentage, referred to as FMAP. The FMAP was greater in prior years with increases from the American Recovery and Reinvestment Act and certain disaster assistance after hurricanes Katrina and Rita, which have now expired.

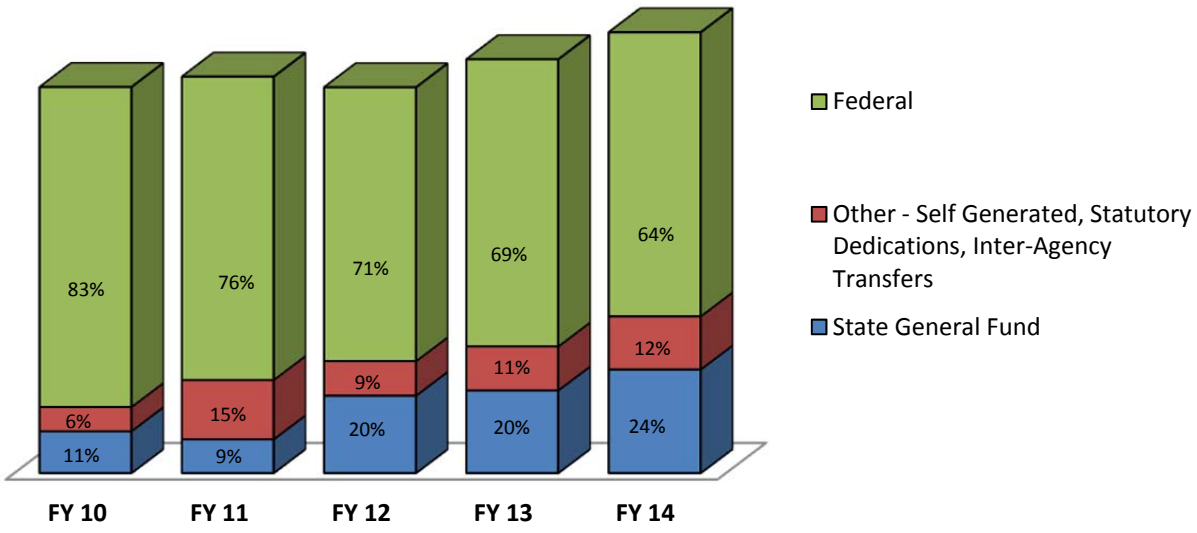
Each fiscal year, DHH produces a report titled "Louisiana Medicaid Annual Report" that provides an overview of the Medicaid program including detail information on expenditures. The reports are available on DHH's website.

Exhibit 1
Medicaid Program Expenditures
Five-Year Analysis



Source: Fiscal Year 2012-2014 Annual Louisiana Medicaid Reports

Exhibit 2
Expenditures by Financing Category



Source: Fiscal Year 2012-2014 Annual Louisiana Medicaid Reports

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

APPENDIX A: MANAGEMENT'S RESPONSES

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

VIA ELECTRONIC MAIL ONLY

October 21, 2014

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

Dear Mr. Purpera:

RE: Noncompliance with Federal and State Regulations Over Contract for New Medicaid Dental Program

The Department of Health and Hospitals (DHH) has reviewed your office's finding titled "Noncompliance with Federal and State Regulations Over Contract for new Medicaid Dental Program" and thanks you for the opportunity to respond to your finding. The Department agrees that the contract was not sent to Centers for Medicare and Medicaid Services (CMS) for approval as assured by DHH in the waiver agreement with CMS. In addition, we paid the contractor before the contract was approved by the state Office of Contractual Review (OCR).

Management recognizes its responsibility to ensure that required approvals are obtained and agreements are finalized before new programs are launched, data is shared, and payments are made. To the recommendations in the referenced audit report, management offers this response:

Medicaid does not concur to this part of the finding.

- Despite waiver assurances "that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP), or Primary Care Case Management (PCCM)," federal regulations do not require DHH to have CMS approval of the Dental Benefit Program (DBP) contract prior to enrollment. While there are no federal regulations required to have CMS approval prior to enrollment the contract was submitted to CMS on 8/20/14.

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- The waiver (not contract) approval enables DHH to restrict freedom of choice and selectively contract with a single PAHP/managed care vendor (see page 8 of waiver application). If a state is in violation of the 1915(b) waiver terms, CMS could revoke DHH's ability to mandatorily enroll individuals in the DBP until the contract is submitted (for an initial waiver application), potentially resulting in a program that only offers voluntary enrollment.

- Federal funds are authorized for managed care capitation payments through contract (not waiver) approval. The DBP contract is a Prepaid Ambulatory Health Plan (PAHP) under federal regulations at 42 CFR 438.2 and all PAHP contracts must be reviewed and approved by CMS under the rules at 42 CFR 438.6(a). However, PAHP contracts are not subject to the regulations at 42 CFR 438.806 that require CMS approval prior to receipt of Federal Financial Participation (FFP).

Medicaid does concur with this part of the finding.

- DHH disclosed protected health information and personal identifiable information prior to having a data sharing agreement in place.

  DHH did submit data to MCNA prior to having the appropriate Business Associate agreement, this was due to lack of internal communication and the short time frame to get the program up in running. We are re-educating staff on proper data sharing protocols to prevent future occurrences of data release prior to executing the data sharing agreement.

- DHH paid Managed Care of North America Dental (MCNA) while the contract was not approved. Aware of the contract's status in the last days of June (pending OCR approval), MCNA opted to begin operations at risk so as not to delay the program implementation and disrupt member services. It did so with the understanding that payment would not be made until OCR approved the contract. Unfortunately, this late date executive level decision was not communicated to the line level programmers responsible for testing and implementation of payments to the DBP; and, the first payment was processed on the timeline specified in the original work order.

  As stated above, federal funds are authorized for managed care capitation payments through contract approval, and CMS prior approval of PAHP contracts is not required prior to receipt of FFP.

DHH regrets the communication break down and will heretofore require a written advance directive from the Medicaid Director prior to implementation of capitation payments to any new managed care contractor.

DHH management is confident that these actions will address the recommendations submitted by your office. Should you have questions regarding this letter, please contact Mary Johnson, Medicaid Deputy Director, at (225)342-3426 or Mary.Johnson@la.gov.

Sincerely,

J. Ruth Kennedy
Medicaid Director

JRK/mtcj

c: Teresa Bravo
Kathy Kliebert
Lou Ann Owen
Bill Perkins
Jen Steele

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

September 30, 2014

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

Dear Mr. Purpera:

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

Please accept this letter as a response to the Legislative Audit finding regarding Inadequate Controls to Monitor Timely Filing and Prompt Payment of Medicaid Claims. The Legislative Auditor's position is that this finding occurred because DHH failed to require Magellan, the Statewide Management Organization (SMO), to submit detail on claims that would allow DHH to monitor compliance with Medicaid requirements for timely filing and prompt payment of Medicaid claims.

DHH concurs with this finding and has taken steps to resolve these findings by ensuring proper controls are in place and ongoing to monitor timely filing and prompt payment of Medicaid claims.

DHH does have knowledge of the date of service of the claim for which the encounter is submitted. The service date is a required field on encounters. OBH receives this information on the encounter data from the SMO.

Additional steps have been taken by DHH to ensure that DHH monitors compliance with Medicaid requirements for timely filing and prompt payment. DHH has entered into a contract with Myers & Stauffer to audit and analyze encounter data from the LBHP SMO. Work under this contract has already begun. The contract requires that M&S, among other functions, to:

- obtain encounter claim data and perform QA processes to arrive at "a clean set of data;"

- perform an analysis and assessment of the accuracy and completeness of reported encounters by the SMO;
- help to establish a process whereby encounters are obtained in a routine, weekly process,
- examine weekly encounter submissions and report on potential issues identified;
- conduct monthly meetings with SMO and address issues to successful encounter submissions;
- Review SMO Systems capabilities as it affects completeness of encounter data reliability and quality, and prepare reports on findings to DHH;
- Perform a reconciliation between the SMO's cash disbursement journals and other financial records and the submitted encounter data to payments to providers for services provided as well as the completeness of the encounter data, and identify any issues thereto;
- Conduct other analyses as necessary to measure reliability of encounter data.

Thus, DHH is able to monitor compliance with Medicaid requirements for timely filing and prompt payment of Medicaid claims. We consider this corrective action to be in place and ongoing.

Should you have questions regarding this matter, please contact Lou Ann Owen, Medicaid Deputy Director, at LouAnn.Owen@LA.GOV or 225-342-1353. She is responsible for ensuring that this corrective action is carried out.

Sincerely,

J. Ruth Kennedy
Medicaid Director

JRK/LAO

c: Michael Breland
Rochelle Head-Dunham
Jennifer Katzman
Jeff Reynolds
Jen Steele
Olivia Watkins

Bobby Jindal
GOVERNOR

Kathy Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of Management & Finance

November 5, 2014

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

RE: Improper Payments of Medicaid Claims—Period of Availability

Dear Mr. Purpera:

The Department of Health and Hospitals has reviewed the audit findings and concurs that there was an issue with the claims processing logic that allowed improper payments to be made. It is important to note that these payments were not fraudulently made, but were the result of a processing logic (computer-programmed system) error by the Department's Medicaid fiscal intermediary (FI). The ineligible payments were self-identified by the FI and reported as part of the audit. We are working diligently to identify the total amount of any ineligible payments and will move to recoup these payments as quickly as possible.

During the process of the Louisiana Legislative Auditor's (LLA) review, our Medicaid FI identified an error in Medicaid claims processing logic which had allowed some claims to be paid that were filed later than 12 months after the date of service. Medicaid policy allows exceptions to 12 month timely filing under certain circumstances, but some of these were not eligible for the exceptions.

A necessary fix to correct this issue has already been implemented; the Medicaid claims processing logic was modified by our FI and put into production for claims processed on or after Oct. 1, 2014.

In the process of developing a recoupment plan for the LLA-identified overpayments, we determined that the $1.6 million in total overpayments originally identified by the Department is overstated. We are now working with the FI to determine the **actual** amount of claims paid that were received after the timely filing deadline and that did not meet an exception which would allow payment. This process will include further examination of claims to analyze the accuracy of payment. We anticipate this validation will be completed by Nov. 7, 2014.

Purpera, Darryl
Improper Payment of Medicaid Claims—Period of Availability
November 5, 2014

Following identification of actual ineligible payments, recoupment will be initiated beginning with the Medicaid check write on Nov. 18, 2014. The date of final completion of any recoupments cannot be determined until we have the amount of overpayments at the provider level and negotiate repayment plans. However, we are projecting that all recoupments will be completed by Sept. 30, 2015.

If you have any questions or need any additional information, please contact Ruth Kennedy, Medicaid Director at (225) 342-9240 or ruth.kennedy@la.gov.

Sincerely,

W. Jeff Reynolds
Undersecretary

Bobby Jindal
GOVERNOR

Kathy Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals

October 31, 2014

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

RE: Improper Payments to Non-Emergency Medical Transportation Services Providers

Dear Mr. Purpera:

The Department of Health and Hospitals has reviewed, and we concur with, the findings and recommendations by LLA in the above-referenced audit. We have already begun to work through solutions to the identified findings through the following means-- by including transportation services management in the managed care contracts operated by the Bayou Health plans and conducting an investigation into whether recoupment of payments should be conducted.

Already, a referral has been made to DHH Program Integrity to further investigate whether recoupment of payments to the providers in question should be initiated.

In addition to referrals to Program Integrity, program staff has been in direct communication with the providers to further educate them on established policies and procedures. Staff has also begun a thorough review of these established policies and procedures to determine where improvements can be made.

Oversight of these services will also be improved by including transportation services in the Department's managed care efforts. Beginning February 1, 2015, a large majority of transportation services will be managed by the five Bayou Health plans. DHH has also contracted with the new transportation dispatch contractor to improve oversight for transportation services provided under legacy Medicaid. This contract began operations on October 1, 2014.

We anticipate all the corrective action measures will be completed by May 30, 2015.

If you have any questions or need any additional information, please contact Ruth Kennedy, Medicaid Director at (225) 342-9240 or ruth.kennedy@la.gov.

Sincerely,

W. Jeff Reynolds
Undersecretary

Cc: Ruth Kennedy, Medicaid Director
William Root, Chief Compliance Officer

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals

Office of the Secretary

November 13, 2014

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

Re: Inaccurate Annual Fiscal Reports

Dear Mr. Purpera,

Management of the Department of Health and Hospitals (DHH) concurs with the finding relative to inaccurate annual fiscal reports. As noted in our cash management response, which addresses some similar issues, we have already implemented numerous changes that address the findings and believe all errors have been corrected.

First, DHH did draw down federal funds for the disproportionate share payments (DSH) for six of the 10 LSU public-private partnership hospitals under three pending state plan amendments (SPAs). This drawdown was based on the understanding that these SPAs would receive approval. Since then, DHH has returned the funds to the federal government and is no longer making payments against pending SPAs. The annual financial report information had already been submitted by the time the federal report was reconciled and the amount to be returned confirmed.

The adjustments noted for Notes FF and GG were the result of new staff preparing these notes for the first time. In addition, the adjustments noted for the Schedule 8 reports were the result of new staff preparing the schedules. There were three revisions involving five agencies out of a total of 17 agencies reported. As noted earlier, practices to help prevent these errors have been implemented.

Ms. Pam Diez, Director of Fiscal Management, is responsible for the corrective action and may be reached at (225) 342-1483.

Sincerely,

W. Jeff Reynolds
Undersecretary

c: Kathy Kliebert, Secretary
Pam Diez, Director of Fiscal Management

Bienville Building • 628 North 4th Street • P.O. Box 91030 • Baton Rouge, Louisiana 70821-9030
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GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals

Office for Citizens with Developmental Disabilities

October 29, 2014

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

Dear Mr. Purpera:

Re: Official Response to Legislative Auditor Finding

Our office is in receipt of the Single Audit Report mailed to Secretary Kliebert on October 13, 2014.

The Office for Citizens with Developmental Disabilities (OCDD) concurs with the Legislative Auditor finding of Improper Payments to Waiver Services. First, it is important to note that the payment errors noted in the audit were not the result of fraud, but the result of confusion regarding billing policies by some providers. DHH is working swiftly to improve provider education and implement new systems to help prevent similar errors from occurring in the future.

We have counseled the providers that incorrectly billed for New Opportunities (NOW) waiver services. We are also reiterating clear billing procedures and policies in a blast message to all applicable providers. OCDD staff will also conduct random billing checks on NOW service providers. It is important to note that once NOW service providers are using Electronic Visit Verification (EVV) technologies within a year, a great deal of the improper billing will be corrected.

Specifically, Paul Rhorer, an OCDD program manager, met with the Provider in question on Tuesday, Oct. 21 and Friday, Oct. 24, 2014 to review DHH policies and federal regulations. It was discovered that the provider was only referencing time sheets and not accounting for the difference in the day and night hours on a consistent basis. In an effort to prevent this mistake from occurring again, Mr. Rhorer and a representative from Capital Area Human Services District met with the owner, billing director, and the individual who inputs the data into the SRI (data contractor) system, to train them on how to correctly input billing data. As a result of this training the provider now understands how billing information should be input and processed.

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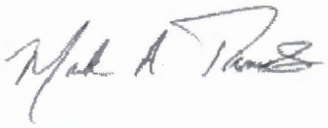
OCDD is issuing a blast fax to all providers explaining the importance of billing according to an individual's plan of care, and not billing strictly prior authorizations. OCDD will also have Support Coordination conduct random billing checks on NOW Recipients to check for billing errors by providers. Again, OCDD plans to utilize an EVV System within a year. The EVV System will be based on when a person calls in/out; this system will eliminate the number of improper payments.

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

Sincerely,



Mark A. Thomas
Assistant Secretary, OCDD

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of Management and Finance

October 2, 1014

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

Re: Noncompliance with Approved Consolidated Cost Allocation Plan

Dear Mr. Purpera,

Management of the Department of Health and Hospitals (DHH) concurs with the finding relative to noncompliance with approved consolidated cost allocation plan.

The three changes noted in the approval memo dated 4/11/2014 from the Department of Health & Human Services did not affect the allocation of costs.

The Director of Fiscal Management will prepare and submit an amendment to the DHH cost allocation plan and update the internal cost allocation process to reflect the proposed amendment. In addition, the DHH Director of Fiscal Management will review the costs to determine if any unapproved costs were charged to federal programs.

If you have any questions or need additional information, please contact Ms. Pam Diez, Director of Fiscal Management at 225-342-1483.

Sincerely,

W. Jeff Reynolds
Undersecretary

C: Kathy Kliebert, Secretary
Pam Diez, Director of Fiscal Management

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals

Office of the Secretary

October 29, 2014

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

Re: Lack of Controls Over Federal Cash Management Requirements

Dear Mr. Purpera,

While management of the Department of Health and Hospitals (DHH) concurs in part with this finding, we disagree with components of the finding. We have also implemented numerous policies and practices to remedy the items outlined in the finding.

First, DHH did draw down federal funds for the disproportionate share payments (DSH) for six of the 10 LSU public-private partnership hospitals under three pending state plan amendments (SPAs). This drawdown was based on the understanding that these SPAs would receive approval. Since then, DHH has returned the funds to the federal government and is no longer making payments against pending SPAs.

The delayed payment to Magellan was done in error, but steps have been taken to prevent similar errors in the future. As of April 2014, the Division of Fiscal Management implemented a check within the system to be conducted by two employees. One employee is responsible for making the payment to Magellan, the statewide management organization (SMO), and a second employee checks the ISIS system to confirm that the SMO has been paid before drawing down federal funds associated with that payment. We believe this system will prevent drawing down funds before payment is made to the SMO.

DHH's Division of Fiscal Management has also implemented a new review of administrative/payroll spreadsheets used to determine the funding technique that resulted in an underdraw of federal funds. Division employees have been trained on the use of these corrected spreadsheets. These changes were implemented in April 2014, but the review of all funding spreadsheets is ongoing.

The payroll overdraw noted in the audit was the result of a Federal Payment Management System (PMS) issue. The PMS is used to draw down federal funds. During the course of the

draw process, the system connection with PMS was lost and the employee believed that the first draw request was not submitted completely. The employee then processed another draw request to ensure the draw occurred correctly, which then doubled the draw. Once the error was noted, these funds were returned swiftly within just a few days.

DHH's Division of Fiscal Management has also implemented additional staff education for benefit draws. These education efforts are ongoing.

With regard to the quarterly reconciliation adjustments, DHH does agree that adjustments were not done on a quarterly basis; however, there is no federal requirement to complete adjustments quarterly, only annually. The Department did comply with the federal requirements for annual reconciliation.

We also do not agree that the information provided on the interest schedules to the Office of Statewide Reporting and Accounting Policy (OSRAP) was not sufficient for use by OSRAP staff in calculating the state's interest liability. All required information is provided on the DHH interest schedules and supporting documentation submitted to OSRAP. OSRAP staff has informed DHH personnel that the information that DHH provided and has been providing for several years was sufficient for the interest liability calculation. Sections 5.3.5 #5 and #9 of the state policy on Cash Management Investment Act (CMIA) lists the data that state agencies must provide to OSRAP in regards to interest liabilities.

Ms. Pam Diez, Director of Fiscal Management, is responsible for the corrective action and may be reached at (225) 342-1483.

Sincerely,

W. Jeff Reynolds
Undersecretary

c: Kathy Kliebert, Secretary
Pam Diez, Director of Fiscal Management

APPENDIX B: SCOPE AND METHODOLOGY

We performed certain procedures at the Department of Health and Hospitals (DHH) for the period from July 1, 2013 through June 30, 2014, to provide assurances on financial information significant to the state of Louisiana and to evaluate relevant systems of internal control in accordance with *Government Auditing Standards*. The procedures included inquiry, observation, and review of policies and procedures, and a review of relevant laws and regulations. Our procedures, summarized below, are a part of the audit of the state of Louisiana's financial statements and the Single Audit of the State of Louisiana (Single Audit) for the year ended June 30, 2014.

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

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

- We performed procedures on the Medicaid Cluster of federal programs and the State Children's Insurance Program (LaChip) for the year ended June 30, 2014 to support the 2014 Single Audit.

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

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

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