MINUTES OF MEETING

Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives

Tuesday, October 16, 2018
9:00 AM - House Committee Room 1
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 called the roll and 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
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
Jarrod Coniglio, Program Integrity Section Chief – Medical Vendor Administrator, Appointed by LDH Secretary Gee

Member Absent:
Michael Boutte, Medicaid Deputy Director over Health Plan Operations and Compliance, Designee for Louisiana Department of Health (LDH) Secretary Rebekah Gee
Dr. Robert E. Barsley, D.D.S., Director of Oral Health Resources, Community and Hospital Dentistry, LSU School of Dentistry, Appointed by Governor Edwards

APPROVAL OF MINUTES

Senator Mills made a motion to approve the minutes for the August 29, 2018 meeting. The motion was seconded by Ms. Steele and with no objection, the minutes were approved.

LOUISIANA DEPARTMENT OF HEALTH UPDATE ON TASK FORCE INTERIM REPORT RECOMMENDATIONS

Mr. Purpera asked Ms. Steele to walk the Task Force through the interim report and explain what has taken place since the last discussion.

Ms. Steele referred to the four different subparts to the first recommendation which basically involves the use of tax data in determining eligibility. The first update is that LDH is planning to import the IRS data into our new eligibility system with the second release of the system. The first release is planned for November of this year and the second release in July of next year. In the interim, we are working with the Louisiana Workforce Commission (LWC) to finalize the data sharing agreement to assist us in doing some targeted post eligibility reviews, specifically identifying those wage earners that are at high risk of ineligibility due to unreported or under reported income. So, for all the subparts of one that is basically our update.

Mr. Purpera asked when LDH implements the new system and will be using the federal portal, if LDH will do one on one looking up a name or have access to a database. Ms. Steele responded that it might be a batch update, but will need to confirm. Mr. Purpera said he assumes it is not bringing that whole data base in but just one on one usage. His office has been in communication with CMS (Centers for Medicaid and Medicaid Services) and some other federal agencies about the potential of one day having the database so that LDH would have access to it.

Ms. Steele continued to the recommendation regarding reasonable compatibility. LDH implemented that on June 1, 2018 and submitted monthly reports to the Legislature on the outcome of that. The latest report was approved internally and should be issued. The current savings to date are $254,000 based on 730 individuals.

The third recommendation was that LDH should develop a standardized process for reporting eligibility fraud review results to the AG and LLA. Ms. Steele said LDH has standardized the process and shared with both entities. LDH created a Medicaid fraud unit in June of 2018 and can provide a one pager with the statistics for the referrals. Between June, July, August and September, we have done 238 case reviews. We have referred 66 cases to an outside agency, 16 to the AG and 78 cases we termed eligibility. The savings associated are $158,000 from the 343 cases and expect another $97,000 in refunds.

Ms. Steele said LDH is working with LWC to put in place the same kind of data sharing agreement that the auditor did for its recent review. That would allow LDH to do targeted review to verify eligibility and income. In response to Representative Bacala's question whether or not LDH considers retirement income for eligibility the answer is that they do.

The next category has to do with coordination of fraud, waste and abuse efforts. So the first piece had to do with data mining coordination, specifically LDH, MCFU and LLA should meet quarterly to discuss data mining activities, and discuss algorithms and planned activities to avoid duplication of effort. That is happening and the next meeting is scheduled for November 5.

The second component of that is Healthcare Fraud Prevention Partnership (HFPP). The suggestion was that LDH should continue working with them and that our managed care organizations (MCOs) should participate. We have begun sharing data with the HFPP including our MCO encounter data. Right now we are waiting to

see whether or not we need the MCOs to submit data separately. The concern is whether or not there would be duplication and misleading results as consequence, but that is something we are working on. In related areas and ongoing future discussion, there was discussion of the depositing of the fines collected by LDH into MFCU. We do have a fraud fund report published in July and we have corrected the deposits to make sure that they are appropriately going into the fund. There is a recommendation for amending the Medical Assistance Program Integrity Law (MAPIL) to allow for greater recovery. It is our understanding that the AG's office is planning to offer legislation to do that.

Senator Mills asked where LDH is seeing most of the activity from reports if it is more recipient fraud or provider fraud and where is that data track trending. Mr. Coniglio said most of what LDH is seeing is on the provider side. The LDH recipient unit is new so maybe in time that can yield some different results, but right now it is mostly provider.

Senator Mills asked for more details of what LDH is seeing– whether more fraudulent claims, or undocumented claims or fraudulent providers. Ms. Coniglio said mostly all just mentioned. But from the SURS (Surveillance and Utilization Review Subsystem) unit in program integrity, which we have mostly in home and community base and fee-for-service, it is undocumented services for the most part. It is a lot of audit coordination with the managed care and program integrity. But it ends up being undocumented services. If LDH sees potential for fraud that goes to the AG and those have increased over the last year.

Senator Mills asked if there is a specific provider base that has more fraud trending in, like from hospitals or pharmacy or physical therapy. Mr. Coniglio answered no, not necessarily, but behavioral health has been a hyperfocus of late with a lot of MFCU and program integrity staff. ABA (Applied Behavior Analysis) providers yield large overpayments but it comes back to undocumented services - not following the rules in documenting what services they are providing.

Representative Bacala commented that the AG's office may be able to provide more information, but he reached out and had a meeting with the AG on recipient fraud. Thus far, they have only looked at cases where an individual has reported that they think someone may be fraudulently receiving Medicaid payments. So the AG has not received any cases as of a month ago that were identified through data mining. All their cases originated with complaints filed with Molina from individual reports.

Mr. Coniglio said that is correct. The vast majority of the cases that they have open come from online complaints. The first month that they were up and running they spent most of the month with the AG's office going over about 45 cases. Up to this point, they have turned over 16 referrals to the AG and the AG still has seven pending and closed nine of them. But this unit is new and data mining is coming. He met with the recipient fraud team the day before and about to start more data mining and more proactive looking like their SURS unit does for providers and how the managed care SIUs (Special Investigative Units) do it.

Representative Bacala called attention that right now it is only the reactive cases and nothing that has been proactively initiated investigations.

Mr. Purpera said that his office has also been doing data mining in that area. It has taken some time to get it perfected. His staff has been in contact with the AG's office recently and in the next few weeks we will be referring a good number of what we suspect and but nothing proven. Representative Bacala asked if

somebody with the AGs wanted to clarify any of that.

Ms. Steele moved on to the next set of recommendations for strengthen oversight and tightened controls in managed care. The first one said LDH should closely monitor to ensure MCOs are meeting deliverables. In this area our current and recent focus has to do with analysis of our service authorization and claims payments by the MCO. So we have two different reports in progress. Both actually independently conducted. The first has to do with hospital service authorizations to ensure that those decisions are appropriate and that final report is in development. The second one has to do with the claims payment analysis and so HB734 directed us to look at very specific aspects of claims payment and processing. We presented the draft findings to a stakeholder group last week and we will have for submission to the legislature by the end of the month the final report including recommendations for future reporting requirements and oversight activities by the LDH.

In addition, we are working to update our MCO companion guide to include the only valid provider type and provider specialty combinations. We have identified roughly 17,000 invalid combinations. They represent about 3.8% of all provider registry records and we have a timeline to correct this. There is a specific table that is included in my summary, which I did not bring copies but I can provide, so that relates to the first of the recommendations and the recent provider registry or the encounter data integrity review that the auditor's office did.

Ms. Steele said in terms of future focus for update purposes, LDH has completed its draft of the upcoming managed care procurement. That document is in review by LDH legal and will go to the Office of State Procurement for review and approval by the end of this month. Pursuant to that, we will be contracting for an assessment of specific pieces of our oversight infrastructure, recommendations for how we can improve those to align both with national best practices as well as the terms of the new contract requirements. We plan to implement recommendations staging that timing to align with the oversight priorities and compliance timelines of the contract. So that will be our next focus.

Next area is to discuss rate setting process versus MLR and the first recommendation is to implement immediate safeguards to adjust PMPMs based on data more current than two years' prior. The industry standard is to use complete claims for the base data so that requires a complete run out which is 12 months from the claims filing limit of 365 days. Because a claim can be turned in a year later, it is necessary to allow a full year plus 12 months. So that is standard in the industry and the base data is always going to be two years old. Now our actuaries do use more recent financial data. Our plans report financial performance information on a quarterly basis and our actuaries do use that more recent data to inform their trend adjustments. But again, the way that it works is you typically have a base dataset that represents two years in the past, usually two years ago, and then on top of that they take the more recent data and they adjust that base data to get to not just the current period, but the future period for which they are setting the rates. So I do not think that we will be able to change that.

The next one has to do with monitoring capitation rate versus services provided and to make more immediate adjustments to the PMPM (per member per month). So again, this is another area where in part, based on the recent interest by external parties, but also based on our own interest. We have recently asked Myers and Stauffer, who is the contractor and the accounting company that is responsible for auditing our encounter data and ensuring that it is complete, and Mercer, which is our actuarial services vendor, to collectively help us in addressing concerns relative to the Washington State audit findings. In particular the concern that the

encounter data would have the effect of driving up premiums by including everything that the MCO submits. Again, as I testified last time, our actuaries do not do a cost plus approach to rate settings. They do not take the entirety of the encounter data and say that is the cost going forward.

Ms. Steele said she currently has a draft project proposal from the joint Myers & Stauffer and Mercer. We are thinking about having delivered basically a slide deck or other educational information for us in terms of norms, best practices and developments nationally and then specifically looking at our encounters to review the issues that have been raised relative to provider enrollment and provider registry and also to identify major categories of encounter data quality concerns, identify risks including rate implications associated with those major risk categories and then to address risk mitigation for the future. Going back to my point about looking at current operations with an eye to making sure that we are best positioned for the beginning of the new contracts in 2020, we fully expect to spend calendar year 2019 in a deep dive around these areas and getting things set up differently as needed. The next recommendation has to do with evaluation of the healthcare quality improvement.

Senator Mills asked about the services as LDH is working on the next round of contracts. As discussed at the last meeting regarding all the advertising that MCOs are doing on buses and billboards and all of that. He asked what that aggregate amount may be and if LDH would put any changes in the next contract because it seems like the advertising is over.

Ms. Steele pointed out the provided responses to the questions that were asked at the last meeting including the question of the advertising. So specifically, marketing is a permissible administrative cost. CMS allows it. States do have to approve the specific marketing materials and establish limits on certain types of cold call marketing, but as far as the ability to do it, it can be done. It is possible for states to issue specific guidance on advertising that may be more restrictive. Currently our actuaries do use the standard industry rates for administrative load and our contracts permit that kind of marketing. I cannot speak to the content of the new contract because of not comprising the bid. The short answer is we can restrict it more than we currently do, but it is an allowable expense.

Senator Mills said I know it is allowable, but does it make sense to continue to allow it and can we prohibited in the next round of contracting. Ms. Steele said I think the answer is we can. Senator Mills asked if we should look into that. I will ask that as a committee as far as a recommendation, but I would like to know what the aggregate that is being spent. Based on complaints received from constituents, they cannot believe the advertising of these programs on billboards and buses and I will tell you it is very unpopular.

Senator Mills said this does not sound popular but was just wondering if other states are looking at going back to fee-for-service versus the capitated model. He asked if Ms. Steele has seen some traction on that or movement in the industry toward going back to fee-for-service.

Ms. Steele responded that she has not seen a lot of movement towards going back to fee-for-service but instead see more alternative models. More accountable care organizations so that you might have entities like Colorado, Oregon, Washington, who do not have traditional managed care but they have regional provider led organizations but they are still capitated. They are still obligated to perform to a risk-based type arrangement. So it might not be a Centene or United or the traditional big managed care companies but you still have capitated. I do not see anybody going back to fee-for-service, but there are states that are doing it in more of a

localized fashion, more direct with providers.

Ms. Steele explained it has to do with evaluating the expenses to determine what is appropriate and what can be claimed. And as we have discussed in the previous meetings about the MLR adjustments, Myers and Stauffer does this on a routine basis - evaluates exactly what is reported and investigates to see whether those expenses are in fact properly classified.

The next recommendation is to evaluate all current value-added services to determine appropriate use of taxpayer funds and restructure the bidding process so that value added services is not a determinant of the contract award. Again, I cannot discuss this because the RFP is pending.

Ms. Steele went to the next recommendation regarding the nonemergency use of the emergency departments (ED). We are doing a number of things in this area, primarily through our quality committee. We have developed some hot spotting dashboards that we are using to try to identify up to two communities that we want to work with at the provider level, literally working with EDs. We use a software called TABLO that is a visual representation which allows us to go in and highlight if we want to look at children, if we want to look at respiratory, or anything Also whether we want to look at it by diagnosis, by age, by sex, by gender, by any way we might want to look at it. So we have presented that to the quality committee. We are in the process of sharing it with some of the subcommittees, particularly PEEDS and emergency medicine. Our next step on that is to identify two communities to go into and that is in progress.

In addition, ED reduction efforts are under consideration as incentive arrangements in the new incentive program that we will be creating next year. Further as a third piece, we will begin introducing into our quality measure set. I know you have probably heard me talk a number of times about the one percent withhold that we put into the contracts for meeting quality measured targets. We have not historically had hospital measures in that but that is something that we will be doing going forward and there are two what we call potentially preventable events that we will be looking at. To start with one is ED and the other is readmissions, so that is also coming up. We will be doing a series of stakeholder visits through the fall. Again, as soon as the contract, the MCO RFP, is out of our hands and into the procurement pipeline we will start activities to update that quality measure set with public input. But we are at this time working with a vendor to establish some of the baselines for those potentially preventable events so that we can incorporate that into the work that has already begun with providers and contracting around value based payment.

The next bullet had to do with the inclusion of long term care and managed care. And again, I would just note that there were a couple of bills last session that failed to pass with opposition. Moving onto the next area about strengthening program integrity functions related to behavioral health.

Representative Bacala asked what do you think it would be- the inclusion of long term managed care, including its impact on access, cost and quality. I would like a greater explanation of what you think the impact would be on access, cost and quality. Those are important factors I think that we were missing in the last legislative session that perhaps could be important to determining if a future bill should be filed and what it might look like. So I would like to see a little more detail on that answer then that it was tried and failed. Ms. Steele said I'll take that back.

Ms. Steele went to the next subject: Strengthening LDH’s Program Integrity function related to behavioral

health. The specific recommendation was to implement electronic visit verification for Mental Health Rehab (MHR) services. We did look at that and determine that it did not make sense from the point of view that the services are rarely delivered in a predictable location. So it does not make sense to do electronic visit verification (EVV) for that particular service.

The next bullet had to do with achieving a single reliable provider registry. I am excited to say that we got through the public hearing. We awarded the contract, completed negotiations and that is in final review with our legal before going to CMS for approval. CMS will have 60 days to approve the contract. So I am hoping that very soon we will be able to move forward with actually putting that into place. But we are making progress.

Regarding the use of a single preferred drug list (PDL), we published in the August Louisiana Register a notice of intent to implement a single PDL in early 2019. We had a public hearing. We submitted the report on the public hearing to the legislature last week and we are actively planning for implementation. Lastly, to require supplemental rebates to be returned to the state, that is a provision of the single PDL rule.

Representative Bacala referred to discussion at the previous meeting about spread pricing and the state public employee insurance system apparently had addressed that. He asked if she spoke with Office of Group Benefits (OGB) to see how they accomplished that. Ms. Steele responded I can provide an update to say that we have been in discussions with them. We are still trying to figure out whether or not what they did is applicable under the Medicaid rules.

Representative Bacala asked if we will have a fair shot at ensuring that spread pricing no longer occurs. Ms. Steele said spread pricing is being eliminated in our contracts with the implementation of the single PDL. So we have already prohibited it and our actuaries are incorporating that change as we speak. Representative Bacala asked if she thought the financial impact of that change might be positive or negative for the state.

Ms. Steele said I do not know the outcome of the rate development yet. We did set a limit on the transaction fee of $1.25. Representative Bacala commented that ultimately it will not be based on the $1.25 paid, but what the actual costs of the medications are once we eliminate the spread pricing. Ms. Steele explained that the ingredient costs, dispensing fee, the provider fee - none of that changes. The only thing that changes is the administrative reimbursement. The other things are specified in the contract separately. Representative Bacala said I thought we would see a reduction in the drug cost. Ms. Steele responded no, it is separate.

Senator Mills asked on the proposed rule if there will be still rebates retained by the PBMs on certain issues or no more PBM retention of any rebates. Ms. Steele responded that anything on the single PDL that we negotiate rebates on, we keep. Senator Mills asked if it is a generic or not on the PDL, will there be retention of the rebates. Ms. Steele said I believe that they can on those things that are not part of the state supplemental rebates. I need to check. I cannot remember if we drafted it as a global or not. Senator Mills asked can you get back with me on that. Ms. Steele answered of course.

Representative Bacala commented that we are not at zero spread or zero rebate yet. Ms. Steele said I need to double check because I think we went back and forth. Senator Mills noted that the way the rule reads, it seems like they cannot retain rebates on what is on the single PDL, but it seems like a grey area. Ms. Steele said I think that it is permissive of things that are not on our list, but I will confirm.

Senator Mills referred to Ms. Steele's presentation about the MLR reports at the previous meeting. We talked about if there was a recurrence of the same violations would there be recurring fines and sanctions. He asked if any more clarity on that issue. Ms. Steele referred to the response in their packet. In most cases we do have provisions in the contract that allow us to impose penalties if for a late or inaccurate reporting in this case. We do not feel like it is an inaccuracy. However, we think for the most part it is a difference of opinion. And so I do not think that it would be applicable. And the other thing that I would note the recurring findings had more to do with the timing of our clarification. So in calendar year 2015, there was a difference of opinion about whether or not the federal provisions applied and some of the plans said they followed the state instructions and did not apply the federal. But our auditor said, no, we meant to apply the federal and the plan said, well, you did not say so. So then we revised for 2016 to say now we say so, but the 2016 MLRs were already substantially complete. So you saw repeat findings because of the timing of our clarification. But you should not see it again in 2017.

Senator Mills commented that is good. It seemed like there was a categorization with the provider fee if it was used for certain segments. Ms. Steele explained that had to do with the fact that we had two different rates certifications, one for expansion and one for non-expansion. So it was important in calculating the MLR that they appropriately attributed essentially global costs to the different populations. We are making sure that they did those adjustments. Today they are all combined, but at that point in time there were different rates certifications and different MLR calculations.

Senator Mills asked if any more information on the Texas issue with the disallowance and any more clarity. He asked if the state has any exposure. The last time we talked about it, LDH was going look into that a little bit more. It was kind of a hot topic that I guess other states were looking at. But tell us from your vantage point what the analysis shows and what potential exposure we may have.

Mr. Steven Russo, LDH Executive Counsel, said we have looked at the Texas situation and disallowance. We have analyzed certain situations where we believe may be similar. If they are similar we are looking at the decision to quickly pivot out of those so that we can insulate the state as best we can. Senator Mills asked how will you pivot out of that. Mr. Russo responded it is not going to be as big of a fiscal hit as Texas is looking at because I do not believe we have situations that closely mimic what Texas is going through. I mean, we basically designed our program looking at what Texas was doing and trying to hedge as best we could to what we thought Texas had exposure to back when we first did the program.

Senator Mills asked if Mr. Russo could give more specifics of what LDH is doing to hedge this. Mr. Russo responded basically what we are doing is going in and looking at situations to where nonprofit facilities or entities are potentially providing physician services. We are going in and making sure that there was not a provider donation under federal law. We are then going through and making sure that our reimbursement methodology back to the hospitals is not directly or indirectly proportionate to the amount of money that the nonprofit has been providing. Therefore our argument will be that we do not have a hold harmless, like Texas. Texas had a pretty much direct proportion of the amount of money that was flowing out of Medicaid back to the private hospitals. Senator Mills asked him to keep this committee posted on what he sees. Mr. Russo said sure, without a doubt as much as I can.

Ms. Steele received confirmation that we do allow the retention of the rebates outside of the single PDL. Part of the rationale for that was that we have to compensate them for any rebates that we don't. If they are

currently getting that and that is built into our rate structure as something we are not compensating them for and we deny them the ability to get that but we would not get those rebates because we don't have a rebate agreement on them, it only costs us money and we don't bring the revenue in. So that was the rationale.

Ms. Steele referred them to the documents in their packets. In response to Senator Mill's question about which states our actuaries Milliman and Mercer are in, there is a table from Milliman and a map from Mercer showing they both provide diverse services. It shows where they are providing each of those different services, actuarial services or just one of them.

Mr. Purpera asked about Representative Bacala's issue regarding non-claims cost and where is it defined for the MCOs explaining what is a claim's cost and a non-claim's cost. Ms. Steele referred to the Appendix A - MLR Rebate Calculation. Her understanding is that the direct paid claims are the claims cost. Other non-claims cost is described in Paragraph B: any services that do not constitute payment for clinical services to enrollees.

Ms. Cindy Reeves, LDH Undersecretary, said in the managed care regulation 42 CFR 438.8, the non-claims costs mean those expenses for administrative services that are not incurred claims, expenditures and activities that improve health care, quality or licensing and regulatory fees or federal and state taxes as defined in part of the paragraph.

Mr. Purpera asked who makes the decision on whether a particular cost is included or not included in the MLR. Ms. Steele responded Myers and Stauffer as the auditor. They evaluate the reported filings and request backup information to confirm. Mr. Purpera referred to his conversation with Myers & Stauffer the other day and was still a little bit confused. He asked if Myers & Stauffer being the auditor, if they making subjective decisions or do they have an objective list. Ms. Steele explained they have the instructions that LDH has provided, and the federal regulations, plus they have everything that pertains federally or state based to the calculation and they use that as the basis for their decisions about how things are allocated or permissible.

Mr. Purpera said he heard about the purchase of a refrigerator for insulin. When discussing that with Myers & Stauffer the other day, they said yes it is approved in certain situations. So then expand it one moment and say well what if the person does not have electricity. What did we buy? Electricity. Are we saying Myers & Stauffer makes that decision to allow certain costs. Ms. Steele responded that they do. They are the ones who look at the detailed information. I mean in that particular case, based on the definition, it is a non-claims cost. Mr. Purpera asked to confirm that a non-claims cost would not go into the MLR calculation. Ms. Steele responded that is my understanding. Ms. Rives agreed saying that is how I read it.

Senator Mills asked if LDH breaks down the non-claims costs into categories like if the plans give a gift card to an enrollee who has done certain things and there are certain rewards that take place. I see there are actual awards, incentives, bonuses, reduction of copays. He asked if LDH categorizes the non-expensive portion that is in the 15 %. Ms. Steele responded that her understanding is that that is in the enhanced benefit expense, which is outside of the medical expenses. That is actually deducted. For one example, the plan has $4.7M reported as an enhanced benefit, which would not count and it is adjusted out.

Senator Mills asked if that is paid for by the plans and Ms. Steele agreed. Senator Mills said so it is not absorbed in the 15%. Ms. Steele responded no, we did make adjustments. So the gift cards are definitely not.

We did allow later for dental and vision which are pure services to be counted.

Senator Mills commented that LDH is going through contract renegotiations and at one point was working to get people healthy and into the Medicaid program. But now that it's stabilizing is LDH looking at fine tuning the expenditures and maybe focus more on implementation. Not just the advertising piece but all the 15% expenditure allowance, is LDH looking at that for the next round of contracts. Ms. Steele responded that she could not say because of where we are in the contract development. Based on the feedback that LDH got, the people did not feel like the gift cards was a good investment and of course we did take into consideration that feedback in developing the RFP.

Senator Mills asked if LDH is fine turning the contract negotiations based on lessons learned. Ms. Steele explained that it is not a negotiation but an RFP, so what we put in the model contract are the terms we are offering for bidders. I mean globally, yes, we are fine tuning those things. Senator Mills asked who is doing planned design on the RFP to make sure that is addressed.

Ms. Steele said that is us. LDH has contracted with a national firm that has expertise in Medicaid managed care contracting and they have been working with us in detail, first on the value based payment components and quality components of the contract extension that we got through almost a year ago and then subsequently on the development of the model contract in the RFP. It is a company called Bailet. They are the company that is sponsored by groups like the National Association of Medicaid Directors, the Robert Wood Johnson Foundation and others as kind of the go-to for that type of resource.

Senator Mills asked what is going to be different for the contract than what we have now. Ms. Steele responded that she cannot say because it compromises the bid if I talk about the elements of the contract in the RFP. Ms. Rives added that there are rules and regulations around RFP and contracting. Ms. Steele said until it is publicly released, given where we are in the process, we cannot. Ms. Rives said we are in the black out period so we would not want to give any unfair advantage to anyone that may be listening.

Ms. Steele went back to the rate setting, pointing out some basic information. She provided a hard copy of a presentation that was developed by Mercer for purposes of educating LDH staff as well as legislative staff. We made this available in 2016 for training purposes and more recently we had contracted with Milliman, which again is sort of Mercer's competition. They worked with us on the single PDL and in that context provided kind of a Medicaid Rate Setting 101 to our staff and that link is on the handout if folks want to learn more.

Ms. Steele responded to the next question by Mr. Purpera which had to do with the expansion and non-expansion rates being different. She explained there are three major groups for purposes of rate setting. One is non-expansion full benefits, so that includes physical, behavioral and transportation services. There's non-expansion partial benefit which excludes physical health but includes specialized behavioral health and transportation. Then the expansion group is also a full benefit. So each of those is based on the experience of those populations and consequently results in different rates. And then there are within those categories, some differentiation based on, for example, supplemental security income as a group with disabilities, family and children as parents and children who are generally not disabled. You are familiar with the home and community based waivers, dual eligibles, Medicare, Medicaid. So again, they all have different costs and that is reflected in the rates.

Mr. Purpera said the reason for this question last time was because if I understand right, we have not looked at the MLR on the expansion population yet. You explained why but then what experience group did you use for the expansion population. Ms. Steele said LDH used family and children. We use the adults and family and children and we modified based on what was known about the expansion population in other states. Mr. Purpera asked have you been able to compare our rates to other states' rates. Ms. Steele answered that she did, but again, states are different. Very few states pay rates as low as we do. Every state has different service offerings that are included in managed care. So they are really not comparable because of different service offerings in different rate structures. So it is really apples and oranges.

Mr. Purpera asked if CMS shares other states' rates with LDH. Ms. Steele said not with us per se. I mean, we could certainly get ahold of them, but again, without understanding all the nuance differences. For example, I was stunned not that long ago to be at a Medicaid directors conference and find out that there are states that routinely offer in excess of Medicare for their Medicaid programs. We are at 60 to 70 percent so clearly those states have a very different capitation rate than we would even if the services were the same.

Mr. Purpera asked if, in general, our capitation rate is lower than other states. Ms. Steele responded she did not know and had not done that comparison. Mr. Purpera said he asked CMS for a list of all the capitation rates across the nation and they told me they could not share it. Ms. Steele said I have never pursued it, but again, because I know that it is not really comparable.

Mr. Purpera suggested it would be good to see and that it might point out areas to adjust what services are offered. Ms. Steele pointed out that the only other southern state that even has expansion is Arkansas and they are not managed care. She explained that to calculate LDH's average rate, they have to know what our enrollment is and we know what all these differential rates are and we do a weighted average. I would have to know the enrollment and all those subpopulations. Again, if you have ever looked at a rate letter, there are many, many, many rates cells that have to be multiplied by the enrollment in those unique categories.

Mr. Purpera asked about CMS' involvement in the rate or do they just accept the rate. Ms. Steele answered that the Office of the Actuary which is actually independent of CMS reviews rate certification letters and approves them. We usually go through two to three rounds of questions and answers with what we call O-ACT regarding our rate certifications. They send us questions, we will respond, they'll send more questions, we will respond. We can get a flavor of what they're interested in from those Q&A, but ultimately the approval comes in the form of a CMS contract approval. So they do not come back and say we liked it in these areas or did not like it in those areas. Ultimately it is either they like it in the aggregate and satisfied with the development or they are not. Mr. Purpera shared that he is meeting with CMS later in the month and one of the things to be discussed is how auditors around the nation can help.

Ms. Steele responded to the question of which waiver LDH is spending the most on and that would be the NOW waiver. There was a question about the initial projections for the behavioral health carve-in, so that data is also provided. The only outstanding question had to do with what is happening with uncompensated care costs (UCC) post Medicaid expansion. And I think the specific question you had asked is whether UCC is reducing because the number of uninsured has gone down.

Representative Bacala shared that he had discussions outside of this meeting and just trying to get a better feel for exactly what is included in UCC. Perhaps LDH could provide a spreadsheet on UCC payment type such

as a line for payment for the uninsured or a line for insurance underpayment or failure to pay a copay or whatever the things are. Because I do not understand what it is and I think a lot of others do not either. A couple of years ago it was understood to be the uninsured, but I am understanding now that may be a small piece of UCC, so I would like a good in depth spreadsheet explanation about the different categories that the UCC covers. Ms. Rives said she talked with the team right after their conversation and LDH will put something together in layman's terms that kind of outlines some of the large categories and specifically looking at the bad debt question that you asked about. Representative Bacala said we will just wait for the next meeting and also speak offline about that one.

Ms. Steele said she covered all three of the questions that were raised in the letter and also the interim report update. Mr. Purpera explained to the members that he had prepared a draft letter for formalizing at the meeting but appreciates LDH answering the questions today.

Representative Bacala said that a couple of years ago we moved mental health into the MCO realm. He asked as we move forward with the new RFP, are there other services that we are contemplating moving from direct pay into long term care as we did with behavioral health. Ms. Rives said we recently moved ABA. Ms. Steele said there is nothing new that is going to go in.

Representative Bacala asked to confirm that LDH was not adding new stuff. Ms. Steele answered no, that at this point it is stable in terms of population and service offerings. Representative Bacala asked if NOW waivers would ever be contemplated to go to the MCO. Ms. Rives responded I will not ever say never, but I don't think it is initially.

Representative Bacala suggested that LDH have an easy to read report about Task Force identified items that had been addressed or are being addressed. Include what has been identified and an all encompassing LDH response to a Medicaid Task Force. Mr. Rives said LDH can put together something that would definitely highlight the activities we have had along with the accomplishments of the Task Force and LDH. Representative Bacala suggested to also identify the loose ends and things we are still working on. So maybe categories could include items we have looked at and those that we are still looking at.

Mr. Purpera said that may help with what I was going to talk about in other business. The statute actually requires we issue another report. So that may help us to put together here was initial report, the things that Ms. Steele has talked about today and other issues we have talked about. Maybe we can kind of formalize that into another letter to be issued as a report.

Ms. Rives said they can wait on your guidance on how you want us to proceed. Ms. Steele offered to turn in her notes for going through and may take care of most of it because she went through each and every recommendation so it is current at this point. Mr. Purpera agreed and said her notes would be very helpful.

Representatives Bacala asked about the renegotiation on the 39% - 61% flip and if they are still working on it. Ms. Steele said they are still full steam ahead.

Representative Bacala referred to the Mercer human services map and the spreadsheet asking if Mercer does all eight listed items for Louisiana. Ms. Steele said that's right. Representative Bacala asked if everywhere there is an X is something engaged with Milliman to do for LDH. Ms. Steele responded that is correct.

LOUISIANA DEPARTMENT OF REVENUE SAMPLE DATA RESULTS

Mr. Purpera said the next item on our agenda is LDR sample results and asked Mr. Morris to update the Task Force.

Mr. Morris said on September 26, LDR received the almost 900,000 records of the adult Medicaid population as of December 2017. We took that data, compared it to the tax return data that we have. Unfortunately, we had hoped to be able to report to you what those results were at this meeting, but based on some concerns of the data, we need to do a little bit more testing to ensure the integrity of the data is proper. We are going to respectfully ask to defer that to the next meeting so that we can have time to ensure that data is in the place that it needs to be.

Mr. Purpera asked if he could explain to the members what the test is going to entail so they can all understand and that way they do not get to the end of it and someone expected it to contain something else.

Mr. Morris said the letter that we received from the Task Force requested that the federal adjusted gross income be compared to the income reported on the Medicaid applications. So we did that exercise. Unfortunately, because of the volume of data, we need to go back and review it a little more in detail. However at the end of the day we will be able to report a similar memo that we sent last year where first and foremost, it will have the number of individuals that were receiving Medicaid benefits that actually filed a Louisiana tax return for the 2017 year. And I would note too that in Louisiana a tax return can be extended until November 15. So depending on when the next meeting will be we may be able to report everything that has been filed through that extension date. From there, we will be able to report to you of those individuals that filed their return where did we have exact matches. If what was put on the tax return matched exactly to what they reported on the Medicaid application. From there, we would compare the cases where the income reported on the application exceeded the amount of the income reported on the tax return. And then on the opposite side of that, we would also report broken down into tiers of differences where the tax return income exceeded the income reported on the Medicaid application as requested from one dollar to $5,000 all the way up to $100,000 or more.

Representative Bacala asked also for the variation in the dependents between the application and income tax forms. We can do it the same way and show where people claimed more and where people claimed less than the application. Mr. Morris said he will add to the data results the number of exemptions claimed on the return versus the household size reported on the application.

Representative Bacala said it may be getting a bit deeper than we can get in that report, but would like identified household earners that are not listed as part of the household. That means specifically if we could identify dads that lists the same address on income tax returns maybe to a cross check with the dependents.

Mr. Morris said he would find out if that can be done because these reports have to be built scratch and would need a little more explanation. Representative Bacala gave the example of an applicant for Medicaid that claims two dependents and when the return is filed, that same person does not file a report, but another person in the same household claims those dependents. Obviously you may have a situation where an unmarried couple is using their non-married status in order to get Medicaid and at the same time to use the same dependents for the purpose of a rebate or income tax return. Mr. Morris said he cannot guarantee because

depends on the limits of what our system can pull and derive from that data, but will certainly have that conversation with our IT staff.

Representative Bacala said one simple question is how many individual recipients show other income earners in the same address. That would not be exactly a final determining factor because we do not know if they are part of the household unit or not. Mr. Morris explained that on the tax return the only income that is going to be reported is that of the taxpayer and the spouse if the taxpayer is married. If they have dependents claimed on the return, they still do not report that dependent's income on a tax return.

Representative Bacala suggested doing a search by physical address to identify other income earners who lists the same physical address and then the next question would be their relationship to the recipient. Mr. Morris said I think I understand what you are asking for. I will meet with the IT staff and see if that can be pulled from the data. Representative Bacala said I think that would be dependent on a search of the physical address which may be the first step.

Mr. Purpera referenced discussion at the last meeting about the potential of LDR also looking at LWC data if possible. Mr. Morris said in regard to the LWC MOU that exists between LWC and LDR, it is limited that the data that can be shared can only be used between our two agencies. So I do not know that we would be able to incorporate that into going further beyond LDR for use by the Task Force. The MOU does not seem to contemplate that. So it may just be a change of the MOU at some point, but I think where it currently stands, it does not contemplate that exchange.

Senator Mills asked as the data is being analyzed and if a discrepancy between the income tax form and what is reported on the Medicaid application is found, what are the consequences. I know we will have information, but what would be consequences.

Mr. Purpera said the first thing we need to know is if LDR can inform LDH of exactly which individuals need to be further examined. Mr. Morris said yes because of Senator Morrell's legislation in the 2018 regular session. So 1508 is the general rule that all tax returns are confidential. There are exceptions to that rule and one of those was amended by Senator Morrell to provide for LDR sharing the data with LDH for purposes of Medicaid eligibility verification.

Mr. Purpera said in the previous sample done a year ago there was concern that LDR had turned over 21 names and we were kind of expecting more. So you are saying this time you do have the ability to do more. Mr. Morris responded that the statute does provide for that.

Representative Bacala said along those lines I think it would be within the realm of this task force to maybe get some follow-up information. You are going to produce a report that perhaps identifies a raw number of how many people apparently have exceeded the income levels. So just kind of forewarning, how many of those names were now turned over to LDH for further vetting or to the AG recipient task force for the purpose of investigation. I think that is a logical next step because we have identified these potential problems. Perhaps you can be prepared at some point in time to say we are working on a process or we referred X number last month.

Mr. Morris said certainly the statute would allow for us to share that information with LDH but I do not

believe we would be able to share it beyond that. Representative Bacala said he is not asking for specific information but generally speaking how many cases were referred. I do not need to know the names of the people you referred so do not that would be violating any laws. We are simply asking how many cases were referred as suspicious or needing a little more review statistically,

Mr. Purpera agreed with Representative Bacala's request. He asked if there is clear legislation between LDR and the AG's office that LDR will provide those names and data to the AG's office. Mr. Morris said no because the exception that exists now in 1508 is only between the LDR and LDH. LDH would be required to maintain the data with the same level of confidentiality that LDR has and we would not be able to forward that information past that point.

Mr. Purpera said so we have a recipient fraud unit that does not have the authority legal authority to get the data they need to do their job. Representative Bacala said it makes me scratch my head.

Mr. Traylor explained that MFCU was not legislatively allowed to prosecute recipient fraud. The Bureau of Investigations within the AG's office would be the correct agency. It would not be MFCU but the Bureau of Investigations and they have a group that can pursue those allegations and possible investigations of recipient fraud. Mr. Purpera asked if they have the legal authority to receive the information from LDR. Mr. Traylor said I do not know.

Representative Bacala asked does anybody have a legal responsibility when there is probable cause to believe that a crime has been committed. He asked if LDR has a legal responsibility to report that to the proper authorities. Mr. Morris responded I do not know. I do know that if someone violates the provisions of 1508 that is a crime. It results in jail time and civil fines that are associated with that. In reference to the AG, we do have 1508 exceptions in favor of the AG. It deals specifically with prosecution of unpaid tax assessments and issues relating to the master settlement agreement with tobacco related issues.

Representative Bacala said the question is if you have strong evidence or suspicion that a crime has been committed of recipient fraud does LDR have an obligation to report that or does LDH have that responsibility.

Mr. Coniglio said I think the way the process would work would be LDR though 1508 would send the information to the recipient fraud unit that LDH has to do further investigations. LDR cannot do those investigations. There is a lot more than just the tax return. So let's fast forward and get to a point where we think there is intent or there is some fraudulent activity. We already are referring those to the AG's new recipient fraud unit. I think the process would be LDR works with LDH. We already had the 1508 exception. We go through the process and depending on what we find, it either goes to the AG for further investigation or it stops with us with just recoupment or maybe disenrollment which is the process now. As we talked about earlier, I think that is the proactivity you are thinking about.

Representative Bacala said I think you are answering the question, but hypothetically if LDR says we have identified 100, and sent those 100 to LDH. Then LDH looked at them and maybe disenrolled 20 and referred 20 to the AG. Then we could ask the AG at some point in the future. I am just trying to trace back so that we can get actual real time, real life information about what is going on in this regard.

Mr. Coniglio said I think you will have that in the near future even without the tax data as we go through this.

In fact the AG's unit and LDH are actually meeting as we speak right now. They meet on a monthly basis and are going over all the cases.

Senator Mills asked if LDR is looking at 2017 tax returns and putting in the same bucket as a 2017 application. Mr. Morris said the data for those on the rolls as of December 207 originated with LDH and came through the LLA. So LDR would compare those against the 2017 tax returns which are filed in 2018. It will be matching within the calendar years.

OTHER BUSINESS

Ms. Richard said was recently informed by a well-known physician in a rural part of the state that doctors are seeing 40 to 50 patients per day which he had a concern about. But doctors and hospital are only allowing patients to make one complaint. If the reason for the visit is a headache or other ailment the patient can only been seen for that issue. The patients are encouraged to make another appointment so that facility or doctor is getting another fee to see them again for any other issue. So my question is if we could look at a certain hospital to review how many visits the patients have in a month and what the visits are for, and also how many patients the doctors see in that month. Mr. Coniglio said if you give me the information away from here, we can actually look at it, ask for medical records for the information and see what we find and then go from there. I am not sure what we can share with you, but it would be a usual tip that we would normally get.

Mr. Purpera said my office will work with LDH to begin putting together a draft report. We are certainly going to wait on the information from Mr. Morris. He offered to be in touch with Mr. Morris over the next couple of weeks and when LDR has that information ready then we will schedule our next meeting. He asked the Task Force members if they have items, issues, thoughts, or questions to be addressed at the next meeting, to submit those to him during the next few weeks.

PUBLIC COMMENT

No public comments were offered.

ADJOURNMENT

Chairman Purpera offered the motion to adjourn and with no objection, the meeting adjourned at 10:45 am.

Approved by Act 420 Task Force on: February 26, 2019

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/oct/1016_18_FraudDetection