MINUTES OF MEETING

Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
Act 420 of the 2017 Regular Session

Wednesday, October 25, 2017
9:00 AM - House Committee Room 6
State Capitol Building

The items listed on the Agenda are incorporated and considered to be part of the minutes herein.

CALL TO ORDER AND ROLL CALL

Chairman Purpera called the meeting to order at 9:10 a.m. Ms. Liz Martin, Executive Assistant for the Louisiana Legislative Auditor (LLA) called the roll confirming quorum was present.

Voting Members Present:
Daryl Purpera, Legislative Auditor
Matthew Block, Executive Counsel, as Designee for Governor John Bel Edwards
Senator Fred Mills, Designee for Senate President John Alario
Representative Tony Bacala, Designee for House Speaker Taylor Barras
Ellison Travis, Director of the Medicaid Fraud Control Unit (MFCU), Designee for Attorney General (AG) Jeff Landry
Michael Boutte, Medicaid Deputy Director over Health Plan Operations and Compliance, Designee for Louisiana Department of Health (LDH) Secretary Rebekah Gee
Tracy Richard, Criminal Investigator, Designee for Inspector General (IG) Stephen Street

Advisory Members Present:
Jarrod Coniglio, Program Integrity Section Chief – Medical Vendor Administrator, Appointed by LDH Secretary Gee
Luke Morris, Assistant Secretary for the Office of Legal Affairs, Appointed by Louisiana Department of Revenue (LDR) Secretary Robinson
Dr. Robert E. Barsley, D.D.S., Director of Oral Health Resources, Community and Hospital Dentistry, LSU School of Dentistry, Appointed by Governor Edwards
Ms. Jen Steele, LDH Medicaid Director, as proxy for Alicia A. Barthe'-Prevost, LDH Medicaid Benefits Management Section Chief – Medical Vendor Administration, Appointed by Governor Edwards

APPROVAL OF MINUTES

Mr. Travis made a motion to approve the minutes for the October 4, 2017, meeting. The motion was seconded by Ms. Richard and with no objection, the motion was approved.

DISCUSSION OF INFORMATION NEEDED FOR FUTURE MEETING REGARDING PHARMACY

Senator Mills referred to the discussion at the previous meeting about spread pricing and LDH explained that it is allowed in the current contracts. After that meeting, further research was done and a letter addressed to Ms. Jen Steele, LDH Medicaid Director, was prepared with questions about spread pricing because it has become a large issue nationwide. Senator Mills quoted from the letter, "Spread pricing is a commonly utilized practice whereby the pharmacy benefits managers (PBMs) charges the managed care organizations (MCOs) an amount greater than that paid to the pharmacist as direct provider reimbursement". The Medicaid Transparency Report issued June 30, 2017, shows the amount retained through spread pricing and breaks down the dollar amount into the profitability which is an administrative charge. He hopes the committee agrees to ask LDH to independently look at the issue as it specifically relates to spread pricing.

Senator Mills explained that the second part of the letter addresses how this impacts pharmacists and the delivery of pharmaceutical care in Louisiana. The spread pricing is that administrative cost coming back to the provider and the letter explains how it could adversely impact pharmacists. Senate Resolution (SR) 163 Report issued September 2017 identifies pharmacy expenditures for all Medicaid recipients in the amount of $75M for the month of August 2017. The committee would like more information independently reviewed by LDH and not reports from the MCOs or PBMs.

Senator Mills pointed out number five of the letter is regarding supplement rebates are collected and retained by the MCOs. He asked how that is different from when Louisiana had its own PBMs, and would like more information on the pass through dollars. These issues are so technical and precise so he felt a written letter of request for a response from LDH would allow the committee to independently look at it all.

Number six of the letter is asking if the administrative expenses and medical expenses are totally categorized correctly and are those medical expenses coming back to the provider that provided those services. Speaking with providers in Louisiana, many say that they are not paid what their costs are.

At the previous meetings these issues were discussed at a very high level, so this letter breaks it all down point by point and a written response from LDH would help the committee determine if the money is being spent wisely and is the experiment working from the part of Medicaid that moved from fee-for-service to managed care. Senator Mills stated that he presented the letter on behalf of the task force to LDH and would hope at the next meeting to have LDH's written response to discuss further. He hopes by laying out the points for discussion in this manner and any other task force members to likewise put their questions and concerns into writing for LDH or LDR to respond. This would be a more efficient and clearer method for all to see.

Ms. Steele said it is very helpful to have the questions in writing and already reviewed and forwarded the letter for response. She would request some flexibility on the response date of November 13 because it is quite a bit of information. Senator Mills asked the committee to break down the rebate issue because what was portrayed by a prior administration about rebates is not happening. Ms. Steele said absolutely. Representative Bacala said he fully supported Senator Mills' letter as well as his idea of a written format to educate members on these topics.

LOUISIANA DEPARTMENT OF REVENUE'S UPDATE ON DATA COMPARISONS

Mr. Morris said LDR hoped to obtain permission by the IRS to use Federal Tax Information (FTI) data in order to compare the Medicaid gross income to line 7 of Tax Form 1040 where W2 wages are reported. The IRS has not given permission to use the data yet but hoping by the end of the year to have that access.

Mr. Morris explained the memo provided to the members. Initially for the last task force meeting LDR had the Medicaid expansion population. His memo details the entire Medicaid adult population of approximately 860,000 Medicaid applicants. That information was provided by LLA which originally came from LDH. LDR compared that population to tax return data in their system. The memo lists out the seven criteria searching for in their comparison. LDR, LDH and LLA all agreed that the comparison of gross income and federal adjusted gross income (AGI) would not match, but the purpose of this exercise is to see to what extend tax return data would be helpful in verifying eligibility for Medicaid.

Mr. Morris explained the results of application and return comparisons of the 860,000 Medicaid adult applicants. Approximately 39% of the applicants filed a 2016 Louisiana individual income tax return, which equaled about 331,000 applicants. (For 2016, a single individual under age 65 and earning less than $10,350 in gross income is generally not required to fila a federal income tax return. The Federal Poverty Income Guideline for a single individual with family size of 1 is $16,404.) The rest of the statistics provided on the memo where about those who did file tax returns. The percentage of applicants whose Medicaid application's gross income matched the applicants' federal AGI reported on the state return was approximately 7% (nearly all matches were the result of zeros reported as gross income and federal AGI). The percentage of applicants whose Medicaid application's gross income matched within $1,000 of the applicants' federal AGI reported on the state return was approximately 10%. The percentage of applicants whose Medicaid application's gross income matched within $5,000 of the applicants' federal AGI reported on the state return was approximately 21%.

The percentage of applicants whose Medicaid application's gross income matched within $10,000 of the applicants' federal AGI reported on the state return was approximately 38%. The percentage of applicants whose Medicaid application's gross income matched within $20,000 of the applicants' federal AGI reported on the state return was approximately 75%. The percentage of applicants whose Medicaid application's household size matched the applicant's exemptions reported on the state return was approximately 52% (of the 39% of applicants that filed a 2016 Louisiana individual income tax return, over 5,000 applicants had an unknown household size).

Mr. Morris said the results were in line with expectations. He did some further digging to look at major differences between gross income and federal AGI to reconcile why such large variances. There were a number of reasons and none were indicative of fraud. A person's income may have been very high in 2016 and then lost their job, or had a material change in circumstance in 2017 that made them become eligible for Medicaid. He asked his audit division to look more closely at previous years to determine if a pattern. Some tax payers had an abnormal year in 2016 with one time income from lump sum withdrawal from retirement, or capital gain income, or sold property. Then 2017 would return to regular income like previous years. There were a few at the top level of the range of income of around $400,000. One person reported gross income over $400,000 but their return was less than $30,000 which could have been an error in the forms. He is looking at the outliers in a case-by-case basis. From the list from LLA, LDR looked at the largest reported gross income of $100,000, there were 292 of those. Then when they looked at the state return side, they found AGI of $100,000 or greater for about 2,100 applications. Right now LDR's audit division is going through and trying to reconcile the large differences to see if more indicative of fraud or a one-time anomaly.

Mr. Purpera asked that since the 860,000 applicants were from 2016, would that change any of the compatibility issues. Mr. Morris said they did compare the applicants with the 2016 tax returns. Mr. Purpera asked if the percentages in the results table were cumulative. Mr. Morris confirmed that it was. Mr. Purpera asked if 25% of the applicants had variances greater than $20,000, and Mr. Morris agreed. Mr. Purpera further determined that 62% of the applicants had variances of greater than $10,000 between their income reported on their Medicaid applicant and their reported federal AGI on the state return. Mr. Purpera said that is some indicator of the difference in self-reported income to actual reported tax income. He said that unemployment compensation is included in the federal AGI, but not sure if included in the Medicaid applicant's income for eligibility. Ms. Steele checked with her staff and later in the meeting confirmed that unemployment compensation is included in their determination.

Mr. Purpera pointed out that LDR's memo showed the deductions that reduced federal AGI including educator expenses, moving expenses, etc. are not accounted for in the reported gross income on the Medicaid application. He said that further reduces the federal AGI, which makes the variances even more notable. He calculated that about 208,000 of the Medicaid applicants are possibly not eligible. He asked how many Louisianans are on Medicaid and Ms. Steele responded 1.6 million.

Senator Mills said this is a good look back on data but need to look forward regarding income because people may be laid off or times get tough, and then they may go back to work again. Mr. Morris said on the tax return side, LDR only hears from tax filers once a year when they file tax returns. The quarterly withholdings from employers does not contain individuals' information because it only shows the number of employees and not specific names. He said LDH uses more current data from Louisiana Workforce Commission (LWC) and so forth. Mr. Purpera said this committee has discussed the use of tax data as a tool to determine eligibility.

Representative Bacala said he appreciates LDR's work and information. It seems like every time one question is answered it brings up 10 more questions. This information gives some pause for consideration and shows the need for a better job on the application process whether to modify the applications or tighten the process of verification. As a committee they need to identify where improvements need to be made and need to all decide where they stand on this issue.

Ms. Steele commented that it is important to recognize the difference between an aggregate comparison versus an individual determination of eligibility. As acknowledged already, this tax data is not the basis for which the decision was made unless the applicant was self-employed. This was likely in the past or a different point in time than the decision, so the real question is what is the error rate on LDH's eligibility determination which is done by the Centers for Medicare and

Medicaid Services (CMS). There are standing measures of what their error rate is and believes that is a more appropriate measure of whether or not LDH's eligibility process is working. Aggregate comparisons of what the IRS shows to what income was shown at the time of determination is not a good indication of how well LDH's eligibility process is working. She believes it is a separate conversation to decide if the income limit is too high. The concern is if LDH is making accurate eligibility decisions, she would suggest looking at CMS' eligibility measures of accuracy.

Representative Bacala said he believes they are on the same page, but the information provided by LDR makes him feel like they need to pay more attention to the eligibility determinations. He does not know how to fix this except to do a better job of coordinating the eligibility standards with LDR being more involved in determining if the application matches the AGI of record. Also the household size is a big issue. The fact that is a variance of 52% for household size is significant. Some recipients could age out, or be born into the household which may affect by 5-10% but do not believe it could sway by 48%. He asked what is next because the task force needs to figure out what to recommend on this topic.

Ms. Steele said LDH is following their current eligibility processes but to the extent that the state return data is germane to their decision making it only applies for self-employed applicants. But federal rules and LDH rules do not require comparing to tax data. It may be interesting to compare but does not believe it helps contribute to an accurate decision.

Representative Bacala asked how eligibility is being determined. Ms. Steele responded that it depends on the individual person, and LDH has 100s of eligibility categories and different rules apply to each. They must look at each application and family deductions and size because it is very case specific.

Mr. Block commented that using tax data is something that LDH will absolutely continue looking at and not set it on a shelf, as they work on the continuously evolving process of improving the intake and determining eligibility. He said that Ms. Steele is making the point to recognize that this comparison is like apples to oranges on the two levels of information. Both have seeds and commonalities, but differences need to be recognized because unable to just extrapolate from this information that 15% of people are committing fraud as that is unlikely. The people who actually submitted a tax return and reported income to the state and federal governments may have some issue where things do not match on their Medicaid application. He said it is absolutely something that everyone needs to continue looking at and get better at. He said that anyone saying they have an absolutely perfect system and cannot get a single bit better is not being honest about it. He does not believe Ms. Steele or anyone from LDH is saying that. He stated that this was a valuable exercise both to shine a light on it and show the limitations in what can be done, but also the opportunities and he encouraged using those opportunities to get better at it. He believed that Secretary Gee would agree and sure that is what LDH is going to do.

Representative Bacala said since this information was from the Medicaid expansion population and that was a case of a floodgate opened, it may make this not representative of the entire population. A difference of only 1,000 applications does not pique his interest but being 85,000 off piques his interest. Also the 48% not matching on household size really is something to look at more closely. He asked how to sample at the next level.

Ms. Steele agreed with Mr. Block's point that LDH wants to use any data available to make good decisions and LDR's information is one of the tools in the toolbox. Representative Bacala suggested digging deeper into the cases where the variances were $50,000 or more, to determine if a change in circumstances. Those worse case scenarios have the highest probability of maybe should not have been approved, and get a better process. He asked what is the next step that the committee needs to take to determine if really have an issue. Ms. Steele said this is a good suggestion and would be interested in following up with LDR on some of the higher variation cases and dig in to understand what percentage of those really appear to be fraud.

Mr. Purpera asked Chris Magee, Performance Audit Services (PAS) Data Analytics Manager, to explain what other states are doing related to these issues. Mr. Magee said that PAS has various eligibility projects going on at LDH, one of which they are planning to look at income using tax data to determine how accurate the eligibility determinations are if this new tool is used. He said that LDH currently uses (Louisiana Workforce Commission (LWC) data which is also delayed anywhere from 3-6 months. TALX The Work Number (TALX) is also used where people report weekly wages, mainly in the restaurant industry. A lot of employers do not participate in that reporting, so those are also imperfect tools. The tax

data is another imperfect tool but may be able to add valuable information as LDR has suggested with their memo. PAS' preliminary research looked at other states' processes, particularly in regards to IRS data or state income tax data. They found that each state turns in a verification plan which tells on a financial and nonfinancial side what tools they use and not just tax data.

Mr. Magee continued explaining that in their research they found 28 states do use either federal or state income tax data in making an application determination. At renewal, 29 states use federal or state income tax data. Eight states use federal or state income tax data on an interim basis. There are some limitations in their verifications plans such as discussed in the task forces meetings, such as being older data even one year old. Even using as another imperfect tool, by putting together many imperfect tools, they might make a better eligibility determination. He mentioned that the population used in the LDR analysis was the entire adult population in Medicaid as of December 2016. Anyone who was eligible and did apply at some point in 2016 is included, so it is a more comparable timeframe and the data is just as delayed as the other data may be. In total 31 states use federal or state income tax data at some point, either at application or renewal.

Mr. Purpera asked how many other states use their state tax data. Mr. Magee said three states use state tax data: California, Illinois and New Jersey. The reason that most states do not use state income tax data is because the federal government allows each state to have access to IRS data. They are able to go in and access and use that data. The waiver, the issues that LDH has had to try to use the data in this manner is already set up for LDH to use in this way. Right now LDH does not use it because their current system was not able to handle that data, and would have had to make some updates to their system because when it comes to storing this FTI, there are a lot of security concerns, and have to segregate the data and employees have to go through criminal background checks. So there is some cost associated with using federal data. LDH is updating their system now, but being designed based on the last system so not designed to handle FTI. If LDH was to design the system to handle FTI, it would cost more money and take hours to write the new rules.

Mr. Travis asked how the states use the federal data whether to match dollars or a formula to gauge it. Mr. Magee said that Louisiana is the only state that uses 25% reasonable compatibility since a few years ago. He said 25 states use 10%, and 17 states use 0% so the data has to match and use purely the data and not self-attestation. For example, Minnesota uses a 10% compatibility, then the income reported must be within 10%. Mr. Travis asked if fields on the tax returns are matchable to the Medicaid applications. Mr. Magee answered that he has not delved into that detail, but the states' do indicate that they use it in some manner.

Mr. Magee sat with LDH eligibility workers to see how the LWC and TALX income data is reviewed when making a determination, but not sure how the other states are reviewing the data. He said that using the federal tax data would give the comparable income fields to provide an apples-to-apples scenario. Each Medicaid application signed by a recipient gives LDH the right to access their tax data to determine their eligibility, but LDH does not currently use that data.

Senator Mills asked what CMS does in their audit of LDH's eligibility process. Ms. Steele responded that CMS does a sampling as they audit the eligibility decisions, looking at individual cases to determine if LDH made the right decision based on their rules. Senator Mills asked if any recipients are kicked out of the program because LDH finds out that they are not eligible. He requested the results of the audits for the last few years. Ms. Steele said most often the case is the recipient may have been placed in the wrong eligibility category. Senator Mills asked if someone who was Medicaid eligible but two months later able to land a job which makes them now ineligible, but did not report to LDH, what catches that change. Ms. Steele said generally LDH reevaluates the recipient when they receive reported data from any source. She said they would be happy to change some of the requirements with the appropriate resources, such as updating the eligibility system to use the FTI if they had the resources to do the follow-up even if not a perfect match. But that 25% decision was made in part due to the severe restraints of LDH's system at that time particularly in concurrence with the implementation of expansion. It's a long story but LDH had a system that was supposed to do matching, but the contract had to be cancelled and they were behind the eight ball, so until certain circumstances change in terms of resourcing, they are stuck. It is not LDH's intention to be out of line with other states but it would take an investment. Senator Mills asked what if the resources were there for LDH, and the return on investment (ROI) would make it worth doing, would that be a 90-10 split because of being the Medicaid expansion population where the federal government would put up 90% and the state put up 10%. Ms. Steele responded yes, for system changes.

Senator Mills said based on Representative Bacala's questioning on the next step, he suggested the committee determine if LDH had the funding sources, what technology and tools could be at their disposal and at what cost to the state. Also if they could get the funding for the technology, to also determine what the ROI would be. Ms. Steele said she would be happy to get with their vendor and see what they think the change to the system would be, and bring that information back to the committee. But she is not sure how to determine ROI because they have not done any analysis yet in terms of comparing reasonable compatibility from 25% to 10% or to 0%. They could do a sample. Senator Mills suggested looking to see if other states might have that information. Ms. Steele said she would investigate and see if any other states changed their reasonable compatibility.

Mr. Boutte asked what parts of the federal income tax data was used and how is the data being used by other states. Mr. Magee said the other states' indicated on their verification plans that they use both AGI income and household size data. There is a section for comments on the verification plans, and some of the concerns that LDH has brought up with this sort of data match, some other states bring up the same concerns. There could be a different tax filing or household size than what is reported to Medicaid which is fine, but it does not always match. Some states also comment that the information is delayed so they use it but do not use as the end-all-be-all decider. It seems that other states use the FTI as a tool similar to how LDH uses LWC and TALX data currently.

Mr. Boutte said his concern is using cumulative data from the prior year to make a decision on someone's status today. In his opinion comparing the 2016 data with the applications from 2016 is not giving a good comparison because that individual come have become eligible in June or July who made $100,000 through March or April, but then a change in status may have occurred. Income tax data is cumulative income for an entire year, and not a reflection of when the income was earned. Eligibility determination is based on a point in time. Mr. Magee assumes the eligibility worker would question the situation and the applicant should prove that they no longer have a job.

Mr. Morris pointed out that only three states use their state tax data. Also Louisiana uses a piggy back tax system where Louisiana residents' tax return piggy backs off their federal tax return which uses line 37 as the reported state return. He believes California is different but the other two states might also not piggyback off the federal return but has an independent state tax return, which may explain why those three states only use their own state returns for comparison.

Mr. Morris said he has not received the entire list of discrepancies yet, but thought one particular case was interesting. One taxpayer was far beyond the $20,000 range in income because their federal AGI was large due to gambling income. The reason this came up in their exceptions was because that taxpayer's gambling losses far exceeded their gambling income. As per federal tax law, they may have $100,000 of winnings and $200,000 of losses, but their losses are limited to their winnings on their tax returns. So the reason it showed up in their report of anomalies is because gambling income is reported as federal AGI but the gambling losses are itemized deductions below the AGI line. While it appeared this individual had $400,000 gambling income, when the income and losses netted out, they had very little income which is probably why they were Medicaid eligible. He said they could have also earned all that income in January and by the end of the year had no other income, which could explain their Medicaid eligibility.

Senator Mills asked if any other states used credit reports to dig down into expenditures to see if match income reported, or if that is even legal. Mr. Magee said on the verification plan the use of credit reports is not one of the tools specifically listed, so not sure. Senator Mills said he was not sure if that would be within CMS guidelines, but the credit report would show their debts and expenditures.

Mr. Purpera asked Mr. Morris if could give an idea of the outliers that came to their attention when they went to $20,000 and above. Mr. Morris said most showed when comparing 2015 to 2016 tax returns, those outliers just had an unusual year because of cashing out retirement or one time capital gain income from selling property, and assume they will return to their normal income in 2017.

Representative Bacala asked if the committee needs to identify the next step in regard to tax data. Senator Mills said that Ms. Steele will bring back what could be done if LDH had the ideal amount of assets and come up with some plans to make their reporting more comparable to other states.

Representative Bacala asked even if LDH cannot build the system, would it be unconscionable to ask LDR be involved in the process to compare the income and be in the loop for income verification and/or household dependent size verification. He asked if that would be possible or not even work. Mr. Morris said the only thing LDR could tell would be the most recently filed tax return shows as their AGI. He explained that LDR has access to income tax returns but subject to all the FTI rules that they cannot disclose even to help. Ms. Steele asked if a change to state or federal law be required to allow LDR to give LDH that data. Mr. Morris said that there is a current 1508 exception to share data with LDH. His understanding from talking to Ms. Diane Batts with LDH is that when the exception was implemented, LDR and LDH were going to implement some verification among the two agencies' processes but then realized that the numbers were never going to match so that process was abandoned. But that exception is still written on the books but the language could be changed and tightened up a little bit because other most other 1508 exceptions are very precise and specific but this one is a little troubling in the language but as it stands LDR can provide LDH with income data. Ms. Steele said that is her understanding as well but it was just how germane was the data.

Representative Bacala said he assumes that roughly 8% of the Medicaid applicants every month go through renewal, and asked if something could be worked out for the next renewal period. Ms. Steele responded that she would have to check with Ms. Batts to make sure they understand the limitations and determine how that data could be used.

Representative Bacala asked Ms. Steele and Mr. Morris to return to the next meeting with a suggestion or recommendation on how to use income tax data to help make the eligibility process as bulletproof as possible. He personally did not have high confidence on the current process based on the numbers shown on LDR's memo. They will never get 100% perfect, but as close as they can to do better. This may include a computer program upgrade, so he requested Ms. Steele share the cost to do that with the federal match.

Mr. Purpera said the committee has a responsibility to make a report by January 1, 2018, so in some manner they should make a recommendation that LDH be afforded every tool necessary to do their job. That may include federal tax data or state income tax data. Representative Bacala asked how specific does the recommendation need to be, or if just a broad recommendation to improve the application screening process. He thinks the more specific that the recommendations are the more likely that something will happen. Mr. Purpera suggested identifying any legislation to review in the next session.

Mr. Travis pointed out that only 39% of the Medicaid applicants filed a tax return so that leaves 61% not filing, and he assumes that some may have large income that disqualifies them. He asked what can be done to target those individuals. Mr. Morris confirmed by and large those who did not file taxes were below the filing threshold, but from his time in LDR's audit department, he knows there are some people who do not file returns but earn significant amounts of income. On the federal level, there is a CP2000 process where if someone has significant income on a W2 but failed to file a tax return, the IRS will take action. If it is a self-employed situation where nothing is being filed to show income, then LDR and IRS have audit functions to identify those people to either compel them to file a return or file on their behalf by way of an audit. Mr. Morris said they try to capture as much as they those who do not file tax returns but should have, so they are fairly covered in that area.

Mr. Block said he felt compelled to point out one of the factors the task force must look at is that under the previous administration, LDH's eligibility staff was reduced by 26%. He hopes that legislators realize that LDH has less people to do the work that is required to do what this task force, legislature and public at large is asking of them. Last year dramatic cuts were proposed to LDH which would have required further cuts. Also next year the state is facing a fiscal cliff with about $1B of reductions being looked at. He assured them that when the executive budget is proposed in January 2018, LDH will not be carved out of those budget cuts. So he hopes the task force can extrapolate further discussion to ensure the agencies have the resources they need to actually do the work being proposed.

Mr. Purpera asked Mr. Boutte about his email stating that in 2016 there were 18 referrals related to eligibility to local law enforcement. He asked if LDH sees potential fraudulent acts by a Medicaid applicant, who they are referring it to and if tracking it. Mr. Boutte responded that LDH's Program Integrity team through the SURS unit refers those that are deemed to be recipient fraud to their internal eligibility unit and externally to local law enforcement such as the sheriff. Mr. Purpera asked for any statistics on the success rate of working that type of case. Mr. Boutte said no information comes back to LDH from the sheriffs on those cases. Mr. Purpera assumed that sheriffs' caseloads are such that these Medicaid case is low on their priority list. He recently saw data that South Carolina is roughly half the size of Louisiana's Medicaid program but yet they track their recipient fraud referrals which is more than 500 per year. This may be an area to review of how potential eligibility fraud is handled.

Mr. Boutte said LDH realizes that to be an area they could improve on and have taken some steps to move forward on that working with eligibility and Program Integrity to have a better, clearer defined process for making those referrals and to track those moving forward, and potentially getting the AG's office involved. Mr. Purpera asked Mr. Travis if the AG's office has any limitations regarding recipient fraud. Mr. Travis said that MFCU does have limitations but LDI can investigate recipient fraud. Mr. Purpera said that one of the objectives of this committee is to look at how agencies are coordinating, so that may be another area to dive into to marry up the departments. Mr. Travis said they need the referrals identifying the fraud, and only 16 is not a large number to refer to law enforcement. His office will be willing to look into those referrals from LDH Program Integrity further, because MCFU is looking at providers and companies. Mr. Purpera asked if the process is in place right now to send recipient fraud to the AG, or if there any reason that they would not take those referrals. Mr. Travis said LDI can take those referrals.

Mr. Purpera said the law requires any agencies that have an allegation of fraud they are supposed to report it to the AG, LLA and the local district attorney. He suggested reviewing they have the right mechanism for reporting. Mr. Travis explained that MFCU receives federal grants which does not allow purely recipient fraud, but can do recipients who are colluding with providers. But MFCU is not allowed to investigate straight eligibility fraud, but that can go to LDI.

Representative Bacala said as small as a 5% rate of ineligibility would equal about $100M in state general funds, not even talking about the federal matched part. He thinks it is important that a good job is being done regarding eligibility because of the financial impact.

Ms. Richard asked how many employees work for LDH's eligibility department. Ms. Steele said around 600 employees handle applications and renewals.

Senator Mills asked how consumers can report if someone is receiving benefits that should not. Ms. Steele answered that LDH's fraud hotline is available. Mr. Boutte said LDH's fraud hotline is easily found on LDH's website with a phone number to call, a form to submit, and also an email address to send information to Program Integrity.

DISCUSSION OF DATA MINING

Mr. Purpera said these four agencies will share their processes in data mining and how they coordinate with the other agencies.

A. Louisiana Department of Health
B. Molina Medicaid Solutions' Surveillance Utilization Review (SUR) Department
C. Attorney General's Medicaid Fraud Control Unit
D. Louisiana Legislative Auditor

Ms. Jeanne Rube, Manager of Molina's Surveillance Utilization Review Subsystem (SURS) department, spoke from her powerpoint presentation explaining how Molina interacts with the other agencies. SURS is operated by Molina for LDH to work primarily with LDH's Program Integrity section to support their efforts guarding against fraud, waste and abuse (FWA). SURS works in the detection, investigation and enforcement of the program policy, rules and laws.

SURS' surveillance includes watching for inappropriate filing of claims for services not rendered; excessive services for the same medical condition; consistent pattern of billing for billing for the most expensive services possible (i.e. billing an X-ray instead of MRI); patient sharing or inappropriate referrals among various providers. The utilization review includes checking for excessive or insufficient procedures; provision of medically unnecessary services; documentation that does not support the services billed; and upcoding and/or unbundling services.

SURS is staffed by primarily registered nurses, as well as dental hygienists, social workers/case managers, physician and dental consultants, pharmacy consultants, and optometry and ophthalmology consultants to assist in their reviews. It is important to have staff with these backgrounds because they can better determine if there is a utilization problem. They can review the data and determine if the situation is unusual or if medical explanation can explain the anomaly.

Ms. Rube continued her presentation explaining that SURS performs post-payment review of claims, data review to identify aberrant billing patterns, data mining to identify potential areas of recovery, and refer credit allegations of fraud to MFCU. Those referrals and notices can be done at any time during the review process, and they stay in contact with MFCU as far as they have SURS case information and can contact that analyst anytime. They share the data that SURS has obtained that may be useful in MFCU's investigation. They also meet regularly with the AG's office to discuss their cases and compare what each are investigating to ensure no overlapping of efforts.

The sources of cases include complaint received via LDH's fraud hotline which is manned by SURS. LDH also sends complaints received from other sources to SURS. REOMBs are recipient explanation of medical benefits which are notices sent to recipients for them to validate that they received the services that Medicaid has paid for. If the recipient sends back that they did not receive the services, then SURS investigates further. Complaints also come from other state and federal agencies, the general public and other Molina departments such as Provider Relations, Prior Authorization, Provider Enrollment, etc.

Ms. Rube explained that when a complaint is received by SURS it is logged and goes through a triage process for research to determine if a SURS case should be opened or if other action should be taken. Other actions may include adding to an existing case, monitoring the provider's billing activity, or refer to another agency that is more appropriate to handle the issue.

Internal referrals come from SURS analyst working their own case may generate questions about other providers or recipients that need to be looked at. That information is kicked over to their data mining team who will look at whatever issue found in one case and check data across all providers and billers. The data mining team consists of Molina as well as LDH staff. The team is constantly running algorithms that generate projects which generates casework. In addition the data mining team has standard productions runs to look at certain issues. Surge by Region means looking at income and providers comparing six months in one year to the same six months a year later checking for a surge in income and any outliers. They also go through all procedure codes that providers bill, checking CPT/HCPC and CDT (dentists) outliers. The data mining team looks for any services being billed after the death of a recipient. They also look at the Deficit Reduction Act which is an annual run required by the Affordable Care Act (ACA) looking at providers that are being paid greater than $5M in Medicaid funds.

Ms. Rube explained SURS case work process. First an analyst receives a case after the triage team, LDH and the manager determines that a case should be opened. Then the analyst prepares an overview analysis including checking if the provider has already been sanctioned by Molina, and checking the policy. Typically the analyst needs records including a scientific sample of the provider's recipients for a certain time period. The request for information from the provider can be sent by mail or the analyst can perform an unannounced visit to the provider's office to make the records request and make the copies at that time. While visiting, the analyst can also observe the provider's business. The review is not done at the provider's office, but at Molina's office. Once the records are all received, the analyst compares the claims billed with the documentation. A physician or dental consultant can also review the records to validate their findings. Once the case is complete it goes to an internal quality control team who reviews the actions, and then given to LDH for their review and sign the letter that the provider ultimately gets. The analyst determines action based on findings of review and case direction from management and/or LDH. The actions can include education, recoupment, monetary penalty, internal

referral, withholding of payment, suspension of payment, exclusion, AG referral/notice, or other referral. If there is an action then the provider will receive a letter, but if no action taken the provider will not receive anything else from SURS. The provider may request an informal hearing to voice his/her concerns to SURS and LDH and provide an explanation of findings or additional documentation. As a result of that hearing, the finding may be adjusted and a letter will be sent to the provider stating if the penalty is reduced or reaffirmed. If the provider is not happy with that outcome, they may appeal. After all has been finalized, the recoupment of the overpayment begins. Once all the money is recovered then the case is completed and closed. There are more steps for some cases and not all cases include all steps.

SURS fosters a good working relationship with LDH and AG by meeting regularly to have open communication. SURS works to identify and report areas of vulnerability. SURS acts as a deterrent for preventing FWA. Their primary goal is to correct behavior and prevent future inappropriate billing. The optimal result is when compliance is achieved and payment errors no longer exist. SURS work to ensure program costs are contained by insuring that each service is necessary, sufficient and of such quality to achieve program purposes.

Representative Bacala asked if Ms. Rube finds one area to be the most problematic. Ms. Rube responded that behavioral health is a big area, and home and community based services (HCBS) is where they receive a lot of complaints and allegations.

Mr. Coniglio asked how many cases are closed on average each year. Ms. Rube said around 800 cases were closed in 2016, and prior to that it was around 1,000-1,200 only on providers. Mr. Coniglio asked for the average collection rate for recoupment. Ms. Rube responded that typically 85-90% recoupment.

Senator Mills asked what oversight is provided by LDH to Molina. Mr. Boutte answered that LDH has several employees embedded at Molina working daily with them to make sure the cases are being work, and to keep LDH management updated. There is a lot of coordination between Molina, SURS, LDH and LDH's Program Integrity department since both are doing data mining and do not want to duplicate efforts.

Senator Mills asked who audits the entire procedure to give a report card grade, or compare to other states, and doing the overview to determine if the contract is actually working. He asked who is independently checking that all is being done in accordance with contractual obligations. Mr. Boutte explained that in the process explained by Ms. Rube, there is a final review and approval by the LDH Program and Integrity Section Chief has the final say on anything coming out of that unit including letters to any providers, and is the eyes over everything related to that contract.

Senator Mills asked Mr. Purpera if there should be a separate set of independent eyes looking at the Molina work for LDH. Mr. Purpera said this contract is important to the Medicaid process and questioned if Molina is doing a good job as it relates to all their requirements. Senator Mills said this committee is to make recommendations and wants to shore up that an independent set of eyes are seeing that all obligations are being met in the contract. The state is paying for those services, so are we getting everything that we are asking for.

Mr. Boutte stated that LDH does receive external reviews by CMS, HHS OIG, the current performance audit by the Legislative Auditor, so there are external eyes reviewing the scope, the work and the nature of what we do through our SURS unit and Program Integrity overall. In fact there was one issue over the summer tied to LDH's notices to MFCU and they passed 100% all of the 225 cases that were reviewed, confirming that all were properly referred to MFCU. Louisiana was one of only four states that had no findings on that review, which is a testament to the work we do in conjunction with our SURS unit because they are the ones on a daily basis doing a triage of those cases working through them, and working with the department to determine what is the appropriate action to take on all those cases.

Senator Mills said that is good information. So from all these external audits taking place and more from moving forward, this committee is looking for who examines those audits and who makes those corrections and where do they go from here. So say CMS did an audit and found 10 findings, who makes sure that those findings where basically addressed correctly. Mr. Boutte said if there are ever any audit findings particularly from CMS' perspective, they require a corrective action plan from LDH. LDH has to give CMS quarterly updates on where they stand on addressing the issues identified by CMS.

So CMS will continuously monitor LDH to make sure they implement the corrective action plan that was a result of findings.

Senator Mills asked if LDH is working on any action plans from CMS' audits. Mr. Boutte responded absolutely. There was a recent CMS audit of LDH's oversight of managed care that was released in August, and it contains recommendations of how LDH can improve oversight of managed care program integrity essentially. They have taken action and put in some amendments to the proposed contract extensions that came up in the Joint Legislative Committee on the Budget (JLCB) last week and will be before JLCB the following week. So we are tightening up on oversight of managed care entities to make sure they are doing the work that they are contractually obligated to do.

Senator Mills said it would be helpful for the committee to get some of the most glaring reports that have the most action plans. Mr. Boutte said nothing is glaring. Senator Mills asked for the biggest thing you are working on that can be repaired. Mr. Boutte said honestly nothing was really big in the audit but I would be happy to share the audit results with you. In fact, in the audit that was released in August, CMS commended LDH for the previous audit and getting the corrective action plan, addressing all the items from that particular audit. It is a constant review process with CMS that LDH is undergoing, particularly in the area of FWA. He offered to share the report and corrective action plan with Senator Mills.

Senator Mills asked if SURS is looking at every aspect of paying included managed care and fee-for-service. Mr. Boutte responded from the SURS perspective we are focused on providers so they have all the data available to them. It is a provider based audit and does not look at whether it is managed care or fee-for-service, but looks at the provider itself.

Mr. Magee stated that LLA is beginning a performance audit of LDH's Program Integrity Unit including the SURS function within it, and the program integrity units at the five MCOs. We have heard a lot about site visits, and maybe there are 20,000 providers and they get six site visits. LLA will look into some of the areas that CMS has already identified, but really looking into the early prevention of fraud, and the detection of fraud and on the back end once it is found it, and how do you enforce penalties and monetary sanctions against those providers.

Senator Mills said his concern is the major security breach of a credit company and at the last committee report it said that this is potentially a huge multistate fraud initiative basically from providers and that information stolen.

Mr. Purpera asked if Molina houses all the Medicaid data. Ms. Rube said that is correct. The MCOs submit their encounter data to Molina and the fee-for-service data is also housed with them for data mining all. Mr. Purpera asked if Molina is in charge of data mining for LDH. Ms. Rube answered that SURS does a lot of data mining within their department, and not sure what all LDH does separately. Mr. Purpera asked if she was familiar with some reports issued by his office such as the report showing the people not living in Louisiana who are receiving Medicaid benefits. He asked why Molina is not finding that. Ms. Rube said she would have to get back to him on that because we are looking at provider information, so not looking necessarily at that, but she would get that information for him.

Mr. Purpera said from what he knows about data mining, everything depends on whether it is good and clean data and in the right columns and what they mean. Ms. Rube agreed. Mr. Purpera said his office issued a report recently about the T1015 code which is a parent code that some detail should be behind that. He asked if she got to read that report. Ms. Rube said she was not familiar with it but the T105 is the FQRAC information, where there is a primary line then the detail following. Mr. Purpera said his report showed there were many instances where the detail data was not in the transaction, or the database, and his understanding is that it is required that the detail be there in order to know what services were performed and if the services were in accordance with the plan. He asked if SURS is housing the data then why is his office issuing that report. Ms. Rube said she would have to get back with him because not in her particular SURS section, but can find out. Mr. Purpera said that might be what Senator Mills' concern is that LDH is depending on Molina and we need to make sure that Molina is accomplishing what LDH needs.

Senator Mills asked if Molina is coordinating along with all the licensing boards in Louisiana to know if a provider is on suspension or revocation, are those systems talking to each other not just with LDH but all the different boards. Ms. Rube

said they have contact with the licensing boards and are notified if a physician is on suspension or if their license is revoked. When they receive that information, they look back to see the stipulations on that position to see if they did services billed for when they should not have been eligible to bill.

Mr. Purpera asked if Molina has encounter data and claims data. Ms. Rube explained they have claims data from fee-for-service providers. Mr. Purpera asked if all the providers are made to enroll because not all are considered enrolled providers. Ms. Rube said no, not all are enrolled, but not able to see in their system if they are not enrolled. She said that would be helpful to have that information of course. Mr. Purpera asked if there is a reason that Molina cannot see which providers are enrolled. Mr. Boutte asked for clarification of who enrolled with. Mr. Purpera said that not all providers are enrolled. Mr. Boutte explained that they are not enrolled for fee-for-service but enroll and credential with the health plans that they contract with, and LDH does have that information.

Mr. Purpera asked if there is any information that Molina needs but does not have. Ms. Rube said the data submitted to Molina just needs to be accurate and up to date, so if the plans stay up to date on submitting their data as far as their voided claims so they do not see duplicate claims that are not valid any longer.

Mr. Purpera said data mining is of no value if the data is not good. Ms. Rube said right, because they may go back and the provider says they corrected that already. Mr. Purpera asked if they have extensive processes to make sure the data is complete since Molina manages the database for LDH. He asked why the T1015 detail was not in the system why it did not catch someone's attention previously. Ms. Rube said she is not sure.

Mr. Purpera asked why transactions were paid when requirements call for there to be detail so LDH or Molina can verify it is a good transaction, but that data was not in the database. Mr. Boutte responded that in most instances it is there but just not mapped in the way that you want to see it, but it is there, so we do have a lot of details for them, and if you want to dive into the specifics we can talk about the ICMs and how they align versus on the Molina compared to the plan side, but there is a way for us to map those together.

Mr. Purpera asked if they are mapped and are we using them in a way that the process would result in only good claims being paid or do we need help, and anything this committee could recommend. Mr. Boutte said we have implemented some changes as it relates to the audit to put in stricter edits around that particular procedure code, so that it does check for those details as the information comes in, and added the lines in the traditional way you would expect it to align. The requirement is that the provider submits the details with the T1015 encounter code to fee-for-service if submitting such claims, or to the MCO if submitting to them. Mr. Purpera asked if LDH can put a check in the system to prohibit a payment going out without the detail. Mr. Boutte said that same letter will apply to the encounters as well, so LDH will deny the encounter. Mr. Purpera asked if LDH has the opportunity to deny the encounter before paid. Mr. Boutte said it will already be paid out by the MCOs, so they are aware that we are implementing this edit, so they are also updating their system to make sure.

Senator Mills suggested sending a line of questioning to LDH for a response because they could spend hours on this. He asked before when it was all fee-for-service and before managed care was carved in was the data cleaner to do the job between Molina and LDH. Has the five MCOs caused the complexity that makes it not as efficient.
Mr. Boutte said the complexity now is that LDH has five additional payors that are submitting information to LDH with five different systems, so they have to map that information to align with what fee-for-service has essentially to map it into Molina's system. Data issues are tied to that, the health plan paid the claim versus fee-for-service paid the claim, but not any significant issues.

Senator Mills said that Senate Health & Welfare Committee recently extended the Molina contract. I think there is a lot of testimony for migration of new types of technology that are all being taken into account. The MCOs and where the plans go next, and you might want to expand on that for the committee.

Mr. Boutte said currently LDH is working on a procurement for provider management system, so working with CMS and the Office of State Purchasing (OSP) to get an SFP issued. That provider enrollment and provider management function

will essentially be peeled off of the Molina contract and will have a separate vendor. That will bring all enrollment and credentialing of providers into LDH, so rather than a provider enrolled with fee-for-service and separately with each one of the health plans, and credentials separately with each entity there will be one single point of entry for enrollment and credentialing. Some of the issues that exist for provider registry will be resolved through that process because now will be taken care of under one umbrella and one source for that information. Senator Mills asked for the time frame for this to happen. Mr. Boutte said it will be done by this time next year. LDH is waiting for the final clearance by OSP to release the SFP, so that should be coming out shortly.

Mr. Coniglio asked Ms. Rube of the cases that are still open, about how many complaints come from the tips hotline, or email, or website versus data mining. Ms. Rube answered that it is probably split because the data mining through one algorithm can identify 100 providers, but they do not necessarily open all 100 but look to see what is going on. That is dealing with only one issue whereas the complaints are across the whole board. Mr. Coniglio asked if with the Molina staff they have enough open cases to work. Ms. Rube said they have plenty of cases and have all the leads that they can possibly do, and constantly working on those. The staff must dive in and work those cases and takes a lengthy period of time. The more leads they get then the more staff they need to work those leads. Mr. Coniglio asked the average length of an investigation with no appeal. Ms. Rube said there are built in rights that they have such as formal notification and getting records, so it could be quick as three months but could go as long as two years if appeals and to get payments back to LDH. Mr. Cognilio said he wants everyone to understand that SURS is mainly provider related and not eligibility, but SURS does receive recipient related allegations. Ms. Rube said calls do come into the complaint line to tell on their neighbor that he makes all this money and I know he's getting Medicaid. Those are the types of complaints that SURS refers to the eligibility department because their area of expertise is not recipient eligibility. Another complaint received may be that a person is on Medicaid and selling their prescription drugs, and that type of complaint is referred to law enforcement and eligibility as well.

Mr. Boutte said he would explain LDH's process and how they identify what they will go after and what resources do they have, and how does LDH coordinate, and the result of that coordination. They receive information and leads from the LDH's sister agencies (OAAS, OBH, OCDB) refer information to LDH that can spin off into a data mining exercise. They get tips from the health plans routinely on cases or investigations that they are working on which can also lead into a data mining exercise. LDH also gets information from other state, their federal partners, through CMS' contracts with MIC. Some of the national organizations that LDH are affiliated with are also sources such as AFB, National Association of Medicaid Program Integrity (NAMPI) has a working group that shares information. NAMPI is comprised of program integrity directors across the nation, and they also host a conference with provides information. The National Healthcare Anti-Fraud Association is another source and able to tap into their leads and request assistance for investigations to make sure that the providers being targeted by federal agencies are not operating within our network of providers. Something brought up at the last meeting by a health plan is the Healthcare Fraud Prevention Partnerships, which LDH is a partner and signed an agreement in April 2017 to provide data through the partnership. It is a CMS initiative with a collection of data from public and private payers, and compiling and using that information to conduct studies and provide information back to the partners with results that are actionable on potential leads. Of course, they also receive tips through LDH's fraud hotline and website submissions and emails.

Mr. Boutte said that the data warehouse mentioned by Ms. Rube is also accessed by LDH, as well as vital records, law enforcement information and the OIG exclusions database, and LDH's adverse action database, and the DSW registry because routinely check for excluded providers to make sure that they are not operating in the programs. The types of analysis that LDH does is the outlier and search runs, and some program rule violations on occasion. They also look at schemes identified or come up as a result of other data mining activities, or from sources previously mentioned. There are a lot of known algorithms that are successful at identifying potential outliers or fraud, waste or abuse they try to capitalize on and take advantage of. Mr. Boutte said that LDH is currently working toward implementing a predictive model specifically toward the identification of fraud, so they are working with MFCU to get actual case outcome information for in order to predict fraud, they must know where fraud exists and cannot be done in a vacuum. The only way feasible to come up with a predictive model is to have information on case outcomes so MFCU has been sharing information on their investigations and the results. LDH is using that information to try and build a fraud model that can be used to say when someone is potentially committing fraud based on the past patterns or behaviors of similar providers. In terms of staffing,

LDH relies on their SURS team with Molina who performs not only data mining but also medical records review which they are heavily involved in that because as you are aware the data is not the end result. You have to go further than what the data represents because there sometimes could be legitimate explanations to why something appears to be fraudulent and it is really not, so until you get into the medical records you don't really know. The SURS team is really instrumental in helping there. They also have two individuals directly in Program Integrity dedicated to analytics that do a lot of ad hoc analysis and other runs that SURS does not do. They make sure to not duplicate effort.

Some of the tools that they use include Sequel, SAS, J-SURS, Python, GIS Mapping, and this is a new area that they are looking at distances between places to identify potential issues. Outside of SURS and LDH coordination, they also coordinate regularly with MFCU partners at the MCOs. They have monthly information sharing calls, and quarterly required meetings, and specific data mining meetings with the fraud control unit. LDH has an MOU with MFCU that specifically outlines what LDH is responsible for, and MFCU is responsible for. One component of that agreement is a specific data mining component, so that requires them to share information on their data mining activities to ensure not overlapping in their efforts. They have regularly scheduled meetings just around data mining to ensure they are sharing and constantly passing lists back and forth of what is going on in each other's worlds. They ask each other questions about the different analytics being performed to make sure they are not all doing the same thing at the same time, especially when it comes to looking at the same providers.

Some of the results of their work in terms of outcomes: year to date, LDH has received over 1,200 tips and complaints; approximately 1,500 on-going reviews or cases at any point in time throughout the year between SURS and the managed care organizations are working on. LDH has already submitted about 500 referrals and notices to MFCU. They have excluded about 140 providers from the program and recovered about $5M from providers. So to put into perspective, at the last meeting with AG they provided a handout with a breakout showing where fraud referrals came from, so it was sources of fraud complaints. Something that stood out that out of the 1,652 complaints represented in the handout, 47% came specifically from Program Integrity. When you expand that scope a little wider and look at LDH as a whole, 63% of the fraud complaints came from LDH. Even going further to lump in the MCO's in the total is 78% of the fraud complaints to MFCU. It goes to show that the process is working. We all agree that everyone can do more but that will also require more resources.

Mr. Boutte pointed out the recent CMS audit issued over the summer concluded that LDH appropriately referred in all instances, and we will continue to make sure that all creditable allegations are properly referred to MCFU.

Mr. Purpera asked how many staff LDH has to do the 1,500 reviews. Mr. Boutte responded that the combination between SURS' 22 analysts and MCO's around 20 analysts, the total would be around 42

Representative Bacala asked if computers run data mining continually or if a manual only process. Mr. Boutte said if LDH identifies a programmatic or systemic issue, LDH can implement edits in the system to look for that. What they find is that the issues are not systemic but one off, so to find those requires manual effort. It is taking what they know based on prior history and working those types of cases to know how to identify certain activities. It's not looking at just one claim to find fraud, and could get to that level of detail with sophisticated predictive modeling, but by and large it's looking at aggregate information and trying to identify who stands out. So it's not necessarily an automated process every step of the way.

Representative Bacala asked if they have some checks to be sure that an MRI is not performed for a cold – that's a way out example, but does data mining system do that as a normal review. Mr. Boutte answered that there are some things that you never expect to see, and CMS publishes a list of codes that should never bill together, NCCI edits and other edits are built into the system to make sure that it never happens.

Mr. Travis said that MFCU has meetings with the MCOs ongoing to look at fraud issues. Molina and LDH are looking for overpayments and more waste and abuse.

Ms. Virginia Brant, Chief Auditor for MFCU, provided a brief outline of their data mining capabilities and activities. MFCU is only one of a handful of Medicaid Fraud Control Units in the country that has the authority to data mine. The regulations that set MFCUs prohibit data mining without that specified authority. Louisiana's MFCU sought and received that authority a couple of years ago. One of the requirements under that authority is to have an agreement with LDH and expected to cooperate with LDH to ensure they are not overlapping their activities to avoid duplication of efforts.

Ms. Brant said MFCU meets periodically with LDH and have an open line of communication regarding data mining activities. They can drill down on LDH's data mining lines and likewise able to do on most of MFCU's as well. The software used for data mining includes J-SURS, which is the same primarily used by LDH and Molina for their data mining activities. That allows them to identify if two claims should not be billed together, such as NCCI codes. They can look at services that may be age inappropriate. A recent data mining run on behavioral health services found children under the age of five. One provider in particular had 29 patients that were under the age of one for behavioral health services.

MFCU also has available to them software called Idea which allows them to take the same claims data from J-SURS or provider histories from LDH and merge that with disparate but related information such as transportation coordinator that may have the actual pick up and drop off locations for transportation services which is not include in the claims data, so they can merge those two data formats together and look at claims for origination and drop off.

Additionally, they are working on getting their own data warehouse to use Sequel to do some data mining, but had some issues with setting that up because it is very large amount of data. The Legislative Auditor has done that already and can attest to how much data is involved and that is a very large undertaking particularly if try to do with existing IT staff, but working on that.

Some of the problems encountered is if the data is not clean, then the results will not be good. In some instances, the unenrolled providers may not have a provider number assigned by the MCO or when their information is crossed over into the Molina system the provider shows up as all nines. Then MFCU cannot distinguish who the provider is much less sort out their claims from the other providers that are in the same categories. Sometimes that data is not the most complete. There is a field for referring provider in the claims data and sometimes that field is empty so they cannot determine who their referring provider was. Or in other instances, it may be the same as the billing provider, we also see that with the attending provider, when they are trying to figure out who exactly is providing the services. The attending provider may often show up as the billing provider which may be a very large clinic, so difficult to identify the specific physician or other licensed professionals providing the services.

Representative Bacala asked what is the issue or problem with the application to say every provider to an MCO must be enrolled in the state system. Ms. Brant said he was preaching to the choir there.

Mr. Purpera asked if the data has in addition to the provider information when a large clinic, also the name of the doctor or identify who gave the services if provided in the home. Ms. Brant responded that if the individual is a licensed provider then it should identify that person. Most DSWs in behavioral health are not licensed individuals. But there is a field for a fill-in provider, which is the person who is paid for the claim. If clinic has 50 physicians, most of those claims would bill under the clinic's number but the attending provider field would identify who was the physician.

Mr. Purpera asked if it would help to fight FWA and improper payments to have in the database the actual person who does the service. Ms. Brant responded most definitely. Mr. Purpera asked for an example where that would help. Ms. Brant said that behavioral health is a big one because those claims are generally billed with the billing and attending provider as being the actual company as opposed to the social worker or the counselor who actually rendered the services. MFCU has seen instances where individuals are providing more than 24 hours of services in day. So without the attending provider details, they cannot identify those types of issues. Ms. Brant explained she can do a real over the top estimate if they have 20 employees and multiply that by 24 hours in the day and make sure the clinic did not provide more than that. But she cannot look at an individual's hours within the provider. Particularly within the behavioral health providers, there

may be some individuals working for several providers, so if they can aggregate the information then it will be more apparent if overbilling for impossible hours of services.

Mr. Purpera said that additional information on the specific physician or worker would provide a better tool and data. He asked if any barrier to including that information in the future. Mr. Magee responded that the worker information should be entered in the field but just not being filled in. He is seeing behavioral health instances where the facility bills for seeing 60 people per day for four years and then all of a sudden a spike to seeing over 300 in one day. Because the attending National Provider Identifier (NPI) matches the billing NPI, Mr. Magee cannot determine if they hired more people and expanded their business. The limited data, in terms of attending NPI actually telling who performed the services for the Medicaid recipient, hinders their auditing. Mr. Purpera asked if the attending provider information is supposed to be included. Mr. Magee responded that according to the data analytics dictionary, which describes what each field mean in the Medicaid data. Mr. Purpera asked if it is a state or CMS dictionary. Mr. Magee said it applies to the state's database. Mr. Purpera asked if there is a way in the future to require that information be included before payment is made, so that clean and complete data is important. No one answered so Mr. Purpera suggested this be considered further.

Mr. Magee discussed the LLA's assess capabilities, tools used and what projects they do on Medicaid data. R.S. 24:513 gives LLA broad access to agency information which includes their data, so this is something with LDH to receive monthly downloads of their Medicaid claims which is brought into the Sequel database where they have a full history of Medicaid data. With this law, LLA has responsibilities to keep the data as confidential as the agency, so it cannot be shared with other agencies.

Mr. Magee explained one area that LLA can add value because of access to many agencies, they can use data sets from multiple agencies to verify information. This is being done for Medicaid and other data sets across the state to figure out the quality of data such as the social security numbers are linked to one person in Medicaid, but to another person in SNAP and in OMV another person. The point is by having multiple datasets they can verify the correct person is in the data. Some tools used by LLA include ACL which is written with auditors in mind with standards to document the work done and keeps a log to show exactly what is put into an analysis and what comes out. They are able to merge different datasets together similar to Sequel, and they use the two programs. ACL is more user-friendly and easier for large joins of data to be analyzed. A new tool called Absolute Insight allowed identification of outliers and attempt to get predictive modeling as Mr. Boutte mentioned earlier.

The majority of LLA's data analysis is rules based testing which detects violations of program rules or improper payments. They take what the program and what it is supposed to pay out, and look to see if following the rules. Outlier testing is also done to determine if providers within provider groups which are operating completely differently than the other providers within their group.

Lastly, they are trying to move toward predictive modeling which is done by taking known fraudulent behavior and apply it such as these are the types of claims or activities that indicate fraud and then see which providers are acting in that same capacity. That is done using the Absolute Insight data tool.

Representative Bacala asked which areas are the most problematic. Mr. Magee agreed with prior testimony that NPI data not showing who actually rendered the service, because may only know where and what facility but not the person. Also through various projects, they have identified issues with the registry which LDH is bringing in the licensing, credentialing feature in November 2018. Also the data in general sometimes the way that the registries are mapped to the Medicaid claims will look like providers who should not be providing services are still providing services that they are not licensed to do. But most of the time it is not fraud, but some sort of connection between the MCO registries and Medicaid claims.

Representative Bacala said when talking about efficiencies, it may be helpful to me to take what you just told me and create a short narrative report – a few pages – and provide that to us, just as insight for something to read and refer back to. Maybe take the highlights with the places that you feel need the most attention and just do a brief narrative report – it can be one page or one paragraph – whatever you think is necessary. Not necessarily a white paper, but it would be helpful to me.

Mr. Travis said the predictive modeling is to prevent the money from going out the door before paid, but not after the fact review. Mr. Magee responded that in some ways the provider must be starting to do that behavior but the idea is to catch it in year one instead of year five. You will probably never initially stop it because they need to first commit whatever activity, but stop earlier than you would have checking in on a post basis.

Senator Mills asked if an overpayment is recouped by an MCO, where does that overpayment go once recouped. Mr. Boutte responded it depends on who identified it. Currently in the contract the MCOs have one year from date of service to initiate an audit or recover payments. If not recovered within that year then LDH has the right to start an audit and recover the dollars. If they start the audit and recover the dollars, it stays with them. But if LDH starts the audit, it stays with LDH. With the extension, LDH has changed that provision and removed the one year, so going forward LDH will have real time access to go out and identify and recover even on MCO claims.

Senator Mills said so moving forward in the new contract if there has been an overpayment, it will go back to the state. Mr. Boutte said correct, with the extension amendment, if LDH identifies and recovers the overpayment then it goes to LDH, but if the MCO identifies and recovers it, then it stays with them. But now there is additional pressure for MCOs to identify it faster. So whoever identifies the overpayment keeps the money. Senator Mills asked if that is a good practice. Mr. Boutte said it incentives the MCOs to be proactive about identifying FWA, so if they identify it and have an opportunity to recover it, then that keeps them whole. If LDH identifies and recovers it, not only does LDH keep the dollars but those adjustments come out of the claims history, so they are hit twice.

Mr. Purpera asked if the MCO identifies the FWA and keeps the dollars, do they also reduce it from their claims data. Mr. Boutte responded yes, those get voided out.

The Task Force took a break at 11:46 am and resumed the meeting at 12:15 pm

DISCUSSION OF BEHAVIORIAL HEALTH

Mr. Ronnie Beaver, Chief Investigator for MFCU Criminal Division, testified that a data breach at an MCO resulted in about 14,000 Medicaid recipients information which was then sold to an individual that owned a company in New Orleans. When he received the case, the first thing he did was a google search and found out that the individual was indicted in Georgia just five months earlier. Mr. Beaver wondered how that individual could set up so easily in Louisiana because by the time MFCU got the case, already $500,000 worth of claims had been filed. Mr. Beaver contacted the Office of Public Health (OBH) and went through their credentialing manual for the process. Basically all the answers were that an attestation was done. OBH was supposed to do an on-site visit to ensure that the office was actually there and fitted with a phone and other requirements. That visit was not performed by OBH but an attestation was accepted by that individual. Mr. Beaver said a lot of the fraud could be prevented by stopping the individuals from being enrolled in Louisiana. OBH is also supposed to do background checks.

Mr. Purpera asked if that provider was enrolled in fee-for-service or under an MCO. Mr. Beaver responded it was under MCOs. Mr. Purpera asked who did the attestations. Mr. Beaver said the owner that was stealing did the attestations. Mr. Beaver read from page seven of the manual regarding the site review report required. But in this case OBH told him that a site review was not done yet but when done then they would confirm the self-attestation. There were about 15 more questions and requirements as per the manual including the State Fire Marshall is supposed to inspect the building, the owner is to report any staff changes and more. In the end all that was required by OBH was self-attestation.

Mr. Purpera asked if the Fire Marshall visit is supposed to happen any time during the year or before enrolled. Mr. Beaver responded that according to the manual, there is supposed to be proof of an inspection and approval by OBH, sanitation department and the State Fire Marshall. He requested from OBH paperwork showing that the inspections were performed. The response he received was, "OBH required an attestation to meeting these requirements. An OBH executive decision was made in 2012 that verification of meeting these requirements would be reviewed during the site visit."

Mr. Beaver said another issue that MFCU is seeing, that LDH is supposed to do back ground checks as per the contract. Evidently, those are not being done at all because MFCU is finding lots of people with a lot of back criminal history working in these facilities, and some are owners and others are actually providing the services. He believes LLA sent him a list of social security numbers that did not match up with the drivers' license numbers. In reviewing those, it was for that very reason because of the criminal history. So that is another issue to look at.

Mr. Beaver continued sharing another big issue is some of the rules and regulations are either very complex or ambiguous and hard to understand. Many providers do not understand them and when he calls LDH to find out what a rule means and they do not understand it either sometimes. For example, he had a medical director with a job to sign off saying that a person has been assessed with whatever medical issues. Mr. Beaver found that the doctor was three hours away from the clinic that he was doing these assessments for, and he was the medical director for seven other clinics, so it did not make sense how he could do that much work from three hours away. Mr. Beaver was told that the initial visit had to be done in person, and then they could do visits on the phone. He specifically asked if there are any regulations on how many clinics one medical director can run. The response from LDH was, "Our regulations only stipulate the need for the medical director or clinical director for the evidence based practice programs. As far as I know we don't tell MDs how many programs they can be a medical physician for and there is no geographical distance. The intent is that they work within their community, a community position, but this is not spelled out. I hope this helps a little. Our regs are broad in many areas." Mr. Beaver requested the committee's help drafting some of the rules and regulations, and credentialing process which would help.

Trevor McCall, MFCU Supervising Investigator, shared some issues seen in the field including provider agencies that are not licensed allowed to bill Medicaid and MCOs. One provider in particular billed $6.9M in 10 months and was paid $2.6M but never obtained a license. MFCU conducted a search warrant and found evidence that indicated they knew that they never had a site visit and did not even try to get licensed until almost 10 months when they ultimately shut their doors. The owner of the agency was also a Medicaid recipient during the time that she did her renewal application to renew her Medicaid she went to a facility that helped her fill out the application. She received mental health services through that facility and that facility also sent clients to her agency via referral for mental health services. The same agencies that were paying her $300,000 - $400,000 per month were also paying for her Medicaid benefits. She never received a proper license, never had a site visit, or met any other requirements.

Mr. Purpera asked who this agency was supposed to be licensed through. Mr. McCall said once a provider goes through the credentialing process they also have to be licensed through LDH to provide the services. MFCU has also seen many agencies submitting billing in excess of 96 units (15 minutes/unit) per day, which is 24 hours. He has seen billing for 104 units which is not humanly possible, but they are still paid for it. He has seen instances where 96 units are submitted for three and four year old children and paid for it. A four year old child was diagnosed with dementia and paid for those services. So there are many different fraudulent activities happening such as unlicensed unqualified individuals are providing services in communities.

Mr. Block asked how these investigations are being referred to MFCU. Mr. McCall responded they receive tips from health plans, citizens calling in, and a variety of different ways. Mr. Block referred to the press release issued by the AG's office the previous week about arrests made, and asked how that particular allegation got to the AG. Mr. McCall answered that complaint came from one of the MCOs because they had questioned if the business was actually doing business because no site visit had been done but already billed over $1M. In the course of the investigation, MFCU also determined that the agency was not contracted with the MCOs but was still paid $47,000 out of the $1M billings. But an unlicensed and non-contracted provider was allowed to do business with their agency, and after MFCU did some interviews and further investigation, then the owner of that agency was subsequently arrested.

Mr. Block said he recognized that we all need to work to prevent those issues on the front end rather than the back end, but in this situation the way your office found out about it was from the health plans. Mr. McCall said that initially the complaint came from a former employee that went to the FBI, LLA, IG and AG. Then the former employee went to the MCO and it came back to MFCU to investigate.

Mr. Beavers said if the proper credentialing had been done the provider would not have been allowed to do any services because they were never licensed. Mr. McCall added that there are many agencies that do not have contracts with MCOs but still allowed to bill Medicaid. In other states like Georgia, an agency is only allowed to be paid for one claim every six months after that they have to sign a contract with that particular MCO. One MCO indicated that they cannot do an on-site for a provider agency even though they have paid that agency around $90,000 because they do not have a contract or right to do an on-site visit. I find that to be totally absurd. If you are going to pay someone then have a contract with them and at least be able to review records if you want to. But to have no right because there is no contract makes no sense. But again these agencies that are not following credentialing process, these are the problems we are left with.

Mr. Block asked what agencies Mr. McCall was referring to. Mr. McCall responded the mental and behavior health agencies.

Senator Mills asked someone from LDH to come to the table because watching the body language shows you want to talk. He said from an administrative standpoint could they provide some clarity on licensing practices.

Ms. Michelle Alletto, LDH Deputy Secretary, said overall LDH over the last year whether done in budget hearings or oversight committees, discussed tightening some of the rules and regs around behavioral health. As Mr. Reynolds explained previously, some services such as mental health and psychosocial rehab that are growing exponentially. When something like that happens, LDH looks to see if people who really need the service are receiving it or is something else going on. She believes most of the references made by MFCU are about the mental health rehab program which LDH is reforming quite extensively and reducing by $50M overall budget as part of the budget reduction. In terms of the oversight of the management of MCOs, LDH's team is very small and only three employees working to monitor the network adequacy and the providers that are contracted with the MCOs. There are 100s of providers and the numbers are growing every day, so LDH certainly can use more resources to provide better oversight of credentialing and licensing. But to that end, as previously discussed the one single enrollment and credentialing service will really cut into the problem to not have five different lists of providers – actually six because Magellan who does our coordinated systems care. We recognized long ago that was something needed so that will take care of part of it. The other thing to clarify is there is a difference between our health standards services divisions who licenses the agency as opposed to the MCOs who ensure that the providers themselves and individuals are licensed and credentialed and have adequate background checks.

Ms. Alletto said there may be some confusion between the two. We are happy to say we are really attacking both of those through health standards over the last legislative session to make sure we had a few remaining mental health rehab providers who were exempted from licensure so they were brought back into the fold and have until the end of the year to be licensed. They have issued over 30 cease and desist letters for the bigger pot of mental health rehab providers who have not been able to come into the fold in terms of our licensing standard, so absolutely addressing those issues on that side. And for that individual level, that practitioner level again they have been working very closely with MCOs to tighten up their lists of the providers that they have, and those that are licensed and those who aren't – kicking them out of their program. We have been able to do that and addressing it at the agency level and the individual level on licensing.

Senator Mills said this issue was discussed at Senate Health & Welfare Committee - they could have some MCOs who have providers who are not licensed. Ms. Alletto said as of now there should be very few because of their last check as a result of the audit by LLA, OBH went through with the MCOs and were able to really find very – under 19% - had licenses that were not validated or perhaps were listed as having a higher level of license than they actually had. She said OBH is now able to go to the MCO quarterly network provider reports and see that the majority of those were taken off their lists, and had very few, maybe 15 or less, that were still on the MCOs as a provider and OBH has required the MCOs to do audit of those providers and send OBH that information if they are not able to verify licensure. She believes that issue has been significantly reined in.

Senator Mills asked Ms. Alletto to address the issue testified about the $1M and explain were the gap would have fallen from the administration side versus the investigative side. Ms. Alletto said she would need to know a lot more details about the provider and when the services occurred in order to address that. But if it is an issue that the provider was not licensed, the MCOs have dropped providers who were not able to be licensed.

Mr. McCall commented that the issue was more than not being licensed, but he also went into the community and that agency had a total of 12 employees. The amount of services billed per day could not be done by those employees, and only had two employees on their roster with a degree that made them eligible to render services. Those two individuals would have to had worked 60 hours in one day for those services to be rendered. Not at any point in time when they were billing Medicaid were they ever incompliance, and did not have enough staff. The MFCU staff personally interviewed around 50 Medicaid recipients, most of which did not even know that they were receiving mental services, because no one had been out to even ask their permission to render service to them.

Ms. Alletto said all the things attested to today are going to prevent anything like that from happening in the future and there is going to be bad actors in any type of service that we provide but the point is to have systems in place that are going to reduce the chance of that happening. Unfortunately, when you have a bad actor, one of the systems in place to make sure that the bad actor is put out of business and it sounds like this really worked. In our own staff going out and talking to mental health rehab providers have turned over some bad actors that we discovered through Program Integrity and turned over to the AG. We will continue to weed out bad actors but our focus is also on reforming the program at large.

Mr. Beaver said that MFCU has approximately 300 open OBH cases just this year, and last year they only had 15-20 cases, and he has a stack on his desk of more cases. A lot of what they are seeing is people providing services who don't have a license to provide those services. You see a lot of kids getting services in school during school hours from teachers that have a bachelor's degree, but there are a lot of issues. The point earlier about why MCFU needs the information and data about who is providing the services, so MFCU can take that name and run it to verify if licensed and credentialed.

Mr. McCall said that credentialing is only part of the problem. Ms. Alletto said we have that. Mr. McCall said that some agencies when they submit their billing they have the name of the counselor who provided the service. One individual with that provider was paid for rendering 24 hours of service in one day. Even if that person was properly credentialed, there is not anyone checking that a person is billing for 24 straight hours.

Ms. Alletto responded that the MCOs are checking those claims. From December 2015 to November 2016, there were 629,201 denied claims for mental health rehab totaling over $63M. So the MCOs are able to look at their systems and outliers like that, and have been denying those claims.

Mr. Beaver said that is an issue, why would you have 629,201 denied claims – why are they being denied.

Mr. Alletto said certainly as LDH has been honest about, the mental health rehab program is one that has just grown exponentially. They have 400 providers now and 100s of applications waiting to be licensed, so this is a program that has a target on its back because when a program grows like that we wonder are we making it too easy to get into this type of business. And we believe that through the work we have done to reform the program and we will continue to, and the MCOs have been great partners in this. We will tighten medical necessity and tighten oversight and we are going to institute a facility needs review so that we will not have to just license providers if they need license requirements, we will stop that and be able to look at geography and determine whether or not the program is evidenced based before granting a license. We believe we are putting a lot of controls in place to prevent that. And we are happy to share our methodology on how we spot check the licensure for providers and encourage the MCOs to do that.

Senator Mills said from a providers standpoint, are you doing any type of preauthorization if it gets to this point where these services, have you tightened up some preauthorizations because it seemed like from where the AG's standpoint or position is that if we really tighten up preauthorization, it seems like that over utilization gets curtailed pretty much.

Ms. Alletto said we absolutely tightened prior authorization and what the definition of medical necessity is for the program. The MCOs started putting that into place, I would say, five to six months ago. We should absolutely begin to see in our monitoring is the utilization of that program.

Senator Mills said that the AG sees it from the investigative side and what systematic issues are out there. If you could, it would be nice to get to the committee, basically what you are seeing, and what you are seeing systemically and if you had the authority what would you do to tighten it up. We can work closely with LDH. From our standpoint, that would be very beneficial to see what you see systemically and if you could have controls in place what would you do. Mr. Beaver agreed to provide that.

Mr. Purpera asked when MCOs want a new professional to provide services, and we talked about enrolled earlier, so are they enrolled, or they licensed, what is the process and what part does LDH and OBH have in that.

Ms. Alletto said we are doing the enrollment as a provider for that contract, but they also have to be – if a professional who does need a license to practice, a social worker, psychiatrist – they are supposed to verify that they are licensed and also be qualified. In other words, just being a physician does not mean you can do heart surgery and psychiatry, so need to be licensed and qualified, so they do validate that. Now have they always validated it as well as they should have, no, but we have seen the numbers go way down for providers that they have on their registries that are not licensed or could not verify licensure and been taken off. She asked Ms. Steele or Mr. Boutte to add to that if there is a part of the enrollment and credentialing process that I am missing. Mr. Boutte said you have hit the high points on this.

Mr. Purpera asked does our data system in some way indicate, and I guess we are talking about Molina as the database holder, does that data in some way indicate whether or not a particular provider has everything in line and enrolled and licensed. Guess I am looking for an edit check that the department can have, and to link that question in would be, does our program allow us to pay the MCO their PMPM if they have not done their due diligence to be sure that a person is licensed.

Ms. Alletto said we should not be paying a claim for someone who was not licensed, no sir, if it is a provider that needs a license to provide that service. Mr. Purpera asked if all the services that OBH deals with are through the MCOs. Ms. Alletto said no, not necessarily, because they have a waiver, Coordinated Systems of Care, and so that is some of those services are managed by Magellan and then some are managed by the five MCOs that are the Healthy Louisiana Plans. I don't think there are any fee-for-service.

Mr. Purpera asked if there is a way to put a hard stop in the process if the medical provider or person is not licensed and not enrolled, that they cannot get paid for those services performed. Ms. Alletto said that would go to Jen and Michael to say, because her understanding is there should be some type of stop now but in terms of the technical edits that you are talking about I would need to defer to them. Especially when we move to a single system, that is something that can be worked in.

Ms. Steele said that really needs to come in at the point of enrollment for credentialing, so once they are added as a legitimate provider that forwarded a claim to be paid. But the issue is to be sure we are catching them on the front end. And if it was not a licensed provider then that claim has been denied.

Mr. Purpera commented that Mr. Beaver testified about $5M worth of claims made and $1M was paid. Ms. Alletto said they will have to look at that specific example. Mr. Purpera said the question is how does that happen and seems like it should have been stopped in the process by internal controls. Ms. Steele said that is what LDH's FWA programs do is identify aberrant claims patterns and seek recovery. I would have to defer to their Program Integrity staff to find out if any overlap between that case and anything LDH is doing, but that is the function of our Program Integrity.

Mr. Beaver said it is after the fact and the claims get paid and then chasing down trying to get the money back. Mr. Purpera said we know that process doesn't work, so the simple perspective would be if a vendor sends my office a bill then my comptroller will look at the bill and vendor list and if not a qualified vendor that has been through our vetting process then they will not get paid. So until they get added to the vendor list in some manner, but they will not be added until all the boxes are checked out, so are we missing a step. Mr. Beaver commented that we could eliminate probably half of the providers right now if you did that to unlicensed providers. Ms. Alletto responded I don't know that half of our mental health providers are unlicensed and I know in fact that they are not.

Mr. McCall said the staff that worked there did not have the qualifications. Ms. Alletto said the other point of clarification is that over the last six months we have had providers who were unlicensed and we brought them under licensure and until January 1, 2018, we have those grandfathered in, maybe 60 of them. Mental health rehab providers who because of legislation last year that we asked Representative Miller to help us pass, are being brought under licensure. We have issued cease and desist letters to providers who were not able to come under licensure. That is why I want to look at this specific example and see where and when they fell out of the licensing requirement and if they did, that may explain it. Again, the mental health rehab program is one that the department as soon as Dr. Gee and I and Dr. Hussey came into behavioral health was one that they instantly pegged as needing reform. We have not stopped doing that and working with providers, MCOs and people in this room to crack down on bad actors in the program, and not done yet. What we absolutely believe there are some in our state that need access to these behavioral health services and fight to make sure that the program is sustainable for the people that really need it. And for the people that don't need it, we need to ensure that they are not receiving this program and the state is not paying for them to get it, and we are going to keep at it.

Mr. Purpera said I could not agree more, but still I go back that we need to make sure the processes in the department are built to stop the payment on the front end and not chase it on the back end. Ms. Alletto said she agrees and her hope is that when they move to the single enrollment in credentialing system, then they will have a lot more control over checking that. But I do not disagree with you - that would save us some energy we could focus on other things because we have a very limited staff.

Mr. Purpera asked if there is anything that any of the department represented here could do to help LDH get the processes and procedures to where we need them. Mr. Boutte said LDH is on the path right now for the credentialing component to have that single point of entry so these types of issues will be prevented going forward. There is a little bit of a time gap admittedly between now and when that system will be implemented but in the meantime I think we are all as Ms. Alletto mentioned, we are ramping up efforts to continuously monitor this from OBH and Medicaid perspectives to identify these instances.

Mr. Boutte asked Mr. Beaver if the provider mentioned that had issues in Georgia was on any exclusions list and still made it through the process or was it just that they did not get licensed appropriately. Mr. Beaver said that provider was indicted in Georgia, and they filled out the paperwork and was credentialed in Louisiana. Mr. Beaver said they did get on the federal exclusion list after indicted. Mr. Boutte said that was a timing issue with them not being identified in the database prior to them going through the process with the MCO. Mr. Beaver said that is correct but every piece of attestation that he sent to LDH was a lie. Mr. Boutte said he agreed in this case it was a bad provider. Mr. Beaver said he understands the one point of entry but if attestations are continued to be used, it will not work. Mr. Boutte said that LDH is requiring that our credentialing component is NCQA certified vendor. NCQA is an organization that certifies credentialing organizations and they have specific standards that a credentialing organization has to follow. NCQA does independent audits once every three years to make sure that the entity is doing the proper primary source verification for all of its credentialing components. So that is a process that will be in place that LDH will control and will work with OBH that these providers which are atypical providers that do not get a NPI typically. So to track them is a little different process than standard credentialing with a physician or some other typical provider that you would encounter.

Mr. Beaver asked if that is similar to CARF. Ms. Alletto said that CARF is a behavioral health accreditation similar to JCAHO. Mr. Beaver said the provider manufactured that document to say they were CARF certified but they were not. The other thing that would help and maybe it has changed, but the credentialing process is going to take place every three years. Mr. Boutte said yes, it has to be done at least once every three years, so if there is a need, we can suggest/ request/recommend/require something on a more frequent basis.

Ms. Alletto said that the OBH network management team will be doing spot checks, desk reviews on those registries and on those providers on an ongoing basis, so even though that process happens once every three years, their management oversight is ongoing. Hopefully we will get more resources to do it, but that will be ongoing process. She also added that with the MCO contract extension amendment there are tightened controls over the MCOs are making sure that they do not have providers on their list who have had their license revoked. We are very much looking forward to having that in place.

Mr. Purpera asked if an MCO made payments to an unlicensed and unenrolled provider, would we expect that MCO to not include that in the encounter data sent to LDH or would expect them to include it. Mr. Boutte responded at the point when the provider is identified to be an unlicensed provider that should not have been providing that service, the expectation is those encounters would be voided out and the MCOs would recover the payments from that provider. Mr. Purpera asked if the MCO should know who the unlicensed providers are. Mr. Boutte said they should and that is what we are trying to work out and make sure that they are aware.

Mr. Block said that Ms. Alletto answered one question he was going to ask about what was being done in the extensions to address these issues. He also wanted to point out that one of the ways we heard from the MCOs at the last meeting was to address fraud is by claims denials. Some discussion about chasing recoveries of fraud is exceptionally difficult in both recovery and the investigations but I want to make sure that we did not miss what you were talking about with the number of claims denials. He asked her to explain why it is important to discuss that as part of this issue.

Ms. Alletto said it means that some of the controls put in place over mental health rehab in concert with the MCOs are working. So medical necessity, prior authorization and making sure the providers are licensed and making sure they are following evidence based practices for these services – if all of those things were not met and the claim was denied means that the MCOs are working with us to reform this program so it's really important to me to see that we are cracking down on providers who either should not be in business are aren't really administering the program correctly because at the end of the day this is about the patient and about serving the people in our state that desperately need access to behavioral health. So we need the MCOs to make sure that the people that they pay to get into this service really need the service. If they are denying it, to me that means it is working.

Mr. Block said so the over 600,000 denied claims were not denied because of fraud but for any number of reasons those claims were denied. Ms. Alletto said that is correct. Mr. Block said his understanding is that at least the claims were questionable for any number of reasons - it could be fraud, or just errors in billing.

Mr. Beaver commented that he has seen some providers with 50, 60, and 70% denials and that claim stays open and then gets paid later, is that correct it can be paid later. Mr. McCall said it is left open so the provider can resubmit the claim. Ms. Alletto responded that is standard if a claim is at first denied, they can send in further documentation.

Mr. McCall said he has evidence from their investigations that these claims were denied and the provider resubmitted information that was bogus as well, and the claim was paid. Some controls need to be in place to at least ensure the data is vetted once it is resubmitted because they are going to send edited bogus data. There was one instance where a provider submitted information about a person providing mental health services, and she signed a document but the MCO denied it because she did not have the license. She sent it back to the same MCO with just changed credentials and it was paid, but no one checked anything. So how is the information being verified that it is valid.

Mr. Block said one of the things, and there's many more than just this, but what I think is good about what this committee is doing is shining light on all these efforts and making sure they are coordinated. But I think we are discovering that we need more coordination and communication because when you find out about this, pick up the phone and tell LDH that they need to hear the story about this guy and we need to fix it. I'm not suggesting that it is not happening but it needs to happen more because we need to make sure that all of the agencies including the plans working through the issues are doing so in a coordinated basis and not in silos where you see things out in the field that LDH can fix or address to stop on the front end. Then LDH can show you what they are doing to address those issues. That is one of the things that need to come from this. I don't know if y'all meet on regular occasions but I think you should.

Ms. Alletto said she was not aware that there is a behavioral task force so we are happy to participate in that. Mr. Beaver said that the MCO's Program Integrity participates in that. Mr. Block said if the task force existed and had to find out about it from the MCOs that makes no sense. Mr. McCall said the AG's office coordinated with LDH upon the implementation of that task force and at the first meeting there was an LDH representative.

Mr. Block's observation was that it seems like the people at the table are not on the same team, but we are and have the same goals. We all need to work together for those goals to not pay those claims that you are talking about. We should be able to stop them on the front end but the only way to do that is to work together and get that done.

Ms. Alletto said she agreed that some providers that either were sent cease-and-desist letters or turned in themselves to Program Integrity. She has extremely limited resources with only three staff to monitor the network accuracy of 100s of providers. So I don't know that the state can afford to work in silos when trying to work on this program. She would absolutely love to coordinate better and have the assistance. She apologized if some member of her team knew about the team and did not tell her but she asked several people. But point being that moving forward I appreciate being able to come and talk about this today and would absolutely solicit the help of multiple agencies in the room to make sure that those bad actors are taken out of the program because we really would like to see this program done in an evidence based way and serve the people who really need it.

Mr. Purpera asked who are the member of the behavioral health task force and when do they meet, and how do the agencies that are not a part of it become a part of it. Mr. Beaver responded that it is normally MFCU, Program Integrity and the MCOs. He had initially invited LLA to join, but talking about ongoing criminal cases and very sensitive information and limited to what can be said. He would rather LLA be there, but the MCOs balked at it and would have backed out if LLA was included. Mr. Purpera said those MCOs work for the state. Mr. Beaver said but if they would not participate then they won't and MFCU needs their help.

Mr. Purpera agreed with Mr. Block to leave with a better plan and believes everyone would gladly participate and help anyway they can.

Representative Bacala went back to his notes from meetings with MCOs in preparation for the task force meetings. One thing to mention is that it is not always about money but also the services being provided to people in need. Number 1 – if we are allowing people's mental health needs to be served by unqualified people then we are not doing our jobs very well. Number 2 – if we allow our people in need to go to mental health providers who are unqualified but still they build relationships over months and then we say sorry, they are not qualified and you cannot go there anymore and must go to someone else, we are not doing our jobs very well. While we are here to talk about the money component, remember there is also a human component where people are suffering because we do not do our jobs very well if that's the case.

Representative Bacala said one of the MCOs mentioned the issue that one day a provider is qualified one day but not tomorrow because the company may lose the qualified proper person, and all they end up with is peer counselors who have no qualification except they have a job at a company that is certified but no longer should be.

One particular MCO said they were familiar with 22 providers who should no longer be certified but had not been uncertified because they no longer had the proper people on staff but they were still obligated to pay because they still had customers going to these providers. That MCO had made the state aware of this issue but nothing happened and did not take the next step to decertify that provider. Then it is difficult to plug those people into another provider after that, so they are not sure what to do about it, so they just let it ride – that's how it was described to me.

Representative Bacala said they are also trying to recoup from the providers who were not certified which is often complicated because the providers go out of business so no one to recoup from. Sometimes those providers close as Company A and reorganize and reopen and Company B, and forced to deal with them again because not doing a very good job of vetting apparently. This is the feel he got from the MCOs.

Mr. Beaver added that company he shared about earlier did pop up two more times as a different company once he got caught with a new name twice until he finally left the state.

Representative Bacala said the MCOs that he spoke with all agree that they want a simple registry because one provider can be billing them for 24 hours and also billing four other MCOs for 24 hours but their records do not always meet up because five different providers are dealing with mental or behavioral health issues. Data mining does not work unless

data mining all five MCOs simultaneously. People can be defrauding the state by dividing up their cases amongst the various providers. MCOs like a central registry and the real legitimate behavioral health providers would much rather certify with one entity than having to certify with five different MCOs.

Ms. Alletto agreed wholeheartedly with Representative Bacala and in very much in line with thinking to keep the patient in mind. These mental health programs are shown to work particularly for the youth who come from very difficult backgrounds and working with DCFS and the Office of Juvenile Justice to make sure that these children are receiving the services needed to grow up healthy. These services also helps adults some of whom they are trying to prevent from being re-incarcerated or going to the emergency room and bouncing out and being homeless. So when done correctly, these programs make an impact. She will definitely look into how they are cross checking across the MCOs and not just individually because that is a very good point.

Representative Bacala said the MCOs just inherited the responsibility for behavioral health and prior to that it was Magellan who was handling it all across the state. The MCOs he spoke with believe there was a lot of overuse when it was under Magellan, so they are taking steps to throttle it back to legitimate levels of use. The MCOs said they felt like one of their jobs on the front end is to clean up the provider list and amount of usage, etc.

Ms. Alletto said that is what they asked them to do, so that sounds in line with her. Representative Bacala asked how LDH and OBH integrate with each other. Ms. Alletto said that she and Jeff Reynolds report to Secretary Gee, and Jen Steele as Medicaid Director reports to Jeff Reynolds. Mr. Hussey and his team report to Ms. Alletto. They all report to the same bosses - Secretary Gee and Governor Edwards. They have had throughout the several years covered behavioral health from 2012 to current, a few different ways that has been managed. They had Magellan handling it until early 2016 when they fully integrated with the five MCOs. After that point I believe Medicaid began to appreciate that managing behavioral health and assisting the MCOs in doing that was far different that managing physical health. So we are very happy to say with Jen Steele and Dr. Hussey's leadership have a unique and new as of July 26, 2016, Memorandum of Understanding between the experts in behavioral health and Medicaid managed care teams so we have just as you would want the right physician, you want an expert within LDH to determine if the behavioral health services rendered was medically appropriate, and if the providers are qualified. OBH is tapping into behavioral health to help the Medicaid program really make sure we are doing the right kind of auditing and criteria set within the MCOs to make sure that quality services are being provided. We feel very strongly that this is the right way for LDH to take control of behavioral health and make sure that it is done right.

Representative Bacala asked if anyway to speed up the process to ensure that all people who are providing services are qualified to do so, faster than next November. I think we ought to do that. Ms. Alletto said she would need more staff and capacity to do that. They are making secret shopper calls and taking staff that was going out around the state and doing desk reviews and want to do more, but only have three staff who are specifically behavioral health experts to do for this program. They are working as fast and hard as they can but stand ready to do more if have more capacity.

Representative Bacala asked if LDH grew by 160 in staffing and if some could be rededicated some staff. Ms. Alletto responded that was mostly direct care staff in their facilities that they added TOs which included nurses and guards for the East and Central hospitals. Representative Bacala asked if these are state employees who are nurses in hospitals. Ms. Alletto explained that Eastern Louisiana Hospital and Central Hospital and Villa Feliciana and Pinecrest are four state facilities. Actually the Central and East Forensic Hospitals staffs are within OBH organizations. It may have appeared that they added staff but that was for those hospitals.

Representative Bacala asked how much overlapping is this with the human service districts (HSDs) which also provide mental health services. Ms. Alletta answered that they do provide mental health and some provide evidence based services and mental health rehab services, and all have to fall within licensure just like any other provider. The beauty of the HSDs is OBH has a lot more say over their quality and they are actually leaders in many of their areas for providing this program in an evidence based way we want to see it done. There's not necessarily overlap, but have to contract with the five MCOs just like any other provider, and be licensed but I have confidence and they have actually helped us inform the ways we work with MCOs to reform the program, so I would consider them to be experts in the field.

Representative Bacala asked when LDH moved from Magellan to the MCOs did they notice a savings or can you tell yet. Ms. Alletto referred to Ms. Steele or Dr. Hussey on that. Ms. Steele said they are looking for a right sizing at this point. Keep in mind that there weren't any Medicaid behavioral health services before they went to Magellan in the Louisiana Behavioral Health Partnership in 2013, so the intent of that program was to take the state resources that were being spent without any federal funds to turn it into Medicaid services where appropriate and provide access. It was a slow going process but after a few years they hit their stride. By the time they moved it into managed care, their question was is that the right pace and level of access. What we are seeing now is some adjusting and is their project right now is trying to understand if it is the right level of access or growing too fast and if appropriate. Coming out of the appropriation act there is a $48M cut in the behavioral health services and the managed care companies. OBH and Medicaid have been working on the MCOs on how they will operationalize that and put pressure on their activities and increased scrutiny on their services.

Mr. Beaver said he understands LDH's staffing issues, but they leave out that the five MCO's have thousands of employees in Louisiana that made $142M in profit last year. Everyone could use more staffing and not trying to be mean, but the MCOs have a lot of people.

Senator Mills asked how much fraud the AG's office discovered from the one provider discussed. Mr. McCall said she billed $6.9M and was paid $2.6M. Senator Mills said from a bank's perspective if they discover fraud they eat it. Who eats that $2.6M? Mr. Beaver said they seized some of it and trying to get it back. Senator Mills asked if it is a deficiency of $1M. Mr. Beaver answered that the state will eat that fraud loss. Senator Mills asked if anything in the contracts with MCOs if they are found to be responsible.

Ms. Steele said that Mr. Boutte is shaking his head no. Senator Mills asked if they should add contractual provisions since doing the extensions with MCOs, so that if MCOs is credentialing any physicians or hospitals who commit fraud. What will start happening is when there is more fraud at the end of the day someone has to eat that fraud. If the fraud is basically an MCO provision, they should eat it. It's a fee-for-service then there is a discussion because the state runs it. I don't believe the fraud should be paid by the taxpayers. Mr. Beaver said that is a good incentive, and if we go after them for the money, they will cut it out and try harder.

Senator Mills asked if they do contractual revisions and joint budget will be looking at it, that fraud is an occurrence of an MCO not doing what they need to do as far as credentialing or licensing, and does not think the taxpayer should pay for it.

Ms. Alletto said there are stricter financial penalties for not appropriately credentialing. We have some now and have issued over $44,000 in fines for not having appropriate and accurate lists of providers. Those fines will stiffen under the contract extension. That's not exactly about claims being paid out and then denied but I just wanted to add that for clarification.

Senator Mills said if the AG's office or whoever investigates and comes back and says that fraud was not detected, that fraud should be eaten by the people that basically made the payments. I'm a president of a bank and if a Visa card has been violated and we continue to make those payments the consumer does not eat that but the facility that issued the payments should eat it.

Ms. Steele said she would check further into that and see if accounted for in the contract. Senator Mills asked about the licensure process - who is licensed – is it just the provider or both the provider and facility. Ms. Alletto said that the facility or organization itself is licensed by health standards, so they must meet all the criteria and that's what we are changing some of that with the facility needs review. But the health standards team would look at, and that is what was mentioned about the Fire Marshall permit, sanitation and all that. So you can be licensed as a specialized behavioral health provider and then there are modules under that for specific services. On the other hand we are talking about licensure as a practitioner of a service, so licensed clinical social workers, psychiatrists, mental health specialists, etc.

Senator Mills said legislation was passed several years back for abortion clinics and what was happening years ago, if an abortion clinic was closed the LLC was just repurposed but the membership of the LLC remained the same, so there was a loophole. So the legislation said if that person is just forming a new entity that entity is denied because it is the person. So if doctor X is saying it will be LLC this, they were able to reopen and the department in fact said we need to close that loophole so if there is a ding on that provider's record, then they cannot open up another facility. Is that something that you have a provision in law, or can they keep opening up a facility if they just change the legal entity?

Ms. Alletto said she was not sure but could certainly look into that and when promulgating new rules and regulations see if that is something that close up. Mr. Beaver said for the fee-for-service in the provider contracts you have to list who the owners are, and if they have a criminal history, but it should be the same for MCOs. Senator Mills said if it is a bad actor, you should not be able to keep acting if you just change your legal entity. Ms. Alletto said if there are charges against the provider and can prove they are opening a new facility, I assume we would have some legal remedy, but would get back to Senator Mills on that. This is not something we want to allow if there is significant criminal charges. I don't see how they wouldn't be able to put something into place to prevent that from happening, but cannot guarantee that's in place now, but would look into that further.

Senator Mills said the legislation years ago blocked a new abortion clinic from being opened if the previous abortion clinic had their license revoked or taken away, and not just change entities.

Ms. Alletto confirmed that if a person has a criminal history, they are not allowed back in the program. But she needs to get a legal interpretation of criminal history and she would get back with the committee and if there is something can be done to tighten up the rules, they will certainly do that.

Senator Mills said so we are going to look into the contractual issues concerning fraud and also look into licensure if there's been a bad actor trying to get a new entity to continue practice.

Mr. Purpera asked if all the providers would be licensed by some licensing board within Louisiana. Ms. Alletto said yes. Mr. Purpera asked if those boards would have databases of who is licensed and shouldn't LDH be able to get all those databases together so when LDH is approving someone they can electronically checking if they have licensing in order.

Ms. Alletto said they have looked into that with the licensing boards specifically. The audit just issued had LDH getting back with in touch with the licensing board for the five or six different types of mental health providers that were included, and they collect the data in different ways so all independent boards. The boards sent lists to LDH manually to check and not given access to a database that was super easy to check, but that does not mean that LDH won't continue to work with them on that especially when LDH goes to the single credentialing and single enrollment, that is absolutely a conversation they must have with the boards on how their data will be transmitted to LDH to populate their single registry. But right now LDH does not have easy to verify or search databases from the licensing boards for behavioral health unfortunately. It's not to say that it does not exist within the licensing boards. Mr. Purpera said he understands what she is talking about, and suggested that maybe this task force could help LDH to get standardized information in an electronic format that can be used with LDH's system. Ms. Alletto said her team in Bienville Building is probably all saying "Yes!" She said the boards are surely doing the best that they can but certainly standardization and easily searchable databases would be very helpful. Mr. Purpera said that same data could also be made available to the AG. Mr. Beaver said they made an MOU with boards.

Mr. Travis asked what type of encounter data for the behavioral health companies would LDH like to see. Mr. Beaver responded that Magellan had time, date, who provided the service, how long the service was provided, who provided to, location, and more. Mr. Travis said there are programs that should be able to ask for that data. Mr. Beaver said that this information should be mandated and not be an option. The enrollment of the providers is not just on the front end but once they are in the system and if they begin to misbehave there needs to be administrative remedies to deal with that provider such as remove their credentialing, stop their billing and stop paying – much more efficiently than two or three layers with MCOs, that's very important.

Representative Bacala said this committee is about recommendations, so anything you want to recommend to us would be very important to hear. Now whether it is included in the report or not is certainly still important. I thank you and it would be helpful to make a submission of what you have talked about.

Ms. Alletto said she appreciates that and right off the bat it would be increased capacity to do some of these high touch oversight activities for behavioral health and support for the contract extensions. We have some tightening on some of the items discussed today but we will absolutely put that in writing.

Representative Bacala said he's thinking one may happen before the other but get it to us. This report is due in January for this committee, but may be a little later on number two.

Mr. Purpera said any data that can be given and shows for each person you add to your staff will be this much better off or save this much money or whatever information you can give will help the task force better.

Representative Bacala asked LDH to work with the licensing boards to certify people and not paying people who are not qualified. It also seems like everyone is not working together as well as we could, so the efforts are not as coordinated as well as it should be.

Ms. Alletto said their checks are only as good as the data they have to check it against, so she agreed.

Mr. Purpera said they may need to discuss behavioral health again at a future meeting.

Jesse McCormick with Capitol Partners said he works with rehab services and introduced Chris Mudd, Chief Executive Officer at Rehabilitation Services which is a state rehab provider that has been involved since the creation of the behavioral health partnership to where we are today. We had an interesting perspective to come from and maybe shed some light on interesting questions. The task force discussed the problems already, but Chris would like to share some solutions and recommendations that he sees every day.

Mr. Mudd said he came with a prepared statement but most of that has been discussed in the meeting, so he would rather just talk about what has been done and some ideas that could be put forth to correct some issues. Some things done thus far, OBH has formed provider work groups to work on standards and also held town hall meetings to educate providers on what all services are being provided and how to properly provide those services. OBH has also terminated unlicensed providers which have been a critical piece because there was a large number of unlicensed providers but to a large extent that has been remedied at this point. Also OBH filed an emergency rule for facility major review which will also go a long way to curb many of the problems that exist today. However, there are other changes that need to be made. One of the things that he has long advocated is that there is not enough auditing of these agencies across the state. We agree with OBH that they do not have adequate staff to properly audit these agencies on an ongoing basis. However, the MCOs as well as other accrediting bodies can take this lead in doing such. The accrediting bodies include CARF which can do regular audits as well as preliminary audits of new agencies that could be opening around the state. Secondly, we are also provider of services in Mississippi. The State of Mississippi does one thing much differently than Louisiana, they not only force agencies to become credentialed or licensed but also require the individual provider seek provider qualification too. They have a group called PLACE with mental health specialists and professionals who would be forced to go through some qualification process that looks at their educational background, their experience and things of this nature. Then the agencies themselves are forced to pay that, so there is no additional cost to the state. These are some of the recommendations on top of what is already being done, and happy to take questions.

Mr. Purpera asked what should be included in the audits. Mr. Mudd said when an MCO or whomever comes into the facilities, they tend to focus on patient audits and client records, but what is not looked at a lot of times is the actual human resources records of those individuals actually providing those services as well as program operations. I think taking a look at those records should be included in the audits.

Mr. Purpera asked what he thought the human resources records would uncover. Mr. Mudd responded that it would show staff that does not meet the qualifications.

Representative Bacala said the oversight responsibility of the entities which are being overseen and paying licensing fees and other fees. If you are a behavioral health provider, is it time to talk about fees being charged to these entities that are guarding millions of dollars for the State of Louisiana to support a legitimate licensing/credentialing process. Mr. Mudd agreed and said he advocated for previously. Currently it is $500 for a primary facility and $250 for an off sight facility and we have advocated increasing that dollar figure significantly for two reasons. First, additional fees could provide the state with resources to hire staff and properly audit these entities. Secondly, to provide additional funds were needed.

Representative Bacala asked if the task force would like to discuss fees in order to do LDH's job in the way it should be done. Ms. Steele agreed and said they tried to advance it in previous sessions to help cover LDH's cost of doing business.

Representative Bacala asked again for any written recommendations or suggestions for the task force's consideration would be very valuable. He asked if going closer to the Mississippi model for licensing for facilities and individuals working in those facilities.

Mr. McCormick said fees typically get politically lost but this fee would be willingly paid by most providers and LDH could use. If we have support from the task force members, and use the fees for licensing and Medicaid fraud, he thinks there is a shot of having fees legislatively passed.

Representative Bacala said there are good solid reasons so the legislation should have a good chance, but only one way to find out is to run with it and see what happens. He asked Mr. McCormick if he would like to make that recommendation because it will have credibility if it comes out of this committee.

PUBLIC COMMENT

No public comments were offered.

Mr. Block said he could set up a meeting with Representative Bacala to carry the LDH fee bill.

Representative Bacala asked Ms. Steele if they should also look at different waivers which are the deviations from the standards set by the federal government. He's pretty sure that he's in favor of all those waivers but just to look and see what waivers Louisiana is receiving and how many of those waivers are costly to the state. He asked if she could provide that information.

Ms. Steele said whether it is done by a waiver authority of the state, it is multiple forms of authority, but it's really more of a vehicle than a deviation of the rules, but she's happy to provide that.

DISCUSS SUBJECT MATTERS FOR FUTURE MEETINGS

Mr. Purpera suggested a future meeting about pharmacy later in November to discuss LDH's responses. There may be a need to discuss behavioral health further, but need to eventually discuss what this committee's report would look like and Senator Mills made a suggestion this morning that maybe on each of the issues that we think we will report on, we would write a letter to LDH or whatever department to spell out what we are thinking and get a response on that.

Senator Mills suggested any members have some issues that need deeper detail and it would make sense from his vantage point to get a formal letter out with all the issues that have concerns about. Just from the AG's presentation and LDH's presentation, there could be some clarification in writing on who does what and what could be the recommendations to help us put our data together for the final report. Mr. Purpera agreed and since the task force started meeting there have been many good suggestions. He would go over the minutes and put the ideas into bullet points and circulate that to all the members and see which ones should be in the final report of recommendations.

Senator Mills said once we have the final report and if there is anything beyond the jurisdiction of the task force, we can send those recommendations as points to consider further to other committees such as JLCB, or Health and Welfare, or Finance or Appropriations.

Representative Bacala pointed out the significant issue that they put a price tag of $100M per year on the non-emergency use of the emergency rooms. You are not going to eliminate it or save $100M, but maybe reduce it by half. I think that's a topic to discuss further. If okay with Mr. Block, I would like to talk about managed long-term care as well, to at least look at. It had a fiscal note of $100M so an efficiency to look at even though it will meet with some resistance. Mr. Purpera asked if he means taking some of the long-term care that is currently under fee-for-service and put it under managed care contracts. Representative Bacala explained there was a bill with a fiscal note of $100M, but that is strictly what would come from the MCOs but probably another $50M in savings if you did that, but I will stick with the numbers in the fiscal note but I consider it to be an efficiency and believes it should be on the list of topics to discuss.

ADJOURNMENT

Senator Mills offered the motion to adjourn, which was seconded by Representative Bacala and with no objection, the meeting adjourned at 2:07 pm.

Approved by Act 420 Task Force on: November 28, 2017

The video recordings of these meeting are available in the House of Representatives Broadcast Archives:

1st Part - http://house.louisiana.gov/H_Video/VideoArchivePlayer.aspx?v=house/2017/oct/1025_17_MedFraudDetect_P1

2nd Part - http://house.louisiana.gov/H_Video/VideoArchivePlayer.aspx?v=house/2017/oct/1025_17_MedFraudDetect_P2