# MINUTES OF MEETING

Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives

**Wednesday, August 29, 2018**
**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 of the Task Force on Coordination of Medicaid Fraud Detection and Prevention Initiatives (Task Force) to order at 9:10 a.m. Staff member Liz Martin documented the attendance as shown below.

Members Present:
Daryl Purpera, Legislative Auditor
Senator Fred Mills, Designee for Senate President John Alario
Representative Tony Bacala, Designee for House Speaker Taylor Barras
Nick Albares, Policy Advisor to Governor John Bel Edwards, Served as proxy for Matthew Block, Executive Counsel
Jeff Traylor, 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
Jen Steele, LDH Medicaid Director, Appointed by Governor Edwards
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

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

## APPROVAL OF MINUTES

Representative Bacala made a motion to approve the minutes for the February 7, 2018 meeting. The motion was seconded by Ms. Steele and with no objection, the minutes were approved.

## MEDICAL LOSS RATIO (MLR) REPORTS FOR CALENDAR YEAR ENDED DECEMBER 31, 2016

Mr. Purpera reflected on the history of the Task Force which began meeting approximately one year ago. The interim report issued on December 22, 2017 covers the issues discussed including the need to

strengthen Medicaid eligibility determinations; need for better coordination of Medicaid fraud, waste and abuse efforts; need to strengthen oversight and controls in the managed care program; need to strengthen LDH's program integrity function related to behavioral health; and the need to strengthen controls within the Medicaid pharmacy program. At the next Task Force meeting they will discuss what has been done to improve each one of these issues. It may be best to discuss that in a full meeting with enough time dedicated to discussing the progress since the interim report was issued.

At the previous meeting Senator Mills discussed the 2015 MLR reports by Myers and Stauffer LC, Certified Public Accountants, and since that time the 2016 reports have been issued. Mr. Purpera asked LDH to give a brief overview of the MLR reports and what was found in them.

Ms. Steele said the 2015 reports' issue was spread pricing adjustments. In the 2016 reports there were some spread pricing adjustments but there are a number of other issues. On a high level, one issue included the allocation of the premium tax. In the first year of expansion we actually had a rate certification letter that was applicable to the expansion population and they have their own unique rates and rate certification, and the nonexpansion population had their own unique rates and rate certification. The MLR corresponded to those distinctions, so there were two separate MLRs computed – one for expansion and one for nonexpansion. Consequently in reporting the allocation between the two there were a lot of adjustments to make sure that it was reflected. She was asked by Senator Mills about it and people may not have realized that those are different rate letters in a separate MLR calculation, so that is straight up making sure the distribution of costs is right.

Ms. Steele continued explaining that there were a number of adjustments including two occasions where spending that related to fraud, waste and abuse was classified in medical costs so that was adjusted out by our auditors. In one case the health insurance provider fee which is a tax payable to the federal government by the plans was counted incorrectly. Then in one case it was not included and in another it was included as a medical cost but had to be excluded. Another adjustment had to do with including premium tax revenues which was excluded. There was one instance again of reclassification of spread pricing as a non-claims cost. One plan in particular had a number of administration functions classified as health care quality improvements as determined by the auditor so utilization management was an issue. An additional issue had to do with the allocation of costs from companies that were owned by the parent corporation so they were related party transactions that our MLR auditors said were not properly allocated and made adjustments to reclassify that. Lastly, there was some duplicate reporting. The take away from the MLR reports is that it is important to have the MLRs audited and have an independent review of it. That is an important part of quality control for LDH as we move forward with this program and deciding on contract requirements. We have a requirement that if the plans do not spend 85% of their revenues on medical costs, they are obligated to rebate to LDH any difference under that amount. So it is really important that we have a good set of eyes making an independent review of how these things are reported so we can ensure that the MLR is not overstated. So most of these adjustments are downward, and a few upward.

Senator Mills asked about the one finding on page 4 of Amerigroup's MLR report, "To adjust Express Scripts, Inc.(ESI) pharmacy expense to actual incurred medical expense". Not to get into the details, but basically they are saying in the last paragraph "this is a recurring finding identified". The response is "we disagree with your finding". So what is the standard operating procedure when there is a $12M discrepancy that is being said to be reoccurring, but the plan is disagreeing, so how is this resolved. Sometimes in these reports the plan agrees and making modifications and corrections, and segregating the money in the right way. He asked what happens when the plans disagree.

Ms. Steele pointed out on page 6, line 13 that amount is adjusted out. The plan can disagree but the auditors are going to make the adjustment that they feel is appropriate. The reason that it is a repeat finding is because our auditors applied CMS regulation to LDH's MLR calculations. The plans disputed that the state had the option and was not audit defacto applicable to the state, and the state had the option to define and LDH had not defined that. So LDH clarified for two years in the context of the audit that they believe it applies. But after the first audit and before the 2016 audit was reported and prior to the correction, LDH changed their instructions to make clear that the CMS ruling did apply and our state was choosing to exercise that option. So for the MLR report coming up next there will not be any dispute over that because the rules will be set up front.

Senator Mills asked if there is a disagreement in the MLR reports would LDH and the contract overrule it. Ms. Steele answered that it is the auditors that ultimately decide on the appropriateness of the adjustment after considering all the information provided by the plans, but in the end the auditor decides how expenses need to be classified.

Mr. Purpera quoted from an MLR report, "despite numerous attempts Myers & Stauffer LC was unable to obtain the actual incurred medical expense for the dates of service covered under this examination period from ESI". He said that normally for an auditor which is following auditing standards that would end up being a scope limitation that they could not express an opinion. In this case apparently the auditor felt that they could get other information. Basically it says "Therefore, we utilized cash disbursement journal information received from Amerigroup and ESI which were available to us unrelated to our specific request to estimate". Mr. Purpera asked what the state is doing to help this auditor get the proper information from our contractor. We are contracting with Amerigroup and yet they are not providing information to the auditor, and seems like we should be stepping in somewhere.

Ms. Steele responded that she would have to go back and get the specific details on this particular adjustment but generally speaking, LDH does step in. Because Myers & Stauffer is also responsible for auditing LDH's encounter data for completeness, that was the other data that was available for them to use. On a bimonthly basis, Myers & Stauffer looks at the general ledger and compares it to the encounter data to make sure that the encounter data accounts for at least 95% of the expenditures in the general ledger. This goes back to Senator Mills' point, Myers & Stauffer will do the best that they can and make an adjustment based on the information that they have.

Mr. Purpera pointed out that the report states "despite numerous attempts" so apparently the auditor for Amerigroup is asking for the information and just not receiving it. Maybe we need to have a sit down with Amerigroup to explain that they must give our auditors information. Ms. Steele said she was not sure if this instance was an issue with ESI but a lot of times when it is a contractor and not an invited company, sometimes it's not as easy to get the subcontractor to abide by the requirements of the primary contactor with the state. That is something LDH has to fight with from time to time. Some of the things we have done to try to ameliorate that is to make penalty actions applicable to subcontractors if they do not comply.

Mr. Purpera asked if the contract with Amerigroup goes far enough to include requirements for the subcontractors to provide information. Ms. Steele said she would check.

Mr. Purpera said that Healthy Blue, Aetna, Louisiana Healthcare Connections (LHC) all had adjustments for spread pricing for more than one year. He asked why they continue to include spread pricing in their MLRs. Ms. Steele explained that LDH's auditors applied a federal policy but LDH did not change the direction to

the plans until after the audit was already in the reporting period. Mr. Purpera pointed out that in the 2015 MLR audit the spread pricing was noted and corrected. Ms. Steele said that the instructions on the reporting template had not been changed yet, so the fact that the auditor said it, then the health plans were waiting for LDH to update their policy which occurred after this reporting period. You have to look at the point in time at which these audits are done and there is a pretty good lag on them. Mr. Purpera asked if any way to correct or shorten the lag time on reports. Ms. Steele said the claims have to run out so they have a period of time to wait.

Mr. Purpera asked what goes into the total net medical expenses, which is the largest number on the report - a general answer for that. Ms. Steele said she would have to get the specific instructions for that and did not want to give a wrong answer. Mr. Purpera said he assumes it is claims. Ms. Steele said she would have to confirm it.

Mr. Purpera said that above line eight are all the funds LDH is paying for the per member per months (PMPMs) plus some adjustments, then get to line eight showing the total medical expenses, then some adjustments and finally get to the MLR percent achieved. He asked if there are any instructions to help explain it. Ms. Steele answered that there are considerable instructions and can provide that.

Mr. Purpera said all reports have an adjustment or two, but when looking at the LHC's report there are many adjustments and some are reoccurring just as pointed out by Senator Mills in Amerigroup's report. He asked what as a government is being done to improve upon that.

Ms. Steele said the bottom line is that adjustments can be made where LDH feels it is appropriate. Similar to spread pricing, if there is an ongoing dispute about LDH's policies or instructions or not being clear about expectations, then LDH will clarify that. In a number of cases, there is one interpretation against another and LDH generally tends to err on the side of not considering some of these allocations as medical expenses. If you notice there are about three that have to deal with related party transactions which are frankly a little challenging.

Mr. Purpera said that auditors like to see findings are corrected and it appears that LHC is not correcting their problems. LDH's auditor is having to go back year after year with the same findings and the risk is there may be more that is not being found. If the auditors are having to look at the reoccurring findings, it gives them less time to review other concerns. We probably need to be encouraging LHC to get their act straight.

Mr. Purpera asked to confirm that the MLR reports do not include the Medicaid expansion population and questioned why. Ms. Steele said that LDH has not gotten to the run out point where they can do the expansion MLRs yet because the expansion was done in July 2016 and they need a complete year. Mr. Purpera asked if the next MLR reports will include the expansion population. Ms. Steele said she believes so but there will be a lag because the rating period on expansion might be July to July or if they did a partial year. She would go back and check the certifications to determine the period but the bottom line answer is that it is too soon.

Senator Mills asked if the contracts with the plans have any sanctions, fines or penalties that can be imposed if the findings continue on a reoccurring pattern. Ms. Steele said she would have to look and not sure if anything specific to the MLR audit but do have certain penalties that are more of a catch all that might be able to leverage.

Senator Mills said the reports seem to show a systematic pattern of issues classifying actual medical expense versus an administrative expense. He asked if LDH sees it as a challenge to have the 85% which is actual medical expenses versus the 15% administrative expenses. Ms. Steele questioned if Senator Mills was asking about the managed care organizations (MCOs) getting the classifications right or meeting the 85%. Senator Mills answered getting the classifications correct which affects the PMPM. Ms. Steele responded that it is an ongoing challenge but it does not affect the PMPM as much as the question of whether or not there is a rebate. The MLRs have consistently run to date in the high 80's and low 90's, and not close even after the adjustments which may lower it by a point maybe but not taking them down dramatically. At the point where they are performing, it is not marginal. There might have been one plan one year even close to it, but in every other situation there are several points above that threshold.

Senator Mills said there are some things classified as medical expense but it is not. Ms. Steele said absolutely. Senator Mills asked how to get a better handle on that. Ms. Steele answered she would be happy to get more information from their peers who have been doing this longer but the information provided by LDH's auditors is just that this is routine. I suppose it's like us doing our taxes and we try to pay as little as we can when it's in our favor. I'm not saying that they are always doing that but it might be an honest difference of opinion. Senator Mills said we will talk more on that issue and may be able to put that on our to do list but it seems that if there is a recurring situation and the auditors keep noting that in the audit report, there should be some penalties.

Representative Bacala said in this example there are three entities involved: Amerigroup, Express Scripts (ESI), and the pharmacy. Basically the pharmacy fills the prescription and ESI reimburses the pharmacy at a set amount, for this example $10. But ESI turns around and bills Amerigroup for a greater amount, correct. He guesses since talking about $132M in total pharmacy in this particular report and an error rate of 12%, so it would seem that ESI is padding the cost by 9% roughly or adding to the cost.

Ms. Steele responded that LDH does not have uniform answer for our state. I knew that Ohio just did an extensive audit and found that number to be roughly 8%. Representative Bacala said the PMPM is being based on some number that Amerigroup is calling their expenses which if we are not careful they are including in their costs the spread price – excess paid – to ESI which is what we are trying to take out.

Ms. Steele explained that the pharmacy benefit managers (PBMs) get paid in three ways traditionally – paid through spread pricing, through transaction fees or through discounts or rebates that they negotiate. I would not necessarily say that it is an error, but an intentional component in their pricing and it needs to be considered as a non-claims cost. They do services for the MCOs – whether it is network development, utilization management – they should be paid for that. It is being negotiated between the plans and the PBMs as to what the appropriate reimbursement for that. The debate that we had through the last legislative session, that Senator Mills' bill was germane to, is do we want them to be reimbursed in that way. I think the outcome of the legislative session was we don't. We want them to be reimbursed on a transaction basis and do not want them to retain spread pricing. As Senator Mill's bill requires, any future contracts with Medicaid MCOs would exclude spread pricing. We are working towards implementing that in the beginning of next year which is roughly one year ahead of that deadline. So I don't want to assume that the dollar value goes away. I think that is still subject to negotiation between the PBM and the MCO in terms of what they think they need to be reimbursed to do and the services that they provide to the MCO. But the technicality of spread pricing, we are hoping to eliminate that in a matter of months.

Representative Bacala asked how that will be done. Ms. Steele explained LDH will tell MCOs that they

have to pay their PBMs on a transaction basis. Representative Bacala asked if that would prevent the PBM from having their own source of income outside the contract. Basically spread pricing is their way of avoiding – you pay one amount and bill as though you paid a different amount. I hate to even categorize what I think about that when it seems to me that no one knows what is going on unless you work within the PBM perhaps.

Ms. Steele said it makes sense that the PBMs will be paid for its administrative services. What that price is and how the MCOs choose to contract to pay it is something that is yet to be determined. It will end up being a transaction basis but as she discussed with Senator Mills, for a small plan with low volume and the same fixed costs in terms of its pharmacy administration expenses you will see one transaction fee. Some of our big plans that have high volume had that same fixed cost and they will end up with a low transaction fee. Again for this first year it's a little bit of a challenge. It's one thing on the front end of a contract to say we expect you to do it on transaction based pricing and let them know to go into the market and get bids on that basis. But for us to go into that now is a little bit of a challenge. One of the things we will watch for is once we say do transaction based then what is going to come back

Representative Bacala said he is curious about companies like CVS which are both the PBM and a pharmacy. The possibilities of what that brings up as far as their ability to. We don't have a pharmacy price but does that allow them to be more generous to themselves when they have both components within the same company. As far as they will do the transaction cost but the drug cost will be adjusted to make up for the loss that they are not getting for the spread pricing of the rebate. Ms. Steele said she assumes they would have more flexibility and doesn't claim to be an expert on that enough to say.

Representative Bacala said at some point in time he would like his pharmacy friend to testify about the concerns that he has about the methodology by which reimbursements are made and some real life stories to tell. Mr. Andrew Bertrand, owner of an independent pharmacy in Gonzales, said his family has run it for over 40 years and his wife is also a pharmacist. He shared some issues and concerns about the PBMs and the largest issue other than deciding on contracts and a lot of the reimbursements being below their cost. He has to look at prescriptions on a loss basis and trying to figure out how to overcome those issues. The PBMs come back and charge the state more than they are paying the independent pharmacies which are getting reimbursed below their costs. This is costing the state more. There is no transparency as far as what the PBMs do, so hoping that Ohio's legislation would get more for transparency and a set cost. We have a set Medicaid reimbursement on prescriptions. We just recently did a cost basis survey for the state and waiting for all those findings to come out. The reimbursements would be based more on that than these arbitrary figures.

Representative Bacala asked for specifics about being reimbursed for less than his cost in certain instances and how much is the loss being experienced. Mr. Bertrand said just the day before a prescription crème may cost him $80 and he is only reimbursed $40. He has to decide whether to deny the patient the medicine and send them down the street or just take the loss to help the customers in his community. Many times he takes the loss and hopes that he can make it up on something else. The independents across the country have dwindled down and only have two left in the Gonzales area.

Representative Bacala said a store gets to decide how much to charge for a soft drink, so who decides how much the pharmacy will receive for reimbursement. Mr. Bertrand explained that the PBMs follow a methodology that is not divulged to the pharmacists, and get some set pricing that they figure out themselves. It leaves the pharmacists to take it or leave it as per the contract signed which does not allow

for negotiations. Representative Bacala asked if they sign a contract to accept the set pricing whether they like or not, and if you decide to not renew the contract what is the consequence. Mr. Bertrand responded that he would not be in the program and be cut out of serving their patients. Representative Bacala asked if the local pharmacists have the opportunity in the next contract to negotiate the reimbursement rates for the drugs. Mr. Bertrand said he is allowed to appeal some pricing but in most cases it goes unheard and really most goes to Express Scripts currently now. He has tried to get organizations with a pharmacy services administrative organization (PSAO) of several independents getting together to negotiate but Express Scripts said they will not allow the pharmacists to do that, and only affiliate with 3-4 PSAOs right now. However, Mr. Bertrand is not in the current PSAOs, so he is one independent store in Gonzales negotiating for a contract with not much power. Representative Bacala asked if everyone in the network is being paid the same amount for the drugs or do the mom and pop pharmacies get reimbursed a different amount. Mr. Bertrand said from what he has heard and seen but has nothing to back it up because of the PBMs lack of transparency but sure if CareMark directs their patients to CVS they are reimbursing themselves at a different cost. That's part of the spread pricing where they can adjust all those in that spread and no one really knows what the spread pricing actually is. Representative Bacala thanked Mr. Bertrand for speaking up.

**DISCUSSION OF RATE SETTING PROCESS**

Mr. Purpera asked Ms. Steele about the adjustments for spread pricing if there is a process to ensure that the costs for the spread are not included in the data going to the actuary to be used to develop the PMPM.

Ms. Steele responded that it is. The actuaries have access to not only the encounter data but also the financial reporting data as well as the MLR audits. For a little explanation on rate setting, there are a couple of ways that people think it occurs but neither of which are the case. Our actuaries take neither a cost plus approach where they just say every encounter that comes in and everything that the plans report on the financials is considered. They do not do that. Nor do they take the fee-for-service equivalent approach applying the exact rates and limitations of fee-for-service. What the actuaries do is consider the fact that these are risk based contracts so the rates are set prospectively and reviewed retrospectively to see how well they performed in terms of projections. Of course the rates vary based on what the state plan covered services and populations are but managed care by definition has a waiver of comparability so they don't have to be exactly the same. In fact part of the attraction to managed care is the flexibility that it offers so when we delegate risks in exchange for that we get flexibility.

The MCOs specifically are able to use the capitation revenues in order to meet the contract requirements but including in ways that are different from fee-for-service. So for example, they can build different networks that fee-for-service, and sub-capitate if they want, or have higher rates for certain providers based on, for example, access demands whether that's specialty care or lots of unique situations that we hear. They may also want to pay quality incentives and we've talked a lot about that in other settings. And then they also have what we call "in-lieu-of" services which are instances where the covered service might be, for example, in patient hospitalization or emergency department services but in fact… Let's say that it's an adult person with a behavioral health crisis and need crisis stabilization services, and we do not cover those services but the MCOs can provide that with the capitation revenues that they have even though it is not a covered service because it is in-lieu-of that person hitting the emergency room department or having an inpatient hospitalization. So it is important to know because that flexibility and those variations and differences are inherent or intentional or built into the program that we are not looking exclusively at. For example, we don't take the encounter data and try to apply fee-for-service edits because if we did that we

would exclude some of those activities that we intend to be included.

Ms. Steele continued explaining that the other piece that is different is value-added services such as an adult preventive dental which is something the MCOs actually provide at their own expense on top of and independent of any rates that we reimburse them. Those we exclude but the in-lieu-of services, for example, we intentionally include. We also make efficiency adjustments, so our actuaries run certain analysis. There is a set of clinical efficiency adjustments related to pharmacy. For example, let's say there is a particular drug that you can dispense 10 of 10MG or 5 of 20MG tablets but cheaper to do one or the other – but that may not be the best example. But they will look at that and say we see you are not doing that thing and we are going to assume that you will change your behavior to achieve that efficiency and we value that at a million dollars, we are going to take a million dollars out of the rates. They do the same thing with hospital admissions, and same with low acuity ED visits. At a very high level, I wanted to point out again that it is neither that we take everything they give us and automatically build it into the rates, nor do we take everything whether it comes in from the encounter data or financial reporting, we don't just ingest it and spit it out, nor do we assume that we have to apply all the fee-for-service rules that their expenditure behavior has to mirror fee-for-service and should be restricted on some basis. I'll pause there and see where that leaves us.

Mr. Albares asked Ms. Steele regarding Mr. Bertrand's testimony how Medicaid relates to pricing for independent pharmacists. Ms. Steele said that Mr. Bertrand's experience with negotiations and contracting with the PBMs is consistent with commercial experience. She noted that there are statutory requirements in Louisiana that independent pharmacists in the Medicaid program must be reimbursed by MCOs at the fee-for-service rate and that fee-for-service rate is established by LDH. Relative to the issue of individual prescriptions being reimbursed below costs is true sometimes because the reimbursement methodology is an average acquisition cost basis and so our vendors take in costs that are paid by everyone in the market. They take the average of those costs and set an average rate so there are some folks who will come out ahead and some folks will come out below. Our goal is to ensure in the aggregate that our pharmacists are not losing money. We cannot guarantee that on an individual prescription. On an average basis, it is by definition not how it works but when we have gotten into situations working with individual concerns, to my knowledge every time when we back it up and look at the aggregate it is okay on the whole. But there will definitely be those instances on the individual drugs sometimes they lose.

Mr. Albares asked about the 85% in the MLRs and the lowest one was at 91% with the adjustments like with the 3-4% point adjustment. Looking back at some of the minutes from previous meetings it says that the rate set is set based on a 9% MLR and 2% profit margin. Ms. Steele said no, the MLR is not the 9%, but the 9% is for the general. The target MLR is 88%, when they set rates they set for 88%. But sometimes the plans out-perform or under-perform that. The higher it is, the more eats into it. So we build 9% into it as a general in terms of their administrative costs for staff, call centers, claims adjudication and have to be compensated for that. We also build in for premium tax for health insurance provider fee, so those are some things that get built in. But 9% is not the MLR itself - it is more what we call the administrative load.

Senator Mills asked who checks the people adjusting the rate. Everybody can make a mistake and calculations could be what CMS or the contracts want. He asked who independently checks the people providing that information. Ms. Steele asked if he meant who is checking Myers & Stauffer, and Senator Mills said yes. Ms. Steele said she would have to check with her pharmacy staff because she is not aware that they have a secondary entity that is double checking their work. I know that they do set the rates for a different methodology at the national level for CMS. We do have a process by which when a pharmacist

identifies a case like that they can provide us their cost information and we can reconsider but I don't believe we have somebody behinds Myers & Stauffer validating their work.

Senator Mills thanked Ms. Steele for the details shared. He asked who checks those calculations on the global picture of rate setting. Ms. Steele said that the U.S. Office of the Actuary reviews and approves ever rate certification letter that our actuaries produce. That is part of our routine approval process with CMS. There's a group of folks and not sure where they are located and most are contracted out. There are two firms that specialize in Medicaid rate setting and they review the work. Frankly that is the area that gets the most scrutiny on the rate letters, and very detailed instructions by their professional society that governs them like accountants have GAAC, so the actuaries have ASOP. The actuaries have to follow those rules as well as the federal regulations. So the Office of the Actuary which is a federal entity receives all those rate letters. We usually go through two to three rounds of questions and answers back and forth with them until they are satisfied and not until they are satisfied do we get approval of our contract and that is inclusive of those rates.

Senator Mills said that is good to know. A complaint that he receives from a lot of constituents is about all the billboards and buses and advertising. He asked if advertising is included in the administrative costs and contractually allowable. Ms. Steele answered yes. Senator Mills asked that in this round of contract negotiations now that people know there are plans out there and people know that there is Medicaid expansion, will LDH look at making those expenses as a disallowance. Ms. Steele responded that they certainly can. Senator Mills asked how much is spent on advertising expenses. Ms. Steele said she does not know off hand.

Representative Bacala commented on an article titled *"Ohio firing pharmacy middle man that costs taxpayers millions"* that estimates it to be a $400 billion a year industry and believes it is referring to spread pricing. The gist of the article is the Ohio is cracking down on spread pricing and basically going to eliminate spread pricing as a component of their state plans. I'm not sure how they do that. I think that LDH may be going down the same path and would like further information on that and if PBMs will be cut out altogether and a single formulary maybe.

Ms. Steele said we have talked a lot with Ohio and my understanding is not that they are firing the PBMs but are cancelling the contracts under which spread pricing has been allowed as a payment term. Ohio is expecting their MCOs to go back to the PBMs and to negotiate new contracts that exclude spread pricing. Ohio did at one point in time carve pharmacy out but at this point in time that is not what is happening. They are forcing them back to the table to have a different payment basis. LDH will come into compliance with the law which prohibits spread pricing before the deadline which is concurrent with our new managed care contracts at the beginning of 2020, but we are going to do it concurrent with the implementation of a single PDL early next year.

Ms. Steele said LDH is not at this time looking at a pharmacy carve-out which would eliminate the whole PBM issue. What we are looking at, and this was really motivated by thinking about the experience of our prescribers and our pharmacists and our members with our program which goes to the broader issue of administrative complexity. Today we have six different preferred drug lists (PDLs) – the fee-for-service and five managed care ones. Our belief is that is unnecessarily complex so we spent some time early this year and Senator Mills helped convene a group of those prescribers and pharmacists to help us define the issue including what challenges they face. We were already interested in but we chose to pursue a single PDL. So we are looking to implement one PDL that applies to both managed care and fee-for-service, and

that will be implemented early next year. That will address the administrative simplification and also provide the state the ability to collect supplemental rebates on those claims that go through the managed care companies.

Representative Bacala referred to a recent JLCB meeting where the director of the state employees' health plan made a presentation indicating that they had eliminated spread pricing for state employees and also taken some actions relative to some other issues such as rebates. Seems like if we are at the state level and doing it for state employees it seems like we should be able to easily adopt the same model for the Medicaid program. Maybe it is not transferrable, but I understood that the state employees' plan was able to do what we are trying to do here as far as cost savings. Ms. Steele said she would reach out to Tommy because she works together with him on other issues.

Mr. Traylor asked if there is a committee that will select the drugs that make the PDL and who is on that and how will the integrity of the process be protected. It is a precious commodity to have a drug placed on that list so how will we ensure that it is done in the proper manner.

Ms. Steele said the way it happens today is the way that it will happen in the future. We have a standing pharmacy and therapeutics committee that meets twice a year. Those members are actually appointed by the governor and come through the boards and commissions. Recently, thanks to Senator Mills we were able to reconstitute that. We had challenges with the source of the nominations and getting timely replacements and getting quorums. So we addressed it this past year by changing the way that appointments are made to give us better ability to ensure a smaller group that is more consistent. It's populated primarily by physicians and pharmacists.

Mr. Traylor asked if she has any concerns about pharmaceutical companies trying to influence some of the individuals on the committee. Ms. Steele said that Senator Mills has more experience as a member of the committee. Senator Mills said he has been on the committee for quite some time and has not seen that issue. It really is a therapeutic discussion. The most maddening thing and Ms. Steele would probably agree is when we are trying to make a therapeutic decision, we are also trying to find the best cost to save taxpayers money but we cannot see what the rebate stream is. It's like negotiating from behind a curtain and cannot see what is going on. There is a lot of frustration for the committee members. The committee takes testimony from the pharmacy manufacturers about their better widget, and it's a good debate that the members take very seriously about costs.

Mr. Purpera asked to finish discussion of PBM and spread-pricing. Senator Mills thanked LDH and the legislature for good things done this session on the market itself. There will be more transparency for private insurers to see what rebates are coming and the true administrative costs and what is being trickled down to the consumer. We did legislatively make this a transactional fee issue only. He thanked LDH and several MCOs who called him because they saw it as a systemic problem nationwide and wanted to address it also. I guess if I have to wrap a big bow around it - in the old days it used to be where a PBM was like a Visa transaction and if they saw there was duplication of therapy or saw three drug stores being used by a consumer or going to ten doctors, there were edits that took place but it looks like this has evolved into a retro process of only a fee and we will take care of the rest. I want to thank this committee for tackling this issue first and brought it to the forefront. We were one of the few states and other states are following, so I think we have addressed the issue.

Mr. Purpera said his intention for placing rate setting on the agenda was to begin a discussion and not make

any conclusions or exhaust it today. Our enabling statute directs us to look for issues of systematic or system wide coordination of Medicaid fraud, waste and abuse. Rate setting might be one place to dive into and appreciates Ms. Steele giving us a broad level explanation. He asked if LDH has any documentation that the committee can review to get a better understanding of rate setting showing processes and procedures. Ms. Steele said what comes to mind is the training materials that LDH has access to through their actuaries for their own staff. She'd like to go back and review those and maybe provide that as an offering, but it may be more than you want but a good introduction and what we use to get our staff up to speed to understand rate setting so it might be appropriate.

Mr. Purpera said he would like to understand when an MCO pays for something that should not be paid then how does that not go into the actuaries' calculations at some point. When Myers & Stauffer shows amounts that should not be included in the MLR since that is one and a half years later, how does that not get included and sure it's more complicated than that. Ms. Steele said if we could coordinate times maybe we could have them come down and talk about their work.

Mr. Purpera asked if the U.S. Office of the Actuary who reviews the rates issues any reports. Ms. Steele said not to her knowledge because their function is more about the state – federal communication, about approval and ultimately we do not even get the approval from them but we get the approval from CMS. The main dialogue is a series of questions and answers between our actuaries and theirs.

Mr. Purpera asked if any nationwide information available, for example, to see regular Medicaid and expansion Medicaid PMPMs across the 39 states that are using managed care to make a comparison to see if we are in the right spot. Ms. Steele explained that the issue in any state is how the benefits are designed, how they construct their rate cells, what services they cover and impact their PMPMs in addition to the rest of the population. That is always the challenge when comparing two Medicaid programs – if another state covers dental and we don't, etc. - depending on the acuity of that state. I will take a look and see what is available but would caution on comparability.

Mr. Purpera said maybe that goes to the heart of the question. For example, what is our regular average Medicaid rate? Ms. Steele said around $350. Mr. Purpera suggested looking at other states and if some are $320 then we can dig down to see why. Ms. Steele said they have to dig down to see if we have the same service offerings and same pricing. She was at a National Association of Medicaid Directors Conference and was shocked to find out that most states actually pay in excess of Medicare when we are about 60-70% of Medicare. In addition to the service offerings themselves, you really are talking about apples to oranges.

Mr. Purpera commented that he did not expect to come to any conclusion today but just opening up the dialogue on it. The rates are set prospectively and reviewed retrospectively. He asked if that review is something that the state is doing or the U.S. Actuary. Ms. Steele said LDH's actuaries do that when they look at how plans performed against the rates. Mr. Purpera asked if any reports are issued on that. Ms. Steele said that is one consideration made by the actuaries when they start looking at the baseline performance was in order to access that starting point but it is not always the same starting point. Sometimes the base data period is updated but sometimes it is not, but it depends on where we are in the cycle.

Mr. Purpera said that is not included in the LDH annual Medicaid report, so is there some data that could be shared with the committee showing what the actuary concluded for the last three years. Ms. Steele said she would see what she could do. Mr. Purpera suggested further discussion at a future meeting about what

procedures are being used to validate the encounter data that is going to the actuaries to be used in the calculation. Just for a general idea, the regular Medicaid rate is about $350 and the expansion population rate is average $500. Ms. Steele said the average was $550 the last time she looked at it but probably higher now. Mr. Purpera asked why the expansion rate is higher. Ms. Steele said the rates were restated last time and actually came down a little bit but you have to factor in what has happened with the supplemental payments so to the extent that the full Medicaid pricing has changed, that also impacts it.

Mr. Purpera said he is just throwing a lot of questions out to think about for our next meeting. He would like to know why the rate is different between regular and expansion. Since we do not have the MLRs for the expansion population, is LDH doing any analysis to gauge whether our rate for expansion is on target. Ms. Steele said LDH receives quarterly financial reports from the plans and actually had a very spirited debate yesterday about what current trend is showing versus the current rates. We are constantly looking at new information as it is available, but again the opportunities for incorporating that into rate setting are periodic, usually annual absent programmatic changes that we initiate. For example, there is a midyear adjustment that takes into consideration some updates to rates having to do with psychiatric residential treatment facilities where we are having some access issues. I think there are a handful of adjustments that are happening midyear but ordinarily we adjust once a year and again we look at what was the experience that occurred, because sometimes the experience is different from what was anticipated, and sometimes it was on track. Last year the issue was the flu season and it was really bad and people did not see it coming, and that contributed to some losses. Does that mean that on the aggregate the rates were still okay? Yes, we thought so, but that is the kind of things that we look back at. But with the expansion a couple of other things are the pent up demand. People who historically did not have access to care, at what point do they get caught up?

Mr. Purpera said he reviewed all five of the Myers & Stauffer's reports and looked at the nonexpansion payments to the five MCOs and according to their reports the bulk of their expenses are for the total net medical expenses. He saw roughly $4.4 billion in payments, and net medical expenses of roughly $3.7 billion making the percentage about 83% expenses to payments. That does not include the adjustments that get them to the 91-93% for MLRs. Then looking at the 2017 Louisiana Medicaid Report which showed total managed care payments which I assume include expansion population - so not apples to apples. On page 17 the total managed care payments to the five MCOs of rounded off $6.6 billion. On page 43 is the total encounter expenses which is medical cost of $4.4 billion. So that percentage is 66% expenses to payments. That is why his attention is on the rate setting. He is sure there are a million adjustments between those two numbers but at some point he would like to figure out what they are.

Ms. Steele explained at a super high level the first issue is claims lag. We pay out to them when they pay out to providers. The other issue is data service versus data payment. We report in the annual report what was paid in that period and not what services occurred during that period so there are some significant differences. But the main difference is the lag between them. Our folks have 365 days to file a claim and that goes back to the question of the MLR report. We cannot complete that until a year after the claims period ends. That's even before we can get the data to start looking at it much less finalize the report and get it out. So that will always be the case that the expenditures to the MCOs are going to be greater than the expenditures to the providers until you get pretty far out.

Mr. Purpera asked if the annual report is on a fiscal year and like a cash basis. Ms. Steele agreed and explained that the MLR reports are calendar year. The expansion MLR report will be an 18 month period and will cover July 2016 – December 2017, so we have to get to December 2018 before we can even start

looking at that. Mr. Purpera commented that for it to be a timing difference then either we have to have constant change or there has to be some periods where services are incurred but not reported and greater and lesser amount. Ms. Steele said IBNR – incurred but not reported. Mr. Purpera said we assume the IBNRs to be somewhat constant and asked if we see experience where the IBNRs are greater because there is a huge gap in 2017 and would expect there are 2016 costs in the 2017 report. I guess what I am saying is some of that would be washed out because we are looking at time. Ms. Steele said she cannot speak to the details. Mr. Purpera said he is laying groundwork for things to discuss in the future meetings.

Senator Mills agreed with Ms. Steele that sometimes comparing apples to oranges. He asked when a PMPM payment is broken down if it is siloed for different services such as hospital, pharmacy. He also asked how the methodology is done to come to that number. Ms. Steele said they look at it in the buildup but when it goes into the rates we do not say to the plans that of the $350 you have $20 on transportation, etc. Senator Mills asked if LDH could compare the breakdown with other states' data and share any of that information. Ms. Steele answered that there is high level experience such as for hospital costs run about 40%, pharmacy is pretty significant and those are the two biggest expenditures. I think there are round numbers that actuaries look at and determine what is right but it depends a little on the population and services. Senator Mills commented that the chairman's initial question about comparisons to other states, he was not sure if states shared that data with each other to see if any norms.

Ms. Steele explained that there are two main actuaries in the Medicaid space – Milliman and Mercer. Both of them have a dozen or more states, but between the two of them they split the country with limited exceptions. They are always looking at their experience in other states and the states that they work in. Senator Mills said any data used by LDH for comparisons to other state would be helpful for the committee and if we do see a PMPM that is significantly less than us, maybe it makes sense to at least see what their practices are and discuss with them further. I know LDH talks frequently with the different states and it would help us to understand it.

Representative Bacala referred to Ms. Steele's testimony that Louisiana pays about 67% of the Medicare rate and many other states pay above the Medicare rate. To complete the story, we are in that situation because our state has chosen to invest a lot in supplemental payments so we are flipped compared to other states. We are the highest percentage of spending of any state on supplemental payments to hospitals so we basically pay a low rate of 67% of Medicare but we overcompensate in turns of disproportionate share of upper payment limit (UPL) etc. I just want to make sure that we are not leaving the topic of how much we reimburse without covering the entire topic instead of just picking out that one piece.

Ms. Steele clarified that when she said 67-70% of Medicare, she was talking about their professional services fee services which is what we generally pay physicians, for lab services and that type of thing. But you are correct on hospitals, and we do not have in that space there is not generally speaking any supplemental payments. But in the area of hospitals it is true and also true that we pay relatively low on what we call the base rates - more or less the fee schedule type rates. In a hospital program we have a particularly heavy dependence on supplemental payments which as you know we have been working to mitigate.

Representative Bacala suggested the committee talk about that at some point and time. When we talk about hospital payments 39% is just the base payment and 61% is the supplemental payments but not all hospitals receive that mix. Ms. Steele added that it is actually about 63% of costs is reimbursed on the hospital based payments so that was close. Representative Bacala said he looks forward to speaking further with Ms.

Steele online or offline, maybe as a committee we will talk about that fix.

Representative Bacala requested to see a breakdown on uncompensated care payments, just with the realization that our uninsured went from around 20% to single digit around 9%. Ms. Steele explained that the report shows the distribution split between Medicaid and uninsured pairs - that particular pair mix and it was a little different on inpatient and outpatient but there was some significant movement between Medicaid and uninsured that changed the pair mix for hospitals. Representative Bacala said the point being that there was approximately 20% uninsured before expansion and about 9% since expansion. Ms. Steele responded that the latest data released on the previous Monday showed a decrease from approximately 22% to about 11% - roughly in half. Representative Bacala said that uncompensated care payments went from $1.1B to $1B, so we have seen about a 9% decrease at the same time that we have seen a 50% reduction in uninsured citizens. That is a head scratcher for me because uncompensated care is more than the uninsured care. Personally I would like more information on how much is uninsured and how much of that is people who just refuse to pay their deductible or whatever the case may be. Are we becoming the automatic fallback if somebody doesn't want to pay their deductible and the state says "bill me and I'll pay it". If that is the case, do we have an avenue where we can go back and seek to be reimbursed for our cost? That is another big topic and would like to go down that path at some time and see what the uncompensated care cost (UCC) breakdown looks like and the reason for each payment. How much is uninsured and how much is something besides uninsured because it's only gone from $1.1B to $1B.

Ms. Steele commented that it is a common misperception. UCC pays for more than the straight uninsured. It also pays for the Medicaid shortfalls, so to the extent Medicaid pays 63% of cost, we make up for that difference between costs and the Medicaid reimbursement in UCC. Representative Bacala asked if that is part of the UPL. Ms. Steele said that UPL is separate from disproportionate share hospital (DSH) – two different types of supplemental payments. Representative Bacala asked which category – full Medicaid UPL or DSH - does UCC fall into. Ms. Steele responded that LDH uses UCC and DSH interchangeably. DSH is the disproportionate share hospital payment which compensates hospitals for their uncompensated cost. So again UCC includes both the cost for the uninsured as well as that Medicaid shortfall – the extent to which Medicaid doesn't fully compensate costs. UPL is the difference between Medicaid and Medicare generally and it is only on the fee-for-service side. Full Medicaid payment is basically the UPL equivalent inside of managed care, so those are your three buckets of supplemental payments.

Representative Bacala said that sort of complicates the whole issue about we only pay 67% of the Medicare rate when we have all these other components added to that. If you just simplified and said how much we really pay, we may be paying more than the Medicare rate when you take all component pieces and put together for the full compensation. Ms. Steele said that is correct in some cases. Representative Bacala said he would like more information on UCC. For a long time it was thought of just being uninsured and apparently uninsured is just a small component piece of UCC – maybe 10% based on what I am seeing. Ms. Steele said the biggest issue is that the DSH count did not go down and early into expansion we did not adjust DSH down. There was an adjustment in the budget but it did not end up being seen through so you have not seen the DSH reduction yet.

Representative Bacala referred to LDH's monthly reports that come in midyear that shows the UCC is $1.1B to $1B, so I think it needs a lot more explanation and I'd just like to go down that path. Ms. Steele said sure. Mr. Purpera said they will have some opportunity as they talk about rate setting.

## REQUEST FOR RANDOM SAMPLE OF MEDICAID ELIGIBILITY CASES

Mr. Purpera reminded members of the previous year's sample of Medicaid recipients from LDH given to LDR for comparison to tax data and the conclusions were in the interim report. The objective today is to ask for another sample of the 2017 data. His request is that his staff selects a statistical sample possibly because not sure who will have tax returns. But using a statistically balanced sample to ask LDH to provide that data to LDR for comparison to tax returns and provide more specific results. This time we would want to know when the income per the tax return is greater than $5,000 more than what was attested to; greater than $10,000; greater than $20,000; greater than $50,000; greater than $100,000. The last thing would be also to ask where the total number of individual and dependency exceptions on the tax return are greater than the household size in department's records.

Mr. Boutte said when we did this exercise last time we focused on the single person household maybe so it sounds like this time we want to change the methodology and look at the entire population or still focus on single person household. Mr. Purpera responded that last time we looked at a sample size of 860,000 which was the entire adult population that existed the entire year of 2016. So it was not just single person households. Mr. Boutte recalled some issue the last time with the comparison of the income because the income was originally pulled for that analysis was not the actual income that was used in the eligibility determination process. So I guess in terms in working together on this request, if it is your desire for your team to pull the sample, are they going to pull it based on any income criteria. Because if income criteria is going to be part of how the sample is derived then we really need to work together so we can supply you with the proper income information if it is not part of your data set today. Mr. Purpera committed to absolutely work together, no doubt at all. Mr. Chris Magee, Performance Data Analytics Manager, clarified that the targeted selection last time was the entire adult Medicaid population and not a specific sample or just the single person household. We used the data captured in Medicaid data tables with eligibility household size, family size and income. As we worked through these issues, we found that those eligibility fields in the Medicaid data are not particularly accurate so it does not properly capture the income that a person has or the household size of Medicaid recipients. So this is not something to be pulled from the data that the auditor's office has access to. It is actually in a different system which Mr. Boutte can explain further, called the **Medicaid Eligibility Determination System (MEDS)** and has to be pulled in a different way actually by LDH to get the true income that was used for the eligibility determination for that individual. Mr. Purpera said he is committed to doing it right and we will all work together on that. Mr. Boutte said that is fine.

Representative Bacala said there was report last year that stirred up a lot of attention and wants to be sure that the data is accurate. He believes that the people in the room today know what we should be looking for. He suggested they sit together and come up with the best way to get the most accurate information which is the only goal. Representative Bacala referred to LLA's report based on the Louisiana Workforce Commission (LWC) data that produced interesting results. He said perhaps on a parallel track to do both the LDR report and the workforce data report and see how well they are matching up. That would be another component piece to either support or does not support the other even though producing separate data. Something to consider as they discuss it further.

Mr. Purpera said his office is looking at LWC data and there will be some reports coming in the next few months on that. But specifically for this sample we want to look at tax data because LWC data does not include everything such as self-employment income, rents, royalties, retirement income and various other

things.

Mr. Morris asked to clarify that in 2016 the entire adult population of 860,000 was used, and they will use the entire adult population set for 2017 again, but what was said about the exemption in the household size. Mr. Purpera said the last analysis showed about 48% disagreed with the household size. Mr. Morris said correct, the household size and the exemptions on the returns disagreed about 48%. Mr. Purpera said he would like to define that further and could work together to figure out what that definition is. He asked if it is the household size per LDH compared to total exemptions which would be the personal and dependents. Mr. Morris said right, so on our returns we will have the personal and dependent exemptions so that is the taxpayer, taxpayer's spouse and then anyone claimed as a dependent which could be a child, grandparent, parent, it could be a whole host of things.

Mr. Purpera asked if any objection to the chairman writing a letter from this committee requesting that. Mr. Boutte said no objection, but wanted to point out related to looking at Workforce Commission and revenue together is that when looking at the tax return as the only source of income that we are considering, we do know it is dated and we make eligibility decisions in real time so we look at current income. He wanted to put that framework out there so when the results come in, we do need to consider the fact that we are looking at old information, potentially a year old, for someone who got determined eligible today. When it comes to LDH's decision we are looking at real time information. So as a word of caution that if are only looking at revenue data for this exercise there will be some limitations on the conclusions you can draw from that. Mr. Purpera agreed that there are some limitations but did not agree with all he just said because we would be looking at 2017 recipients and would be looking at their 2017 incomes, so that's why we are going back a year. I think we are trying to match apples to apples the best that we can. What I would love to do is add to the LWC data but that requires LDR to give us specific information on the recipients and they have not desired to do that in the past. So I do not know that we can get that unless LDR can someway work with LWC so could look at all the databases at once.

Mr. Boutte said he does not disagree that the 2017 income and the 2017 eligibility are essentially the same time frame but when the income was earned actually matters for us. So if all the income was earned in the first two months of the year and that person applies in the third or fourth month and have no income the remainder of the year, even if that one to two months of income would presumably exceed what would qualify them for Medicaid, because of the point in time when they apply they have no income and unemployed, then they would still be eligible. So LDH taking the entire calendar year approach might produce some false positives. Mr. Purpera said he understood.

Mr. Alvarez agreed with Mr. Boutte's question of how they would address people who have lost jobs for say a three month period over the course of the year but have nine months of income. He asked if that would be looking at LWC data or how to part that out for people coming onto the program for a finite period over the course of the year. Mr. Purpera agreed there are limitations because the rules of the system allow if a person works for two months and then don't work the third month then they can qualify for Medicaid, and if they return to work in the fourth month that person is supposed to go back and report their earning. The person is not supposed to be left on the rolls. So theoretically the annual income should give some good indication if the individual's eligibility. Unless we are saying as Mr. Boutte's example, the individual works two months and let's say $35,000 is the maximum earnings that person can earn for the year and still qualify. So if they make $35,000 in January and February but doesn't work the rest of the year - that would be the outlier.

Representative Bacala suggested another point that we might want to separate out because we are talking about percentages. What we are basically trying to find out is what percentage of applicants may have issues. So the simplest way to address the concerns that you guys mentioned is to do a separate study of only individuals who were enrolled in Medicaid for the entire year. So they were in twelve months in Medicaid and see what their twelve month income was, and that way you eliminate the guy that came on midway through the year and may have had earnings for the first six months and none for the second. Not as a reboot on the whole study but as a sub-study within the study to look at those for the entire twelve months and see how they look on the income.

Mr. Magee provided a good scenario of how it currently works if someone begins to be on Medicaid in January 2017, and applied in December 2016. The caseworker is using the information available to them at that time to make the eligibility determination. Tax data may give some more information that can be helpful in making your determination. Right now when a caseworker is looking in December to determine whether or not a person qualifies, they are most likely using wages from the third quarter of 2016. So LDH uses wages from July – September to make that determination in December for January to December of the following year. You can have a job for the entire year and lose it on the last day of that year and can qualify the next day for Medicaid. It's just the way the program works and is real time decisions. So the point of the whole tax data exercise is to identify those individuals who are not reported in workforce commission and who are potentially risky. This would give a little more information to make the correct eligibility determination and to ask additional questions. But as stated by Mr. Boutte, it is older data and LDH is really assessing at the current time. But this is just another tool that LDH can use in their eligibility determinations, and these tests must be done to decide whether this is a useful tool. So if LLA, LDH and LDR work together to bring all these concerns and considerations into the test to make it as appropriate as possible then I think that's how it would work best.

Senator Mills asked if any states use asset testing in their eligibility process. He finds from working in a bank that people may be instantly Medicaid eligible but they own a lot of assets and liquidity. I guess theoretically you could have a million dollars in the bank but lose your job and then qualify for Medicaid. Ms. Steele said LDH does asset tests in long term care so that applies to their institutional populations for sure. But for the modified adjusted gross income (MAGI) group we are prohibited by federal law from using that. So that is your parents, your kids, expansion adults are all off the books in terms of ability to do asset testing. Senator Mills asked if no one has been allowed to apply for a waiver for asset testing and if nonnegotiable. Ms. Steele said she does not believe it is waivable because this question was asked last time and LDH researched it.

Mr. Purpera said the assets would matter only where the individual's assets are sitting in an investment account and their earnings are greater and reflected on their tax returns. The problem is that the current system would not find it because we are looking at LWC data and not tax returns.

Senator Mills said in this theoretical discussion you could be generating passive income and that passive income would not be in the determination process. Ms. Steele said that income earned on assets is counted but not the asset itself. Mr. Magee added that it is not captured anywhere in the eligibility determination process unless the applicant volunteers their investment income information. Mr. Purpera asked if there is any verification of that information. Mr. Magee answered that there is not a system checked to his knowledge. Senator Mills asked if that could be developed because that seems like it should but it would be strictly tax return data. Ms. Steele said we would have to dig into it and do not know tax returns well enough to see if that identifies the source.

Mr. Purpera asked if LDH has made the decision to begin to use federal tax data going forward. Ms. Steele responded that her top priority is to get their new eligibility system up later this year. Their first go live will not include the IRS data but there will be a release two which will include some enhancements including the IRS data and expects that to be done next summer.

Mr. Purpera asked when LDH begins to use federal tax data will they use it on a one-to-one basis or will you be using a data base using data analytics. In other words, when a person applies for Medicaid will you look in the portal at that time to look up that individual or will you have the ability to do some advanced data analytics to look at all recipients and periodically compare them to the tax return data. Ms. Steele said they are checking but did not want to say until confirmed. Based on some of the initial findings of the work that LLA has going on, LDH's data analytics section is trying to obtain the LWC data to do some targeted reviews of the nature that you have already done. It will be more automated in the new system. Right now we would be doing the same thing you are in terms of some targeted reviews and identifying high risk areas and particularly as it relates to more interim review not necessarily just at application and renewal.

Mr. Purpera asked if LDH is also considering to use tax data in those data analytics because I understand there is a working relationship between LDH and LDR. Mr. Boutte said we have been having those discussions around what the next memorandum of understanding (MOU) might look like between our two departments so that we can facilitate some sort of relationship by which we can share some data more freely for the purposes of additional analysis on the back end that might be outside of what we get from the federal hub when that piece gets implemented next summer. Mr. Purpera said he believes the federal hub has some real limitations and trying to work on that at a federal level.

Mr. Morris echoed Mr. Boutte and Mr. Alvarez's concerns that the data is not going to be comparable and will disclose that as usual in LDR's report back to the Task Force. But going back to the LWC data, we have currently an MOU with LWC where we receive LWC data but do not know if we can go so far as to use it in our report but will check on that. If so, I think it would be very helpful in our report back to this Task Force to show what you have asked for but in addition to the LWC data because I still stand by my belief that the LWC data is much more reliable than tax return data. So if we can import that into our work we will definitely do that. Mr. Purpera agreed that it would be great if you can incorporate that and maybe we'll include that in the letter if it is at all possible to incorporate that. Mr. Morris said we are happy to do that, but we will just have to see if possible operating under the MOU.

Representative Bacala said that some people have reached out to him on occasion and spoken about automatic enrollment. It seems like it has created some issues for some people and not saying it created issues for everyone. It is related because people are being signed up for Medicaid who never applied for Medicaid so there might be a lot of skewed data because of whenever this policy comes into play. In one particular instance, a college student who was auto enrolled did not know he had Medicaid until he went to get a job and the employer was going to put him on their insurance only to find out then that he was on Medicaid. The student had no knowledge or desire to be on Medicaid. That's another group of Medicaid recipients who are out there. He wants to know how does that happen and what is auto enrollment and how many people are in Medicaid who are auto enrolled who never actually said they want to be part of the program.

Ms. Steele explained that in particular with expansion you saw a couple of things going on. One has to do with people who applied to the federal exchange and they report income below the limit that the exchange

allows, so the federal marketplace determines them to be eligible for Medicaid and passes them on to LDH and we accept that. That is a choice of the state. At points in the past in what was called a determination state where we accept the decision of the marketplace. The marketplace makes a referral to LDH and we make the decision. We were initially a determination state and briefly were a referral state but with the advent of expansion we made the decision to go back to being a determination state because of the volume we anticipated. So it does occur that people report an income thinking they are applying to the exchange and end up getting Medicaid eligibility because the federal government requires that single point of entry. They only want people to apply once and don't want them to have to figure out for themselves that their income is below or above *X* and go to the appropriate door. So that is one of the, I suppose, downsides of that automatic and consolidation. And of course that is one of the recommendations or at least points of discussion, is whether or not we should go back to being a determination state, and we can have that conversation.

Ms. Steele continued explaining that the other issue is that when we went to expansion there were people who we moved – what we called flipped – automatically from a limited benefit program which they were currently entitled to, to expansion because the basis of expansion. The rules under which they were eligible under the old program were basically the same or comparable rules to what they would have been eligible for under expansion. So there was a flip there. Actually this time of year is the highest for those who track our enrollment trends. This time of the year – June, July and August – is when you will see the greatest change in enrollment because of that big group of people moved at one time and the reviews going on with them. Those are the two points of interest in our enrollment.

Representative Bacala said the point is if you are auto enrolled, I assume you never reported your income to LDH. Ms. Steele said in the application to the exchange in the first case was where it first occurred. Representative Bacala asked if any idea of how many people are auto enrolled. Ms. Steele said she did not know off the top of her head but can tell her from different sources, and what comes in from the marketplace. Representative Bacala asked for the total expansion population number at the end of the fiscal year because it was projected around 494,000 and maybe downgraded to 487,000. Ms. Steele answered we are roughly at 470,000 now. Representative Bacala said we were at about 480,000 in April. Ms. Steele said they never reached that high but their counts if you look at unduplicated numbers including members who have been enrolled at any point in the year versus those who are enrolled at this point in the year, that number is higher right because it includes those who were with us in April but not with us in July. Representative Bacala said he would look for those enrollment numbers.

Mr. Magee offered that about 190,000 Medicaid recipients were auto enrolled at expansion from what were known as fee-for-service plans Greater New Orleans Community Health Connection (GNOCHC) and Take Charge Plus. Ms. Steele explained that it was a family planning program that was about 130,000 people and in the GNOCHC program was about 60,000 people. Mr. Magee said the premise was that because they qualified for those plans and because the eligibility guidelines were similar for expansion that they would qualify so they were automatically enrolled.

Representative Bacala asked if they see any problems with auto enrollment. Mr. Magee said in those situations the individual should know that they have Medicaid because they were on Medicaid in the past. The situation that Representative Bacala described was most likely from the federal marketplace that Ms. Steele was describing where the individuals are pushed down to the state level due to their income level. At that point if the state is a determination state then it has to accept the determination made by the marketplace whether or not it was correct. The state is not accessing whether or not it is correct because the federal

marketplace has said that these people are eligible for your Medicaid program. At that point they do get enrolled into Medicaid and may not know that they are enrolled. Some people are done that way and have no claims in the Medicaid program so those are potentially unaware that they were on Medicaid.

Representative Bacala said the student had no idea that he was on Medicaid until he tried to get private insurance. If the student goes to the doctor assuming he is uninsured, but LDH is paying an MCO, but he never enrolled, so it seems like something is missing there. Mr. Magee said that if an individual does not choose a plan to enroll into, then that person is automatically assigned to one of the plans. Mr. Boutte said that is correct. Representative Bacala asked if that is something that needs to be looked at more closely because he heard concerns from several people because they were caught in that. Mr. Magee commented that the LLA is looking further into that as part of the eligibility work. Representative Bacala asked after looking into it to please come back and share what is found.

Mr. Alvarez commented on Mr. Morris' memos from the prior year about the sampling which was a quintessential apples to oranges approach regarding the federal deductions and also household size and exemptions. He asked if that would be the case for this new analysis as well and if there is anything that can be done to mitigate that especially regarding the exemption and dependent piece.

Mr. Morris said in the comparison for the 2017 year, he would still have the same disclaimers in place because as he mentioned in the previous memo you would not be comparing things that would necessarily align. On the federal side your income is going to be different than your household income because you have to consider the income from the entire family versus what you report on a tax return is only what you earned. Then on the household size versus the number of exemptions, it is the same approach there. It is understood that these items are not going to agree. Obviously this is a tool that can be used to review the data but it is not going to be the end all determination of that. Since you brought this up, I wanted to also say as well that the LWC data when I said earlier that it is more reliable, it is more reliable in the sense that it is more real time monthly data that is more relevant to a Medicaid determination for eligibility. What's reported on a return is annualized data over 12 months so the more current income is always going to be your more reliable thing to go with.

Mr. Purpera asked Mr. Morris if from LDR's perspective there is a household size and the family income can include more than one individual. Mr. Morris said that based on his appreciation of the Medicaid rules, you would look at the entire household income and that is not going to necessarily be what is reported on the return. Mr. Purpera said that tax returns are going to either be the individual or married filing joint, or whatever. So if what we are asking is if the income per the tax return is greater than what the income for the recipient is, then that really should not be a problem because as in your illustration it would be family income including more people would be theoretically more than one individual. Mr. Morris said another part would be that the types of income that you report on your tax return may not be used in the determination for your Medicaid eligibility, so it could be exactly opposite from what you just said. The Medicaid eligibility income could be higher than what is on the tax return.

Mr. Purpera said if you look at the rules when it comes to a taxpayer, so you have two different types of eligibility – the nontax filers and the tax filers. But for the tax filers the rules are really close to the MAGI for the tax return. There are some nuances and differences but I think they are not prevalent.

Mr. Alvarez asked if household size could be more people in the household for Medicaid purposes but fewer dependents that are claimed on a tax return. Mr. Morris agreed because for tax return purposes, who you

can claim as an exemption is very regulated with a litany of rules specifying the only people who can be claimed as an exemption and get the appropriate credit or whatever may flow from that. For the Medicaid purpose it can be a much larger number. Mr. Purpera said it is really complicated. Mr. Morris offered to give a lesson on everything dealing with income tax. Mr. Purpera asked if he would give a lesson on how to compute household size for Medicaid purposes because he has read it many times.

**DISCUSSION OF THE WAIVER PROCESS**

Mr. Purpera said this is one of the items that he wanted to begin this discussion and does not expect it to be exhausted today. Primarily to begin discussing what is a waiver and his understanding is that the waivers are supposed to be cost neutral. Mr. Boutte responded that it depends on the waiver because some are cost neutral and others are cost something else, but they would get the right terminology.

Mr. Purpera shared that the prior week in Washington DC, the Comptroller General of the U.S. Gene Dodaro testified for a Senate Health Committee along with Seema Verma, Administrator of CMS. Mr. Dodaro testified that across our nation the waiver process is supposed to be cost neutral but are in fact not cost neutral and the costs are hundreds of millions of dollars. The administrator of CMS did not disagree with that. He would want to know for this committee looking at system-wide systemic issues, what is our process for determining whether our waiver programs are cost neutral and do we have some reportings on that on a regular basis.

Ms. Steele explained that it depends on the type of waiver and she assumes the GAO report was where he received that information. That report is focused primarily on the 1115 demonstration waiver. When you hear us during budget season discussing waivers, we are really talking about the B&C waivers which are different and they have their own cost reporting. But the focus of the GAO report was really on the 1115 waivers, of which we have only had two to her knowledge and currently only have one. One was a very small family planning waiver which has long terminated. The other was the GNOCHC program which is also over. The current waiver is a recent waiver but it is not a traditional demonstration waiver. There are two types of 1115 waivers – some that are small and technical and others that are big. If you look at the GAO report, they are really talking about the big waivers – the Texas, Florida, New York district type waivers. California has a very big waiver that includes supplemental payments, so that is a lot of what they are talking about in the GAO report. The one that we have is a substance use disorder waiver and it is specifically targeted to the in-lieu-of services as discussed just a little bit ago. We have from the beginning of time provided as an in-lieu-of service in-patient, what we can institutions for mental disease (IMD) services, so in-patient psychiatric services. More recently CMS came up with a new rule that said that we could pay for those but they wanted us to go through this waiver process, so nothing changed about what we are doing except that we had to go through this substance use disorder (SUD) waiver approval process. So the demonstration on that is basically to show what we used to spend on the IMD services other than in-lieu-of services and what we will be spending on the exact same thing under the waiver. Big picture is that it really depends on the type of 1115 waiver and it is really just those 1115s that are the focus of that GAO report.

Mr. Purpera asked if other waivers have similar restrictions to be cost neutral or do not have to be. Ms. Steele explained they do not have to be budget neutral. So the 1115 waivers have to be budget neutral which means that they do not result in Medicaid cost to the federal government that are greater than what they would have been absent the waiver. And the 1915B waiver is one of the two that we typically talk about during budget season and those have to be determined cost effective so that means that the

expenditures would not have been higher than they would have been without the waiver - so similar to the 1115. The 1915C waiver is a cost neutrality and those are to show that would not have spent more on a per capita basis with the waiver than without, and so that is when we talk about the New Opportunities Waiver (NOW) for example. Would we have spent more to keep them in an Intermediate Care Facilities (ICF) than to have them in the community and we have to show that it would not be more. So there are different types of calculations depending on the type of waiver.

Mr. Purpera asked which waiver program is LDH spending the most on. Ms. Steele responded probably the NOW waivers and can get the numbers. Mr. Purpera asked if expansion is a waiver. Ms. Steele said it is not a waiver but a state plan amendment. Mr. Purpera asked if there is a reporting back to the federal government about the waivers that do have to be budget neutral. Ms. Steele said yes, but LDH has not done reporting on the SUD waiver because just months old and just received that approval not that long ago.

Senator Mills asked if there is a fiscal projection of what the waiver will cost. Ms. Steele said yes, we have to turn in budget neutrality worksheets or cost effectiveness worksheets on a quarterly basis, so that is a routine report for us. Senator Mills asked how often do we analyze what was the projected cost versus the actual cost. He asked if the pediatric daycare was a waiver. Ms. Steele answered that it is a state plan amendment, and we do not have to do it on state plan amendments. Senator Mills asked if we do a state plan amendment does it have to be cost neutral. Ms. Steele said no. Senator Mills asked if we did a state plan amendment and did a projection of what it would cost Louisiana, would we look back to compare projections versus actual expenses. Ms. Steele explained that effectively we do that with our expenditure reports on a monthly basis. So every month starting in November tells how we have allocated the budget which is essentially the distance between what the appropriation was (at a higher level) and how we spread it to the programs. Then each month we tell you what the actuals were and what our projection is for the rest of the year, and that is the process through which we do that. But you have a pediatric day health care (PDHC) line in there.

Senator Mills asked for the state plan amendment for pediatric daycare did we project what we thought would be the cost of the program initially and look at where it is now because that program expanded more than our actual projections were. Ms. Steele said she worked on that a lot in 2016 when she first came into this role. In the prior legislative session was the debate about the program growing at a rate that was unsustainable. We looked at what the program was costing and made some programmatic changes including clarifying the eligibility criteria and can speak more specifically on that. But yes, we do look at that and do interventions just as done over the last couple of years about the behavioral health spending.

Senator Mills suggested it would be beneficial for the committee to see the projections of what we thought it would cost to what it has grown to and use for discussion purposes. Ms. Steele said he might need to go back to finance. Senator Mills said he finds we don't do a good job from a legislative stand point to compare the projections to the actual costs in 5-7 years. Ms. Steele said they do look at it internally and on a monthly basis and absolutely on an annual basis.

Senator Mills asked which program was out of whack for the projected cost compared to actual cost. Ms. Steele said that the behavioral health piece was a start-up program in 2012 or 2013. We did not have a Medicaid behavioral health benefit prior to that. We had concerns about access, which was partly why we created it. We took the state funds that were in other agencies and leveraged them to create the Medicaid benefit and for a good two years we projected to spend more than we actually spent. It took a long time to get the capacity up and then we hit a tipping point about the time that it was carved in the managed care –

coincidentally. That expenditure started going higher than what we initially anticipated, so that is why you are seeing some of the course corrections over the past couple of years. Senator Mills asked what was the initial projection of costs. Ms. Steele said she would have to go back and look at it by service line but again I can tell you from memory that it was a good two to three years our expenditures were well below expectations and then that changed. Senator Mills suggested we continue to think this through and thanked Ms. Steele for the good information.

## DISCUSSION OF PHARMACY BENEFIT MANAGER (PBM) AND SPREAD-PRICING

Mr. Purpera asked if they fully exhausted discussion of PBMs and spread-pricing already and the members agreed.

## TEXAS DISALLOWANCE

Mr. Purpera pointed out a letter in the members' packets from CMS to the Texas Health and Human Services Commission regarding a disallowance in the amount of $26.8M. Ms. Steele said she could give a short answer that LDH's legal team is still reviewing that decision to really understand what the situation was exactly in Texas and how that may or may not differ from what our situation is. But she does not have the outcome of that review at this time.

Representative Bacala said it appears that the Low Income and Needy Care Collaboration Agreement (LINCCA) in Texas where payments were being made by private hospitals to the Texas LDH equivalent and being used to receive match. Ms. Steele said her limited understanding and waiting for her lawyers to tell her their view, but the Texas case was really about the source of the state match and whether it was provider donation that was bonafide or allowable. Again Texas does have an arrangement similar to us but it is really important for us to look into the details of what exactly the situation was there and whether it is exactly what we have. There are some similarities but trying to get a fine point on any distinctions.

Representative Bacala asked Ms. Steele to tell us our potential exposure on this. Ms. Steele said once she has that assessment, she will be happy to share it. Mr. Purpera asked if LDH could write a letter back to this committee with that information when you arrive at it. Ms. Steele said she could certainly ask.

Senator Mills said Texas must have had approval from CMS to do this methodology. Ms. Steele said she assumes so but do not know the details in Texas. Senator Mills said from the standpoint on the methodology that Louisiana uses that may be similar, he asked if it would be an accurate statement that CMS approved it. Ms. Steele said she would rather their legal counsel answer that because she does not know all the ins and outs on LINCCA. Senator Mills said that if CMS approved then how could they make a disallowance unless Texas violated the approval or did not meet the terms and conditions. Mr. Purpera suggested the members read the letter because there is some potential for us.

## OTHER BUSINESS

Representative Bacala asked for a future meeting to discuss the article about the Florida legislature use of smart cards and apparently it is a system that has potential to identify specifically fraud cases. This might be something that Ms. Steele could educate the members more about. It is being contemplated in other states.

Ms. Steele said they met with LDH early in the administration but it was not something that LDH felt was readily applicable to us. But we will certainly talk to Florida about where they are. Representative Bacala saw that in the Florida model the potential was to save $58M, and smart cards nationwide could save $30B but not sure exactly how that happens. Ms. Steele explained that when the initial concept was brought to LDH, it required everybody to have special readers and seemed complicated and not sure who would pay for that, so if the model has changed it is something that we can look at.

Representative Bacala said that LDH recently released a report on reasonable compatibility, a partial implementation for two months. Ms. Steele said it was just the initial implementation and some partial in the sense of reporting for a piece of it but not for all of it. Representative Bacala said for the initial partial rollout, you identified 187 applicants who were not allowed to enroll because of the reason compatibility. That is certainly not a big number but it represents millions of dollars in savings in the partial rollout. He asked if the report would be issued monthly. Ms. Steele answered yes, she believes that is the requirement but not sure if monthly or quarterly. Representative Bacala was curious about LDH checking 360,000 applications that are renewals in the initial period. He commented that is was a pretty staggering number if in one or two months. Ms. Steele explained that it reflects their renewal volume over a two month period because we have a total of approximately 1.7M people. LDH has really high volume and there is a hump in the summer with a higher volume which is not representative of the other months of the year. The report will come out monthly. We put the change into play in June but we piloted the tracking mechanism for it in July so that is why we explained it as a partial reporting. Not every one of those 360,000 would have been subject to that. What we have in place is a tool that identifies who would have fallen between 10-25% and then we look at those to see if we would have made a different determination. So the results are those small numbers as the output of that funnel. Representative Bacala said out of around 900, maybe 30% was disallowed for some reason. Ms. Steele added out of that small pool. Representative Bacala said he looks forward to what it actually comes out to be when it is fully implemented.

Mr. Purpera said referred to the article in their packets explaining the use of high tech methodologies to curb costs and would invite the consultant to a future meeting. Senator Mills asked if we were to do something like this would it be a 90/10 split where the feds pay 90% of technology and we pay 10%. Ms. Steele said she would have to research that. Senator Mills said on some technology the feds pays the majority of the cost.

**PUBLIC COMMENT**

No public comments were offered.

**ADJOURNMENT**

Chairman Purpera said he would be polling for another meeting in late September or early October and appreciates all the good input. He offered the motion to adjourn and with no objection, the meeting adjourned at 11:26 am.

**Approved by Act 420 Task Force on:** __October 16, 2018_____

The video recording of this meeting is available in the House of Representatives' Broadcast Archives:
http://house.louisiana.gov/H_Video/VideoArchivePlayer.aspx?v=house/2018/aug/0829_18_MedicaidFraudDetection