MINUTES OF MEETING

Task Force on Coordination of Medicaid Fraud Detection & Prevention Initiatives

Act 420 of the 2017 Regular Session

Wednesday, October 4, 2017
10:00 AM - House Committee Room 5
State Capitol Building

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

CALL TO ORDER AND ROLL CALL

Chairman Purpera called the meeting to order at 10:00 a.m. Ms. Liz Martin, Executive Assistant for the Louisiana Legislative Auditor (LLA) called the roll confirming quorum was present.

Voting Members Present:

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

Advisory Members Present:

Jarrod Coniglio, Program Integrity Section Chief – Medical Vendor Administrator, Appointed by LDH Secretary Gee
Luke Morris, Assistant Secretary for the Office of Legal Affairs, Appointed by Louisiana Department of Revenue (LDR) Secretary Robinson
Dr. Robert E. Barsley, D.D.S., Director of Oral Health Resources, Community and Hospital Dentistry, LSU School of Dentistry, Appointed by Governor Edwards

Advisory Member Not Present:

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

APPROVAL OF MINUTES

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

Louisiana Department of Revenue

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PRESENTATIONS BY MANAGED CARE ORGANIZATIONS

a) Aetna Better Health of Louisiana

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b) AmeriHealth Caritas of Louisiana (AmeriHealth)

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

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

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

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

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

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

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

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

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

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

c) Healthy Blue

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d) Louisiana Healthcare Connections (LHCC)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

e) United Healthcare (UHC)

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

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

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

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

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

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

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

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

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

Continuation of Louisiana Healthcare Connections (LHCC)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PRESENTATION BY LOUISIANA DEPARTMENT OF HEALTH ON REASONABLE COMPATIBILITY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PUBLIC COMMENT

No public comments were offered.

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

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

ADJOURNMENT

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

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

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