



Task Force on Coordination of Medicaid Fraud Detection & Prevention Initiatives

Act 420 of the 2017 Regular Session

Act 294 of the 2018 Regular Session

December 19, 2018

Transmitted Via Email Only

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

Re: Calendar Year 2018 Report

Dear Governor Edwards, President Alario and Speaker Barras:

This letter serves as the calendar year 2018 report from the *Task Force on Coordination of Medicaid Fraud Detection and Prevention Initiatives (Task Force)*. The Louisiana Legislature created the Task Force during the 2017 Regular Session and extended the termination date during the 2018 Regular Session (see Appendix A) for the following purposes:

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

Task Force Members

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

- **Daryl Purpera**, Legislative Auditor, Chairman of the Task Force
- **Representative Tony Bacala**, Louisiana House of Representatives
- **Senator Fred Mills**, Louisiana Senate
- **Matthew Block**, Executive Counsel, Office of the Governor
- **Jeff Traylor**, Director of Medicaid Fraud Control Unit (MFCU), Office of the Louisiana Attorney General (*replaced Ellison Travis in August 2018*)
- **Michael Boutte**, Medicaid Deputy Director over Health Plan Operations and Compliance, LDH
- **Tracy Richard**, Criminal Investigator 3, Office of the Inspector General
- **Jarrold Coniglio**, Program Integrity Section Chief, LDH
- **Luke Morris**, Assistant Secretary of the Office of Legal Affairs, Louisiana Department of Revenue (LDR)
- **Jen Steele**, Medicaid Director, LDH
- **Dr. Robert E. Barsley**, Oral Health Resources, Community and Hospital Dentistry, Louisiana State University School of Dentistry

During calendar year 2018, the Task Force met three times. See Appendix B for the dates and minutes of these meetings. This report provides an update on the *actions/accomplishments* or *ongoing progress* that LDH (see Appendix C) and other Task Force members have made on recommendations outlined in the previous Task Force report (issued December 2017). This report also outlines ongoing and future issues that the Task Force will continue to discuss and goals it will work toward in the coming year.

Accomplishments/Progress on Prior Task Force Recommendations

Issue 1 - The Need to Strengthen Medicaid Eligibility Determinations

Prior Recommendations:

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

Ongoing Progress (See Appendix C, p.1):

- LDH will import IRS data into its new eligibility system beginning in May 2019.
- LDH has executed a data sharing agreement with Louisiana Workforce Commission (LWC) and is working with LDR to finalize a data sharing agreement to assist LDH in conducting targeted post-eligibility reviews, specifically identifying wage earners and tax filers, respectively, at high risk of ineligibility due to unreported or underreported income

2. Reasonable Compatibility

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

Actions/Accomplishments (See Appendix C, p.1):

- LDH reduced the reasonable compatibility standard from 25% to 10% on June 1, 2018. LDH produces monthly reports to the legislature (<http://ldh.la.gov/index.cfm/newsroom/detail/4710>) on the impact of the change in accordance with HB 1 of the 2018 Second Extraordinary Legislative Session.

3. Eligibility Fraud Reviews

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

Actions/Accomplishments (See Appendix C, p.1):

- LDH developed a standardized process. Results are shared with the LLA and AG on a monthly basis.
- LDH established an internal Medicaid Recipient Fraud Unit in June 2018. The unit has completed 284 reviews from June 2018 through October 2018 which resulted in 129 recipients being terminated from the program.
- LDH currently receives quarterly wage data and weekly unemployment benefits from LWC. Until it can use federal tax data, LDH will obtain additional information from LWC for income verification purposes. Quarterly income checks are scheduled to take place starting in January 2019.

Task Force Goals for Calendar Year 2019:

- i. Review of new eligibility system (LaMeds).
- ii. Review LDR's analysis of the tax data for a sample of Medicaid recipients (requested from LDR on 9/4/18 and 12/3/18)
- iii. Review impact of eligibility business process changes on eligibility workload to workforce balance, enrollment, churn and its impact.

- iv. Review of MCO's process for identifying ineligible recipients and communication to LDH.
- v. Research the use of recipient-verification processes (e.g., card activation by applicant) prior to activating Medicaid benefits.

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

Prior Recommendations:

1. Data Mining Coordination

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

Actions/Accomplishments (See Appendix C, p.2):

- LDH and MFCU, and recently the LLA, meet quarterly to discuss data mining activities.

2. Healthcare Fraud Prevention Partnership

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

Ongoing Progress (See Appendix C, p.2):

- LDH has started sharing data with the HFPP, including encounter data. Three studies have completed and preliminary investigations are ongoing. LDH is working with the managed care organizations (MCOs) on the best way to work with the HFPP.

3. Depositing Fines Collected into the Medicaid Fraud Detection Unit.

Actions/Accomplishments (See Appendix C, p.2):

- The LLA issued a report entitled "[Louisiana Dept. of Health and Office of the Louisiana Attorney General - Medical Assistance Programs Fraud Detection Fund](#)" in July 2018. LDH took immediate action to correct all findings.

Related Areas of Ongoing/Future Discussion:

- Amendment of the Medical Assistance Program Integrity Law (MAPIL) Statute which would enable greater recovery for the state in MAPIL litigation.

Task Force Goals for Calendar Year 2019:

- i. Review of number of cases referred by LDH, identified by MCOs, identified by LLA, and identified by AG and the outcomes.

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

Prior Recommendations:

1. MCO Contracts

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

Ongoing Progress (See Appendix C, p.2):

- LDH conducted an MCO hospital service authorization analysis in the summer of 2018. Final report in development.
- LDH conducted a claims payment analysis (Act 710 of the 2018 Legislative Session). Sent a [report](#) to the Legislature on October 31, 2018, including recommendations for future MCO reporting requirements/LDH oversight activities. The report is published on the LDH website: <http://ldh.la.gov/index.cfm/newsroom/detail/4894>.
- Updated the MCO systems companion guide on 11/9/18 to include only valid provider type/provider specialty combinations. MCOs are in the process of correcting their provider registries with an expected completion date of November 30, 2018.
- During the winter of 2019, LDH will conduct a comprehensive assessment of its oversight infrastructure, including recommendations/activities to align with new MCO contract terms/national best practices.

Related Areas of Ongoing/Future Discussion:

- Further discussion of the rate setting process versus Medical Loss Ratio (MLR), to include:
 - The implementation of immediate safeguards to adjust per member per month (PMPM) rates based on data more current than two years prior.
 - Particularly for the Medicaid Expansion population, monitoring of the PMPM versus services provided and make more immediate adjustments to the PMPMs to more accurately reflect the cost of services provided.

Ongoing Progress (See Appendix C, p.3):

- LDH asked Myers & Stauffer and Mercer for assistance addressing concerns with encounter data and subsequent rate setting. Myers & Stauffer, in consultation with Mercer, will provide a project proposal by mid-December of 2018.

- Evaluation of Healthcare Quality Improvement/Health Information Technology (HCQI/HIT) expenses to determine appropriate maximum amounts that MCOs may claim as medical expenses versus administrative expenses. *(LDH states it does this annually in independent audit of MCO MLRs reported--identifies expenses and adjusts accordingly to produce final audited MLR on which rebates are based.)*

- Evaluation of all current “value-added” services, to determine appropriate use of taxpayer funds and to restructure competitive bidding by MCOs such that “value-added” offerings are not a determinant of contractual award. *(Per LDH, cannot discuss RFP content until public release in early 2019.)*

- Addressing the non-emergency use of emergency rooms.

Ongoing Progress (See Appendix C, p.3):

- LDH continues to work on emergency department (ED) data analysis via the Quality Committee. ED reduction efforts included in new Managed Care Incentive Payment (MCIP) program. MCO ED Potentially Preventable Events (PPE) quality measure is under development in 2019, in addition to baseline data collection.

- The inclusion of long term care in managed care, including its impact on *access, cost, and quality*. *(Per LDH, HB 334 and SB 357 failed in the 2018 Regular Session with lots of public testimony in opposition.)*

Task Force Goals for Calendar Year 2019:

- i. Review reliability of encounter data.
- ii. Review of current LDH encounter data integrity activities and opportunities for improvement
- iii. Review the performance of the Dental MCO, including the MLR report which is to be issued in January 2019.

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

Prior Recommendations:

1. Enabling Task Force Legislation Requested LLA to Develop Recommendations Related to Medicaid Program Integrity Functions
 - LLA released report entitled [Oversight of SURS – Medicaid Program Integrity Activities, December 5, 2018](#). Findings as follows:
 - The system SURS uses to track improper payments does not contain accurate or complete information on cases.
 - SURS focuses primarily on improper payments in fee for service claims even though 85% of Medicaid recipients and 71% of expenditures were for managed care during fiscal year 2017.
 - The amount of improper payments identified by SURS has decreased, in part, due to revisions to the Molina contract that reduced the number of cases SURS is required to close each year, and the loss of the Recovery Audit Contractor.
 - LDH settled with providers for 11 (36.7%) of the 30 improper payment cases we reviewed for less than the original identified amounts, without documentation justifying the reductions.
2. Electronic Visit Verification for Mental Health Rehab Services
 - The 21st Century Cures Act requires that states implement electronic visit verification (EVV) for personal care services or home health care services requiring an in-home visit by a provider. EVV is one way to determine where services are being provided and it also provides an opportunity to prevent payments from being made when services are not rendered. While the 21st Century Cures Act requirement does not apply to community-based mental health services, LDH should conduct a feasibility study to determine if there is value in pursuing EVV for these services, what impact implementation would have on its current use of EVV, and the costs associated with a potential implementation. *(Per LDH, it has determined not to pursue a study at this time as other reforms are being put in place to comply with Act 582 of the 2018 Regular Session in order to strengthen oversight of MHR services. However, LDH is currently in the process of implementing EVV for EPSDT PCS services. The implementation will be in 2019.)*

Related Areas of Ongoing/Future Discussion:

- Provider Registry – achieving a single, reliable provider registry

Ongoing Progress (See Appendix C, p.4):

- Provider management contract has been awarded. Public hearing was held on 9/17/2018 and contract negotiations were completed on 10/12/2018. The contract is going through the final review and approval process with the Office of State Procurement (OSP) and CMS. CMS has 60 days to conduct its review.

Task Force Goals for Calendar Year 2019:

- i. Review of LDH's efforts to ensure the adequacy of MCO PI programs.
- ii. Review of MCO's process for identifying ineligible recipients and communication to LDH.
- iii. Review LDH's oversight of the Mental Health Rehabilitation program. Review of issues identified by the MFCU.
- iv. Review of commercial market approaches to FWA identification and recovery for potential applicability to Medicaid.

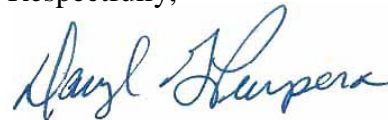
Issue 5: The Need to Strengthen Controls within the Medicaid Pharmacy Program

Areas of Ongoing/Future Discussion:

- Restructuring of Pharmacy Program – discuss option of using a single preferred drug list (PDL) managed by a single pharmacy benefits manager (PBM). *(LDH states it plans to implement in May 2019.)*
- Increase Transparency – discuss option of using PBMs that do not profit from spread pricing on drugs or any other incentives, but rather operate based on a flat administrative fee for each transaction. *(LDH states it plans to implement concurrent with single PDL in May 2019.)*
- Supplemental Rebates – discuss requiring supplemental rebates to be returned to the state. *(Per LDH, no rebates will go to MCOs with single PDL and transaction fee implementation.)*

The Task Force will continue its efforts in 2019 to improve Medicaid fraud detection and prevention initiatives through coordinate between state agencies and branches of state government.

Respectfully,



Daryl G. Purpera, CPA, CFE
Chairman

DGP:NBE:lm

cc: Task Force Members Via Email Only:
Senator Fred Mills
Representative Tony Bacala
Mr. Michael Block
Mr. Jeff Traylor
Ms. Jen Steele
Mr. Michael Boutte
Ms. Tracy Richard
Mr. Luke Morris
Mr. Jarrod Coniglio
Dr. Robert E. Barsley, D.D.S.

APPENDIX A

**Act 420 of the
2017 Regular Legislative Session
&
Act 294 of the
2018 Regular Legislative Session**

ACT No. 420

2017 Regular Session

HOUSE BILL NO. 459

BY REPRESENTATIVES BACALA AND HOFFMANN

1 AN ACT

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

10 Be it enacted by the Legislature of Louisiana:

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

14 §440.1. Medical Assistance Programs Fraud Detection Fund

15 * * *

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

20 * * *

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

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

3 * * *

4 SUBPART D-1. COORDINATION OF FRAUD AND ABUSE

5 DETECTION AND PREVENTION INITIATIVES

6 §440.4. Legislative findings; purpose

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

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

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

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

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

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

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

24 (1) The governor or his designee.

25 (2) The attorney general or his designee.

26 (3) The legislative auditor or his designee.

27 (4) The inspector general or his designee.

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

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

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

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

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

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

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

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

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

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

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

21 §440.6. Purposes of the task force

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

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

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

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

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

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

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

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

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

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

15 §440.7. Reporting

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

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

24 §440.8. Termination

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

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

SPEAKER OF THE HOUSE OF REPRESENTATIVES

PRESIDENT OF THE SENATE

GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____

ACT No. 294

2018 Regular Session

HOUSE BILL NO. 156

BY REPRESENTATIVES BACALA, BAGLEY, CHANEY, HENSGENS, HOFFMANN,
HORTON, POPE, RICHARD, STAGNI, AND STOKES AND SENATOR
WALSWORTH

1
2
3
4
5
6
7
8
9

AN ACT

To amend and reenact R.S. 46:440.8, relative to the task force on coordination of Medicaid fraud detection and prevention initiatives created within the office of the legislative auditor; to extend the termination date of the statutes creating and providing for the task force; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 46:440.8 is hereby amended and reenacted to read as follows:

§440.8. Termination

The provisions of this Subpart shall terminate on August 1, ~~2018~~ 2019.

SPEAKER OF THE HOUSE OF REPRESENTATIVES

PRESIDENT OF THE SENATE

GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____

APPENDIX B

Meeting Minutes

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

Act 420 of the 2017 Regular Session
Wednesday, February 7, 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 9:15 a.m. Ms. Liz Martin, Executive Assistant for the Louisiana Legislative Auditor (LLA) called the roll confirming quorum was present.

Voting Members Present:

Daryl Purpera, Legislative Auditor

Matthew Block, Executive Counsel, as Designee for Governor John Bel Edwards (Mr. Nick Albares served as proxy for the first hour of the meeting.)

Senator Fred Mills, Designee for Senate President John Alario

Representative Tony Bacala, Designee for House Speaker Taylor Barras

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

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

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

Advisory Members Present:

Ms. Jen Steele, LDH Medicaid Director, Appointed by Governor Edwards

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

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

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

APPROVAL OF MINUTES

Senator Mills made a motion to approve the minutes for the November 28, 2017, meeting. The motion was seconded by Ms. Steele and with no objection, the motion was approved.

DISCUSS INTERIM REPORT

Mr. Purpera requested input from the members on how they wanted to proceed and when to have future meetings. He went through their Interim Report and listed out the five purposes of the Task Force as per the law and how they had addressed those purposes (see handout). Purpose #1: To study and evaluate on an ongoing basis the laws, rules, policies, and processes by which the state implements Medicaid fraud

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
February 7, 2018**

detection and prevention efforts. The Interim Report addressed many of the issues but also detailed that further discussion was still needed on the development of a Recipient Fraud Unit and LDH's current resources/structure for verifying eligibility and the Amendment of Medical Assistance Program Integrity Law.

Mr. Purpera asked if the members wanted to continue discussing the issues in Item #1. Mr. Travis said that the AG's office has an amendment to change the Program Integrity Law and certainly would want to discuss these items in a future meeting.

Senator Mills said that the handout is an excellent roadmap and they must determine if the changes can be done legislatively or administratively by the different departments or if LDH could look at it internally.

Mr. Travis said LDH needs more of a recipient fraud program integrity unit for eligibility, like they have for provider fraud to analyze data. A recipient fraud unit can be done by consent such as in South Carolina which has a Memorandum of Understanding (MOU) between their single state agency and their attorney general's office. The single state agency then refers cases and is basically modeled after the MFCU but because of the rules for MFCU, the state is doing it on their own consensually. Mr. Purpera asked how the funding is handled. Mr. Travis responded that South Carolina's single state agency funds it because they get the match and administers the funds with a flow through and a 50/50 match on those administrative costs. Ideally, his office would prefer if the feds would allow them to do it and get a 3 to 1 match, but the feds are not allowing it so his office has to do it another way until it can be worked out.

Mr. Purpera said there are two ways to handle that either legislatively or by consent agreement for the recipient fraud unit. Mr. Travis said his office will have a proposal on the Medicaid Assistance Program Integrity Law (MAPIL) audit to modify it to comply with the U.S. Department of Health and Human Services (HHS) requirements in order to get higher recovery on the T10 type lawsuits.

Mr. Purpera asked if the members want to discuss a recipient fraud unit further or believe it would be handled elsewhere. Representative Bacala said based on the information uncovered or discovered by this Task Force, he has legislation to do with identifying recipient fraud. It would give LDH a few tools to use to better vet candidates or applicants and on the back end to give the LLA the ability to better audit the application data and eligibility standards. The players need to sit down and discuss the bill but he did not have it far enough along to bring before the Task Force yet.

Mr. Purpera asked Ms. Steele if LDH is going to do an internal study on their current resources for verifying eligibility. Ms. Steele responded that they have internal and external reviews already on eligibility decisions. Mr. Purpera asked if LDH has the proper personnel and structure for eligibility because as previously discussed LDH had staff reductions over the previous years. Ms. Steele said they are not actively developing proposals to show how much more they could do if they had more staff, but for those specific requests or recommendations about changes they are determining what that would require but not beyond that right now.

Mr. Travis said that the AG's office will offer a bill regarding the Amendment of MAPIL. Mr. Purpera stated that it would be a legislative issue during the regular session.

Mr. Purpera and the members continued discussion of the purposes of the Task Force and how the Interim Report addressed those purposes and what issues still needed further discussion.

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
February 7, 2018**

Purpose #2: To identify and recommend opportunities for improving coordination of Medicaid fraud detection and prevention initiatives across state agencies and branches of state government. Mr. Purpera said that his office is actively working on a report that would be discussed after issuance.

Purpose #3: To identify any system or system-wide issues of concern within the Medicaid program with respect to fraud, waste and abuse. Future discussion would include: rate setting process versus Medical Loss Ratio (MLR), non-emergency use of emergency rooms, and inclusion of long-term care in managed care. Mr. Travis asked to add another issue for discussion about labor programs and the personal care attendants (PCA) and personal care services (PCS) programs. MFCU encounters people who are receiving those services and very questionable that they should be receiving those types of services and how they become eligible for those services. He suggested having testimony on that issue and review how that happens. For any problem it is possible for someone to falsify billing and this issue permeates the program.

Mr. Purpera asked if the members wanted to further discuss the issue of achieving a single, reliable provider registry or the restructuring of the pharmacy program to increase transparency and supplemental rebates. Mr. Boutte said that LDH issued a solicitation for proposals to obtain a new provider management system, so that is ongoing now and working through the process to have a single source for enrollment and credentialing. That company would handle all that rather than the current process which is where the providers have to enroll with Medicaid fee-for-serve and each managed care organization (MCO) that they want to contract with. The new process would be a single point of entry to enroll and credential one time with the state agency and information would flow out from there. That will help achieve a single reliable provider registry. Mr. Purpera said that sounds great and asked when the RFP would be complete. Mr. Boutte said the bids were due on December 12, 2017, and working through that process now.

Ms. Steele said that LDH had a meeting with Senator Mills and other stakeholders to kick off a process of developing a single preferred drug list (PDL), but not managed by a single Pharmacy Benefit Manager (PBM). The first step would be a single PDL across fee-for-service and all managed care plans. Her aim is to have a proposal for consideration by the legislature by spring. This would not require legislation, but may require rulemaking. Currently they have six preferred drug lists because the five MCOs and the fee-for-service program all have different drug lists which create some burden on the part on members and providers and lots of complexity. So LDH is trying to address that issue first and foremost and also having a single PDL will allow LDH to capture the supplemental rebates that today the plans get to keep. So those are the two big objectives and on the fast track to have something for consideration soon. This is an issue of great interest to members of the legislature.

Representative Bacala asked when that would be in effect. Ms. Steele responded that it all depends on implementation planning and what needs to be done, and hoping to do it in fiscal year 2019. She explained that many of those issues are about education and not subject to change because of industry standards to have tiers. There are professional standards that the actuaries have to work by. Some education about what is required and what is industry standard would be appropriate. In terms of the evaluation of value-added services, that is actually occurring in terms of regular financial management of the program as is, but also in their consideration of how they would use value-added services in the next generation managed through contract which LDH is actively working towards now. She said LDH is very cognizant of the interest of the legislature to be part of that development up front, so they have a draft strategy that they are proposing to membership over the next week or two. After their input LDH will share what they plan to do around

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
February 7, 2018**

legislative engagement and public stakeholder engagement more broadly. This topic and others will be included in that consideration.

Representative Bacala asked what specifically LDH will be looking at in that regard. Ms. Steele said they will determine whether value-added will be done as it is today or differently. Representative Bacala said other legislators are looking closely at the non-emergency use of emergency rooms. He will continue looking at managed long term care and maybe try to bring legislation and is evaluating that right now. For some years LDH has spent a great deal of time meeting with partners, etc. He would appreciate the findings be put on the record officially about the benefits or anything else discovered with managed long-term care but knows it is a political hot potato. He asked if Ms. Steele would be able to speak to this issue at some time to give him better direction on where he should go. Ms. Steele responded that she would have to check on who to speak on that. Representative Bacala said that would be a topic for a future meeting discussion, and LDH had a couple of years invested in that before it was abandoned. Certainly LDH would not have put that much time into it unless saw some benefits if designed properly, and he is curious to look at what the benefits may have been that had LDH looking at it for several years.

Ms. Steele explained that throughout the discussions on the managed care contract extension they talked about the work done to elevate quality and the financial incentives that we built into the contract and in particular the quality measures that LDH designated that 1% of the plan's gross revenues are at stake for. One of those measures is emergency department usage (EDU). We have a Medicaid quality committee that is populated primarily with clinicians on the ground and in the field with our members. One of the things they are focusing on first and foremost is that EDU utilization and not because we believe hospitals are the problem but believe that the EDU usage is a lens through which to understand other breakdowns in the system. We are going to be working with the quality committee and others to really dig into that and understand the state of primary care access, and what changes it. As that work develops, that will certainly be shared.

Representative Bacala asked if they would benefit from the different MCOs speaking to the Task Force about the efforts they are making and maybe identify some best practices. Ms. Steele said they intend to make that part of their process. They want to stop doing what is not working and if problems in practices or evidenced-based practices that are working they want to bring them here. LDH is making an intentionally focus on that and make a dent in that. Representative Bacala asked if specific testimony on that topic from the MCOs would be beneficial. Ms. Steele said yes, potentially. Representative Bacala said he would like to keep that on the list.

Mr. Purpera referred to a previous meeting discussion about the contracts with MCOs regarding the acceptable level and LDH is adjusting the rate process. Ms. Steele said the efficiency adjustments are done by the actuaries looking at the claims data and identify where they think there was avoidable EDU and adjust a portion of those cost out of the rates pushing the plans in the direction of addressing it. That does not get to the ground level to see what the plan is doing in response, how are they engaging the providers and members.

Ms. Steele said they look at EDU utilization profiles for a number of months and what the trend is, and the plans have to either meet the national average of at least improve 2 points from their prior year to earn that 1% back. Financial incentives are used to encourage the plans to aggressively change that behavior.

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
February 7, 2018**

Mr. Purpera asked if LDH plans to do a study about long term care and managed care to see if that would be something the state would want to do. Ms. Steele answered that she was not aware of it.

Mr. Reynolds commented that a proposal regarding that went through Health and Welfare Committees and Legislature for the past two years and was not passed out of committees. The legislature has spoken related to those bills for tasking LDH to do that, so it is not a case that LDH can unilaterally do that but the Health & Welfare Committees that have oversight over LDH rulemaking have to approve such changes.

Representative Bacala said that he had his teeth kicked in on that bill but at the same time the House of Representatives as a whole voted on a resolution urging and requesting LDH pursue that, so if the committee may have spoken so did 105 members of the House. Mr. Reynolds said he absolutely agreed. Mr. Bacala said to make sure to put both on the record and not just one side. The vote was clearly more than a majority to pass the resolution and the will of the House was to pursue it but the will of a single committee was to not pursue it.

Senator Mills said he received from LDH the list of audits coming up. Our Task Force may want to keep the Medicaid Loss Ratio (MLR) reports on our agendas as they are released since a lot of their required tasks were a result of the findings in those audits. Then the findings could be addressed at this committee level.

Mr. Purpera continued to Purpose #4 which was to develop recommendations for policies and procedures by which to facilitate and implement all of the listed items which included: Random sampling of Medicaid cases to be selected for verification of enrollee eligibility; Improvements in the Medicaid program integrity function of LDH; Optimization of data mining among state-owned data sets for purposes of Medicaid fraud detection and prevention.

Mr. Purpera stated that in previous meetings they discussed that all were ongoing items. Future discussions needed to include: Greater access to tax data will be needed to perform meaningful random sampling for eligibility; Further discussion needed to recommend improvements to LDH program integrity unit; and Optimization of data mining will require greater access to tax data.

Mr. Purpera referred to the provided handout of pages 9-10 from the State of Minnesota Office of the Legislative Auditor's (MNOLA) Financial Audit Division Report issued January 28, 2016, on the Department of Human Services (DHS) – Oversight of MNsure Eligibility Determinations for Public Health Care Programs – Internal Controls and Compliance Audit – January 2015 through March 2015. The finding was that DHS did not adequately verify the people enrolled in the public healthcare programs. They took a sample of 157 people enrolled in their Medicaid program and looked at their quarterly wage and unemployment information, and income tax information from their Department of Revenue, and a variety of other documentations. Of the 157 people tested, they found 38% were not eligible for the public health care program in which they were enrolled. Then they found that 28% were not eligible for any public health care program and others were just in the incorrect program. He mentioned this to point out the need for access to tax data.

Mr. Purpera asked how the state can verify eligibility without access to tax data. He understands there are barriers but believes this makes them work with their hands tied behind their backs.

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
February 7, 2018**

Representative Bacala asked Mr. Purpera to explain how the LLA can assist in this. Mr. Purpera explained that current law allows his office total access to tax data for the purposes of auditing LDR. However, it is the opinion of various lawyers that the law excludes LLA from access to the tax data when auditing the Medicaid program. They have dealt with this issue for many years.

Representative Bacala asked what legislation would be necessary to give authority to the LLA to assist in the program integrity. Mr. Purpera suggested adding to the audit law R.S. 24:513 to give specific authority to LLA, or to add to the exceptions in R.S. 47:1508. The exceptions allow LDR to give access to various parties for verifying particular programs.

Mr. Morris commented on Mr. Purpera's statement about the general exception that allows the auditor to audit LDR's records is more specific to matters of the state's fiscal situation, i.e. whether refunds had the appropriate refund interest applied to them, and such as that. Something specific as reviewing tax returns for the purpose of Medicaid eligibility is not within that current exception to 1508. We do have an exception to 1508 that allows LDR to share data with LDH for purposes of Medicaid eligibility so that is an existing avenue. However, there is nothing specific to the LLA.

Mr. Morris agreed with Mr. Purpera that they could do a 1508 exception giving LLA the ability to review the records of the department. But he was not sure if that is the best way and there are other avenues available such as whenever an applicant sends in an application to receive benefits they can give at that point authorization to LDH, LDR and LLA to review their tax return. So it does not have to go through the legislative route because there are other avenues. Any data on a state tax return is currently protected by 1508 including their income, liability owed to the state and even something as simple as the date that the tax return was filed with LDR. The AG has opined that something as miniscule as the date is still protected from disclosure. In the report to the governor and legislature, there is an item that recommends creating such a type of exception, but there are other ways. He reiterated his believe that he does not know how hopeful state tax return data would be. The better approach would be for LDH to have access to federal tax data which is much more relevant to the purpose of reviewing income to see if the eligibility was permissible. In LDR they have two buckets of info: what received from taxpayers including the state tax returns and information contained therein; and the information received from the IRS which is federal tax information (FTI) which cannot be shared with anyone including LDH pursuant to an exception, and that data must stay within LDR. Mr. Morris said when state returns are filed with LDR they are subject to the 1508 provisions and cannot be shared unless an exception to 1508.

Senator Mills referred to the MNOLA report and asked if LDH has access to the comparable data in Louisiana such as the quarterly wage and unemployment information. Based on his review of the report, some was stale data because looking at the benefits from January to May 2015. He asked if LDH looks at quarterly wage and unemployment data because that is the most current information and everything else is stale data.

Mr. Purpera said that MNOLA looked at 2014 income tax data for their 2015 review, so they went one period back. LLA has access to quarterly wage and unemployment information, so he could compare that, but does not have access to self-employment information or 1099 earner information.

Representative Bacala said that retirement income would also not be listed. Mr. Purpera asked if retirement income would be considered for Medicaid eligibility. Ms. Steele responded that she would check.

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
February 7, 2018**

Representative Bacala said that income tax data is not relevant to an income tax application but relevant for a renewal. If someone applies in July and accepted, then on their renewal date the next July then the income tax data is relevant for renewal to see if remained eligible throughout the period they have already gone through. It is a look back and not a look forward but useful to identify the total wages earned the previous year.

Senator Mills asked what is allowable by federal law that is a key component of a resource not currently using. When looking at MNOLA's report, the finding showed 38% was not eligible. If that sampling number is a trend throughout different states, what is Louisiana lacking that is permissible. Mr. Purpera said that in other states the auditor has access to tax data but not allowed in Louisiana because no exception in R.S. 24:513 or R.S. 47:1508 giving LLA access to state tax data. Apparently MN does have access to the tax data. In previous meetings they discussed that the data is not used to determine people are not eligible, but use the data as the tool to center in on people who are not eligible.

Senator Mills asked if legislation would be recommended. Mr. Purpera said either the Task Force or he would be recommending legislation.

Ms. Steele commented that due diligence must be done on the allowability of the use of the information. For example, if she had income of \$1,000 per month and a year later her tax income is reviewed for the period of certification that followed that and find out that it was \$1,200 a month. That is a future period so she does not know the allowability for LDH to say based on the most recent data her income was different so for this retro period take eligibility away. She is trying to figure out what the use would be for even if they get the information. She needs to find out if she has the right to go back and reconsider eligibility and take it back after the fact when based on new data.

Mr. Purpera suggested using tax data for future eligibility because if the applicant attested that they have a zero income but see on the tax return that they have a \$60,000 self-employment income, that should mean a personal visit with that person for them to explain why they attested to no income. Ms. Steele added that they must be sure it is the same period of time. Mr. Purpera said we are looking for fraud and people who are lying. Ms. Steele said she wants to make sure we are not reversing a decision based on information that was not available at the time. She asked if LDH make a mistake if the information was unavailable.

Mr. Purpera suggested that they look at it as a continuous base that LDH has access. So if LDH had access to the federal tax data portal at all times, and the person attests that they have a zero income but the portal shows \$60,000 income, then LDH would have to go further on their eligibility determination. Ms. Steele said her concern is the sequencing of the time, and what information is being used at what time to make the decisions.

Senator Mills asked if LLA would be able to do a sampling exactly the same as in the MNOLA report right now. Mr. Purpera responded no. Senator Mills said that LLA should be able to do that type of sampling to respond to the legislature and LDH. Mr. Purpera said his office is trying to do something similar to this and he has been working with Mr. Morris to get the original 860,000 sample population, and not faulting Mr. Morris because his hands are tied and unable to transmit the data in any way even after removing identifiable information.

Mr. Morris said they were going to structure the data for the LLA in such a manner that they could not identify a single taxpayer, but even doing that will not get them outside of the constraints of 1508. Any

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
February 7, 2018**

number off a return is protected by 1508 so there is nothing they can do. His concern with a 1508 exception is that it would be a new type of exception to provide tax return data which could end up in a position where someone is being accused of fraud from a criminal perspective. The exceptions in 1508 include the AG for the Tobacco Settlement matters. But this is a new type of exception being contemplated and his concern is there could be a chilling effect for taxpayers. LDR does the best they can to drive voluntary compliance and have people file their returns, but if these taxpayers knew that their data would be shared with so many different agencies then he is worried. Because if someone is going to commit Medicaid fraud, then they will just turn around and commit fraud on their tax return and be in the same position that we are in now.

Mr. Purpera said the purpose today is not to debate whether one of these gentlemen would be bringing a bill. He asked how many exceptions to 1508 currently in law. Mr. Morris responded that there was one added exception in the last session so in the 40s. Mr. Purpera said that one more exception would not be a chilling effect. If there can be an exception to determine if there is a proper amount being put into the Start savings account, he does not see why there cannot be an exception for a \$10B plus program that the state is operating.

Ms. Steele asked how fruitful that sharing of data would be. She suggested looking at a sample of 10 cases where LDH looks at what they can see today and determine what they are short and then LDR could see if they even have the information to see if this would even go anywhere. Mr. Morris said he would love to do that because LDR and LDH can go through a random sampling and he has all the data in spreadsheets readily available if they could work together. Ms. Steele said if it isn't useful then they can let go of the idea but right now just debating about whether we can share the data but don't really know what the data use case is. She has a theory that it will be useful but a test of that utility would be information.

Mr. Morris shared that some of LDR's auditors went through some of the largest differences that existed between the federal AGI versus what they put on their application. He thinks they went through the top 10 or 20. While he cannot provide any relevant information, it might be useful for the Task Force to see what those differences were. He cannot share the amounts but can explain what caused the difference and whether or not that would lend itself to a potential fraud or if a reasonable determination as to why it differs and that the person would still be eligible for Medicaid.

Mr. Chris Magee, LLA Data Analytics Manager, suggested to make this a more useful and fruitful practice, they do not need to do a random sample but need to do a targeted selection of those that do seem to have the bigger disparities. The idea of getting the data would be to identify those who are outside some sort of allowable amount and have the highest variance between what was reported to Medicaid and what is on the tax return. So doing a random sample is not as beneficial as doing a targeted selection as Mr. Morris said. To circle it all back, the tax data is a tool but not the end all and be all. A majority of the states use tax data as a tool. The workforce commission data is the most up to date; however, it is also time lagging because 3-6 months stale but still the most current. It would be another tool that would allow LDH's eligibility to understand whether or not the person is eligible.

Representative Bacala said there are tools at the disposal of LDH and when LDR and LDH cooperate more closely there is an ability to do some things that need to be done without the 1508 changes giving LLA access. With that in mind, four months and three days ago we received a report at this committee from LDR that stated the percentage of applicants whose gross income matched within \$20,000. At least it said for this sampling was that 25% of the applicants' income tax data was \$20,000 or more in error. We are

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
February 7, 2018**

sitting here and saying we have the ability to maybe use the samplings and then target. Well four months ago LDR identified probably 70,000 people who just did not look right and 48% had the wrong number of dependents. So in four months has anybody said this is very concerning and asked that maybe we ought to look deeper into those who fell within those two categories. He asked if anyone dug into that in the past four months or taken action or do we just sit here and talk and do nothing. That's why if we are going to talk and do nothing, when we could have done something in the last four months, then I guess we do need legislation to have an outside entity look at it. Unless you say that you have dug into this, and in which case I will say that you are on the ball and I don't need to do anything. So maybe we can address if anyone took this very disturbing data and do something with it or about it and really check to make sure these folks are eligible that on the surface seem to be ineligible.

Mr. Morris responded that the discrepancy was between 20%, and when his staff handled it internally and looked at the data, most of the cases where an application was filed in the early part of the year when they reported zero income but by the end of the year they earned another \$20,000 between two individuals that had \$10,000 each. It does not necessarily mean that they were not eligible for Medicaid but the way that the tax returns work is shows the entire year as a point of time. When they filed their application they may have had truthfully zero income and after the year progressed they earned income.

Representative Bacala said that is exactly on point with the brief statement by our legislative auditor, this is not the final determining factor but a clue that we might need to dig deeper into these people to make sure we are not allowing people into the program that are ineligible. Of this number, not every one of them will be ineligible but I think it's a pretty good pool to dig into to say you know what, let's make sure. This is not the final determining factor, but the hint that maybe we need to look closer at this group of individuals. Not to mention when you have 48% with an issue about the number of dependents. Eighteen year olds turn nineteen, and babies are born, so there will be some fluctuation, but cannot imagine that we are off 48%. That should not be a number that we are comfortable with for the discrepancy between application and income tax data. My guess it involves that parent number one claims the children for income tax and parent number two claims them for Medicaid, and never the two shall meet. We are not including the income tax dependent data in the process, but just a speculation. The point is that we have identified a pool that we need to look at more closely and have we looked at them closely yet.

Mr. Morris explained that his internal audit staff went through the data focusing mainly on the largest discrepancies and not the 20% as a whole. He can provide the factual information pertaining to those returns and tax payer situations to explain why we don't believe – not that we are making the determination of whether fraud is taking place – but why the difference is understandable. There is one issue where an individual received a large settlement and it was not included for Medicaid purposes but it was taxable for federal tax purposes so they were still eligible for Medicaid but their tax return income was higher than what you would think would make them eligible.

Representative Bacala asked if they identified anyone on the list who was ineligible. Mr. Morris answered that his staff would not make that determination if the applicant was eligible or not but there were a couple that did raise an eyebrow. Representative Bacala asked what did we do with the eyebrow raisers to make a determination whether they were correctly or incorrectly on the Medicaid rolls, and what final decision making process was in place to say they are fine or not. Mr. Morris said that is not LDR's determination but LDR is absolutely willing and has a 1508 exception with LDH and can go down that road. Representative Bacala said that goes back to his original question, what we can do and what we are doing are two – I'm not trying to be too critical but just trying to point out that if all this information has been

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
February 7, 2018**

brought to light, what do we do with it? You don't need legislation you say, or this or that, but what did we do on the ones that raised the eyebrow. Guess you are saying that you told LDH about it, so I guess the question reverts to LDH.

Mr. Morris said that he did not provide the information to LDH. Representative Bacala asked why didn't he. Mr. Morris said he can provide it today. Representative Bacala asked why didn't he do it four months ago when he saw somebody who raised your eyebrows, why didn't you say this is really suspicious and let LDH know about it. Let me tell you, therein lies the question or real issue here is we might have the tools but let me tell you a hammer in the toolbox does not do any good driving a nail. You have to pull it out the toolbox and put it in your hand and hit the nail. So whether the tools are present or not, you still have to use them. Why haven't we? Why haven't you said these are suspicious and let LDH know, and then the question would be what did LDH find and what did you do about it. I'm off the soapbox.

Mr. Magee said one of the parts of the mission of the LLA is to foster accountability and so if we were able to access that data we could determine whether or not those decisions were made and whether or not that information was shared. We do that with various different data sets right now. At the beginning of December, we had a report issued that identified deceased individuals who were still on the Medicaid rolls. That is information that LDH has and we went in to see if their process is working. So if the process is put into place, there is still that oversight entity to make sure the process is working.

Senator Mills said thank you for the debate on the top. I guess what I'd like to see is an action step and I look to Mr. Chairman for guidance. What the state of Minnesota did, and it looks like they had some problems too because they say in the report that this is repeat findings. So it seems like they have some disconnect going on over there but they have their conclusions. I guess I'd ask from an action step if this is some model of what would need to be randomly tested or targeted tested, if there is data that could be absolutely achieved that would meet federal requirements and there are some gaps in it. I recommend that you look at any legislation and I'd be happy to work with you on it.

Mr. Purpera thanked Senator Mills and commented the legislators would probably want their auditor to be able to do something independent here. When he looks at the MN report and sees such a high rate declared not eligible, it gives him angst. Not saying that the number in the report was accurate or not, but his office would drill into that even more.

Senator Mills asked how many recipients are under the five MCOs that for a 12 month period received absolutely no primary care. That was an issue brought out and discussed by the MCOs, and it troubled us because we want people to get primary care. It seems like the numbers were extremely low on primary care visits. The MCOs' response was that they were not sure how accurate that data was. He asked LDH if they could look at the data to determine it independently.

Ms. Steele responded that the best measure of that is now featured on their expansion dashboard, but it is not for Medicaid as a whole. For expansion alone, 75% of the members had preventive or primary care visit. There are some statistics that focused earlier that just focused on new patient visits for preventive care, but when using the national HEDIS quality measure it is 75%. The best performing states are in the mid 80's, so there is a certain misperception that you will get to some extremely high number. Think about ourselves – did you make it in this year for your visit? I've definitely had my years where I did not go. But that is the best indicator I have and we can do it for the population as a whole, but again we are not

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
February 7, 2018**

dramatically out of line with other states when it comes to that. Most states are not anywhere near 100% if that is the expectation.

Senator Mills said he feels there is a confidence level when you have an independence source auditing anybody and one thing he heard in this committee is that we have confidence in LLA and if you have more tools at your accessibility I think it gives everybody a checks and balance. Mr. Purpera said he agrees and the issue you are talking about... look we do have access to that data in LDH and looking at that now – the expansion and whole Medicaid population as to what portion of that population has no visits or services whatsoever, what portion has some services but no primary care physician visit. We are also attempting to look at the amount paying in the payment-per-person-per-months (PMPMs) versus what are the encounter claims, so what is that ratio. The expansion population is new for all of us. I understand that the PMPM for the expansion population is greater than the traditional program. Ms. Steele said that is right. Mr. Purpera said his staff will go backwards and see how well we did on the rate setting – was it good a rate setting or some MCOs doing better than they should. Senator Mills said that is critical as LDH is looking at 2 ½ years from a new RFP coming out. That data is more critical than ever.

Mr. Gooch, LLA Healthcare Specialist, confirmed his staff is looking at utilization now so their information is preliminary but once complete will be able to share with the Task Force.

Mr. Purpera asked if they already discussed the need to recommend improvements to the LDH program integrity unit. They would leave that on the list for future discussion but already discussed data mining. Mr. Boutte asked if the recommended improvements to LDH program integrity are coming from the LLA performance audit. Mr. Purpera said his staff is doing a performance audit and will have a report, so it may be worthy to wait for that report. He asked his staff for the estimated time period on the report. Mr. Magee responded it would be ready in a few months.

Mr. Purpera went to the last purpose which is to make reports to the governor and legislature. The interim report was issued on December 22, 2017, and he read from the law that reports are required semi-annually thereafter. He assumes that means the next report is due June 30, 2018.

Representative Bacala said that a couple things have come before this committee that he believes LDH is pursuing and it may be because of the committee or it may not. He asked if LDH is pursuing Diagnosed Related Groups (DRGs) which is something discussed as a committee. Mr. Reynolds said that Jen is more of the expert on that topic than he is. It is part of the hospital payment reform that LDH has spent the past 18 eighteen months on and meeting with hospitals and hospital association. They are getting in the position to present a proposal to the Health and Welfare Committees and their chairmen about where we want to go with that and the hospital program.

Representative Bacala read the report by LDH in response to HCR86 which is very interesting and LDH noted that \$1.2B a year is spent on Disproportionate Share Hospital (DSH) payments. The report noted that part of the Affordable Care Act's (ACA) purpose was to eliminate the DSH program that we now spending \$1.2B on. It also came with a kind of asterisk that maybe it would be extended or something, and would appreciate some kind of insight into that.

Mr. Reynolds said that the DISH program is the largest optional program in the Medicaid program and it is to cover the uninsured cost for the uninsured individuals that seek treatment at the hospitals across the state but it also covers the Medicaid shortfall. The Medicaid shortfall is what Medicaid pays the hospital for

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
February 7, 2018**

services compared to what Medicare the federal program for the elderly would pay. So that shortfall can also be paid through the DSH program. So even if you eliminate all the uninsured in the state, you will still have a DSH program as long as we are paying less than what Medicare does in those hospitals. We do not pay DSH to all the hospitals across the state, and predominately pay our partner hospitals, and recently expanded in the past few years the DSH Low Income Needy Care Collaborative (LINCCA) is paying the DSH expenditures at those hospitals.

Mr. Reynolds agreed that in the ACA it was assumed once you expand Medicaid and no longer have the number of uninsured that there was before, it should be less DSH cost. So in the ACA they projected reductions in the DSH allotments out to the states. What the federal government has done is since all the states have not expanded Medicaid they kept postponing those reductions in DSH allotments. So it is absolutely a case where it is still absolutely federal law, and in 2018 it is on the books as a proposed reduction but the feds have not done anything to implement that. In 2019 there are also proposed DSH allotment reductions and that is contemplated in the executive budget pending in front of House Appropriations. It is a case where the federal law currently is constricting that and wanting us to pay less and less DSH. Also in the rules put out by the feds want LDH to pay less and less supplemental payments to the hospitals and want to put more into the base rates. That has been very much a passion of Dr. Gee over the last two years since she has been secretary is that she wants to stop having all these supplemental payments out to the hospitals and put it into the base rates. You may say why does it really matter. From my perspective if the base rate properly reimburses the hospitals, we don't need all these extra deals and to cover the cost of the hospitals providing services to the citizens that we serve but it also with Medicaid expansion those clients now have a card. Those clients in New Orleans are no longer required to go to the former big charity hospital and can now go to Oschner Hospital or to Touro or wherever they want. The same thing here in Baton Rouge, they don't have to go to the Lake, they can go to Baton Rouge General. You want to set it up where the money follows the clients and want the markets to pick the winners and the losers in the hospital program not Baton Rouge and whoever came and cut the best deal.

Mr. Reynolds continued sharing that has been very much a passion of Dr. Gee. The payment reform that I mentioned before about DRG is sort of the first step what LDH is ultimately doing is instead of just paying a hospital a flat per diem. If you have a Medicaid client in a bed for a day, you get this dollar amount and does not matter what you do to them, you get that set dollar amount. What the DRGs do is if that person has a heart attack and it is very serious, we pay them a rate that is concerned for the acute or however sick the patients are, and how much the work has to do to treat those clients. That's very important so we are paying for services and not just paying to have someone in a bed, and that's what DRGs do. But also a big part of the proposal is to move \$300M from DSH payments and UPL payments into the base rates. Trying to get those base rates as high as possible for the hospitals so when a Medicaid client decides they don't want to go to the historic charity hospital and want to go to another across town, they have that option and the money will follow them when the hospital provides those services. It is a case where Dr. Gee wants us to change and all the hospitals will publicly say they want LDH to change. Personally I think it's the right thing to do, because as I said earlier, I think we should be setting it up where the market decides who's the winner and the losers in the market and not whoever came to Baton Rouge and had the best lobbyist. That's really why I've been so supportive of changing that. It is a case where if I ruled the world I'd say "it's all in the base rates and no more supplemental payments and we are done", but politically we cannot do that. There are lots of things we have to work through. We have to work through the partnerships, do the partnerships continue in the same manner that they are today or do we need to change them. Senator Mills and I have had this discussion and believe the Health & Welfare Committees are going to start having this discussion about where is future of the partnerships and the future of the hospital program and look at

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
February 7, 2018**

making changes with the ultimately goal of getting away from supplemental payments and putting it into the base rates so the clients decide where they want to receive the services and not where the state is driving the money.

Representative Bacala said I am waiting to get a copy of report #17 but just to put a better face on it, one of the reports that I was privy to, and this has evolved over a dozen years, so don't take this anyway except an observation but if I'm not mistaken one of the major hospitals in the state is reimbursed - when you combine all the programs - 444% of cost is what I saw.

Mr. Reynolds said that is part of getting away from the supplemental payments because there are cases where we are making payments to hospitals way in excess of their cost and then they are helping move funding to where it needs to be to support payments so it is a case where part of this payment reform that Jen and them are working on is that there are limits. We are not repaying somebody 400% over cost. It is a case where I feel very passionate and strongly that no one should be reimbursed for above cost, but will be some exceptions to that - the rural hospitals and all that. The payment reform is going us to where we are paying based on the current cost levels and current activities and not in a situation where we are paying somebody that far in excess of cost.

Representative Bacala said I applaud the efforts and giving you the opportunity to talk about the good things going on but the other thing is we are paying one hospital 444% and it's a big hospital. We have others who are being reimbursed with 20% of cost, so we really have created a haves and have-nots, winners and losers, and I'm not sure that it is always because of the need or the community that they serve. Again you hit the nail on the head on Baton Rouge, but I would really like to sit down and get some in depth briefing at some point, maybe other members of this committee might enjoy that as well to talk about how you guys are trying to get away from the model we have had.

Mr. Reynolds said we are more than willing to come talk and show you the steps we have gone through. Jen has spent a huge amount of time, even meeting individually with each hospital and listening to their concerns. It is something I am proud of and to be honest with you, it is something that I never thought I would see in my career.

Representative Bacala said to put a better face on it, the direct reimbursement we are making is about \$1.2B and I think the other methods by which select hospitals get funded from the state is maybe \$1.6B. So out of about \$3B, only \$1B is the direct payment for the cost of service and the other is supplemental. We are heavy into supplemental and look we can never get away and I would never support, but if we just paid 100% of the Medicare rate and no one got anything else, the state would save like \$1B in total and probably \$300M in state general fund.

Mr. Reynolds said I don't know about them numbers. Representative Bacala asked him to give a quick cycle here. Mr. Reynolds said when you look at the total hospital program as a whole, you cannot pay more than what Medicare pays, so it is a case where in that example you said earlier that we are paying one hospital way above cost and another hospital way below cost and that is the inequities in the system that have been built up over time that we are trying to correct. But it is a case where the hospital payment reform, LDH is not looking at it as a cost savings but a case where we are trying to redistribute - you know take the money and equitably distribute it across the players in the market. There is a case where if you provide the service, you get paid. I think the only area where potential savings could potentially occur is once you get that Medicaid rate up to the Medicare and no longer have that Medicaid shortfall I talked

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
February 7, 2018**

about earlier. If we continue to see the trend as far as the uninsured continuing to go down then it is a case where that billion dollars of DSH payments could go away. Of course, the committee might be saying why not flip all the supplemental payments to base and tell the hospitals tough. The problem is so much of the hospital program is funded by local governmental money and not funded by state general fund. If it was all state general fund then we would have a lot more say on it. But if a local governmental entity is transferring the match to Baton Rouge they want to ensure that they will get the money back to them or back to their partners or back to the hospitals that they want supported and they don't want the money to go someplace that they have nothing to do with. It is a case where the one limiting factor is the source of match or ultimately funding these payments. That's the piece I've been working with all the hospitals with and of course that's the most contentious part and we are working through it. But it is a case where I think we can get there as a small first step to do this but it is very much the administration and LDH's point of view is that we are taking the money that is currently in the program and reinvesting it in the program to create an equitable program, not to generate savings.

Representative Bacala said you made one point but the other point is that some of that needs to continue to be in the pipeline for the educational hospitals. Mr. Reynolds said that is absolutely correct, a big piece of the payment reform is properly identifying the medical education cost. LDH is looking to have Graduate Medical Education (GME) payments that is based on the actual cost and based on the number of students working at those hospitals as a way to do that. Some of that is funded with local money and it is a case where as we go through this I've yet to talk to anybody that does not support medical education and the importance of that to the state. Of course, that's a big component of whatever we do, we still properly supporting those medical education and ultimately the medical schools.

Representative Bacala said one more thing is talking about the supplemental and think the LINCCA agreement, the value of that might be about \$156M. Is that included in that number or is LINCCA off the state books?

Mr. Reynolds said every dollar that we put out is on the state books and as per state law every dollar comes in and every dollar that goes out must be on our books. DHS LINCCA is about a \$300M program and then we have a smaller LINCCA program in the UPL that is about \$50M. That is reimbursing those hospitals for eligible costs but it is a case where we are using that to help support other local programs. They have come forward with programs and asked for help supporting them.

Representative Bacala said understanding the evolution of how we got to where we are today is important and my understanding is in the last 10-12 years what happened through the years is that we tried to pull money out of LDH to use for purposes and LDH had to continue to try to creatively figure out ways to fill holes. One of those is the LINCCA program, and I have a few questions about that, but the other part is that is another program with perhaps about a dozen providers who are the benefits of the LINCCA program but does not benefit the 250 hospitals. A couple of hospitals get \$20M out of it and some get \$12-15M out of it, and about 250 hospitals get nothing out of it.

Mr. Reynolds explained so the committee knows during the previous administration there were literally rate cuts after rate cuts every legislative session and every mid-year there were a rate cuts. The hospitals took in excess of 20% reduction over all in their rates and of course no one can continue to provide services with those types of cuts, so there was very much not a global plan. I was there with my predecessors and it was very much a piece meal approach. A local entity that could put up the match instead of the state putting up the match, and it was sort of piece meal approach which created some of the inequities I talked

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
February 7, 2018**

about earlier. It is a case where LDH and Dr. Gee and this administrator is trying to reset that and make it fair and reasonable. The DSH LINCCA if just an example of a way to try to help offset the hospitals that were receiving these big rate cuts. Those guys were receiving payments for services for Medicaid and uninsured, so it was totally appropriate but it is case where it is only going to a select few and not the whole market like we would like to see.

Representative Bacala said a good way to describe it is you recognize things that need to change but it's tough to turn the ship around.

Mr. Reynolds said absolutely, because in payment reform I think, all the hospitals agree that the program needs to be reset and acknowledge the inequities and acknowledge that their reliance on the supplemental payments that the feds are eventually going to make it where we cannot do that. The current model is not sustainable and needs to be changed. But with any change there is potential for winners and losers. Of course the winners will offend the status quo and the losers will fight to change the model or the system. And that's the piece that Jen and I and the department spends a lot of time massaging the numbers, making sure we have data, making sure we are making decisions based on data and not speculation. And be fair and open and reasonable with everybody and give everybody input. As I've told all the hospitals, I said nobody will be completely happy with this first go round but this is the first step in the numerous steps to reset this whole program. Everybody has been very reasonable and open to our approach because I think everybody acknowledges that it has to change. But absolutely the winners that are potentially going to lose something from it and probably going to be on the legislators saying no, don't let LDH do that because it will affect your hospital, so that's the politics of it. That's what happens when you change any big program – talking \$3B and making material changes to it. There will be certain percent of those providers that are going to want to maintain status quo, and that is part of my job working with administration to identify those and alleviate their concerns so we can get them to support the change and not fight the change.

Representative Bacala asked if the group that is at 444% willing to go down to 100% right now. Mr. Reynolds said he could give pure speculation but believes Representative Bacala knows that answer.

Mr. Block apologized for being late but had a couple other things going on. He felt obligated to point out given this discussion that is happening over the past minutes is based on the assumption that we will not go off the cliff for this next fiscal year. So I am hoping that as we discuss the things that need to be done and the things that were done over the last eight years or during the previous administration that required this creative financing. Part of it is because money was not put into the appropriate places, so I hope I can count on my friend here to help us make sure that we fix the cliff so we don't force choices that will not allow for any of this to be done because if we have to eliminate funding for partners, etc., all of what Mr. Reynolds just talked about is going to be thrown out and changed dramatically. So I hope we can count on everybody to work together to make sure that we don't do that.

Mr. Reynolds said he totally agrees with Mr. Block and what he has told the hospitals is that the payment reform is separating from the budget because the budget is so bad and we have to wait and see what happens on the revenue side. But if the revenue is not raised then the hospital program reform kind of blows up and we are status quo and limping by until we can get to the position where we can actually make some changes.

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
February 7, 2018**

Mr. Purpera expressed appreciation for all the members' input, communications and edits on the Interim Report issued on December 22, 2017. Senator Mills moved to officially approve the December 22, 2017, Interim Report of the Task Force to the governor and legislature. Representative Bacala seconded the motion and with no opposition or further discussion, the motion was passed to officially approve the report by the Task Force.

DISCUSS FUTURE TASK FORCE GOALS

Mr. Purpera said a lot was discussed today and on several issues we are waiting on report either from my office or LDH. The one issue brought up by Mr. Travis regarding the waiver and how some people are eligible might be an item for a future meeting and hear testimony.

The other goal of the committee is to get a progress report on the items listed as issues on the Interim Report. He asked for any input on future agenda items and goals. Representative Bacala said to keep in turn with LDH's efforts to reform the hospital payment methodology. The work of this committee has been very helpful to me in understanding and hope it has also been helpful to others and probably getting perspective who sits at the other end of the table and probably it has opened up some eyes on what we can do a little better if we all work together and share information. Before we leave the meeting today, I think it's time to ask the question. This Task Force was formed from a bill and an end date was set intentionally at June 30, 2018. If it is of value I will submit a bill to extend the Task Force for another year and perhaps refocus the efforts of the Task Force or broaden the scope. But I am looking for input on that. He asked Senator Mills for his input on whether or not to continue the work of the Task Force.

Senator Mills said they should continue and as the Medicaid program evolves, especially Medicaid expansion and future audits coming in we set ourselves some goals maybe legislatively and administratively. I think this is a good committee with a good representation of expertise. I would recommend that we continue to work on those issues to make the program better and help the public and taxpayers. I commend everybody for their work and our chairman has kept us on task. It's not a high paying job and if you'd like to stay on, well we can continue on that track if okay with everybody. Mr. Travis agreed that he would like the Task Force to continue their work.

OTHER BUSINESS

PUBLIC COMMENT

No public comments were offered.

DISCUSS SUBJECT MATTERS FOR FUTURE MEETINGS

Mr. Purpera asked when they would like to meet again, and maybe between the special and regular legislative sessions. Mr. Travis suggested waiting until after the regular session begins.

Mr. Block said trying to coordinate something between the special and regular session will be very challenging for at least those of us on the administration side of it. The special, to the extent that there will be one and it will be all encompassing, and with only a mere matter of days between the sessions. I recognize the importance of doing this but think frankly if we could do this early in the regular session, I don't think we would be limited at all in the beginning and the slow pace of it because of the work that would be done beforehand. That is my request.

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
February 7, 2018**

Senator Mills said Mr. Block was correct and they could possibly meet during the early part of session. They have the opportunity to file five late bills, so if something has not been filed but the committee wants to look at, they could see what's been proposed and see where there is a gap from a committee level.

Mr. Purpera asked when the regular session would begin and when they would like to meet. Several said the second week would be best, but Ms. Steele said she was not available the second week. Mr. Purpera said a polling email would be sent out for the third week of the regular session. Mr. Block requested if any Task Force members have requests for LDH or LDR to comment on specific bills or to be in a position to discuss specific bills, if you could give them as much advance notice so they can be prepared and we can try and avoid any duplicative testimony because those bills will be assigned to committees where the departments will be working to get information to those members as well. As much as we can avoid duplicative work and also to make sure they have as much advance notice, that would be very helpful.

Mr. Purpera asked the legislative members if they would want any testimony on their bills in a Task Force meeting, and both declined.

ADJOURNMENT

Senator Mills offered the motion to adjourn, which was seconded by Representative Bacala and with no objection, the meeting adjourned at 10:53 am.

Approved by Act 420 Task Force on: _____

The video recording of this meeting is available in the House of Representatives' Broadcast Archives:
http://house.louisiana.gov/H_Video/VideoArchivePlayer.aspx?v=house/2018/feb/0207_18_MedicaidFraud

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

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
August 29, 2018**

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.

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
August 29, 2018**

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 contractor 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

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
August 29, 2018**

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.

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
August 29, 2018**

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

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
August 29, 2018**

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

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
August 29, 2018**

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

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
August 29, 2018**

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

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
August 29, 2018**

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 every 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

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
August 29, 2018**

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

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
August 29, 2018**

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

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
August 29, 2018**

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

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
August 29, 2018**

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.

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
August 29, 2018**

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.

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
August 29, 2018**

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

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
August 29, 2018**

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 somehow 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.

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
August 29, 2018**

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.

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
August 29, 2018**

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

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
August 29, 2018**

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

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
August 29, 2018**

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

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
August 29, 2018**

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

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
August 29, 2018**

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 –

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
August 29, 2018**

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.

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
August 29, 2018**

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

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.

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
October 16, 2018**

**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

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
October 16, 2018**

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.

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
October 16, 2018**

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

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
October 16, 2018**

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.

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
October 16, 2018**

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,

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
October 16, 2018**

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 than 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

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
October 16, 2018**

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

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
October 16, 2018**

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

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
October 16, 2018**

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

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
October 16, 2018**

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-

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
October 16, 2018**

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.

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
October 16, 2018**

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

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
October 16, 2018**

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.

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
October 16, 2018**

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

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
October 16, 2018**

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 2017 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

**Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives
October 16, 2018**

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: _____

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

APPENDIX C

Louisiana Department of Health's Responses to Interim Report Recommendations

10/16/2018 Fraud Task Force Prep – Interim Report Recommendations from Louisiana Department of Health

12/22/17 Interim Report	Interim Events/Actions
1. Use of tax data in determining eligibility	LDH will import IRS data into its new eligibility system beginning in May 2019. LDH and LWC are working to finalize a data sharing agreement to assist LDH in conducting targeted post-eligibility reviews, specifically identifying wage earners at high risk of ineligibility due to unreported or underreported income.
LDR & LDH should improve DSA to give LDH additional tools to properly determine eligibility	LDH and LDR are working to finalize a data sharing agreement to assist LDH in conducting targeted post-eligibility reviews, specifically identifying tax filers of high risk of ineligibility due to unreported or underreported income.
Legislation to give LLA access to state tax data	LDH to import IRS data in May 2019, working on LDR and LWC data sharing agreements for targeted post-eligibility reviews to begin in the interim.
LDH should consider using IRS data	LDH will import IRS data into its new eligibility system beginning in July 2019
2. Reasonable Compatibility LDH should analyze cost/benefit of reducing RC standard	LDH reduced reasonable compatibility standard from 25% to 10% on 6/1/18. Monthly outcome reports submitted to legislature. See 10/18 report for latest data.
3. Eligibility Fraud Reviews LDH should develop a standardized process for reporting eligibility fraud review results to AG and LLA.	A standardized process has been developed. Results are shared with both the AG and LLA. Medicaid Recipient Fraud Unit created June 2018. See attached 1-pager for info and stats.
<ul style="list-style-type: none"> Development of Recipient Fraud Unit 	Bill for MRFU in AG's office (HB 163) failed in 2018 regular session. LDH established an internal Medicaid Recipient Fraud Unit.
<ul style="list-style-type: none"> Current Resources/Structure for Verifying Eligibility 	<p>LDH currently has access to LWC on an ad hoc query basis. LWC provides quarterly wage data and weekly unemployment benefits.</p> <p>From reasonable compatibility report:</p> <p><i>Prior to the use of federal tax data, LDH will obtain additional wage information from the Louisiana Workforce Commission (LWC) for income verification purposes. Specifically, LDH plans to use the LWC data for targeted quarterly reviews of cases at high-risk for income ineligibility due to a change of circumstances prior to annual renewal. These quarterly checks are scheduled to take place beginning in the fall of 2018, and LDH plans to later expand to a wider scale with systematic integration into LaMEDS.</i></p> <p>LDH and LWC are still working to finalize a data sharing agreement to assist LDH in conducting targeted post-eligibility reviews, specifically identifying wage earners of high risk of ineligibility due to unreported or underreported income. We are modeling our DSA off the LLA/LWC agreement, which we received on Friday 10/15.</p>

10/16/2018 Fraud Task Force Prep – Interim Report Recommendations from Louisiana Department of Health

12/22/17 Interim Report	Interim Events/Actions
	Yes, retirement income is considered for eligibility.
<p>1. Data Mining Coordination LDH, MFCU, & LLA should meet quarterly to discuss data mining activities; discuss algorithms and planned activities to avoid duplication of effort</p>	<p>LDH and MFCU meet quarterly to discuss data mining activities. LLA was recently added to the invite list. The next meeting is scheduled for 11/5/2018.</p>
<p>2. Healthcare Fraud Prevention Partnership LDH should continue working w/ HFPP. MCOs should participate also.</p>	<p>LDH has started sharing data with HFPP, including MCO encounter data. We are awaiting study results to determine if MCOs also need to submit data. Our concern with requiring the MCOs to submit data at this point is a lack of clarity from HFPP on how it will handle the duplicate information. If we send our encounters and the MCOs submit the same information from their claims systems, it could produce several false positives because the HFPP analysis would consider both the encounter submitted from LDH and the claim submitted directly from the MCO.</p>
<ul style="list-style-type: none"> • Deposit fines collected by LDH into Fraud Detection Unit 	<p>Fraud Fund report published July 2018. LDH took immediate action to correct all findings.</p>
<ul style="list-style-type: none"> • Amend MAPIL to enable greater recovery for state in MAPIL litigation 	
<p>1. MCO Contracts LDH should closely monitor to ensure MCOs are meeting deliverables</p>	<p>Recent focus (summer):</p> <ul style="list-style-type: none"> • MCO hospital service authorization analysis. Final report in development. <p>Current focus (fall):</p> <ul style="list-style-type: none"> • MCO claims payment analysis (HB 734). Stakeholder review of draft findings on 10/10. Summary report to Legislature by 10/31, including recommendations for future MCO reporting requirements/LDH oversight activities. • Update MCO companion guide to include only valid provider type/provider specialty combinations. 17,188 invalid combinations have been identified (3.8% of all provider registry records), and we’re developing a timeline to have the MCOs correct this data. MCO-specific findings included as a separate table in this document. <p>Future focus (winter and through 2019):</p> <ul style="list-style-type: none"> • Comprehensive assessment of LDH oversight infrastructure, recommendations/activities for update to align with new MCO contract terms/national best practices • Staged timing to align with oversight priorities/compliance timelines

10/16/2018 Fraud Task Force Prep – Interim Report Recommendations from Louisiana Department of Health

12/22/17 Interim Report	Interim Events/Actions
<ul style="list-style-type: none"> Discuss rate setting process vs. MLR 	
<p>Implement immediate safeguards to adjust PMPMs based on data more current than 2 years prior</p>	<p>Industry standard is to use complete claims for base data, which requires run out (12 months from 365-day filing limit). More recent financial data is used to inform trends adjustments to base data, which is typically at least 2 years old.</p>
<p>Monitor PMPM vs. services provided and make more immediate adjustments to PMPM</p>	<p>LDH recently asked M&S and Mercer for assistance with addressing LLA concerns relative to WA audit findings (encounter data and rate setting). Pending finalization of draft project proposal, including:</p> <ol style="list-style-type: none"> 1. PowerPoint educational deck <ol style="list-style-type: none"> a. Educational information regarding norms, best practices and developments nationally 2. Encounter review report <ol style="list-style-type: none"> a. Address provider enrollment and provider registry issues b. Identify major categories of encounter data quality concerns c. Identify risks, including rate implications, associated with the major risk categories d. Address risk mitigation in how currently addressed and future considerations, including how Mercer and M&S activities interrelate e. Discuss encounter quality activities
<p>Evaluate HCQI/HIT expenses to determine appropriate max amounts MCOs can claim as medical vs. admin expenses</p>	<p>M&S does this annually in independent audit of MCO MLRs reported. Identifies unallowable expenses and adjusts accordingly to produce final audited MLR on which rebates are based.</p>
<p>Evaluate all current VAS to determine appropriate use of taxpayer funds, restructure bidding process so that VAS isn't a determinant of contract award</p>	<p>Cannot discuss RFP content until public release.</p>
<ul style="list-style-type: none"> Non-emergency use of ED 	<p>LDH continues to work on ED data analysis via quality committee. ED reduction efforts under consideration for MCIP inclusion. ED PPE to be added as a monitored quality measure beginning in CY19 DRG vendor modeled PPV baselines by MCO and hospital. To be introduced to hospital stakeholders before end of year. Tool for future use in VBP contract negotiations, driving quality and value.</p>
<ul style="list-style-type: none"> Include LTC in managed care, evaluate 	<p>HB 334 and SB 357 failed in 2018 session, lots of public testimony in opposition.</p>

10/16/2018 Fraud Task Force Prep – Interim Report Recommendations from Louisiana Department of Health

12/22/17 Interim Report	Interim Events/Actions
impact on access, cost, and quality	
<p>1. EVV for MHR Services Conduct feasibility study to determine if value in EVV for these services, impact on current EVV use, and costs.</p>	<p>Did not complete a study but have determined to not pursue at this time; the nature of MHR services makes the service location unpredictable. Other reforms are being put in place to comply with Act 582 of the 2018 regular legislative session in order to strengthen oversight of MHR services. One of the provisions in the Act requires the individual rendering the PSR or CPST services for the licensed and accredited provider agency to have an individual NPI number, and that number must be included on any PSR or CPST claim submitted by that provider agency for Medicaid reimbursements. This will address an issue discussed in a previous Task Force meeting on not being able to identify the individual who rendered services through claims data. This provision of the Act has an effective date of 1/1/19.</p>
<ul style="list-style-type: none"> Achieving a single, reliable provider registry 	<p>Provider management contract awarded. Public hearing on the award was held on 9/17. Contract negotiations were completed on 10/12. LDH legal is conducting a final review prior to the contract going to CMS for its review and approval. CMS has 60 days to conduct its review.</p>
Pending	
<ul style="list-style-type: none"> Use of single PDL 	<p>NOI in Aug. 20 Register. Public hearing report submitted to legislature last week. Plan to implement in early CY 2019.</p>
<ul style="list-style-type: none"> PBMs that don't profit from spread pricing, are paid on administrative transaction fee 	<p>Legislation passed – SB 130. Plan to implement Jan 1, 2019, a year in advance of statutory deadline.</p>
<ul style="list-style-type: none"> Require supplemental rebates to be returned to the state 	<p>No rebates will go to MCOs with single PDL and transaction fee implementation.</p>

10/16/2018 Fraud Task Force Prep – Interim Report Recommendations from Louisiana Department of Health

Invalid Provider Type/Provider Specialty Combinations in Registry

Plan	# of incorrect records
ACLA	1,361
Aetna	2,243
HBL	1,472
LHCC	1,548
UHC	10,549
Total: 17,188 incorrect records out of 446,004 total records (3.8% incorrect)	

10/16/2018 Fraud Task Force Prep – Interim Report Recommendations from Louisiana Department of Health

MCO Summary of Administrative Actions

Administrative Actions, SFY 2018

Category	Issue	Letter Sent	Penalty Assessed	Penalty Amt
Claims Management	Timely Claims Reprocessing	2		
Financial	Failure to Timely Submit Required Reports	*	1 (ABH)	\$16,000
Provider Services	Failure to Update Provider Directory	5	5 (All)	\$250,000
	Geographic Access Requirements	2	1 (UHC)	\$205,000
Reporting	Failure to File Accurate Report	*	2 (ABH)	\$226,000
	Failure to Timely Submit Required Reports	1		
Systems	Failure to Meet Deadlines - CPT/HCPCS Update	1		
	Failure to Meet Deadlines - Modernization Project	4		
Utilization Management	Service Authorization	1		
TOTAL		16	9	\$697,000

*Letters sent during SFY17, monetary penalty collected in SFY 18

Administrative Actions, SFY 2017

Category	Issue	Letter Sent	Penalty Assessed	Penalty Amt
Claims Management	Failure to Comply with Encounter Data Requirements	2	1 (ABH)	\$570,000
	Payment to Providers	2		
	Pharmacy Claims Processing	1	1 (UHC)	\$495,500
	Remittance Advice Deficiency	1		
Financial	Failure to Timely Submit Required Reports	2	*	
Member Appeals & Grievances	Failure to Timely Process Grievances and Appeals	2		
Reporting	Failure to File Accurate Report	4	*	
Systems	System and Data Integration	4		
Utilization Management	Service Authorization	1		
TOTAL		19	2	\$1,065,500

*Letters sent during SFY17, monetary penalty collected in SFY 18

August 28, 2018

General Info

- Created June 2018
- 5 full-time LDH staff
- Investigate recipient fraud referrals received from a variety of sources, including but not limited to:
 - SURS
 - Online
 - Fax
 - Mail
 - Email
 - MCO
 - AG
 - DCFS

Referrals, Savings, and Recoveries

Month	# Case Reviews Completed	Total # Cases Referred to Outside Agency	# of Cases referred to AG	# Cases - Elig Termed	Savings (#mos. /\$ amt.)	Expected Refund (#mos. /\$ amt.)
June 2018	45	18	9	12	63 / \$24,246.05	147 / \$28,010.15
July 2018	52	18	2	25	104 / \$45,871.38	45 / \$23,071.05
Aug 2018	74	18	4	23	116 / \$61,210.82	51 / \$35,328.07
Sept 2018	61	12	1	18	60 / \$26,712.08	16 / \$10,988.81
Total	238	66	16	78	343 / \$158,040.33	259 / \$97,397.07

- “Outside” Agencies Referred to:
 - DCFS
 - SSA
 - AG
 - SURS
 - LDH Pharmacy
 - LDH Recovery
 - MCOs
- # of cases referred to AG is a subset of the total # cases referred to an outside agency
- Savings – case closure prior to scheduled renewal date will result in a PM/PM savings, that savings is reflected in months and dollar amount
- Expected Refund – Once a substantiated period of ineligibility has been established, a formal recovery is requested. The ‘expected refund’ is reflected in months of ineligibility and dollar amount.