



Task Force on Coordination of Medicaid Fraud Detection
& Prevention Initiatives

[Act 420 of the 2017 Regular Session](#)

December 22, 2017

The Honorable John Bel Edwards
Governor
The Honorable John A. Alario, Jr.
President of the Senate
The Honorable Taylor F. Barras
Speaker of the House of Representatives

Re: Interim Report

Dear Governor Edwards, President Alario and Speaker Barras:

This letter serves as an interim report from the *Task Force on Coordination of Medicaid Fraud Detection and Prevention Initiatives (Task Force)*. The Louisiana Legislature created the Task Force during the 2017 Regular Session (see Appendix A for Act 420 of the 2017 Legislative Session) for the following purposes:

- 1) To study and evaluate on an ongoing basis the laws, rules, policies, and processes by which the state implements Medicaid fraud detection and prevention efforts.
- 2) To identify and recommend opportunities for improving coordination of Medicaid fraud detection and prevention initiatives across state agencies and branches of state government.
- 3) To identify any systemic or system wide issues of concern within the Medicaid program with respect to fraud, waste, and abuse.
- 4) To develop recommendations for policies and procedures by which to facilitate and implement all of the following:
 - a. Random sampling of Medicaid cases to be selected for verification of enrollee eligibility.
 - b. Improvements in the Medicaid program integrity function of the Louisiana Department of Health (LDH).
 - c. Optimization of data mining among state-owned data sets for purposes of Medicaid fraud detection and prevention.
- 5) To make reports to the governor and legislature.

Task Force Members

The Task Force has 11 members supported by the staff of the Louisiana Legislative Auditor (LLA). The members of the Task Force are as follows:

- **Daryl Purpera**, Louisiana Legislative Auditor, Chairman of the Task Force
- **Senator Fred Mills**, Louisiana State Senate
- **Representative Tony Bacala**, Louisiana House of Representatives
- **Matthew Block**, Executive Counsel, Office of the Governor
- **Ellison Travis**, Director of Medicaid Fraud Control Unit (MFCU), Office of the Louisiana Attorney General
- **Michael Boutte**, Medicaid Deputy Director over Health Plan Operations and Compliance, LDH
- **Tracy Richard**, Criminal Investigator 3, Office of the Inspector General
- **Jarrod Coniglio**, Program Integrity Section Chief, LDH
- **Luke Morris**, Assistant Secretary of the Office of Legal Affairs, Louisiana Department of Revenue (LDR)
- **Ms. Jen Steele**, Medicaid Director, LDH
- **Dr. Robert E. Barsley**, Oral Health Resources, Community and Hospital Dentistry, Louisiana State University School of Dentistry

Public meetings commenced on August 17, 2017, and continued on a monthly basis through December 2017. This interim report outlines the issues related to fraud, waste, and abuse that have been discussed to date, along with recommendations agreed upon by the Task Force to address them. This report also outlines ongoing and future issues that the Task Force will continue to discuss, and develop recommendations for, in the coming year. See Appendixes B and C for meeting minutes and handouts, respectively

Issues Discussed & Task Force Recommendations

Issue 1 - The Need to Strengthen Medicaid Eligibility Determinations

Recommendations:

1. Use of Tax Data in Determining Eligibility
 - LDR and LDH should improve their cooperation, coordination and data sharing agreements, to provide LDH with additional tools to properly determine eligibility
 - The legislature may wish to consider appropriate legislation giving the Louisiana Legislative Auditor (LLA) access to state tax data for use in health care program management and audit.
 - LDH should seek to obtain, through the federal hub, Internal Revenue Service (IRS) data for use as a tool in the eligibility determination process, subject to the limits of federal and state law and regulation. In doing so, LDH should identify associated costs, including IT systems changes and eligibility staff, and seek state appropriations as necessary to support.

2. Reasonable Compatibility

- LDH should conduct an analysis of the potential costs and benefits of reducing its reasonable compatibility standard, report its findings to the Task Force, and reduce the standard if appropriate.

3. Eligibility Fraud Reviews

- LDH should develop a standardized process for reporting the results of its eligibility fraud reviews to both the Attorney General and LLA. Doing so would allow those agencies an opportunity to further pursue these potential fraud cases. Consideration for pursuing these cases should be dependent on the potential return on investment.

Related Areas of Ongoing/Future Discussion:

- Development of a Recipient Fraud Unit
- LDH's current resources/structure for verifying eligibility

Issue 2: The Need to Better Coordinate Fraud, Waste, & Abuse Efforts

Recommendations:

1. Data Mining Coordination

- In order to enhance and better coordinate fraud, waste, and abuse efforts, LDH, MFCU and the LLA should meet on a quarterly basis to discuss data mining activities. Information shared during this meeting should include a discussion of algorithms being used and planned activities in order to avoid a duplication of effort.

2. Healthcare Fraud Prevention Partnership

- The Healthcare Fraud Prevention Partnership (HFPP) seeks to foster a proactive approach to detect and prevent healthcare fraud through the voluntary sharing of data and information between the public and private sectors. LDH should continue to work with the HFPP to share data in order to take advantage of the resources available including the results of studies that identify potentially fraudulent activity. The managed care organizations (MCOs) should also participate in the HFPP and share data in order to achieve those same benefits. Combining LDH and MCO data with all other HFPP partner data will contribute to a comprehensive fraud, waste, and abuse detection and prevention system.

Related Areas of Ongoing/Future Discussion:

- The depositing of fines collected by LDH into the Medicaid Fraud Detection Unit (Note: This issue is currently being addressed by an LLA audit of the LDH Program Integrity Unit. Developing recommendations that result in “improvements in the Medicaid program integrity functions of LDH” is a purpose of the Task Force’s enabling legislation.)
- Amendment of the Medical Assistance Program Integrity Law (MAPIL) Statute which would enable greater recovery for the state in MAPIL litigation.

Issue 3: The Need to Strengthen Oversight and Tighten Controls in the Managed Care Program.

Recommendations:

1. MCO Contracts

- LDH should ensure that all MCO contracts are closely monitored to ensure the MCOs are meeting all of their deliverables.

Related Areas of Ongoing/Future Discussion:

- Further discussion of the rate setting process versus Medical Loss Ratio (MLR), to include:
 - The implementation of immediate safeguards to adjust per member per month (PMPM) rates based on data more current than two years prior.
 - Particularly for the Medicaid Expansion population, monitoring of the PMPM versus services provided and make more immediate adjustments to the PMPMs to more accurately reflect the cost of services provided.
 - Evaluation of Healthcare Quality Improvement/Health Information Technology (HCQI/HIT) expenses to determine appropriate maximum amounts that MCOs may claim as medical expenses versus administrative expenses.
 - Evaluation of all current “value-added” services, to determine appropriate use of taxpayer funds and to restructure competitive bidding by MCOs such that “value-added” offerings are not a determinant of contractual award.
- Addressing the non-emergency use of emergency rooms.
- The inclusion of long term care in managed care, including its impact on access, cost, and quality.

Issue 4: The Need to Strengthen LDH's Program Integrity Function Related to Behavioral Health

Recommendations:

1. Electronic Visit Verification for Mental Health Rehab Services

- The 21st Century Cures Act requires that states implement electronic visit verification (EVV) for personal care services or home health care services requiring an in-home visit by a provider. EVV is one way to determine where services are being provided and it also provides an opportunity to prevent payments from being made when services are not rendered. While the 21st Century Cures Act requirement does not apply to community-based mental health services, LDH should conduct a feasibility study to determine if there is value in pursuing EVV for these services, what impact implementation would have on its current use of EVV, and the costs associated with a potential implementation.

Related Areas of Ongoing/Future Discussion:

- Provider Registry – achieving a single, reliable provider registry

Issue 5: The Need to Strengthen Controls within the Medicaid Pharmacy Program

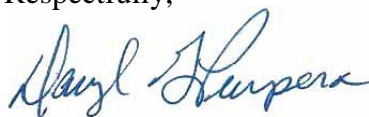
Recommendations: Pending

Areas of Ongoing/Future Discussion:

- Restructuring of Pharmacy Program – discuss option of using a single preferred drug list (PDL) managed by a single pharmacy benefits manager (PBM).
- Increase Transparency – discuss option of using PBMs that do not profit from spread pricing on drugs or any other incentives, but rather operate based on a flat administrative fee for each transaction.
- Supplemental Rebates – discuss requiring supplemental rebates to be returned to the state.

The Task Force will continue its work in 2018 and provide semiannual reports concerning the status of Medicaid fraud detection and prevention initiatives and the status of efforts to coordinate such initiatives across state agencies and branches of state government.

Respectfully,



Daryl G. Purpera, CPA, CFE
Chairman

APPENDIX A

**Act 420 of the
2017 Regular Legislative Session**

ACT No. 420

2017 Regular Session

HOUSE BILL NO. 459

BY REPRESENTATIVES BACALA AND HOFFMANN

1 AN ACT

2 To amend and reenact R.S. 46:440.1(E)(2) and to enact Subpart D-1 of Part VI-A of Chapter
3 3 of Title 46 of the Louisiana Revised Statutes of 1950, to be comprised of R.S.
4 46:440.4 through 440.8, relative to Medicaid fraud detection and prevention; to
5 create a task force on coordination of Medicaid fraud detection and prevention
6 initiatives; to provide for the membership, purposes, and duties of the task force; to
7 authorize appropriation of monies in the Medical Assistance Programs Fraud
8 Detection Fund for activities of the task force; to provide for a termination date; and
9 to provide for related matters.

10 Be it enacted by the Legislature of Louisiana:

11 Section 1. R.S. 46:440.1(E)(2) and Subpart D-1 of Part VI-A of Chapter 3 of Title
12 46 of the Louisiana Revised Statutes of 1950, comprised of R.S. 46:440.4 through 440.8, are
13 hereby enacted to read as follows:

14 §440.1. Medical Assistance Programs Fraud Detection Fund

15 * * *

16 E. The monies in the fund shall not be used to replace, displace, or supplant
17 state general funds appropriated for the daily operation of the department or the
18 medical assistance programs and may be appropriated by the legislature for the
19 following purposes only:

20 * * *

21 (2) To enhance fraud and abuse detection and prevention activities related
22 to the medical assistance programs, including the activities of the task force on

1 coordination of Medicaid fraud detection and prevention initiatives established
2 pursuant to Subpart D-1 of this Part.

3 * * *

4 SUBPART D-1. COORDINATION OF FRAUD AND ABUSE

5 DETECTION AND PREVENTION INITIATIVES

6 §440.4. Legislative findings; purpose

7 A. The legislature hereby finds and declares all of the following:

8 (1) Cost containment in the medical assistance program operated pursuant
9 to Title XIX of the Social Security Act, referred to hereafter in this Subpart as
10 "Medicaid", is an urgent priority of this state.

11 (2) It is the policy of this state to combat and prevent fraud and abuse
12 committed by any healthcare provider participating in the Medicaid program and by
13 any other persons including Medicaid enrollees, and to negate the adverse effects of
14 Medicaid fraud and abuse on the fiscal integrity and public health of this state.

15 B. The purpose of this Subpart is to create an interagency task force to
16 coordinate existing Medicaid fraud detection and prevention efforts and to
17 recommend means for enhancing the efficacy of those efforts.

18 §440.5. Task force on coordination of Medicaid fraud detection and prevention
19 initiatives; creation; membership

20 A. There is hereby created within the office of the legislative auditor a task
21 force on coordination of Medicaid fraud detection and prevention initiatives, referred
22 to hereafter in this Subpart as the "task force".

23 B. The task force shall be composed of the following members:

24 (1) The governor or his designee.

25 (2) The attorney general or his designee.

26 (3) The legislative auditor or his designee.

27 (4) The inspector general or his designee.

28 (5) One member of the House of Representatives appointed by the speaker
29 of the House of Representatives.

30 (6) One member of the Senate appointed by the president of the Senate.

1 (7) The secretary of the Louisiana Department of Health or his designee.

2 C. The task force shall include the following nonvoting advisory members
3 who, upon request of the task force chairman, shall cooperate with and assist in the
4 efforts of the task force:

5 (1) One advisory member appointed by the secretary of the Louisiana
6 Department of Health.

7 (2) One advisory member appointed by the secretary of the Department of
8 Revenue.

9 (3) One advisory member appointed by the governor who represents the
10 medical field.

11 (4) One advisory member appointed by the governor who represents the
12 dental field.

13 D. At the first meeting of the task force, the members of the task force shall
14 select one eligible member to serve as chairman. Any member except a legislator
15 shall be eligible to serve as chairman of the task force.

16 E.(1) The task force shall adopt rules of procedure and any other policies as
17 may be necessary to facilitate the work of the group.

18 (2) The task force may form subcommittees for examination of special topics
19 and issues within the overall subject matter of Medicaid fraud detection and
20 prevention.

21 §440.6. Purposes of the task force

22 The purposes of the task force shall include the following:

23 (1) To study and evaluate on an ongoing basis the laws, rules, policies, and
24 processes by which the state implements Medicaid fraud detection and prevention
25 efforts.

26 (2) To identify and recommend opportunities for improving coordination of
27 Medicaid fraud detection and prevention initiatives across state agencies and
28 branches of state government.

29 (3) To identify any systemic or systemwide issues of concern within the
30 Medicaid program with respect to fraud, waste, and abuse.

1 (4) To develop recommendations for policies and procedures by which to
2 facilitate and implement all of the following:

3 (a) Random sampling of Medicaid cases to be selected for verification of
4 enrollee eligibility.

5 (b) Improvements in the Medicaid program integrity functions of the
6 Louisiana Department of Health.

7 (c)(i) Optimization of data mining among state-owned data sets for purposes
8 of Medicaid fraud detection and prevention.

9 (ii) For purposes of this Subparagraph, "data mining" means the practice of
10 electronically sorting data through statistical modeling, intelligent technologies, and
11 other methods in order to uncover patterns, relationships, and other indicators of
12 actual or potential Medicaid fraud, waste, or abuse.

13 (5) To make reports to the governor and to the legislature in accordance with
14 R.S. 46:440.7.

15 §440.7. Reporting

16 A. On or before January 1, 2018, and semiannually thereafter, the task force
17 shall prepare and submit to the governor and the legislature a report concerning the
18 status of Medicaid fraud detection and prevention initiatives and the status of efforts
19 to coordinate such initiatives across state agencies and branches of state government.

20 B. At minimum, the report required by this Section shall include
21 information, analysis, and commentary related to each purpose of the task force
22 enumerated in R.S. 46:440.6, and may include any other information as the task
23 force deems necessary or appropriate.

24 §440.8. Termination

25 The provisions of this Subpart shall terminate on August 1, 2018.

1 Section 2. The legislative auditor shall take such actions as are necessary to ensure
2 that the task force on coordination of Medicaid fraud detection and prevention initiatives
3 created by the provisions of Section 1 of this Act convenes on or before September 1, 2017.

SPEAKER OF THE HOUSE OF REPRESENTATIVES

PRESIDENT OF THE SENATE

GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____

APPENDIX B

Meeting Minutes

MINUTES OF MEETING
Task Force on Coordination of Medicaid Fraud Detection
& Prevention Initiatives

Act 420 of the 2017 Regular Session

Thursday, August 17, 2017

9:00 AM - House Committee Room 2

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

Mr. Purpera called the first organizational meeting to order at 9:08 a.m. Ms. Liz Martin, Executive Assistant for the Louisiana Legislative Auditor (LLA) called the roll confirming quorum was present.

Voting Members Present:

Daryl Purpera, Legislative Auditor

Matthew Block, Executive Counsel, as Designee for Governor John Bel Edwards

Senator Fred Mills, Designee for Senate President John Alario

Representative Tony Bacala, Designee for House Speaker Taylor Barras

Ronald Beaver, Chief Investigator Medicaid Fraud Control Unit (MFCU) Criminal Division, Proxy for Ellison Travis, Director of the 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 Kimberly Lewis Robinson

Dr. Robert E. Barsley, D.D.S., Appointed by Governor Edwards

ORGANIZATIONAL DISCUSSION

Introductions – Each voting member briefly introduced themselves.

Review of Act and Purpose of Task Force – Mr. Purpera read the purpose from Act 420.

Election of Chairman – Representative Bacala made a motion to appoint Mr. Purpera as chairman, which was seconded by Mr. Block, and with no objection, the motion was approved.

OVERVIEW OF CURRENT MEDICAID FRAUD
DETECTION & PREVENTION PROCESSES

Attorney General's Medicaid Fraud Control Unit

Mr. Beaver explained that allegations are received from the LDH, and Managed Care Organizations (MCOs) and the general public, as well as other law enforcement agencies. The MFCU screens those allegations to determine if criminal and determine action if warranted. They create a new case and assign it to an investigator and attorney and additional staff if needed. They try to go through their investigation within six months or as fast as possible. They do surveillance, search warrants, conduct interviews, and

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effect arrest if enough probable cause. The MFCU interacts with LDH in regular meetings, biweekly and monthly meetings, as well as meet with the MCO's on a monthly basis to find out what is going on. They also receive recommendations from the FBI and the Federal Office of Inspector General.

For 2017 the MFCU has already received 1,600 complaints to date, and have 534 open investigations, made 72 arrests, and conducted eight search warrants. They collected \$125M annually for the last five years. The budget is comprised of 75% federal funding and 25% from the Medicaid Medical Assistance Fraud Fund that is received from self-generated revenue that goes into the MFCU. So currently the MFCU is not using any state dollars.

Representative Bacala asked for a profile of the 534 open cases. Mr. Beaver explained that the majority of the complaints are regarding behavioral health fraud. They see people opening companies with no good mechanism for the way the billing is done and difficult to see who is actually doing the billing. Also there is no way to determine if the services are actually rendered. The MFCU is seeing a lot of Adderall being prescribed from these facilities. They have established a task force within MFCU to just look at behavioral health companies.

Mr. Block asked if the \$125M collected was broken down by year and categories of fraud, and asked for more details. He explained that the report he received from the MFCU was difficult to decipher and suggested discussing further at a later meeting.

Louisiana Department of Health

Mr. Boutte reviewed LDH's most recent legislative quarterly report which contains statistics of the number of complaints received, the dollar value of recoveries, some cost avoidance referrals and notices to MFCU. All potential fraud complaints are referred to MFCU for investigation. Also in the report are LDH's ongoing case reviews and information on excluding and terminating providers.

Mr. Boutte said that the case types and dollars identified with those cases are shown in the tables, as well as the 525 open cases that their Surveillance Utilization and Review System (SURS) unit is working on. Page 4 of LDH's report shows the managed care summary which is received from the health plans and their special investigation units. The report also shows the tips, recoveries, cost avoidance, and providers on prepaid review, their notices and referrals to MFCU, and the number of audits that they conducted. This report gives the high level overview of some of the statistics in terms of what LDH program integrity actually does. On page 5 they broke out two major bullet points: first, a list of entities that LDH identified as performing fraud, waste and abuse investigations. These are specific contractors that work with LDH through CMS and those would also be involved in fraud, waste and abuse efforts. The second bullet is LDH's prevention and detection processes which include their claims processing system edits. There is a claims adjudication process that looks for issues with claims. Then each health plan has its own claims editing system which identifies issues with claims.

LDH does prior authorization for high risk areas and electronic visit verification that was in place on a limited basis but is being expanded this year and primarily driven at their home community based services areas. They have database checks again on the providers' side looking at adverse actions and making sure the providers are not on the federal exclusions list before they enroll in Medicaid and that is checked monthly to ensure that they keep excluded providers from providing any services in the state. LDH does provider education on how to analyze claims, identify billing patterns, provide information to providers on potential hotspots and issues that LDH identified to address some of the prevention efforts. On the

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detection side, they have a complaint hotline where individuals can call, send emails, or complete forms to share concerns or issues and LDH's SURS unit will review those for validity.

Mr. Boutte shared that LDH also has internal data mining where they look for known issues, such as information from other states and counterparts, and from health plans directly that they are seeing in their networks so LDH can try to identify those same issues in not only fee-for-service but also the managed care side.

Mr. Purpera asked if Mr. Boutte could provide the claims' dollars of fee-for-services versus the MCOs. Mr. Boutte answered that it is about 55% MCO and 45% fee-for-service but about 90% of their members are in MCOs. Mr. Purpera asked if the efforts by the SURS unit are strictly for fee-for-service or also for MCO. Mr. Boutte responded that they look at both but the majority of the cases are with fee-for-service. Most of the open cases will be in the personal care services and home community based services and that specific service is still a fee-for-service carve-out.

Mr. Beaver asked for numbers on the recipient side. Mr. Boutte said they are looking into that specifically and one of the purposes of the task force is to identify recipient fraud. They are looking for a way to identify if someone was kicked out specifically for fraud. LDH has a list of case closure codes but to his knowledge there is not one that explicitly says fraud, but they are looking at how to identify the cases closed for fraud related reasons.

Representative Bacala asked Mr. Boutte to bring to a future meeting the rate per thousand or per ten thousand fraud investigations on the MCO side versus the fee-for-service as that would be interesting differences to review. Mr. Boutte said that on both sides all credible allegations or notices of fraud get referred to MFCU.

Inspector General

Ms. Richard said that any complaints received in regard to Medicaid are referred to the AG's office, even if in another investigation and an allegation arises regarding Medicaid, it is also referred to the AG. They have no open cases regarding Medicaid. She works in the Lafayette FBI office and has access to federal DHH and OIG staff, so sometimes she gets involved in health and hospital issues. Her staff is small but has data mining techniques and willing to help anyway possible.

Representative Bacala asked if she serves on a task force with the FBI. Ms. Richard said the IG's office has a public corruption task force with the FBI. They use IDEA software program for data mining and any time they can get access to raw data they can drill it down. Representative Bacala asked if she has access to other databases than the members on the task force. Ms. Richard responded that she can get access to other information.

Legislative Auditor's Medicaid Audit Unit (MAU)

Mr. Purpera explained that his office has always audited the Medicaid program but after the past year and a half, they have begun to take a new focus. State auditors from around the country are also focusing on Medicaid auditing. He just returned from the National Association of State Auditors, Comptrollers and Treasurers' (NASACT) 2017 Annual Conference where they discussed a major effort on the Medicaid program and benefit payment programs which are becoming such a large portion of Louisiana's budget. The idea is rather than just an annual audit but to do continuous auditing of the Medicaid program because of the high cost and the error rates that the federal government continuously says they have. CMS calls their Payment Error Rate Measurement (PERM) score rate for Louisiana to be around 10.3%, but was as

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high as 18% at a particular period of time. He questions if CMS's numbers were accurate and how they determined those numbers, so his auditors will be looking into that in the future. Some of the other state auditors are also questioning the process that CMS uses to arrive at the PERM number and if it is accurate.

Mr. Purpera had spoken with Senator John Kennedy because Congress is debating the health care act, to see if state auditors could be required to look at Medicaid on a continuous basis. He also spoke with the House Committee on Oversight and Government Reform staff because they are considering legislation along this line. Earlier in the week he spoke with Scott Pattison with the National Governors Association about what that organization can bring and help spread the word to the state auditors. The state auditors were doing what they had to do in order to issue financial statements each year, but there is more that can be done to audit on a continuous basis.

Mr. Wes Gooch, Assistant Director of Financial Audit Services, said he has been associated with the Medicaid audits for the last 20 years. Historically the LLA audits LDH each year and primarily does two things in those audits. First, the auditors look at LDH's financial information that would be significant to the state's Comprehensive Annual Financial Report (CAFR). Every year the Medicaid and LaCHIP federal revenue and expenditures and all of the Medicaid accounts receivable and accounts payable accruals are always significant material items that are audited. That information is provided to LLA's team that audits the state's financial statements. Mr. Gooch explained that Mr. Purpera must sign an opinion on those financial statements. Secondly, they audit the major federal programs under the Single Audit Act. Because of the size of Medicaid and LaCHIP, as well as because the federal grantor call them high risk every year, the LLA audits them every year under the Single Audit. These audits are focused on determining whether or not LDH is in compliance with the requirements set by the federal grantor. The audits are not designed to specifically look at fraud, waste and abuse. However, one of the requirements of the audit is that if the LLA notes any fraud, waste or abuse, then they must run that down and report it. Routinely they examine allowable activities, allowable costs, eligibility, cash management, the state matching requirements, period of performance, federal financial reporting and any special provisions that the federal grantor requires. Routinely findings are noted in the audits when they do this compliance work but it is not normally indicative of fraud. However, any improper payments are considered waste and abuse.

Mr. Gooch further explained that the LLA's performance audit services is also required to be in every major state agency every seven years, but for an agency as large as LDH, the performance auditors are there every year and over the last few years most of their projects have been regarding Medicaid. Performance auditors are looking at programmatic issues as well as specific compliance issues for some categories and projects that they take on. For the last few years, they have had a number of Medicaid projects and given many programmatic recommendations as well as pointed out some compliance issues that could be improved. Again, while not specifically looking for fraud, they are heavily working in that abuse and waste category.

The LLA also receives frequent legislative requests and some of those are regarding Medicaid. They also receive a number of allegations through the LLA fraud hotline and reporting through the website. Most allegations regarding Medicaid are eligibility issues such as a reporting that someone is working but also on Medicaid and should not be. Most of those allegations are referred to LDH for their review in program integrity.

Mr. Gooch issued a caution regarding who the LLA is and what the auditors can do because of the auditing standards. In order for Mr. Purpera to give his opinion on the state CAFR and to do the Single

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Audit, the auditors must maintain their independence. He explained that the LLA absolutely wants to coordinate and cooperate but at the end of the day they are still the auditors and they must still perform an audit function. He explained that the LLA can provide technical expertise, advice, coordination, cooperation, idea sharing, and finance sharing, but reiterated that as they go through the process on this task force, their independence is always going to be an issue to discuss and consider. Some of the main things that the auditors cannot do or lines they cannot cross include making management decisions for the entities that they audit, but they can make recommendations. The other issue is that the auditors cannot be put in a situation where they would be auditing their own work because that would definitely impair independence. Also auditors cannot be performing a consulting service for the same entity that they provide auditing services. Those are some of the issues for discussion on this task force, but there is still a very wide scope of things that auditors can do.

Mr. Gooch reiterated what Mr. Purpera said about how for the last several years the LLA has been branching out and had four separate reports in recent months regarding the new focus with the Medicaid Audit Unit (MAU). The MAU has combined the expertise of our financial, investigative, and performance auditors as well as expanded outside of traditional hiring practices by not just hiring accountants and CPAs but also people with specific data science expertise, knowledge and skills. They have looked for opportunities to further use data analytics with existing software and purchased software. Mr. Purpera has led the office to look at any opportunities for new partnership, coordination, and cooperation on both federal and state sides, as well as reaching out to other state auditors throughout the country so all can share information and do more on a broader scope rather than in independent silos.

Ms. Nicole Edmonson, Assistant Legislative Auditor for State Audit Services, said the MAU's software and use of data analytics allow more than just sampling because now the entire Medicaid database can be put into the software system and run scripts to look for improper payments and outliers. The days of sampling are gone because more of an impact by looking at the data in its totality. The MAU is building the infrastructure with the purchased software to input all of the Medicaid rules so they can run the data through the rules to see instantly if any improper payments. Many of the reports issued by MAU have been on improper payments. They are also looking to build a predictive model to help find outliers that can be fed to the AG's office and LDH to find more fraud, waste and abuse.

Ms. Edmonson commented that Louisiana is on the forefront of a more comprehensive look at Medicaid fraud, waste and abuse by coordinating with the federal government and other states. This task force is a great way to pull everyone together to make sure they are not being redundant. Also helpful is that each agency's tools and skills can be partnered together while still keeping auditors' independence in mind but together making a comprehensive dent in Medicaid fraud, waste and abuse.

Representative Bacala pointed out on page 4 of Act 420, "Random sampling of Medicaid cases to verify eligibility of the enrollees", which the primary factor is verifying household income. He asked if the MAU has sampling capabilities to do that. Mr. Gooch answered that the auditors routinely test eligibility by sample when testing the Medicaid program for the Single Audit each year. Representative Bacala asked what that entails. Mr. Gooch answered that they look at eligibility determination in the files at LDH which LLA has access to that data. The auditors look to ensure all the required documentation and all aspects of eligibility were met for that sample. Representative Bacala asked how they know the integrity of LDH's files – in other words are those simply completed applications showing household income or has LDH checked that number against the income tax records. He asked if LDH or LLA has gone so deep to confirm that the children listed as dependents for the purpose of Medicaid coverage are the same children that are legally listed as dependents on tax documents.

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Mr. Gooch responded that auditors do not currently go that far. LDH has interfaces with certain data sources in order to do that but it is certainly an area that LLA is interested in looking further into eligibility and looking at removing some current obstacles to data that cannot be accessed. Representative Bacala asked what the obstacles are. Ms. Edmonson said access to the data at LDR in terms of looking at people's tax data is protected by law unless they are doing an audit of LDR. But the LLA cannot look at LDR's data to compare it against the Medicaid recipients.

Representative Bacala said he understood the confidentiality of tax records, but the next step if LDH cannot look at the actual tax records to verify the applicant information is correct, is if LDH could send a request to LDR to confirm the household income matches. Also to confirm that the person making the application for dependent children with LDH are not dependents of someone else in the income tax records. He explained further that he is not requesting LDR shares the information but would it still be in compliance with the statute if LDH gave LDR 50-100 random Medicaid applications for comparing against LDR's records in areas A,B and C and determine if they match or not – just a yes or a no, not detailed information.

Mr. Morris responded that unfortunately the secretary's records which would include tax returns necessary to verify those applications are protected by their confidentiality statute. Representative Bacala said he is not asking to look at the records but asking LDR to confirm just for the sampling of the 100 or 50 if the information matches. He must decide if legislation is necessary to aid in this.

Mr. Morris said in his opinion LDR would not be able to provide absent an exception to 1508, which may be the proper remedy to this issue because he understands the efforts of the LLA. He suggested getting an exception to that confidentiality statute, so LDR could provide a lot more useful information to the LLA.

Representative Bacala said he is not an accountant or a lawyer, but does not see where it would be a violation of the principles of confidentiality if LDR just confirms if the samples from LDH matches the tax data. He suggested in the next couple of weeks to get a legal opinion to see if that would be a violation of law. Mr. Morris responded that he would have his staff look at that as well.

Representative Bacala said that is essential to look at the applications for Medicaid and the State of Louisiana has the records necessary to ensure accuracy to some degree. He suggested Ms. Richard look at the federal side since she sits on an FBI task force. He reiterated that he was not asking for information – names or anything like that - just to check a sampling of applications to be sure in compliance.

Mr. Morris said he would have his staff look into this further, but in order to make that determination, LDR would be disclosing if the applicants have the dependents which would fall under the 1508 confidentiality. Representative Bacala said it is no more violating confidentiality than LDR saying they collected X number of dollars for the state last year because nothing specific, just general information.

Mr. Purpera asked if Mr. Morris was aware of any other exceptions. Mr. Morris responded that it is actually done frequently because LDR wants to be able to work with other agencies to arrive with the correct amount of tax collection. Title 47:1508 is the Louisiana state law citing that everything the LDR secretary has is confidential and there are a whole host of exceptions to that rule. Mr. Purpera asked if that statute is being governed by a federal statute. Mr. Morris said this is specific to Louisiana, but there are federal components but that are covered under the federal rules: FTI - federal tax information. Taxpayers' tax return and any information that they give LDR including the number of dependents are

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protected by R.S. 47:1508.

Representative Bacala asked if an applicant was applying for Medicaid benefits for children and in a search of the records of LDR those children were actually listed as dependents of someone else, would that be considered fraud, waste, abuse or a crime. Mr. Morris said certainly if a taxpayer listed a person as a dependent on a return that they are not entitled to, then it is a crime. Representative Bacala reiterated that importance of confirming dependents of the tax filer to be matching dependents of the applicant for Medicaid benefits. He said they must ensure no fraud at the applicant level or even fraud at the income tax level looking at household income to make sure it is being reported and not just one parent's income. He believes all this to be vitally important to the business of the state ensuring compliance.

Representative Bacala would like to see an official request for that information under the random sampling for verification of enrollee eligibility. He questioned if the will of the legislature amounts to an exception since Act 420 specifically asked for the sampling - just not directly from LDR - and maybe that will play into the decision as to whether LDR can give anonymous information back or not. Mr. Morris said he would certainly look into this.

Representative Bacala made an official request that LDR provide this task force with confirmation of sample data stating the percentage of applications to be correct with the tax records. For example, tell the number of applications to be 100% correct and the remainder had some issues with them one way or the other. He clarified that he was not asking for specific information about the difference - only the percentage of information supplied by the applicant compared to the information contained at LDR that did not match up. He hoped by the next meeting LDR can definitely state if they believe this would be a violation of the law.

Mr. Beaver commented that MFCU also sees it on the provider side where some companies show zero income reported. He suggested that if confirmations were made on the recipients that they could also get approval to get confirmations on the providers. Mr. Beaver said that he sees all the time companies that are billing \$2-4 million a year but they report zero income.

Mr. Purpera expressed appreciation for Mr. Morris serving on the committee and thanked Secretary Robinson for designating him. He introduced the two other advisory members – Mr. Jarod Cagnilio and Dr. Robert Barsley and asked if they wanted to speak but both declined. He thanked everyone for their presentations because it does give a good idea of what each agency represented is currently doing for Medicaid fraud waste and abuse detection, prevention and investigations.

PUBLIC COMMENT

Mr. Jeff Drozda, Chief Executive Office of the Louisiana Association of Health Plans (Association), explained that all the health plans represented from all different lines of business including commercial and Medicare as well as all five of the MCOs are members of the Association. He explained that the Association members are not fee-for-service, but are on the MCO side so they have nothing to do with eligibility. He offered their assistance and any information that the task force would be interested in. All five of the plans have very aggressive internal waste, fraud and abuse mechanisms. They incorporate national best practices and turn over any possibly fraud to the appropriate agencies.

Senator Mills thanked Mr. Drozda for the work the Association has done and since he sees best practices in other states that have helped MCO's providing managed care on Medicaid, the task force would

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welcomed his input on any issues or barriers that can be corrected from the standpoint of rulemaking or legislatively.

Mr. Purpera asked if the MCO's would be willing to testify about their program integrity units - what they doing, seeing and finding. Mr. Drozda answered absolutely the Association would assist with that. Since all five MCO's incorporate best practices, he suggested having only one or two come to the table and walk through what they do internally. Mr. Drozda commented that the MCO's are being stewards of state dollars, so their goal is to make sure that the payments do not go out the door incorrectly at all because once out the door it is much more difficult to collect it back.

PLANNING

Future Meeting Dates

Mr. Purpera asked if Thursday, September 7 would work with everyone's schedules. Dr. Barsley requested Wednesday, September 6 because he lectures every Thursday morning. All members agreed that Wednesday, September 6 at 10 am would be the next meeting.

Assignments

Mr. Purpera said after discussion about R.S. 47:1508 he is very interested in that and it has been a issue for auditors for years, so he will ask his legal counsel to look into it and coordinate with LDR to determine exactly what the statute requires. He asked if the AG's office has dealt with this issue. Mr. Beaver responded affirmatively and said he will request an opinion from his office.

Mr. Purpera said his auditors look at the data for only specific purposes so being able to have that information to do data analytics would be huge. He said that this is not looking for the needle in the haystack but a whole field of haystacks, and as Ms. Edmonson stated earlier, sampling does not work in this situation if they want to have a large impact. Sampling only points the auditors to a problem, but does not go to the specific transactions to correct them.

Representative Bacala suggested discussing with LDH on how best to break down this task force study into component pieces. The task force needs to identify component pieces that they want to address and maybe dedicate a meeting to get all the people in to discuss each piece thoroughly. For example, eligibility might be a good topic that may take a whole day. Another identified piece that they need to dig into is behavioral health. He was not sure what all the pieces are, but reiterated that the first step is to identify those pieces.

Mr. Purpera agreed that eligibility is a big piece and another is in Section C of Act 420 "Optimization of data mining among state owned data sets for purpose of Medicaid fraud protection, prevention." They need to inventory those datasets and determine who has access to them. The LLA may have access to data that the AG does not, or vice versa, but they could possibly share. Mr. Purpera said they need to remove as many obstacles to data as possible. Ms. Edmonson said the MAU is pulling together data systems statewide and office wide in the different programs in terms of data systems that have to do with Medicaid. However, the LLA does not know all the data systems. She suggested that all agencies on the task force bring to the next meeting a list of the data systems that they use and what they provide. Then they can look at access issues and sharing agreements and such.

Senator Mills said that years ago when Unisys manned the Medicaid program there were regional committees that pharmacists and physicians sat on and looked at raw data to see what was happening as

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far as doctor shopping. Recipients were going to four doctors and getting duplication of therapy, but MCOs have really worked on correcting that.

However, the task force may want to look at that issue of Medicaid eligibility because people's income streams are fluid and tax returns do not give a true picture especially for seasonal workers. If possible to ensure people that need the services are receiving Medicaid but if they are no longer eligible, then that should be addressed. However, tax returns can definitely help confirm dependents.

Senator Mills said the main thing he would like the task force to see what is happening on the fee-for-service issue and is that care being managed as well from the standpoint of potential doctor shopping. For example, the same person is going to see an internist for diabetes five times. Not sure if that is fraud, waste and abuse but something the committee can look at more. He also wants to look at narcotic usage for Medicaid recipients using the data from the prescription monitoring program. The task force can look at data from the Board of Pharmacy and State Police and get our strategic partners to look at it too.

Ms. Edmonson said that the LLA went to court to get access to the prescription data and looking at that data while doing an audit right now. The auditors have realized that different data systems throughout the state could be pulled into the audit including the Louisiana Workforce Commission and Office of Motor Vehicle data. The LLA's report showed issues with social security numbers being incorrect, but as the auditors become aware of more databases, and as they get access to those databases and using their new data capabilities it can all be pulled together to find more fraud.

Senator Mills said the prescription monitoring program could maybe show doctor shopping, and even look on the providers' side if there have been some issues. Ms. Edmonson said the auditors are doing work on opioid use among Medicaid patients and that leads to all kinds of questions that may have good answers or may show areas where improvement is needed in the state.

Mr. Purpera commented that Senator Mills brought up some really good points, and his staff is doing some work that will show not only financial results such as reducing improper payments but also improving some public safety policies. Senator Mills learned that educating the recipients helped a lot when he sat on peer review committees, and suggested integrating that into the task force goals.

Mr. Purpera said another item as per Act 420 is "(4) To develop recommendations for policies and procedures by which to facilitate and implement all of the following:...(b) Improvements in the Medicaid program integrity functions of the Louisiana Department of Health." The LLA is embarking on a performance audit on that now.

Ms. Edmonson said doing a thorough performance audit on LDH's Medicaid program integrity unit has been on their to do list for a while, but this task force has pushed it up on the priority list, so LDH will receive a formal notification. She explained that the purpose of performance audits is to look at a program, its operations and weaknesses and come up with recommendations to fix it. The performance auditors will work with LDH to see what some of their challenges are, compare it to other states and then determine what can be done to basically strengthen it.

Mr. Beaver mentioned that he was in a MCO meeting the day before and they put together a presentation showing that since the Medicaid expansion the opioid addictions have as nearly doubled. He suggested that the task force also look into this issue. Mr. Purpera commented on a discussion at the NASACT conference about opioid abuse is an epidemic and on the minds of every governor around our country and

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something needs to be done about that.

Mr. Purpera said that Act 420 requests sampling, but in the future sampling will not be the way to fight the problems of improper payments with Medicaid but must use data analytics and predictive models in a more sophisticated manner. The other issue is not only sharing data among the state counterparts that are represented at the meeting today but the auditors around the country are hopefully sharing algorithms so they will not each have to recreate the wheel.

Representative Bacala pointed out that handling of allegations and complaints, and conducting investigations seems to be a little disjointed between the AG, IG, LDH and LLA. When the AG has 434 open cases, then how many open cases does everyone else have or is there one database that coordinates the efforts instead of separate shops and never do they cross. He expressed interest in discussing how these agencies are handling allegations and complaints to ensure that every complaint is at least documented and assigned.

Representative Bacala commented that every dollar saved from fraud, waste and abuse can be pumped back into the system whether through LDH or the state in general. He pointed out that one in three people which means 1.5 million people are covered by Medicaid in the State of Louisiana, so even a small percentage of money saved adds up to a lot of money.

CONSIDERATION OF ANY OTHER MATTER
THAT MAY COME BEFORE THE TASK FORCE

Mr. Purpera thanked the members and advisory members for coming to the meeting that day and reminded them of the next meeting on September 6, 2017.

ADJOURNMENT

Senator Mills offered the motion to adjourn and with no objection, the meeting adjourned at 10:20 a.m.

Approved by Act 420 Task Force on: September 6, 2017

The video recording of this meeting is available in House of Representatives Broadcast Archives:
http://house.louisiana.gov/H_Video/VideoArchivePlayer.aspx?v=house/2017/aug/0817_17_MedFraudDetect

MINUTES OF MEETING
Task Force on Coordination of Medicaid Fraud Detection
& Prevention Initiatives

Act 420 of the 2017 Regular Session

Wednesday, September 6, 2017

10:00 AM - House Committee Room 2
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

Mr. Purpera called the meeting to order at 10:08 a.m. Ms. Liz Martin, Executive Assistant for the Louisiana Legislative Auditor (LLA) called the roll confirming quorum was present.

Voting Members Present:

Daryl Purpera, Legislative Auditor

Matthew Block, Executive Counsel, as Designee for Governor John Bel Edwards

Senator Fred Mills, Designee for Senate President John Alario

Representative Tony Bacala, Designee for House Speaker Taylor Barras

Ellison Travis, Director of the Medicaid Fraud Control Unit (MFCU), Designee for Attorney General
(AG) Jeff Landry

Michael Boutte, Medicaid Deputy Director over Health Plan Operations and Compliance, Designee for
Louisiana Department of Health (LDH) Secretary Rebekah Gee

Tracy Richard, Criminal Investigator, Designee for Inspector General (IG) Stephen Street

Advisory Members Present:

Jarrod Coniglio, Program Integrity Section Chief – Medical Vendor Administrator, Appointed by LDH
Secretary Gee

Luke Morris, Assistant Secretary for the Office of Legal Affairs, Appointed by Louisiana Department of
Revenue (LDR) Secretary Robinson

Dr. Robert E. Barsley, D.D.S., Appointed by Governor Edwards

APPROVAL OF MINUTES

Representative Bacala made a motion to approve the minutes for the August 17, 2017, meeting. The motion was seconded by Senator Mills and with no objection, the motion was approved.

PRESENTATION BY LOUISIANA ASSOCIATION OF HEALTH PLANS
ON MANAGED CARE ORGANIZATIONS

Mr. Jeff Drozda, Chief Executive Officer (CEO) of the Louisiana Association of Health Plans (LAHP) explained that LAHP is the trade association for all the major health plans that operate in the State of Louisiana. LAHP covers not only the five Managed Care Organizations (MCOs) but also all the commercial and Medicare plans as well. He would share what the plans do in terms of program integrity and how they manage fraud, waste and abuse (FWA).

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Mr. Purpera questioned why none of the MCOs chose to attend the meeting. Mr. Drozda responded that the MCOs belong to LAHP so rather than five people speaking for about 4 ½ hours because all the plans do something similar in program integrity, he would provide information for all the MCOs in a clear succinct manner. Mr. Drozda said if anyone had any questions for more specific information to let him know. The LAHP has a close working relationship with the AG and LDH and all three work together on issues. Mr. Purpera said that the state pays the five companies roughly \$6B and personally would have liked for the MCOs to be present to answer questions themselves.

Mr. Drozda said between LAHP, LDH and AG's office they work very closely to identify any FWA issues. He wanted to make the presentation as efficient as possible because the five MCOs have a lot of redundancy in their policies based on federal regulations. He provided background information on the LAHP and said it is committed to a broad based membership including all models of health care organizations that embrace the provisions of quality, cost effective health care benefits. He pointed out health care changes may occur depending on what happens in Washington D.C.

Mr. Drozda began his powerpoint presentation explaining that *Healthy Louisiana*, formerly known as *Bayou Health*, is the state's Medicaid managed care program. There are 1.4 million beneficiaries and if broken into parishes, approximately 1 in every 3 persons would be participants in *Healthy Louisiana*.

The five MCO plans are paid a flat monthly rate determined by LDH which can be determined by region, population, and it is a very complex formula. LDH also sets the provider payment rates. The legislators receive calls from providers not happy with the Medicaid rates, and obviously no one is happy with the rates, but that is set by the state and not the MCOs. However, the MCOs do have flexibility to offer quality incentive payments in terms of trying to give the best care to the members.

Mr. Drozda explained that the five MCOs operate in numerous states and have been operating for decades. He discussed the economic, care, human and community impacts of the MCOs. On an annual basis the MCOs save the state over \$400M compared to the fee-for-service costs. Fee-for-service had little to no accountability, and a limit on doctor visits and unlimited cost to the state. Louisiana and other states realized that moving to managed care does make sense compared to the old fee-for-service model.

Mr. Purpera asked for data on the \$400M in savings. Mr. Drozda referred the members to LAHP's website which has a link to the Wakely Consulting Group's report and offered to pass it out at the next meeting or send a link to the report to the members. The Wakely Consulting Group is an independent actuarial firm for the healthcare industry.

Mr. Drozda said competition between the MCOs regarding free market principles of the program leads to the reduction of overall cost of care. The plans do have flexibility to be as competitive as possible because whenever there is an open enrollment it is up to the plans to offer the best services and benefits to the members across the state. On LDH's website it shows that the enrollment changes month to month based on competition which provides the best care for beneficiaries across the state.

The five MCOs are judged on a national basis for their HEDIS scores which is quality scores that include factors such as the number of visits to the primary care physician; how many individuals are identified with breast cancer or colon cancer; and meeting other chronic care thresholds. The plans are under constant scrutiny to be sure they are meeting these quality measures. The quality of care has surpassed the fee-for-service. The Medicaid recipients have unlimited visits to their primary care physicians with the

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hope to keep them out of the emergency rooms for any nonemergency visits. LDH's website has a wonderful dashboard for *Healthy Louisiana* that shows HEDIS quality threshold measures and scores by each plan.

Mr. Purpera questioned the statement, "The five MCOs are able to offer quality-based payments to physicians...". Mr. Drozda explained that on the commercial side there are star ratings based on the quality measures and outcomes so the plans which are based on millions of claims' data are able to see which doctors show results from their care. The MCOs look for the best doctors and providers and when the budget allows they offer incentive payments

Mr. Drozda explained that the rebate process is complicated and based on a drug by drug and dosage basis. Representative Bacala requested more data about rebates and how they are split between MCOs and LDH because the larger the population then the larger the rebates should be. He also asked if contracts for the MCOs are identical or customized by plan. Mr. Drozda said that the contracts are uniform for all five MCOs to some degree but no one knew the rates at the time when the RFP's came out so the MCOs assumed the risk.

Representative Bacala said it is important for the MCOs to attend the next meeting to answer questions. He asked Mr. Drozda what changes could the state make to save money because he had previously been told that Louisiana requests many more reports than other state. Mr. Drozda responded that the plans have looked at several ways to save money including payment reform within the hospitals, and setting up triage care in emergency rooms for people who are there for less than a full blown emergency. Representative Bacala asked for Mr. Drozda to bring specific information about those ideas for saving costs.

Mr. Drozda said that he received an email from LDH Medicaid Director Jen Steele stating that the current average payment per month per member for MCO's is \$559.44 which includes behavioral services and medications.

Representative Bacala asked if the MCOs are responsible for Medicaid eligibility. Mr. Drozda deferred to LDH to answer that question.

Senator Mills commented that the rebate process is very complicated and the Senate Health and Welfare Committee had spent a lot of time on that issue. He asked Mr. Drozda how MCOs integrate with eligibility from LDH. Mr. Drozda explained that LDH gives a list of eligible persons to the MCOs who work immediately to enroll the people into the health plan.

Senator Mills asked if the MCOs also work with the recipients on goal setting since Louisiana is ranked #1 in obesity, HIV, etc. so the state can only save money if people get healthier. Mr. Drozda responded that they do as many preventive measures as possible working with the hospitals. Based on how many recipients have chronic diseases the payment of \$559.44 is very low.

Mr. Drozda said the MCOs use algorithms and program integrity to find fraud, waste and abuse (FWA) and have turned over numerous cases to the state for investigating. But the plans assume all the risk.

Mr. Purpera asked if the plans work closely with LDH on eligibility because a report from his office showed that about 500 people on Medicaid had no claims for four years and were found to have not lived in the state during that time. Mr. Drozda said that some folks do not utilize their Medicaid benefits and new members need education. If they notice underutilization, they try to find the individuals because

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many are transient and difficult to track down. It is LDH's responsibility to determine eligibility and the plans send out letters immediately to new Medicaid eligible persons when LDH provides that information.

Mr. Purpera suggested the five plans partnering with the state and doing their own data mining to determine if real people. Mr. Drozda said that the information is only as good as received from LDH but difficult if there is no forwarding address. Mr. Purpera asked if any of the five MCOs do work in the state of Washington because that state auditor looked at the MCOs when making improper payments. Mr. Drozda responded that the plans will go after improper payments to get that money back.

Representative Bacala asked about cases for out-of-state care. Mr. Drozda responded that some people live on the state borders and if closer to the metropolitan area in another state, they may visit those physicians and hospitals but must be in the network.

Mr. Drozda resumed his presentation explaining that 2,300 organizations are supported by the five MCOs, which has a large impact on the state. They use many tactics to detect potential FWA, but their goal is to identify FWA before the claims are paid. They have expensive programs to review real time pharmacy activity to curtail the opioid epidemic. Education is the key and they go through great lengths to ensure providers are filling out forms correctly because they do not want to turn a provider over to law enforcement for simple mistakes. Open investigations are referred to LDH and MFCU. Federal regulations guide most processes and govern all FWA for managed care. Louisiana is one of the top in the country for going after FWA. All five MCOs and LDH's program integrity shares information to identify doctor shopping, etc.

Mr. Purpera asked if the five MCOs receive internal or external audits. Mr. Drozda agreed that oversight is important and the MCOs do have audits but could increase onsite audits but that is determined by LDH. Mr. Purpera said that the five MCOs do not get five external audits to look over their processes. Mr. Drozda responded that he can get information about their external audits. He added that the state is taking over credentialing by providers.

Representative Bacala asked for the number of cases turned over to the state. Mr. Drozda said that he prefers to let the state give that number. Mr. Coniglio provided the stats of FWA cases turned over to MFCU from MCO's: 27 cases were turned over in January–March 2017; and 16 cases in April-June 2017.

PRESENTATION BY LOUISIANA DEPARTMENT OF HEALTH ON ELIGIBILITY PROCESS

Ms. Diane Batts, LDH Medicaid Deputy Director – Eligibility Division, and Ms. Shirley Ranger, Medicaid Program Manager 2, and Mr. Chris Chase, Medicaid Program Manager 2, went to the table to make their presentation. Ms. Batts explained that their presentation would be at a high level because there are many ways to apply for Medicaid and a lot of variables. Mr. Purpera asked if there is one place to look for income guidelines. Ms. Batts referred to the links on LDH's website. She gave the percentage breakdown of how applications are received including online, telephone, paper (mail, fax, email or scan), and in person. The eligibility staff must verify missing data, and verify income through Federal Data Services HUB, Louisiana Workforce Commission, DCFS and State Online Query.

Mr. Purpera asked if LDH uses income tax data. Ms. Batts said only if the applicant is self-employed do they request verification from LDR. She explained some of the issues with using tax filings because within one household there may be two tax filing units and it can be very complicated. Representative

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Bacala asked if LDH requests income for everyone in the household. Mr. Chase responded that they use data sources for each person separately and it depends on each situation. Ms. Ranger explained the Modified Adjusted Gross Income (MAGI) federal exception if a child lives with a parent but not claimed on their taxes.

Representative Bacala asked if LDH gets income verification. Ms. Batts explained that if there is a dispute between the applicant's income and what is shown on the sources they use, then LDH will contact the applicant for an explanation. Mr. Chase added that if the explanation is not sufficient, they would also ask for documentation. Mr. Purpera asked if LDH's system continually checks the recipient's income to verify eligibility. Ms. Batts responded that the applicant is required to report any changes to income.

Mr. Morris asked if a self-employed person's state or federal tax returns are accepted at face value. Ms. Ranger said that under MAGI, they accept Schedule C. Mr. Morris asked if tax returns for self-employed persons are being confirmed and Ms. Ranger responded not at this time because they accept the applicant's statement.

Mr. Purpera pointed out that other states use the tax returns to verify income. Ms. Batts explained that a Memorandum of Understanding (MOU) had been put in place between LDH and LDR but it would not work. Only the total household income on the return and number of dependents could be confirmed. LDR was helpful but could not give the necessary information. Medicaid can only use income at the time of application for verification.

Representative Bacala pointed out that LDH must check databases to accurately verify eligibility. Ms. Batts responded that the Centers for Medicare & Medicaid Services (CMS) allow self-attestation. Mr. Chase added that not everyone is a tax filer. Representative Bacala asked what stops or prevents LDH from taking verification a step farther. Ms. Batts explained that LDH and LDR spent a lot of time trying to work out the verification of data, but could not get it to work. Representative Bacala asked why LDH could not ask for all tax filers for a specific address. Ms. Batts said she would check with staff and LDR to answer.

Mr. Purpera pointed out that 28 states currently uses their state tax data to identify residents who are eligible for Medicaid. Senator Mills asked about CMS' minimum requirements for eligibility and if they would allow a higher level of verification. Ms. Batts said that years ago LDH asked for a light bill but CMS wants LDH to accept self-attestation, so a state plan amendment with CMS may be required.

Senator Mills asked for CMS' allowable standards, minimal standards and not only what other states are doing but also other venues. Mr. Purpera stated that LDH chose a variance of 25% between what is self-attested and what the workforce system shows. He asked if LDH had to get approval by CMS since Louisiana is the only state that uses 25%. Ms. Batts responded that the verification plan was reviewed by CMS and does vary by state because some use 0%, 5% or 10%. The state had a 26% reduction in eligibility so LDH had to streamline the process, and the Payment Error Rate Measurement (PERM) rate did not go up.

Senator Mills noted that the Supplemental Nutrition Assistance Program (SNAP) population automatically qualified for Medicaid. Ms. Batts agreed that most people did meet the requirements for Medicaid, so they sent a notification and maintained contact. The health plans will try to find persons within 30 days.

Mr. Purpera asked about the 13,000 out-of-state persons receiving Medicaid benefits from Louisiana but

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had no claims for a four year period. Ms. Batts said that LDH established new processes but some are on state borders and still eligible for Medicaid. Also some people work out of state but are still Louisiana residents. Currently 1.7 million people in Louisiana are on Medicaid and LDH only has 450 Medicaid analysts. Approximately 300 people are on the monthly reports being reviewed and LDH works with the Social Security Administration to verify Supplemental Security Income (SSI).

Representative Bacala asked for further explanation of reasonable compatibility. Ms. Ranger said they review the applicant's income and if under 25% variance between self-attestation and verified income in the system, they can still qualify.

Senator Mills asked if a Medicaid enrollee is on the system but has not utilized any services for 12 months, does the health plan report that information to LDH and how do they handle recoupment processes. Ms. Batts explained that if anyone gives false information that is grounds for fraud. LDH receives many complaints but only has a very small team to investigate complaints so they partner with many agencies. However, eligibility cannot be taken away, but only closed prospectively because of information received, unless they reapply later. Mr. Ellison asked for the number of complaints sent to law enforcement. Ms. Batts said she can find out.

Representative Bacala asked if LDH saw opportunities for improvement in eligibility. Mr. Jeff Reynolds, LDH Undersecretary, responded that LDH only has about 400 eligibility workers and over 1.7 million participants. Representative Bacala commented that there are legislative and other issues but at the very least getting information from LDR about household income and dependents and verifying income quarterly should be done to ensure the right people are on Medicaid. Mr. Reynolds responded that the ultimate problem is the use of data sources. Even if they receive data from LDR the staff must pick and choose data systems and they could still get fraudulent information.

Representative Bacala asked Mr. Reynolds if LDH could come to the next meeting to do a presentation on reasonable compatibility and Mr. Reynolds said they would. Representative Bacala also asked if a random sampling of about 100 applicants including household income and home addresses could be done with LDR and determine the percentage of errors. Mr. Purpera suggested using 300-350 to be statistically valid.

Mr. Morris said that a new exception to RS 47:1508 was added and he would reinitiate the efforts to verify with LDH. LDR can pull tax returns by addresses and wants to help provide the necessary verification. If LDH could provide the name, social security number, and the number of dependents, then LDR can give a percentage that matches but cannot tell which ones do not match or specific details.

Mr. Purpera pointed out that Minnesota's Department of Health did receive access to tax data and found 36% to be ineligible. Representative Bacala asked if LDH could provide 1,000 names to LDR. Mr. Reynolds responded affirmatively and would try to have that verification done by the next Task Force meeting. Mr. Purpera said that his auditors would like to help choose the sample for testing.

Senator Mills asked about the external contractors helping LDH with eligibility. Ms. Batts said the University of New Orleans eligibility staff sits with LDH's eligibility staff to help choose which MCO would be best for each applicant. Also Maximus is an enrollment broker that helps connect people to the health plans. Mr. Reynolds pointed out that LDH determines eligibility and auto assigns the applicants to the MCOs.

Senator Mills mentioned the Myers Stauffer audits on MCOs and that he may want it on a future agenda.

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Mr. Reynold said that Jen Steele would need to be at the meeting to answer questions. Senator Mills commented that it looks like a huge amount of non-allowable costs and would be something for this committee to discuss. Mr. Reynolds said to put it on the next agenda and he will be glad to bring people to discuss.

DISCUSSION OF ACCESS TO DATA

Mr. Purpera said that they had already discussed the issue of access to data. Mr. Travis said that part of the mission of the Task Force is data mining, so future discussions about how the agencies can help each other would be good in a future meeting.

PUBLIC COMMENT

No public comments were offered.

CONSIDERATION OF ANY OTHER MATTER THAT MAY COME BEFORE THE TASK FORCE

Mr. Travis also suggested for a future meeting to discuss behavioral health issues. Mr. Purpera recapped some issues for the next meeting included inviting the MCOs and discussing the Myers Stauffer audits.

Mr. Purpera thanked the task force members for coming to the meeting and they tentatively set the next meeting on October 4, 2017.

ADJOURNMENT

Senator Mills offered the motion to adjourn and with no objection, the meeting adjourned at 12:35 pm.

Approved by Act 420 Task Force on: October 4, 2017

The video recording of this meeting is available in House of Representatives Broadcast Archives:
http://house.louisiana.gov/H_Video/VideoArchivePlayer.aspx?v=house/2017/sep/0906_17_MedFraudDetect

MINUTES OF MEETING
Task Force on Coordination of Medicaid Fraud Detection
& Prevention Initiatives

Act 420 of the 2017 Regular Session

Wednesday, October 4, 2017

10:00 AM - House Committee Room 5
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 10:00 a.m. Ms. Liz Martin, Executive Assistant for the Louisiana Legislative Auditor (LLA) called the roll confirming quorum was present.

Voting Members Present:

Daryl Purpera, Legislative Auditor

Matthew Block, Executive Counsel, as Designee for Governor John Bel Edwards

Senator Fred Mills, Designee for Senate President John Alario

Representative Tony Bacala, Designee for House Speaker Taylor Barras

Ellison Travis, Director of the Medicaid Fraud Control Unit (MFCU), Designee for Attorney General (AG)
Jeff Landry

Michael Boutte, Medicaid Deputy Director over Health Plan Operations and Compliance, Designee for
Louisiana Department of Health (LDH) Secretary Rebekah Gee

Tracy Richard, Criminal Investigator, Designee for Inspector General (IG) Stephen Street

Advisory Members Present:

Jarrod Coniglio, Program Integrity Section Chief – Medical Vendor Administrator, Appointed by LDH
Secretary Gee

Luke Morris, Assistant Secretary for the Office of Legal Affairs, Appointed by Louisiana Department of
Revenue (LDR) Secretary Robinson

Dr. Robert E. Barsley, D.D.S., Director of Oral Health Resources, Community and Hospital Dentistry, LSU
School of Dentistry, Appointed by Governor Edwards

Advisory Member Not Present:

Alicia A. Barthe'-Prevost, LDH Medicaid Benefits Management Section Chief – Medical Vendor
Administration, Appointed by Governor Edwards

APPROVAL OF MINUTES

Representative Bacala made a motion to approve the minutes for the September 6, 2017, meeting. The motion was seconded by Senator Mills and with no objection, the motion was approved.

Louisiana Department of Revenue

Mr. Morris stated that at the previous meetings the members discussed and questioned to what extent tax return data would be helpful in the Medicaid verification process. Provided to the members was an LDR memo updating their tax return analysis of Medicaid applications. LDR worked in conjunction with LDH and LLA to choose the sample population which included approximately 387,000 applicants representing the Medicaid expansion population. The information from the LLA included the applicant's name, social security

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number, date of birth, as well as their gross income annualized by the LLA, and their reported household size. Using that date, LDR was able to provide three different statistics. They wanted to see what percentage of those 387,000 individuals filed a 2016 income tax return. Secondly of those who did file a tax return, to see what percentage matched on their Medicaid application for income versus their federal adjusted gross income (AGI) that was reported on their state income tax return. Third, to get a percentage of those who filed returns how many matched for household size. Generally because of income level those on Medicaid are not required to file an income tax return, which explained some of the results. He shared the methodology of the preliminary review and the results. LDR, LDH and LLA all met to discuss this sampling and agreed that the comparison of gross income and federal AGI would likely produce very few matches. Federal AGI is not very comparable to the Medicaid gross income because AGI includes all income – W2 income, 1099 income as well as employment compensation income. Secondly, federal AGI takes into account several deductions listed on the memo include moving expenses, educator expenses, etc.

Mr. Morris further explained how they compared household size and the number of exemptions on the return. The reason that this is not a very fluid comparison as well is because the dependents that can be claimed on a tax return are not necessarily going to match household size. Because people living together may not have to claim each other on their tax returns but for Medicaid purposes, they would have to report income return together because all in one household unit. He stressed that the memo only disclosed preliminary findings because LDR is still digging through the data and in the testing phase. By the next meeting he would be able to state if the numbers are in fact correct. Of the sample data, they estimated that 56% of the applicants did file a 2016 tax return. Federal tax returns require only reporting when income is over a certain amount. In 2016, a single individual under age 65 with no dependents that earned less than \$10,350 is not required to file a tax return. Using the same criteria, of the 387,000 Medicaid expansion sample only 8% of those would have been required to file a return. So that could explain why only about half of the individuals filed a return. The second comparison is comparing federal AGI reported amounts to the Medicaid reported gross income, and the result was about 6.8% matching. The overwhelming majority only matched because the federal AGI reported \$0 and their Medicaid application was also \$0. There were less than 100 of the entire 387,000 sample that had income greater than \$0 that matched. He did not take this to be indicative of fraud because they did not expect and knew that the income amounts would not match.

The third comparison was of the household size compared to the exemptions reported on the tax returns and preliminary results were a 60% match which was better than expected. This is the taxpayer's spouse and number of dependents matched to the number reported as household size on Medicaid applicants. These were only preliminary results and LDR is considering comparing if the income amounts are only maybe \$1,000 variance which may produce better results.

Mr. Morris stated that LDR noted some of the more concerning discrepancies such as individuals who entered gross income as \$0 on their Medicaid application, but their tax returns showed an income that would put them out of Medicaid eligibility. But before Mr. Morris can report on that he will go through the tax returns to verify information was copied correctly from the handwritten returns.

The LLA provided LDR with the full adult population which is over 800,000 so LDR will be running the same calculations on the full population to see if any difference statistical results. The prior week LDR also requested permission from the IRS to use the Federal Tax Information (FTI) data by completing a *Need In Use Statement* that explains why they want to use the information. They hope to be able to drill down to a certain line on the Tax Form 1040 for a better match to gross income. Mr. Morris said that LDR will continue testing using other methodology and expects to provide the further information at the next Task Force meeting.

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Mr. Purpera asked if asking LDR for only exact matches is not an accurate way to compare. Mr. Morris agreed and said they hope to get approval from the IRS to use the FTI data. LDR already uses FTI data for revenue projections, but because this case is not tax related, and is for Medicaid verification, he is not sure if the IRS will approve their request. Mr. Purpera asked if LDH could make the same *Need In Use Statement* request to the IRS to use FTI data in their eligibility determinations. Mr. Morris said he would have to defer to LDH to answer that. LDR already has an existing sharing arrangement for FTI data for specific uses, but he was not sure if LDH has that same arrangement.

Mr. Purpera commented that this Task Force's purpose is to make recommendations as to ongoing practices and coordination between agencies. He noted that roughly 217,000 of the 387,000 populations filed a tax return, and only about 100 matched because of \$0 income. About 87,000 of the applicants matched because their household size matched which means about 300,000 did not match. Mr. Morris explained that some individuals could be living in the household but because of federal rules are not reported on the federal income tax return and by extension on the state returns. These results appear low and may seem to indicate people are not being truthful in their Medicaid applications, but these are not perfectly matched data.

Mr. Purpera asked if there is a way to modify the analysis to eventually use tax data for household size. Mr. Morris explained if simply a husband and wife, and file jointly they will have two exemptions and if they both file for Medicaid then household size is two. But in the example of grandparents living in the household as well, and if their income is over a certain threshold, they can count the grandparents as a dependent. Mr. Purpera commented that greater detail could be requested regarding the household size on the Medicaid application.

Representative Bacala said the goal of the income study is to determine if people are being granted Medicaid eligibility when they should not. He asked if between the Medicaid application and the income tax filing the dependent units included more details. Mr. Morris said the tax return would list all the dependents. Representative Bacala asked if the dependents have been compared to ensure that the Medicaid application does not include dependents that are being listed on someone else's tax returns. Mr. Morris responded that the IRS confirms that dependents are not being included on more than one person's tax returns, and sends a report to LDR of any such instances so that LDR can disallow dependents being counted twice.

Representative Bacala suggested for the income comparisons to break it out into various ranges to show suspect variances, and also those highly unlikely to be eligible. Mr. Morris said he believes they can have something like that ready for the next meeting showing if maybe less than a 10% variance, and then 10-20%, etc. Representative Bacala said the reported number on the Medicaid application is important and does not want to discount that variance to the tax return, but the important issue is if the income amount for that unit on the tax return exceeded the allowable amount. Likewise if a dependent was included in the unit on the Medicaid application was actually claimed by someone else on a tax return. Mr. Morris agreed that LDR should be able to do that exercise because they have the information from LLA showing the household size and federal AGI.

Senator Mills questioned if the tax data is too stale to provide true value for verifying income because of employment changes and does not give a good picture in time for eligibility. He said the employee's quarterly estimates of paying on taxes of an employee would be more current data. He asked what value to LDH by using that old information. Mr. Morris agreed that the tax data does not provide much value in verifying eligibility for Medicaid, but could be at the most another check box in the process in reviewing the Medicaid application claim, but in and of itself it is completely unreliable data. The employers' filed quarterly

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information with Louisiana Workforce Commission (LWC) or unemployment benefits is already being taken into consideration by LDH. That is very recent and the most current information. Mr. Morris pointed out that someone could have made \$100,000 in 2016 but just now made an application for Medicaid, so he did not see how the 2016 tax return information would have any effect on the last six months of the current year because the person may be unemployed or went through some hardship. Senator Mills said he appreciates the work being done by LDR but does not see the value in it.

Representative Bacala suggested comparing last year's Medicaid application with last year's tax returns. Mr. Morris stated that the sample population was applicants from 2016. Representative Bacala commented that LDR's preliminary results showed only 40% of the applications had matching dependents, and basically the only income matches were \$0. He requested someone from LDH's Medicaid eligibility staff explain what is being done to ensure the applicant is actually eligible and what databases are checked to verify the numbers are correct.

Ms. Jen Steele, LDH Medicaid Director, said that she agreed with Senator Mills' comments because there is a real disconnect in the point in time between when eligibility decisions are made and the tax data. She explained that LDH verifies with the most current available data and not necessarily historical data because circumstances can change so much.

Ms. Diane Batts, Medicaid Deputy Director-Eligibility Division, explained the various data bases and sources that her department uses to verify income for all who apply for coverage. The databases include: LWC; Work Number that provides employment information in better real time than LWC; SoQ to verify social security income; access Paris to get information from the Department of Defense; and records from the Department of Children and Family Services' (DCFS) Supplemental Nutrition Assistance Program (SNAP) to see how the income data compares.

Representative Bacala asked if the SNAP income information is also self-reported. Ms. Steele said that DCFS verifies income when someone applies for benefits and decides if that person's information is accurate. Representative Bacala commented it is a big circle, and asked if the household income has to be determined and who falls within the dependent unit. Ms. Batts said they look at income for everyone applying for coverage and even if they may live under the same roof, they may not be considered in the same financial household because it depends on their relationship

Representative Bacala asked if LDH believes they have a bulletproof eligibility determination plan in place. Mr. Jeff Reynolds, LDH Undersecretary, responded that he cannot say it is bulletproof but with the resources given they do their best. He said the LDR reports that there is not a central point that has all the different data elements. When the federal government passed the Affordable Healthcare Act (ACA) it made a material change to how LDH does eligibility which is to verify as much as they can against the data elements available. LDR may be another data element to help verify income but will not be the catch all fix for what they are looking for. It is a case where the state has to accept the client's provided information unless it can be verified differently. The issue with having to do more verifying and analyzing, then more eligibility workers will be needed. LDH's eligibility workers verify as much as they can but the previous administration cut funding and caused a large reduction in their staff and had to automate more. Maybe they went too far and need to put more resources back into eligibility. LDH is being transparent with the Task Force and welcomes recommendations that can be made to improve the process to be fair both to the clients and to the state. Representative Bacala said that LDH knows better than anyone where any gaps might be and appreciates any recommendations from LDH of how to improve processes because this is a partnership to figure out how to do it better.

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Mr. Block asked how many eligibility workers work for LDH. Ms. Batts responded there are around 420 eligibility workers and some contract support through the University of New Orleans. Mr. Block questioned if some household changes such as layoffs, or a new child being born could cause the tax return to not match the family's current income status. Ms. Batts concurred stating that LDH receives many change reports for people moving in or out of a home, or a baby is born, etc.

Senator Mills complimented LDH for doing as good a job as they can with the resources that they have and the criteria that they must follow. He asked what audit functions are performed to ensure the accuracy of the data. Ms. Batts responded that there are multiple reviews including supervisors closely monitoring any eligibility decisions, and some internal mandatory reviews monthly and quarterly, and also have Payment Error Rate Measurement (PERM) reviews by PERM contractors that review eligibility decisions.

Senator Mills asked for the result of reviews by independent people and if any reversal of approvals where people lost eligibility. Ms. Batts said they used to have an old case review system but it did not collect the data needed, so they have a pretty much manual process right now. There is an appeals process when someone appeals a decision by LDH, then they can do an agency reversal if something done incorrectly at the worker level. Ms. Batts said that she does not have the statistics, but supervisors must review cases before eligibility granted.

Ms. Steele further explained that they have 100's of categories and an error may be made but the supervisors review and correct most. Senator Mills asked if the eligibility process could be fine-tuned from the aspect of the mission of this Task Force and understands that human errors can be made. He requested LDH to report to the Task Force on their current process and also if LDH could have the best of all worlds how it would they improve the process. Ms. Steele said they can certainly do that and added that LDH just completed the design phase and working into development so by next summer they will implement a new eligibility and enrollment system. It will automate many of the functions that are manual today and provide much better data. A large piece is doing verification of cases where data was in the current system but the computer could not access it. With the new enrollment system they will have much cleaner data by next summer.

Representative Bacala asked if an eligibility worker determines eligibility only after checking all sources of data and not just accepting the application at face value without verification. Ms. Steele said there is a clear protocol for different cases to go through a checklist of steps and if they are able to verify with one database then may not need to go further.

Representative Bacala said he assumes that LDH finds people who were not eligible to be on Medicaid but have received the benefits for some time, so that creates the second nightmare of having to remove them from the rolls, recoup federal funds, MCO premiums, and payments to providers. Ms. Steele responded that generally speaking if that determination is made it is prospective because a Medicaid recipient reports that they have a new job, or reunited with their spouse so they have two incomes in the household. At that point in time, LDH will make the change. She said it is rarely retrospective, such as when they learn that the person got on Medicare, or a person becomes incarcerated and the notification is usually not right away, as well as delays in notification of a member's death. There are a number of cases where it is routine to find out after the fact, and those are the ones where LDH has to go backwards.

Representative Bacala asked if any situations where a person could be on Medicare for as long as four years and LDH failed to catch that so must recoup years of expenses. Ms. Steele said usually someone gets Medicare as a byproduct of having applied for disability which that process takes a long time and may have

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appealed several times, so by the time a decision is made, it could be years that LDH has to go back to recover Medicaid expenses.

Mr. Block asked Mr. Morris if someone were to cheat on the number of dependents to become eligible for Medicaid under expansion. Mr. Morris responded that if an applicant were to be not forthcoming about their actual household size it could push a person into another tier where the income level would allow eligibility. Mr. Morris explained that his example on the memo only showed to four dependents, but LDH's chart extends to eight in a household and after that they use a formula.

Mr. Purpera commented that it appears ACA's directive was to maximize enrollments and minimize income-based denials. He asked if there is a federal portal to verify income data from the IRS and asked if this Task Force could do anything to help LDH use it. Ms. Batts explained they do use the Federal Data Services Hub but opted to not use information from the IRS because of the stringent security requirements which the state's Office of Technology Services (OTS) security department would have to explain further. She understood that it would require significant effort to access the IRS data. Mr. Purpera asked if LDH had access to the IRS data with all the security agreements necessary, would it be beneficial for them. Ms. Batts said the information would be in line with what LDH already receives from LDR.

PRESENTATIONS BY MANAGED CARE ORGANIZATIONS

a) Aetna Better Health of Louisiana

Chief Executive Officer Richard "Rick" Born provided background information about when Aetna's contract started for the state in 2015 and is currently the smallest MCO. Mr. Born shared his personal experience and education. He said that fraud is intentionally criminal. MCOs primary purpose is to help remove the waste in the system. Abuse is the unintentional means of gaining within the system. He then gave an overview of Aetna's multi-prong approach to identify fraud, waste and abuse (FWA). Within their claims system they have upfront claims edits to identify – which is industry accepted methodologies in order to identify different coding issues that a provider may do. Additionally from the perspective of ongoing care management within the hospitalizations they monitor and insure that the person needs to be in that setting. They try to manage the patient to insure they have the proper care in the proper setting at all times. On the back side, once the claim has been paid they run a lot of different analytics and sometimes a single claim may look very proper. For example, a behavioral health case may look right but when Aetna reviews the medical record on the back end and finds no start and stop times, then that is an improperly billed claim. They have to do a lot of digging and running analytics to identify those issues.

All the MCOs have a quarterly meeting to discuss different cases and sharing of data for potential FWA activities within a provider in the community. They check their systems to identify any additional items that need to be questioned. If they identify a potential fraud situation, they turn it over to MFCU, but when it's waste and abuse they handle it internally and put claims edits to hold the claim pending medical record review on 100% of that suspicious provider's claims. They recoup the money which goes into the counter data to identify that they no longer have that valid claim - it offsets it with the encounter data turned over to the state. Any recoupments are run through the encounter data to reflect what was actually paid out.

Mr. Purpera asked what efforts Aetna takes to aid LDH in eligibility determination. Mr. Born gave examples of their internal process for communications with LDH when issues locating the member, including guardians who are outside the state but the member lives within Louisiana. Mr. Purpera asked if an individual has not received services in four year, does Aetna notify LDH of that. Mr. Born said they do call visits to identify

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anyone who has not seen a doctor in the past 12-18 months, and take a proactive approach to make sure that the members are receiving their well care visits.

Mr. Purpera pointed out the LDH Managed Care Transparency report dated June 2017 which shows recipients with at least one primary care physician (PCP) visit for Aetna was approximately 20%, so then 80% of Aetna members are not receive at least one PHP visit that year. Mr. Born explained some members only visit specialists but not their PCP. Mr. Purpera said the report also showed that Aetna members receiving one or more services was 88% so assume those might be pharmacy benefit or specialist. Mr. Born explained the time frame of that report was from July 1, 2015 – June 30, 2016, so Aetna's outreach efforts would not have had time since Aetna signed on February 1, 2015, so future numbers will be better.

Representative Bacala asked how Aetna could lower the nonemergency use of the emergency rooms (ER). Mr. Born believes there are some opportunities for better managing utilization. Some methods they use is better transportation especially for the homeless to PCPs, giving some members a cell phone so they can schedule appointments, and partnering with an Orleans Parish company to send an Emergency Medical Technician (EMT) to identify if really an emergency. Mr. Born further explained how difficult to identify claims if it was truly an emergency, but Aetna works with hospitals to offer triage for nonemergency situations in the emergency room, as well as direct members to utilize urgent cares. Representative Bacala asked for the average cost of an urgent care visit compared to an ER. Mr. Born responded that urgent care visits cost around \$100-150, whereas, ER visits cost \$1,000 plus.

Representative Bacala asked if each MCO is asked to do their own certification of behavioral care providers rather than a central registry doing all certifications. Mr. Born said that the state went through a revised process to relicense everybody. Aetna receives a list of those who are not relicensed to remove them out of the network and also try to see if a mistake within the system of them getting relicensed. Aetna partnered with the state to ensure only licensed providers are in their network. Representative Bacala asked if they were able to recoup payments given to unlicensed facilities which could have even gone out of business. Mr. Born confirmed that is a problem.

Representative Bacala asked about children being referred to outpatient and psychiatric residential treatment facilities. He understood that some children use it as an alternative to detention or foster care. Some students that need school tutors are being provided services using behavioral health funds. Mr. Born said they have different controls in place to monitor the appropriateness of those types of services and if inappropriate services are identified as being provided, Aetna will put a stop to it. They also work to recoup any moneys paid for inappropriate services.

Mr. Born said they use data analytics to check times and billings for providers, and will put any questionable providers on a prepayment hold so every situation is reviewed

Representative Bacala asked how much the per member per month (PMPM) rates are and if it included any extras. Mr. Born responded that the PMPM changes on a daily basis because there are 65 different rate cells and multiply that for the four different regions, end up with 260 different rate cells. In 2016, their PMPM overall was \$356.21 excluding the supplemental and kick payments, for example newborn kick payments.

Representative Bacala asked if there is an opportunity to save money if move from the per diem payment basis for neonatal and go to the diagnosis-related group (DRG) rate payments. Mr. Born said the standard nationwide is DRG groupings and definitely good because it creates a closer partnership between the health

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plan and the provider to make sure that the patient is receiving the appropriate level of care and appropriate setting.

He explained under the per diem for every day that the patient is in the hospital, they get paid X dollars. But under a DRG for that inpatient admission, the hospital receives a bundle payment that represents so many days, so the onus is on the physician to manage back to that, so the length of stay for that member is based on a standard length of time. Representative Bacala asked if the per diem basis pays the hospital but they also add for every nurse visit, and doctor visit. Mr. Born confirmed that under DRG the physician components will still be billed separately.

Representative Bacala asked about the selection of drugs based on not just how well they work, but also generic or name brand. He specifically asked about Makena because it costs \$3,850 for a four dose regimen or a pharmacist can compound an alternative for \$262 but yet the state directs the MCOs to use expensive Makena. Mr. Born responded that all aspects must be considered for drugs on the formulary, and not being a pharmacist cannot discuss the efficacy of one drug versus another. Aetna has partnered with LDH on drugs of choice. Within Aetna their generic utilization is in excess of 90%. Representative Bacala asked if the drugs of choice are also based on rebates. Mr. Born said at the end of the day they first must look at the efficacy of the drugs comparison, then look at the lowest net cost and then make the choice based on that perspective.

Representative Bacala asked about quality outcomes. Mr. Born said MCOs have the opportunity to make a difference and work to improve the health outcomes of the patients they serve.

Senator Mills asked if mail is returned as undeliverable if it is reported to LDH because that could be an indication of fraud. Mr. Born responded that it is handled various ways, including verifying with LDH on the address and look at any claims data relative to the member so Aetna will reach out to the provider to verify if they have any different address information.

Mr. Born shared that Aetna provided incentive gift cards to members to encourage them to visit their PCP, but approximately 30 were returned as undeliverable. Those members' phones were also disconnected, so they could be homeless, so they checked with homeless centers. Aetna tries any way to contact the members. He said when he worked in Illinois and the Medicaid program kicked off in October 2015, in his office alone he had a 20 foot wall by three foot tall stacks of members mailing packets returned because of bad addresses. It is a manual process in most regards. Senator Mills asked if Aetna sees some best practices being done in other states that can be shared with the Task Force, and welcomes any input. Mr. Born said that Aetna's national Special Investigative Unit (SIU) team supports the states and runs data analytics but will definitely check if any additional things could be done locally to improve Louisiana's best practices.

Mr. Boutte said that LDH does collect information on why cases are closed. In the previous year approximately 36,000 cases were closed because of out of state movement. Most of that information comes from the plans but sometimes it is reported straight to LDH. He asked about Aetna's more fruitful data mining activities and some sources used to identify FWA. Mr. Born said he could come up with a list and provide to the committee because there are many aspects such as the software used for the upfront claims edit perspective which is pretty standard within the industry. The data analytics is looking from a broad perspective to understand what could go wrong in a billing situation, such as ambulance upcoding but the city ordinance may allow them to bill at that level, so they have to pay it because otherwise it was not justified. Mr. Born provided other examples of where data analytics found abuse and recouping from claims. When a

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new provider comes on board there is a lot of education upfront and ongoing versus beating them up when they make mistakes.

Mr. Purpera asked if Aetna's SIU undergoes an audit. Mr. Born said that all MCOs participated in an external review of their program integrity by CMS in March 2017 and a report was issued to the MCOs and LDH. Additionally they also have External Quality Review Organization (EQRO) which is part of the transparency report and have that type of audit every year.

Mr. Purpera assumed that Aetna makes regular referrals to LDH and the AG's office, but data from the AG's office only showed six referrals. He asked for statistics of referrals for criminal cases. Mr. Born responded that in 2016 they made two referrals and in 2017 so far four have been made because those were identified to be fraudulent, but within their monthly report to LDH they have over 75 open cases that they are collecting data and evaluating if those cases fit within the FWA perspective. Mr. Purpera asked approximately how many claims are processed by Aetna each year. Mr. Born said a lot, but not sure, but definitely millions of claims. Mr. Purpera had heard LDH state there are about 150 million claims per year between MCOs and fee-for-services, so to only have three referrals for possible fraud seems very low. Mr. Born forwards only the claims after thoroughly vetting and identified as fraudulent and does not refer frivolous waste items to LDH to investigate for fraud.

Mr. Born said at the quarterly meeting with LDH is where they share data and do further data mining. Mr. Purpera pointed out that the fraudulent allegations from the fee-for-service providers are vastly more than the MCOs. His other concern is that the longer MCOs probe and vet out a possible fraud, then it will be old data and not useful for the AG to investigate.

Mr. Purpera asked about the report dated December 31, 2015, by Myers and Stauffer LC, that Aetna Better Health of Louisiana achieved a Medical Loss Ratio (MLR) of 97.1%. Then in an article he found online stated that Aetna's MLR had fallen to 78.6% in its commercial business. He asked if Aetna is able to be more efficient in its commercial line than the Medicaid business. Mr. Born said they are not comparable because for commercial line business, Aetna has complete control on the rate setting to sell to the marketplace. Within the Medicaid program, it is based upon a retrospective review of claims and trend information to set the rates, and those Medicaid rates is a big driver of the MLR. He said prior to the Medicaid expansion Aetna's MLR was 97%, but they are now managing it down. Later information coming from Myers and Stauffer will indicate that Aetna's MLR is much lower than currently.

Mr. Purpera asked if Aetna would have any recommendation for the State of Louisiana to achieve a lower cost. Mr. Born said they share ideas through the dialogue and partnership with LDH, and have advocated for changes such as DRG reimbursement versus per diems. Currently there is not a copayment on ER visits, and that may be something to look at changing to help control unnecessary visits to the ER. On the pharmacy side, one of the biggest challenges for Aetna is the cost of HIV drugs and Hepatitis C drugs. They need to be sure that the correct medications are being appropriately prescribed. There are other refinements that can be made from a managed care perspective.

Senator Mills asked for any best practice suggestions to bring down expenditures from all the MCOs. He asked if the aforementioned gift cards are included in the 85% spend or if above and beyond the call of duty. Mr. Born responded that is a value added benefit that is not included in the calculation for the rates that LDH provides to the MCOs or in the MLR. Each MCO made a commitment to a certain level and proud to state that Aetna committed to \$2.55 and have actually exceeded that so providing additional benefits beyond what agreed to in the contract.

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b) AmeriHealth Caritas of Louisiana (AmeriHealth)

Ms. Melissa Bezet, Director of Compliance and Regulatory Affairs representing on behalf of the President Kyle Viator, explained that AmeriHealth started operations in Louisiana in 2012 with the rollout of the Bayou Health program which is now Healthy Louisiana. AmeriHealth is a privately owned corporation and has over 30 years of Medicaid Managed Care experience. They currently have full risk Medicaid operations in Washington DC as well as six states.

Ms. Andrea Lopez, Director of Special Investigations Unit, said that AmeriHealth is committed to being as proactive as possible. In July they held a fraud protection week at the plan and invited participation from MFCU and LDH. They held an internal panel to discuss case development from inception to completion all the way to possible prosecution. To help educate the entire team and get the word out to increase the awareness for those who have hands on experience with members and providers. The goal is to review and investigate any tip from any source to either negate or substantiate them. The fraud protection week was a very successful partnership and event and plan to continue and expand to other lines of business as well. Ms. Lopez said that they participate in the quarterly and monthly calls and meetings with LDH, MCOs and MFCU to share data and information on all the activities for the providers and any member issues going on, so all work together on the issues collectively.

Ms. Lopez shared some of the benefits of the proactive working group with the MCOs and LDH, and through that collaboration found a possible federal and nationally dispersed case. They take provider screening very seriously and conduct on an ongoing basis as their handout indicated. Each month AmeriHealth sends an extract of participating and non-participating facilities, pharmacies and providers to their vendor to perform a screening to prevent inappropriate payments. The vendor also monitors various databases daily and notifies AmeriHealth of any issues. AmeriHealth also does ongoing monitoring of the exclusion listings to ensure timely notification to the plan of any facility, pharmacy or provider that becomes excluded. Representative Bacala asked for the results of the screenings. Ms. Lopez responded that she does not have the statistics with her but can provide to the committee, and assured him that it is low.

Mr. Purpera asked for the number of referrals sent to MFCU. Ms. Lopez said the referrals have increased dramatically this year but would have to get the specific number for him. Representative Bacala asked the reason for the dramatic increase. Ms. Lopez responded AmeriHealth ramped up their proactive data mining activities which have resulted in a number of additional cases that are being opened. They added another step within their process that they conduct additional screening of a tip to remove as many false positives as possible prior to it escalated to a full investigation. They also added resources for the investigative unit locally so that increased the number of cases that they can work until the point of referral. They refer creditable allegations of fraud to MFCU and the state.

Representative Bacala asked if they see more cases in any area. Ms. Lopez responded that they work a high number of cases in the behavioral health area such as billing for services not rendered as well as some transportation issues. They do member service verifications and found providers billing in excess of units provided. AmeriHealth also does proactive data mining in the pharmaceutical area dealing with opioids.

Mr. George Ramsey, Director of Program Integrity Client & Vendor Management, shared AmeriHealth's goal for continuous process improvement by using Business Intelligence gleaned from the retrospective process, focused audits and SIU investigative trending, to implement and improve increased prospective savings. Various algorithms are running in the front end with vendors and internal systems to prevent up front

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erroneous payments. And retrospectively, they utilize advanced data analysis such as data mining, also using lead detection and pattern analysis tools, and respond to tips and referrals that suggest claims are being paid inappropriately. He explained their Program Integrity overview flowchart on the last page of their handout in detail with examples. Claims Overpayment Recovery System (CORS) is an in-house system developed by AmeriHealth to track all projects and recoveries.

Mr. Purpera asked if they discover an overpayment are they changing the encounter claims data used for the actuaries. Mr. Ramsey responded that if they chase the carrier from coordination of benefits or if a claim reversal, that feeds into the encounter process which is sent to LDH. Mr. Purpera asked if independent auditors are reviewing the design and performance of their processes. Mr. Ramsey said that CMS comprehensively reviewed their process in March 2017 and had gone through five CMS reviews in the last two years, as well as answered questionnaires in four different states approximately two years ago from the Office of Inspector General. Mr. Purpera asked if CMS actually visits their offices or just reviews the data. Mr. Ramsey explained that some visits are made depending on the state but not going through the details, because CMS mostly reviews the process and data.

Representative Bacala asked for AmeriHealth's PMPM. Mr. Ramsey said he did not have that information because his area is Program Integrity.

Senator Mills asked if LDH makes the MCOs follow through on the recommendations given in the Myers and Stauffer report. He pointed out the final recommendation in the MLR report regarding a sizable amount of money which AmeriHealth's management disagreed with Myers and Stauffer. Ms. Steele said that the decision on how to make the adjustments rests with Myers & Stauffer because they are the auditor. The health plan can disagree and provide additional information but if Myers & Stauffer does not believe it is an allowable cost or it's misclassified, they make the adjustments as they see fit in their calculations.

c) Healthy Blue

Mr. Chris Utley, SIU Manager, represented Healthy Blue formerly Amerigroup on behalf of the Chief Executive Officer Aaron Lambert.

Mr. Purpera asked how Amerigroup sent MFCU 28 referrals in fiscal year 2016-17. Mr. Utley responded that an investigator who worked in Louisiana was heavily involved in two projects that made many referrals to LDH and MFCU for them to possibly work on that information. Mr. Purpera asked if Amerigroup worked those cases to the point that they knew it was definitely fraud and ready to go to a prosecutor. Mr. Utley said several cases were worked to that point but others had the same method of operation, so turned over the similar cases to avoid a delay in getting all information to LDH and MFCU. He enjoys very open communication with LDH and MFCU because one of their investigators in Louisiana is a former MFCU agent so he has a great report and they all work together as a good team.

Mr. Purpera commented that already eight referrals were sent to MFCU in the current fiscal year. Mr. Utley said that Healthy Blue is working a lot of behavioral health cases which is a large issue in Louisiana.

Representative Bacala asked of the 28 referrals were those individual providers. Mr. Utley confirmed that each referral was about separate providers. But he could not absolutely confirm that all the same providers were working for all five MCOs. Representative Bacala asked if Healthy Blue provides greater scrutiny to providers once they learn other MCOs have identified them to be questionable. Mr. Utley said he participates

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on the conference calls with the other MCOs that are organized by LDH and share information about problem providers and other issues.

Representative Bacala asked if behavioral health is the biggest problem area for outright fraud in the state, and Mr. Utley agreed based on his experience. Representative Bacala commented that the MCOs took over the behavioral health side within the last year from Magellan, so that is brand new area for the MCOs. He asked if similar behavioral health issues are seen in other states. Mr. Utley said there is a higher concentration in Louisiana, but behavioral health is a top tier issue in most other states. The residential setups in Louisiana are a little different than other states, and he would be glad to get with some other states and see if any regulations imposed that might help keep that problem at a lower level.

Senator Mills asked if Mr. Utley was familiar with spread pricing, and he responded that he was not. Senator Mills asked Mr. Reynolds and Ms. Steele to look at Adjustment #4 of the Myers and Stauffer MLR Examination on Amerigroup. The report states “As a result of our analysis, we estimated the difference between actual incurred claims cost and the amount reported on the MLR was \$6,894,601.” Senator Mills said Amerigroup’s response was “The State has not prohibited inclusion of spread pricing...Absent formal guidance from the State on these types of limitations in the MLR calculation process, we do not believe that the auditors have the authority to exclude spread pricing from the MLR calculation.” He asked for an explanation of spread pricing and how some of these groups own their own pharmacy benefit managers (PBMs) and also how it was resolved.

Ms. Steele explained that spread pricing is the distance between what the plans pay the PBMs on a PMPM basis and what the PBMs actually pay the pharmacies for the drugs. Shown in this and two other MLR audits is an adjustment where Myers and Stauffer adjusted out the delta because they just want to know for MLR purposes what was the medical expense and that was the dollars spent on the pharmacy service, not the administrative service provided by the PBM. So LDH has provided guidance for prospectively saying MCOs cannot count it that way, but must be reported the way that the auditors have recommended.

Senator Mills asked if the \$9.8M was clawed back. Ms. Steele said it was not clawed back, but did not count it in their MLR, so it counted as an administrative expense for them. Senator Mills asked if they allow spread pricing between the PBM and the MCO. Ms. Steele explained that the MCOs have to make it fit within their margins. LDH will pay the MCOs for their medical costs and pay a certain amount for their administrative costs, and if they can figure out how to work in paying for the services that the PBM provides within that aggregate amount, and also meet LDH’s MLR minimum requirement, then LDH does not prohibit the MCO for paying for the PBM service.

Mr. Reynolds further explained that the \$6.8M got classified as an administrative cost rather than a programmatic or cost for service, and did not get credit as providing services for that \$6.8M to the citizens. Ms. Steele said it was not an unallowable as an expense, but not allowed as a medical expense. Senator Mills asked for an explanation of the consequence of doing that. Ms. Steele said for example if they were on the margin at 85.5% and had included this as a medical expense, then LDH said no, because the goal is to make sure that they are not counting things that are not true medical services in determining the MLR. Senator Mills asked if other states allow spread pricing as part of the administrative cost. Ms. Steele responded yes.

Mr. Purpera asked if Healthy Blue makes site visits to the providers of those behavioral health services. Mr. Utley responded that all their investigators are in Louisiana so they pair up and go on site visits often. They also have a Program Integrity Officer that is separate from SIU but works with that person frequently. All cases are solidified if a fraud issue or a billing error when make those site visits.

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Mr. Utley said besides him, their SIU has three investigators located in Louisiana with combined experience of over 80 years between healthcare fraud, law enforcement, corporate investigations and homeland security agent backgrounds. He explained Healthy Blue's Program Integrity's efforts across the board corporately and within the state to stop FWA. They stress the prepaid side to stop the payments before made. In Louisiana alone between 2015 and September 1, 2017, they prevented \$8.4M from going out the door on the prepaid side by SIU. Their SIU also recovered about \$461,000, and their total internal recovery for the Program Integrity is at \$9M in physical dollars that they got back. So the total program saving for Louisiana is \$91.5M between Program Integrity and investigative efforts. Also they have had Monitor the SWAT Team for SIU for national projects that include every state because they have 23 markets with Anthem including Louisiana. They have had successes for the NICU upcoding, DRG situation, and lidocaine review, and looking at outliers for prescribers and members, as well as opioid prescription recipients who are not getting other medical care. They are also looking at the ER and ambulance transports to confirm if actual medical care is being billed.

Mr. Purpera asked what Healthy Blue does to assist LDH in eligibility. Mr. Utley said they have a member services group that verifies members and any suspected fraudulent referrals are sent to SIU for investigation to vet before sending to LDH or MFCU for law enforcement.

Mr. Boutte asked Mr. Utley to elaborate on the difference between SIU and Program Integrity. Mr. Utley said that SIU falls under Program Integrity, but SIU handles the reimbursement policy and claims editing and algorithms constantly running, and vendors that are "scrubbing" all the claims to make sure all is appropriate and if not then picking them up. There are also internal people within Anthem and Program Integrity officers within Healthy Blue in the state handle administrative edits, coding issues, clinical edits, reimbursement policies, and provider education. Within Program Integrity they also do prepaid claims reviews, recovery sections and coordination of benefits and complex audit looking at the medical records by the nursing staff to ensure care properly being done. The final piece of that is SIU but all work together in tandem for program integrity overall.

Representative Bacala asked how many nonemergency uses of the emergency rooms occur. Mr. Utley said they investigate that issue some but probably the only way to determine is if there is a lack of medical care at an ER visit. But that is usually a case-by-case basis and they have to look at the records. Mr. Utley responded to Mr. Purpera's question about Medicaid coverage stating that Healthy Blue is available in 23 states.

d) Louisiana Healthcare Connections (LHCC)

Vice President of Compliance Alesia Wilkins-Braxton, SIU Director Dan Kreitman and SIU Manager for Louisiana Sparky Heevner represented LHC on behalf of Chief Executive Officer Jamie Schlottman.

Ms. Braxton said they welcome the opportunity to share their very proactive focus on FWA prevention program as outlined in the powerpoint presentation. They run a Program Integrity function as well as SIU that includes both proactive reviews of claims' edits as well as post payment investigations. They work collaboratively with the MFCU and LDH Program Integrity Unit. LHCC has six investigators who live in the state and are primarily focused on Louisiana investigations, and of that three are focus primarily focus on behavioral health investigations. Ms. Braxton commented that they have heard the questions from Representative Bacala but are not prepared to answer those questions today but plan to follow up with him on those.

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Mr. Kreitman explained that Centene Corporation owns LHCC and about 30 other MCOs and specialty companies that they operate in over 30 states, and is currently the largest provider of Medicaid services in the entire country. Centene has over 110 investigators, analysts and clinicians that work on their very collaborative team and most work out of St. Louis, Missouri where the corporate headquarters are located. Mr. Kreitman is a retired police officer who was primarily focused on narcotics enforcements and tactical teams. After retirement he managed and developed large scale SIUs for MCOs.

Mr. Heevner said that he manages the central region for the SIU which includes eight MCOs and also the behavioral health investigative team. He also has a law enforcement background and has been both property casualty and healthcare investigations.

Mr. Kreitman shared about their strategic focus on FWA cost prevention with 30-35 team members focused on prepayment reviews before money is sent out the door. It is a very tedious process of looking at laws for each state and reviewing the claims thoroughly. The fraud team works with the payment integrity team which works on all the waste and light abuse issues for Centene, and Mr. Kreitman oversees the fraud team that works the heavy abuse and fraud cases. This year to date between the payment integrity and the SIU they have saved over \$17M from going out the door being paid to providers for various reasons, i.e. not billing properly, modifier concerns, etc. The old pay and chase model that the medical health industry uses is very slow and labor intensive and typically does not get recovery. Some providers will set up shop for a couple of months and then leave, and LHCC sometimes gets only settlements for pennies on the dollar, so they much prefer the cost avoidance model.

Mr. Kreitman directed the members to page four of their presentation that gave details on their comprehensive FWA program. They use state of the art software to systematically evaluate “aka scrub” every claim that goes through their system. They prevent the FWA from that system and it triggers investigations. LHCC does prepayment investigation for in-depth medical record reviews and unannounced onsite audits – quite a few in Louisiana. They have 12 analysts on their team of which two are dedicated to Louisiana for data mining/analysis to identify aberrant billing patterns and outliers for both internal and third-party analysis. But they are a very collaborative workspace and every week they have a round table meeting and all investigators from every state gets together to discuss FWA going on in the industry. Typically fraud starts in Florida, for some reason, and then it migrates over to Mississippi, and Louisiana all the way to California. So it is very good for their investigators to have the signs on their radar in the states that they are responsible for. Centene also has 30+ clinical compliance reviews such as CPC coders, nurses, occupational therapists, licensed professional counselors, etc. Behavioral health is a big issue in the industry as a whole right now, and opioid epidemic which is completely out of control. Mr. Kreitman said that he speaks around the country and testified to the major issue of concern with the \$45B a year industry of sober home living facilities and intensive outpatient therapy center which will also be an issue of concern for Louisiana moving forward.

Centene specializes in Medicaid and especially behavioral health and pharmacy. Mr. Kreitman said that Mr. Heevner runs a team of 8-9 behavioral health investigators, and they also have 9 behavioral health investigators that only work in intensive outpatient therapy and sober home living facilities. They have very good cooperation and support with investigations with referrals to law enforcement. Their investigative team includes former law enforcement, chiropractors, and lawyers. They have internal SIU counsel so when cases are presented to law enforcement they outline those cases well for prosecution.

Mr. Purpera asked if they have a number of cases that are prosecuted each year. Mr. Heevner said three referrals have been made to MFCU in the past year and nationwide it is much more than that. In California alone they are reviewing providers with federal and local law enforcement. Mr. Kreitman said they have

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about 300 open cases in Louisiana that are going through medical record review and quite a few may be presented for prosecution. Their SIU as a whole runs about 5,000 cases open on average and obviously Florida and California have been affected the most with the opioid epidemic.

Mr. Purpera commented that LHCC has the most members in Louisiana and is the largest MCO. He noted that only three referrals were made by LHCC to MFCU in FY2016-17 and none for the current year to date. Mr. Kreitman said that is due to their extremely aggressive prepayment reviews so it does not get to the level of fraud by stopping the payments, and put edits within their system to stop providers from billing them. Mr. Purpera asked if they have an outside audit firm review their process other than CMS. Mr. Kreitman responded that annually an outside audit firm reviews all their files and processes, and do tracer samples from inception to completion.

Mr. Purpera asked how many site visits have been done in the past year. Mr. Heevner estimated six to eight site visits in the last 12 months. They are working on big projects coming to fruition before the end of the year such as an “impossible day” which is where providers are billing in excess of possible hours in one day. Their primary focus is to work with all the MCOs because claims data may look normal in their data, but find out that same provider is billing other MCOs. By working in partnership with other MCOs and combining data it shows the overall billing is a problem.

Mr. Purpera asked for the number of behavioral health providers in their system. Mr. Heevner responded that it is 1,000s and not sure the exact number. But LHCC has as many open behavioral health cases in Louisiana as they have Medicaid cases at this point because of a huge problem with behavioral health across the board. Almost every case has huge concerns such as start and stop times, but see plans of care with no end outcome to them, and providers trying to get to the next billing rather than how to get the person better based on the documentation. The plans of health and care for people with behavioral health issues are really poor.

Representative Bacala asked if LHCC verifies credentials to ensure qualified and licensed providers. Mr. Heevner said they do check all licensing from several sources and specialize in SIU with licensed clinical social workers, psychiatrists, physical therapists so they can better understand the records that they are reviewing.

Mr. Kreitman said on a national perspective they work with an organization called the Healthcare Fraud Prevention Program which is a CMS run program. This program did an “impossible day” study for the behavioral health providers across the entire country and covers about 15 of the largest MCOs along with maybe 30 other smaller MCOs and work the FBI, OIG, DEA, CMS and other federal organizations. This study found a huge problem after aggregating all their claims data together for every MCO and discussing best practices. Centene is working in Texas currently and proactive to help states organize health care fraud task forces to aggregate data. Mr. Kreitman said they have 14 million members and billions of claims that go through their system annually. The last year they found over 500 behavioral health specialists across the country that were billing more than 40 hours a day to all the MCOs that were participating in this program. The providers know that if the MCOs do not collaborate and work together, they can get away with stealing from MCOs.

The referrals to SIU by LHCC include reactive, prepay and retrospective. They utilize media and social networking to find any newspaper articles about the providers and red flag those. LHCC verifies services with members, track any suspicious patterns or billing outliers prior to payment, perform data mining for member and provider data. They use Health Care Fraud Shield (HCFS) which does all their retrospective referrals. They run about 1,500 different algorithms to look at provider billing patterns and assign every provider and

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facility a risk score within this system. They work with the investigators at local plan levels to help understand the different areas and root out the real fraud issues.

Mr. Block asked if all LHCC's efforts, as well as the other plans, are basically to improve the bottom line of the MCOs because they carry all the risk. Mr. Kreitman agreed that it does help the profit of the MCOs but his investigators are not held to any particular return on investment (ROI), but instead they focus on relationships and opportunities for improvement. Their main focus is member care and safety. He personally dealt with over 1,300 providers in California and 4,500 members that went through sober home living facilities and intensive outpatient therapy and 10% of those members died because they went through fraudulent facilities and therapy. He personally spoke with many of the parents and very sobering experience. If the MCOs do not stop the providers from conducting FWA, not only are they stealing from the state of Louisiana but also hurting and killing members. Centene does not push the bottom line and ROI with their employees.

Mr. Block asked if the construct of MCOs is that the risk of fraud is on MCOs, so they are incentivized to root out the fraud on the front end before prepayment and also to recoup when fraud is found. Mr. Kreitman agreed that money is saved as an organization because of their robust FWA program. Mr. Block said if the MCOs are making payments because of recipient or provider fraud, those are payments made by the MCO and not additional payments by the state. Mr. Kreitman agreed.

Senator Mills asked how many providers has LHCC reported to the Board of Medical Examiners or the Board of Dentistry or Nursing. Mr. Heevner said once the investigation is complete it goes back to the health plan who will then make the referrals to the boards or law enforcement. Senator Mills asked if any reportable action against a provider has led to sanctions or revocations by any state boards. Mr. Heevner responded that in the past year Louisiana's main issues has been documentation so they educate the providers, and now require the providers to sign attestations that they received the education so they can be held accountable for their errors. Only if they find real intent to commit fraud and documentation to substantiate fraud will they refer the cases to LDH or MCFU.

Mr. Kreitman said they find a lot of opioid over utilization from the member perspective, and will lock those members into one provider or hospital or pharmacy. Mr. Heevner commented that sometimes after locking in the members to limit their accessibility to pain killers that is when the member may call an ambulance to try obtaining medications through the ER.

Mr. Kreitman continued their presentation on the prepayment review process, records review process, clinical prepayment reviews and retrospective reviews. They let providers know when they are doing a great job, or educate them if find errors, delve deeper into their medical records if any issues, and may do onsite visits. If providers do not respond to LHCC they will do prepayment reviews for up to 100% of their services. This is a very tedious process because LHCC understands network continuity, provider abrasion and cognitive of that when working with the health plans.

Mr. Purpera asked LHCC if they had any time restraints and would mind allowing UHC to testify because they had a flight to catch.

e) United Healthcare (UHC)

Mr. Joseph Popillo, Director of the Medical SIU, and Andrew Kahara, Director of Program & Network Integrity for Optum (sister company to UHC), represented UHC on behalf of Chief Executive Officer Allison Young.

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Mr. Popillo said that they did not have a presentation but wanted to state that they are very passionate about protecting people. But there is a ROI component, and their saying is “Protect people and the dollars will follow”.

Mr. Purpera pointed out that UHC is the second largest provider in Louisiana. MFCU’s data shows that UHC sent 56 fraud complaints in FY2016-17 but sent only one referral so far this fiscal year. Mr. Popillo said he would have to look at the data because they have sent more cases into LDH and may be under development. Once UHC has an allegation of FWA, they do the development and if credible suspicion of fraud then it is sent to LDH, but other steps are necessary before sent to MFCU for criminal investigations.

Mr. Purpera asked about their prepayment process and if any auditors perform an external review of their process. Mr. Popillo responded that an advantage of national coverage is testing and reviews are done multiple times each year for everything from system demonstrations to walkthroughs. They will pull samples of a claim or provider under investigation and go through every component including notes by the investigator and corrective action. Mr. Purpera asked again if they have an external review. Mr. Popillo said from an external review perspective, he could not answer that question. Mr. Kahara redirected to Mr. Block’s question about incentives for a commercial customer that bears all the administrative costs and risks themselves, pointing out that they are very interested to make sure that all the prepayment reviews are working effectively because they are actually on the hook for those dollars. So they see a lot of auditing through the Administrative Service Only (ASO) customers. Maybe not by a big four audit firm but some of the other entities that will audit processes on behalf of their ASO customers.

Mr. Purpera assumed that the MCO is totally at risk and to their advantage to find all improper payments. However, he also believes that if the MCOs do not find the improper payment then it is just another claim which is going to the actuary who will use that data to compute future PMPMs. He proposed a future conversation on how PMPMs are devised to get to the bottom of that issue. The State of Washington’s Auditor did a report on this and concluded that if FWA or improper payments are not discovered, then all the costs will go into the data which results in higher PMPM for the future. He agreed with Mr. Block that it is to the advantage of the MCOs to find improper payments or FWA, but cannot discount the effect on future PMPMs. Mr. Kahara purposed that if an MCO does not address the problems then they would probably fall behind. Mr. Purpera suggested further discussion at a later meeting with LDH to understand the calculations of PMPMs.

Senator Mills shared that the Senate Health & Welfare members receive a lot of calls from providers complaining that they are being underpaid for services. As MCOs are investigating there is also a disconnect because providers believe they are highly underpaid for contractual obligations. Senator Mills said there is data showing friction between the providers and the plans. He asked how the plans distinguish between provider fraud and recipient fraud, and what triggers them to determine fraud on both sides and then determine what to be reported to a regulatory agency and share that data with other health plans.

Mr. Popillo said one distinction is when services are not rendered, and might be that a beneficiary states that they do not recognize the supposedly performed service. When UHC asks for medical documentation from the provider to verify services it is because they already billed UHC. But when there is no sign in logs or medical records to substantiate the billing, then UHC can only determine that the services were not performed. His investigators do not stop at that one claim but also look at the rest of the claim universe and possibly go back three years of data and do a random sample to request medical documentation on whatever services is in question. If documentation cannot be provided on half of the services, then very tough questions

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must be asked of the provider and sometimes they do not have a good answer. Those are the types of referrals that are very powerful to LDH and, as all MCOs have mentioned, the partnership of every MCO and state and federal agencies is the only way to be successful. LDH disperses the information to the other MCOs and that helps connect the dots for the investigative teams. Across the United States today, it is not the provider submitting a single claim that is the biggest threat but it is organized crime. When you hear things like Equifax losing 143 million identities, our harsh reality in this country is that the problem is not going away. Those are potentially credit cards against every state and federal agency and the MCO. One question that was asked was how to strengthen this partnership. They need more prosecution and to do that we need a larger number of cases. UHC has regional task force opportunities that do not just take in one state because organized crime utilizes the banking and legal system in their ground intel to propagate fraud. So the success comes in a regional attack. Not only Medicaid is at risk because one example is the opioid crisis has spurred labs popping up across the country billing for all types of testing. They are finding these labs are billing for every possible test they can once they get a person's name. When that information is shared on a regional or national level, they can get these labs off the street because to attack the root of the problem is to remove the nefarious actors in the system and prosecutions become critical.

Senator Mills asked if those types of fraud are being identified in Louisiana. Mr. Popillo said they have numerous investigations across the country that have Louisiana coverage, and maybe the dollar value is lower but it does not mean that the act is not happening. When they combine their information with other MCOs it turns the case into something larger. Organized crime today is focusing mainly on the commercial space and Medicare space primarily because their ROI is higher because the fee schedules are there. But occasionally that does impact Medicaid, but UHC treats it all the same because they want to protect people.

Continuation of Louisiana Healthcare Connections (LHCC)

Ms. Braxton referred the task force members to slide 16 of their presentation regarding the best practices used by other states for consideration. Mr. Kreitman shared that the Healthcare Fraud Prevention Partnership is one of their best practices as far as in the federal task level to share the claims data and consolidating all the claims. It is tedious and takes time to get MCOs working together because they do not want to give up proprietary information. They do not give up any HIPPA or private information of their recipients. They only share claims data which has been scrubbed.

Mr. Heevner said the Texas Fraud Prevention Partnership is a state task force that consolidates the MCOs' claims data to get a comprehensive view of provider billing and get a full picture of what is happening. When MCOs look at only their data it may look normal, but when start combining the billings with other MCOs they can then see a pattern or concern. As they get more information, then they can do more robust investigations. Mr. Purpera asked for the members of the Texas Fraud Prevention Partnership. Mr. Heevner responded that it includes all MCOs, MFCU, IG, OIG, and all the different entities are involved in that partnership. Mr. Purpera asked where the combined data is maintained. Mr. Heevner responded that the Texas Department of Health maintains and runs the data.

Mr. Heevner said LHCC has outside sources perform audits but also put a corporate internal audit team together that audits LHCC's investigative department by reviewing their processes, practices and makes sure they have good solid investigations. They also have monthly management audits on their investigators by looking at cases that are closed to review from open to close what works and does not work in their practices. The health care industry changes weekly if not daily sometimes as regulations and policies change. They strive to be the best SIU that they can be. Mr. Kreitman added that they have an internal auditor that works within their team that just audits files of their investigators.

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Mr. Purpera asked if LHCC is providing data to the Texas Fraud Prevention Partnership that is not being provided to LDH. Mr. Heevner responded that every claim that comes in is scrubbed through many different software and sent to the Texas Department of Health and all the other MCOs so a full picture can be seen. Ms. Braxton added that it is encounter data. Mr. Purpera asked if the spread of the data is possibly 500 fields. Mr. Kreitman said the universe is fairly close because if they have 500 fields that is just too much information to look through.

Mr. Purpera asked if the Texas task force is working, then maybe that idea is something to be considered by this task force. Mr. Kreitman said that encounter data is not provided in Louisiana where all the MCOs are sitting down at the table and sharing what they see with providers – that is not being done in the state of Louisiana. Mr. Purpera asked if Molina is capturing all that data in Louisiana.

Ms. Braxton said that the data being provided of each of the MCOs in their encounter files but what is different in Texas is that their Department of Health is comparing the date and feeding it back to the MCOs via the task force. They have had instances where the Department of Health Program Integrity Unit has shared information about providers for a particular issue, for example an “impossible day” or a comparison for all the MCOs of an ob-gyn that had a large number of deliveries across all the health plans. When LHCC does investigations they can only see their data on a particular provider, but as they work through monthly calls and quarterly meetings with the Department’s Integrity Unit that is where they can receive additional data about another health plan that may be reviewing a provider for a similar issue, and get feedback to determine that a provider could not see that many MCO members in a particular day across all MCOs. Mr. Heevner added that in Texas they are trying to be proactive rather than reactive.

Mr. Purpera explained that over the last year his office and LDH have worked together to create a vault of information with LDH’s system. He understood that the MCOs were providing information to that vault which in turn his office performs data analytics and predictive analytics using that vault data. He asked if LHCC is providing data to Texas that they are not providing to Louisiana. Mr. Heevner said he was not sure but would definitely get an answer for him. Mr. Purpera said he believes Louisiana is doing similarly and responding to the MCOs when an issue has been identified.

Mr. Travis stated that MFCU, LDH and the MCOs do have quarterly meetings and share data. There is also one task force with all MCOs which is very aggressive. If there are any issues or problems with a particular provider, LDH will provide comprehensive data across the MCOs so that they can compare and watch out. Mr. Heevner asked if that is the Payroll Task Force and said that it has provided a lot of good information. Mr. Travis confirmed that LHCC is active on the task force but not sure why the number of referrals was so low.

Senator Mills asked if LHCC is seeing different numbers in Texas or other states on fraud and abuse. He reiterated the purpose of this task force is to give recommendations on better standard operating procedures. Mr. Kreitman responded that there are about 1.5 million members in Texas, so based on the size alone they will see more cases. They also see more organized crime in Texas especially in southern Texas where drug cartels are getting away from bringing drugs across the border and now they are owners of hospital systems, pharmacies and DME companies and committing fraud in those areas. That issue is not prevalent in Louisiana, but more common in Texas or Florida.

Senator Mills asked if Louisiana is part of the Healthcare Fraud Prevention Partnership. Mr. Kreitman said it is only the MCOs and not any individual states. Senator Mills asked if all five of Louisiana’s MCOs are a part

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of that partnership, and Mr. Kreitman said he only knows that United, LHCC, and Anthem are in the partnership, but not sure about the other two MCOs.

DISCUSSION OF MEDICAID MANAGED CARE TRANSPARENCY REPORT FOR STATE FISCAL YEAR 2016

Senator Mills commented that this report had already been discussed partially such as PMPM, MLR, and PCP visits. However, he would like for the task force to get more clarity because as page 33 of the report shows PCP visits are still a concern. He said that even if a member visits a specialist, they should also visit the primary care physicians for wellness visits and vaccinations. Louisiana leads the nation in almost all bad health categories. Senator Mill discussed the pharmacy benefits portion of the report on page 48 and 50. He explained the portion of the state's supplement rebates versus the federal rebates comparing pre-managed care and when a fee-for-service with only one program. In 2010-12, the state was averaging \$40M on the state supplemental side and he would like to find any potential savings.

Ms. Steele explained that the state is always eligible for federal rebates whether fee-for-service or managed care. But the supplemental rebates were lost when the state went to managed care. While the total federal rebate revenue has been going up because the enrollment has also gone up, but the supplemental rebates have gone down. Some alternatives for getting some of that back can be discussed. Senator Mills suggested a frank discussion on whether six prescription management companies are really necessary, or maybe consolidate into one to get a better savings on the rebate side.

Ms. Steele said LDH advanced a notice of intent to do a single preferred drug list (PDL) for select therapeutic classes but concerns were raised by some stakeholders that LDH felt were legitimate and needed to address specifically. As Mr. Born from Aetna raised the point earlier, there are two approaches to minimizing or optimizing drug costs. On the fee-for-service side historically in Medicaid we chase the rebates because that is how we get the net lowest cost. But on the managed care side, they chase the generic utilization. What we are considering actually after pausing on that notice of intent is to take an approach more like the latest state that is moving forward with a single PDL which is Ohio. What Ohio has done in their strategy is instead of our last when we were going forward with a PDL by therapeutic class, we were really focused on that traditional fee-for-service approach, so some of the questions that were posed to us were "well what about the generics". What Ohio is doing that is different is they are striking the optimal balance between the generics and the brands to make sure that they are getting the best across the board that is clinically approved. But looking at net cost on both sides and not just chasing one of the other, so again on the MCO side we will see heavy emphasis on the generic dispensary but on our side we are focused on the net rebate, but Ohio is blending the two to get the best of both worlds. LDH is in active discussions with actuaries and rebate vendors who did that in Ohio to see if they can guide us on how to get there. They are doing a wholesale single PDL not by therapeutic class.

Senator Mills asked about the Miles and Stauffer MLR reports that shows spread pricing and how LDH watches the process with the MCOs owning their own claims processing prescription benefits and it is like first cousins dating each other. How are we figuring out the true cost and how we get the best bang for our dollar. Ms. Steele said in response to some of Senator Mills' questions, they came up with a number of formats to do the transparency report that year and met and talked about it, but LDH is trying to become more granular in their reporting requirements so they can see as much as possible. But there is a part that they just cannot see, and there is a point at which we cannot have total transparency because of the contracts between entities.

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Senator Mills said that if the PBMs have charged for a certain service owned by that entity, they should not be able to up spread or pricing on it. It just does not seem fair to the taxpayers of Louisiana, but he knows there are constraints. He suggested meeting to discuss further and report back to the task force on the spread pricing issue. Just one PBM that is owned by the MCO is \$19M in spread pricing. Another spread pricing owned by the PBM is \$16.3M. Ms. Steele agreed. Mr. Reynolds said they are willing to work and look at the issue to determine what recommendations can be made, and knows the Ms. Steele and her staff have spent a lot of time looking at this issue.

Ms. Steele commented on the primary care questions that the measures in the transparency report are per the statute so not necessarily the way that LDH would measure it following national standards. For example, that particular measure is looking at the number of people who went to their linked PCP. Keep in mind that not everyone chooses that because the PCP may be assigned and not know who that person is, so they consequently do not go to that physician. However if you look at national measures called HEDIS measure which is measured in a standard way called adult access to preventive primary care. For fiscal year 2017, the rates for that was 78% overall, and for the non-expansion group it was 84% and for expansion group it was 73%, which is not bad. This focuses on people who have been continuously enrolled for 12 months, so not saying that person who signed up just last month has not seen a doctor yet. She said it is important to look at those standard measures, not that the homegrown one is not instructive in some way, but it is a very limited lens into the PCP visits. Senator Mills said if that transparency report needs to be modified to make more standardized so that they are comparing apples to apples we welcome any input from the committee level on that reporting. He knows they fought for so long to just get the report out there and it was a battle legislatively years ago. Ms. Steele said that LDH has been working with some of the stakeholders who advanced the legislation about the possibility of aligning it with the reporting measures that are standard. LDH just recently updated what our incentivized quality measures will be and those overlap with these in a number of ways so it would be nice to have standardized measures that have national credibility instead of homegrown measures. Mr. Reynolds added that they have reached out to Senator Johns who was the author of the original bill.

Senator Mills wanted to get some information out to the committee so that we can understand. In response to SR163, it is tabbed and he knows that it is raw numbers but wants LDH's help to understand the spreads. On page 5 and table 4 it shows the PMPM paid to each plan just the expansion population in August 2017 was \$226.5M, and on page 6 is shows that the service expenditures for the six most costly service covered by Medicaid totals \$64.4M. So is that spread \$226.5M - \$64.4M, is that a gross profit number or what does that reflect.

Ms. Steele said that claims lag and how does it take for someone to get in and how long does it take for the bill to come in and how long does it take for that to be reported. So just the encounters alone which she believes the data was generated off of, they have 25 days to turn it in to us from the time that they pay it. First they have to get the claim and has to be billed. We've talked about this a lot because knew it would look terrible, but it does because I paid you \$100 for month and you put that in your pocket and I did not come in until say October for a first visit. So the way that the capitation rates are structured is, for example if it is determined that it costs \$1,200 per year to cover Senator Mills' healthcare cost, I will pay \$100 per month. You may not use that benefit until November when you get the flu. It does not mean that the health plan ran a profit for all those months, it just means that the cost is incurred later. So those PMPM rates are the average of what they think they will spend each year on a monthly basis. So that is what you are seeing here, a combination of when the costs hit plus the claims lag. Senator Mills asked if they will have that delta at the beginning of every fiscal year. Ms. Steele said it will close over time.

Representative Bacala suggested dedicating some meeting time to pharmacy issues as well as other specific

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topics, and would appreciate input from LDH on that. Ms. Steele said some time on pharmacy could help with education. Representative Bacala asked if over the last few years LDH has changed and allowed the MCOs to handle the pharmacy issues and perhaps now tightened up to be more uniform. Ms. Steele responded yes, a little bit.

Representative Bacala said he's not trying to draw any conclusions, but alerting them to topics that he might want to talk about. He asked if each MCO negotiates their own rebates. Ms. Steele said that is correct. Representative Bacala asked if at some point in time LDH is supposed to know how much rebates the MCOs are getting and using that number to back it out of the administrative fees or use in the calculations of the MCO's PMPM. Ms. Steele said that is right.

Representative Bacala said he received some information from Mr. Reynolds yesterday to pass on. Their highest mark around 2012 on state rebates was about half a billion dollars, and that has gone down to about \$100M today. It seems like it is gradually going down, so today the state receives about \$403M in drug rebates. Mr. Reynolds said that is what LDH is budgeted to receive in 2018 right now. Representative Bacala said it might be good to discuss the formularies because every MCO has their own preferred drug list driven by the fact that they have negotiated rebates on their own. Ms. Steele said that is correct.

Representative Bacala said he's not sure if that's a bad idea but they should discuss whether it is or isn't because they will point their members to the drugs that have higher rebates rather than cost savings to the state – not sure if that's a true statement but wants to ask that question. Ms. Steele said they have a common PDL because there was a requirement added to the contracts, that the MCOs agree on a common PDL, so not required that they agree amongst themselves to put certain drugs on a common list and then those do not require prior authorization. There is some synergy.

Representative Bacala said prior approval for some of the more expensive drugs, and not sure if they would benefit or consider if they would benefit without harm to the participants in some manner of preapproval of some the more expensive drugs especially if there are alternatives that are just as effective. That would be a topic for further discussion rather than just in passing.

Representative Bacala said the feeling he is getting about the ERs is that probably about 50-70% of emergency room visits are for nonemergency care. Yet all of those people had simply gone to urgent cares, and know they can never make it 0%, but if we were able to - the potential there is for about – if you could bring them all from \$350-400 emergency room visit to a \$150 urgent care visit, you would be talking about saving a quarter of a billion dollars. At some point he would like to talk about how big this problem is, and what the potential savings are, and if it really is a quarter billion then worth pursuing options that we can take to perhaps reduce that. He said this topic should be on a future list of To Dos.

Representative Bacala asked if roughly \$50 is added to every PMPM for supplemental payments. Ms. Steele said that is really included, but the reason when you are asking each plan that they give you a slightly different answer is that it depends on their mix of membership. Some have more high costs. But roughly it is \$370 PMPM inclusive of the supplemental payment.

Mr. Reynolds said that includes the hospitals, physicians and ambulance. Representative Bacala said if the supplement payment PMPM is roughly \$50 then that amounts to \$900M paid to the MCOs that is just pass through money to the hospitals, ambulances that receive supplemental payments. He would to look at this issue further, and he understands that the supplemental payments are largely driven by....there are specific factors like hospital in Monroe compared to a hospital in Winnsboro get different payments based on

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geographical or census factors, but if those factors were last studied in 1993 but a lot has changed since then.

Mr. Reynolds said that is correct and Jen could probably talk for the next four hours on resetting the hospital program and all the work she has done in the last year to do that in the department – taking guidance from Dr. Gee and actively working with the hospitals and hospital association to reset that program because of those issues you just identified. It is a case with Medicaid expansion we feel like there has been a material change to the program and we are looking to reset these programs where the money follows the patient and not whatever deal you cut back in 1993. Representative Bacala said he is glad they are working on it and think its worthy of discussion. Mr. Reynolds said he completely agrees. Ms. Steele said they intend to put out a report by the end of this month that will give a recap of everything that is going on with the hospital payments and bring everyone up to date. It would be good after the report is published to discuss it further.

Representative Bacala said they touched on the DRG – and LDH is interested in that as well. Ms. Steele said yes, it's a bundle. Representative Bacala said he heard LDH being highly complimented on the fact that if someone does not respond to mail in 60 days, LDH is very aggressive to find out where they are or cut them off.

Mr. Boutte suggested for future meeting topics to include the purpose of the task force is coordination of Medicaid FWA, and the one element on data mining has not been touched on yet. He suggested giving attention to all the data mining activities that all are doing so that the report due in January incorporates all the elements that the task force has been charged with covering.

Mr. Purpera asked about the Wakely Report that covers February 2015 and January 2016 regarding assumptions and actuarial data. He asked if there is a way to look back now and determine the real cost savings. Ms. Steele said that the LLA did a report following the Wakely Report. The last time LDH did that comprehensive cost saving analysis was around the transition right after the transition to fully capitated model. Ms. Steele said the recommendation in the LLA's report was to bring in an outside independent actuary not hired by the plans or LDH to do the evaluation. They have not had the means to do it yet. She stated that it is all in the assumptions. Fundamentally this would be an exercise in what would the program have cost absent managed care, which there is really no way to know how much that would be. The report by LDH was reviewing parallel populations at a time when they both existed in Louisiana, so it is purely a hypothetical exercise and does not believe it to be a good use of money but others may disagree. Mr. Purpera agreed it would probably not be worth it.

DISCUSSION OF THE 2015 MYERS AND STAUFFER MEDICAL LOSS RATIO AUDIT REPORTS

Mr. Purpera said these reports were already discussed throughout the meeting.

PRESENTATION BY LOUISIANA DEPARTMENT OF HEALTH ON REASONABLE COMPATIBILITY

Ms. Diane Batts, Medicaid Deputy Director – Eligibility Division, presented a powerpoint presentation based on questions at the previous task force meeting. The Affordable Care Act (ACA) introduced a new concept of reasonable compatibility to streamline the eligibility decisions. This process is to minimize the amount of paperwork required to verify income when LDH can get that information from other data sources. So basically an individual's sworn attestation is compared to electronic data sources. State regulations say that the self-attestation and data sources are considered "reasonably compatible" if both are both below, at, or above the eligibility threshold, even if the amount of income in the attestation is difference from the amount in

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the system check. LDH requests documentation only when the difference between the attestation and data source affects eligibility.

Ms. Batts' presentation provided the regulations and verification plan followed. In September 2013 LDH initially submitted Louisiana's Verification Plan with a 10% reasonable compatibility income standard. Then in September 2014 LDH changed the plan to increase the standard to 25% which was consistent with how income was verified prior to the ACA for certain populations. Federal regulations do not allow self-attestation for citizenship, immigration status or social security number because all needs documentation. Louisiana accepts self-attestation for the following eligibility factors: residency, age, household composition, pregnancy and caretaker relative status. LDH also accepts self-attestation with additional data source verification for: Medicare entitlement/enrollment, third party liability and income.

Ms. Batts explained LDH's income verification process for reasonable compatibility and the data inventory and sources utilized to verify income. She explained that income verification is a manual process and requires worker intervention. LDH's powerpoint presentation also explained the frequency of income review and provided date on the cost for bi-annual and quarterly income reviews. Their current system is unable to do more frequent reviews and prohibitive because they are in the middle of developing a new eligibility system is scheduled to go live in July 2018.

Senator Mills asked if LDH could have the best of all worlds and modify their current Medicaid Eligibility Data System (MEDS) to interface with Louisiana Workforce Commission (LWC) for the estimated \$2M, what percentage would the federal government pay. Ms. Steele said that it depends, but most likely between 75%/25% – 90%/10%. Ms. Batts pointed out that the issue is the time it would take to modify the current system when LDH will be using a new system by July 2018. Ms. Steele added that LDH has been in the development of the new eligibility system for over a year and literally just passed the window to make any further changes. They are in a delicate period where they have to lock down any changes to their current system and will have to make some patches to the Legacy system. They simply have to stop design and get the program completed.

Mr. Purpera asked for the number of reductions in the eligibility staff. Ms. Steele said over the course of the prior administration it was roughly 26% and Ms. Batts said that equaled about 250 people less in her department. Mr. Purpera asked if the new system will be able to compare to the tax data. Ms. Steele responded no, and explained that tax data is not a good data source for decision making because they need current real time information. She further stated that tax records are only necessary for verifying income for self-employed applicants.

Mr. Purpera questioned if the reasonable compatibility income standard had stayed at 10% and not changed to 25% in September 2014, could that have caused a population to not be eligible for Medicaid. Ms. Steele explained why they changed the percentage. In 2014 the federal government expected LDH to change how they made eligibility determinations to what they called modified adjusted gross income. It was the first time that they had to look at tax households in determining eligibility. This change was a complete reorganization of how LDH made decisions, policies, systems, etc. Immediately proceeding that, LDH was in the middle of the new eligibility contract which was ultimately cancelled. It put them on the eve of compliance with the CMS requirement as unable to deliver. So LDH was late in 2014 coming into compliance with a patch to their Legacy vendor and could not handle the volume, so they had no choice. She believes once they are in the new system and able to automate some steps and have some workload reductions, then they might be able to adjust that percentage. However, retrospectively she is unable to answer the question of whether the outcome would have been different by staying with 10% but frankly they had no choice but to do what they

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did to handle the workload. The eligibility staff was getting a backlog of marketplace applications in the 100's of 1,000's that had to be worked, so it was just not feasible to stay where they were.

Mr. Purpera stated that from everything he read from CMS and other groups, it appears that whole idea behind the reasonable compatibility standard was the streamlining to not use documentation. Ms. Steele said that is absolutely true because if it will not affect the eligibility decision then it was a waste of effort. Mr. Purpera said by stretching to 25% then it seems to somewhat open it up to individuals who are not eligible but are now eligible. Ms. Steele said it certainly could, and reiterated what Undersecretary Reynolds stated that if they had the resources then they could do more.

Mr. Purpera commented that this Task Force is looking for ways to save money and sometimes spending \$1 to save \$5 if a good idea. Having those comparisons could be worthwhile, but definitely did not want to cost additional money. Ms. Steele pointed out that they also certainly do not want to be unable to perform their core responsibilities of timely application processing, etc. just because of adding workload.

Mr. Travis asked if the new inputting system is for processing the recipients. Ms. Steele responded that the new system is more automation and more data interfaces for verification and require less manual labor. Mr. Travis asked for some features or differences in the new system, and what savings it may have because that information may figure into what the task force would recommend for next year. Ms. Batts answered that years ago they had a streamlined efficient process for determining Medicaid eligibility and was even the "Goldstar Child" in the nation because people looked to LDH for ideas. When the ACA came and the contract for a new system had to be cancelled and LDH basically put bandages on the current mitigation system to get to where they need to be. This caused a lot of work arounds. For example, just a simple address change used to be in one place, but now workers have to go to three different places to locate an application and check the status, this it has increased the workload. Processing an application would ideally be one worker from start to finish, but unfortunately now it takes multiple people working that one application. With the new system they will be back to faster and smoother processes.

Mr. Travis asked if the new system will have any extra verifications. Ms. Batts believes the interfaces that LDH has today will also work in the new system. Mr. Travis requested more information on the annual renewal process, and Ms. Batts explained that it depends on the type of renewal because some require full touch where a form may be required back from the applicant. Otherwise, they verify ex-parte where they go to other sources to get the necessary information to determine the member's eligibility and extend their renewal. Mr. Travis asked for what triggers the renewal process. Ms. Batts said that CMS requires and LDH agrees that best to look at the available data sources and no sense in contacting the member. Ms. Steele explained that it is more efficient from the standpoint that nothing has to be mailed out and wait for it to come back, or close the case because of no response and then reopen the case because a month later the member's swipe card was not activated and they needed care.

Mr. Travis asked if anyone is automatically renewed without having to verify information. Ms. Steele said they do have select cases that are put into administrative renewal for a more efficient use of time. For example, grandparents who are raising their grandchildren, as per LDH's rules the grandparents' income is never counted so as long as the child in that home. It is pointless to do income verification and does not require the full review. LDH tries to be cost effective and efficient, and they had to economize due to the staff reductions. During that period of time after staff reductions their PERM rates were extremely low and Ms. Steele offered to provide the reports from that time. They streamlined the process with no loss in quality control.

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Mr. Travis asked how many referrals were made by LDH to law enforcement. Ms. Batts said she could not answer, and Ms. Steele said she would get that information for him.

Mr. Purpera asked if the 25% factor allowed ineligibles to be on the Medicaid roles will that put the state at risk with CMS. Ms. Steele responded that LDH is following their rules and the verification plan is approved by CMS for the 25%. Mr. Purpera's research found that 10% was the most commonly found reasonable compatibility percentage, and states can also use a fixed dollar amount of \$15 as an example. He understood that tax data may have a lag in information and not be the most current. However what if someone has a regular job but also has their own business or investments earning income and does not disclose that information to LDH, and basically that person is committing a fraud against the state. He questioned why LDH would not want to use the tax data to provide more information.

Mr. Purpera expects that when the samples are run again by LDR they will see some absurd differences in income amounts. Mr. Reynolds suggested that LDH's eligibility department work with LDR to use the tax data as another tool in order to have as much information as possible. As they learned today it will not be the cure all, but would be beneficial. His hope is with the new system LDH can interface with LDR to get that additional information so the eligibility staff can make the most reasonable decision in the best interest of the state. Mr. Purpera agreed and said he just wants to help get the best information for LDH.

Representative Bacala understood that LDH could not handle the load of processing in 2014 so that was why the reasonable compatibility was changed to 25%. He assumes it was also because there were so many people outside of the 10% that LDH had to change it to 25%. Ms. Steele explained that 2014 was when the ACA was implemented so it was the year that the exchanges began which brought interfaces between Medicaid and the exchange. Part of LDH's job with that exchange was to take the application and decide if the applicant gets the subsidies or goes to Medicaid. There was a whole bunch of data coming in, and the applications were coming into the marketplace and going into the ether. It took a while to work out the kinks with that, and literally it was not about people between 10-25% and had nothing to do with the variance, it was simple the volume of applications that started coming in and had to make decisions on. By having that 25% threshold it meant fewer verifications were required and they could say it was close enough. The eligibility staff could make a decision and move on to the next of the 99,000 applications.

Representative Bacala said he believes they are agreeing that 10% was going to put more work on LDH's staff. The extra 15% gap helped because of the anticipation that a lot of people would be beyond the 10% mark. Ms. Steele said she could not answer the question whether it would really make a difference in the outcome, but it makes a difference in the work process.

Representative Bacala asked if the reported income covers all income earned within the dependent unit. For example, the application comes in showing the applicant's income is \$20,000 and two children. What if that person is married and the spouse is not on the application, would LDH check the husband's income or verify there is no one else in the dependent unit that should be included? Ms. Batts said it depends. If they identify that someone has another person in the household or the income unit that they have not reported by looking at other data sources, then LDH would definitely follow up and request additional information.

Representative Bacala wanted to be sure that LDH is also identifying as best as they can who should be included in the unit and not just accept the self-attested document. As mentioned earlier, LDH cannot use the grandparent's income when they have grandchildren living with them and they are automatically renewed. He asked if it simply about residence but what if the parents are wealthy. Ms. Steele responded that is a federal rule. Representative Bacala asked hypothetically if he had children and did not want to pay for health

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insurance, could he just say that they live with my parents. He asked if anyone checks further than just an attestation that grandchildren are live with grandparents. Ms. Steele said her understanding is that the grandparents have to have custody of the grandchildren. Ms. Batts added that not all have court orders because sometimes the parents do not take care of the kids so the grandparents step in to provide shelter, food and necessities. Representative Bacala asked how they verify other than attestation. Ms. Batts said the grandparents attested on the application that they are taking care of the kids. Representative Bacala commented that he does not trust people as much as LDH apparently does.

Representative Bacala asked that even though federal law does not require more what if the parents are making \$200,000 annually and their children are in the custody of the grandparents. Could LDH consider the parental income? Ms. Batts agreed that federal law does not require verification. Representative Bacala asked if there is anything that prohibits Louisiana from going back to those same parents to recoup some of the PMPM expenses paid by the state for their children. Ms. Steele said she would have to research it. Mr. Reynolds said he does not believe under the current law they could but possibly the legislature could give LDH authority to do that. Representative Bacala questioned if the legislature gave LDH authority could they also go back to absentee fathers that may be gainfully employed and have some degree of wealth to recoup or subrogate when the children are raised by a single mom because everybody in the world whether they are alive or not has a father. Mr. Reynolds purposed their doing some research because he did not want to guess off the top of his head. He offered to also find out of other states are doing that kind of recouping and give the Task Force that information. If no other states are doing it, then the question would be if the federal government would allow the state to do that.

Representative Bacala said it seems like Louisiana has laws in place that are preventing the sharing of information between LDH and LDR, in spite of how much both would like to. He asked LDH to let the Task Force know when the law stands in the way of making common sense actions because that is where they can probably help the most. Mr. Reynolds said he agrees.

Mr. Boutte asked if everything LDH is doing today to verify eligibility is in accordance with the CMS approved process. Ms. Steele answered affirmatively. Mr. Boutte asked if LDH identifies income that exceeds the 25% it does not mean that the person is automatically ineligible, but it just means that LDH has to do more work to validate the income because typically it is looking at income from the past and must figure out what is their current income. Someone may be attesting to their income today and LDH is using past information, but from the viewpoint of the employed individuals that apply for Medicaid do they always have a steady income? He asked Ms. Batts to elaborate on if she sees fluctuating income for applicants.

Ms. Batts said state employees would know their salary because typically a set amount, but some people may work at Walmart and have varying hours. That is the reason why she uses the data sources such as the Work Number, and Workforce Commission to give that employment history and income information. The applicant's income may not always be consistent, but it varies.

Senator Mills asked if LDH would have to do a state plan amendment to make modifications or changes to the process. Ms. Steele responded that the verification plan would have to updated, and it is a different process. Mr. Reynolds explained it is the contract between the state and the federal government on how LDH determines eligibility. Senator Mills asked if other states have more stringent processes of eligibility than Louisiana. Ms. Steele said yes, on this issue there are states that vary. Senator Mills asked if there is a report on what other states do for eligibility to provide it to the task force because it would be helpful to see what other states are doing, and then the Task Force could have a better discussion on it.

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PUBLIC COMMENT

No public comments were offered.

CONSIDERATION OF ANY OTHER MATTER THAT MAY COME BEFORE THE TASK FORCE

Mr. Purpera proposed having another meeting in less than a month and they all agreed upon October 25 at 9 am. He would reach out to the members regarding topics and plan on a full day with one topic in the morning and another topic discussion for the afternoon and provide lunch for the members.

ADJOURNMENT

Representative Bacala offered the motion to adjourn, which was seconded by Senator Mills and with no objection, the meeting adjourned at 2:16 pm.

Approved by Act 420 Task Force on: October 25, 2017

The video recording of this meeting is available in House of Representatives Broadcast Archives:
http://house.louisiana.gov/H_Video/VideoArchivePlayer.aspx?v=house/2017/oct/1004_17_MedicaidFraudDetect

MINUTES OF MEETING
Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
Act 420 of the 2017 Regular Session
Wednesday, October 25, 2017
9:00 AM - House Committee Room 6
State Capitol Building

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

CALL TO ORDER AND ROLL CALL

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

Voting Members Present:

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

Advisory Members Present:

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

APPROVAL OF MINUTES

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

DISCUSSION OF INFORMATION NEEDED FOR FUTURE MEETING REGARDING PHARMACY

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

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

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

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

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

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

LOUISIANA DEPARTMENT OF REVENUE'S UPDATE ON DATA COMPARISONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DISCUSSION OF DATA MINING

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Senator Mills suggested sending a line of questioning to LDH for a response because they could spend hours on this. He asked before when it was all fee-for-service and before managed care was carved in was the data cleaner to do the job between Molina and LDH. Has the five MCOs caused the complexity that makes it not as efficient.

Mr. Boutte said the complexity now is that LDH has five additional payors that are submitting information to LDH with five different systems, so they have to map that information to align with what fee-for-service has essentially to map it into Molina's system. Data issues are tied to that, the health plan paid the claim versus fee-for-service paid the claim, but not any significant issues.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DISCUSSION OF BEHAVIORIAL HEALTH

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PUBLIC COMMENT

No public comments were offered.

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

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

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

DISCUSS SUBJECT MATTERS FOR FUTURE MEETINGS

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

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

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

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

ADJOURNMENT

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

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

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

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

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

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 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:

Jarrold 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

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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.

DRAFT MINUTES - NOT APPROVED BY THE TASK FORCE

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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

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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-

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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

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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.

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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 math 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

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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-procuring 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 procurement 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

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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.

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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.

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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

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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 procurement, 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

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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,

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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 than 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.

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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 1/17th 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.

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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.

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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

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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

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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.

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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

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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

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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

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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.

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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.

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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.

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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

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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.

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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?

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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

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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

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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

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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.

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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

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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.

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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

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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.

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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

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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.

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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

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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: _____

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

APPENDIX C

Handouts

OFFICE OF LEGAL AFFAIRS
MEMORANDUM



TO: Task Force on Coordination of Medicaid Fraud
 Detection and Prevention Initiatives

617 North Third Street
 Baton Rouge, LA 70802

FROM: Luke Morris, Assistant Secretary

DATE: October 4, 2017

Phone: 225.219.2165
 Email: luke.morris@la.gov

SUBJECT: Update on LDR Tax Return Analysis of Medicaid Applications

The Louisiana Department of Revenue (“LDR”), working in conjunction with the Department of Health (“LDH”) and the Legislative Auditor’s Office (“LLA”), has performed a preliminary review of Medicaid applications, as follows:

Methodology of Preliminary Review

The LLA provided LDR with information on approximately 387,000 Medicaid applicants on September 18, 2017. This population represents the Medicaid expansion population. The information was derived from the applicant’s Medicaid application and consisted of:

1. Applicant first name, middle initial, and last name
2. Applicant social security number
3. Applicant date of birth
4. Applicant reported gross income annualized by the LLA
5. Applicant reported household size

Using this information, LDR compared the data to the applicants’ Louisiana income tax returns to:

1. Identify the percentage of applicants who filed a 2016 Louisiana individual income tax return;
2. Identify the percentage of applicants whose Medicaid application’s gross income matched the applicants’ federal adjusted gross income (“AGI”) reported on the state return; and
3. Identify the percentage of applicants whose Medicaid application’s household size matched the applicants’ exemptions reported on the state return.

Return Filing Requirements

Tax Return		Medicaid Application	
Tax Return Exemptions and Dependents	Federal Return Filing Threshold ¹	Family Size	Federal Poverty Income Guidelines (138% Monthly) ²
1 – Taxpayer Only	\$10,350	1	\$16,404
2 – Taxpayer and Spouse	\$20,700	2	\$22,116
3 – Taxpayer, Spouse, and One Dependent	\$24,750	3	\$27,828
4 – Taxpayer, Spouse, and Two Dependents	\$28,800	4	\$33,540

¹ Federal return filing threshold based on 2016 returns.

² Federal poverty income guidelines based on Louisiana Medicaid Eligibility Manual.

Preliminary Results

LDR, LDH, and LLA all agreed that the comparison of gross income and federal AGI would likely produce very few matches. This exercise is a quintessential apples to oranges approach for several reasons. The applicant's reported gross income is generally a rounded off estimation of current monthly income. The applicant's federal AGI is a sum certain number based on reported income such as from Forms W-2 and 1099 from the preceding year. Additionally, federal AGI includes unemployment compensation. Further, federal AGI includes several deductions including educator expenses, moving expenses, student loan interest deduction, and tuition and fees deductions. These deductions are not accounted for in the reported gross income on the Medicaid application.

Additionally, the agencies also agreed that the comparison of household size and exemptions would likely produce few matches. Household size includes all individuals living in one household. Exemptions include taxpayer, spouse, and dependents. An individual may live in the same household as another but may not be claimed on another's tax return as a dependent based on the Internal Revenue Code.

Understanding the comparison would almost certainly result in few matches, LDR analyzed the data and found the following preliminary results:

Preliminary Results of Application and Return Comparisons	
Comparison	Result
Percentage of applicants who filed a 2016 Louisiana individual income tax return	Approximately 56% of applicants filed a 2016 Louisiana individual income tax return ³
Percentage of applicants whose Medicaid application's gross income matched the applicants' federal AGI reported on the state return	Less than 7% of applicants' gross income matched the applicants' federal AGI reported on the state return ⁴
Percentage of applicants whose Medicaid application's household size matched the applicant's exemptions reported on the state return	Approximately 60% of applicants reported household size matched the applicants' exemptions reported on the state return

The information provided above is disclaimed insofar that LDR has not had adequate time to test and analyze the results. This report is prepared merely to provide an update to the Task Force as to the extent and progress of the LDR's efforts.

Methodology of Current Review

Considering the unreliability of comparing gross income to federal AGI, LDR is undertaking a different methodology and expects to provide an update at the next Task Force meeting scheduled after October 4, 2017.

³ For 2016, a single individual under age 65 and earning less than \$10,350 in gross income is generally not required to file a federal income tax return. Assuming all applicants were single individuals with no dependents, approximately only 8% of the 387,000 applicants would have been required to file a federal return.

⁴ Of the applicants with matches of gross income and federal AGI, nearly all matches were the result of zeros reported as gross income and federal AGI. Less than 100 applicants matched when income exceeded zero.

OFFICE OF LEGAL AFFAIRS
MEMORANDUM



TO: Task Force on Coordination of Medicaid Fraud
Detection and Prevention Initiatives

FROM: Luke Morris, Assistant Secretary, Office of Legal Affairs
Task Force Member

DATE: October 25, 2017

SUBJECT: Update on LDR Tax Return Analysis of Medicaid Applications

617 North Third Street
Baton Rouge, LA 70802

Phone: 225.219.2165
Email: luke.morris@la.gov

The Louisiana Department of Revenue ("LDR"), working in conjunction with the Department of Health ("LDH") and the Legislative Auditor's Office ("LLA"), has performed a review of Medicaid applications, as follows:

Methodology of Review

The LLA provided LDR with information on approximately 860,000 Medicaid applicants on September 29, 2017. This population represents the entire Medicaid adult population. The information was derived from the applicant's Medicaid application and consisted of:

1. Applicant first name, middle initial, and last name
2. Applicant social security number
3. Applicant date of birth
4. Applicant reported gross income annualized by the LLA
5. Applicant reported household size¹

Using this information, LDR compared the data to the applicants' Louisiana income tax returns to:

1. Identify the percentage of applicants who filed a 2016 Louisiana individual income tax return;
2. Of those applicants who filed the state return, identify the percentage of applicants whose Medicaid application's gross income matched the applicants' federal adjusted gross income ("AGI") reported on the state return;
3. Of those applicants who filed the state return, identify the percentage of applicants whose Medicaid application's gross income matched within \$1,000 of the applicants' federal adjusted gross income ("AGI") reported on the state return;
4. Of those applicants who filed the state return, identify the percentage of applicants whose Medicaid application's gross income matched within \$5,000 of the applicants' federal adjusted gross income ("AGI") reported on the state return;
5. Of those applicants who filed the state return, identify the percentage of applicants whose Medicaid application's gross income matched within \$10,000 of the applicants' federal adjusted gross income ("AGI") reported on the state return;
6. Of those applicants who filed the state return, identify the percentage of applicants whose Medicaid application's gross income matched within \$20,000 of the applicants' federal adjusted gross income ("AGI") reported on the state return;
7. Of those applicants who filed the state return and household size was known, identify the percentage of applicants whose Medicaid application's household size matched the applicants' exemptions reported on the state return.

Results

LDR, LDH, and LLA all agreed that the comparison of gross income and federal AGI would likely produce very few matches. This exercise is a quintessential apples to oranges approach for several reasons. The applicant's reported gross income is generally a rounded off estimation of current monthly income. The applicant's federal AGI is a sum certain number based on reported income such as from Forms W-2 and 1099 from the preceding year. Additionally, federal AGI includes unemployment compensation. Further, federal AGI includes several deductions including educator

¹ Of the 860,000 applicants, the household size was unknown for approximately 39,000 applicants.

expenses, moving expenses, student loan interest deduction, and tuition and fees deductions. These deductions are not accounted for in the reported gross income on the Medicaid application.

Additionally, the agencies also agreed that the comparison of household size and exemptions would likely produce few matches. Household size includes all individuals living in one household. Exemptions include taxpayer, spouse, and dependents. An individual may live in the same household as another but may not be claimed on another's tax return as a dependent based on the Internal Revenue Code.

Understanding the limitations of the data match comparison, LDR analyzed the data and found the following results:

Results of Application and Return Comparisons	
Comparison	Result
Percentage of applicants who filed a 2016 Louisiana individual income tax return	Approximately 39% of applicants filed a 2016 Louisiana individual income tax return ²
Percentage of applicants whose Medicaid application's gross income matched the applicants' federal AGI reported on the state return	Approximately 7% ³
Percentage of applicants whose Medicaid application's gross income matched <u>within \$1,000</u> of the applicants' federal AGI reported on the state return	Approximately 10%
Percentage of applicants whose Medicaid application's gross income matched <u>within \$5,000</u> of the applicants' federal AGI reported on the state return	Approximately 21%
Percentage of applicants whose Medicaid application's gross income matched <u>within \$10,000</u> of the applicants' federal AGI reported on the state return	Approximately 38%
Percentage of applicants whose Medicaid application's gross income matched <u>within \$20,000</u> of the applicants' federal AGI reported on the state return	Approximately 75%
Percentage of applicants whose Medicaid application's household size matched the applicant's exemptions reported on the state return	Approximately 52% ⁴

² For 2016, a single individual under age 65 and earning less than \$10,350 in gross income is generally not required to file a federal income tax return. The Federal Poverty Income Guideline for a single individual (family size of 1) is \$16,404.

³ Of the applicants with matches of gross income and federal AGI, nearly all matches were the result of zeros reported as gross income and federal AGI.

⁴ Of the 39% of applicants that filed a 2016 Louisiana individual income tax return, over 5,000 applicants had an unknown household size.



Task Force on Coordination of Medicaid Fraud Detection
& Prevention Initiatives
[Act 420 of the 2017 Regular Session](#)

October 25, 2017

Ms. Jen Steele, Medicaid Director
Louisiana Department of Health
Post Office Box 629
Baton Rouge, Louisiana 70821

Dear Ms. Steele:

This correspondence serves as a follow-up and request for additional information by the Task Force on Coordination of Medicaid Fraud Detection & Prevention Initiatives (“Task Force”). As provided in R.S. 46:440.6(3), a purpose of the Task Force includes identifying any systematic issues of concern with the Medicaid program with respect to fraud, waste, and abuse. During the October 4, 2017, meeting several matters regarding the Medicaid pharmacy program as it relates to the managed care organizations’ (“MCOs”) pharmacy benefits managers (“PBMs”) and potential waste and abuse were raised to the department. Based on your responses, the task force believes that greater attention to this matter is warranted.

Spread pricing is a commonly utilized practice whereby the PBM charges the MCO an amount greater than that paid to the pharmacist as direct provider reimbursement. The PBM then retains the difference. This amount is in addition to the agreed-upon maintenance fee between the MCO and the PBM and percentage of rebate retained by the PBM. The Myers and Stauffer 2015 MLR Examination audit reports of the MCOs dated identify \$42 million in funds retained by the PBMs for three of the MCOs which they initially identified as medical costs but were in fact the result of spread pricing.

	United Healthcare	Louisiana Healthcare Connections	Amerigroup
PBM/Owned or Contracted	OptumRx/Owned	US Scripts/Owned	Express Scripts/Contracted
Amount Retained Through Spread Pricing	\$16,302,540	\$19,014,657	\$6,849,601

Source: Medicaid Transparency Report, June 30, 2017; Myers and Stauffer 2015 MLR Audits.

This is a significant amount of money being expended by the Medicaid program, retained by the PBMs, and not benefiting Louisiana pharmacists who are often reimbursed at an amount less than what it costs them to stock the prescribed drug. It is unquestionable that PBMs are profit-driven entities. For instance, United Healthcare's most recent third-quarter earnings increased 26 percent, its operating earnings grew to \$2.4 billion, and its Optum segment saw earnings increase to \$1.7 billion. (Source: *Associated Press 10/17/17*) Another example of profit focus can be found in the most recent Securities and Exchange Commission filing by Centene (the parent company to both Louisiana Healthcare Connections and US Scripts [now called Envolve Pharmacy Solutions]), wherein they state that its PBM could have materially and adversely affected financial positions and cash flow if they were not allowed to operate under current industry practices. Spread pricing is a current industry practice. Since Medicaid is funded with taxpayer dollars to benefit those most needy in our state, it is imperative that the contractual relationship between the department and the MCO be truly patient focused.

When the state chooses to do business with profit driven entities, great effort should be made to ensure that money is not being wasted and that funds are being utilized for direct reimbursement paid to providers to increase the provider pool, thereby increasing access. With this in mind, please answer the following questions with significant details to assure this task force that you are exercising sufficient oversight of your contracts with the five MCOs to identify, address, and prevent wasteful spending by your agency:

1.) After the department received the Myers and Stauffer 2015 MLR audits dated, which included the management (MCO) responses, specifically as it relates to spread pricing:

- (a) Who from the department was responsible for reviewing the audit findings and making a final determination on department action regarding this audit item?
- (b) What specific steps were taken to identify the total amount of funds retained by all five PBMs through spread pricing, not just the amount Myers and Stauffer identified as inappropriately claimed medical expenses by three of the MCOs, but the entire amount retained by the PBMs of all five MCOs through this practice?
- (c) A state may, by contract, prohibit spread pricing and provide only for a maintenance or transaction fee. Did Louisiana Medicaid pursue or consider pursuing this option?
- (d) What was communicated with the MCOs regarding spread pricing?
- (e) How is this being monitored on an ongoing basis to ensure compliance?

2.) Spread pricing affects PMPM calculations. After the adjustment by Myers and Stauffer to the plans Medical Loss Ratios (MLR), were rates recalculated and funds recouped? There is significant lag between audits and the department has testified that rates change continuously. Once the

department is made aware that a MCO inappropriately identified funds as medical expenses, thereby affecting their PMPM, are the rates recalculated and recouped for the period in which the rate was unaudited? Did this happen after the June 30 audits?

3.) Spread pricing adversely impacts pharmacists. Louisiana pharmacists have extensive data on instances where they are not reimbursed an amount equal to their cost for stocking a particular drug. If the MCO is willing to pay the “spread” amount and they want to identify this as a medical expense, then it should be to the benefit of the Louisiana pharmacist, not the PBM. By way of example, we found an instance in a report on this problem at the national level that shows a PBM billing a MCO \$26.87 for antibiotic azithromycin. The PBM reimbursed the pharmacist \$5.19 and retained \$21.68 through spread pricing. If the Medicaid program is able to provide funds in the amount of \$26.87 for this drug, then that amount or an amount closer to what was actually paid by the pharmacist should be paid to the pharmacist. Do you agree or disagree that under this analogy, spread pricing adversely impacts pharmacists and that money that could be going to direct patient care is being diverted to administrative costs?

4.) The department testified during the October 4 Task Force hearing that your only concern regarding spread pricing was that the MCO stayed within their 15% MLR requirement. The SR 163 of 2017, September 2017, report identifies pharmacy expenditures for all Medicaid recipients in the amount of \$75,204,747 for the month of August 2017.

(a) Of this total amount for the month of August, how much was actually paid in the form of reimbursement to providers and how much reflects spread pricing retained by PBMs?

(b) For the most recent calendar year or fiscal year (whichever you have a complete set of data), please provide the total amount identified as pharmacy expenditures and of that total, how much was direct reimbursement to providers and how much reflects spread pricing retained by PBMs.

5.) The Medicaid Transparency Report dated June 30, 2017, identifies \$20,408,788 in prescription drug supplemental rebates collected and retained by the MCOs. Through the Myers and Stauffer audits it is known that in some instances the PBM is retaining a portion of the supplemental rebate and passing the remaining portion to the PBM. For example, we know through audit findings that under the parent company of Centene, US Scripts is retaining 25% of the rebate and passing 75% of the rebate onto Louisiana Healthcare Connections. In no instance does the state obtain any portion of the supplemental rebate. There was not agreement, in the case of Louisiana Healthcare Connections, between management (MCO) and Myers and Stauffer on how this funding should be reported. Since the PMPM is reflective of rebates, this appears to be an important matter for final clarity and decision by the department. Regarding the retention and identification of rebates:

- (a) Who from the department was responsible for reviewing the audit findings and making a final determination on department action regarding this audit item?
- (b) Since the rebate amount collected is used to calculate their PMPM, what specific steps were taken to provide clear direction to the MCOs on the calculation and reporting of supplemental rebate amounts to ensure that the MCO could not artificially inflate or deflate reported medical expenses?
- (c) How is this being monitored on an ongoing basis to ensure compliance?
- (d) Does the department believe that there is a difference between PBMs that are owned or are affiliated with a MCO versus PBMs contracted with MCOs with regard to spread pricing (as asserted by Louisiana Healthcare Connections in their management response)?

6.) MCO expenditures are most easily broken down into two categories, administrative expenses (15%) and medical expenses (85%). Medical expenses are considered both direct reimbursement to providers and health care quality improvement (HCQI)/health information technology (HIT). Allowable HCQI activities include such vague items as improving health quality, increasing the likelihood of desired health outcomes, improving patient safety, etc. Based on the Myers and Stauffer audit, for the reporting period ending December 2015, the MCOs expended \$50,546,423 on HCQI/HIT that were considered medical expenses. During the course of the audit, Myers and Stauffer identified \$11,828,003 in funds that four of the MCOs attempted to identify as HCQI medical expenses which should have been identified as administrative expenses. Regarding the matter of HCQI/HIT expenditures:

- (a) Who from the department was responsible for reviewing the audit findings and making a final determination on department action regarding this audit item?
- (b) For the time of this audit, \$50.5 million in HCQI/HIT represents funding not going to providers as direct reimbursement, yet considered medical expenses. If a quality initiative is developed and mandated by the department, such as opioid and prescription control and drug utilization review, is that considered an administrative implementation expense for the MCO or a medical expense?
- (c) Has the department pursued any opportunities to limit the amount of Medicaid dollars that can be expended by the MCOs for HCQI/HIT since many of the best practice outcomes are achieved at the provider level and not at the payor level, such as discharge planning, reducing medical errors and lowering infection rates?
- (d) Can the department require HCQI/HIT to be administrative expenses such that true medical expenses reflect actual services provided to Medicaid recipients by enrolled Medicaid providers?

Ms. Jen Steele, Medicaid Director
Louisiana Department of Health
October 25, 2017
Page 5

and manager (MCO) may disagree about the findings, but the department as the contract holder and funder of this massive undertaking must swiftly make decisions and impose final directives in order to avoid waste in spending.

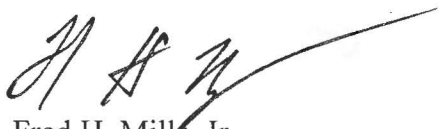
The amount of Medicaid funds diverted by the MCOs away from direct reimbursement paid to providers is significant. Making it even more so concerning is the fact that all of the data available in the Medicaid Managed Care Transparency Report and the Myers and Stauffer audit referenced throughout this correspondence are all pre-expansion. With 400,000 new recipients enrolled, \$226.5 million in additional PMPMs per month going to the MCOs, and pharmacy continuing to be the greatest spend, the opportunity for waste is indeed far greater than as it appears here.

We trust and hope that all of the issues we bring before you in this correspondence have been given due attention by the department to ensure that we are not wasting precious Medicaid dollars. The task force submits these concerns and corresponding questions to which a written reply is requested by November 13, 2017. We look forward to receiving your responses and pursuing a dialogue on the matter as necessary.

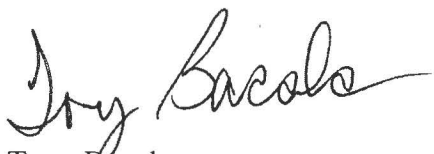
Sincerely,



Daryl Purpera, CPA, CFE
Task Force Chairman
Legislative Auditor



Fred H. Mills, Jr
Chairman of Senate Health and Welfare



Tony Bacala
State Representative – District 59

LDH Response to Medicaid Fraud Task Force Letter Dated October 25, 2017

1. *After the department received the Myers and Stauffer 2015 MLR audits, which included the management (MCO) responses, specifically as it relates to spread pricing:*
 - a. *Who from the department was responsible for reviewing the audit findings and making a final determination on department action regarding this audit item?*

Medicaid Managed Care Finance staff

- b. *What specific steps were taken to identify the total amount of funds retained by all five PBMs through spread pricing?*

LDH revised its financial reporting requirements to require MCOs to identify PBM spread pricing, in addition to aggregate payments to subcontractors.

- c. *A state may, by contract, prohibit spread pricing and provide only for a maintenance or transaction fee. Did Louisiana Medicaid pursue or consider pursuing this option?*

No, LDH does not in its contract dictate how MCOs pay for pharmacy benefit management services. Spread pricing is an industry standard way of paying for the service. If prohibited, PBMs will likely renegotiate MCO payment terms to include the value of the spread pricing in another industry standard payment, such as fees.

To protect the State from unreasonable administrative cost regardless of its form, LDH, consistent with national practice among state Medicaid programs and federal regulations, requires spread pricing to be classified as an administrative expense. It also limits administrative expenses through a Medical Loss Ratio requirement that at least 85 percent of capitation rate revenues be spent on medical costs.

- d. *What was communicated with the MCOs regarding spread pricing?*

LDH's financial reporting requirements direct MCOs to exclude spread pricing from medical costs in the MLR calculation. Individual MCOs were notified of adjustments made to exclude spread pricing from medical costs in the 2015 MLR audit, consistent with LDH reporting requirements and federal regulations.

- e. *How is this being monitored on an ongoing basis to ensure compliance?*

Each year, Myers and Stauffer, on behalf of LDH, audits the MLR calculations to ensure compliance with LDH reporting requirements and federal regulations, including the correct classification of MCO expenses.

2. *After the adjustment by Myers and Stauffer to the plans Medical Loss Ratios (MLR), were rates recalculated and funds recouped? Once the department is made aware that a MCO inappropriately identified funds as medical expenses, thereby affecting their PMPM, are the rates recalculated and recouped for the period in which the rate was unaudited? Did this happen after the June 30 audits?*

No. Capitation rates are set prospectively based on historical information (CY2015 rates were set based on CY2013 data). With the capitation rate payment, MCOs accept full risk

LDH Response to Medicaid Fraud Task Force Letter Dated October 25, 2017

for costs incurred during the rating period, both upside (when revenues exceed expenses) and downside (when expenses exceed revenues). There is no retrospective reconciliation or recoupment with a full risk MCO model. However, LDH's MCO contract requires an MCO to refund to LDH the difference between its capitation rate revenues and medical expenses if the MCO's audited MLR is less than 85 percent.

3. *Do you agree or disagree that spread pricing adversely impacts pharmacists and that money that could be going to direct patient care is being diverted to administrative costs?*

LDH disagrees. Spread pricing is not to blame for instances of a pharmacist being reimbursed less than their cost of stocking a particular drug. More likely, it is Medicaid's pharmacy reimbursement methodology, Average Acquisition Cost (AAC). The law of averages means that the AAC rate sometimes reimburses less than an individual pharmacist's cost and sometimes more. To prevent reimbursement below an individual pharmacist's cost in every instance requires a change to the pharmacy reimbursement methodology, independent of spread pricing.

As for "spread pricing diverting money to administrative costs that could be going to direct patient care," even if the State were to prohibit MCO use of PBMs (see 1.c. above on why prohibiting spread pricing alone is unlikely to eliminate the expense) and carve pharmacy services out of the MCO contract, it is unclear whether the value of the spread pricing would be available to increase direct reimbursement to pharmacists. The State would still incur administrative costs for the management of the Medicaid pharmacy benefit, and it could incur an increase in pharmacy claims costs, even net of rebates, depending on the acumen of its pharmacy benefit management resources.

4. *The SR 163 of 2017, September 2017, report identifies pharmacy expenditures for all Medicaid recipients in the amount of \$75,204,747 for the month of August 2017.*

a. *Of the total amount of pharmacy expenditures reported for the month of August [in the September SR 163 report], how much was actually paid in the form of reimbursement to providers and how much reflects spread pricing retained by PBMs?*

All of the amount reported was paid to pharmacy providers. None was retained by PBMs.

b. *For the most recent calendar year or fiscal year (whichever you have a complete set of data), please provide the total amount identified as pharmacy expenditures and of that total, how much was direct reimbursement to providers and how much reflects spread pricing retained by PBMs.*

As of October 31, 2017, \$803,534,530 was paid to pharmacy providers for SFY17, none of which was retained by PBMs for spread pricing. Separately, MCO paid PBMs \$67,055,880 for administrative costs.

LDH Response to Medicaid Fraud Task Force Letter Dated October 25, 2017

6. *Regarding the retention and identification of rebates:*

- a. *Who from the department was responsible for reviewing the audit findings and making a final determination on department action regarding this audit item?*

Medicaid Managed Care Finance staff

- b. *What specific steps were taken to provide clear direction to the MCOs on the calculation and reporting of supplemental rebate amounts to ensure that the MCO could not artificially inflate or deflate reported medical expenses?*

LDH financial reporting requirements instruct MCOs to report all rebates received by the MCO, or their owned, contracted or sub-contracted PBM as a credit to total pharmacy expenses.

- c. *How is this being monitored on an ongoing basis to ensure compliance?*

Independent auditors verify the pharmacy rebate amounts reported in the annual audit in accordance with the Agreed Upon Procedures (AUP) in LDH's financial reporting requirements.

- d. *Does the department believe that there is a difference between PBMs that are owned or are affiliated with a MCO versus PBMs contracted with MCOs with regard to spread pricing (as asserted by Louisiana Healthcare Connections in their management response)?*

No. There is no difference in how LDH treats PBMs, whether MCO owned or contracted, for financial reporting purposes.

7. *Regarding the matter of HCQI/HIT expenditures:*

- a. *Who from the department was responsible for reviewing the audit findings and making a final determination on department action regarding this audit item?*

Medicaid Managed Care Finance staff

- b. *If a quality initiative is developed and mandated by the department, such as opioid and prescription control and drug utilization review, is that considered an administrative implementation expense for the MCO or a medical expense?*

Federal regulations define Health Care Quality Improvement (HCQI) expenses and require States to consider them a medical expense in MLR calculations, independent of the origin of the expense (e.g., State mandate). Opioid and prescription control are allowable quality improvement activities when primarily designed to improve patient safety, reduce medical errors and lower infection and mortality rates. Prospective prescription drug utilization review activities aimed at identifying potential adverse drug interactions are also allowable. Prescription control as a cost containment measure (e.g. generic substitutions) and

LDH Response to Medicaid Fraud Task Force Letter Dated October 25, 2017

concurrent and retroactive drug utilization reviews, however, are not. See 45 CFR §158.150 c.7.

c. Has the department pursued any opportunities to limit the amount of Medicaid dollars that can be expended by the MCOs for HCQI/HIT?

No, LDH permits HCQI/HIT expenses as allowed by federal regulations.

d. Can the department require HCQI/HIT to be administrative expenses such that true medical expenses reflect actual services provided to Medicaid recipients by enrolled Medicaid providers?

No, federal regulations require health care quality improvement activities to be considered medical expenses. See 42 CFR §438.8(e)(1).



Task Force on Coordination of Medicaid Fraud Detection
& Prevention Initiatives

[Act 420 of the 2017 Regular Session](#)

November 8, 2017

Ms. Jen Steele, Medicaid Director
Louisiana Department of Health
Post Office Box 629
Baton Rouge, Louisiana 70821

Dear Ms. Steele:

As we continue to delve into ways in which our State might become more fiscally efficient in the delivery of Medicaid services to the people of Louisiana, there are a few areas that the Task Force would like to examine that could potentially benefit the State, cumulatively, by as much as \$533 million.

Non-Emergency use of Hospital Emergency Departments: In meetings with MCO's, it has been represented that roughly two thirds of Medicaid recipients who seek care through hospital emergency rooms do so for non-emergency conditions. One MCO estimated the average cost of an emergency department visit at \$371 while an average urgent care visit cost only \$160. Based on the average cost of an emergency department visit compared to the average cost of a visit to an urgent care clinic, it would appear that the use of emergency departments for non-emergency conditions could potentially add approximately \$100 million in Medicaid expenses annually.

We are requesting that LDH provide accurate information regarding emergency department visits by individuals enrolled in Medicaid, specifically:

1. The percentage of hospital emergency department visits for non-emergency conditions.
2. The total potential savings if all non-emergency cases had been treated at an urgent care clinic instead of at an emergency department.
3. Potential methods that Louisiana might employ to deter non-emergency use of emergency departments, including methods in use by other states.
4. Potential methods that Louisiana may employ within the hospital emergency department setting to decrease the costs of non-emergency visits, including methods used by other states (e.g., Fast Track areas, placing urgent care settings within or close by the hospital environment, etc.).

Medicaid Waivers: Assuming that waivers represent expansion of services, relaxing of eligibility requirements, or other deviations from approved state plan services, it would seem logical that waivers add to the cost of Medicaid.

We are requesting that LDH provide accurate information regarding waivers in the Medicaid program, specifically:

1. A description of all waivers which have been granted to Louisiana.
2. The estimated additional cost incurred by Louisiana as a result of each waiver.

Managed Long Term Care: The cost of providing long term care to Louisiana Medicaid recipients is about \$2 billion per year, and this is one of the last "populations" not served through managed care organizations. There was legislation filed last year (17RS HB152) regarding managed long term care where a fiscal note indicated that going to managed long term care would increase "MCO Tax" revenue by \$100 million. Additionally, there has been committee testimony indicating that managed long term care would result in savings of about \$50 million per year.

We are requesting that LDH provide accurate information regarding the transition to managed long term care, specifically

1. Verification that the state would financially benefit, by \$150 million, by adopting managed long term care.
2. Verification that LDH has the authority to adopt managed long term care without the necessity of legislation, although legislative contract approval might be required.

Co-pays and Cost Sharing: A fiscal note on a House Bill (16RS HB309) filed two years ago relative to implementing Medicaid co-pays and other means of cost sharing, indicated an estimated savings of \$91 million per year.

We are requesting that LDH provide accurate information regarding the transition to co-pays and other means of cost sharing, specifically:

1. Verification that the potential savings to the state would be \$91 million per year.
2. Whether or not legislation is required to implement Medicaid co-pays and other means of cost sharing.

Behavioral Health: Testimony before the Medicaid Task Force has indicated that behavioral health is an area that is in great need of expanded oversight. Testimony has indicated that there are issues with the credentialing and licensing of behavioral health organizations, and individuals providing services through these organizations. There was also a great deal of discussion about fraudulent billing costing the state millions of dollars per month.

We are requesting that LDH can provide further insight into issues that exist in behavioral health, specifically:

1. The steps needed to properly regulate behavioral health providers.
2. The steps needed to create a central registry of approved behavioral health providers.
3. Measures employed in other states to properly regulate the behavioral health industry.

Enrollment: In testimony before the Medicaid Task Force since its inception, it appears that the systems in place for verifying eligibility for Medicaid need to be strengthened. Some areas of concern include the 25% Reasonable Compatibility standard, lack of use of IRS databases for income verification, the lack of use of IRS databases for dependent verification, and very limited interaction between LDH and LDR for the purpose of eligibility verification. Based on information recently provided to the Medicaid Task Force, it appears that there are potentially a significant number of individuals enrolled in Medicaid, who are actually ineligible.

Of note, in a sample of 860,000 Medicaid enrollees, 335,400 (39%) were found to have filed income tax returns. Of these 335,400 individuals who were approved for Medicaid:

1. 207,948 (62%) provided income information that did not match within \$10,000 of the applicant's federal AGI (adjusted gross income)
2. 83,850 (25%) provided income information that did not match within \$20,000 of the applicant's federal AGI
3. 160,992 (48%) provided inaccurate household information

Extrapolating upon these results, it is possible that up to 208,000 of the sampled enrollees (13% of total Medicaid enrollment) are not eligible recipients. At the LDH stated average PMPM of \$500, this would equate to approximately \$1.2 billion in improper Medicaid payments annually.

Assuming that only 5% of the total number of enrollees in the Louisiana Medicaid program is actually ineligible, the total improper payments would be \$480 million and the savings to the Louisiana could be roughly \$192 million.

During our meetings, we have learned that LDH confirms income using Louisiana Workforce Commission data. In addition, when applicants purport to be self-employed, LDH requests tax information for verification purposes. Furthermore, we learned that LDH does not conduct post-review of self-attested income using FIT or State tax information, although applicants sign a waiver allowing LDH to use tax information to make eligibility determinations.

In addition, it has been stated that LDH currently does not record, within its electronic case files, a notation that self-attested data has been accepted nor the amount of income verified through LWC or through applicant provided tax information.

Ms. Jen Steele, Medicaid Director

November 8, 2017

Page 4

We are requesting that LDH provide insight into:

1. Policy changes needed to improve eligibility verification.
2. Computer system upgrades necessary to improve eligibility verification.
3. Legislative actions necessary to improve eligibility verification.
4. Any actions that could be taken now to remove ineligible recipients from the Medicaid program.
5. What penalties might be implemented to discourage false representations being made by applicants.

Overview and Conclusion: Assuming that the estimated savings contained in this letter are correct, the cumulative savings potential is \$533 million per year, or \$5.3 billion over a ten year period. However, the list of topics contained in this letter is far from being all inclusive, and other areas of expenditures need to be examined, such as pharmacy and home health. The task force submits these concerns and corresponding questions to which a written reply is requested by November 28, 2017.

It is our hope that LDH will be proactive in bringing other ideas up for discussion regarding the purposes of the Medicaid Task Force. We firmly believe that the employees of LDH represent a wealth of untapped knowledge, and it is hoped that the Task Force will be recognized by those employees as a tool to be used to facilitate positive changes in Louisiana's Medicaid program.

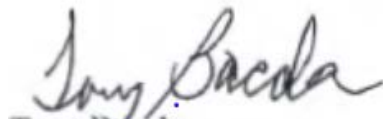
Sincerely,



Daryl Purpera, CPA, CFE

Task Force Chairman

Legislative Auditor



Tony Bacala

State Representative – District 59



Ellison Travis

Director of The Medicaid Fraud Control Unit

Office of Attorney General



State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

November 16, 2017

Mr. Daryl G. Purpera, Chairman
Task Force on Coordination of Medicaid Fraud Detection & Prevention Initiatives Louisiana
Legislative Auditor
P.O. Box 94397
Baton Rouge, Louisiana 70804-9397

The Honorable Tony Bacala
Louisiana House of Representatives
15482 Airline Hwy., Suite A
Prairieville, LA 70769

Mr. Ellison Travis
Director of the Medicaid Fraud Control Unit
Office of Attorney General
P.O. Box 94005
Baton Rouge, LA 70804

RE: LDH response to Task Force on Coordination of Medicaid Fraud Detection & Prevention Initiatives letter dated November 8, 2017

Dear Mr. Purpera:

As per the request of the Task Force on Coordination of Medicaid Fraud Detection & Prevention Initiatives, the Louisiana Department of Health (LDH) offers the following responses to the questions posed in its letter dated November 8, 2017. Should you have any follow-up questions, please contact me at Jen.Steele@la.gov. Thank you for your consideration.

I. **Non-Emergency use of Hospital Emergency Departments:**

1) *The percentage of hospital emergency department visits for non-emergency conditions.*

Response: As determined by LDH's actuary, 16% of emergency department visits in 2016 were considered low-acuity, non-emergency (LANE) visits for the purposes of rate-setting.

- 2) *The total potential savings if all non-emergency cases had been treated at an urgent care clinic instead of at an emergency department.*

Response: If all of the 2016, non-expansion LANE visits were refinanced at the office visit rate used by physicians in urgent care, it would save the state approximately \$15,276,886.

- 3) *Potential methods that Louisiana might employ to deter non-emergency use of emergency departments, including methods in use by other states.*

Response: In 2014, LDH facilitated the SR29 work group to develop strategies to reduce primary care use of emergency departments (ED). The effort resulted in a multi-prong approach, including establishment of an ED Visit Registry through the statewide Health Information Exchange designed to provide timely notice of Medicaid ED visits to MCOs and providers to facilitate member interventions, from education on appropriate use of the ED to direction to non-acute care resources to engagement in case management programs for people with complex medical conditions. LDH is presently partnering with the statewide Health Information Exchange to evaluate the impact of the registry, now 2 years in operation, to develop recommendations for enhancements to better address the issue.

In 2016, LDH proposed legislation to implement an \$8 copay for non-emergent use of the emergency department (ED) in order to deter misuse, however, the bill failed legislative passage. LANE efficiency adjustments in rate-setting remain a key factor in incentivizing MCOs to maintain low non-emergent utilization as it reduces the MCO rates by the amount calculated to be preventable.

Additionally, LDH monitors MCO performance on the Health Effectiveness Data and Information Set (HEDIS) measure for utilization of ambulatory care ED Visits per 1,000 member months as an incentive measure. The MCO contract extension adds a 1% withhold of capitation rate revenues to be earned back for MCO performance on select HEDIS measures, including ED use (overall, not just non-emergent). Should the MCO fail to meet performance targets, the withheld amount is permanently retained by LDH. LDH is also leveraging the medical professional expertise on its Medicaid Quality Committee to more broadly identify and overcome practical barriers to the program achieving its performance target for the ED visit HEDIS measure.

LDH is also facilitating a pilot of a community paramedicine program in the Orleans region intended to reduce LANE visits through diversion to non-acute service settings and even telemedicine visits. The pilot will be independently evaluated for its outcomes and purposes of spread beyond the New Orleans region if proven successful.

For practices in other states, please refer to the summary table enclosed.

- 4) *Potential methods that Louisiana may employ within the hospital emergency department setting to decrease the costs of non-emergency visits, including methods used by other states (e.g., Fast Track areas, placing urgent care settings within or close by the hospital environment, etc.).*

Response: Most deterrents utilized within the ED revolve around cost-sharing or copayments. In prior legislation (HB 309 of the 2016 Regular Legislative Session), an attempt was made to limit reimbursable emergency room benefits for recipients that had more than three non-emergent visits within a year. However, the ED would still be required to do all necessary triage and screening to meet the requirements of EMTALA and these costs would either become the responsibility of the recipient who is unable to pay, or be absorbed by the hospital provider. This is often the case for copays as well. For practices in other states, please refer to the summary table enclosed.

I. **Medicaid Waivers:**

- 1) *A description of all waivers which have been granted to Louisiana.*

Response:

Louisiana's 1915(c) Waivers	
Adult Day Health Care Waiver	The Adult Day Health Care (ADHC) Waiver is designed to enhance the home and community-based services available to individuals who meet nursing facility level of care. The ADHC waiver serves elderly (age 65+) and physically disabled adults (age 22-64). All participants in this waiver receive support coordination/case management and Adult Day Health Care in a licensed day program.
Children's Choice Waiver	The Children's Choice Waiver is designed to enhance the home and community-based supports and services available to children from birth through 18 years of age with intellectual and/or developmental disabilities, who meet ICF/DD level of care. Participants receive support coordination/case management and have access to supplemental services and supports including but not limited to family support services, respite, and environmental accessibility adaptations while living at home with their family or who will leave an institution to return home.
Community Choices Waiver	The Community Choices Waiver is designed to enhance the home and community-based services available to individuals who meet nursing facility level of care. The Community Choices Waiver serves elderly (age 65+) and physically disabled adults (age 22-64). Each participant receives support coordination/case management and has access to a wide array of services including: nursing and skilled therapy assessments and services, in-home monitoring systems, home modifications and assistive technologies, personal care, home-delivered meals, monitored in-home caregiving, and caregiver respite.
Coordinated System of Care (CSoC) Waiver	The Coordinated System of Care (CSoC) Waiver provides a single point of entry for families of children who have complex behavioral health needs and are either in or at risk of being in out-of-home placement (e.g. foster homes, group homes, juvenile detention facilities, residential treatment centers) by combining resources of the State's four child-serving agencies: Department of Children and Family Services, Department of Education, Department of Health and, Office of Juvenile Justice. Families enrolled in CSoC will receive

	intensive, individualized services in their communities. In this process, the family and child partner with a team of people they choose and work together to develop a plan that meets their needs, rather than having other people develop a plan for them.
New Opportunities Waiver (NOW)	The New Opportunities Waiver (NOW) is designed to enhance the home and community-based supports and services available to children and adults 3 years of age and older with intellectual and/or developmental disabilities, who meet ICF/DD level of care. Participants receive case management and an array of services aimed at assisting people to live as independently as possible in the community. Services include but are not limited to individual and family support services, day habilitation, skilled nursing, and supported living.
Residential Options Waiver (ROW)	The Residential Options Waiver (ROW) is designed to provide services and supports with the goal of promoting independence through strengthening the participant’s capacity for self-care and self-sufficiency. The ROW provides opportunities for those with intellectual and/or developmental disabilities of any age and who meet ICF/DD level of care to receive home and community-based services which allow them to transition to and/or remain in the community. Participants receive support coordination/case management and have access to services which include but are not limited to host home services, day habilitation, community living supports, and prevocational services.
Supports Waiver	The Supports Waiver is designed to offer focused, individualized vocational services to individuals age 18 and older with an intellectual and/or developmental disability and who meet ICF/DD level of care. The waiver provides meaningful opportunities to its participants through vocational and community inclusion. Participants receive support coordination/case management and have access to services which include but are not limited to supported employment, day habilitation, and prevocational services.

2) *The estimated additional cost incurred by Louisiana as a result of each waiver.*

Response: Home and Community Based Services (HCBS) waivers are designed to provide a less expensive alternative to institutional services for individuals who require that level of care. In the absence of HCBS waivers, eligible individuals would be have only the more costly institutional setting for care. Budget neutrality is a required component for CMS approval of an HCBS wavier and for ongoing reporting. Therefore, there is no “additional” cost resulting from the waivers because waivers are less costly than institutional care, which benefits the state. For the FY 17 actual costs by waiver, please refer to the table below:

	SGF	FED	SFY 16/17 Total Cost:
Adult Day Health Care Waiver	\$2,967,045	\$4,855,377	\$7,822,422

Children’s Choice Waiver	\$4,293,935	\$7,026,749	\$11,320,684
New Opportunities Waiver (NOW)	\$169,690,039	\$277,686,810	\$447,376,849
Residential Options Waiver (ROW)	\$218,867	\$358,163	\$577,030
Community Choices Waiver	\$40,636,442	\$66,498,919	\$107,135,361
Coordinated System of Care (CSoC) Waiver	\$4,837,008	\$7,915,453	\$12,752,461
Supports Waiver	\$4,818,297	\$7,88,833	\$12,703,130

II. **Managed Long Term Care:**

- 1) *Verification that the state would financially benefit, by \$150 million, by adopting managed long term care.*

Response: The RFP drafted under the previous administration included various assumptions and used population and expenditure data from 2014. The estimated savings and projected premium tax revenue would have to be redone using more current population and expenditure data. This activity would have to be done by an actuary at a cost of several hundred thousand to a million dollars.

- 2) *Verification that LDH has the authority to adopt managed long term care without the necessity of legislation, although legislative contract approval might be required.*

Response: An initial RFP and/or resulting contract would not be required to go through any legislative approval process, but an extension of that contract past the initial term would have to go before JLCB for approval.

III. **Co-pays and Cost Sharing:**

- 1) *Verification that the potential savings to the state would be \$91 million per year.*

Response: The cost-sharing measures in RS16 HB309 included the following:

- 1) Cost sharing for inpatient and outpatient services (42 CFR 447.52).
- 2) Cost sharing for preferred and non-preferred drugs (42 CFR 447.53).
- 3) Cost sharing for nonemergency services furnished in a hospital emergency department (42 CFR 447.54).
- 4) Assessment of premiums upon individuals whose income exceeds certain levels specified in federal regulations (42 CFR 447.55).

The updated fiscal impact of these cost-sharing measures are as follows:

1. \$171,536,575 - total projected cost avoidance from maximum allowable copay initiatives (does not consider reallocation to NOW slots as per HB 309)
2. \$6,216,074 – projected revenue increase from enhanced premium collections
3. \$3,796,021 - projected administrative cost associated with implementing cost sharing initiatives

- 2) *Whether or not legislation is required to implement Medicaid co-pays and other means of cost sharing.*

Response: Yes, legislation would be required to implement any new or enhanced copay requirements in the Medicaid program.

IV. **Behavioral Health:**

1) *The steps needed to properly regulate behavioral health providers.*

Response: Behavioral health providers are licensed by the Health Standards Section (HSS) within LDH (unless authority lies with some other licensing board), and the regulatory process mirrors all other licensing programs in this section. HSS ensures that licensed entities are in compliance with the regulatory aspects of licensure.

The programmatic aspects of the program are overseen by the Office of Behavioral Health (OBH) and Medicaid. The following are some of the steps that assist or will assist OBH in monitoring the specialized behavioral health provider network within managed care:

1. In July 2017, LDH/Medicaid revised its monitoring and management structure to align with subject matter expertise within the program office for behavioral health. An MOU was finalized and signed on September 8, 2017, giving OBH full oversight of specialized behavioral health services.
2. Implementation by Medicaid of a centralized provider credentialing system (scheduled for 2018) to resolve current provider registry issues.
3. Requiring increased accountability on the part of the MCOs related to contract deliverables in the requested contract extension (amendment 11). Amendment 11 provides clearer directives, increased accountability and more penalties for MCO noncompliance related to provider and network issues, and adds new provisions directly tied to the Medicaid Managed Care Final Rule to ensure Louisiana's compliance with federal regulations. The requested revisions include provisions such as:
 - Requirement that the network be developed to meet the needs of members with past history or current display of aggression, runaway behavior, sexual offenses, or intellectual disability.
 - A requirement for the MCO to report the number of out-of-state placements; LDH may require the MCO to take corrective action should LDH determine the MCO's rate of out-of-state placements is excessive.
 - A requirement for the MCO to maintain a 90% accuracy rate on the data in their provider directory including monetary penalties.
 - New requirement for MCOs to monitor specialized behavioral health providers and facilities across all levels of care including onsite reviews and member interviews.
 - Requirement that the MCO have a system with dedicated staff for routine internal monitoring and auditing of compliance risks, promptly respond to compliance issues as they are raised, investigate potential compliance problems as identified in the course of self-evaluation and audits, etc.
 - Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers.

2) *The steps needed to create a central registry of approved behavioral health providers.*

Response: Medicaid currently has an RFP out to contract with a single entity for all Medicaid provider enrollment, including credentials verification. This will result in all physical and

behavioral health providers being credentialed and enrolled in Medicaid by this single entity. The MCOs would then contract with these Medicaid credentialed providers, rather than credentialing and registering them independently, as they do now. The target implementation date is November 2018.

3) Measures employed in other states to properly regulate the behavioral health industry.

Response: OBH reviewed the network access adequacy plans for New Hampshire, Connecticut, and Colorado in the development of Louisiana's access monitoring plan. OBH also researched North Carolina and Illinois' monitoring tools in developing Louisiana's monitoring tool related to provider qualifications. OBH began developing a formal specialized behavioral health Network Monitoring Plan in Access and Adequacy over a year prior to the passage of the new Medicaid Managed Care Rule. OBH took an assertive approach in its monitoring plan activities by including direct tests, e.g. "secret shopper" calls, administrative desk reviews and on-site provider visits in addition to the more typical review of periodic reports, provider registries, provider directories and encounter data. OBH sought to include behavioral health access standards, inclusive of geographic travel distance standards for specific behavioral health provider types, through Amendment #6 to the contracts with the Medicaid MCOs.

The review of the other states policies was part of the research done in order to address the Managed Care Rule and Access to Care requirements noted above. Some of the items listed were also included (or a version of such) in the state's plans.

V. **Enrollment:**

1) Policy changes needed to improve eligibility verification.

Response: To potentially improve eligibility verification, LDH is implementing a new eligibility and enrollment system with increased verification checks and controls. LDH could reduce the reasonable compatibility standard from 25 percent to 10 percent, and conduct post eligibility data matches with new and existing data sources. This would require staff increases to conduct reviews, system modifications, data use agreements, interface adjustments.

LDH is in the process of evaluating the enrollment impact of a reduction in its reasonable compatibility standard from 25 to 10 percent. While it is as yet unclear whether the change will result in fewer people being Medicaid eligible, LDH has determined the workload impact to be a 13 percent increase in requests for additional verifications at application and renewal, requiring an additional 16 Medicaid analysts and two supervisory positions at an annual cost of \$848,100 per year. The staff and cost increase were determined as follows:

- Medicaid analysts review available data sources to verify self-attested income on applications and renewals. On average, analysts manually review 662,000 instances of self-attested income per year on applications. When self-attested income is greater than the reasonable compatibility standard, a notice is generated to the applicant to request additional information.
- The reduction to a 10 percent standard is estimated to result in an additional 86,000 notices issued each year on applications received. Medicaid analysts also process an average of 1.5

million renewals each year. This change is estimated to result in an additional 192,000 notices issued per year to evaluate ongoing eligibility. Each request takes an analyst an average of 6.5 minutes to complete, resulting in a need for 30,055 additional staff hours per year.

LDH can also establish additional data sources to verify eligibility factors such as income and household composition. This would require system enhancements, security improvements, interfaces, Memorandums of Understanding, data sharing agreements, etc.

2) Computer system upgrades necessary to improve eligibility verification.

Response: The total cost of the Medicaid eligibility and enrollment system (LaMEDS) using federal tax information data for Medicaid eligibility determinations is estimated at \$849,135 with an anticipated implementation date of July 2019. This includes system changes, background checks for staff, security requirements of CMS and IRS, and data storage.

It is important to note that utilizing Louisiana Department of Revenue (LDR) and IRS data as an additional verification source has certain limitations. In the determination of household budgets for eligibility, the Task Force had concerns over Louisiana Medicaid not using IRS databases for income verification. Using sample Medicaid data provided by the Louisiana Legislative Auditor (LLA), the Task Force cited a number of examples where income from the Medicaid system did not match income data from LDR. These discrepancies are not unusual, and were actually expected based on the timing and methods of data collection. In a meeting between LLA, LDR, the Office of Technology Services and LDH, all parties agreed that matching income and household data from the two systems was not a possibility, but a sample would be conducted to see how many Medicaid enrollees filed a state tax return.

The LLA pulled data from the Medicaid MMIS Data Warehouse (MDW). **This system is not used to determine Medicaid eligibility.** Gross income and household size in the MDW are generated from household budgets in the Medicaid Eligibility Data System (MEDS). Household budgets are based on current income rather than the previous year's income reported to tax authorities. Moreover, the gross income on the Medicaid budget is not the income of an individual but rather the aggregate of countable income, per federal and state regulations, for case members included in the individual's household budget. Medicaid household size will often be different than the LDR household size because of differing rules for determining what constitutes a household and applicable members. Thus, as noted during the meeting between all applicable agencies, it is to be expected that the Medicaid gross income and household size often will not match LDR income data.

3) Legislative actions necessary to improve eligibility verification.

Response: LDH recommends the Task Force consider updated legislation that allows LDR to share more specific tax form information with LDH, and increase departmental resources through the appropriations process. This includes increases in staff to both reduce the reasonable compatibility standard from 25 percent to 10 percent and to conduct post eligibility reviews, as well as increased investments in security, hardware and software to be used for other enhancements.

4) *Any actions that could be taken now to remove ineligible recipients from the Medicaid program.*

Response: Identify ineligible enrollees through one of the following mechanisms:

- Utilize an LDR data match based on tax information. This requires that LDR provide the file data for anyone not matching including the individual, the individual's Adjusted Gross Income, any dependents or spouses and their income. Currently, LDR only provides percentages of results.
- Complete manual renewals on a percentage of individuals that could otherwise be administratively renewed. There are currently over 20,000 administrative renewals each month. This would require that LDH increase staff to accommodate manual review.
- Complete post eligibility reviews after the initial eligibility determination on a statistically appropriate sample according to criteria as established by LDH. This would require that LDH increase staff to accommodate the additional workload of conducting manual post-eligibility reviews.

5) *What penalties might be implemented to discourage false representations being made by applicants.*

Response: LDH could refer any lost appeals/appellants to recovery. Additionally, at discovery of fraudulent actions, LDH can refer to appropriate interoffice department and/or law enforcement for action.

An additional concern was raised by the Task Force related to information captured in the LDH Electronic Case Record; specifically, that the state does not include "a notation that self-attested data has been accepted nor the amount of income verified through LWC or through applicant provided tax information." However, the Summary of Verification Response in the Electronic Case Record, does in fact note attested income, as well as income from other sources, such as the Louisiana Workforce Commission.

Respectfully,



Jen Steele
Medicaid Director

Enclosure [1]

c: Rebekah E. Gee, Secretary, Louisiana Department of Health
Jeff Reynolds, Undersecretary, Louisiana Department of Health

JS/jlk

State	Action	Scale	Source
Alabama	CMS Innovation funded TransformMED: Care coordination among PCMH, specialty practices, and hospitals. Creation of "medical neighborhoods."	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
	CMS Innovation funded Transitions clinic network: linking high-risk Medicaid patients from prison to community primary care. Connects chronically ill, formerly incarcerated people with primary care and other medical and social services to coach them in chronic disease management.	Community Health Center	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Alabama.html
	Alabama Medicaid does pay for Emergency Room visits when a person has a serious health problem that he or she reasonably believes could cause serious damage to their health or body if they do not get medical care right away. For ER visits that are not urgent, Medicaid pays for three non-emergency outpatient hospital visits per calendar year. Examples of non-emergencies include upset stomach, sore throat, mild cough, rash and low-grade fever. There are no limits on outpatient hospital visits for lab work or x-rays.	Statewide	https://medicaid.alabama.gov/content/9.0_Resources/9.5_FAQ_Pages/9.5.3_FAQ_Benefits.aspx
Alaska	Alaska ED Coordination Project: 7 best practices model 1) Electronic ED info system 2) Implemente pt education 3) Institute extensive case mgmt program 4) ID frequent ED users 5) Develop pt care plans for frequent ED users 6) Implement narcotics guidelines to discourage narcotic-seeking behavior 7) Track progress of plan to ensure success.	Statewide	http://webcache.googleusercontent.com/search?q=cache:MQNxa0sS6MJ:www.ashnha.com/wp-content/uploads/2017/01/AK-ED-Coordination-Project-from-SB-74-to-H-HSS.pdf+&cd=1&hl=en&ct=clnk&gl=us http://www.ashnha.com/edep/ http://dhss.alaska.gov/HealthyAlaska/Pages/Initiatives/Initiative-13.aspx
Arizona	Medical respite care for people experiencing homelessness provides acute and post-acute care for homeless persons who would be medically unable to recover on the streets but who are not ill enough to stay in the hospital.	Statewide	https://www.nhchc.org/resources/clinical/medical-respite/tool-kit/
	\$8.00 copay per visit for non-emergency use of ED	Statewide	https://www.azahcccs.gov/PlansProviders/RatesAndBilling/copayments.html
Arkansas			
California	National Health Care for the Homeless Council: Community outreach and case coordination for homeless individuals.	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
Colorado	Community paramedic program parameters outlined legislatively by governor	Only a few counties have CP programs	http://www.legispeak.com/bill/2016/sb16-069
	Accountable Care Collaborative: enrolled 610,000 clients in care coordination and connec members to primary care, specialists, and community resources. *% fewere ED visits than those not enrolled.	Regional	https://webcache.googleusercontent.com/search?q=cache:Nric12adnL8I:https://www.colorado.gov/pacific/sites/default/files/Accountable%2520Care%2520Collaborative%2520News%2520Release%2520and%2520Fact%2520Sheet%2520-%2520November%25203,%25202014.pdf+&cd=4&hl=en&ct=clnk&gl=us
Connecticut	CMS Innovation funded TransformMED: Care coordination among PCMH, specialty practices, and hospitals. Creation of "medical neighborhoods."	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
	Medical respite care for people experiencing homelessness provides acute and post-acute care for homeless persons who would be medically unable to recover on the streets but who are not ill enough to stay in the hospital.	Statewide	https://www.nhchc.org/resources/clinical/medical-respite/tool-kit/
	CMS Innovation funded TransformMED: Care coordination among PCMH, specialty practices, and hospitals. Creation of "medical neighborhoods."	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
	State funded \$4.5 million grant which it later rescinded which was then provided at only \$300,000 by hospital industry to care teams to reduce ED use by homeless population. Care teams are based at six hospitals.	Six hospitals	http://www.courant.com/news/connecticut/hc-homeless-hospitals-emergency-0630-20160629-story.html
Delaware	Christiana Care Health System Bridging the Gap provides care management to patients with ischemic heart disease transitioning from hospital care.	Hospital System (Christian Care Health System)	https://christianacare.org/services/heart/bridges/
Florida	CMS Innovation funded TransformMED: Care coordination among PCMH, specialty practices, and hospitals. Creation of "medical neighborhoods."	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
	Medicaid and Medicare Administration Physician Incentive Program (similar to an ACO)	Statewide	http://ahca.myflorida.com/medicaid/statewide_mc/mma_physician_incentive.shtml
Georgia	CMS Innovation funded TransformMED: Care coordination among PCMH, specialty practices, and hospitals. Creation of "medical neighborhoods."	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
	\$2.5 million federal grant to increase number of Georgians with medical homes by establishing alternate non-emergency services provider programs.	Four FQHCs	https://dch.georgia.gov/georgia-alternative-non-emergency-services-provider-project-gnespp
Hawaii	Attempting to get federal Medicaid funds to reimburse efforts to help homeless Medicaid recipients find and maintain housing. Waiver pending.	Statewide	http://www.modernhealthcare.com/article/20170929/NEWS/170929867
Idaho	St. Luke's Regional Medical Center Tele-critical care and emergency services. Remote intensive care unit monitoring and care management in rural areas.	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Oregon.html
	Rural Health Care Access Program and Rural Physician Incentive Program: grants to nonprofit entities working to provide access in rural communities, and loan repayments for physicians practicing in rural communities.	Rural Regionals	http://healthandwelfare.idaho.gov/Health/RuralHealthandPrimaryCare/HealthCareAccessPhysicianIncentiveProgram/tabid/409/Default.aspx
Illinois	University of Chicago Housing First Program: Provide housing for homeless people to reduce ED use.	Citywide (Chicago)	http://www.chicagobusiness.com/article/20160402/ISSUE01/304029992/this-program-could-lower-health-care-costs-in-chicago

Illinois	National Health Care for the Homeless Council: Community outreach and case coordination for homeless individuals.	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
	\$3.90 copay for non-emergency use of ED	Statewide	http://www.dhs.state.il.us/page.aspx?item=17633
	Low case loads for doctors to facilitate doctor/pt relationships, 24hr hotline to help patients make next-day appointments, transportation for those in need.	Clinic group that primarily serves Medicaid and Medicare patients	http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/2/24/states-strive-to-keep-medicaid-patients-out-of-the-emergency-department
Indiana	CMS Innovation funded TransformMED: Care coordination among PCMH, specialty practices, and hospitals. Creation of "medical neighborhoods."	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
	\$8 copay for first and \$25 copay for subsequent non-emergency use of ED	Statewide	https://www.google.com/url?sa=t&rc=j&q=&esrc=s&source=web&cd=2&cad=rja&uact=8&ved=0ahUKEwric6l.82sDXAhVK3mMKHTMUA4EQFggMAE&url=http%3A%2F%2Fprovider.indianamedicaid.com%2Fihcp%2FBulletins%2FBT201503.pdf&usq=AOvVaw3PFtoePjMQay4j2v-Y6k9
Iowa	\$8 Copay for non-emergent use of the ED.	Statewide	https://www.kff.org/report-section/medicaid-in-an-era-of-health-delivery-system-reform-premiums-and-cost-sharing/
Kansas	CMS Innovation funded TransformMED: Care coordination among PCMH, specialty practices, and hospitals. Creation of "medical neighborhoods."	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
Kentucky	\$8 Copay for non-emergent use of the ED.	Statewide	http://chfs.ky.gov/NR/rdonlyres/F6B5F330-EE69-4CC8-83A8-1A1C0DC4BF46/0/FINAL%20Handbook62014.pdf
	MyHealth Team: Regional team-based and closed-loop control innovation model for ambulatory chronic care delivery.	County	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Tennessee.html
	CMS Innovation funded TransformMED: Care coordination among PCMH, specialty practices, and hospitals. Creation of "medical neighborhoods."	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
	Kentucky ER SMART ER Super Utilization Initiative: Develop communication network for Community of Care Team providers to identify, monitor, and support super users.	Regional	https://khie.ky.gov/nr/Documents/KHIE%20Guide%20for%20KY%20ER%20SMART.pdf
Maine	Submitted 1115 waiver proposing \$20 copay for non-emergency use of ED	Statewide	https://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/me-mainecare-pa.pdf
	Community paramedicine	Regional by ambulance provider	https://www.maine.gov/ems/documents/cp_muskie_report.pdf
Maryland	Federal and state funded initiative in Montgomery County. Referred 10,000 uninsured and Medicaid ED users to local primary care clinics in effort to build primary care relationship.	County (Montgomery)	https://www.umdrihtnow.umd.edu/news/umd-study-finds-connecting-uninsured-patients-primary-care-could-reduce-er-use
	CMS Innovation funded TransformMED: Care coordination among PCMH, specialty practices, and hospitals. Creation of "medical neighborhoods."	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
	CMS Innovation funded TransformMED: Care coordination among PCMH, specialty practices, and hospitals. Creation of "medical neighborhoods."	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
	Christiana Care Health System Bridging the Gap provides care management to patients with ischemic heart disease transitioning from hospital care.	Hospital System (Christian Care Health System)	https://christianacare.org/services/heart/bridges/
Massachusetts	\$800,000 state funded pilot program, ID 318 people with at least four #D visits in four months and linked to primary care doctors, insurance, mental health, substance abuse, and social services.	Hospital (Sinai Baltimore)	http://www.baltimoresun.com/health/maryland-health/bs-hs-super-utilizer-20150916-story.html
	CMS Innovation funded TransformMED: Care coordination among PCMH, specialty practices, and hospitals. Creation of "medical neighborhoods."	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
	CMS Innovation funded TransformMED: Care coordination among PCMH, specialty practices, and hospitals. Creation of "medical neighborhoods."	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
Michigan	National Health Care for the Homeless Council: Community outreach and case coordination for homeless individuals.	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
	\$3 copay for under 100% FPL and \$8 copay for expansion population for non-emergency use of ED	Statewide	https://www.michigan.gov/documents/mdch/Healthy_Michigan_Copayment-final_452237_7.pdf
	CMS Innovation funded TransformMED: Care coordination among PCMH, specialty practices, and hospitals. Creation of "medical neighborhoods."	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
Michigan	Detroit Medical Center Gateway Program, \$10 million PPACA grant for three year program. ID patients with particular chronic conditions or frequent ED visits, enroll in Gateway program where they receive coordinated care services.	Hospital System (Detroit Medical Center)	http://www.craisdetroit.com/article/20170625/NEWS/170629920/dmc-gateway-program-reduces-er-visits-admissions-improves-primary
	Medical respite care for people experiencing homelessness provides acute and post-acute care for homeless persons who would be medically unable to recover on the streets but who are not ill enough to stay in the hospital.	Statewide	https://www.nhche.org/resources/clinical/medical-respite/tool-kit/
Minnesota			

Minnesota	Community paramedic program in which paramedics receive payments via Medicaid fee-for-service or MCO reimbursements. Community Paramedics undergo enhanced training, then receive care plans from patient's physician and provides home health services to the patient.	8 counties	http://www.health.state.mn.us/divs/orhpc/workforce/emerging/cp2016cptoolkit.pdf
Mississippi	CMS Innovation funded TransformMED: Care coordination among PCMH, specialty practices, and hospitals. Creation of "medical neighborhoods."	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
	University of Mississippi Medical Center telehealth program to provide distance care	Hospital (University of Mississippi Medical Center)	https://www.ume.edu/Healthcare/Telehealth/Telehealth_Home.html
Missouri	Uses claims data to ID frequent ED users then arranges primary care appointments for them. Uses triage hotline staffed by nurses. Reduced ED visits by 9.5% in year one.	70,000 member Medicaid MCO	http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/2/24/states-strive-to-keep-medicare-patients-out-of-the-emergency-department
Montana	Passport to Health Health Home	Statewide	http://medicaidprovider.mt.gov/Portals/68/docs/training/2017/falltraining2017/FallPresentations/04_PASSPORT_PRESENTATION.pdf
Nebraska	CMS Innovation funded TransformMED: Care coordination among PCMH, specialty practices, and hospitals. Creation of "medical neighborhoods."	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
	National Health Care for the Homeless Council: Community outreach and case coordination for homeless individuals.	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
Nevada	St. Luke's Regional Medical Center Tele-critical care and emergency services. Remote intensive care unit monitoring and care management in rural areas.	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Oregon.html
	Community paramedicine for recently discharged patients, ambulance ED diversion, and nurse staffed helpline	County (Reno)	http://remsa.us/documents/systemevaluation/stratplanning/140423NevadaREMSAProgramsPresentation.pdf
New Hampshire	Pilot project to map high utilizers in one hospital system	Hospital	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3692844/
	Care coordination for individuals with substance abuse issues.	Regional	https://www.healthcare-informatics.com/news-item/population-health/new-hampshire-care-coordination-pilot-program-reduces-overdoses-34
	National Health Care for the Homeless Council: Community outreach and case coordination for homeless individuals.	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
New Jersey	Christiana Care Health System Bridging the Gap provides care management to patients with ischemic heart disease transitioning from hospital care.	Hospital System (Christian Care Health System)	https://christianacare.org/services/heart/bridges/
	Mapping of high frequency ED users and chronically ill patients, so team of NM, social worker and community worker can do outreach and preventive care.	Regional	https://khn.org/news/er-super-users/
	Project ECHO telemedicine to link University of New Mexico providers to community health centers in rural New Mexico.	Regional	https://healthit.ahrq.gov/ahrq-funded-projects/past-health-it-initiatives-transforming-healthcare-quality-through-health-it/project-echo-bringing
New Mexico	Home visitation program for residents of rural county.	County	https://www.pepcc.org/initiative/home-visitation-program-ben-archer-health-center
	Blue Cross Blue Shield New Mexico community paramedicine pilot ID superuser patients or those at high risk of readmission and deploy community paramedics to provide care	Regional	https://www.fiercehealthcare.com/member-engagement/paramedic-house-calls-help-blue-cross-and-blue-shield-new-mexico-reduce-er-usage
New York	Mobile acute care team to address acute care needs in outpatient settings. Received CMS Innovation funding.	Hospital System (Mount Sinai)	http://inside.mountsinai.org/blog/mobile-acute-care-team-mact-provides-hospital-level-care-at-home/
	Call back program for super users to connect them to primary care services.	Provider System	https://www.politico.com/states/new-york/albany/story/2016/10/community-partners-of-wny-begins-making-calls-to-so-called-super-utilizers-106530
	ED Care Management Initiative: Preventing Avoidable ED Use. Multi-disciplinary team to create care plan and coordinate care of patients upon discharge from hospital.	Hospitals	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards-Round-Two/New-York.html
North Carolina	CMS Innovation funded TransformMED: Care coordination among PCMH, specialty practices, and hospitals. Creation of "medical neighborhoods."	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
	Max federally allowed copayment for non-emergency use of ED.	Statewide	https://www.kff.org/report-section/medicaid-in-an-era-of-health-delivery-system-reform-premiums-and-cost-sharing/
	National Health Care for the Homeless Council: Community outreach and case coordination for homeless individuals.	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
North Dakota			
Ohio	National Health Care for the Homeless Council: Community outreach and case coordination for homeless individuals.	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
Oklahoma	SoonerCare Choice ER Utilization Reduction Program: PCMH integrating behavioral and medical care	Statewide	https://www.okhca.org/WorkArea/DownloadAsset.aspx?id=15159

Oklahoma	CMS Innovation funded TransformMED: Care coordination among PCMH, specialty practices, and hospitals. Creation of "medical neighborhoods."	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
Oregon	Implemented/expanded five complementary care model interventions: Tri-County 911 Service Coordination Program, Intensive Transition Teams Program, ED Guide Program, Health Resilience Program, Care Transitions Innovation C-Train.	Regional	http://oregon.providence.org/our-services/c/center-for-outcomes-research-and-education-core/population-health-dashboards/the-health-commons-project/
	Health Resilience Program: new workforce of non-traditional health care workers who serve as "engagement specialists" for high-acuity/high-cost patients.	Regional	http://oregon.providence.org/our-services/c/center-for-outcomes-research-and-education-core/population-health-dashboards/the-health-commons-project/
	Tri-County 911 Service Coordination Program: Coordinates care of frequent 911 callers when other services would be better than emergency services.	County	http://oregon.providence.org/our-services/c/center-for-outcomes-research-and-education-core/population-health-dashboards/the-health-commons-project/
	ED Guide: puts non-traditional health care workers in ED to help non-acute patients find the appropriate place for care.	Regional	http://oregon.providence.org/our-services/c/center-for-outcomes-research-and-education-core/population-health-dashboards/the-health-commons-project/
	Employs high-intensity support to high-utilizing patients to help with transition from inpatient to outpatient care.	Regional	http://oregon.providence.org/our-services/c/center-for-outcomes-research-and-education-core/population-health-dashboards/the-health-commons-project/
	St. Luke's Regional Medical Center Tele-critical care and emergency services. Remote intensive care unit monitoring and care management in rural areas.	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Oregon.html
	Medical respite care for people experiencing homelessness provides acute and post-acute care for homeless persons who would be medically unable to recover on the streets but who are not ill enough to stay in the hospital.	Statewide	https://www.nhchc.org/resources/clinical/medical-respite/tool-kit/
Pennsylvania	EveryBODY Get Healthy: he innovation uses health analytics technology to track risk criteria and update integrated health profiles, and to deploy targeted alerts, outreach, wellness, and support services in a closed-loop environment that evolves with successful behavioral change. Includes peer mentors.	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Pennsylvania.html
	Comprehensive longitudinal advanced illness management: comprehensive set of home care services for patients with cancer who are receiving home care and have substantial palliative care needs.	Regional (Philadelphia)	http://www.jpmsjournal.com/article/S0885-3924(14)00621-6/abstract
	Christiana Care Health System Bridging the Gap provides care management to patients with ischemic heart disease transitioning from hospital care.	Hospital System (Christian Care Health System)	https://christianacare.org/services/heart/bridges/
Rhode Island	Care Transformation Collaborative of Rhode Island: brings together key health care stakeholders to promote care for patients with chronic illnesses through PCMH model.	Regional	https://www.pecc.org/initiative/care-transformation-collaborative-rhode-island-ctc
South Carolina	ED telepsychiatry program	Statewide	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4699583/
	Train and deploy community health teams to low income area of Columbia, South Carolina.	City (Columbia)	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/South-Carolina.html
	Team care model that engages participant as team member in health care decision making.	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/South-Carolina.html
South Dakota	Nurse-Family Partnership Pay for Success: program that pays for successful outcomes of nurse work with women and children.	Regional	https://www.nursefamilypartnership.org/wp-content/uploads/2017/02/SC-PFS-2-Pager.pdf
	CMS Innovation funded TransformMED: Care coordination among PCMH, specialty practices, and hospitals. Creation of "medical neighborhoods."	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
Tennessee	MyHealth Team: Regional team-based and closed-loop control innovation model for ambulatory chronic care delivery.	County	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Tennessee.html
	Max copay federally allowed for non-emergency use of ED.	Statewide	https://www.kff.org/report-section/medicaid-in-an-era-of-health-delivery-system-reform-premiums-and-cost-sharing/
	Project SAFEMED: improve care transitions with emphasis on medication management among high repeat utilizing patients. Employs multidisciplinary teams.	Regional	https://www.pecc.org/initiative/project-safemed-university-tennessee-health-science-center
Texas	National Health Care for the Homeless Council: Community outreach and case coordination for homeless individuals.	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
	Integrate health care into existing behavioral health clinics using multi-disciplinary care team to coordinate care for 260 homeless adults in San Antonio.	City (San Antonio)	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Texas.html
	Mobile Integrated Health Care: Pilot program run by the San Antonio Fire Department	Citywide (San Antonio)	http://www.sanantonio.gov/SAFD/About/Divisions/Emergency-Medical-Services/MobileHealthcare
Utah	Intermountain Healthcare Disruptive Innovation using data to predict need and cost effectiveness of care.	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Utah.html
Vermont			
Virginia	Improving health for at-risk patients by sharing medical records with pharmacists to include pharmacists in medication adherence.	County	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Virginia.html
Washington	ER is for Emergencies program: 1) Track ED visits 2) Implement pt education efforts to re-direct care 3) Institute extensive case management 4) Reduce inappropriate ED visits with collaborative use of prompt primary care visits 5) Implement narcotic guidelines 6) Track data on patients prescribed controlled substances 7) Track progress of plan	Statewide	http://www.wsha.org/quality-safety/projects/er-is-for-emergencies/
	Prosser Washington Community Paramedics Program	County	https://pmhmedicalcenter.com/index.php/957-flexicontent/stories/emergency-department/281-community-paramedic-program-now-underway

Washington	Medical respite care for people experiencing homelessness provides acute and post-acute care for homeless persons who would be medically unable to recover on the streets but who are not ill enough to stay in the hospital.	Statewide	https://www.nhchc.org/resources/clinical/medical-respite/tool-kit/
West Virginia	Improving health for at-risk patients by sharing medical records with pharmacists to include pharmacists in medication adherence.	County	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Virginia.html
	CMS Innovation funded TransformMED: Care coordination among PCMH, specialty practices, and hospitals. Creation of "medical neighborhoods."	Regional	https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nebraska.html
Wisconsin	Pilot pairs social workers with high frequency ED users to try to manage causes of ED use	Hospital (Aurora Sinai in Milwaukee)	https://www.npr.org/sections/health-shots/2015/10/23/451154605/a-hospital-reduces-repeat-er-visits-by-providing-social-workers
	Pay providers to prevent bad outcomes and ED visits rather than paying them more to provide ED care. Pilot proposal passed by lawmakers. Not sure if it was approved by Walker administration.	Statewide	http://www.jsonline.com/story/news/politics/2017/05/27/wisconsin-proposal-would-help-keep-chronically-ill-out-emergency-rooms/347804001/
	EDs ID Medicaid beneficiaries and uninsured who are frequent users, share information with each other, and make primary care appointments for patients. Resulted in 44% reduction in number of ED visits among frequent users who were connected to primary care.	Citywide (Milwaukee)	http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/2/24/states-strive-to-keep-medicaid-patients-out-of-the-emergency-department
Wyoming	Wyoming: A frontier state's strategic partnership for transforming care delivery. Developing medical neighborhoods which include telehealth and telemedicine.	Statewide	www.cheyenneRegional.org/hcia-app