MINUTES OF MEETING

Task Force on Coordination of Medicaid Fraud
Detection & Prevention Initiatives

Act 420 of the 2017 Regular Session
Wednesday, February 7, 2018
9:00 AM - House Committee Room 4
State Capitol Building

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

CALL TO ORDER AND ROLL CALL

Chairman Purpera called the meeting of the Task Force on Coordination of Medicaid Fraud Detection and Prevention Initiatives (Task Force) to order at 9:15 a.m. Ms. Liz Martin, Executive Assistant for the Louisiana Legislative Auditor (LLA) called the roll confirming quorum was present.

Voting Members Present:

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

Advisory Members Present:

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

APPROVAL OF MINUTES

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

DISCUSS INTERIM REPORT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DISCUSS FUTURE TASK FORCE GOALS

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

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

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

OTHER BUSINESS

PUBLIC COMMENT

No public comments were offered.

DISCUSS SUBJECT MATTERS FOR FUTURE MEETINGS

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

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

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

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

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

ADJOURNMENT

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

Approved by Act 420 Task Force on: _____

The video recording of this meeting is available in the House of Representatives' Broadcast Archives:
http://house.louisiana.gov/H_Video/VideoArchivePlayer.aspx?v=house/2018/feb/0207_18_MedicaidFraud_