MINUTES OF MEETING

Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives

Act 420 of the 2017 Regular Session

Tuesday, November 28, 2017
9:00 AM - House Committee Room 4
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 9:15 a.m. Ms. Tanya Phillips, Administrative 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(Tina Vanichchagorn, Deputy Executive Counsel served as proxy for the first 30 minutes of the meeting.)
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, Appointed by Governor Edwards

APPROVAL OF MINUTES

Representative Bacala made a motion to approve the minutes for the October 25, 2017, meeting. The motion was seconded by Ms. Steele and with no objection, the motion was approved.

LOUISIANA DEPARTMENT OF HEALTH'S RESPONSES

a) Task Force Letter Dated October 25, 2017
b) Task Force Letter Dated November 8, 2017

Ms. Steele began the meeting by discussing LDH's responses to the questions in the October 25 letter which was provided to the members. Ms. Steele stated that the LDH Medicaid Managed Care Finance staff is responsible for oversight of the medical loss ratio audits. LDH revised their financial reporting

requirements to require Managed Care Organizations (MCOs) to identify spread pricing. Previously MCO's had to identify the aggregate cost of their subcontractors but not distinguish that for Pharmacy Benefit Management (PBM) systems. Representative Bacala asked when that change was made. Ms. Steele would get the answer.

Ms. Steele continued answering the question if LDH's contracts prohibited spread pricing or otherwise directed the MCOs in terms of how they are supposed to pay for pharmacy benefit management services. LDH chose not to dictate how they pay for those PBM services. The Task Force's letter questioned if spread pricing was a good or bad thing. From LDH's perspective spread pricing is a standard way the industry pays for the service. However LDH put in place protections to ensure that the spread pricing is counted as an administrative expense and those expenses are capped.

LDH uses the Medicaid Loss Ratio (MLR) audits as a way to protect against excessive administrative expenses. LDH specifies in their instructions - consistent with federal regulations - how plans have to classify expenses whether they are clinical expenses or administrative expense. Our auditors adjusted expenses as reported by the plans to make sure the classifications were appropriate. On that basis, the adjusted MLR was the basis for determining whether or not the plans owed LDH under the provisions of the contract any sort of a rebate. If the medical portion of the expense is less than 85% then they owe LDH the difference in whatever the 85% would be and what they actually spent. In 2015 none of the plans failed to meet that threshold.

The MLR is intended to ensure that the MCOs spend a minimum amount on clinical services and keep in mind that the 15% is not what was billed into the per member per month (PMPM) rate for administrative expenses. LDH only includes about 9% and builds in 2% for profit. There is a 2% profit margin that is built in if they are on target, meaning they spend the way the rate is built then they can achieve that profit margin but if they don't then quite frankly their administrative expenses are eating into what otherwise would be their profit.

Mr. Purpera asked if the MCOs' MLR is for example 92, then 92% of the dollars paid to the MCOs is being spent on claims for actual health care and not administrative or profit. Ms. Steele responded yes, for medical and clinical expenses.

Representative Bacala stated that spread pricing is a commonly utilized practice whereby the PBM charges the MCO an amount greater than that paid to the pharmacists as a direct provider reimbursement. He asked if the MCO is overbilling the state by retaining the difference.

Ms. Steele explained that the PBM provides a service so they have to get paid for the service in addition to the cost of the drug. So the spread pricing is not the only way but it's the predominant way in our model because they also retain a portion of rebates - supplemental rebates and again they also may have some sort transaction fee or administrative fee but it's the sum of those – the revenue from those mechanisms that covers the costs of the pharmacists who develop their single -- their preferred drug lists. The pharmacists who handle prior authorizations, the folks who develop the clinical criteria for prior authorizations, the folks who maintain the claims payment system and all the edits that ensure clinical safety – so it's not for nothing. The administrative costs are really for the service of managing the

pharmacy benefits so I think that's important to note that there is not no cost to the plan other than dispensing the of the drug – I mean to the PBM.

Representative Bacala asked if the cost is over and above the PMPM. The retention PMPM is the amount the state pays for the MCOs to do everything.

Ms. Steele explained within that amount the MCOs decide how they are going to pay for pharmacy services and within that $300 - $500 PMPM, depending on who the person is, they know how much they expect to spend on the clinical costs of pharmacy and then they figure out what they need to spend to get that pharmacy benefit administered. In no case are these plans doing it themselves – all of them contract with a PBM either as part of their own company or as an independent company.

Mr. Jeff Reynolds, LDH Undersecretary, further explained that the misconception out there is that if the spread pricing was not occurring then the pharmacist would somehow get paid more and that's not correct. Because the pharmacists get their average acquisition cost plus the dispensing fee per the state plan. That's the rate floor so whether this is in place or not would not put one more penny into the pharmacist's pocket. The misconception is that if spread pricing would go away then the state would all of a sudden be paying the pharmacist more money and that's not the case.

Ms. Steele said that LDH notified MCOs in their individual MLR audits where we adjusted those costs out away from medical and back into administrative. Mr. Purpera asked if additional reports have been issued by Myers and Stauffer (M&S) and if the practice of spread pricing would continue. Ms. Steele responded that the 2016 audits are being finalized and the reporting requirements are clear but that's the purpose of an independent audit to ensure proper classifications. Ms. Steele explained that MCOs were adhering to federal regulations and the MCOs said that the instructions were not specific on spread pricing, but now they are.

Ms. Steele said that M&S not only performs annual MLR audits but they also do LDH's bi-monthly audits of encounter data so they know our data very well. M&S basically compares the MCOs' check register to the claims they submit to LDH to ensure LDH has all the claims so M&S has a deep knowledge of MCO encounter data. Paired with the MLR audits, it kind of rounds out the picture around the completion of that data and the accuracy of the reporting. LDH has been doing that since 2013 - right after the program was established and stabilized.

Ms. Steele continued to Question #2 stating that it communicates a foundational misunderstanding of how managed care works. The questions are once there was adjustments to the MLR did LDH go back and recalculate the rates and recoup funds. She explained that in a full risk capitation model, rates are set perspectively based on historical information, and when the plan accepts that capitation rate they accept the risk of costs that either exceed their revenues or within their revenues. If it is within their revenues then they have the ability to break even or make a profit. If it exceeds then they are at-risk for that. In a full risk model you don't go back and adjust for what actually happened. You always look at the historical data when setting rates perspectively but there is no such recoupment or reconciliation that is sort of inherently contrary to what the full risk capitation model is about. However, going back to the

MLR piece we do look to make sure that the plans – let's say for example that the rates for some reason were set too high and all of the plans underspent they came in at 75% MLR. That is the place where we look to recalibrate and look back and see where they are spending that target and if it didn't we would look to adjust there and take money back. So again I just want to make sure people are clear that we don't look back and take money.

Representative Bacala asked what the loss ratio has been for the last few years. Ms. Steele answered that typically the MLR audits run low 90's. LDH watches the unaudited MLR every quarter and again early in the program. It took Aetna a while to get to critical mass so for a while their fixed costs exceeded their membership revenues so they were running literally in the high 90's. We've had one plan that's been kind of border line maybe around 87 but they pop up and down depending on what the membership mix is and what's been going on for that rate period. So for example, when LDH went to the rate floor without much advance notice and people weren't quite ready, it took them a while to adjust their spending down. So during that period you would see MLRs that were higher than you would have expected had they had sufficient lead time to plan for that level of expenditure. Generally speaking MLRs run in the high 80s to low 90s which again is the target but there was a period early on that was running much higher but that was mostly startup costs.

Representative Bacala asked if 85% is the rate range, but Ms. Steele said that 85% has nothing to do with the rate range.

Mr. Purpera said that he read in the newspaper that one of the MCO's MLR had gone from 82 to 84% in their commercial business. He asked how an MCO can achieve 92% for state Medicaid. Ms. Steele answered that she could not speak to the commercial side but LDH build the rates to and MLR of 88% which is their target. If the MCO is even a point or so higher they are alright but if they start running in the low 90s or mid 90s then LDH gets concerned.

Mr. Purpera asked if the 88% includes all medical expenses and not profit or administrative expenses. Ms. Steele agreed. She made one clarification that Healthcare Quality Improvement (HQI) is counted as medical expenses and not administrative. Mr. Reynolds explained that LDH is paying the minimum allowed by the federal government in the rate range so that puts more pressure on the MCOs and that's probably why they are in the low 90s in a lot of cases because we are paying the minimum amount for administrative expenses to make the program work. If the MCOs were testifying they would probably explain that LDH is paying at 0% of the range, not the higher range, and therefore it is pushing them up into the low 90s.

Mr. Block took his seat at the dais and Ms. Vanichchagorn stepped down.

Ms. Steele provided the MLRs for calendar year 2015; Aetna was at 97.1% because in the beginning they had very low membership so their revenues didn't cover their fixed costs so that was to be expected; AmeriGroup was 91.3%; ACLA 89.9%, LHC 86.8% and UHC 87.2%. Everybody is within a point or two of where we expected them to be except for Aetna which again we knew with their membership volume it

was going to take them time to get to critical mass to get to MLRs that we anticipated. The other question having to do with when the changes were made to the spread pricing was clarified in the 2017 reporting.

Question 3 asked if LDH agrees that spread pricing adversely impacts pharmacists and that the money could be going to direct patient care instead of being diverted to administrative costs. LDH disagrees with that because spread pricing is not to blame for a pharmacist being paid less than what they spent on a drug. The fee-for-service pricing methodology is average acquisition cost plus a dispensing fee so with the law of average sometimes you are going to get paid above your cost, sometimes you are going to get paid below, but the idea is that in the aggregate you come out okay.

Ms. Steele said if a pharmacist is never wants to be paid below cost and move to cost based reimbursement so it's never above and never below that's a change in our pharmacy pricing methodology. Spread pricing has nothing to do with that but to the point that somehow money is being diverted that could be used to be pay for an increase to pay pharmacist again there is a cost associated with the service of providing a pharmacy benefit management. She sent out a query through the National Association of Medicaid Directors when this question came up. She was uniformly told that nobody does that and that if you do that they will drive the value of whatever that administrative cost is into a different mechanism. So if you say it is okay to have a PMPM for the PBM service then whatever that $64 million or whatever is identified, it gets converted to an acceptable means of reimbursement and so again it's unclear that after you pay for the PBM service whether it's through a PMPM fee, whether it's through spread pricing or whether it's through some other mechanism, it's unclear that we would have money left over to redirect to pharmacy rates. Again you are talking about a change in our reimbursement methodology for the actual drugs dispensed to change how pharmacists get paid.

Ms. Steele continued that the next few questions were just trying to clarify the numbers we reported. We reported $75M in pharmacy expenditures for August 2017 – the question was how much of that was retained by the PBM. None. That was purely pharmacy provider payments. Similarly, the next question asked how much was paid total to pharmacy providers versus PBMs. $800M was paid to pharmacy providers and $67M was paid to PBMs again that represents about a 7% administrative cost which is under what our overall average is for the plans in terms of overall expenditure expectations – the overall is closer to 9%.

Question 6: The Medicaid Managed Care Finance staff is responsible for the identification of rebates. Did we provide clear direction to the MCOs on how to report those? Yes. Our instructions require them to report all of the rebates they receive regardless of what the relationship of the PBM is to the MCO. The question is how do we monitor that? Again those are independently audited to verify that the rebate amounts reported are consistent with standard accounting requirements - the AUP in our financial reporting requirements. And again do we treat PBM's differently whether they are MCO owned or contracted? No. For our financial reporting purposes it doesn't matter.

The next question is who monitors Health Care Quality Improvement (HCQI) and Health Information Technology (HIT) and that is her finance staff. LDH answered relative what HQI is relative to the MCO

contract extension and we provided the exact language from the Federal Regulations. Basically federal regulations require us to count HCQI and HIT as a medical expense in the MLR calculation so again that's how we define our reporting requirements and we do that consistent with federal regulations. There were a couple of specific examples where it was they requested clarity about how it was classified. But before going through those what I would like to do is quickly run down the list of how the feds define a HCQI expense so broadly they define it as activities designed to improve health qualities so examples would be the basic idea is if you spend on this you are going to reduce – you are impacting clinical outcomes and you are going to reduce clinical costs. Again it has to be grounded in evidence medicine, best practices recognized by accrediting bodies, etc. It needs to increase the likelihood of desired outcomes in the specified populations it has to be able to be verified. Concrete examples effective case management care coordination, chronic disease management, Medication compliance initiatives all of the quality reporting and documentation, the HIT to report this so electronic medical records – preventing hospital readmission through a comprehensive program for hospital discharge, comprehensive discharge planning ranging from managing transitions from one setting to another, Patient centered education and counseling, personalized post-discharge reinforcement counseling by a health care professional. HIT to reduce medical – lower infections and mortality rates – it goes on – perspective prescription drug utilization review aimed at identifying potential drug interactions, health and wellness promotion activities, coaching programs designed to achieve specific and measurable improvement. So for example, obesity treatment or prevention, management of diabetes those types of things - these are all – when the auditors look at the expenses they are looking for those kinds of things and making sure they qualify and that things are adjusted out. Expenses that are prohibited include things for example: anything with fraud prevention should not be included here; things that are strictly to control or contain costs are not included; more of your less clinically minded utilization management activities. Maintaining a claims payment system – they can't count that – they can't count hotlines for providers that have to do with claims payment, they can't -- concurrent review where they have to authorize hospital stays that doesn't count so again there are four pages of federal regulations that say exactly how you define these HQIT and so from our perspective and from the perspective of the feds they are not spending this money – these are really not true administrative expenses. This is really extensions of the clinical practice.

Mr. Purpera asked if this state has any leeway in those classifications because of federal regulations. Ms. Steele responded that LDH has allowed the reporting of those expenses consistent with federal regulations and cannot reclassify those expenses to force them to be administrative expenses.

Representative Bacala said asked if LDH pays the MCOs for both expense and administrative expenses and as it pertains to prescription drugs it looks like FY 2017 we show $803M plus $67M that we pay to the administrative costs. Assuming that sometimes it's 95% or 90% but just using the 85% , so if we pay them to the point that they have a loss ratio of 85% then 15% is administrative and profit? Ms. Steele responded yes, profit.

Representative Bacala asked if MCOs are also paying $67M in administrative cost to the PBMs then are we double paying administrative cost since LDH is paying 15% on top of that. Ms. Steele explained that the 15% is not on top. For example if the PMPM is $500 a month for Representative Bacala – whatever it

cost to serve you is included in that. So whatever the cost of dispensing the drug is, whatever the ingredient cost of the drug is, whatever the cost of the PBM running its enterprise to get that drug dispensed and paid is included. So that entire amount has to be used and not just for the pharmacy cost but for all of the cost for doing business for enrolling and credentialing providers, for maintaining the networks, for their fraud activities, for their member services, etc. Pharmacy is embedded in that expense.

Representative Bacala said that it almost seems like we are double paying the administrative cost when you are paying the MCO and administrative cost and they are turning around and billing the state as an actual expense for something they are paying to the PBM as an administrative cost. Ms. Steele said that the MCO is not doing that. Representative Bacala asked if administrative cost paid to the PBM is an expense to the MCO. Ms. Steele explained that it is included. There is a total amount paid to the MCO and within that they choose how to spend that including contracting for that PBM so it's included.

Representative Bacala asked how many PBMs are used by the five MCOs, and Ms. Steele said they each have one but two plans use the same PBM – four PBMs service five MCOs. Representative Bacala asked how long the MCOs have been involved in pharmacy benefits. Ms. Steele answered that contracts started with MCOs in February 2012, and pharmacy was carved in later that year when MCOs started with PBMs in November 2012.

Representative Bacala said it has been suggested outside of meetings that if the State would contract with a PBM for all pharmacy benefits there would be no middle man. The state and the PBM would contract together outside of the MCO contracts. The potential savings could be $40M or $50M if we did it that way and LDH put out an Request for Proposal (RFP) for a PBM statewide for all Medicaid patients.

Ms. Steele said that some PBMs have been talking to LDH, but nobody can really tell you the cost of the job is until we put the RFP out. Some of the folks that LDH has been working with are new to the Medicaid space and so they must understand the requirements and not price from a commercial perspective. There are a lot of requirements that apply to the Medicaid world that do not apply to commercial and so companies coming from that background may need a little more orientation to not give any false conclusions.

Representative Bacala said that it was suggested that $40M would be the bottom level of savings potential with a single PBM contract. Apparently some other states have gone in this direction and saved significant dollars.

Ms. Steele explained that there are three basic models. One model is you allow inside the MCOs and they manage it. The other model is the state directly manages it either through a carve-out or through control of the single PDL itself. All three of those things have been under consideration by LDH. For the carve-out quite frankly there are a couple of considerations: one is what is the net cost in the end even after you consider what you spend for the MCOs to do it, even after you consider what you spend for the PBMs to do it - what is that aggregate cost and it's not an easy thing to figure out. As Senator Mills knows we have spent quite a while looking at those three options including the single PDL wholesale, including single PDL by selected therapeutic classes as well as this idea of a carve-out. There are a lot of considerations

including the carve-out, you would lose the premium tax revenues on almost a billion dollars which is significant. We have to do the match to figure out would the total cost of the service be less than the premium tax revenues are worth to us. As I've discussed with Senator Mills we actually did a notice of intent a few months ago

Representative Bacala asked what experience have other states had as far as the monetary value of moving in the direction of single formulary, single PBM. He's heard from pharmacists that they get confused having to deal with a whole bunch of different plans - this one pays this and this one pays that - this one covers this and this one covers that. So at least from the neighborhood pharmacy side, it's a little minefield for them to maneuver through.

Ms. Steele said at last count there are about seven states either doing single PDLs and then there are a handful of states that have done carve-outs. Tennessee most famously, but it really depends on what you started with. For example, Ohio carved-out but in talking to their Medicaid Director they carved it out because they knew there was excess cost built in. Ohio carved it out for the purpose of getting the cost down and then they carved it right back in, so it was really about trying to reset what the reimbursement was to the plans.

Some of the debate when LDH did a notice of intent around the single PDL was that the state is seeking to maximize just the rebate revenues and not paying to generic dispense rates and we really have to pay attention to both so we pulled back. After discussing with Ohio's Medicaid Director, found that they have taken a new approach which is more of a hybrid not a traditional fee for service just go after rebates which some do not like that because it is heavily brand dependent and one of the adverse impacts is on the pharmacies because they have higher inventory costs. Ohio is actually pursuing the best of both worlds by doing the single PDL and they are doing the rebates where it makes sense but they are also seeking to maximize that generic dispense rate. So the MCOs typically go for that GDR and the fee-for-service world typically goes for the rebates because we get such a good advantage on that.

But the short answer to your question is it depends on where you are starting from and where you are going to. Some states that have gone carve out have carved back in and some states that have gone single PDL have gone back and vice versa. But again there is a lot of learning going on and we are fortunate to be engaging in a new contract with the folks who have done all of the carve out states and all of the single PDL states so that we can really understand what would the strategy have to be for us to make this work financially because the biggest issue now is regardless of your preference we have a baseline. LDH's concern in the current budget situation is to not make things worse. The goal is to simplify things for pharmacist and prescribers and members but LDH has to be careful about how we do that but are committed to finding a way that is responsible from a budget perspective.

Ms. Steele continued explaining that LDH has the authority to do the rule making for a single PDL. As LDH testified at JLCB regarding the MCO contract extensions, these are all programmatic changes that can be made at any time through their normal process. She hopes by spring to have a single PDL model for consideration. The challenge for LDH with a single PBM is that this is a part of the overall MMIS modernization strategy. So in consideration of where LDH is in that as well as the timeline of re-

procurring MCO contracts, her preference is to move forward with a wholesale PDL if they can make the money work and then we could look forward to a single PBM. But all would be subsequent to the next MCO reprocurement again. Everything cannot go live at once because a real risk. The Medicaid systems modernization is total resource management. LDH and OTS have invested in this enterprise architecture where the eligibility enrollment piece will go live first in the summer and late next year their provider management will be the first MMIS piece to go live.

LDH is actively developing their strategy and next is the PBM which is in the data warehouse, then is the program integrity module. LDH has to figure out what's the next best step and again having to align that with other things trying to accomplish. Going live with a new MCO contract concurrent with trying to move to a new PBM would be a pretty high risk thing to do. LDH has to balance major changes but their hope is to go from the current five PDLs to one PDL, and maybe down the road one PBM.

Mr. Purpera asked for more explanation of how Tennessee and Ohio work as single PDLs. Ms. Steele responded that Tennessee is a carve out but Ohio currently has PBs separately managed by each MCO but starting next year Ohio will have a single PDL. Which means each MCO will still have the pharmacy benefit and can have their own PBMs, but they have to have the same PDL and same clinical criteria so it is nearly invisible to the end user except they are sending it to All Scripts except Express Scripts, for example.

Mr. Purpera asked if Tennessee has had the MCO model for about 17 years and if LDH has worked closely with them. Ms. Steele shared that LDH spent two days with TN just to look at how they did their oversight and compliance monitoring etc.

Senator Mills thanked Ms. Steele for all her and LDH's hard work and the conference calls, and the information provided by LDH. In 2015 between fee-for-service and MCOs, about 11M prescriptions were filled. He asked if the total spread pricing administrative charge was around $67M. Ms. Steele did not have that information, but LDH reported $803M spent on pharmacy claims.

Senator Mills explained his question that if spread pricing in 2015 was $70M and we filled 11M prescriptions in fee-for-service, so estimating $7 per prescription administrative cost on spread pricing. What did the plans retain on the supplemental rebates and then what fees were paid through transmission costs? He believes it makes sense to break down what spread pricing per prescription was, not the total dollar amount per transaction. His question is if Louisiana is getting the best deal of the 49 states considering their volume. Pharmacy cannot really be controlled on the expenditure side because ingredient cost is hard to manage so only the administrative cost can be managed. This committee's job is to make recommendations for further study administratively or as a legislative body. Senator Mill's first recommendation would be is to do a complete drill down on the administrative cost - segregating the fees, the transmission cost, the spread pricing cost and also the rebates. As the Task Force has been told that spread pricing is the norm throughout the United States, then what is the rationale for it and what does it break down. His second recommendation would be to have a single PBM versus five from an administrative cost standpoint.

Senator Mills said about two years ago a fiscal study about doing a single PDL was done that showed Louisiana would spend more money because the five MCOs with their PBMs would not be able to drive the rebates as hard as they could because of that aspect. So it sounds good but we must make sure we are saving that amount of money. He asked why couldn't all the rebates be returned to the state, or if a contractual issue.

Ms. Steele responded that the state could keep the rebates but further explained about a markup. The MCOs receive basically 9% administrative load which is their cost of doing business. So using the previously quoted numbers of $803M pharmacy provider payments and $67M in spread pricing comes to about 7%. Again if the PBMs have determined in the market that 7% is their cost of doing business on top of paying for the drugs, etc., whether or not we call it spread pricing or call it a transaction fee or call it their share of rebates because it is the sum of those things that get them to that 7%. It is undetermined whether or not we could get it for less. When we put something out for people to bid on then we can get a definitive answer whether or not it is more or less but anything short of that is really just a guess.

Senator Mills asked if LDH ever sent out a competitive RFP looking for transmission costs only and everything else will be retained by the State of Louisiana. There are PBMs that just do transaction business for a fee and nothing else is retained by the PBMs. Ms. Steele said that the MCO contract extensions are moving forward but in order to do the reprocurement, LDH is working on finishing that content by next summer. They are getting input from anybody interested on how that design looks going forward but if we only want the MCOs to provide pharmacy services but only pay a transaction fee then we can certainly do that.

However keep in mind we are bidding for the MCO business and the MCO's then have to subcontract with the PBMs so the competitive pricing thing will be figured out by them so they may put out an RFP subsequent to our business with them to figure out who is the most competitive on transaction fees. But until we put out an RFP for our own PBM services, if we were to do that, we won't know the outcome of that except to know that they chose Express Scripts

Senator Mills asked Ms. Steele what she would do to get the most efficiency. He believes from a business standpoint putting one PBM out on bid for only transmission charges would save the state money. Ms. Steele explained that she has talked to other states but no state is the same so there is really no side-by-side cost comparison. Many states shared their experiences of going from one model to another and the financial results, but not all are exactly the same.

Senator Mills asked if they look at how much they are losing on rebates and what we are getting charged on spread pricing and what is the transmission fees and any other charges and then divide that by 11 million prescriptions you should have an administrative oversight per prescription. Ms. Steele agreed.

Senator Mills said it seems like LDH could compare what it would cost for just the fee. The industry charges per fee in the private sector should equate to what's going on in the government sector. Ms. Steele said she would love to have access to that information. Senator Mills responded that he would provide it to her but believes that analysis would be helpful for this committee to see.

Ms. Steele said LDH can definitely figure out what our transaction cost is but would be interested in those comparisons. Senator Mills asked what is the transaction fee the PBM's charge. Ms. Steele responded that she would have to get that information and come back with it.

Representative Bacala asked in the model of the MCO and PBM both involved, would the MCO make 15% because of two administrative fees for using both in the process of filling a prescription drug

Ms. Steele answered no, explaining that the transaction fees of the PBM are included in the 15% it's not a direct lay on because it's a subcontract right so again but for financial reporting purposes as we've shown here the pharmacy spread pricing is counted as an administrative expense of the plan even though it's a payment by the MCO to the PBM and all of that stuff it's still – from the perspective of what we pay the MCOs it is part of their administrative expense.

Mr. Reynolds further explained that whether that fee is zero or $500M what we pay the MCOs does not change one penny. I want to make sure everybody understands because we calculate the PMPMs, our actuaries calculate that and they build in the administrative costs. So whether the MCOs pay the PBMs zero or $500M it's not going to change what we are paying in our PMPMs.

Representative Bacala agreed but asked if the PMPM costs are raised in the calculations due to the administrative costs paid by the MCOs to the PBMs. Similar to shoplifting costs are built into the convenience store model and pricing.

Mr. Reynolds said as long as it is in within the ranges that Ms. Steele has been talking about he's not sure that it would affect the figure PMPMs but would have to defer to the actuaries. Representative Bacala said the effect may even be indirect, and asked what the average PMPM today is. Ms. Steele responded that it is a little over $500 for expansion and a little under $300 for non-expansion population PMPM. Mr. Reynolds added that non-expansion is mostly kids and most are health.

Senator Mills asked if problematic for the state to save money on spread pricing and different things and get pharmacy services delivered at an administrative savings.

Mr. Reynold answered absolutely not and that's the goal of the department and obviously the goal of this committee and certainly we want to do that and come up with recommendations the piece I've struggled with as Jen has testified – all of the states are all over the place on this there is no consistency. I'm coming up on 28 years with the Department and the pharmacy program has always been a struggle for me simply because of the way we reimburse them. We reimburse the pharmacist average acquisition cost and the pharmaceutical companies can charge whatever they want and drive that up and the state has no ability to control that and you mentioned that earlier. So it is a case where it's a thing where the feds have our hands tied so much we are just scratching at the surface and until D.C. decides to fix the pharmacy program you know how we fix this is very much up for debate or what we can control or not control and that's the piece I struggle with because there is no consensus about how to go forward absolutely you know this stuff much better than I do and we are working with you and we want to be the most efficient that we can and you have my commitment to do that and we will have to see where we want to go and what we want to do. Jen and her staff have a plan on where we want to go but of course with your input and your committee's input we will see how we want to change the program but I don't know there's a

magic answer out there and I think looking at the other state's tells you there is not a magic answer out there

Senator Mills agreed and said maybe we have done a real deep dive on what's the true administrative cost per prescription and as we analyze that it seems like we don't have to call any other sates if to administer a prescription is say $10 and we can whittle it down to $5 and we are filling 11 million prescriptions it seems like we don't have to call anybody. Mr. Reynolds said he agreed and that LDH simply needs to run the numbers, run the scenarios and see what makes sense.

Representative Bacala asked if LDH could do a comparison of the cost for a prescription drug in Louisiana and compare to the cost in Ohio and Tennessee. Mr. Reynolds responded that only the gross accounts are available but individual rebates are top secret per federal regulations. The detailed rebate information is not public record because pharmaceutical companies have built that into the program. Unfortunately the amount in rebates each of those states is getting is not available. Ms. Steele added that each state has their own pricing methodology for the ingredient cost as well as the dispensing fee so those are all variables that impact the net cost.

Mr. Purpera asked for LDH's perspective on pharmacy issues and what the Task Force should be recommending and focusing on. Ms. Steele responded that LDH's priorities are to try to simplify for the prescribers and the pharmacists in a way that saves money or not cost any more. Their current approach is to model a single PDL after Ohio's model. Ohio is the first state that really does the hybrid of the traditional fee-for-service rebate seeking mostly brand approach and the traditional MCO generic dispense rate approach and to try to maximize the optimal blend of those things, but not pursuing one to the exclusion of the other. She is not averse to the idea of a single PBM that the state actually contracts for and runs. However given where LDH is with OTS and its maturation around the enterprise architecture and the deployment of the MMIS modules, particularly where that would likely land concurrent with the MCO reprocurement, Ms. Steele does not believe LDH or OTS can take on more. The MMIS stuff is big and our business runs on systems, so we have to be very deliberate about the way we replace those systems so while we may want to make a programmatic change, the timing of that is important.

Mr. Purpera asked Ms. Steele to email all her recommendations to him for the Task Force report, and Ms. Steele agreed.

Senator Mills asked about HCQ/HIT issue and asked if a Medicaid recipient receives a $50 gift card to go see their doctor, does that count in the 85% expense portion. Ms. Steele responded that it could be but LDH has not allowed it. Ms. Steele gave the list of approved HCQ/HIT expenses: case management care coordination; counseling somebody on how to manage their diet with diabetes; true patient engagement type activities; electronic medical records; things that build in safeguards prevent infections; hospital readmission type items. It's a hybrid of preventing avoidable utilization but also we don't want somebody to be readmitted because there is a cost. It includes discharge planning and that kind of services. It is not prior authorization functions, and not things associated with clinical activities but truly administrative and very clinically directed.

Senator Mills asked if the gift cards goes into the 15% administrative piece to MCOs. Ms. Steele explained that it is up to LDH. For example there is a community paramedicine pilot we are looking at in the New Orleans area with the purpose to take off-duty EMT's and deploy them when somebody calls EMS and have them basically triage the emergency situation. That off-duty EMT can provide CPR or other life-saving acts as well as determine if not an emergency situation, and using an Ipad get screening by a doctor or send to a hospital. LDH believes this should be counted as a medical expense even though the plans are going to provide it as a value added benefit.

Senator Mills saw an advertisement for diabetics ages 18-75 who can earn $50 gift cards each year by just completing these tests to stay healthy. He asked which pot that $50 would go -either the 15% or 85%. Ms. Steele explained that LDH does not pay the MCOs for that $50 gift card because when the plans bid for this work they included a value added benefit to spend - for example, an aggregate of $3.81 per member per month on value added services. This may include eyeglasses, dental screenings and fillings up to $500 a year because the state does not provide these, but the MCOs quite frankly do it to attract the members. It's the MCOs' expense and at our discretion we can count it but it is not included in the per-member per month capitation rate. To date we have not counted any of this and we do not pay them for it but again we are selectively considering. For example that community paramedicine pilot really is a medical service; likewise, the eye exams, eye glasses, and dental would be considered.

Senator Mills said he gets calls from the general public complaining that they wish somebody would give them a $50 gift card to have their eyes tested. Ms. Steele told him to tell his constituents that LDH is not paying for that.

Representative Bacala asked if those value added expenses were being calculated into the PMPM. Ms. Steele responded that value add-ons are at the MCOs' expense.

Representative Bacala asked if there could be savings with a single preferred list – potentially a single PBM like the Tennessee or Ohio model. This committee is about finding financial efficiencies. Ms. Steele said she does not have a number but it depends on where you are starting from and where you are going.

Representative Bacala asked if responses to an RFP would show if potential savings. Ms. Steele said only pure administrative cost if a fixed cost could be mailed down, but the drug ingredient cost, and dispensing fees are dictated by your own state reimbursement methodologies

Mr. Reynolds suggested that the Task Force recommend that LDH does a study on single PBMs and single PDLs to determine what savings could be realized. But LDH needs to look at several scenarios and run the numbers with consideration of the MCO tax and all the other stuff, so they can see what makes sense before making any recommendations.

Representative Bacala asked if a single PBM was selected but still ran through the MCOs would they not lose the MCO tax. Mr. Reynolds answered that they would not lose the MCO tax on that model. Representative Bacala asked if LDH would gain the benefit or three-fourths of the benefit that may exist,

and Mr. Reynolds agreed.

Ms. Steele began discussing LDH's responses to the November 8, 2017, Task Force letter. She said that the first question is regarding the non-emergency use of the hospital emergency department (ED). LDH does not count all of the MCO expenses when they bill the rate. LDH's auditors M&S clean the encounter data submitted and excludes any inappropriate expenses which are the second layer of review. First Molina edits out things out in the encounter data. Then M&S makes sure the encounter data is complete and some things are filtered out. Then the third level of actuaries filters out some costs too. The actuaries do an analysis for each rate setting cycle. They run an algorithm that identifies those ED visits that were considered basically non-emergent. In 2016 it was determined that 16% of emergency visits met this same criteria so that is roughly 130,000 of roughly 790,000. The question of savings if those were repriced at an urgent care clinic rate would be calculated by looking at an average cost of roughly $168 dollars for ED versus a non-emergency doctor's office visit of roughly $51. She calculated the total saving at approximately $15.2 million. That is interesting but it's really just math and not part of the way we run the program. So for these types of ED visits identified, LDH's actuaries would say that the MCO plans could have done a better job and diverted at least 25% of those, so LDH will deduct from their rates $5.4 million dollars.

Representative Bacala said that from his discussions with MCO's, they felt like 58% of emergency room visits were for non-emergencies but it depends on what code you look at. Ms. Steele agreed.

Representative Bacala said that often the doctor's code is non-emergent but the hospital's staff has changed from a non-emergent code to an emergent code. But the MCOs trust the doctor's analysis more that the administrative/clerical staff, so going by doctor's code they see 58% of the emergency room visits as being non-emergency.

Ms. Steele explained that this is a really controversial area. For example a person goes to ED for chest pain and then the doctor says it is reflux, so the question is whether to look at the symptoms or the admin discharge diagnosis to determine whether it was non-emergent. A strategy used by Tennessee and other states to reduce ED visits is something called a triage fee which is a flat rate.

The debate is how to determine whether it was really an emergency and the Lane analysis has an algorithm that looks at the diagnosis codes to make that determination. But the hospitals say they have to look at the patients no matter. LDH uses the Lane analysis to calculate a reduction from MCOs for non-emergency visits in the ED to force them to figure out how to decrease those visits. So from the rate setting perspective and the state achieving the savings we are doing that. And forcing them to change their behavior whether that means better access through their networks, to afterhours care, to a nurse line or whatever it is that is going to get that ED visit avoided.

Senator Mills asked how quickly LDH receives the data to make those decisions and how much is in real time to hold the plans accountable. Ms. Steele explained that the claims data is always about two years old for rate setting purposes but the actuaries also look at more current information on the financial reports but again you have got to make sure the claims data is complete. The actuaries also look at more recent

utilization patterns nationally and do a trend adjustment to update to the current period. The bottom line is rate setting is based on historic experience adjusted for what people understand as more current utilization. They do look at more current data but can only make limited judgments about it because it's not complete or audited or final.

Senator Mills asked what accountability is on the MCO's for non-emergency visits to ED. Ms. Steele said there are strategies aimed at the provider, and strategies aimed at the member as well as strategies aimed at the plan. So we haven't been successful with strategies toward the provider or member. LDH attempted an $8 ED co-pay which failed. They tried a triage fee which would impact the hospitals but it failed. So at this point LDH is limited to what can be done administratively which is take it out of the MCO's pocket. We can't assume they are going to get 100% prevented but we can say it's your responsibility to take 25% to 35% of this and fix it. But again it doesn't give them a lot of tools – they can't change providers or member's behaviors. It's the will of the Legislature ultimately but we are a little constrained in our tools at this point.

Mr. Purpera asked if the $8 co-pay and the triage fee are still recommendations that LDH would make to this committee. Ms. Steele responded only the co-pay. LDH debated whether or not to just concurrently raise the provider rates which would net it out.

Senator Mills added that LDH has tried that for years and because the recipients don't have to pay for then it is a provider cut. Ms. Steele said it depends because they could off-set it with an increase. For example, for a $50 visit with a $8 co-pay, we assume the hospital/doctor received the $8 and the MCO only pays them $42. Mr. Purpera said that would be a cut to the provider if the co-pay is not paid.

Ms. Steele explained that based on federal requirements that say if a co-pay is charged, you must assume the provider collected it but at the same time the provider cannot deny service for failure to pay. Mr. Purpera asked for LDH's recommendations since this is even a national problem.

Ms. Steele said it is important to note is that all states face this problem and she would not propose to have the complete answer. In 2014 LDH worked closely with a group of stakeholders to try to figure out an approach and looked closely at the effective steps taken by Washington State. From that LDH developed opioid prescribing guidelines for the ED because there was a lot of prescription or pain/drug seeking. LDH created a registry of ED visits by Medicaid members with the State Health Information Exchange for purposes of making sure that the health plans got information about a visit within a couple of days instead of when the claim got filed. This gave MCOs an opportunity to call the recipient and discuss the ED visits and try to connect them to their PCP or engage them in case management or whatever is appropriate. LDH is currently doing an evaluation of that to see what further enhancements can be done and how effective that intervention has been.

During her testimony about the MCO contracts, she explained that LDH put 1% of their revenues at risk for meeting quality targets. There are 17 total quality measures that the 1% rides on, so if they fail to make targets on the ED measure the MCOs has $1/17^{th}$ of 1% that they are not going to get back. Based on the size of this program 1% is pretty significant.

Mr. Purpera asked if any statistics to identify the population of individuals who are repeatedly using emergency room visits when it is a non-emergent visit. Ms. Steele explained that each plan has their own methods for identifying what we call "super utilizers". It is called "hot spotting" where you take the data and try to identify where they are coming from and narrow in on that.

LDH is also working through the Medicaid Quality Committee which is a group of clinicians from across the state including Senator Mills to really drill down. LDH just met with a sub-committee led by ED physicians to provide again part of this quality withhold. She has asked the Medicaid Quality Committee to be LDH's boots on the ground and tell us what the practical barriers are to achieving those goals whether it is a policy in the way or an administrative practice of the plans. LDH did a deep dive on the ED utilization just in the last month and figured out that it is not the largest cities but in Lafayette, Lake Charles and Monroe. Next they will look at the networks to determine if the issue is access to primary care or the drive time, to find out what is causing the problem in smaller towns.

So LDH can identify the EDs in the region that has the biggest ED volume and work with the frontline physicians to really try to gather data about what's going on. It may be that your largest Medicaid volume provider has no after-hours access so that can be addressed on a very practical level. Ms. Steele found dealing with it at a very high level statewide statistics does not get you very far, so LDH's approach at the moment is to really identify where it is happening and to go in those communities and to rely on the people on the ground to help us figure out what's going on and to change it. Whether it is a policy or a practice, if it is within LDH's control then they have to act on that. Not everything is within our control and again if it's the value added benefits it could be something different like the community paramedicine that makes an impact, let's do that. We are trying to get micro on it and really dig down and do the hot spotting we are talking about. But it's not just super utilizers. You've got a lot of utilization – like a new mom who has a baby with a fever it's not just super utilizers it's both. So we are looking at the problem overall.

Mr. Purpera asked if there is a population of super utilizers that are costing the state a lot. Ms. Steele agreed but also there are one-off's - people who don't know who their PCP is.

Mr. Purpera said that Representative Bacala tried to pass legislation about limiting ED visits but it did not pass. Not wanting to sound insensitive, but he said that he does not go to the ER because he doesn't want to pay the $100 co-pay. If a co-pay was charged but not expected to be paid by a Medicaid recipient, he doesn't see how ED over usage can be controlled.

Ms. Steele said it's more complicated than that because it is important to understand the different drivers for different people and do some targeted intervention. She is very interested in really getting on the ground and understanding where this is happening and what's driving it.

Mr. Purpera asked if the MCOs have a real stake in this game and if there are any models where the MCOs have representatives at the EDs. Ms. Steele responded that the MCOs do have a stake and most of her financial leavers are on MCOs but there are two other pieces to the puzzle. The idea of an MCO representative has been considered but not all hospitals are interested in that. Whether that is the right

model is to be determined. LDH's response includes three pages of all of the things that are going on and she highlighted a number of states that did the ED co-pays – AL, AZ, ME, IN, IL, Michigan, etc. There are several states that are doing this community paramedicine pilot – I mean Of the states that tracking the ED visits and doing outreach, several states are doing this community paramedicine pilot, as well as other approaches, but no one has found the silver bullet.

Representative Bacala asked what outcomes and success has LDH seen with the New Orleans pilot program. Ms. Steele said the program has not been implemented yet but will go live in 2018 and it will be independently evaluated. Mr. Reynolds explained that several legislators proposed legislation regarding an ER co-pay has never made it through the Health & Welfare committees. As Senator Mills mentioned the providers really look at this as a rate cut and they oppose it as such and that is why that legislation including the one filed by Representative Bacala never passes.

Representative Bacala asked if there a way to off-set through kind of the supplemental payments to hospitals. Mr. Reynolds agreed that the only practical way to get it through the legislative process is to figure out how to make the providers whole one way or another, otherwise they are never going to support it. Passing legislation to make any changes to the process becomes very difficult if providers are opposed to it. Representative Bacala asked about directing a hospital supplemental payment to make whole any unpaid $8 co-pays.

Mr. Reynolds said that LDH can look into that and there are different options. The supplemental payments were redesigned and still looking at how to reset that whole program with expansion going on. So he believes everything is up for debate and that is obviously one of those things we probably need to discuss.

Senator Mills agreed and suggested the providers provide every three months a summary of how much they received and did not receive in co-pays. He said that can be further discussed if there was a way to track it, reimburse it, and audit it. However years ago when the first co-pays came out everybody said they could not afford it and it was a disaster.

Mr. Reynolds added that was in the pharmacy program. Senator Mills said if there was a way to get a cost report showing the amount of co-pay dollars billed and received.

Mr. Reynolds referred to Ms. Steele's comment to raise the hospital's rates by $8 and whatever they collect on the ED co-pays is gravy or extra money to them. That is a simple way but we need to discuss that and think about all of the implications. Senator Mills asked if the co-pay would be billable and what could be collected. Mr. Reynolds responded he would have to check with LDH's legal counsel to find out if the federal regulations would allow LDH to settle up with providers.

Ms. Steele added that unpaid co-pays already fall under the bad debt category under the Uniform Commercial Code (UCC) and the problem is not everybody gets the UCC. Not everybody gets the dish payment either at all or in equal proportions.

Mr. Block said to be respectful of the time of the task force members, and since this letter was sent to all the members two weeks ago as well as Ms. Steele testified in front of JLCB about every item in the letter, he asked the prerogative of the committee. He said that even though Ms. Steele would be happy to go through every item in the letter and answer questions, but since most members have read the letter it would be his preference to go straight to any questions about these issues.

Mr. Block said it is very obvious even though some of the topics in both of these letters may be a bit afield from the original jurisdiction of this committee which is about Medicaid fraud. He believes it is obvious that LDH is taking all of these issues very seriously and is here to discuss any and every subject that may come up including all of these issues that are raised in these letters. He suggested in light of the lengthy agenda to shortcut some of this, but if the members' prerogative is to have Ms. Steele go through the letters she will be happy to do so.

Mr. Purpera stated that the method of discussion was agreed upon earlier in the meeting and wanted to ensure everyone's questions were addressed. The next question in the letter asked for a description of all waivers which have been granted and an estimated additional cost incurred by Louisiana as a result of each waiver. LDH answered basically that there is no additional cost but an explanation may be helpful.

Mr. Travis said in theory the idea of the waiver program is that those people who are in those waiver programs would otherwise be in some kind of facility. But through their investigators' encounters and cases he can factually say that many people on these waiver programs would not otherwise be in an institution. It is not really a fraud issue because they have gone through the process and they get approved for these waiver services but a lot of people getting the PCS, the home care, the cleaning and cooking are not people who would otherwise be in a facility. Mr. Travis suggested reviewing the screening process because those on the waiver program and receiving those services should have to pass some test and provide the medical necessity to get into a nursing home or other facility. His staff could present testimony about what they have seen and possibly discuss this topic further in the spring.

Mr. Purpera asked if further explanation was needed for LDH's response about the additional estimated cost is that this is a budget neutrality issue. Mr. Travis agreed in theory, but believes people are getting these services who should not and would not be in an institution.

Ms. Alletto explained that the 1915(C) waiver by definition has to be budget neutral for home and community based services (HCBS) so we have to report to the Centers for Medicare and Medicaid Services (CMS) on an annual basis the cost that we are not incurring as a result of having people in a home and community based setting as opposed to an institution.

Representative Bacala said LDH's answers on managed long-term care are self-explanatory but did not verify the potential financial benefit. He asked if $150 is a reasonable number.

Ms. Alletto explained that prior calculations that were done to determine savings and costs of long term care were done back in 2014 so there has been updated CMS guidance on managed long term services and support. There are also different services to include potentially than were included in the 2014

calculation so LDH has not put forth the hundreds of thousands of dollars it would cost for their actuaries to look into what a potential savings would be. The models do include premium tax but particularly with our experience with managed care for the general population we did incur first year costs so there is a multitude of variables so LDH cannot confirm that $150M would be an accurate number.

Representative Bacala asked for her expert opinion of what the savings could be, but Ms. Alletto said she would not place a number on it. Mr. Reynolds explained that CMS has also recently put out new managed care regulations that would affect this, so going forward we would have to incorporate all of that into it so that work has not been done. He concurred with Ms. Alletto that LDH is not in a position to give this estimate.

Mr. Purpera questioned if saving even $100M seems it would be worth spending the hundreds of thousands of dollars to get to the number. Mr. Reynolds said that Ms. Alletto mentioned earlier when we put in managed care back in 2012 we had to get a couple of million dollars from the legislature and there was a big debate about that and it ended up on the floor of the Senate if I remember right about doing that and really did the state want to make that investment to go into managed care and because of the claims lag and those various things where you have to close out the old system before you start the new system there is an upfront cost and there is an overall cost for that. Also with this there is a case where the cost savings in long term care are not what we have seen and physical health it is a lot of manipulation and everything else. The managed care tax is of course is a benefit that helps that was not out there before. So it is a case where LDH would have to re-run all of these numbers to see if it is appropriate and – but for the first year there is absolutely a cost because there was a cost when we put in managed care that very first year

Representative Bacala noted that that there was a fiscal note on a bill to this effect it was $100M just in the MCO tax side, and undetermined other savings amount – so I just wanted to make that for the record at least on a fiscal note to this effect it's $100M. He asked if LDH could move forward if they chose to. Ms. Alletto said they would need upwards of $1M added in their budget for the actuaries to do all that work.

Mr. Reynolds explained it is not a case where LDH can just unilaterally does this. It's a case where if LDH went down this path we still have to go through rule-making process and everything else and those rules would get called oversight into those exact same committees that you testified in front of last year when you tried to run your Medicaid long-term services and supports (MLTSS) bill. So the Health & Welfare committees have oversight so if we try to do a rule and we don't have consensus among all of the participants of that more than likely that rule is going to get Called into oversight and get shot down similar to the mental health rehab stuff we had done, when we tried to eliminate the hospice program several years ago. So it's a case where LDH cannot unilaterally do that – we have to have buy-in from the Legislators, buy-in from the providers, buy-in from the constituents in order to make a change of this size. I struggle when you ask that questions because I've seen how the MLTSS bills have gone when they have gone in front of the Health & Welfare committees.

Representative Bacala said that LDH's written response says an initial RFP and/or a resulting contract would not be required to go through any legislative approval process. Mr. Reynolds agreed but the rule making and anything like that absolutely has legislative oversight and he cannot unilaterally do this. Ms. Alletto said LDH would need a budget request in order to get the work started.

Mr. Purpera asked if the long term care is a $2 billion dollar program per year. Ms. Alletto answered that for all of the waivers combined for DD adults and nursing facility care maybe close to $2 billion dollars. Mr. Reynolds said the nursing home program by itself is about $1 billion and when you add all of the waivers and that's about $750,000 so that sounds about a reasonable number. Ms. Alletto explained that it also doesn't necessarily mean that all of the services would be included in a managed long term care model. Mr. Reynolds said it does cover all nursing homes.

Mr. Purpera asked if they had read LLA's reports regarding nursing homes. Mr. Reynolds said yes, and that LLA's staff did a very good job documenting where LDH's hands are tied either by the constitution or the law as far as the way we set rates and those types of things. There are absolutely things LDH can improve in but there are also recommendations to the Legislature on potential changes to the law that need to incur a lot of those recommendations that your staff has made.

Representative Bacala asked for some of those recommendations. Ms. Alletto read from the report highlights page: one is about calculating the rental factor differently, one is conducting full scope audits, one is if a nursing facility submits a late cost report we should fine them.

Ms. Karen LeBlanc, LLA Director of Performance Audit Services, further explained the audits. They looked at the accuracy of payments, primarily the rates to nursing facilities and I guess the biggest two findings we had were related to the rate reimbursement methodology. The first being that in some ways the rate reimbursement methodology is generous compared to other states. The first difference than other states is that we include in the Medicaid rate we include the acuity level – which is basically the need level or the sickness level of all residents in a nursing facility including Medicare and private pay so that raises the Medicaid rate. Other states just include the Medicaid population in that calculation. So that was one recommendation and that would require a law change for LDH to do that.

Mr. Purpera asked if there are any savings. Ms. LeBlanc responded yes, it was about $19.6 million per year if we just included Medicaid residents in the rate. The second one related to the rental factor. We used a rental factor to calculate the fair rental value of the facility and the capital component of the rate. Ours is a minimum of 9.75 or 9.25, I believe. If you went with the Treasury Bond Rate plus a risk factor – it is very complicated – but the report kind of spells it all out you can save about $52 million a year and most other states have between 6% and 9% so even going down to 9% would save about $3 million a year and then we just made some recommendations for the Department.

Mr. Purpera asked if Louisiana is the outlier as far as the states go on that. Ms. LeBlanc responded yes, for other states that have similar reimbursement methodologies. And then we recommended full scope audits, right now they are not doing full scope audits, P&N is the contractor that does these audits and the full scope audits identified about $34 million in related party costs which about $14 million was

disallowed in the cost report which is used to calculate the rates so those amounts were taken out of the cost used to calculate the rates so expanding those audits would help us save more money as it would identify more disallowed costs.

Mr. Purpera asked if LDH has the ability to expand the audits. Ms. Alletto responded yes, and in LDH's response say some of our resource issues just in terms of conducting the full scope audits but we are going to look at doing more of those this year and next year but we can also rely on federal assistance to conduct full scope audits.

Representative Bacala asked for the full sum of the savings. Ms. LeBlanc responded that the first two which are primarily the most savings which would be about $19M plus $58M. Representative Bacala said $77 plus another few million so maybe $80 million. Ms. LeBlanc explained that is if all of the recommendations are implemented and that includes penalizing nursing facilities when they have repeat findings or when they submit late cost reports, so all together it could be about that $80M.

Senator Mills thanked Ms. LeBlanc for the audit findings because it gives us good information to maybe move forward legislatively. He asked how she could compare Louisiana to the other 49 states. Ms. LeBlanc said they only compared to states that had similar reimbursement methodologies and worked with M&S who is also LDH's contractor to calculate the rates so they do this work in other states so they had that information.

Senator Mills said it is interesting and this topic shows there might be some opportunities if you compare apples to apples. How much can LLA do on the whole global aspect? We already drilled down a lot on spread-pricing for prescriptions, we drilled down a lot on transmissions fees and as the Department testified they have limited resources from there. So could LLA gather data - not just on this sector that you are talking about - but all different sectors and compare data because it seems like LDH is short-handed.

Ms. LeBlanc answered that they would try to do whatever he asked. Senator Mills suggested that as a recommendation from the committee. Mr. Reynolds added that from his perspective they never leave so they are always over there doing something. Senator Mills commented that was interesting how the auditors were able to compare different states and see what was maybe not the norm and it seems like that could be done globally.

Mr. Reynolds said from his point of view that's the real value of the Performance Auditors. They really have the ability to go out and look at what the industry best practices are and make those recommendations and I really look at them as a tool that the Legislature has given us to help us improve the program and yes, I go back and forth with them but at the end of the day I do appreciate all of their work and recommendations because it does help us improve the programs.

Senator Mills said just from the aspect to kind of finalize the thought process here, in Joint Budget it seemed like on the House side it was in the negotiations to the contract that they wanted to make sure if the auditors needed to do some additional digging on the five MCO's that they had the authority within

the contract does that look like it's been wrapped up with the new plan of action to basically have new contracts out there – does the language satisfy what you need to be able to look as deeply as you can within the practices of the five MCO's?

Mr. Reynolds said LDH added that auditor language to the emergency contracts that are currently going through the reprocurement process with DOA and as I testified at JLCB the auditors, every single piece of paper in the building they have access to and if somebody doesn't give them access to it I've always told them to come talk to me and I will get it for them and that's very much how I feel that they have access to every piece of paper and review every dollar and every penny that goes through that place. I feel like it does I defer to Daryl, you know, we added that language to the emergency contracts I don't know if he's had a chance to review them or not. Mr. Purpera said he had not.

Senator Mills asked if LDH would amend the contracts if Mr. Purpera sees any problems. Mr. Reynolds answered that they would look at where it is in the process and see what we can do to address his concerns.

Mr. Purpera asked if any questions about LDH's response about co-pays and cost sharing stating that verification of potential savings to the state would be about $91 million per year. Representative Bacala asked if Ms. Steele believes the savings are closer to maybe $180 or $190 million. Ms. Steele answered yes, that the change reflects expansion – keep in mind the co-pays are largely not applicable to the child population so that's the reason the expansion makes such a difference. Representative Bacala asked if the co-pay is $171 plus six plus three, if that would be the savings. Ms. Steele said yes, on the outside. Mr. Purpera asked if in this situation the co-pays would get paid or would this be a cut into. Ms. Steele answered yes, it's the same deal as before.

Mr. Purpera asked if any questions regarding behavioral health or enrollment. In the enrollment response, LDH is implementing a new eligibility enrollment system with increased verification checks and controls to reduce reasonable compatibility standard from 25-10, conduct post-eligibility data matches with new existing data sources and I know there is a lot of discussion and there is a lot of discussion in the Department's response about the tax data so in the new, I guess in the Department's plan is the Department's plan to move towards the use of the FIT data and is the Department's plan to move towards the use of state tax data and I guess the reason I'm asking this is because at the moment the committee, as we start drafting a report, would be thinking in terms of those things being part of recommendations – not saying it would be the end we as a committee haven't discussed that at length so is that something you can speak to?

Ms. Steele responded yes, I would just say briefly that from our perspective we can build our systems to take the data in we don't currently do that – we did get a price to do that it's about $850,000 for the system's build out and about a half a million dollars for the staff to help us comply with the IRS audit requirements to make sure the systems interface is secure so that's the cost for us. We've also testified to the fact that our eligibility system is in the midst of being replaced and so with two releases coming up on

that before we can implement anything new we would be looking at roughly summer of 2019 to be able to do that. I'm not commenting on the utility of doing that but rather what it would involve for us to do it.

Representative Bacala asked if there would be any value or recommendation on LDH's part relative to perhaps LDR being responsible for income verification as part of the process and just kind of take you out of that – take LDH out of that so that LDR is also one of the entities that may have to approve.

Ms. Steele explained that federal requirements obligate the single state agency which is LDH to do those eligibility determinations so again I don't know that I can make that LDR's responsibility. Representative Bacala asked if that would be something we could ask as one of the waivers or is that absolute. Ms. Steele said no, and many states have tried to get a non-state entity and the answer has always been no.

Mr. Purpera asked for clarification - so you are saying as a state the federal government prohibits us from using – because we are organized by Department. Ms. Steele explained that a single-state agency is the federal government's word for the state Medicaid agency. The state Medicaid agency is the one that is responsible for making that eligibility determination.

Mr. Reynolds added that from the fed's perspective, they don't want to deal with multiple entities they just want to deal with one entity and they make everything ultimately the responsibility of the single-state agency whoever they are sending the money to and running that Medicaid program. And as Ms. Steele mentioned, you know, several states have looked at trying to contract out their eligibility process instead of having state employees do it have a contractor do it and the fed's have very, steadfastly said no the single-state agency must be the final say-so in the determination of eligibility for the program because ultimately the single-state agency is responsible, you know, if a provider gets overpaid the Feds don't go try to get the money out of the provider they come to the single-state agency and make us pay them back and then we've got to go get it out of the providers so it's a case that they just want to deal with a single-state agency and that sort of…

Mr. Purpera said he understands the feds not wanting LDH to rid itself of the responsibility. But if Senator Mills could put in extra money for LDH for additional Table of Organizations (TOs aka budgeted positions), could you then sublet those TOs over to LDR, and there is a portion of LDH within LDR that has access now to the tax data and all of that sort of thing because it seems like the issue we talked about a little while ago and now this issue is that the state has its hands tied behind it's back a little bit on the program because we have all of this information over here but we can't use it over here.

Mr. Reynolds agreed that getting the data or having the data exchange with LDR is absolutely probably where we need to go and giving those eligibility workers one more tool and in your example there you could have those workers over there and they pass the information back into the eligibility system with the eligibility system and that process going through its final determination of eligibility. My concern about Representative Bacala's question is that LDR can say this is their income for last year but eligibility is what is your income for this current month year end and so you can't have them saying oh this person is eligible or not eligible when their situation might have materially changed to the current month. So I think

it is a case as I've testified many times we need to use that data as a tool to help us make the best possible determination of eligibility when LDH is asked to make that determination

Mr. Purpera asked for Mr. Morris' input since he's with LDR. Mr. Reynolds agreed but believes the frustration is there is not one point that we can go and that computer or that data is captured that answers the question unequivocally this person is eligible or not eligible.

Mr. Purpera said he knows tax data is not the only consideration for eligibility determination but if you looked at their tax data and you saw that the individual made $80,000 each year for the last five years and now they tell you they make zero and they are self-employed. Mr. Reynolds said then that person needs to explain or document the change. Mr. Purpera reminded them that they all said it over and over again – it's a tool– but to not use the tool seems like we are not doing our due diligence as a state

Mr. Morris spoke about the given example of a self-employed individual who made $80,000 consistently that in my opinion would not preclude them from qualifying for Medicaid if the facts were such that let's say you have a self-employed farmer well he has a certain season of the year where he is going to harvest a crop or whatever the agricultural business he's engaged in - so for maybe two months of the year he is going to earn $80,000 and at the end of the year when he has no income whatsoever he would be eligible for Medicaid because it's on a monthly basis. So to that end – and I know this is coming up later in the other business – but we have gone through some of the outliers that we think would raise a concern and from the ones we have looked at so far we can provide a rational reason why the income may be higher than what you think it should be but the income was earned in one part of the year and the later part of the year they had no income and qualified for Medicaid.

Mr. Purpera asked if they actually have individuals that qualify for Medicaid for two months out of the year in the state of Louisiana. Ms. Steele answered yes, there are certain programs – medically needy programs. There are certain programs that are 12 months but some that are more limited.

Mr. Purpera asked if LDH has any individuals that are put on the rolls for one month because this particular month they don't have income but they do have income for the other 11 months. Ms. Steele responded that LDH does not do it that way. We have one program again it's a three month certification based on whether or not your medical expenses are three times your income for that period but that's different – that's not what you are talking about

Mr. Purpera asked from the perspective of using tax data and if the person applied for the Medicaid during the month they have no income, then would we put them on the rolls for a one year period. Ms. Steele said that is right, but that person would have an obligation for them to report changes. Mr. Purpera asked if any methodology to determine whether or not the individuals who have an obligation to report are actually reporting those changes. Ms. Steele responded no, they do not.

Mr. Purpera said that this Fraud Task Force would have to consider if fraudulent if the farmer does not come back in to report that his income has changed when his beans come in and are sold. Say the farmer legitimately had no income for a month or two, but are we are going to put him on the roll for 12 months.

Mr. Purpera asked if at the end of the year does the farmer get automatically reenrolled or are we going to go out and really evaluate him.

Ms. Steele said generally speaking all of the cases are up for annual renewal so they get reviewed either manually or we have some cases that are reviewed by direct contact with the person, there are some that are reviewed by looking at other sources of data, there are a handful that are administratively renewed without contact as she recently provided an example of.

Mr. Purpera said for a farmer who is probably self-employed and probably no records at the Workforce Commission so when LDH then goes to administrative review of that individual, what are you going to look at what to determine that he had income.

Ms. Steele said that scenario would not fall into the administrative renewal category. We would have to change our policy if you wanted us to re-touch everybody just to make sure they didn't report anything in the meantime. And I wanted to go back to the whole tax data thing -- do keep in mind that we look at the Workforce Commission data which is real time earnings. Mr. Purpera pointed out that the Workforce Commission data doesn't include everyone, and Ms. Steele agreed.

Mr. Purpera said he is trying to figure out how the state can do a better job because someone being dishonest could receive Medicaid because LDH is not able to look at tax data and self-employed people are not in Workforce Commission data. Ms. Steele pointed out that LDH does verify tax data for self-employed applicants. Mr. Morris brought up that the Schedule (C) and (F) tax data filed by an individual who is self-employed is only going to be as good and honest as they are. Ms. Steele said that LDR is not going out to see if they are true either.

Mr. Morris said he hates to say it but taxpayers aren't always honest. In his former capacity at LDR he was an individual income tax auditor and self-employed individuals seem to think every expense they have personal or business related is going to go on a tax return and they are going to write it off. So the tax return would be a useful tool but it comes with its own built in limitations. If you have an individual who is going to commit Medicaid fraud they are probably going to commit tax fraud too.

Mr. Purpera asked how LDH was receiving the tax data for self-employed individuals because he did not think they had that access. Ms. Steele said that her staff requests the information from LDR but LDH does not go into LDR's electronic system to get it. Mr. Morris clarified that the claimant submits their own copies of their tax returns to LDH. LDR does not come into that process.

Mr. Purpera asked if LDH can take the submitted tax data and ask LDR to verify if the tax returns are the same as they have on file. Mr. Morris said he's not sure if that is part of LDH's current process but yes, that can be done. LDR has a form that a person could designate another person to receive tax returns that have been filed. If we receive that from LDH we could give them our copy of what we have on file.

Mr. Purpera said he understood that when someone applies for Medicaid they signed a waiver at that point in time saying that LDH can have their tax data. Mr. Morris said that is correct, but was unsure if there has ever been that communication between LDH and LDR.

Mr. Purpera apologized for sounding combative but frustrated that the data is in our government but it cannot be used. He understands that lawyers have written the laws that way but there are two lawmakers right here so maybe we can undo some of that.

Representative Bacala asked if someone lives in Vidalia but works every day in Natchez, does LDH have access to that Workforce Commission data or is there none because they work in Mississippi. Ms. Steele responded she was unsure, but the Workforce Commission is not the only source used by LDH. They also use the Work Number which is a national source, as well as Social Security Administration (SSA).

Representative Bacala gave possible scenario of a farmer who is unemployed for a couple of months so they are eligible but their annual earnings far exceed the monthly amount. At the renewal time if LDH looks at that person's W-2 for the prior year showing they made $80,000. But that person was enrolled for 12 months because he qualified because of making zero for one month. Would LDH go back and say that the farmer should not have been covered for 10 months out of the year? Ms. Steele responded no, because that is not the basis of our eligibility decision. LDH looks at what current income is reported and does not go back and undo it because eight months later it was a different situation. It is not an annual income determination. Representative Bacala asked if a person is eligible for one month then they are eligible for twelve months regardless of their financial status changes unless they self-report a change. Ms. Steele answered that's right.

Representative Bacala asked about seasonal workers that are unemployed one or two months of the year. If the point in time when LDH is checking their financial earnings records is during those unemployed months, then they could go on for their entire life with zero income in those one to two months and higher income for the rest of the year and unless they self-report LDH would not catch that.

Ms. Steele agreed and explained that the only way to change this is if you choose to have more frequent eligibility determinations and you provide the workforce to do it.

Mr. Reynolds said that his staff texted him that for the farmer example, LDH would have the farmer turn in his prior year tax returns to then calculate monthly income. He was not absolutely sure in that example if LDH would qualify them based on one month based after seeing his tax return reflecting $80,000 income for one year. Mr. Reynolds said if they are self-employed we make them file their prior year tax returns as part of the eligibility process. Representative Bacala brought up other situations such as a farm hand or tractor driver. Mr. Reynolds said Dianne Batts in his eligibility department would have to get the specific answer for that because that is more in the weeds.

Mr. Block said that this issue has been discussed at JLCB two weeks ago and in this committee. It is an important issue that does need to be addressed and I think you have the commitment of the Department of Health, Department of Revenue and the Governor's office that this issue will be addressed. Now I do think

it is important to address two things. This has been discussed at length but I think it's important to point out again is the limitations of this data. I had a member in the discussions over the extension of the contract tell me well they heard that this committee was going to come out with a report that said hundreds of thousands of Medicaid recipients are improperly on Medicaid. Well we all know that's not what this committee is going to come out to say because that's not what the reports that Mr. Morris has put together show. They do show that income verification in a lot of instances don't match up with the income tax returns but that does not mean by any stretch of the imagination that that person is ineligible for Medicaid. In fact that person may be absolutely 100% eligible for Medicaid. So we know that's not what this committee is going to say because we just don't know that that is in fact the case and that's not what the data has shown. The second thing, and I think this goes a little bit bigger picture but Mr. Chairman, you said if LDH had additional TOs that they could look at maybe lending those to the LDR. I think LDH would certainly welcome that. I suspect that when we go across the hall here in the Legislative Session the topic in the Appropriations Committee is not going to be how much additional TO can we get to LDH, it's going to be how many hundreds of millions can we cut out of LDH's budget. So I think it's important we talk about this topic in context of the reality of what we are going to be facing in this next Legislative session and that we know that the work – the additional work that this task force and the people of the state would require LDH to do require resources and they require resources within LDR and LDH. I hope the point I'm making is that this topic continues on into the appropriations process this next session as we discuss the needs of LDH.

Mr. Purpera said he recalled 39% of 860,000 applicants actually filed a tax return and he remembers 25% of that 39% actually had a wage that was different than what was reported to LDH by greater than $20,000 which would certainly be a key indicator that they may not be eligible.

Mr. Block added that they also may have had a change in income, or a change in their dependents. That's the only point I'm making – it shows the limitation of the data it shows there was a change in something

Mr. Purpera said his frustration with the whole process is we have their income data sitting in one department and we have another department that needs that data and they can't get it. He is not a lawmaker but these gentlemen next to him are. He was not sure if the issue is strictly a state law or federal law or what we've got to do about that.

Mr. Purpera mentioned his letter to LDR asking to provide his office the results of the data from the population of 860,000 and to strip out all personal identifying information (PII). Then his auditors can take the data and determine if some individual were highly unlikely to be eligible. He said that he had been informed the day before that LDH was still scrubbing the data but instead of giving exact amounts, only ranges would be provided. He asked Mr. Morris why the information was being scrubbed to that extent.

Mr. Morris explained that in the last two memos that he prepared for this task force we have given a percentage just because under R.S. 47:1508 (1508) we are not able to give you the exact information that would allow you to identify taxpayers. Because this is a public document we are giving it to the task force

and whoever else gets their hands on a copy this. As it relates to LDR and LDH we have an exception to 1508 on the books – Exception 33 if I remember correctly that allows us to provide tax data to LDH. That exercise happened years ago and it was determined to be an exercise in futility. There was nothing good coming out of it because the numbers never matched. The adjusted gross income (AGI) would not match to the gross income report on the return, the household size for Medicaid purposes does not by definition match the number of exemptions claimed on individual returns. We went down this road a while back and realized there was no benefit coming out of it. But to your question about the request we received from the task force about the broader information – we don't have an exception of 1508 to the LLA so in order for us to provide you that information we have to scrub the data so that you cannot identify any taxpayer in that so that requires us to remove the name, date of birth and the social security number (SSN). It also would require us to remove the reported Medicaid gross income amount if it's greater than zero. The overwhelming majority is zero. We can tell you what their federal AGI is because you won't be able to identify those. But if I have a particular recipient that received $1,159 from Medicaid and if I tell you that he received that much and he also had $100,000 of federal AGI you can take that very unique number and match that to who that person was and then we run afoul of 1508.

Mr. Morris further explained that in the information he received from LLA it included the annualized gross income amount and if it's not zero and a unique number you'd be able to match – you wouldn't necessarily do it – but it would be reasonably possible for you to do that and that's not something that we can provide. What we could do and what we are planning on doing and working on now is that for those that have a positive gross income number we were going to give it some type of range or round it to the nearest thousand – something where it's not identifiable and then also give you the federal AGI amount.

Mr. Purpera asked if the data being provided to his auditors would enable them to do data analysis which could help this committee. Mr. Morris said I'm not sure what you are going to do with the data because you are just going to get a list of two columns from me – one showing what the gross income amount was and one column with the federal AGI. You will be able to see what the Federal AGI numbers are but you are not going to be able to tie it back to an individual person so I don't know if useful.

Mr. Purpera explained the auditors do not want to tie it back to a person, but instead calculate a number of recipients that had specific income ranges higher than what they recorded.

Mr. Morris said LDR is working on providing that information to LLA. He can't give if there is a specific person that reported a specific gross income number and it's unique to that one person. However he can provide a range because otherwise you can identify that person. I can't give you that information for the very same reason I can't give any person in this room your tax data – it is protected by 1508.

Senator Mills asked Mr. Reynolds if they could be creative in integrating the information under the one agency umbrella potentially with an MOU or something that at the end of the day the lead agency would be LDH – but it just seems that if we had an opportunity to integrate what we've got the creativity can kind of take place from the aspect of – I'm just throwing this out – you could potentially take the monthly sales tax returns that have to be filed on the 20th of every month. So right now I can look at data from the

October sales tax if somebody is reporting sales tax from their individual business – that's pretty current data. That's data you could get immediately. I know we look at that from the banking aspect when we are underwriting a small business loan we will look at the sales tax returns and we can get the last three months. Senator Mills asked if there was any way you can kind of get something where we can be creative to be able to integrate that data and live within the CMS laws.

Mr. Reynolds shared that he and Ms. Steele have discussed this and he tasked her and her eligibility staff to figure out how to integrate use this data so we are making the best possible determinations. He encouraged the committee to recommend that LDH identify if there is some law or some regulation that is prohibiting LDR from providing the data to LDH. Then LDH can come back to this committee and ask for that law or regulation change. It is a case where we realize we need to start using this data as a tool to determine eligibility and we've got to do the leg work and the eligibility worker has got to get down in the weeds with the LDR guys and figure out the best way to incorporate that data to meet in the new eligibility system as we bring that up.

Senator Mills confirmed that LDH wanted to make that a task force recommendation and asked if LDH would identify laws prohibiting the sharing of data. Mr. Reynolds said that his staff has not identified nor has LDR pointed out any laws preventing them from giving the eligibility staff use of this tool. Of course if they do have any barriers, LDH will ask Senator Mills or Chairman Hoffman to work with LDH to sponsor a bill to get that changed. Senator Mills asked if other states are using any other data to determine eligibility and Ms. Steele answered no.

Senator Mills asked if any data that we can be creative and ask the feds if we can do it uniquely for Louisiana and I'll just throw one out and I'm not sure if it's a good idea or bad idea – but if you want to see what a person's day to day activity is on income you can figure out pretty quickly on a credit report because if you pull a credit report right now you can see if somebody is spending thousands of dollars a month and they are paying their bills – you don't need tax returns you can see what's going on in real time if we would determine that would be a tool we would use to determine eligibility what would be the mechanism to get that done?

Mr. Reynolds deferred to Ms. Steele but said his understanding is we would identify how to use that – the credit reports is absolutely a tool that we would potentially use and incorporate how we would do that and include that in our application to CMS about changing the way we determine eligibility and get their input and see if we can do that or not

Senator Mills asked if someone lost their job but on their balance sheet they might have $2M in the bank, would they qualify for Medicaid. Ms. Steele responded that it depends on the type case but generally speaking LDH does not have asset tests. Senator Mills asked if they check what the applicant has in the bank or in savings. Ms. Steele answered that unless its long term care, LDH does not look at their cards, their house or their assets. Senator Mills asked if somebody is sitting on a tremendous amount of liquid assets but they are not employed right now, would they be eligible for Medicaid.

Mr. Reynolds said he believes that changed when the feds put in the Affordable Care Act. They had LDH go to modified adjusted gross income (MAGI) which changed that process if I remember correctly. Ms. Steele said they will verify but does not think it changed the assets piece.

Chris Magee, Data Analytics Manager with the LLA, testified that generally speaking LDH uses all of the data sources that are nationally used except for tax data. Twenty-seven or 28 states do use tax data either at application, renewal or some point in the interim but our state does not. A couple of other places where we do differ are with things such as the Workforce Commission where most states use that at application, at renewal and on an interim basis so either quarterly or semi-annually. LDH uses Workforce Commission data only at application and re-determination but not used on an interim basis and as LDH discussed it is due to resource limitations. The other one would be SSA data. We use it both at application and at renewal we do not use it on the interim. The majority of states do use that but again it would take those resources to be able to do that on a more frequent basis.

Senator Mills asked if someone is applying for Medicaid and they have lost their job, is it legal to do any kind of dive or do other states do any kind of dive on what's on your balance sheet as far as liquid assets or marketable securities or things that you would have to be able to withstand that loss of employment. Ms. Steele answered no, and not to her knowledge does any other states. Senator Mills asked if a state plan amendment would allow it to be part of the due diligence process. Ms. Steele said she would definitely get him answers on the credit report piece and on how we can consider assets.

Mr. Morris stated that LDH is not holding this data hostage. They do have an exception to 1508 on the books. LDR is committed to working with LDH to provide this information if again I mean I can't stress enough that the information it would serve as a tool but in and of itself is not going to be conclusive but we are eager to work with LDH and enter into a data sharing agreement. We have the authority under 1508 maybe we can do an MOU or something to that affect but we can provide that federal AGI information so I just wanted to make that clear.

Mr. Purpera read from LDH's response to the November 8 letter, "*LDH recommends the task force consider updated legislation that allows LDR to share more specific tax form information with LDH"*. So that sounds like something that we ought to be looking at. This includes increasing in staff, both reduce the reasonable compatibility standard from 25 to 10 which we've talked about in several meetings and to conduct post-eligibility reviews as well as increase investments in security hardware and software to be used over other enhancements. And I know the argument the Legislators have to deal with and the budget folks have to deal with but if there is some way we could even begin to estimate the potential savings that we may have as a result of doing these things maybe it'll help the Legislature make these budgetary decisions.

Ms. Steele pointed out that as per federal law LDH cannot apply an asset test to either adults, pregnant women or children so that leaves largely the long term care population which we already do apply asset tests.

Senator Mills asked if any way that Louisiana could apply for a pilot program to be a unique state. Ms. Steele did not believe so. LDH can ask but the MAGI Standard sets those rules.

Mr. Boutte asked if Mr. Purpera's team had already researched what other states are doing and how they are using income tax data. I think that would be beneficial to us as we look to craft recommendations is maybe if that research can be shared with the rest of the task force. I know LDH is definitely interested in getting that information and maybe save us some time on doing some research on how other states are using that information. Mr. Purpera said that information may have been provided in the first meeting but would resend it to everybody.

Representative Bacala said that part of the reason this task force was formed is so that we can maybe move beyond speculation about potential savings. Maybe even to fact but at least a good educated guess – one of the things we initially started with was this topic: make sure eligibility was being done in a manner that does as much as it can that only people who are needy receive it. If you take the 39% of the 870,000 and then the 25% of those who appear, at least on the surface, maybe to be questionable that's 84,000 and that's only on half of the overall population. If you take into the fact that 48% of the dependent unit is reported differently even though the rules may be different. I think if we really want to get this right, and that's the purpose is to get this right – if we really want to get it right then somebody needs to get together in this room and let's dig in a little deeper and let's try to really see to what degree are we allowing people to sign up who are not eligible and we are talking gentleman and ladies about tax payer money that we are entrusted with to spend properly. So if we need to dig into this topic a bit more to get clarity on the degree of our best guess about what degree there is of potential variance – trying to pick my words carefully – then why don't we do that. It doesn't have to be at this meeting today but why doesn't somebody come back and say look we think we know how to dig in a little deeper to figure out exactly if we have a 10% problem, a 2% problem or a half percent problem. I think that's what the public should expect of us when we are talking about billions of dollars being expended.

Mr. Purpera referred back to LDH's last response that was dealing with "*are there any actions that can be taken now to remove ineligible recipients from the Medicaid program"* and I trust all of you have had an opportunity to see these responses but Ms. Steele is that something you want to elaborate on or comment on.

Ms. Steele said all have been mentioned already but again we can do post-eligibility reviews with sufficient staffing. We could do manual reviews on all of the administrative renewals now but again it's a staffing issue so it really all boils down to resources for us maybe we could nail everything down to the penny if that's what you want us to do but I think the important thing is always to consider the cost benefit analysis. How many people are you actually going to find them ineligible and what was the cost of finding that person and what was the cost incurred of even -- let's just say they were – did have sufficient income for nine months out of the year is it worth what it costs to find them?

Mr. Purpera asked if he read the response wrong. I read it wrong. This requires LDR provide the file data for anyone not matching including the individual's AGI and any dependent or spouses and their income.

Am I reading into that the Department currently doesn't have the ability to receive that information and I know Mr. Morris told us there is an exception. Ms. Steele said it goes back to his point about the matching of the actual people and the income, because they are reporting tax households which may not be who is actually applying for Medicaid. Not everybody's eligibility decision is made on the basis of tax household income information so it's getting the right income for the right person and it's going to be different the way it is presented to him compared to how presented to me.

Mr. Morris said they will have the same problem whether using LDR data or IRS FTI data. It's just the nature of tax data and the way it works but when you are going from households to individuals who are actually applying for benefits so that is an issue. We can give you that information to the extent we can or to the extent that we have it, but it's an issue regardless of where you receive the data from be it from the IRS or the LDR.

Mr. Purpera asked if for Medicaid purposes the household includes all of the individuals living together and any earning income needs to be as part of that household income. Ms. Steele answered that it goes beyond that - it goes to relationships, too. For example your sister is living in the house but she's not going to be part of your family. Mr. Purpera asked if when talking about the tax data then your sister would most likely have a separate tax return so that shouldn't complicate the issue. I guess the complication is what we talked about a few weeks ago where husband and wife report separately.

Mr. Morris responded that would be a complication but to the first example if you have a sister or some other relative living in the home they would be included in the Medicaid calculation for household income but they wouldn't necessarily be claimed on the individual's tax returns as a dependent. Ms. Steele said it all depends because there are hundreds of rules that apply to different scenarios. I could have Dianne Batts come back and we could talk about in this scenario this income counts, this income doesn't. Again, it's not cookie cutter.

Mr. Purpera said the reason that he and Representative Bacala suggested earlier having an LDH staff who understands the program embedded in LDR then that would give us all the knowledge and information we need to be able to make these kinds of determinations. And again that's looking for the individuals who are trying to defraud the government. The one thing about fraud is that it's hidden and hard to find and so you have to go to extreme measures to try to find it. In earlier meetings they discussed the tests run by LDR showing recipients with incomes greater than reported to LDH. He asked if LDR is capable of telling LDH right now who those individuals are so that LDH can then go and investigate to determine whether or not we have somebody committing fraud against the government. Mr. Morris answered yes. Mr. Purpera asked if it was being done. Mr. Morris said they are not and provided an example of why. So we went through the biggest outliers when we did this match. We had an individual who received substantial income and he was also receiving Medicaid benefits. When we drilled down to look as closely as we could, the individual received a substantial amount of money as part of a settlement for damages to a moveable property. He received that in March 2016. Four or five months later at the end of the summer he applied for Medicaid benefits and was approved for that because his current monthly income for the last few months was zero. He got that one-time payment early in the year in March but that wasn't

included in the eligibility determination at the time he filed for his Medicaid claim. So using that as an example when you look at this tax return data you would think he wouldn't be able to qualify but with the Medicaid rules he would because it's on a monthly basis not annually.

Ms. Steele confirmed that the example was for a settlement of property damage. She said not knowing the exact circumstances but that money could have been reinvested in the property – I don't know if you can say any more about the particulars. Mr. Morris could say that typically damages to property are not taxable but in this case it was, so he did reflect quite a large income of taxable income.

Mr. Purpera asked if an individual sells a piece of property for greater than $500,000 in one month but the next month they decide they are not going to work would they qualify for Medicaid. Mr. Morris said that the facts are he received a settlement because of damages to moveable property. Ms. Steele interjected maybe the house flooded or burned down. Mr. Morris said the person was not working before or after that, and he just got this one time lump payment.

Mr. Purpera asked if that information is passed on to LDH or does LDR just make the determination whether it impacts LDH. Mr. Morris said they have not done either but can provide that information to LDH. Mr. Purpera summarized that there is no current mechanism to make this process work because this is just one incident and we have 4 million people in Louisiana. Mr. Morris said that they can work with LDH to get a procedure in place to make it happen.

Mr. Block reiterated that this issue would be addressed and everyone on the Task Force makes the commitment to do so. He fully expects this to be part of the Task Force recommendations that the two departments come up with some procedures together to be able to address those issues - to be able to do some random sampling, some spot audit, etc. to make sure that they are sharing data within the statutory limitations that they have. They will determine if any statutory changes are needed to address those issues. The point you are making is a good one – there needs to be some way the two departments can work together to make sure that if there are those – and look I do think we are talking about very, very, very limited exceptions here of you know individuals who are making $500,000 and who are on Medicaid. I think we need to be honest that we are talking about if it exists at all we are talking about a very small amount of individuals that doesn't make it okay and it makes it even in fact even more important that we find ways to identify those people because you are right if someone is making $500,000 a year and they are on Medicaid they are committing fraud. However if you get $500,000 because of an insurance settlement and you are on Medicaid that doesn't mean you are committing fraud in fact you most likely are not. So we need to find ways to do that. The commitment is there are going to be ways we can address those.

Mr. Morris explained years ago the exception 1508 was put into legislation but the process broke down because of the fact that tax data does not match up to gross income but we will absolutely revisit the process. We've been in communications the last few weeks and we will continue on,

Senator Mills thanked Mr. Block and the administration because he is basically saying give us your ideas, give us your thoughts, give us your ideas, and we will work on it. I think at my vantage point at the

50,000 foot level if there can be an integration and Jeff said he would work kind of on the federal level but if we can integrate that data and even have alerts – you can have an alert and it costs money but you can have an alert that once somebody is on Medicaid then maybe it is flagged in LDH and if some tax returns start coming in there is an alert that comes up and there is an integration of data but I think what Mr. Block is saying let's each one from our discipline that we sit with get the Chairman some recommendations and LDH will look at it.

Representative Bacala asked Ms. Steele if approximately 100,000 people are going to renew in December. I mean 1/12th of the number whatever it is, could we do some checks and dive in on some just to spot check. Could we do 100 with the staff you have now and let's just do a super verification on 100 just so we can start to get some idea of what an accurate number may be and the accurate number may be there is no problem.

Ms. Steele said LDH is already doing a sample relative to the reasonable compatibility standard and will be able to share the results - again we had to give people time to respond and that window has not closed yet but we will have some information on that. I think we still had a few weeks left because we have to give them a certain number of days. She hopes to have it ready by the next meeting.

Mr. Purpera thanked all from LDH who provided the very prompt and very thorough responses that helps the Task Force a lot.

SOUTH CAROLINA RECIPIENT FRAUD UNIT

Mr. Purpera stated that the next two items on the agenda will be presented by the Attorney General's office on the South Carolina Recipient Fraud Unit and then the Penalty and Fee Collections by the Department of Health.

Mr. Ronnie Beaver, Chief Investigator for the Medicaid Fraud Unit in Louisiana, stated that another part of the puzzle is going after those people who committed the fraud and the AG's office is dedicated to finding a way. The AG is trying to get some federal legislation passed which may take some time but will help the Medicaid Fraud units. Mr. Beaver has look at what other states are doing and South Carolina (SC) actually contracted with their state agency and seem to have good results. Our MFCU has recommended following SC's model. SC's budget is about $7.6 billion compared to ours and we are getting close to $14 billion, so Mr. Beaver believes Louisiana could double the numbers. SC's recipient fraud unit in 2014-15 gave back $540,000, and Louisiana could easily pay for itself in stopping fraud. Right now we work with program integrity, we work well together, we know it works and I think we could do the same thing on the recipient end.

Mr. Travis suggested that LDH needs to have an equivalent program integrity unit for eligibility because that is where MCFU receives most of the complaints. The program integrity unit for the South Carolina single-state agency is the one who is making the referrals and identifying these people. And the other thing about it is we are not just talking about straight up eligibility fraud, lending your Medicaid cards out, buying or selling Medicaid cards, using Medicaid cards to obtain opioids and other drugs illegally – it just

provides a lot of relief. It's funded through their single-state agency because their single-state agency is getting a federal match. If you just appropriate the money straight from general funds we are paying the whole cost of it but SC is paid for through their single-state agency as part of the administration of their program so they get a 50/50 match from the feds so it makes more sense for them to pay for it. We get 25/75 match but we are not allowed to do that. The Attorney General has personally lobbied in Washington and with the U.S. Department of Health and Human Services (HHS) and with Congress to get the authority for us to do that but at this point we do not have that authority and we are just looking for some options.

Representative Bacala agreed that getting the information needed to verify people's income through a unit, like LDH currently can do that now for providers, but doing the same thing for recipients.

Mr. Travis explained that the key for this working is if you notice the complaints they are getting and they are getting over 200 law enforcement complaints a year from their single-state. Those are all coming from their program integrity unit in their single-state agency so the things we are talking about doing – sharing the information, getting the program integrity here - would have to be kind of ramped up to generate those complaints but once you generate those complaints you have to have a place for them to go and it's similar to the model that has worked in our state with provider fraud.

Mr. Purpera asked if LDH already has this kind of unit or is it something that needs to be build or rebuilt. Mr. Boutte said this Task Force has discussed more investigations related to eligibility. LDH currently has a small team looking at that and we are looking to expand that and give it more of program integrity slant so it is an avenue that we are currently pursuing. Mr. Purpera asked if it is a task force issue and what do we need to do within LDH and what resources do we need.

Representative Bacala explained that an MOU or an agreement between the state agency and MFCU like SC has modeled would be necessary. Mr. Block said that SC's budget is around $650,000 and they are funded by the state agency to pursue this work and looking at the back side at the recoveries – is it self-sufficient, does it ever become self-sufficient, does it stay self-sufficient I guess how does that mechanism work because it looks like only a couple of years that they actually recovered more than the costs and Mr. Beaver mentioned that in a couple of years you felt like you guys would be self-sufficient. How do you come to that conclusion based on South Carolina's experience?

Representative Bacala explained that SC's total budget is $650,000 and they receive a 50/50 federal match so really you are only looking at $300,000 or $325,000 in the state's portion that we would have to recoup or they would have to recoup for it to be budget neutral.

Mr. Block asked if the recoveries mentioned on the backside of the handout are that just the state portion or cumulative total recoveries for the unit. Mr. Beaver responded that it is total recoveries.

Mr. Block said SC recovers roughly the state portion but not the federal portion for most years. Mr. Beaver agreed but added that our investigators are pretty good at what they do so I think we can improve those numbers. Mr. Beaver also commented that right now there is no law enforcement other than they

can refer it to a law enforcement agency but you don't see that happening so I think to have actual investigators out there looking at it would be a benefit.

Mr. Purpera agreed and having worked in the fraud section for 20 years he worked with many sheriffs around the state. He knows if you referred a recipient fraud to the sheriffs that it's probably not going to be real high on their level of importance because they have so much else to deal with already.

Mr. Beaver said that SC also included a type of cost avoidance which we do not normally do. That accounts for when people see you out there rounding up recipients and he believes that would stop some of the fraud.

Mr. Travis added that when you kick people off the rolls who are not eligible you are saving money – you may not recover money but you are cutting off money going out the door that otherwise would be in there. Mr. Purpera said the cost avoidance factor which Mr. Beaver had included on the document was $700,000 a year.

Mr. Block asked if the proposed doubling in Louisiana over SC's numbers is based on the total Medicaid spent. Representative Bacala said the budget is what they are referring to because Louisiana has double the number of Medicaid members than SC. Mr. Block just wanted to make sure that they were not suggesting that people in Louisiana commit more fraud than people in SC. Representative Bacala answered not at all.

PENALTY AND FEE COLLECTIONS BY DEPARTMENT OF HEALTH

Mr. Travis said the bottom line is that his office had some proposals last year about the Medicaid Fraud Detection Fund. Money from our office goes in there which comes from penalties and criminal costs associated with recoveries – we're not talking about program money that goes back to LDH and to the Feds but that money goes in there and that funds our unit and that money or at least half of it has been appropriated towards LDH. Under our reading of the law, the penalties and fees that LDH collects through their program integrity should also be put into this fund to be used for program integrity purposes. First off, if that was done that would provide more money for program integrity to pursue fraud and get after fraudsters. It would make it easier for them to have more people to do what we are talking about the program integrity for the eligibility and it would just provide more money for all of our purposes because what we're talking about we need funding for these items that we've talked about - the sharing of the information, more investigators, more eligibility examiners, that's where that money can come from and that's our position, basically.

Mr. Beaver explained that the AG's office tried legislation and tried working with LDH. They tried a couple of other things and the AG is getting pretty aggravated so he's running out of options but under the law they are supposed to be putting money into the Fraud Detection Fund and we don't know why they are not.

Mr. Travis said that the authority for collection of fines and penalties comes from the MAPPA statute requiring any money collected through fines, recoveries, extra recoveries to go into this Medicaid Fund and we think it would be beneficial for program integrity and us if that money would go in there it would show the state what resources they are collecting and would provide more resources for program integrity functions.

Mr. Purpera asked the current balance in that fund, and Mr. Beaver answered currently about $3 million. Mr. Purpera asked if all the funds come from recoveries.

Mr. Nicholas Diaz, Assistant AG for the Medicaid Fraud Control Unit, said that the fund is set up and it's authorized by Title 46:440.1 - it really splits it into two segments – the amounts to make the Medicaid program whole and a balance over and above that so MAPL itself has a couple of different sections. You have the administrative sections embodied in Sections 437, et seq you have the false claims theories liability and then you have the key tam section. The False Claims section has penalties of $5,500-$11,000 per false claims plus up to treble damages plus actual damages – actual damages would go back to LDH and the only thing that goes into our detection fund would be the treble damages or the para claim penalty. LDH has the authority through MAPL in Section 437.4 to make regulations including regulations for fines, penalties and other sanctions on Medicaid providers. Some of those sanctions may be remedial type sanctions where it is just making the program whole which would not go into the Fraud Detection Fund. Some of those sanctions re penalties and fines that LDH can assess on a provider which we believe based on the reading of the Fraud Detection Fund statutes which says anything recovered under this part, this part being MAPL over and above makes the Medicaid should be deposited into this fund. We believe that those fines and penalties authorized pursuant to 437.4 should be going to the Fraud Detection Fund.

Mr. Block suggested talking about how it would apply in the real work circumstances. For example, if the AG's office brought an action against provider under Medicaid fraud under the MAPL statute and there was a claim for actual damages to the Medicaid department and also for penalties, etc. and there was some settlement so it was resolved by a payment of an amount of money by that provider, who decides what amount of that settlement is related to penalties and fees and how much of it is the actual damages

Mr. Diaz responded that it would usually be negotiated between the AG's office and the provider or if it is left up to the discretion of the AG or LDH, if there is an administrative sanction then we determine based on the facts of the case.

Mr. Block explained that in circumstances where it is an action purely brought by the AG's office and MFCU for provider fraud so is it, I think based on what your answer was that essentially the AG's office decides how much of it is related to actual damages versus the amount of penalties related to MAPL.

Mr. Diaz said that is possible and it depends on every case and every case is different. There are some cases where liability is very clear we would always collect 100% of actual damages plus getting over and additional from that. But when that's happening what is clear is the over and additional going to the fraud detection fund. When there is a lot of litigation risk involved and liability is not quite as clear cut that ends up being a negotiated issue.

Mr. Block said he is trying to understand who the negotiations are between. Mr. Diaz said between the state represented by the AG and the provider.

Mr. Block asked if this is a recommendation or what they are asking the task force to consider but his recollection of the bill that was proposed by Representative Edmonds was that the bill would actually do the reverse of what was just stated. Instead of recoveries that were brought by the AG that would be forced to go into the Medicaid Fraud Task Fund that in fact it would essentially be if the AG made a recovery the AG would receive 100% of that recovery and if it was LDH, then LDH receive 100% of that recovery.

Mr. Diaz said he did not think that's a fair summation what that bill was. We have to break up the recovery. When there is a recovery of actual damages or recoupment that always goes to the Medicaid agency to reimburse the Medicaid program it is only those additional amounts or those amounts that designated that go into the fund. Now what the bill last year was supposed to do because the problem we are having is if you look at the history of this Fund the only entity putting any substantial amounts of money into this Fund is the AG's office. Now back in the day when the money was flush and coming in that was fine. The cases coming out nowadays they are harder to investigate generally not worth much money and take a lot longer to get through. So now we have two agencies that the AG's office is being required to fund and we have less money coming in so we are looking to get some assistance from LDH and get money put in that Fund. Now the bill last year what it was going to be was whenever there is an additional recovery that is recovered by the AG the AG could use that for his fraud purposes. When there was an additional recovery gathered by LDH pursuant to their fraud functions they would get to use that money for their Fraud detection purposes

Mr. Block asked how that was different from what he just said because that's exactly what he just said. Mr. Diaz said no, you said recovery is wholesale. Mr. Block said if that's where you are taking issue I understand that because we are talking about the penalties. Mr. Diaz agreed.

Mr. Block said that Representative Edmonds' bill was trying to ensure that if the AG initiated the action then the AG would receive 100% of the penalties. Mr. Diaz said correct.

Mr. Beaver said that is kind of how it is now. If LDH recovers above and beyond what makes the state whole they just keep it for themselves rather than putting it into the fund. We put what we recover into the fund. We would just like to see them do that which is required under that statute.

Mr. Block said he is trying to understand what his recommendation or request of this committee is. Mr. Beaver requests that LDH start putting the money they recoup and extra recoveries into that fund. They've done it before. When the statute came out for the first several years that they put money in -- $1M one year, $900,000 and then at some point it just stopped. We know they are getting extra recoveries we just don't know where the money is going

Mr. Block commented that they do not know if the recoveries are due to penalties or whether they are actually damages to the Medicaid Department. If they were damages to the Medicaid Department then

those funds should not go into that fund. Mr. Beaver agreed, but further explained that when we get our referrals from SURS they put in their extra recoveries, you know what has happened to this provider and I can give some examples but they will tell you this is above and beyond – this is recoupment monetary penalties that they are asking from this provider that are not going into that Fund and it should be. Mr. Block said he appreciated the clarification.

OTHER BUSINESS

Mr. Purpera mentioned that he had sent the letter to LDR which the discussed already. The final issue is the law requires that we report by January 1, 2018, and you can go back and look at your law as to what it requires us to report on but basically the status of Medicaid Fraud Detection and Prevention initiatives and establish efforts to coordinate and then in Item B it's got some minimum things that we need to include in the report. I think I had previously sent out an email asking committee members for any ideas, suggestions, thoughts you had for the report and I've taken some of what's been submitted and I've taken some of the things submitted by my staff by going through. We went through all of our minutes and just took those and kind of walked through and said what the key issues we might be reporting on. Mr. Block made several comments about things we might want to report on and then today we had the conversation about the single PDL's and PBM's so how do we move forward from here and get everyone involved in the report.

Representative Bacala suggested Mr. Purpera' office in conjunction with LDR and LDH and perhaps DOA write a draft report for this committee's review and at least get us off the ground floor. Then we can make recommendations for additions/corrections/deletions, anything that we may want to do but I think that probably there is not just one entity here. LDH and LDR are the best component pieces of that initial draft – so that would be my recommendation subject to a better idea from somebody else

Ms. Steele asked if Mr. Purpera went through the minutes and made a list from those. He responded that he did and came up with some major themes that they talked about already. Ms. Steele suggested that process might be the easiest because if you already had an inventory of the 25 things that were recommended, but not sure how many of them elevated from discussion to recommendation.

Mr. Purpera agreed because so many things were discussed, and we have learned more and come to different conclusions. Ms. Steele suggested each entity or member represented turn in three or so recommendations. Senator Mills said he has been working on his recommendations will submit it for including in the draft. It includes exploring the cost benefits of a single PDL and the rebate issue – the same thing not to rehash it but I tried to reduce it to writing

Ms. Steele said that all the members have the minutes so each member could be responsible for identifying three to five or so recommendations but not sure if we are trying come up with consensus recommendations.

Representative Bacala said they all know what topics have been spoken about and know which ones have probably risen to the top so-to-speak. He trusts the entities here – the full time agency staff – to write an

initial draft. Then the members can add to it or if Senator Mills wants to ask about something else going in, I think that would be very proper in the procedure but again I think we need to get an initial draft started and we'll work from that draft towards the final.

Senator Mills said he thinks conceptually as a committee we all know what the hot topics have been—I think what has been really beneficial from the different Departments and Administration is there could be some federal laws prohibiting it, some state laws prohibiting it, so if we can understand the path to victory and understanding what we need to do either legislatively, administratively or also work from maybe the waiver standpoint from the state plan amendments I think that's where the different Departments could help us a lot on that issue – adding to your thought process. Representative Bacala agreed.

Mr. Purpera asked if the members could send their recommendations to him by December 6th. Ms. Steele asked if Daryl would be willing to take the list and aggregate them – having done these reports before it doesn't have to be elaborate it could be a simple letter with a bulleted list of brief recommendations

Mr. Purpera asked if the members wanted to meet again in December. Ms. Steele said LDH would have their recommendations emailed in by December 6th. Representative Bacala asked Mr. Purpera to email the draft so all the members could review that on our own time and come back as a committee and review or modify. So I say let's get a draft after we've had ten days or so to review then let's come back together and make approval or adjustments.

Mr. Purpera said that would put us back together the third week of December and questioned if they could get all the members back together to meet. Ms. Steele suggested doing like the LLA's draft reports, everyone provide feedback and then aggregate it. Representative Bacala said even if the report is not out until mid-January that should not be an issue because the idea is to get the report out. Mr. Purpera said he would rather not break the law and turn in the report by January 1.

Senator Mills suggested meeting on December 13 because it seems like that would be enough for us to look at the draft, approve it or modify it because if we are trying to make the 1st work we might have to say hey let's modify it and meet one more time or if you want to poll us. Ms. Steele urged trying to do as much via email as possible. She has been part of things like this before and we just circulate drafts and provide feedback.

Mr. Purpera said he was just trying to avoid any issue with including or cutting some recommendations or ideas. He said they would work from the perspective that everybody will submit your requests by the 6th and his staff will get it all together and then submit that to everyone. So we will try to get it back to you by the 11th and then between the 11th and 15th we will try to all go back and forth by email and see if we can come up with a consensus. If I get to the mid part of that week and find that I'm just absolutely in opposition to Senator Mills on something or he is in opposition to me then I'll start trying to get you on the phone to get a meeting together. Representative Bacala agreed.

PUBLIC COMMENT

No public comments were offered.

DISCUSS SUBJECT MATTERS FOR FUTURE MEETINGS

ADJOURNMENT

Senator Mills offered the motion to adjourn, which was seconded by Representative Bacala and with no objection, the meeting adjourned at 12:42 pm.

Approved by Act 420 Task Force on: February 7, 2018

The video recording of this meeting is available in the House of Representatives' Broadcast Archives:
http://house.louisiana.gov/H_Video/VideoArchivePlayer.aspx?v=house/2017/nov/1128_17_MedicaidFraudTF