Task Force on Coordination of Medicaid Fraud Detection & Prevention Initiatives

Act 420 of the 2017 Regular Session
Act 294 of the 2018 Regular Session

Please Note:

These are the minutes of the last meeting of the Task Force which was held on Tuesday, February 26, 2019.

The Task Force terminated on August 1, 2019, as per R.S. 46:440.8.

The Task Force issued its Calendar Year (CY) 2018 Report on December 19, 2018.

This report outlined the Accomplishments/Progress on Prior Task Force Recommendations and the Future Goals and Ongoing/Future Discussion topics that would have been addressed during CY 2019, should the Task Force not been terminated.

This report can be accessed at the following link:
https://wwwcfprd.doa.louisiana.gov/boardsandcommissions/RulesAndRegulations/627_Task%20Force%20Interim%20Report%20&%20Appendices%2012-19-18.pdf

For additional documentation and history related to the Task Force, see the Division of Administration's Boards and Commissions' database:
https://wwwcfprd.doa.louisiana.gov/boardsandcommissions/viewBoard.cfm?board=627

MINUTES OF MEETING

Tuesday, February 26, 2019
10:00 AM – Senate Committee Room A
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 of the Task Force on Coordination of Medicaid Fraud Detection and Prevention Initiatives (Task Force) to order at 10:10 a.m. Staff member Liz Martin called the roll and documented the attendance as shown below.

Members Present:
Chairman Daryl Purpera, Legislative Auditor
Senator Fred Mills, Designee for Senate President John Alario
Representative Tony Bacala, Designee for House Speaker Taylor Barras
Mr. Nick Albares, Policy Advisor to Governor John Bel Edwards, Served as proxy for Matthew Block, Executive Counsel
Mr. Michael Boutte, Medicaid Deputy Director over Health Plan Operations and Compliance, Designee for Louisiana Department of Health (LDH) Secretary Rebekah Gee
Mr. Jeff Traylor, Director of the Medicaid Fraud Control Unit (MFCU), Designee for Attorney General (AG) Jeff Landry
Ms. Tracy Richard, Criminal Investigator, Designee for Inspector General (IG) Stephen Street
Ms. Jen Steele, LDH Medicaid Director, Appointed by Governor Edwards
Mr. Luke Morris, Assistant Secretary for the Office of Legal Affairs, Appointed by Louisiana Department of Revenue (LDR) Secretary Robinson
Mr. Jarrod Coniglio, Program Integrity Section Chief – Medical Vendor Administrator, Appointed by LDH Secretary Gee
Dr. Robert E. Barsley, D.D.S., Director of Oral Health Resources, Community and Hospital Dentistry, LSU School of Dentistry, Appointed by Governor Edwards

Member Absent:
None

APPROVAL OF MINUTES

Representative Bacala made a motion to approve the minutes for the October 16, 2018 meeting. The motion was seconded by Senator Mills and with no objection, the minutes were approved.

LOUISIANA DEPARTMENT OF REVENUE SAMPLE DATA RESULTS
Chairman Purpera stated on October 25, 2017, the Task Force issued a report discussing the previous sample that we had done as a committee between LDR and LDH that sample had resulted in the discovery or the results that 860,000 recipients were tested, 39% of those had a tax return in 2016, 48%

of those recipients who had filed taxes had household sizes that differed from their tax returns exemptions, 25% of recipients who file tax returns or roughly 83,850 recipients had incomes that different from their self-reported Medicaid incomes by greater than $20,000. On September 4, 2018, this Task Force sent a letter to LDH and LDR asking that we once again do the same test or same sample but no longer for 2016 but for 2017. In our October 16, 2018 meeting, Mr. Luke Morris reported that they were working on that sample but they wanted to wait till the complete deadline for the extensions to be done and those extensions would be done sometime during November, so we put it off waiting till that was completed. On December 3, 2018, we again requested an update and did not receive a response to that update. On December 10, 2018 and on January 10, 2019, my office asked for updates and we did not receive responses on those. So then on February 11, 2019, the Task Force wrote another letter to the LDR asking for an update and that we wanted to meet and discuss the results of the sample. So that is where that work is at the moment, we are waiting for that. If the LDR comes today they can present that evidence to us.

LEGISLATIVE AUDITOR'S UPDATE ON 22 RECIPIENTS PREVIOUSLY IDENTIFIED BY LOUISIANA DEPARTMENT OF REVENUE

Chairman Purpera stated about a year and a half ago in one of our meetings when we were talking about the sample of the 860,000, Mr. Morris identified that there were 22 or 21 Medicaid recipients that had incomes that differed from their Medicaid income by $100,000 or more. We began asking questions and discussed the recipients' information being given to LDH so they could look into that. Then my office requested the information which was shared a few months ago with my office. Mr. Wes Gooch, Director of LLA's Medicaid Unit will provide an update but cannot discuss the names or anything that must be kept confidential.

Mr. Gooch stated that on January 18, 2019 we received 22 Medicaid ID numbers from LDH. We did not receive names, addresses, ages, social security numbers or anything else that appears on a tax return just the 22 Medicaid IDs. We took those Medicaid IDs and did three things. We traced them into the eligibility cases in Medicaid eligibility system. We also performed a quick data match between those individuals and the Louisiana Workforce Commission (LWC) wage data that we have looked at before in detail and then we also searched the Secretary of State's (SOS) corporation database to see if any of the individuals in that case were affiliated with a Louisiana corporation as an officer, an agent or an owner.

According to the eligibility records we found that 13 of the 22 (59%) were currently ineligible and those cases had been closed. We found that 9 of the 22 (41%) were still shown as eligible in the LDH files when we started our review on this. For the 13 that were closed, five cases were closed between December 2016 and March 2017, eight cases were closed between March 2017 and December 2017. There were multiple reasons for closures: five cases were closed because the recipient was unable to be located; three cases were closed because there was an increase in earned income that was noted; two cases were closed due to recipients requesting the closure of their case; one case was closed due to the postpartum eligibility period ending; one case was closed due to a recipient having credible insurance; and one case was closed due to a failure to provide requested information. So those were the 13 cases that were closed.

That left nine cases still showing as eligible when we looked into the eligibility files. Of those, three are

scheduled to be closed by the end of February this week - one due to excess of earnings through winnings, one due to no response to a request for information and another due to not meeting a program requirement. Of the six remaining cases, four of those six are currently noted as being under review by the Medicaid Recipient Fraud Investigative Unit at LDH and then two of those cases remain open. One of those is a Medicaid expansion case and the other one apparently a caretaker relative case.

When we did our match with LWC wage information, we found two of the 22 that had consistent LWC wages in 2016, 2017 and 2018 were both Medicaid expansions. One of these cases is scheduled to be closed this week and the other is one of the cases that remain open. There were multiple individuals that are attached to that case, so it was not just a single individual but children involved in that case.

When we looked at the SOS corporation database to see if any were affiliated businesses, out of the original 22 there were five. Of those, two were closed prior to our review, one is the adult is no longer eligible but a child remains open on the case and that is one of the cases that's currently under review by LDH's fraud unit and then there were two cases still eligible. We consider those two cases that are still eligible to be a rather high risk because there is a chance that there may be tax data information that LDH could have to help determine the eligibility but we found no tax returns when we were looking at their eligibility cases. So out of the 22, there were 12 closed, three that will be closed, six open but four of those six are currently under further investigation by LDH.

Representative Bacala asked if one of the individuals was found to have private insurance. Mr. Gooch answered yes. Representative Bacala asked is there a database of all private people who are privately insured. Mr. Gooch responded there are databases out there. I know the MCOs (managed care organizations) sometimes share that information with other commercial groups. LDH does go out there and look for third party liability coverage and they keep a file that is active so that information is there and sometimes noted in those cases. There are some situations that people can still be eligible for Medicaid because of what the insurance does not cover and then others that are credible policies.

Representative Bacala referred to the Amanda Schwab case where she was auto enrolled but had private insurance. I am just curious if there is a private insurance database of folks that are insured and should that be cross checked against to make sure that people enrolled do not have private insurance. It may be a negligible number. Mr. Gooch responded that LDH does have processes looking for that third party eligibility and do check databases for that.

Representative Bacala referred to the one case were an adult is no longer eligible but the child was still on the plan. I know that there are some restrictions on removing a child if you are enrolled. I think my understanding is you are in for 12 months with no removing of children from the plan but the adults can be removed from the plan. Mr. Gooch responded that is correct.

Mr. Purpera asked if these files could have been closed back in December 2016. Mr. Gooch responded we really do not know. It's hard to determine that. All we can do is go by what we see in LDH's eligibility files. So they note things and they take action on them. We have no idea when that person might not have been eligible or how far that money could go back.

Mr. Purpera asked when you say that you saw consistent income, are you saying that you saw consistent income from wage data or are you saying you saw consistent income documented in the

LDH files. Mr. Gooch responded the LWC wage data when we went and ran it on those two cases, there were two individuals that had consistent wages in 2016-2018. Mr. Purpera asked since 22 comes from a sample not compared against wage data but against tax data. Mr. Gooch responded correct, reported income within the tax data. Mr. Purpera stated in those particular cases the wage data also verifies that the individual had income that made them non-eligible. But you do not have access to the tax data and the tax data if it was looked at by LDH there was no note notification in the file of what their income was during that time. Mr. Gooch responded no, we did not see anything specifically. Mr. Purpera stated it makes it really hard to determine whether or not these individuals should have been taken off the rolls. Mr. Gooch stated we could not tell even from looking at the files whether these dates the individuals were taken off the rolls through the regular course of business, through regular renewals, or fraud compliance or whatever that the department might have received, or whether it was a specific investigation based on the 22 that were given to them. We really do not know.

Mr. Purpera asked under the new LaMed system will it include information where somebody looking back and go back and determine what the tax income was at that time. Mr. Gooch responded not at this point. They do hope to implement the tax data starting in May was the last date that I have heard. No tax information to go back in time but occasionally we see a file where a tax return has been provided to support the eligibility determination process. But you never can get to that from an overall data stand point, it is just individually looking it up in the individual case records.

Mr. Purpera stated in December of 2016, we are alerted that we have 22 individuals that their income differs by $100,000 or more. LDH has the ability to get the tax returns but in these 22 cases the department did not get the tax returns. Mr. Gooch explained that Mr. George Bucher, Senior Data Analyst with the Medicaid Audit Unit was the one that went and looked through these files. Mr. Purpera asked when you went through the files were the copies of the tax returns in the files. Mr. Bucher responded of the 22, we found one copy of a tax return on one recipient. We did not find any other tax returns throughout the case notes. Mr. Purpera asked if that was obtained prior to or after this work began. Mr. Bucher responded it was in the current LaMed system, so it should have been done sometime after November 13th.

Senator Mills asked what lessons were learned and what would you do to shore up procedures. Mr. Gooch responded that there is still a huge gap for us as auditors when it comes to either LDH not using tax data and us not being able to consider tax data for eligibility. It puts us in a spot. In our last report issued December 2018, we said that because of this it has put us in a position where we have a scope limitation because we cannot make a determination as to whether or not anyone truly is eligible. We can look into LDH's files and see if there are things in that file that make them specifically ineligible. We can match them to LWC wages possibly and show that they might access income that made them ineligible but we cannot ever say that we are sure that this person's eligible because we have that scope limitation in our audit and we reported that. We also put two paragraphs in the State's CAFR reporting this year explaining that situation - a scope limitation that we have on Medicaid eligibility. So going forward with LDH using the tax data would be a major stride. The other major report we put out was in mid-November, where we talked about those periodic routine quarterly checks of the wage data and LDH started their first one this past month. So that was also I think a major stride towards this because two of the risky areas that we have seen most frequently are the individuals who do not tell about other income that they would have other than the LWC data and other individuals who are eligible when they start but then they get a job later and they do not report that change in their status. Using the LWC data

routinely every quarter and using tax data going forward, that will fill a couple of the major risk gaps that we saw through our work over the past two years on eligibility.

Representative Bacala stated some examples of income that are not reported to LWC and LWC is the primary source of information for eligibility determinations in regards to income. Military paid is not reported, self-employment not reported, investment income not reported - all those things are not within the realm that would be seen in LWC. I know there are some other areas. So LWC is not the only source of income verification. Going forward, would LLA have a recommendation to give to the eligibility system, a component within LDH of how to capture that data or used that data in the best manner? Mr. Gooch responded LDH was already in development to use that data in their new LA Med system. It is something that they hope to launch May 1st. I do not know exactly what all that entails but we will be looking at that as that piece rolls out. Representative Bacala asked so the May 1st, they would be looking at what? Mr. Gooch responded tax data information. Representative Bacala stated I do not know exactly what is captured in the tax data beyond the tax return but I know every month there is some reporting or some monthly remittance to the LDR that reflects income. He asked if LDH will be just looking at the tax return or will other information be available. Mr. Gooch responded that he has not seen it yet so LDH would have to answer that.

Representative Bacala stated I will note that that I think the original contract for the development of the LaMed system that was one of the deliverables in the original three year contract. So that was not an add-on component as a result of renewing that contract for a fourth year. I guess it kind of gets outside the scope but I want to make sure that what was paid for was delivered. Now it looks like it might be delivered after the completion of the three year period in which it was supposed to be delivered. He asked for any insight into that. Mr. Gooch responded from what I have been told by LDH that was at their request - this was pushed farther out as a second phase rather than the initial phase in order to get the system up and running as quickly as they could.

Mr. Albares stated it seems like we have the benefit of time in terms of looking back at the tax data. In terms of real time eligibility decisions, would you agree that the workforce data really is kind of the primary data point for those real time decisions since the tax data is a look back in terms of a prior year return. So it can be a tool but that the primary data source is that LWC wage data, would you agree with that? Mr. Gooch stated I would agree with that and we have said from the beginning that this would just be an additional tool. It would be a flag that if you saw a high income level in a tax return that is inconsistent with what you are seeing in wage data, it would be something that would be a key for the eligibility worker to go back, look at and consider and determine whether or not they needed to get additional information to reconcile those two differences. Mr. Albares stated as you noted the LWC wage data checks have begun and the tax data will be incorporated in May. Mr. Gooch responded correct that what we are being told.

UPDATED FROM LOUISIANA DEPARTMENT OF HEALTH'S MEDICAID RECIPIENT FRAUD INVESTIGATIVE UNIT

Mr. Michael Boutte, Medicaid Deputy Director over Health Plan Operations and Compliance stated that LDH kicked off last summer a Medicaid Recipient Fraud Unit Initiative. Prior to that time period we had a unit in one of our field offices that was sort of a centralized hub for receiving any fraud

complaints and that unit would then funnel those complaints out to the regional offices where the regional offices would work through those complaints and report back to that centralized unit. We took the initiative to bring that into the headquarters in the main office and start up a unit that would specifically focus on these types of cases in these referrals. Since the inception of that unit in June, we have completed 436 reviews that range from complaints that were given to us either from external parties or internally generated from the field.

In terms of statistics on what has been the outcome of those 436 reviews, 161 individuals have been terminated meaning their eligibility was closed, 250 maintain their eligibility based on our review and 25 had been previously closed even before we initiated our review. In terms of some of the additional outcomes related to those cases, we have referred about 118 of those cases to external agencies. Those external agencies can involve the DCFS (Department of Children and Family Services) if it is SNAP (Supplemental Nutrition Assistance Program) recipient, the Social Security Administration when it is a social security involved individual and to the AG's office. We have referred about 33 cases to the AG's office in that period of time.

Mr. Purpera asked of the 118 that have been referred to the external agencies do we know the number that was referred to the AG for prosecution. Mr. Boutte responded 33 total and the AG came back with nine as unsubstantiated and 24 are pending review. Mr. Purpera asked how a review starts and where does the information come from. Mr. Boutte responded it can come in a variety of forms. Sometimes in the field a complaint that comes through such as someone reports a person that should not be on Medicaid and that gets funneled into our unit. Other times we get it from external parties. For example, some of the work that has been done by LLA resulted in cases that were initiated by our recipient fraud unit.

Mr. Purpera asked if LDH receives any from the MCO's by partnering with the state in any way to try to identify those that are ineligible. Mr. Boutte answered yes. We get referrals from them in instances where they think someone might not be eligible. Mr. Purpera asked if any idea how many they have referred. Mr. Boutte responded I do not have that number in front of me right now but I can get that for you.

Mr. Purpera wanted to know what the MCO's are doing to help us identify those that are ineligible. A lady came and testified at the Joint Legislative Committee on the Budget (JLCB) that she never knew she had Medicaid but had insurance through that same insurer and the insurer did not notify LDH that they had two policies for the same person. In the cases where the internal fraud unit determines that there should be recoupment, do we recoup from the individual or do we recoup from the MCO.

Ms. Jen Steele, LDH Medicaid Director, referred to a handout that provided some questions and answers on our recipient fraud unit from the summer. One thing that I would add is that we have had more recent conversations with CMS (Centers for Medicare & Medicaid Services) to clarify what is allowable under federal regulations for recoveries. They have clarified to us that we cannot retrospectively recover any funds from a member with the exception of a convicted fraud case. So we did not pursue recoveries on those. We did make the referrals to the AG and if they get a conviction then we will follow up. Mr. Purpera asked about potential savings. Ms. Steele responded that was based on our thinking that we could recover but that is not true at this time.

Mr. Purpera asked what about an individual who is ineligible? Let's say they have been with one of our MCOs and we discover that individual was ineligible and that individual never had any services performed. Do we go back to the MCO and asked for the money back? Ms. Steele answered the answer to that from CMS was also no. We cannot do anything retrospectively unless it was an instance of convicted fraud and at that point it is a member recovery. Mr. Purpera asked in a case where Ms. Schwab had her own insurance but we were paying the MCO who also had an insurance policy with that individual, we cannot tell the MCO they owe us our money back. Ms. Steele responded we can debate the evidence in that particular case but the understanding that I have from CMS, the MCO had nothing to do with the fact that a decision was made. They were outside of that scope so they were not at fault for the fact that the person was enrolled with them. Built into their rates is the assumption that some percentage of the population will not use services, so the fact that services did not occur is not a justification for not making a capitation payment.

Representative Bacala commented that based on the location from which they get complaints it would seem that the unit is reactive rather than proactive. Do they have a proactive component where they go and search for fraud cases through the database search or anything of that nature? Or is it simply if it's not reported from an outside entity to them they don't do anything except that? Are they strictly a reactive unit or is there a proactive component where they would perhaps do some other things to identify on their own? Mr. Boutte responded it is primarily referral based. There are lots of complaints that come through that we have to work through. In the future, yes, we are interested in opportunities to do proactive data mining but at this point it is been largely referral based.

Representative Bacala stated we are on the verge of seeking some new contracts for MCOs. Have you contemplated including some fraud avoidance or anything of that nature within those contracts beyond what exists today? Maybe one of the components could be making sure they don't have private insurance from the MCO or that might be transferring a responsibility to them that perhaps we should have as a state, but are you contemplating anything where they would be more of a partner in the fraud avoidance? Mr. Boutte responded first, the managed care of the reprocurement, the RFP, went public yesterday. So that contemplated in terms of what the new contracts might look like is out there. I do not have that provision committed to memory on what would specifically be in there but we can look at what's out there in terms of a model contract. The second piece is that just because someone has private insurance does not mean they are not Medicaid eligible. You can have private insurance and still be eligible for Medicaid. Medicaid would just be the payer of last resort. It would be more of a secondary insurance instead of a primary. Just because someone has existing insurance does not mean they are ineligible for Medicaid specifically.

Representative Bacala noted there's not much chance of ever getting back from anybody the recoupment of funds expended for ineligible individuals. He asked if any federal regulations that allow for consequence for being improperly enrolled short of criminal conviction. Ms. Steele responded the primary action we can take is to prospectively disenroll. Kentucky has sought authority to lock members out of Medicaid for a period of time for failure to report but speaking to CMS there were no other examples of states that had done anything of that kind. Representative Bacala asked for more information about the Kentucky model that has a consequence. Ms. Steele responded we can provide the model. My understanding is it's a six month lockout, so they cannot re-enroll for six months. Representative Bacala asked if the recipient failed to report an increase in income do they get locked out and if that is by a waiver. Ms. Steele responded by an 1115 waiver – it is part of their larger waiver

around work requirements. Representative Bacala asked have you contemplated doing anything like that since it does not require legislation and would be within your realm to do something of that nature. Ms. Steele responded we only receive that information in the last couple of weeks so we have been trying to evaluate whether there are options in addition to that but at this point we have not made any determinations. Representative Bacala asked if that is on the table for further discussion. It seems like there should be some consequence for failure to follow the rules. He asked if it is being contemplated or just something you are aware of but not being contemplated as an option. Ms. Steele responded at this point we are gathering information to see what our options are. I do not know whether or not that is something we are contemplating.

Chairman Purpera stated we also invited the AG's Medicaid Recipient Fraud unit to come but they would not be able to attend today.

DISCUSSION OF MANAGED CARE ORGANIZATIONS' ASSISTANCE TO LOUISIANA DEPARTMENT OF HEALTH IN IDENTIFYING INELIGIBLE ENROLLEES

Chairman Purpera asked is there something that we can do to get the MCO on board with us because they should have the data. Going back to that example when an MCO is insuring the same person twice it seems like they would have the data to help the state identify those on our rolls that should not be on a roll. From my office's perspective we asked for information from the MCO on this. Eventually I had to get that through all kinds of secrecy agreements. I do not even think I could tell you what they told me but what they did tell me did not prevent what happened to Ms. Schwab.

Mr. Boutte restated just because someone has insurance does not mean they are categorically ineligible for Medicaid. In terms of the contract there are provisions related to what the MCO's are required to do and notices that they do provide to us when they suspect that someone has either moved out of state or there is information that someone might be ineligible. They are required to report to us on any return mail that they receive and then that information is used by our eligibility team to determine if those individuals have moved out of state. There are other provisions in cases in which they would be identifying someone who is deceased or has been incarcerated. If they get that information before it cycles through our data then they do notify us of those instances and there are specific forms that they submit to us around member disenrollment for those types of reasons. So there is information that is shared with LDH from the health plans around ineligibility but they would not have information on income based eligibility decisions.

Chairman Purpera questioned Mr. Boutte was saying that that an individual who has a health insurance policy through the private insurance issued by one of our MCOs that they can also have Medicaid through that same MCO. Mr. Boutte responded it is not through the same MCO - those are completely separate entities. They are completely different corporate structures. Chairman Purpera repeated to confirm that the MCOs might have the same name but they are a different organization. He asked if they have different locations and different buildings and different people managing it or is it two corporations in one building with the same people managing it. Mr. Boutte explained that there is a plan specific CEO with the Louisiana Medicaid specific team that works with us and they operate in Louisiana.

Chairman Purpera asked if that individual did not have insurance through the same entity it just happens to be the same name. Ms. Steele responded that the parent group, United Health Group, owns all of it nationwide but there are distinct plans that are not overlapping.

Chairman Purpera asked would it not be a good idea for the State of Louisiana to require the parent group to help us control since they have both policies. Ms. Steele responded they already have contract requirements. The functions that both the department performs and the health plans with regard to identification of third party liability, we have files that we constantly run to identify people who have coverage independent of Medicaid while they are enrolled with Medicaid. That has been a longstanding function. It is not limited to a single parent corporation - it's across all payers.

Chairman Purpera asked if LDH is regularly getting third party liability information from the MCOs that is used to determine whether people are eligible or not. Ms. Steele responded we have done it differently over time. When we started out we had a process where they identified it to us. We all had unique contracts. We changed that because of some discrepancies that we are having where we have the primary contract but they still maintain their own contracts but ours is the source of truth. There are really two companies nationwide who provide this and we contract with one or the other. This is nothing new. This is something we have been doing for a long time but it is for purposes of not determining that they are ineligible on the basis of having coverage but for making sure that Medicaid is the payer of last resort. So if there is an opportunity for us to collect on claims that another payer should have paid that is what we use it for.

Chairman Purpera asked if in those cases Medicaid would be the payer of last resort and pay the MCO like they are the payer of last resort. Ms. Steele responded it is the payer of the claim not the payer of the recipient of the capitation payment. Chairman Purpera commented it seems like as a state and the federal government (because we're taking their money and spending it), we are paying out 100% as if it's not the payer of last resort but then the MCO is not having to pay the claims because in this case and their parent, they had another policy being paid for by that individual. Ms. Steele responded the eligibility decision and the entitlement to eligibility is supreme to the payment of the claim. The payment of the claim is subordinate to the eligibility decision. They have the right to be enrolled in the eligibility program for which they qualify and if they qualify then they are enrolled or choose a plan and we make a payment to the plan.

Chairman Purpera said he was trying to understand whether or not the eligibility rules given to us by CMS have a hold of them here because it sounds like it does. Do the MCOs ever give us information on individuals that are enrolled in Medicaid under their MCO but the individuals have no services being performed? Ms. Steele responded no. Chairman Purpera asked why would they not do that. Ms. Steele responded that is something we can figure out from our own data. We do not request information that we already have.

Chairman Purpera asked what is done when we find that individuals do not have any services being performed. Ms. Steele responded our focus is on making sure that people get access to care that we think is important. For example, we have a 1% withhold of the capitation rate payments. That is for plans to meet targets around quality improvement, specifically adolescent well care visits. They focus on preventive and primary care. They also focus on things that we want to avoid. We are very specific about the kinds of outcomes we want to see. We are not looking at there were no claims therefore

something is wrong. We take the more positive side of it which is: we want you to deliver these specific services. We want you to seek out these members. We want you to try to get them into care. This is not a program of conscription. We cannot mandate people to seek care that we think is useful or important. If you talked to any of our providers and our plans, they will express frustration to you about their ability to get people to come in and do some of those things just like you probably have family members that you would like to go to the doctor who don't. So I think it's important to remember that people have choices and we provide the incentives that we can but we can't force people to do things that they choose not to do.

Chairman Purpera asked if a person had no services delivered since they became enrolled for a period of two years and we have a risk that that individual doesn't even know they have Medicaid services, how do we make sure that we're contacting that individual to let them know that they are on the roles and that the state is paying a per-member-per-month (PMPM) for them monthly. Ms. Steele responded the MCOs are identifying those people who are not currently in care. They do a variety of outreach to them, whether it's direct mailing, whether it's calls, whether it's seeking to reach them through providers. We met yesterday with a group of Federally Qualified Health Center (FQHC) who talked about the work that they do to try to get people into care. The people who are assigned to a primary care physician (PCP) – there is a significant percentage that do not come into care. At the level of the MCO you have outreach. At the level of the PCP you have outreach, in addition to the communications that we send annually. It is not uncommon to have a material percentage of people who choose not to come into care. At both the plan level and the contracted provider level we have outreach efforts.

Mr. Purpera stated I agree with you on that there are a percentage of people who are not going to seek care but when we see somebody not seeking care it raises a risk that that individual does not even know that the state is paying the PMPM. What can we do as a state to maybe close that loophole that we do not pay a PMPM on that individual? Ms. Steele responded when we do send our annual renewal packets. Let's assume that the letter is going to someplace that they never even lived or there's a failure to respond. We closed the case.

Mr. Purpera stated we get a lot of junk mail that we just throw away such as described by Ms. Schwab. Ms. Steele commented we can't make people open their mail either. Chairman Purpera said that the state pays $5,000 - $6,000 a year PMPM, so what can be done when people do not respond and never receive any services? Ms. Steele responded we can privately talk about the evidence in Ms. Schwab's case. But people need to take responsibility for managing their benefits. If they are getting communications from us and they do not believe they should be then they need to open the letters and respond and if they fail to respond when they come up for renewal we are going to close that case.

Mr. Purpera asked if the envelope says Healthy Louisiana on the outside or does it say State of Louisiana official business. Ms. Steele responded that it depends on who it comes from. If it comes from the plan it's going to have their markers and if it comes from us, it's going to have ours. Mr. Purpera stated if someone never applied for Medicaid, they won't have any clue what Healthy Louisiana is and that would not make me open it. He asked if LDH ever considered a debit/credit card approach that required being activated before being used. He asked if any state offering Medicaid requires that the individual has to activate their policy and until it is activated the state does not pay a PMPM. Ms. Steele responded I don't know the answer to that.

Representative Bacala commented that individuals in the managed care populations are supposed to select a specific plan. The Amanda Schwab case, which we've referenced earlier, was a case where she never selected a plan so she was enrolled in United. He asked if LDH could require the recipient to choose a plan and if you don't choose a plan then the state will not pay for that person. Steele responded my understanding is that federal regulations do not allow us to require a choice and the choice statistics are not great but proactive choices are not the vast majority.

Senator Mills asked how many individuals have dual eligibility in Louisiana. Ms. Steele responded around 130,000. Senator Mills asked if other states have challenged the issue of dual eligibility and could we tighten up those restrictions. When would a dual eligibility claim kick in when the payer of last resort is there? Ms. Steele responded when we say dual eligible we are talking about Medicare/Medicaid. Senator Mills asked when it's private insurance, what kicks in the payer of last resort. Ms. Steele responded the TPL system depends on the plan specific. For example, for waiver services most private insurance companies do not cover those kinds of long-term care services, so we would end up paying for those services. It depends on the type of enrollment. Some are entitled to have just premium sharing, some we pick up copays and deductibles, others we don't, so it depends on the details of an individual's coverage. Senator Mills asked is there any ways to tighten up the dual eligibility or is it as tight as can be on the private insurance piece. Ms. Steele responded there are two levels of it. One is they are entitled to have the two coverages. Then the second piece is our responsibility to make sure that when a claim comes in that it is ours and that somebody else shouldn't have paid at first or to whatever extent that balance is supposed to be. Senator Mills asked if any other states have been proactive as far as the activation process by the Medicaid recipient. Ms. Steele responded I am not aware of that but we could look into that for the committee. Senator Mills commented it would be a good idea to be more proactive.

Mr. Albares asked if the capitation rates take into account people being enrolled but not utilizing services. Ms. Steele responded yes, they do. They look at the universe of utilization for the population. If the entire population have used *x* services they allocate with *y* costs, they allocate that utilization and cost across the entire population. In a fee-for-service program that is how we looked at it. We had two ways of looking at it – PMPM and per recipient per month. The recipient looks at the people who are actually getting the services, the membership looks at every person who is enrolled. In managed care that's essentially the same thing that's happening. We are not paying on a per recipient basis – we are paying on a per member basis. It was factored in the old way and it's factored in now. It wasn't as much a focus but it's always been that way. Mr. Albares stated that’s consistent across Medicaid and commercial insurance. I have health insurance and have not been to the doctor probably in three years. If I was on Medicaid and got hit by a tour bus I would be glad to have that insurance. I think the state would be glad that I had that insurance because the state would be getting a much more favorable match rate than we would if I were uninsured and we were paying uncompensated care. Would you say that's correct? Ms. Steele responded yes.

Mr. Traylor noted that the renewal period is each year and assumes the recipient would confirm that their financial status and job status has not changed. He asked if there has ever been any discussion about cutting that in half where you would send something every six months just regarding the eligibility issue. He noted that once someone gets on Medicaid it's up to the recipient to say when they have a change in circumstances. To wait a whole year to get them to reconfirm gives them a lot of leeway. Ms. Steele responded we are effectively doing that now quarterly with the use of the wage data

and at any point in time that we get information on a case that changes that circumstance we will send out something asking for confirmation. The wage data is the most significant change where four times a year for the entire population we are looking at whether or not earnings changed and whether that puts them over the limit. Also letters go out that people have to be responsive to and if they're not, if they can't demonstrate ongoing eligibility than their cases are closed.

Representative Bacala asked in your quarterly wage data check for the fourth quarter of 2018 was the entire population surveyed. Ms. Steele responded it was all adults including but not limited to expansion. Representative Bacala asked if some enrollment includes only children. Ms. Steele responded historically prior to expansion we had that commonly because our income limits for children were up to 200% and our income limits for adults who are not disabled where in the teens in terms of percentage of the federal poverty limit. Representative Bacala asked how many enrollments are children only. Ms. Steele responded I don't know. Representative Bacala asked if LDH will get to the point of checking to find out if the children come from eligible family households. Ms. Steele responded the basis of eligibility for a child may be different than it is for an adult. Representative Bacala stated you ought to be able to plug those numbers in to the modified adjusted gross household income. He said there has to be that standard for the children no matter what the limit is. He asked if there is a limit. Ms. Steele responded correct. Representative Bacala commented the fourth quarter did not include a review of children. Ms. Steele responded because children have 12 months continuous eligibility. These checks are outside of the annual renewal cycle. We will check those children when it's their annual renewal period but we are not going to disenroll the children on the basis of the wage information in between those two times.

Representative Bacala asked since every month somebody comes up for renewal could that include children. Ms. Steele responded correct. Representative Bacala asked if LDH started checking those for renewals. He knew that LDH postponed a review of renewals and that you're gradually getting back into verifying eligibility for renewals but you're not going to be there until maybe June. Ms. Steele responded we caught up on the child renewals in January and those are running routinely. In October and November we did not do any renewals because we were training people to get ready to go live and we were focused on converting data from the old to the new system. In December we began some limited renewals. In January we added more. In February we did the wage data as a prelude to bringing back the adults. Next month we'll start routine adult renewals. We will have a few more months to catch up and phase in but we anticipate being done with that in June.

Representative Bacala asked if a family unit has an adult and children are we checking that unit. Ms. Steele responded we are checking everyone who is up at renewal and we are checking all adults quarterly. The unit gets checked but nothing happens to the children until their renewal date. Representative Bacala stated the adult would be sent a letter but not the children. Ms. Steele responded correct. Representative Bacala commented that in a scenario where you have one adult, two children, income of $100,000, you would notify the adult that they are no longer on the plan but the children would be basically untouchable even though they do not meet eligibility standards. Ms. Steele responded correct. Representative Bacala asked if that is by federal rule or our plan documents. Ms. Steele responded I would need to confirm but think it is federal. It definitely is for pregnant women but let us check. Representative Bacala stated if I recall it was children, pregnant women, people in nursing homes and one or two other categories.

Representative Bacala asked when we are doing these checks are we including LaCHIP. Is that included in the total numbers or is that considered separate as far as quarterly checks, monthly checks? Ms. Steele responded there are multiple categories for children - it's just a different income limit. Representative Bacala stated that's where you go up to 200% for LACHIP. The adults have to pay some premium amount, it is subsidized. Ms. Steele responded your talking about LaCHIP affordable - it is 200 to 250%. When I say children it is all of those categories. It's LaChip, Champion - everything.

Representative Bacala stated we have about 1.6 million people enrolled in Medicaid. He asked how many were reviewed in the fourth quarter of 2018 in February. Ms. Steele asked if he was talking about the outcomes of the quarterly wage check. Representative Bacala responded the outcome was 37,000 were sending notices or letters. That 37,000 was out of how many? Ms. Steele responded it was about 8% of the total. Representative Bacala asked if 8% of the total surveyed. Ms. Steele responded 8% of the total number of adults that were bumped up against wage data received a letter. Representative Bacala asked of the group that you chose to survey for eligibility, 8% were suspect? Ms. Steele responded 8% appeared to have income that was over the limit. Representative Bacala responded that would mean around 450,000 people were included in the quarterly wage check which represents less than 1/3 of the total population. Ms. Steele responded the vast majority of our enrollees are children.

Representative Bacala inquired if at the 12 month point could we expect that 8% of the two-thirds who are not being checked in the quarterly reviews are likely to come from families whose income exceeds the eligibility amount. Ms. Steele responded it depends because the income limit for adults even under expansion we have lots of categories of eligibility for adults. Some of them are as low as 13%, 14% of poverty. Some of them are 74% of poverty. Some of them are 138% like expansion. For kids, LaCHIP affordable is 250%. LaCHIP is up to 200. Regular Medicaid up to 133%. Everybody above that 133% or 138% depending on how you count it, those children are going to be judged on a different standard than their adult parents.

Representative Bacala stated as we are trying to plan for the future budget of the state this is information that that is vitally important to create a budget document that accurately reflects the needs of the state. Even though we might not be able to act upon improperly enrolled children, it would be nice to know how many of them are might exist. What might happen in the next six or 12 months - is that 8% going to be across or not across the population? It's a lot of questions that I think are important for the creation of the next budget. Ms. Steele responded that the next budget was presented last Friday. We do not have the results of the 37,000 letters that went out for LaMed. We will not know until the beginning of April how many of those actually close. We won't know for another several months how many of them come right back to us as soon as they hit the doctor's office and realize their card has been deactivated. We do not know what the net result of that is going to be nor do we know what the result of renewals will be under the new system. We believe it will take us a year to see how the dust settles. You'll be looking at next year going into the 2021 budget before you would have anything close to enough data to make up a forecast that I would have any confidence in. This is the first check of the wage data and until we see the data results it is all speculation and I wouldn't make budget projections based on those at this point.

Representative Bacala stated there are three components to eligibility: income, household size, and marital status. Are we doing anything to verify marital status? Ms. Steele stated she did not know the

answer to that. Representative Bacala asked if doing anything to verify dependents. The LDR report from last year stated that 52% of Medicaid recipients reported a different number of dependents on their income tax return than reported on their Medicaid application. Are we doing anything to address dependent fraud? Ms. Steele responded we have not been using tax data. The LLA's interest in the tax data is in household size, tax filing status as it relates to marriage and to income. When we start using that tax data we will begin looking at those factors but at this time we are not.

Representative Bacala stated that the income tax data is best as a renewal tool but is it going to be disregarded as an initial application tool? You could look at the income tax return and say you had two dependents now, three months later you have six dependents or you said you were married on your income tax return now you say you are not married. Are those going to prompt questions to be asked prior to the initial application being approved? Ms. Steele responded we have not fully formulated how we are going to apply the tax data. Representative Bacala asked if they would recognize that dependents and marital status - although not bulletproof in the tax data - is probably the best source available. Ms. Steele responded I'm not so sure. Just in responding to some of the letters, divorce is messy and trying to show separation is not simple. We are asking people can you provide a utility bill in your name where somebody else has a utility bill in their name at a different address. For low income families getting a divorce paid for is difficult.

Representative Bacala stated a case where someone went to his office who was married with a special needs child and income was an impediment too and an eligibility worker told them to get a divorce and could still live together. The divorce would make them eligible which is the horrible side of that loophole. We can have biological mothers and fathers living with children but we are not counting them all together as a household unit because the marital status is not married. He asked if he was missing something. Ms. Steele responded she did not know about those living in the same household. Representative Bacala said one of LDH's documents states it makes no difference where you live only if you are married. Is that something that would be worthy of a waiver? The household income would be determined through an address you provide on your Medicaid application. We could go check for all earners who report that same address for income tax purposes. We could go back and verify everybody who is claiming the same children as dependents. They should be red flagged. If I have someone who claims a child as a dependent for the purpose of Medicaid and I have someone else who claims that same child for the purpose of getting a higher income tax return or an earned income tax credit. Somewhere those two should diverge and that is where the Medicaid Fraud Unit comes in on a proactive basis. Somebody ought to take an interest and care about this. Ms. Steele responded we are preparing technologically to bring the tax data in but there are a lot of decisions that have to be made about the application of that in the system and elsewhere. What makes the system more robust in terms of its ability to consume and use that data is the automation and we are trying to be sensitive to where automation produces a predictable result and where it is going to be misleading. We are trying to be careful about how we choose to use that particularly in an automated way which is the only way that we can practically. The reason we did not do these type of wage checks more frequently before is because of the manual labor involved. Until we put logic in about how that tax data gets applied, we are still looking at automation bringing it in but not necessarily automation about how it's used. We are trying to be careful about how we use the data in a way that is both predictably accurate and workforce manageable.

Representative Bacala stated you said the fail rate on the audit was 8%. Once you kick off the bad

players the data should become more pure. We ought to have a higher confidence level that those who are in the program are supposed to be in the program. So what I anticipate the 8% will go to 5%, go to 3% or am I missing something? Ms. Steele responded it would be less than 8% but we don't know what that number is. We have already had a number of those people come back and provide information that is pending review. There have been some that have demonstrated ongoing eligibility and anyone who can demonstrate eligibility stays. The numbers were higher on the Quarter 4 comparison then on Quarter 3 because people take seasonal jobs, people get year-end bonuses. There are a lot of things that happen in December that could make a person over income in that quarter but they would not be in the next quarter. Those are things that we are seeing as people are sending in their information and we would expect to see. Every quarter is probably going to be different and it will take years for us to figure out whether every January has higher results than every subsequent quarter. So, I would emphasize the caveat about needing a duration of information to make any kind of projection.

Representative Bacala proposed that a person's average income for a three month period rises to the level of ineligibility, not necessarily one bad month. You can be ineligible, it doesn't matter how much you make in October, November, and December. If you managed to reduce your hours, get fired, quit your job in January you automatically get back into the program because in January I made myself eligible again and then you're safe for the next three month period. Is that acceptable that we don't care enough about that to look at Kentucky's model and say if you are ineligible in October, November, December on average and didn't bother to report it, so see you in July? You can do that check by rule. Ms. Steele responded we are looking at options. Representative Bacala stated none of us would run our households like that. If it was my personal checking account I would make sure there was no loophole. We should feel just as adamant about the taxpayer dollar. We shouldn't say we don't have to do it. We should do it because it's the right thing to do.

Chairman Purpera asked Ms. Steele if the 2016 adult population was 860,000 - why the test of 450,000? Ms. Steele responded I will provide how we got to that number I do not have it with me.

LOUISIANA DEPARTMENT OF REVENUE SAMPLE DATA RESULTS

Ms. Kimberly Robinson, Secretary Louisiana Department of Revenue, stated we received your request for the information and we did wait for the additional tax return data for 2017. The returns are due May 15th and for those who file an extension taxes are due November 15th. We allowed time for those returns to be processed and then ran a comparison. We allowed processing time for those to get in the system until the beginning of December. We discovered the first time that we ran the data that running what we think our social security numbers to tax ID numbers does not work. There are data mismatches and we had to run it over again and actually run names, which is time consuming. We worked with LDH to gather that information and have been working with them since we got the request. They had to get their new system up and running and we have been providing them with information on what we learned from that. In preparing the answers to the questions, we looked at the information and the data that you requested and the specific breakdown and it is more of an audit. The comparison you requested of the information on the Medicaid recipients there's no easy way to give you a breakdown of information on Medicaid recipients that is the result of an audit that fits under our disclosure statute. We can give that information to LDH which is what we have done so that they can take that information and use it in their review process.

Secretary Robinson stated that the goal of this Task Force is to ensure that LDH is using all the tools that are available to them. But giving this Task Force a breakdown to say this is the variance between a recipient's LDH application and their tax return even in those broad groups - that is not the type of statistical information the LDR is authorized to disclose under our disclosure provisions. Mr. Morris had previously provided some broad categories and then reviewing what he provided we should not have provided that. It is not a statistical publication. Our tax exemption budget, our annual report, we give you broad categories. We say these are the number of tax returns with income between this level and that level but it does not go into specifics to say this person reported this amount of income to one agency versus this is what they reported to us. We do not give audit results. We do not go into anyone's audit information and say this is what this business reported on their tax return, this is what we found is a result of an audit. In responding to the request, giving a breakdown of that level is not something that I could put into a chart and give to this Task Force. What I have given you is the ranges of AGI and how many recipients are in that AGI level. We have given the information to LDH so that they can use the information from the tax return data from 2017 to review those individuals and make determinations using the data they have, do their own research on those accounts and make their determinations. We are happy to answer any questions and continue to provide you data on Medicaid households as it relates to their income levels for 2018. This is what we know from a broad perspective across the state but specific data to do a comparison household size to what they reported to LDH, that kind of audit related information there is not an exception to our disclosure statute to really lay that out.

Chairman Purpera stated we gave you a sample of 893,527, you determined that 36% of those or 326,757 had tax returns for 2017. Those individuals enrolled in the program in 2017 you compared that against your tax data for 2017. Of the 326,757 that had tax returns, 85,378 had incomes that were greater than their Medicaid income by $20,000 or more. Secretary Robinson replied no, this does not break down household size, because Medicaid income level is dependent upon household size. This is strictly AGI.

Chairman Purpera stated you compared the recipient in the Medicaid application to the tax data for that recipient. So I do not know why I need to know about household size? Secretary Robinson responded because the income for that return is their AGI, it doesn't break down. Chairman Purpera questioned if this is not a variance or the income they made. Secretary Robinson responded this is the AGI reported on that income tax return. Chairman Purpera asked for clarity that the law gives you the authority to give us the breakdown of their income but you can't make a comparison to the data we gave you. Secretary Robinson responded I'm not giving you specific data comparisons for this person applied. This is what their income was on their LDH application. This is if you look at all of the persons who filed a return these are the broad categories that they fall in for AGI.

Chairman Purpera said being a little unhappy is an understatement. So from a legal perspective you're saying that you can give me the ranges of their real income but you can't give me a comparison of their income to another set of data and that's a legal decision. Secretary Robinson responded when you conduct an audit you go in and you look at someone's records. When I do an audit of a taxpayer's information, I look at their return to determine if they reported their income correctly - I make that determination. What you have asked me to report is whether their income is reported correctly, what the difference is between what they've reported to LDH and what they report to the LDR and to break that information out so you could make a determination. Statistically what I report in the annual report is income ranges for all taxpayers, these are how many filers are between zero and $10,000 AGI in a

statistical publication. Chairman Purpera stated the law gives you authority to report income ranges for individuals and we've taken the individuals who happen to be Medicaid recipients and we've reported their income ranges. Secretary Robinson stated right because you can't determine the specific income for any of the individuals in that range. Chairman Purpera asked you're saying the law doesn't allow you to actually make a match of the two and report that. Secretary Robinson responded right because I'm giving identifiable information in a comparison between two different data sets.

Chairman Purpera commented he guessed the only entity in the State of Louisiana that can actually make this comparison is LDH. He asked if LDR gave LDH ranges or provided specific information such as recipient #23 has an income that differs by a certain amount. Secretary Robinson responded I gave them the data that they use in their Medicaid Fraud Unit. Chairman Purpera asked if she gave LDH all Louisiana tax return information data dealing with Medicaid recipients. Secretary Robinson responded the information for the 326,757 that have tax returns. LDH has the information necessary for this comparison, they have a subset.

Senator Mills asked what LDH's next action steps will be with the data provided. Mr. Boutte responded we have been working with LDR to basically understand what we can do with this information and the information for a subset has been turned over to our recipient fraud unit for review. We looked at the highest wage earners and try to identify any individuals who might currently be on Medicaid and start working to understand if they should currently be enrolled. We did a sample of a hundred individuals and we ended up closing 73 of those cases - their eligibility will end this month. Then 19 remain eligible and 12 are pending because additional time was asked for by the recipient to provide additional information or it's already in an appeal status or we had to refer that out to the Social Security Administration to get some clarification. We have also send out requests for information to an additional 789 individuals in order to determine if they are currently eligible and the information is due back this week and working to determine if any of those cases should remain open.

Senator Mills referred to the sophistication of the software and the reporting requirements and the integration of data, asking if LDH sees any laws that need to be amended to give more authority to the agencies that are working so closely together. Secretary Robinson responded there was a change in the language in 2018 because it was tied to a tax filing unit within Medicaid that does not exist anymore. We now have a broader language in the statute. Senator Mills inquired if any need to allow more accessibility or more integration between the two departments. Secretary Robinson responded not at this point.

Chairman Purpera restated that out of the 326,757 that had tax returns LDH has removed 73 from the eligibility. Mr. Boutte said so far that is correct.

Representative Bacala asked Secretary Robinson when the income tax returns for 2018 are due. Secretary Robinson responded November 15th is the extension date for individuals and some will still come in after that because people fall late. Representative Bacala asked what percentage had been turned in as of February 26th for the 2018 year. Secretary Robinson answered as of last week we had over 200,000 plus returns - 10% roughly. Representative Bacala asked by May typically how many would you expect to have been received. Secretary Robinson responded generally by May we receive 60% to 70% of the returns. The returns after that are on extension, we have received payments for but people haven't gotten those returns done.

Representative Bacala questioned LDH on why they wait to use tax data until completely closed out the November late filing period. Once 60% are in May, why wouldn't we do a check in May then come back in November and catch the late filers? Why do we wait 12 months after the close of prior year before you tap into that data? Why not take the 10% or 20% that are filed now and check them? Ms. Steele answered we have not provided a timeline of when we are going to use the data. We've said we're going to bring the data in May but we haven't determined a schedule of whether it's going to be an initial batch or a follow-up batch. We haven't ruled it out.

Representative Bacala asked how LDH plans to use the tax data. What will the timeframes be with the tax data? Ms. Steele responded we're thinking about what our policies should be, how we're going to apply it, how we're going to use it in the system, what changes to the system need to make it automated to the extent that it can be automated. We have not decided those things. I would say, go back to the provided table as a frame of reference. This is the income that was reported and as it relates to the federal poverty guidelines, just for illustration for a single person household the limit is $16,753, for two people it's $22,700, for three people it's $28,600, for four people it's $34,600, for five people it's $40,600.

Representative Bacala said he did not disagree. But four years ago it was contemplated to use tax data because tax data was included in the original design features in the Deloitte contract. How was it originally contemplated to be of value or used? Ms. Steele responded I can't answer that question. It was postponed as a functionality because there were things that we thought were more important. We're bringing the data in this last phase but we have not fully developed those specs. Our focus is on consuming the data and then we'll figure out how to apply it.

Secretary Robinson stated the tax data that LDH will have is both state and federal tax data and its two different data sources. The federal returns come in more electronic format and the federal due date is April 15th, so that's going to be slightly earlier. The requirements to access federal data are slightly different and working through the necessary resources with OTS to have access to federal tax data takes a bit more time. So how the software communicates and how you have access is something that has to be built in. We spend a lot of time working through access to FTI ourselves to have it at the LDR and we have that functionality built into our system. It's something that LDH is working through right now. We're working through how to have our system communicate with their system to make providing the data to them easier with their new system. But having two different systems that weren't necessarily built to talk to each other is often times complicated. There are returns in as of May. We'll have that information available but the returns are still being processed. The electronic filed data returns make life easier. We are working to get that information to them as soon as possible so they can use 2018 tax return information to verify that.

Representative Bacala stated what we were talking about is wage data that may not be available such as interest income, self-employment income, military income, as well as marital status where there may be a listing on the income tax return to verify or dispute and show who else claims the dependence that I'm claiming. About 52% of the Medicaid applicants have a different number of dependents on their Medicaid application as compared to their income tax returns. With an unmarried couple the higher earner going to claim the dependent for income tax purposes and the lower earner is going to claim the dependent for Medicaid purposes. We should address that.

Secretary Robinson responded that is not always the simple answer. Sometimes there's a court order that dictates who claims the child for tax purposes. Representative Bacala said let them provide the court order. There should be parental responsibilities by both biological parents when we know who they are. We are here to address legal issues that maybe do not fit in today's world but if we leave a legal loophole where this is allowed, we should learn about it and address it. I know there's not one rule that applies to everybody. Every individual has unique circumstances. But we should contemplate it.

Chairman Purpera told Secretary Robinson that the requested data included $100,000 and more and you stopped at $50,000. He asked if that means none were found having $100,000 or more or if she did not want to disclose that information. Secretary Robinson responded when you get to those smaller categories after $50,000 you have so few tax payers in those categories. Chairman Purpera noted that Ms. Steele had pointed out that with the ranges here it could be possible that these individuals are eligible but it would be hard to see how somebody with an excess of $100,000 would be eligible. I noticed that is missing from the tables, so we cannot determine whether or not there were individuals with $100,000 or more. There were about 22 individuals from a couple of years ago that had $100,000 or more. Secretary Robinson responded when you get to more than $50,000 there were very few individuals but we can give you an update. Chairman Purpera stated we only asked for $50,000 to $100,000 and then $100,000 and more. Secretary Robinson asked Mr. Morris to provide an update with more than $100,000 in income.

Chairman Purpera stated I'm not the lawyer but I've been reading law for a long time. So, I'm probably going to ask for an AG opinion on exactly what LDR can provide this committee. Has your office written some type of a white paper or a legal analysis of your position that I could use to give to the AG to ask them if they agree with that? Secretary Robinson responded our office has not written a legal analysis or white paper on this issue beyond that statistical analysis does not include an audit but we're happy to submit a request to the AG. Chairman Purpera asked if she was saying the statistical analysis does not include an audit. He said he would ask for an AG opinion because we're splitting the hair here of “is this an analysis” or “is this an audit”. If it was analysis you could provide it but if it’s an audit you can’t.

Secretary Robinson explained that statistical publication is what the exception is. An audit of LDH data compared to tax return data. Chairman Purpera asked wouldn't it be statistical publication to provide the same exact thing we asked for. I don't see why that's not a statistical publication. Secretary Robinson responded the difference here is that statistical publication is to go through the tax return data and say here is the filing information on tax payers. The statistics we published is how many people claim that particular tax incentive, here's the sales tax information for a particular parish. It’s strictly stats. To go in and evaluate the eligibility based on income of a person that is receiving Medicaid based upon their application and say based upon what you submitted to LDH and based upon your income tax information, here's where the difference between what you submitted to your income tax return information. That is not statistics. Chairman Purpera stated I’ll ask the AG’s office about that to see if they agree.

Chairman Purpera commented that LDR provided information a year and a half ago and now you said maybe you shouldn't have. Has the state been sued as a result of it? Has any tax payers said I did not

want you to provide that statistical information? We did not identify a particular taxpayer.

Secretary Robinson responded the state has not been sued. We didn't identify a particular taxpayer but we've had several legislative sessions in which the issue of taxpayer information, the provision of that information through this process of auditing Medicaid recipients, and ongoing discussions on the issue. The AG opinion exists about whether tax return information could be utilized by the Legislative Auditor's office in anything other than auditing the LDR. All of the exceptions that are in place under 1508 for when tax return information can be utilized. We are looking at the questions that were asked, the analysis that was asked to be provided, getting to a comfort level that I am not violating a statute because there are criminal prosecutions if you violate the statute and looking again at the statutory provisions creating the Task Force. Yes, we are working with this Task Force. We're doing the analysis that you asked for. The information that you requested has been provided to LDH so they can use it in their work because I think this Task Force wanted to make sure that tax return information was utilized by LDH in their review of Medicaid applications. But a report to that level was not something that I felt fit under 1508(B)2. I know you said you're not a lawyer but I am.

Chairman Purpera stated you're trying to make the data available in some fashion so that LDH will be able to use it because we are expecting LDH in May to be using tax data. Will it happen in May? Secretary Robinson responded I think that's going to happen in May but they're going to have two different data sets, federal tax information from the IRS as well as state tax data.

Chairman Purpera thanked Secretary Robinson for coming to the meeting and sorry he could not hide his frustration. Secretary Robinson stated I came because I knew Mr. Morris should not have to take the heat for my decision.

Chairman Purpera asked if the AG opines that yes, you can provide that data would that be sufficient enough for you to provide the data. Secretary Robinson responded I can't say if I would agree with the AG or not. I don't think you agree with the opinion that I couldn't provide the data to you. We may agree to disagree. Chairman Purpera stated that he abided by the AG opinion.

OTHER BUSINESS

No other business was discussed.

PUBLIC COMMENT

No public comments were offered.

ADJOURNMENT

Senator Mills moved to adjourn and with no objection, the meeting adjourned at 12:06 pm.

The video recording of this meeting is available in the House of Representatives' Broadcast Archives:
http://senate.la.gov/video/videoarchive.asp?v=senate/2019/02/022619MedicaidFraud_0