LEGISLATIVE AUDIT ADVISORY COUNCIL

Minutes of Meeting
November 21, 2019
House Committee Room 6
State Capitol Building

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

Chairman Julie Stokes called the Legislative Audit Advisory Council (Council) meeting to order at 9:45 a.m. Ms. Liz Martin called the roll confirming quorum was present.

Members Present: Representative Julie Stokes, Chairman
Senator Mike Walsworth, Vice Chairman
Senator W. Jay Luneau
Senator Danny Martiny
Senator Rick Ward, Proxy for Senator John Smith
Representative Clay Schexnayder
Representative Jimmy Harris
Representative Edmond Jordan
Representative Tony Bacala, Proxy for Representative Blake Miguez

Members Absent: Senator Wesley Bishop

Also Present: Daryl G. Purpera, CPA, CFE, Louisiana Legislative Auditor (LLA)

Approval of Minutes

Vice Chairman Walsworth made a motion to approve the minutes for the September 12, 2019 meeting and with no objection, the motion was approved.

Extension Requests

Chairman Stokes noted that there were no extension requests submitted requiring Council approval.

Louisiana Department of Health:

a) Medicaid Eligibility Determinations: Status on the Use of Federal Tax Information – Issued September 11, 2019
b) Improper Billing of Services Within the Medicaid Behavioral Health Program – Issued September 4, 2019
c) Identification of Behavioral Health Service Providers – Issued May 15, 2019

Mr. Wes Gooch, Special Assistant for Healthcare Audit, presented a summary of the Medicaid Eligibility Determinations audit. He said that LLA's position on the use of federal tax information (FTI) on Medicaid eligibility is no secret and have discussed the need for years. In a previous Medicaid audit report issued last December, we tested the modified adjusted gross income (MAGI) determination process and Medicaid eligibility. The MAGI determination was new as part of the Affordable Care Act (ACA) and it began in 2014. In the previous report, we noted that Louisiana Department of Health (LDH) did not use federal and/or state tax information to verify certain self-attested eligibility factors. Those include tax filer status, household size, self-employment income and other types of non-wage income.

The LLA determined that this lack of verification was a weakness in internal control because the tax information was the only trusted source to verify these critical MAGI eligibility factors. Since LDH did not use tax information, and federal and state law do not allow the auditors to use tax data for the purpose of auditing Medicaid, we determined that this became a scope limitation for our audit. Because of that we were unable to obtain sufficient appropriate evidence to provide an audit opinion on Medicaid eligibility compliance in Fiscal Year 2018 Single Audit report. In that report, we recommended that LDH ensure that all critical eligibility factors were verified and LDH concurred with our recommendation. LDH noted that they would be using federal tax information once they launched their new eligibility

system. LaMEDS was launched in November 13, 2018 and LDH gave a target date at the time of implementing the FTI in LaMEDS for May 2019. So the purpose of our report that we issued in September, which is being presented today, is to provide a follow-up on the status of LDH's use of FTI for those MAGI eligibility based determinations.

Mr. Gooch noted the six issues detailed in the report. The first issue was that LDH had ceased its efforts to develop the automated use of FTI through LaMEDS. The IRS has voluminous security requirements that must be met before sharing FTI with any states. Based on LDH and IRS discussions, only two IRS compliant options were possibly identified for the automated use of FTI in LaMEDS. The first option was that nothing could be stored in the system that will allow anyone to see or even deduce that an action was taken based on the FTI – so no verification data, no system actions, no requests for information – no information that could be included in the system that could be traced back to an individual and their FTI. LDH determined that that option one just was not viable. They did not want to give up the degree of verification documentation and the audit trails that they had built into LaMEDS.

The second option would allow the system to be designed with documentation and audit trails. But all of LaMEDS and all of its users would have to comply with the IRS security requirements, meaning hundreds of LDH employees, administrators, contractors, application centers, everyone there would have to meet the security requirements for individual background checks for all personnel who had access, even if it was only read-only access and any access point where the LaMEDS system could be assessed and opened. LDH determined that this would actually be cost prohibitive for them at that time. However, we did notice in the report that they had not actually done a full cost analysis of that, but it was pending. We did note that in the report that the Louisiana Department of Revenue (LDR) operates a fully IRS compliant department and environment where they do use FTI and we suggested that LDH reach out to LDR for guidance and for assistance in their cost analysis.

The second issue that we noted in our report is that LDH had developed an IRS compliant information technology (IT) environment to receive and store federal tax data for part of a post-eligibility review process. The IRS security requirements address three large general areas: IT environments, personnel, and physical security. So LDH has met an approved IT environment with the IRS and we refer to it in our report as the vault. So rather than adding FTI to the application and the renewal processes and automated through a system, LDH was now developing a process to use federal tax data as a post-eligibility review. The post-eligibility review would primarily be manual. It would be performed in the vault by a few selected LDH personnel. So it would limit both the number of background checks and the amount of physical security that would be needed. At the time of our report, LDH noted that the vault was storing cases where income as reported in LaMEDS and then the income shown in FTI for the recipient varied by $100,000 or more. For these cases, the recipient was determined to be eligible without considering tax data, but additional review would be done when it was possible and all of the IRS approvals had been obtained. According to LDH at the time, the cases for review were being stored in the vault, but no reviews had begun because the background checks were not finished and the physical security was not finished. They did not give us a timeframe but said that it could take several additional months.

The third issue was that at the time of the report LDH had not met those IRS physical space requirements and also had not completed their IRS background checks. LDH confirmed they had begun the background checks but could not give us a timeframe as to when those would be completed and they had identified office space and they were currently working on modifications in order for that to meet the IRS security requirements.

The fourth issue we mentioned in our report is that LDH temporarily discontinued using FTI in consideration of its long-term care eligibility cases in April of 2019. Prior to April 2019, LDH had used IRS tax data for the long-term care eligibility determinations. Historically they had used that data because all income and evidence of income that could be derived from assets were part of the testing for the long-term care eligibility requirements. With their negotiations with the IRS on these other issues, they noted that the IRS increased their background security standards in 2016 and the background checks that they had for their employees were no longer 100% IRS compliant. So at the time of our report they were developing a plan to reinstate the use of IRS tax data in the long-term care eligibility determination process.
The fifth issue is that while LDH is allowed by state law to obtain and use state tax information for Medicaid eligibility determinations, they were not using it at the time. In LLA's Medicaid audit unit report issued in May 2018, "Strengthening of the Medicaid Eligibility Determination Process," we noted that LDH had an agreement with LDR to receive state tax information. However, LDH was not using the data at the time. Because of the way that the information

was shared by LDR to LDH, it really was not useful in their making eligibility determinations. Instead of receiving a full dataset of tax information, the LDR was only allowing LDH to make specific requests for particular individuals when it came to looking at IRS data. Also in this previous report, we noted that 30 other states did use federal or state tax data as part of their Medicaid eligibility determination process.

So while the FTI may have been LDH's first choice to use as a data source, the state tax data with a proper data sharing agreement between LDH and LDR could possibly provide the verification on the self-attested information for the tax filer status, the household size, and the self-employment income. Since LDH had ceased their efforts to use FTI due to the IRS restrictions, state tax data could be a good alternative information source for them to try and automate in LaMEDS. The final issue that we noted in our report is that because LDH did not use federal and/or state tax data during each MAGI based eligibility determination for both application and renewals, LDH continued to be able to verify all critical eligibility factors.

In fiscal year 2019, LDH paid approximately $5.5 billion in managed care premiums for MAGI based recipients. That was approximately 44% of the Medicaid vendor payment budget. Because LDH had not implemented the use of this FTI, they continued to be unable to verify all critical eligibility factors. Once again because LDH did not use that tax information and auditors are not allowed to use it for the process of auditing Medicaid, we continue to have a scope limitation for our fiscal year 2019 audit because we are unable to obtain sufficient appropriate evidence to adequately test Medicaid eligibility. Until this scope limitation is removed from our audit of Medicaid, it is likely that we will continue to be unable to provide an opinion on Medicaid eligibility in the state single audit report. We will again disclaim an opinion on the Medicaid eligibility requirement.

In this report we made two recommendations and had one suggestion for legislative consideration. Recommendation number one was that LDH management should conduct a full cost analysis for the option of using an IRS compliant method for utilizing automated federal tax data in LaMEDS before deeming the possibility to be cost prohibitive. LDH in its response agreed with the recommendation and stated that they were working on conducting a full analysis of both fiscal and programmatic impacts of the system integration of FTI into LaMEDS. Our second recommendation was that if the cost analysis shows that IRS compliant method for utilization of automated federal tax data in LaMEDS is truly cost-prohibitive, that LDH probably should explore the possibility of using state tax data in LaMEDS instead. LDH agreed with this recommendation.

In the matter for legislative consideration, we suggested that the legislature might wish to consider moving all or part of Medicaid eligibility functions to LDR to utilize an established secure environment that is already IRS approved and experienced in the security and the use of the FTI.

Mr. Purpera explained that with the ACA implementation, a couple of things became real important – the verification of household size and the verification of income. CMS currently is not requiring states to use FTI. They are permitting, but not requiring, so I want to make that point that about half of the states are using FTI primarily on a one-on-one look up. What we are suggesting is something better than that. It would be put into our LaMEDS system and it is done on every individual so that it's a more thorough look. That is really important in a managed care state because we are paying out 100% regardless of whether an individual received services. The alternative to using FTI, if that hurdle is just too high, would be to use state tax information. I know that in our state we combine those two things together so that would require for our state to separate that data out some way so that LDH could strictly receive the state tax information and not get into all the federal problems.

The one-on-one lookup is not really sufficient for internal controls because we have 1.6 million people in our process. We have had to disclaim an opinion on a portion of the audit of LDH's program. That is really important across the nation. A lot of state auditors this year are going to be doing the same thing in some of the states. In some states, the law allows the state auditor to use the state tax or federal tax information and so they are able to get over that hurdle. In our state we do not have that.

Senator Luneau asked when or how were you able to make the determination about how much money the state of Louisiana had spent on ineligible people that we had discussed in prior meetings. Mr. Gooch answered that we have had several different audits with different methodologies where we have reported the potential for large quantities of

improper payments. Senator Luneau said he heard about the potential for payments. Did y'all make a determination about what that number actually was? Mr. Gooch said the report about the income verification where there was a projected $86 million and that one was issued last November.

Senator Luneau asked how did LLA verify those numbers since the report was issued. I am assuming those numbers are verified because I saw lots of political ads that said we misspent $85 million. Mr. Gooch said that is still referring back to our report from last November. We have not issued another report on that issue since that time. Senator Luneau commented that was based on the speculation to be $60 to $86 million. Mr. Gooch explained that based on our error rate it was projected to those amounts. Senator Luneau said he guessed all those commercials that said we misspent $85 million on the eligible people weren't accurate. Mr. Gooch explained that based on the evidence in our report that projection was very likely between the $60-$86 million. Senator Luneau asked if we still have not verified to a single dollar of that being for sure have we. Mr. Gooch responded I don't know how you say that we have not verified that.

Chairman Stokes asked about the matter for legislative consideration to move the eligibility function to LDR if there could also be a problem with having health related information over at the LDR. Mr. Gooch answered that there certainly are HIPAA rules that cover those things. But when it comes to the eligibility or the payment for claims, all those kinds of things, there are HIPPA exclusions for that. That is part of the process to make the delivery of healthcare, the payment for healthcare, and the audit of health care work. Chairman Stokes asked if that might create problems with moving it to LDR. Mr. Gooch responded he does not believe there would be an obstacle regarding HIPAA. Chairman Stokes asked if there are any other parts of eligibility that have to do with anything other than just the financial part. Mr. Gooch explained that would certainly be a way to go ahead and utilize an environment that has been developed and they are very experienced in that. When you start looking at their security regulations which LDR shared the regulations in a large binder. There is a lot to do and LDR has already crossed that threshold many years ago, and they are very experienced in the use of it.

Chairman Stokes referred to the ability to use the state tax information and if a hindrance because only the AGI is reported on the state level and we do not have any of the details of what makes up the starting number since it comes straight from the federal tax return. Mr. Gooch said that the state data certainly would not be the first choice. The FTI is the best information that could be used but the state data would be an alternative.

Mr. Purpera said to put it in perspective, the use of tax data is never a determinant. We have never said that you can go back to the 2017 tax return and determine that a person is not eligible in 2019, but we have said it is an indicator. So you use it as an additional tool to know what questions to begin to ask and to look for such as self-employment income or retirement income that would put them over the threshold. I am not sure you would need the detail but just need something to point you in the right direction

Chairman Stokes asked if it matters what makes up your AGI when it comes to Medicaid for their calculations. Mr. Purpera said ultimately it does, but you need to get that information for the current period, not for the old period. So it just directs you to go and question the applicant along those lines. Chairman Stokes said her understanding is that if you made $1 million between January to November and then in December you have no income then would you be eligible for Medicaid in December. Mr. Purpera said you would probably be eligible in January if you expect to make no income in the future, but the department would have to respond.

Chairman Stokes said that is why I have always had a little bit of a hang up about using it. That is fine to use FTI as a benchmark but you can misrepresent because of the way that the federal government, which we have no control over, has deemed that you are eligible. Someone can in fact make $100,000 easily from January to October and then be unemployed for November and receive benefits in September. So that then the AGI, even though it is a useful tool to scan the universe of recipients and pick one to take a deeper look at, still has problems because of the way the federal law is structured.

Mr. Purpera stated that he believes FTI to be extremely useful. LDH could explain to us more because they did some work. You might remember about eight months ago the fraud task force was trying to get information from LDR to assist us in that. LDR and LDH identified roughly 1,600 individuals who had an incomes that were greater than $100,000 and another 8,000 individuals that had incomes greater than $50,000, and the LDH did more work on that and

removed maybe 70% of those individuals from Medicaid. So it would not have been the determinant but it was the thing that gave LDH the information to go and ask more questions and as a result removed a substantial portion of those individuals from the enrollment, which means they did not qualify.

Chairman Stokes said that as a former auditor it is just such a plainly obvious thing that you would think that this sort of cross checking would be done all the time. And you're saying that it is done in 30 of 50 states. Mr. Purpera corrected that around 25 or 27 states use FTI, but it may be just used on a one-on-one verifying process. We are not trying to say it is used in their database, like what we would think would be the better approach. Chairman Stokes said you are advocating running it as a crosscheck in essence between all the files continuously in the background so that it just puts up a red flag. Mr. Purpera agreed.

Representative Bacala asked if the contract for the LaMEDS program contained the requirement of an interactive piece with income tax data. I don't know if I recall reading that contract but curious if the contractor has met that requirement in the programming. Mr. Gooch said that LDH would have to answer that because we have not looked at that specifically. Mr. Purpera said he recalled something in the contract and was discussed at previous meetings as to exactly what that meant and then if I recall right an amendment made later on that would have brought it in to the doing what we are doing now. Representative Bacala said he wanted to ensure that the contractor has met the requirements even if we have it turned off – it is ready to be turned on.

Ms. Mitzi Hochheiser, LDH Deputy Director of Medicaid, said it is in the contract as a requirement for determining eligibility or evaluating eligibility and they did meet that by the vault. The terms of the contract were met by the activity that is going on in the vault. Representative Bacala asked if it is ready if we can get over the security hurdles. Ms. Hochheiser said that is correct.

Representative Bacala said there was a requirement in the 2018 appropriations bill that LDH shall begin using income tax data for eligibility determination. He asked if LDH was in compliance with the requirements of the appropriations bill. Ms. Jen Steele, LDH Medicaid Director, said their report reflects that we began receiving the data in either May or June. The use of the data though did take longer because we did have to meet those physical space and background check requirements. The report was released in September. The physical space requirements were met in October and the data use began at the end of October, I believe.

Representative Bacala asked if LDH is using income tax data today to some degree. Ms. Steele answered yes, we are. Representative Bacala asked for her opinion on the value of that data. Ms. Steele said as of mid-November, we had a number of tasks in the vault that we had identified. We have a threshold that we have looked at that mirrors the report that the auditor did. So we are receiving significant variances at this point, so greater than $50,000 or $100,000 and of those we are reviewing them actively. In many cases we can use existing data sources to verify that the circumstances are no longer what they were in terms of the income reported in that prior period. But there are a number of cases where we have sent requests for information to verify in fact that the income meets current requirements.

Representative Bacala asked if the tax data has been a useful tool. Ms. Steele said yes, again, it has its limits, but it is an indication of where we might need to look further. Representative Bacala noted their conversation concentrates on the income levels but also in regards to marital status it is probably the only source of verification. Ms. Steele explained there are limits to what you can identify with regard to tax filer status and dependence. Now we took a phased approach to the use of the tax data. The most simple and straight forward use was with that household income and that is what we are using today. We have not yet begun use in terms of either the tax filer status or the dependent status.

Representative Bacala asked if she anticipates that being of some value in the future. Ms. Steele responded I can't speculate at this point. Again, there are some limitations to it in terms of what we can access. We can only query based on individuals that we know. We can't draw in all information. I can search for Tony Bacala, but I can't say, tell me everybody else in his house. So there are some limits but we have not tested. Representative Bacala asked if after you have identified me, can you look at any other filers or any other people within my household. Ms. Steele answered that I can validate your self-attested household size. I'm sorry, that is not available in FTI. What we can do in FTI with regard to validating the number of dependents on the application against the number on the tax returns that is not available in

FTI. If a dependent is listed on the application, we cannot check to see if anyone else claimed that individual. We can only seek information on that individual. I have some details that we can go through.

Representative Bacala said he remembered one of the LDR reports showed that there was a variance of the Medicaid recipients who filed income tax return. There was 52% who showed a different number of dependents on their income tax return as compared to their Medicaid application. But we're not going down that path right now. Ms. Steele said not right now. Again, as they stated, we're still trying to size what the workload is going to be. And again, right now we're only looking at significant variances. They have recommended we look at any variance greater than 10%, which is a much larger scope. So again, until we can even see what it takes to handle these large variances, you know, again, part of our feasibility study or the fiscal impact, is to look at what it would be if we were to go at the scale that's been recommended.

Representative Bacala said he normally would have asked ahead of time but did not know he was going to be on this committee till that morning. I would have asked you ahead so we could have been prepared but can you tell me how many people have been removed from the Medicaid role since January 2018 as a result of income. Ms. Steele said she did not bring the wage data results and sorry but was prepared for federal tax data. Representative Bacala asked if at one point it was 127,000 removed from Medicaid and since done some more. Ms. Steele explained there have been disenrollments for a number of reasons, not exclusively due to the wage checks. Again, I'm happy to pull to provide that but did not bring with her today. Representative Bacala said you know I would have asked ahead of time if had known I would be in this position.

Mr. Purpera noted if we are using the tax data on a one-on-one lookup, then it is going to have a lot of limitations. But if LDH could have the entire database of state tax information, then they would be able to search for those dependents to determine whether they are in other households and those sorts of things. So that's why we keep advocating that the department get the use of the full database, not a portal or single type of search.

Chairman Stokes asked what are the reasons other than the security, the space limitations, and the background check limitations, what do you think you would rather see this database that did background checking so that it would send up red flags for people to check to a greater extent or to continue with one-on-one? I'm just curious what would be the best in terms of what the department would prefer. Ms. Steele explained her consideration is how many false positives will they get. So one of the things that we have strived for with the new eligibility system and nationally with what the feds have expected of us is to maximize real time eligibility as much as possible. So if you're in a situation where you are using information that's as dated as tax data is, we don't yet know what is the likelihood of a false positive? What's the likelihood that your income from last year or 18 months ago is reflective of your current situation today? So I think our current real time eligibility dates are something in the 30%. Just on household mismatch alone, the name doesn't exactly match. When we initially looked at that, the numbers were exponential and so again, we have to weigh what is the risk of delaying or denying access to care for a reason that ends up being insubstantial or incorrect or outdated. It depends on the circumstance and so that's I think our biggest consideration. Separate and apart from the manpower, the physical space, the security, those more practical concerns.

Chairman Stokes asked if LDH uses workforce data. Ms. Steele said that is what we're currently using. We use it at application, at renewal, and we use it quarterly. Mr. Purpera commented that he understands the cost and understands the concern of the false positives. As auditors we deal with that every day, and we don't like designing a test that's going to result in tremendous amounts of false positives that we all run for the next six months to achieve nothing. But I'll go back to what the LDH has already done and that is those individuals who had incomes greater than $100,000 in 2017, around 1,672, and those who had incomes greater than $50,000 was 8,800 and some odd, and if I recall right, the department eventually as a result of those tests removed 80% of those over $100,000 and 60% of those over $50,000. I do not think it matters what it costs you to do that. It is a huge savings over paying the PMPMs for all those individuals.

Ms. Steele responded that that is a targeted approach. That's not a blanket approach. And so you are looking at similar to the wage data study that they did. It was looking at those highest-end outliers and you're always going to see high rates of closure among your higher high-end outliers. It's the recommendation that's in the direction of anything about of 10% or greater that gets us much more concerned. And that's the comprehensive view that I think that they've ultimately recommended. And so, you know, again, you have to figure out what the right balance is here. And so we're certainly

not saying that that tax data is not useful. It's just, you know, how far do you go with it? Chairman Stokes said that sounds like a good point where I could probably see y'all being able to reach some consensus on this.

Mr. Purpera said we are certainly able to reach a compromise on it. We just want the department to use the data in the best way that we can all determine is the best way to use it. And I think what was kind of done over the last couple of years with tax data has resulted in significant savings so I do not know why we would not continue to do that in the future. And if we can develop laws and whatever we need to do to make it easier, better then we ought to be doing that.

Mr. Gooch said one of our biggest concerns is getting finally to a point where the tax data, even if we cannot see it, is being used in a routine manner that we can go and audit that process and get to a point where we can remove those scope limitations and go back to being able to give opinions on Medicaid. Chairman Stokes said that sounds like something that everybody ought to be able to work with to make it a bigger exception possibly. If you use 10% it will kick out all a whole lot of variances.

Representative Bacala said just to be clear that the problem with workforce data is it does not include military income, self-employed income, nor does it include investment income and perhaps several other things. So it's not all inclusive. I just wanted to make that point. And also just a compliment and congratulate Ms. Steele on her imminent retirement. This may be her last audit advisory meeting and I am sure she's going to miss it greatly and thanked Ms. Steele.

Representative Stokes highly recommended that LLA and LDH explore the possibility of using a higher threshold from 10% to something, maybe 50%. Something that would enable you guys to be able to work together and get on the same page, remove the limitation and have one big happy Louisiana family. It would be amazing. We can now move on to the next topic.

Mr. Purpera said we have two reports that we are going to discuss together, both of them dealing with behavioral health. Mr. Chris Magee, Data Analytics Manager with the LLA performance audit section, and Mr. Brent McDougall, Senior Data Analyst and the auditor in charge of these two projects, presented both reports.

Mr. Magee said that both reports deal with increasing the accuracy of the Medicaid data to better ensure program integrity within the Medicaid program. These two reports are actually the first two in a series of reports that we are doing on the behavioral health program. We are looking at this program very specifically for a few different reasons. From the beginning of calendar year 2017 through present day, 70% of fraud referrals from the managed care organizations (MCO) are behavioral health providers. So 30% of the referrals are all other provider types.

From a cost perspective, the expenditures on the program have increased from $213 million in to 2012 to $446 million in 2016 and those numbers continue to rise as Medicaid has expanded. There is a significant need for behavioral health services in our state. There has also been legislative interest in this topic and these behavioral health providers. In 2018, Senator Luneau passed the bill that required a national provider identification number for each attending provider and that is going to be the first report that we discuss. In the 2019 legislative session, there was a bill passed that limited the number of hours that an individual person can provide behavioral health services to 12 hours in a day. Historically and still to the present day, there are providers who are allegedly providing hundreds of hours of service in a day, which is a red flag and why the bill was passed.

Mr. Magee explained that LDH’s role shifted from a fee-for-service model to the managed care. They have now shifted to a contract monitor. LDH’s role is now to ensure that the MCOs are overseeing these providers to increase the integrity of this program. However, LDH historically has not looked at managed care. We issued a program integrity report in December 2018 that found that in fiscal year 2018 only 15% of program integrity cases were in managed care, even though over 75% of expenditures are in managed care. So really with all of these factors and the fact that these services are very important and very needed by an increasing number of individuals in our state we have decided to take a focus and look at these services in these providers to help to instill more integrity in the program.

The first project was issued in May 2019 dealing with the identification of behavioral health providers. Senator Luneau’s bill, as I mentioned earlier, passed in the 2018 legislative unanimously by the House and the Senate. It required that each person who is actually rendering services, attending to the Medicaid recipients, needs to be identified

in the data with a national provider identification number (NPI). NPI is basically this is like a social security number for medical professionals that allow you to uniquely identify who is providing these services. Prior to the enactment of this law, historically 88% of the types of behavioral health services affected by this law actually identified a business as the attending person.

Mr. Magee gave the example of "Magee's Behavioral Health Service" was considered the "person" who provided the service. So it was difficult to monitor the program and ensuring that people are not working some of those impossible days - 24 hours or 36 hours. You were really only limited to 12% of the claims in the past prior to this law going into effect. So this new law went into effect January 1, 2019, approximately six months after it was signed by the governor. We tested the first three months of data to ensure or to see whether or not providers in the managed care organizations and LDH were ensuring that this law was being followed. What we found was that 10.5 million of the $26 million in services or about 40% did not comply with state law. These claims and encounters still identified a business as the attending person who was providing the services.

In the meantime, prior to January 1, 2019, LDH did take a few steps to educate providers and the MCOs about this requirement. LDH did amend the contracts with the MCOs to say that this needs to be done. LDH and the MCOs issued guidance to providers saying they needed to comply with this new law. However, we found the most critical component of it was that no edit checks were put in place to ensure that these types of claims did not get through. If that was done, then these dollars would not have been identified. But this audit really is the perfect example of how an audit adds value to an agency and adds value to the state and taxpayers. Because as soon as we identified this issue and communicated it to LDH, they immediately reached out to the MCOs and told them to fix this issue and resubmit these claims and make this issue go away. LLA recommended that they establish edit checks to stop this from occurring. LDH agreed with that. Prior to this meeting we actually ran the data on an informal basis to see whether or not it still existed and in the last month there are no claims that have this issue. So again, this is really the perfect example of an audit working the best way that it can, and improving the state. In summary what this bill really allows for LDH, for the attorney general's Medicaid fraud control unit, or anyone else who is trying to monitor Medicaid dollars, it allows the data to be better so you can properly analyze and monitor these types of providers and programs.

Mr. McDougall presented the second audit, which was issued in September 2019, and is somewhat similar to the first audit because reviewing data to determine if the billing for the encounters and claims is accurate. The basis of the report was to evaluate whether or not LDH had established sufficient edit checks to ensure that behavioral health and providers were properly coding the claims for the services that they were billing as being provided. This is important, as Mr. Magee just testified, that claims data must be accurate because behavioral health providers submit the claims for reimbursement to the MCOs and Magellan who then pay providers based on LDH's specialized behavior behavioral health fee schedule.

LDH and other stakeholders such as the Medicaid fraud control unit rely on this data and depend on it to be accurate in order to use it to identify improper payments and possible potential fraud. This audit report shows that the MCOs, Magellan, and LDH do not have adequate controls in place to ensure that behavioral health services are properly being billed and paid. We identified $47.5 million in claims and encounters for services that were provided between December 2015 and June 2019 that were paid even though the actual billing codes used to bill the services did not comply with LDH's fee schedule. The fee schedule provides the rate of pay for the type of service. But then in addition to that procedure code for the service, there's additional coding called modifier codes – up to four of them – that can be used. These modifier codes identify things such as the recipient's age, the education level of the individual providing the service, the location where the service was provided, if it was provided in a one-on-one basis or in a group setting. So these are all characteristics of the individuals or the recipients that affect the rate that has to be paid for the certain service. So for instance, a service provided in the office is going to be provided at a lower rate than one that's provided in the community. And so that's why ensuring that this information and data is accurate is extremely important because without having this data being accurate, you can't tell what should be being paid based on the data.

Mr. McDougall explained that the report was broken down into three categories for our findings that comprise the $47.5 million. The first is that we had $38.5 million of services that were paid where the wrong procedure and modifier code combinations were used. For more detailed explanation, a little over $30 million of this was paid for procedures that required a modifier code such as the education level of the provider, but had no modifier code at all. Then

$6.8 million of the services that were paid had procedure codes with modifiers that were invalid for that type of procedure code. Then an additional $800,000 was paid for procedure codes that had multiple conflicting modifier codes.

So for instance, the education level modifier would be listed twice. One would show a master's degree and the other one would show a bachelor's degree. Now you could say you want to go with the higher or the lower of the two but at the end of the day you don't know what the proper billing rate should have been. Or there may be an instance where it shows that the services are being provided in the office and in the community. Well, again, you don't know where it is because the data's not accurate and so you can't rely upon it.

The second of the three categories has to do with the fact that providers were paid $9 million more than they would have been paid if they had billed using the fee schedule rate. So, for instance, if the fee schedule rate shows that $100 should be paid for the unit of service that was provided, the provider billed $150, and therefore they were paid an extra $50 for the service. And so that is where the $9 million comes from. It's that additional over the amount that is listed on the fee schedule.

Chairman Stokes asked if that difference was because of a wrong modifier code or should it have cost $100, but the provider put $150 and that's just accepted. Mr. McDougall said based on the procedure code and the modifiers that were billed, the overage is based on what should have been paid compared to what was actually billed.

Mr. McDougall noted that the third category is a much smaller number but important to point out. $7,800 was improperly billed and paid for add-on procedures, which require a primary service to be provided in addition to it. So for instance, it is going to be like a service where they will go in and they are required to have a diagnostic evaluation or prescription management services in addition to the add-on service that they received. However, they didn't receive any primary service and so that add on service should not have been billed without the primary.

In conclusion we recommended that LDH implement edit checks to check for these issues with the data and the billing. However, they disagreed with our recommendation. We would like to point out that we contacted all five MCOs and Magellan who all agreed that they do use LDH’s fee schedule and require the providers to bill at those rates with the exception of individual providers that are contracted with those MCOs, which we did not include in our analysis. We did send examples to two of the MCOs, based on our time constraints we only sent them to two, but both of those MCOs agreed with our examples and took action to correct the examples that we sent them.

Mr. Magee explained that LDH’s disagreement with this report because they claim it is inconsistent with a risk-based managed care model. But again, LDH has shifted from providing services to being a contract monitor. LDH issued guidance to the MCOs and the organizations saying you need to use the specialized behavioral health fee schedule. The MCOs say we use the specialized behavioral health fee schedule. The MCOs are agreeing that the examples that we sent were incorrect and they took action to fix them. In our opinion, it's LDH’s role to ensure that criteria that is supposed to be used is used. So while yes, they may have some validity to the claim that it is not a part of a risk-based managed care model, it is still LDH’s role to ensure that the MCOs follow the rules that are set out and that providers follow those rules.

Chairman Stokes asked if these systems could be modified so that when you put in a code, the billing rate pops up and then as you click for modifiers it adjusts the billing rate so that it would generate the amount that would be charged. Mr. McDougall explained that LDH does actually have these edit checks in place for other types of services. But for these behavioral health services, the edit checks are not currently in place for them. So it's something that we would assume could be implemented just from the sheer fact that they have it for other types of services.

Representative Bacala asked if the MCO contracts reflect the requirement to do these things in the way that the LLA expects it to be done for coding and such. Mr. Magee responded that there are requirements that claims and encounters as they're ultimately submitted to LDH are coded in the correct way and in accordance with guidance. One of those guidance pieces is that LDH stated the specialized behavioral health fee schedule should be used for these types of services and that the MCO stated they do use it.

Representative Bacala said the point is while we do not expect the LDH to be an audit agency, we do expect LDH to enforce the requirements of the contracts that they enter into with vendors. Mr. Magee said just as we took the data and coded it out, you just have to take the data and code it out against the fee schedule and basically state if it doesn't match this then deny it.

Representative Bacala asked if out of the five MCOs were any substantially better or worse or all about the same. Mr. Magee pointed out in Exhibit 1 on page 3 of the May report the NPI analysis showed a significant difference in the performance of the MCOs. Some MCOs had 98% of their claims still including a business as the attending NPI, whereas other MCOs were down as low as 2%. So some MCOs were almost fully compliant with it at the time of the report, whereas others were almost fully noncompliant.

Mr. McDougall stated that in the second report, for the first findings, three of the five MCOs were very high and the other two MCOs were very low. In regards to the second finding, there was one MCO that was significantly higher than the other four MCOs. He pointed out regarding the over billed procedures finding in our second report that MCO contracts do allow for them to pay rates that are in excess of the fee schedule. However, currently LDH is not provided with the providers that are contracted at these excessive rates and therefore they can't check to verify whether or not a provider is billing at the rate they're contracted with the MCOs.

We obtained that information from the MCOs and the providers that were billing at rates that they were contracted to provide at which exceeded LDH's fee schedule. We removed those findings from our analysis. And so the $9 million that's included in our finding does not include the providers that were contracted with the MCOs to bill at rates that exceeded the fee schedule. So they are allowed to do it; however, LDH does not know who is doing it. And so that was one of the things that we took into account and we identified who they were and removed them.

Mr. Magee said that goes back to the contract monitor role. That would be information if you were trying to monitor the performance of the MCOs that would be pertinent information for you to have to properly monitor. Chairman Stokes asked if the five MCOs noted on page 3 of the May report range from having 98% of the claims being by the business instead of the individual all the way to only 2.3% being done that way and the majority of them being per individual person. Mr. Magee said that when he ran the informal analysis today, it appears that all of them have corrected the issue.

Mr. McDougall added that in September of this year there were no claims that we identified that were paid that fell under this criterion. There's about $475,000 worth of paid claims are still outstanding that fall under this criteria. But when we notified LDH of this issue they contacted the MCOs and all claims at that time were supposed to have been voided and then resubmitted using the required criteria. So it looks like the controls have been put in place and as of September they were working properly.

Chairman Stokes asked if edit checks have been put in place for these qualifiers that should be $100 but are billed at $150. Mr. McDougall responded that LDH disagreed with LLA's recommendations that those edit checks be put in place. So one of the rationales behind it and sure they will expound on it is that the MCOs have other methods to try to identify that same information. It is going back to that same point of those MCOs stating that they do follow the fee schedule and LDH has told them and providers you need to follow this fee schedule. So how can LDH properly monitor whether or not a provider bills the right rates, if they are saying that they had both a bachelor's degree and a high school education and they can bill those at two different rates based on their education level. It's very important to know which one of those education levels they have.

Chairman Stokes said she sees some head shaking so LDH does not plan to testify. It really sounds like this is a time when audit procedures in the one instance really works because now that all the providers have corrected the information from being the companies providing the services that really is very helpful. I am kind of curious about these edit checks because that just seems like an easy thing but I don't know why they're not doing that. So I would like to follow up on that with somebody from LDH maybe give me a call or sure come on up.

Ms. Karen Stubbs with LDH Office of Behavioral Health addressed the question regarding edit checks and LDH's disagreement with the finding in September's audit. She said that Chris actually summarized what she was going to say. The actual recommendation is that there be an edit in place to where the fees paid are in strict alignment with the fee

schedule. The reason why we disagreed with that is because there are cases that not only are the MCs allowed to pay above and beyond the fee schedule. The fee schedule is set as a minimum rate. There are cases where we want them to pay above and beyond the fee schedule for things like services in rural communities where it's harder to get those providers we want them to pay above and beyond.

Ms. Stubbs noted also for things like specialized cases, they may have a contract for a certain rate that might be in alignment with the fee schedule, but they get a specific patient that's not their usual. Maybe this one's dually diagnosed or the woman happens to be pregnant at the time. The services that are going to be wrapped around that special individual case are of the nature where the MCO and the provider have negotiated a higher rate. In a case like that, it's not contractually set across the board. So if we have an issue set to deny that it is a legitimate case, again that we actually encourage the MCOs to pay above this fee schedule. Let me say improper payments are improper. Our issue was the way the recommendation was worded, that there be a hard edit to deny anything above and beyond the rate schedule and the auditor's alluded to that as well.

Chairman Stokes said what seems like a reasonable or alternative would be to have a checkbox or modifier that could be something to say that there is an exception placed on this file and that way you could spot the exceptions without testing every attribute, which is I'm sure what these guys have to do. I think of other cases like worker's comp. It's a set number of dollars an hour no matter what exceptions are out there. So I kind of hesitated on that a little bit, but I do think probably audit efficiency and your ability to see where these exceptions had been granted would be enhanced by having the edit checks and just having a checkbox for the modifier of being an exception or rural or dual diagnosis or whatever.

Vice Chairman Walsworth asked if we allow the MCO to do that in other areas besides just behavioral health. Ms. Stubbs explained that the fee schedule is a minimum across the board, outside of behavioral health I would ask Jen if she wanted to make one last appearance up here. But I think generally the fee schedule is a minimum, so they would be allowed to pay be paid above and beyond.

Senator Walsworth asked when the MCOs go over and beyond if LDH reimburses them at that over and beyond. Ms. Stubbs explained that for the risk-based contracts the MCOs are allowed to pay anything above the rate schedule. Senator Walsworth asked if LDH reimburses the MCOs at that higher rate. Ms. Stubbs said that because of the way the capitation model is, we don't reimburse dollar for dollar. They take that out of the pot of money to put it simply that they're given.

Mr. Michael Boutte, Medicaid Deputy Director, explained that LDH pays the MCOs a per-member-per-month, a capitated rate. So they have to work within that rate that we pay them. It's not a cost plus model. Senator Walsworth asked if they have the flexibility to do whatever they want to and if that is across the board or just behavioral health. Mr. Boutte said that is correct. We do have a minimum fee schedule. Some providers do negotiate rates that are higher than the minimum fee schedule and as Karen pointed out, there are special cases where the provider may enter into some arrangement with the MCO on an individual case where it's not an across the board contract for all of the services they provide. But some of those unique difficult cases they can negotiate a special rate for that individual case. Ms. Stubbs added the reason is for difficult cases or certain areas of the state or certain provider types where it's harder to get them on board.

Mr. Magee noted that this discussion that we are having right now is really centered around the second piece of the report which is billed and paid higher than the fee schedule – the $9.8 million finding. The first finding, which is really the majority of the dollars $38.9 million of the $47.5 million are just that it's incorrect combinations of the modifier codes. So this discussion that we are having is certainly legitimate and valid because there are all those special cases but it really applies to about $10 million of the $47 million that we are talking about in the report.

Chairman Stokes said it still seems like there ought to be something where you can't put all the different modifiers that aren't related, they should be grayed out or something. I don't know what the limitations of the system and I've certainly never audited or worked with it, but if there is a way to have some kind of control in place that can be automated.

Ms. Stubbs noted that in the May audit that addressed the NPI and specifically that example that Mr. Magee uses with the masters versus bachelor's degrees, which is really directed at the PSR and CPST services that is addressed now through the NPI requirement. The rendering provider includes that since January, so that will help that specific because there are edits where if they don't have the rendering provider NPI that comes through, it will be denied and that helps identify the correct rate. Chairman Stokes said with as many things as we can automate to not allow to put in different things that don't make sense. Ms. Stubbs agreed with Mr. Magee that it has been successful.

Representative Bacala asked Mr. Boutte about the capitated rates because while the MCOs could pay additional fees this year and it's not going to affect the PMPM this year, it could affect the PMPM next year if a lot of claims are paid at a higher rate. Because every year we are going to calculate the MCOs experience.

Mr. Boutte answered that what they pay is one component of how the rates are billed out. It's not solely based on what they pay out. So we do work with our actuaries to identify efficiencies. That way if they did pay out a substantial amount but we think they should be paying less, that could be reflected in the rate. So it's not necessarily exactly what they pay out always turns into an increase later on. Representative Bacala said but it could be a component and the PMPM could go up next year if they were paying substantially more on a substantial number of claims this year. Mr. Boutte said that is a possibility.

Vice Chairman Walsworth said let's be honest, the MCOs are not going to keep going down that same road unless they are getting reimbursed. We know that if they're doing something that we want them to do and we either have to increase the fees or we are going to catch it on the next end, otherwise they are going to quit doing it. If we want them to continue to do what we want to do, then we've got to reimburse them at a better rate. I would hope that we agree to that.

Chairman Stokes told the auditors and LDH that she appreciates their hard work. We love to see it when on both sides are working together to make good changes to make the state more efficient in all of its business.

Senator Walsworth said that Jen Steele has been a real asset to our state and to LDH and wanted to thank her for tremendous hard work and she had probably one of the most difficult jobs there is in this state. We do appreciate and hope that the future is great for her. Chairman Stokes said she echoed that appreciation and commented on the excessive amount of patience Jen had while in charge of a very tumultuous job.

Department of Public Safety and Corrections – Corrections Services – Issued October 23, 2019

Mr. Barrett Hunter, Assistant Director of Financial Audit Services, and Ms. Dawn Moeller, Audit Manager, presented the findings and recommendations made to the Department of Public Safety & Correction (DPS&C). Mr. Hunter referred to page 4 of the report that outlined what the auditors found after reviewing the headquarters, some of the facility prisons, and prison enterprises. So for the most part they had controls in place, but we did find three areas with weaknesses that needed improvement. Those three areas are the inmate sentence computations, inventory, and payroll. The weaknesses we found with the inmate sentence computation were also addressed in a performance audit issued in October 2017.

Since October 2017 the department has put in guidelines, training manuals to help their employees calculate these and that's what we used to do our test. So we tested 40 of these computations using that guideline. We were looking to see if the information in CAJUN was correct and we were tying stuff back to support and we were trying to determine if the release dates were correct. We found five errors total with three having inaccurate release dates and two errors with eligibility being inaccurate. On the release dates it dealt with good time credits and forfeitures not being applied correctly in CAJUN. And all three of the inmates had earlier release dates then should have been in CAJUN. So the department corrected these. No inmates were released early. These were dates well into the future. The other two dealt with parole eligibility. One of them was flagged as eligible when they should not have been and one of them was not flagged as eligible when they were.

Mr. Hunter said one of the biggest concerns we had was with the review. We found that the department had no formal process that required a review by a second level. In our test, we found about 50% of the 40 we looked at did not have evidence of a review. So due to the complexity of these computations and their importance we recommended that they

put in a process for a second level review and that review be evidenced. Management agreed with our finding and they implemented some corrective procedures to make sure that all initial computations and changes in computations would have a review.

The second area that we found issue was with inventory. We looked at pharmaceutical inventory at Elaine Hunt and we looked at canteen and fuel inventory at three of the facilities: Allen Correctional, Raymond Laborde, and David Wade. We found no issues with the canteen. They had controls in place and we were able to reconcile back the counts to inventory records. However, we did have issues with pharmaceutical and the fuel. So for the pharmaceutical we found in our test about 60% of the ones that we looked at could not be tied back to the records. Some of the reasons for this is the department participates in a program where they receive donated medications from nursing homes. These donated medications received are not tracked in inventory. They also do not take a physical inventory of those donated drugs. So you don't know how much should be on hand. Another issue is when they disperse medications – whether it's a purchased medication or a donated medication – they all run through the system into disbursement. So what ends up happening is your disbursements have numbers in there that's taking away from the purchased drugs. So we could not reconcile the purchased drugs either. So that caused our high exception rates. The report outlines their quarterly inventory reports. We had issues with them on not updating the accurate counts on some of those. These reports are used to update the system, so that is important that when they count their physical inventory, to update the system.

The department also had weaknesses with the stock order forms. They could have improvement on their descriptions. It was hard to tell on some of them what was being issued and they were not pre-numbered so could not tell if any were missing. At the three facilities we looked at all their fuel tanks. From the total of eight tanks, we determined that five of the tanks were short. A couple of those tanks were as much as over 200 and 300 gallons short. There was a sixth tank that we could not determine if it was short or not because they were not keeping logs and records for that tank.

So we recommended that they develop a tracking system for the donated and returned drugs; that they develop a process to reconcile between the records and their physical counts; update their forms; and also repair any of the meters on the fuel tanks that is not providing accurate readings. So again management agreed with our findings and is implementing several things to improve their inventory processes. They did indicate in their response that they may be discontinuing the program with the nursing home for the donated medications due to the staffing issues. They say they just do not have the staff to be able to do that. We do want to say that we would rather see them implement some kind of tracking system than take a program away that is saving the state money.

The final issue dealt with payroll. We looked at payroll for 42 employees looking at their time and attendance and leave records. This was done for the headquarters, three prison facilities, and Prison Enterprise. We found no issues with the prison facilities and Prison Enterprise, but we did notice when we were doing that test that there was some issues with the electronic certifications at headquarters. So we expanded our test and looked at 4,000 time sheets over a nine-month period. Of those 4,000, we found over 200 that were not certified by the employee prior to the payroll being disbursed. And then over 550 were not being approved by the supervisor electronically before being disbursed. The department does have policies in place that require approvals ahead of time. They also have monitoring reports that would identify when these certifications are not done. However, we still had this many errors. So we recommend that they enforce their policies and they use these monitoring reports as a control to identify those and make sure they get certified ahead of time. Department management agreed and is implementing corrective action. They are going to improve on the notifications that go out to timekeepers and supervisors by certain dates. We would like to thank the committee for allowing us to present the report and we are available to answer any questions.

Chairman Stokes asked how much were these release dates were off by, and is that a thing that undergoes further review before somebody is released. Mr. Thomas Bickham, Undersecretary for the Department of Corrections, pointed out that every time computations get reviewed prior to release even though it may not be done initially, it is done on the backside. He also gave the committee an update on some additional things that the department has done since the end of this audit. The audit finding was that we should have a second level of review for these time computations. Now understand we do 60,000 of these a year. For example, if somebody goes to a class, they get credit, and we have to go in and adjust time. Or if somebody commits a violation, they lose good time or they appeal to get it back. So every time something like that happens, we have to go in and open this file and recalculate. We have designed and pending civil service commission approval, it's called an ARDC4. It is the highest level position with the sole responsibility or major

responsibility is going to be auditing these time comps. That is their job to do that. I think that would answer the recommendation of ensuring that these time computations have a secondary level of review.

Vice Chairman Walsworth said to be honest, I think this is better than I expected and overall a pretty good report. He asked how many different people have access and can make adjustments to the time.

Mr. Bickham answered as far as the actual worker bees doing the time computations we have 67 positions throughout the department. Now, understand we have a population of 32,000. We do it for our state institutions, and we do it for all the ones at the local level that are under our jurisdiction that are DOC offenders. So we basically have 67 people that actually do the time computations and 12 supervisors. So to ask them to review all 60,000 computations while they're also still doing their supervisory responsibilities, it is a big request, which is why we're creating this fourth level position whose responsibility is to check these time computations.

Senator Walsworth asked what other states do. Mr. Bickham responded that other states do not have near the sentencing guidelines and are so much more simplified. If you remember, Senator, we tried to go to a different classification system back when we were doing a criminal justice reform to make things a little bit easier. I do not think any other state has the laws like we do as far as time computation. It is not as prescriptive as say Texas or Mississippi or Alabama. There are a lot of criteria that goes into determining time computation for us.

Senator Walsworth commented that credits are given for this or that or whatever it may be, and what we expect for Louisiana. Mr. Bickham said it has been tried to be revived again as far as coming up with the felony class system. That would be a big help to us. Senator Walsworth said there is a new legislature coming in so good luck. Chairman Stokes said we appreciate everybody's hard work and our ability to make operations more efficient and effective and work together.

Fiscally Distressed Municipalities in Louisiana

Mr. Bradley Cryer, Director of Local Government Services, said that LLA posted a list on our website last week of fiscally distressed municipalities in Louisiana and we have been getting a lot of phone calls. The list itself is not really a new list. It's one that we've provided to other departments, the bond commission, and other entities in the past upon request. But we decided to go ahead and post this out there for the general public, and it is a list of those communities that we feel have the highest risk of not being able to provide basic services to their residents in the near future. The ones that are not on the list are the ones that are already under fiscal administration: Jeanerette, St. Joseph, Bogalusa, Sterlington, Clarence, and Clayton.

However for the last year we have been getting a rash of municipalities that are having financial problems. Rather than trying to deal with those one-on-one, we wanted to put it out there for the general public to understand what communities are being impacted and which ones have the highest risk. We can reach out to those municipalities and try to provide assistance to them and provide counseling to try to get them turned around on the right path. As part of what we included on this list, we did look at factors such as disclaimers of opinion, which means the auditor could not give an audit opinion on a particular town's financial audit; going concern, which means the auditor felt the town had the potential to not continue operating; negative fund balance, which means they have more liabilities than assets. Also the governor's rural water infrastructure committee issued a list last year, which included six municipalities that have the most precarious water systems in the state. Those are included on this list of fiscally distressed municipalities as well. We also looked at financial data and looked at trends within our own financial information. Now certainly because the financial reports we get come in at least six months after the fiscal year-end cut off, so that information is sometimes dated. So between the different types of opinions we had, the other facts identifying back to the external auditors and our own internal information, we compiled 18 municipalities that we feel have a high risk of financial problems in the future. Certainly we're trying to work with some of these, in fact, most of the ones on the list we've either reached out to in the last few months, some of which we've been working with for a number of years.

Both Baldwin and Epps are on the list and have come before the Council in the last year because of three strikes enforcement as well. So some of these names are not new names and we continue to try to work with to get them turned in the right direction. Our goal really is to try to keep them out of fiscal administration and to make sure they can

continue to pay their bills. I get asked a lot of times from reporters and why are we seeing this large influx of towns reaching this critical point and the reality is it's kind of reached a tipping point in Louisiana. We are seeing a lot more because of declining populations, either aging or underfunded water systems and sewer systems, and then a lot of times just poor financial decisions by town officials that either don't understand the consequence or some of the consequences that deal with utilities. So choosing not to fund your utility system at the full amount today may impact that system 20 years down the road under different administrations. Now we certainly do not advocate using utility revenues to support general town operations, but that's also a common factor that we see across these municipalities as well.

Mr. Cryer said he has received questions about the fiscal distress list as compared to our noncompliance list. Noncompliance just means the agency has not turned in the report within six months and they don't have a current extension with us. So that list drives the suspension of state funding. This list is just a watch list and it's a way for the residents to understand exactly what their towns are facing. And it gives elected officials the ability to start looking a little harder. We often find situations when I talk with council members that they do not understand what the mayor's doing, and the mayor doesn't understand that the council members are doing, and there's a disconnect.

We are trying to get people to talk about this, trying to get the information out there for residents to ask their elected officials what's going on and what should they be concerned about and ask what is happening with their rates and being done with their taxes. So the citizens can ask those hard questions that often don't get asked. Mr. Cryer offered to answer any questions about individual municipalities.

Chairman Stokes asked about the Town of Jonesboro, if they came to the Council, and if they have a new mayor. Mr. Cryer said that the new mayor was a former mayor from several administrations ago. He did serve some jail time and he has been reelected. But the reason they are on the list is because they had disclaimers in 2017 and 2018 before he took office this last time. So these are from the previous administration that created these problems. And I think the last report we had from Jonesboro was 2017, and they had over 20 findings in that report.

Chairman Stokes recalled when she first became a legislator that she worked on a bill because of this particular mayor and the town having a disclaimer of opinion many times in a row, and I see it is a disclaimer again. So the new mayor is the old mayor back from 2013? Mr. Purpera said that Jonesboro went through fiscal administration as you recall for several years and was revitalized and their accounting infrastructure was rebuilt and then they went to a new mayor and the fiscal administrator was removed. But it has basically went back to where it was, many problems as Mr. Cryer said, with over 20 findings in the 2017 report. That is unfortunate but that is what happened. Chairman Stokes asked how long the new mayor was in office. Mr. Purpera responded one term.

Mr. Purpera commented that the problems facing small downs have been discussed in several Council meetings. Some of the problems that that lead to the situation include depopulation. For example, a municipality that has gone from 2000 individuals to around 800 and if they don't change their size of government and the services offered, they are not going to be able to afford to continue business, water and sewer departments. We have 850 water systems in the state of Louisiana. And some of them are now of the size where there is no economy of scale. So we really need to be looking at a couple of different things going forward. How do we bring some of these water and sewer systems together so that there is economy of scale? Then what do you do with an entity that's just too small to survive now and yet our current law requires the population there to vote and decide to dissolve. And then there's a problem with the debt. What do you do with the debt? How do you dissolve an entity that has debt? Who's going to take the debt? Well, the answer is that nobody is going to take the debt. There are just a lot of issues here.

Mr. Purpera said that the focus of my office these last several years has been trying to educate through our Center for Local Government Excellence (CLGE) which we conduct seminars free to those who attend. We not only try to educate that way, but our local government section within the office is continuously assisting and monitoring. We also brought the struggling agencies to this Council to try to get them out of their situation. Fiscal administration is absolutely the last ditch effort to try to repair them but sometimes it's necessary.

Chairman Stokes said it begs to my mind the problems that we face as a state in that hopefully this brand new legislature will be brave and take on some of the issues that we have and make positive change.

Vice Chairman Walsworth commented that as he is leaving out of here, it is by far, one of the biggest jobs that we've got is the depopulation of some areas. And then you have the political reality that we have mayors come in and raised the rates of water to make them solvent. And then in the next election, the opponent comes in and says "I'm going to lower your rates. The other person raised your rates and I'm going to lower them". The opponent winds up getting elected, and they go right back into the hole. We cannot be the nanny state with your state government looking over your shoulder every time you get there. But we have to figure out how to make this whole thing work in a better way than it has been. I think we're getting worse because the depopulation of these cities and town where some of them had 2,000-3,000 population and now they have gone into almost village types with the same infrastructure that they had 20 years ago.

Mr. Purpera agreed and these smaller municipalities are still trying to provide police protection rather than letting the sheriff take care of it. So there are some things you can do such as convert back to a sheriff. What the citizens can't put up with is bad water and sewer systems. So we need to protect those water and sewer systems the best we can currently. As Mr. Cryer alluded to a moment ago is currently what you find in some of these entities is they are producing a profit in their water and sewer operations but they're taking that money out of there and using it to operate the town, which is somewhat an illegal tax.

As we discussed at the last meeting, we need to look at legislation this next year that would require the water and sewer systems to operate alone, separate and apart, and any excess money that should be collected is reserved for fixing the infrastructure and keeping it up-to-date. You might remember the Town of St. Joseph had a new water system put in. Twelve years later it became completely unusable. The state had to jump in with $9 million to correct the system. That's the kind of thing that we cannot allow to happen in the future.

Senator Walsworth said we are always bailing people out in case something does happen and at the end of the day we're just not going to have the funds to be able to bail everybody out. This is a pretty extensive list here and I think that list is going to grow instead unless something is done. I think there are other states out there that we could model after and see how they do that. In a lot of cases, the parishes cannot take over the responsibility. In Sterling, the voters allowed the mayor to do what he did and to have this $20 million in debt, but the parish did not vote for that infrastructure that wound up being a very nice baseball field facility.

Senator Walsworth asked how do you force someone who did not vote on that to take that responsibility and the tax on what maybe 1,500 people did. So I think we have some areas that we have to figure out how to do a better job of that. I think in the long run we are going to ask the bond commission to look a little bit stronger at the right thing to do before they come over and we allow them to do that. The next thing you know we are looking at some real issues. So I think that is going to be some reform in local government that we're going to probably need to look at it and in parish government. Mr. Purpera referred to the investigative report on the Town of Sterlington. The bond commission did look at that issue but the bond commission was given incorrect information.

Chairman Stokes thanked everyone for attending and the committee members. She said there will be one more meeting before the year end.

Other Business

No other business was discussed.

Adjournment

Senator Walsworth offered the motion to adjourn and with no objection, the meeting adjourned at 11:25 a.m.

Approved by LAAC on: December 12, 2019

The video recording of this meeting is available in House Broadcast Archives:
http://house.louisiana.gov/H_Video/VideoArchivePlayer.aspx?v=house/2019/nov/1121_19_AuditAdvisory