LEGISLATIVE AUDIT ADVISORY COUNCIL

Minutes of Meeting
August 17, 2020
House Committee Room 1
State Capitol Building

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

Representative Barry Ivey called the Legislative Audit Advisory Council (Council) meeting to order at 10:10 a.m. Ms. Liz Martin called the roll confirming quorum was present.

Members Present: Representative Barry Ivey Chairman
Senator Jay Luneau, Vice Chairman
Senator Louie Bernard
Senator Jimmy Harris
Senator Fred Mills
Senator Beth Mizell
Representative Edmond Jordan
Representative Barbara Freiberg as proxy for Representative Aimee A. Freeman
Representative Stephanie Hilferty
Representative Rodney Schamerhorn

A**lso Present:** Daryl G. Purpera, CPA, CFE, Louisiana Legislative Auditor (LLA)

Approval of Minutes

Senator Luneau offered the motion to approve the minutes of the June 18, 2020 meeting and with no opposition, the motion was approved.

Extension Requests

Mr. Bradley Cryer, Director of Local Government Services, pointed out that in a typical year, our office receives about 4,000 reports and we would normally have about 50 or 60 extension requests during the course of that year. The listings provided today include about 700 extension requests, most of which are COVID-19 related. These fall under the governor's executive order for the Coronavirus emergency declaration.

We have granted those extensions and our protocol is that LLA can approve any extensions that are 90 days or less, and that we come to the Council for any extensions greater than 90 days. If those extension requests that are greater than 90 days fall between meetings, then must receive temporary approval from Chairman Ivey until we bring before the Council. Today is really out of the ordinary. We have never had this many extensions at one time even after Hurricane Katrina. I will briefly go over the lists but can provide more details if questions. In the end we are asking the Council to confirm our "90 day or less approvals" and to officially approve those that are "greater than 90 days".

Mr. Cryer proceeded to the first list "COVID-19 Extensions – Less than 90 Day Extensions Relating to Pre-June 30, 2020 Due Date" that have all been approved by LLA. Several hundred agencies have a due date of March 31st and some others that fall between June and March but all of these were happening right after the lockdown. We have approved all the extensions for these agencies up to 90 days through June 30th and only a handful has not yet turned their reports in. We reached back out to those agencies to ask whether they needed further extension or simply continue until they finish those reports. The impact is that if the reports do not come

in on time and no extension is in place, those agencies will have their state funding cut off including federal pass through dollars. The extensions are certainly important for most agencies. However for school boards and certain agencies, even in situations where there is a pattern of problems getting the reports in on time, we still always look at public health, safety, or welfare when making those decisions on the extensions.

The next list "COVID-19 Extensions – Less than 90 Day Extensions Relating to June 30, 2020 Due Date" is over 500 extension requests. Typically we get about 1,200 reports in for fiscal year end December 30th. So roughly half of the reports are late at this point. The last column shows the reports that have been received as of August 7th. These have been granted through September 30th and we expect to see the same type of pattern that we did for the March 31st where most are submitted by the due date. We may have to come back to this Council at some point after September to address any other late reports from that point forward.

The third list "Pre-COVID-19 – Less than 90 Day Extensions" are some very old extensions that go back to January and February since we have not presented extension requests since the Council meeting in December 2019. All these extensions have been approved and exemplify what to expect for extension requests at future meetings. We will show the agency name and the reason for the extension. We also bring a large stack of the extensions themselves so if members have questions about particular agencies we can discuss that in detail. However all these reports have been received so no need to go into any detail on this particular list.

Mr. Cryer continued to the fourth and final list "Greater than 90 Day Extensions" which required the Council's approval. He provided further details on the various categories. There were 12 agencies that were originally granted as non-emergency extensions less than 90 days in December, January and February of last year. Because of COVID, they were further extended beyond that point for a 90 day period.

The Town of Washington was granted a non-emergency extension, not greater than 90 days. Our office was heavily involved with looking at the town's financial situation and budget. We worked with the previous mayor and mayor pro tem. And when the mayor resigned the governor appointed an interim mayor, who's still serving at this point. So that was a very unusual situation, one that we would normally bring to the Council.

We have two non-COVID emergency extensions less than 90 days. These school boards had cyberattacks last year. There was a governor's declaration of disaster for four or five school boards. There are five agencies that were originally granted as COVID emergency extensions that have asked for additional time. He briefly explained the reasons for extension requests for the remaining entities as shown on the list. Mr. Cryer asked for the Council's confirmation of approvals for extensions less than 90 days and to approve those extensions greater than 90 days.

Senator Bernard asked about the recovery and mediation for the school boards that were cyberattacked. Mr. Cryer responded that it depends on their backups. We have best practices on disaster recovery but it comes down to a cost benefit. If you have an agency that can bring their systems back up within a week and restore that data in a week, certainly going to cost a lot more than those that were down for three or four months. Each school board to my knowledge is dealing with their situation individually. The governor's office during the disaster offered GOHSEP's assistance and from other agencies regarding their controls. My understanding is the Department of Education has worked with the governor's office to try to get some guidance out to all the school boards so they have more consistency with the backups and that recovery process.

Senator Luneau asked for more background on the Town of Washington's situation. Mr. Cryer explained the problems and issues within the town and why the governor had to appoint a mayor due to the council not approving the mayor pro tem after the mayor resigned. The appointed mayor Dwight Landreneau is a former secretary of the Department of Wildlife and Fishery. The LLA began working with Mayor Landreneau early December 2019 and the town is now stabilized financially. The mayor and auditor worked with our office for a

plan of action to do a two year audit report to catch them up and save money for the town. It still includes both years of information. They town is moving in the right direction. When a new mayor is elected in the fall we will be glad to work that person.

Mr. Cryer explained that the Council would need to confirm the extensions on the first three lists and approve the greater than 90 day extensions on the final list. Senator Luneau made the motion to confirm all the less than 90 day extensions and with no objections, the motion was approved. Senator Bernard made the motion to approve all the greater than 90 day extensions and with no objections, the motion was approved.

COVID-19 Data Discrepancies Between the Louisiana Department of Health and Red River/DeSoto Parishes – Data Analytics/Medicaid Audit Issued August 6, 2020

LLA Senior Data Analyst Brent McDougall and Data Analytics Manager Chris Magee presented a summary of this audit. Mr. McDougall explained that the LLA received a legislative request following some Facebook posts from Red River Parish and DeSoto Parish claiming that they believed that the Louisiana Department of Health (LDH) was over-reporting positive case results in each of their parishes. We reviewed the numbers that they believe were over reported. Red River Parish claimed that 38 cases were over reported and DeSoto parish claimed that 105 cases were over reported, which was essentially 39% for Red River and 21% for DeSoto. In the process of doing this audit, we conducted multiple meetings with all parties involved and also state police.

Mr. McDougall said the data moved from LDH to local parishes, after LDH would receive it from the testing labs. They would then provide it on a daily basis to state police, state police would then provide it to go setup and to the Louisiana Sheriff's Association, which would then distribute it to the local parishes. That is the process for how the data was distributed until July 23rd when it changed. We also found that this data for the most part was generally accurate in terms of what was reported on the state website versus what was going out to the parishes. The data that was going out to the parish was being provided as soon as it was possible to provide it to them but not necessarily reviewed for complete accuracy or duplication before it was published on the website.

Mr. Magee stated that the data did really have a long and winding road to finally get out to the parishes. We looked into why is there the discrepancy and which numbers were correct. We found four main reasons as to why there was a discrepancy. The first and main issue was the first responder reports, which were really intended for first responders to know who has COVID-19 positive in that parish and never intended to be a check of LDH numbers on a daily basis. For example, it did not matter if Chris Magee who lived in Red River Parish was listed on the report eight times they just needed to know that he had COVID.

The second issue was that the initial reports that were being sent to these parishes did have incomplete and duplicated information. But again, the duplicated information didn't really matter as much because you really just needed to know who has COVID in the parish. More importantly the labs did not always include all identifying information including the parish where the person lives with the test information sent to LDH.

LDH was sending a comprehensive list to state police on a daily basis and there were usually people who were not assigned to a parish as of that day. So state police was taking these cases and assigning them to one of 64 parish tabs to assist the parishes in knowing who was positive in their parish. The issue is there was a 65th tab, which was a “no parish info” tab that people were also being put under. However, a few days later through LDH’s data integrity processes, they would find the address associated with the person and assign to the correct parish. So for example that case was updated to be associated with Red River Parish and would then be sent to state police. However, because that case was already assigned to the “no parish info” tab, it was not being updated because they were trying to identify just the new cases. So the old case just had additional information

and was not moved into the Red River tab. Therefore Red River or DeSoto Parish did not know this case belonged under their parish.

The last two issues that led to this discrepancy really fit into two different timeframes. The first was from April 6th to June 17th. LDH was sending these comprehensive lists on a daily basis. If there were 20,000 cases on June 1st, and there were 2000 new cases. The next day, the list that they would send out would have 22,000 cases. So each day it was the newest, comprehensive list with the most updated information. But as just described state police, whenever those changes were made to a person being assigned to a parish or moved from one parish to another based on updated information that was not making it to the parishes themselves. On June 18th, LDH did not report this information to state police. They increased their manual deduplication process and removed 1,666 duplicates on that day. There is an automated removal process of duplicates, which if all the data across all elements matches, you can easily remove those, but what's harder to do and really requires a manual review process is where every data element is the same but the spelling is slightly difference. For example, spelling differences such as Magee or McGee can cause confusion. Humans have to go through and look at that or else the computer will remove too many false duplicates. So LDH went through and did the manual review process that day. Then starting on June 19th, they began only reporting new cases within the last 30 days on the report that was going to state police. However, the updates for older cases were not being communicated to the state police and the state police was only sending those new cases out to the parishes.

So from that time period the parishes still were not receiving all the cases that existed out there. What we really found in the end was that when comparing LDH's numbers reported on the COVID-19 dashboard to the numbers that the parishes were attesting to that generally speaking LDH's numbers were correct. We have received other legislative requests and complaints and requests from the public to further look into the dashboard. There is also a national effort to try to look into COVID data and how data is being reported differently across all the states. We are going to perform a full audit of the dashboard to try to look at tests, cases, deaths, and all of the information that's out there. But for the purpose of this report, we found that LDH's numbers were generally accurate.

Chairman Ivey asked for the primary purpose of the first responder report. Mr. McDougall responded that the sole purpose was to get the information out to the first responders of possible positive cases as soon as possible and it was primarily due to the lack of available personal protection equipment (PPE). And so essentially they wanted to know going forward if it was going to be necessary to prepare for contact with a positive case versus going out to an address where they would not have it just because there was a limited supply of the PPE.

Chairman Ivey questioned the right to privacy because of the transmittal of medical data from LDH to first responders. He asked what federal privacy laws come into play on this. Mr. Magee answered that it involves HIPAA and LDH can expound further but there was an exception granted in this case because it was needed for a health purpose. It was transmitted in the past under a HIPAA exclusion or exception due to the issues that arose with the reporting of the information. LDH has recently entered into specific data sharing agreements with the parishes that specifically outlines how this data is supposed to be used and how after a certain time period, the data should be expunged from the records, because the idea is you really just need to know who is currently positive for COVID in your parish

Chairman Ivey asked if based on LLA's research would they say that DeSoto Parish and Red River Parish, or whoever's responsible for that use of the data for purposes that do not fall into the permissive uses under HIPAA (Health Insurance Portability and Accountability Act). Mr. Magee deferred to LDH for that specific answer. I do know that it was not being shared for the purpose of checking LDH's numbers. It was really just for first responders to know who had COVID in their parish, so they can ration the PPE especially at the beginning of the pandemic.

Senator Luneau asked how did they not violate HIPAA laws since it is clear that they violated HIPAA. Mr. Magee deferred to LDH's lawyers but the data was not being used for the intended purpose of sharing. Senator Luneau said it appears that both Red River and DeSoto Parishes came up with their own calculations on these numbers based on incorrect information that they were gleaning from accurate reports. So the reports were not inaccurate, just the way they interpreted them was the problem. Mr. Magee explained that the data maneuvered through a long and winding road to finally get to them which caused them to not have a complete picture of what actually existed and allowed them to not check LDH's numbers correctly.

Senator Luneau felt the bigger concern was why they went to social media instead of calling and asking why the numbers did not look right. I wonder why the parishes did not try to find out what information was being supplied or did they explain about that. Mr. Magee responded that he could not speak specifically as to why they didn't do it. But what I can say is that communication could have helped to have prevented this issue from arising in the first place. But I do believe that the officials are here to speak to that.

Senator Luneau said one question is whether there were protocols or some policy and procedures especially for the parish office of homeland security. They should have at least reached out and questioned this potential problem before they spread it out there on social media. Mr. Magee shared from discussions with state police they did get questions sometimes about the numbers and why they were not matching. State police would instruct them to go look at the "no parish" info tab and sometimes they would find the individual there. State police can speak to how many instances they instructed parishes to look at the "no parish" info tab to potentially find additional individuals in their parish.

Senator Luneau said in a normal audit the agency is asked to respond, did LLA ask the parishes if they agreed or disagreed with this audit or was this not a normal audit. Mr. Magee explained that this was not technically an audit but a letter so they did not officially respond. We did, however, work with them through various meetings to try to understand this process. And then also once we had the results we worked with LDH and state police, because it was their process, to make sure the language was correct and that we understood it and made some edits based on those conversations. Senator Luneau asked if Red River or DeSoto Parish go back on social media and acknowledge they made a mistake. Mr. Magee said he was not aware of them doing it and we did not request them to do that.

Senator Bernard commented that he spoke with some officials and no one purposefully made this as controversial as it has turned out to be. He asked if the auditors had subsequent conversations with the officials and if they agreed and understood why these discrepancies occurred and were they satisfied with the results. Mr. Magee confirmed there was a call with DeSoto Parish and Red River Parish officials to discuss what was found in the reason for the discrepancy. They stated that they understood what we were saying and that did make sense as to why the numbers would not agree if that was what was happening.

Senator Bernard said when looking at the tsunami of statistics that came in since records started being kept on COVID-19, it is really predictable. I am surprised we have not had more situations where people disagreed with the numbers and nobody likes their numbers to be higher than they actually were. As far as I know there is some degree of satisfaction with the way everything has turned out.

Representative Schamerhorn asked if LDH is really trying to remove all duplications on their dashboard so not counted twice. Mr. Magee answered that there were really two main processes – automatic and manual - and there may be more that LDH can describe. The automatic process removes the obvious duplicates. Manual editing includes checking for misspellings or minor errors in date of birth to try to figure out if the same person or not. The task is arduous and difficult because of the number of cases that exist in Louisiana, and delays in receiving test results or additional data.

Representative Schamerhorn noted that Red River Parish with an 8,400 population and there was a 39% discrepancy. He asked if disposing of the positive cases every 90 days is a good idea. Mr. McDougall clarified that it is only for the first responder report and I believe it's every 30 days because in LDH's opinion after 30 days the individuals are no longer contagious.

Ms. Theresa Sokol, LDH Interim State Epidemiologist, and Mr. Lee Mendoza, LDH Director of the Bureau of Health Informatics in the Office of Public Health (OPH), presented an overview of the testing and reporting process. Ms. Sokol said their office uses CDC (Centers for Disease Control and Prevention) and CSTE (Council of State and Territorial Epidemiologists), an organization of state health departments, for case definitions and for case counting purposes. These case definitions are a uniform set of criteria for defining public health conditions and using these case definitions for case purposes allows us to sort of consistently and systematically count cases across Louisiana and across the United States, so that everybody's counting these cases in the same way. So if you're looking at the LDH COVID-19 dashboard, the case count number that you're going to see in the top left hand corner is a cumulative case count starting back of cases that have been reported starting back from the beginning of the pandemic.

Ms. Sokol explained these cases are individuals who have tested positive for a confirmatory laboratory test. A confirmatory laboratory test is a PCR test basically. A PCR test is going to detect SARS CoV-2 nucleic acid. It's a viral test or diagnostic test that tells if someone has a current or an active infection. Now this is different from an antibody test, which is going to check someone's blood and it's going to detect antibodies to SAR CoV-2. It will tell us if someone has a previous infection or a previous exposure. And let me just let everybody know that these antibody tests are not included in LDH's case counts at all. So the case counts that we have are cumulative results for individuals who have tested positive. These are not all of the positive test results that have been received by LDH.

We have a process for both automated and manual deduplication of these test results, because we know that individuals are tested multiple times. We have individuals that we have multiple positive test results for and multiple negative test results for, but in our case count, each individual is only counted one time for a single positive test. We do not count them multiple times even if they have multiple tests. That is where this deduplication process becomes very important. Now I would just like to mention that even despite all of the effort that we put into it, we know that the number of cases in our case count is actually lower than the actual number of cases that are occurring in the community.

The reason for that is because there are a lot of individuals that don't get tested. People who have mild flu or cold like symptoms may think they have COVID and just think that there's no point in seeking medical attention, or they might think it might be some other type of infection and they never get tested. In addition to that, we also know that between 20% and 40% of all COVID infections are completely asymptomatic. And so most of the time, these individuals are not going to seek testing because they have no indication that they have been infected. So I think it's important to just keep in mind when we're thinking about these duplicates and all of the work that goes into it. We really know that what we have in our case counts is actually an underestimate of the actual infections that are in the community.

Mr. Mendoza thanked the committee for moving them up in the agenda and relieving some stress in an hour when they calculate the updated case counts for the LDH dashboard. We receive COVID-19 tests from IDFE every day, if you look at the dashboard we have about what 1.6 million tests that have been performed. And so we go through these tests every day, as Chris Magee said, we have a simple, automated process that will check to see if all the data elements are the same. And we're looking specifically at first name, last name and date of birth. And if anything is identical, we'll throw that out. We'll identify that as a duplicate right away, keep in mind. As soon as we find a positive test, it doesn't matter if a person has tested positive 10 times, 50 times or one time that person is counted as a case one time and you can actually see this in our downloadable data. So

we recently made a data set downloadable, where you can see for each parish and sometimes with the census track, how many positive tests there are as well as how many cases there are. And you can see that the number of positive tests is higher than the number of cases in the vast majority of instances, depending on how many tests have been conducted. So it's obvious the data are there. You can see for yourself that there are many more positive tests than there are cases. Apart from that automated process, we have a manual process as Chris Magee alluded to. There are times when we receive tests where two characters in a name will be transposed or two characters in a date of birth will be transposed. The automated process wouldn't pick that up. It would say these are two different individuals. With the manual process where we review periodically and look over the cases for some particular parish will lead us to investigate something. In some cases we're talking about twins so you'll see a minor difference in someone's in a pair's first name, last name will be the same date of birth will be the same. And so at that point, we can either look into LEERS (Electronic Death Registration in the State Registrar & Vital Records) and some of our other vital records systems to determine whether or not these are actually twins or simply call them and duplicate and throw them out and move on. I think the process that we have strikes a real good balance between identifying duplicates and being overly aggressive and throwing out things like twins or junior and senior, we see that a good deal too, where you'll have a pair of individuals with first name and last name being identical. But if you look closely at the date of birth, you see that the date of birth is 18 to 30 years, 40 years different. And so again, using both the manual and the automated process helps to refine those lists down to something that is really quite robust.

Chairman Ivey asked for an explanation of the process with regard to someone goes into a clinic somewhere or a testing site and submits the tests. Ms. Sokol answered that it is going to be a little bit different depending on the site where the person is tested. Everybody is aware about the laboratory testing capacity and the number of laboratory assays that are available have increased dramatically since the start of the outbreak. So if someone is being tested for instance, by an acute care hospital or in a community care setting that collects a nasal swab, and they send this sample out to a reference lab, or it gets tested in a hospital lab, then usually those laboratory testing facilities have an automated electronic laboratory reporting feed that goes directly from that facility to the LDH electronic laboratory repository. Now, if you're talking about some other point of care tests, so for instance, a lot of the rapid tests you may be hearing about that are conducted at a physician's office or some other community care site. Usually those types of clinics do not have a system established, some sort of mechanism for that electronic laboratory feed. And so what we have had to do is establish a separate reporting mechanism for those facilities. So it's basically a secure web based portal where there they can either upload or manually enter those results, and then it actually comes to the same place.

Chairman Ivey asked what percentage of results are being fed into the first example of the primary electronic database. Ms. Sokol responded that the vast majority are coming in that way at the current time. However, more and more probably rapid tests will become available, but right now the majority is coming in through that established feed. Chairman Ivey asked for an explanation of the trickle of data where maybe a name and result came in but not necessarily the rest of the address. Ms. Sokol said LDH reports information on a daily basis. And so we receive results from the electronic laboratory feed continually. And so the information that is on those laboratory results, because we have such a quick turnaround for reporting the cases every single day with the exception of Saturdays. We are basically reliant upon the quality of the data that is submitted on those laboratory reports. Some laboratories have excellent quality of data. We need complete demographic information, address information, phone number, race, and ethnicity. There are other data elements in fact, that HHS (U.S. Department of Health & Human Services) has recommended that these laboratories also report to us. And so we are working with facilities and providing guidance about exactly what's necessary, but what will happen is sometimes we receive reports with only have names and dates of birth and we don't have good information about address or phone numbers. We unfortunately need to report out every day but we have these processes in place that really do a good job of identifying this information through other sources. And so that's how the information that might initially come and be reported from those laboratory results gets updated with much higher quality information after we're able to implement additional processes.

Chairman Ivey asked if they can still maintain that it's only one positive count and Ms. Sokol agreed. Mr. Mendoza added that for cases where there is missing information then over time as they collect more tests and pool that information across all these tests then they can identify if some tests are coming from a single individual. So we'll do a simple assignment at the beginning and then as we get more information about this person, then we'll refine that address and reassign them based on that additional information, still only counting them as a single case.

Chairman Ivey commented that LDH is effectively at the mercy of the quality of the laboratory submitting the results such as missing data or misspelled names. But the added manual process brings a greater level of aggregating the data correctly. He asked for an explanation of the evolution in process and procedure on gathering data from day one to the well-oiled machine LDH has today. Ms. Sokol responded that it has been a huge change. At the very beginning the state laboratory was the only facility conducting testing and my program approved every lab test that was performed by that lab. We actually, at the beginning of the outbreak had much better quality control over the data because providers would call us to request the testing and we would collect every single bit of information that we needed right then and there before the test even got to the lab. But then what happened was all of the different laboratories developed the capability to conduct testing - hospital labs and reference labs. And so these providers started sending all the laboratory tests out to these other laboratories, and that's really where the quality of the data that was coming in really declined at that point. And because a lot of the information at first, we still tried to get them to fill out this form that we had developed, but that quickly sort of fell by the wayside because it wasn't required by the reference labs.

Ms. Sokol further explained the labs really submitted the basic information that the physician or provider had sent to the laboratory and then they sent that to us. Sometimes the laboratory was the problem and sometimes the provider didn't send it to the lab so they did not have it to send to us. We have worked with an internal OPH laboratory testing collaborative that includes participants from a lot of different area hospital laboratories to talk through some of these different issues. We have sent out various health alerts that explain the reporting requirements and really tried to put it in the context of why it's important both for public health follow-up and for reporting purposes. But it's still a challenge that we're continuing to address each and every day.

Representative Schamerhorn said sure they have heard the horror stories of people sitting in line getting tired of waiting to be tested. They fill the paperwork out, they get aggravated because it's taking so long, they drive off and three or four days later, they receive a notice in the mail that says they tested positive for COVID-19. They never were tested. What's the truth behind that? Ms. Sokol said she heard those stories too and do not really know. I really don't have awareness of what the issue is in those circumstances. We have heard similar stories directly reported to the health department and we have tried to understand what was happening. The reports that have come to us have been directly to us have been few and far between, and it's still not clear to us. We don't have visibility on exactly what the problem was. Representative Schamerhorn said he has been looking for that letter and nobody has furnished me a letter yet but since he hears it all the time just wanted to know if LDH were hearing the same stuff and if they had found one of those letters. As you know, Facebook is a good tool and it is a bad tool. He asked if equivocal group positive is counted as a positive. Ms. Sokol answered that if it's equivocal then it is not counted as a positive.

Representative Schamerhorn asked if the antibody blood test is accurate. Ms. Sokol responded that there are a lot of different assays and it's really variable. We have four different coronaviruses that are commonly circulating in the United States and in Louisiana right now. So it appears that some of the antibodies tests do cross react with some of these Corona viruses. I think some of the other antibody tests are probably better and more reliable. But it's really going to depend on the specific assay that is used for that test and I think we're still learning more and more every single day. Representative Schamerhorn commented that he had nine days of locked down sickness and that was before anything was ever brought out about COVID-19. He went to two

different places and tested negative on the flu both times. So right after the antibody test became available, he was tested and showed no antibodies. He is unsure what he had but would not ever want it again. That is the reason he questioned the reliability of the antibody testing. Ms. Sokol said one thing that they're also still trying to understand are whether or not the SARS CoV-2 antibodies wane over time which means that you might be exposed and might develop antibodies, but then the levels of those antibodies are going to decrease over time. We still don't know that yet.

Representative Schamerhorn asked the chances of catching this virus again within the same year. Ms. Sokol said that is also something we are trying to figure out. What I can tell you is that CDC is saying at the current time that if you have tested positive, then three months from the date that you've tested positive, they feel like any sort of subsequent positive test result that you get is related to your initial infection. After that 30 day period, if you become symptomatic again, and then you test positive again, it is possible that it might be a re-infection, but there's still so much that we're learning. CDC is still trying to figure out would this potentially be a re-infection, could it be a reactivation. There's still so much that's not known. But we are sort of actively monitoring for the potential of reinfections that might occur after this three month period from the first positive result. It's something that we're looking to evaluate in our cases. It's something that CDC is paying attention to and they have established a Sentinel surveillance system for this. So I'm hoping some more data will be available soon from a national perspective.

Senator Bernard shared that one of the things raging across the state is the sentiment about not being able to see a mother or father who's in a nursing home. Then someone receives a call that their parent died and was unable to see them. I believe in every bit of the data that's being out, the medical community has done a great job, and I understand the responsibility they have with the protocol of CDC and Medicaid. You can't risk populations that are that vulnerable. I fully understand that, but it seems to me that the medical community would be able to design a system or a scenario that would be safe enough to go in and see a mother that you haven't seen since March 9th. So I have three quick questions. Why couldn't a family member who got tested and is negative, why would that not constitute a safe environment for them to go in and visit with that family member?

Ms. Sokol agreed 100% with Senator Bernard and assured him that within LDH they have had many discussions about visitation and when it would be safe to allow visitation in our nursing homes, because I think that the isolation and the depression that these residents are suffering, it can have really important health consequences for them. So it's a critical issue and one that we're closely paying attention to. In terms of the negative test, there are a couple of issues. If you want someone to have a negative PCR test, which is right now the gold standard for active infections of the viral tests. That PCR test usually takes a couple of days turnaround time. And so if someone wants to go visit a family member on Thursday and they get tested on Monday, then by the time they get the results on Thursday, they may not still be negative because taking that sample tells you that that person was negative on Monday. They may not still be negative on Thursday. Now this is where some of the rapid tests come in. There's a rapid antigen test in particular, which is another type of diagnostic or viral test. That one has a quick turnaround of 15-30 minutes but the problem with those tests is that they tend to have a higher proportion of false negatives. And so if someone tests negative, depending on the assay, there's a 5- 20% chance that it's a false negative.

Senator Bernard noted that they cannot risk that chance with the vulnerable population. There was a news story from Texas where they designed an exterior room at a nursing home where the entrance to that room was not through the facility, but on the exterior of the building. Is that not a possibility and also if that's not, then could outdoor visitation - even 10 feet or 12 feet apart, supervised, masked - wouldn't that be a possibility and minimize the risk of a family member seeing their mother or their father.

Ms. Sokol responded that is really sort of the model that we are looking at for when visitation is a possibility. I think everybody here knows the level of community transmission that we currently have in Louisiana is really

what's preventing us from being able to move forward with this visitation right at this very minute. However we are making plans and looking forward to the time when it is going to be a possibility. And I think that example that you've just given is a model that could potentially be safely employed. What you're going to want to do is look at certain factors that are specific to each facility. So for instance, have they demonstrated that they have had no new positive cases within the last 14 days? So if we are not seeing transmission within the facility and we are seeing a lower level of incidents within the community then the center could establish a system for outdoor visitation where they maintain a certain distance and do screening of the family members that come to visit and everybody is masked. Senator Bernard asked if nursing home visiting will continue to be on LDH's radar. Ms. Sokol said absolutely and they are looking at best practices and making plans for when we think that that's going to be a possibility.

Senator Luneau noted that this is a daunting task and you guys are kind of the unsung heroes so thank you for what you do. It is very important work and I appreciate very much what you do. I agree with Representative Schamerhorn that he has heard about some people who did not get tested but received a positive notification but I have not seen that proof myself. So it is either being greatly exaggerated and by the way, I understand that it's possible that it could happen, or it was maybe an isolated case, or maybe non-existent, I don't know. Do you believe that this is really an issue or is this just something that it's one of those kind of mythical things that happens on social media?

Ms. Sokol said all I can tell you from my perspective is that we have only gotten direct reports of this a couple of times. I honestly don't have a lot of time to look at social media, so I don't know how much it's been reported there. But from our perspective, we have not gotten reports more than a couple of times of this happening. Mr. Mendoza commented that he has seen that on social media as well but it is certainly not anything that we would be able to determine based on the data that we have. He does not get a lab result that says the person did not really show up, but is positive. So there's nothing that I can speak to since I have no data.

Senator Luneau asked about the uniform definitions that you use from the CDC is that part of the reason where maybe some of these folks got this data that was being released to them. Is it possible that they could have confused the numbers and believe the numbers were being over reported? Ms. Sokol answered that she does not think so because we are reporting the cases that we are sharing for first responder notification purposes are the same ones that are PCR confirmed. So we are not sharing any of the other tests. They are the same laboratory positives that we report for cases.

Chairman Ivey asked if every positive case that is reported to the dashboard is a PCR positive case. Ms. Sokol said yes. Chairman Ivey asked if any of the quick tests results are part of that case count. Ms. Sokol responded not at this time. Those quick tests are fairly new to Louisiana. We are in the process of adding those to the dashboard but it would be a completely separate count because according to the case definition, those are counted as probable cases. So they would be kept separate from the confirmed cases that are PCR positive. There is usually a reference standard for a laboratory result and anything other than that reference standard typically is assigned a lower level sort of case classification. Also I think when the antigen tests report positives that are fairly reliable. It's the negatives that I'm a little bit more concerned about. Some of them may have a few issues with positives, but overall I think their positive results are fairly reliable. Because it is not the reference standard PCR tests, CDC has assigned it as a probable case. So that is how LDH will be reporting it on our dashboard. Both types of tests indicate active infection. So the important issue really for public health follow-up is that they will both be incorporated into our contact tracing system for individual case follow-up and then notification of exposure for close contacts.

Chairman Ivey asked if someone is reported with the quick antigen test and then later tested with the more advanced PCR test, are they counted in the potential or probable positive and then would they get migrated over to the positive result on the dashboard. Ms. Sokol explained that is typically how it works. This is a standard

reporting process across all of our reportable infectious diseases. What happens is if we classify someone as a suspect or a probable case, but then we get a confirmatory laboratory result, which would essentially upgrade them to a confirmed case, then their case classification changes. We would not count that individual twice - once in the probable and once in the confirmed. They would only be counted in one of those two categories. Usually what CDC reports out is they might report out both of those. They might combine them, or they might keep them separate, but at any rate, each individual is only going to be counted one time - might be improbable might be confirmed – but not going to be in both.

Chairman Ivey said we can then expect the probable count to fluctuate as the more advanced test results may come in. Regarding the current data set being reported on the dashboard, to what degree of confidence do you have that all has been scrubbed and it is accurate.

Mr. Mendoza explained that on the dashboard there is a variety of data elements. Speaking specifically about the lab data and the case counts, we think that there are fewer than 2% duplicates in there at any given time, but then as we've already said, we've got the manual process to go through and refine that. So it's going to fluctuate somewhere, but never more than 2%. Chairman Ivey said that is pretty good and thanked Ms. Sokol and Mr. Mendoza for providing testimony and for all that they do. He asked for LDH representatives to answer how seriously LDH takes the HIPAA concerns.

Mr. Steve Russo, LDH Executive Council, responded that LDH takes HIPAA concerns extremely seriously. He had the pleasure of being the interim secretary back when the COVID-19 pandemic blossomed in Louisiana. We were very leery at first of even sharing this list. We wanted to keep the list on a minimum and need-to-know basis. We wanted to keep a tight lid on a list so that this wouldn't get out to the public and then potentially misused. We did decide though, at that time, consistent with HIPAA public health emergency and we didn't really have a good idea about the potential ability to spread COVID during that time. We thought that maybe in some of these smaller parishes we still could maybe get on top of it and maybe stamp it down. We did not have widespread PPE out there. So we reluctantly went ahead and shared that list because we thought if somebody was going out with limited PPE should know who was positive so they could use a mask and gloves. Now today, to be honest with you right now, we know that COVID is out there and it is widespread. But now we can now get masks and gloves. To be honest with you all the list shows you right now is the name of who is positive. It does not tell you whether or not, for instance, Senator Mills may have it or not. So currently right now if you are going into somebody's house right now, you should mask and glove up whether or not somebody's name is on that list we share with the sheriffs' offices or not.

Chairman Ivey commented that in the beginning with the lack of PPE available and out of an abundance of caution for our first responders' safety felt it was a great enough need to go ahead and share that data in the first responder report. Mr. Russo agreed and the understanding was the list was going to be for a limited purpose and believed at the time that one or two folks at each of the sheriffs' offices would have access to the list and then upload it into their computer dispatch system. That way when the sheriff's office received a call to a person's house, their dispatch system would show if that person was COVID positive, so that the responding unit could take the appropriate measures.

Chairman Ivey asked what type of communications did LDH and state police have about transmitting the list with regard to the HIPAA requirements. Mr. Russo said he did not know whether he had a direct meeting with Colonel Reeves. But he did have a direct meeting with the Sheriff's Association and we made it pretty crystal clear in my mind that this was a very limited purpose that they were going to receive this list and it was a need-to-know basis and that list needed to be kept tightly under wraps, so to speak. So I was quite taken aback when I heard about the Facebook posts. I don't get on Facebook either and think it is bad for business.

Senator Luneau asked when you have an exception to a law like that, and that exception does not fall into the

category of the dissemination of information, I would say that would be a HIPAA violation. Do you disagree or agree with that? Mr. Russo commented that Senator Luneau is an exceptional attorney so he would tend to agree and dealing with the facts here. We provided a list with a very limited purpose on a need-to-know basis. It appears through some of the Facebook and some of the hearsay that I hear, and the whole reason why we're having this hearing today is that the list seemed to be used for trying to tick and tie back to the numbers that LDH was reporting, which is not the purpose for which we released that list. Mr. Russo said he agreed with Senator Luneau.

Representative Schamerhorn asked about when a tracer is trying to find out who a tested positive person has been in touch with. So whenever a tracer is trying to contact a person who may have been around a positive person, would that be a HIPAA violation there too. Mr. Russo responded that this legislature went to great length during this last session to make it clear that people's civil liberties were closely guarded and so they made participation in contact tracing to be voluntary and under no circumstances can it be mandatory. Also when a tracer calls you, in addition to being a voluntary choice, you are not to my knowledge, a covered entity for HIPAA purposes. That's how that works.

Chairman Ivey questioned Mr. Russo's opinion if he believed that Red River Parish and DeSoto Parish violated the HIPAA guidelines or requirements. Mr. Russo answered that with the limited facts he has, he believes that is probably the case.

Representative Jordan said based on discussions with a couple of employee attorneys regarding COVID tracing, and his understanding is that the tracers do not release the names of the people tested positive. But by telling a person that they were potentially exposed they may be able to determine who has COVID, but the tracer is not actually giving out a name. So I don't know if they're violating HIPAA from that. Somebody called me on one of those scenarios and by process of elimination was able to figure out who had COVID but the tracer did not release a name. So they are trying to balance your right to know about potential exposure with the privacy of the individual whose health information is somewhat being released.

Mr. Russo said his understanding of Representative Schamerhorn's question was whether the person being called by a contract tracer was violating HIPAA by releasing someone else's name. But LDH is not sharing names and linking names through the contact tracing.

Louisiana State Police (LSP) Superintendent Colonel Kevin Reeves and Executive Counsel Ms. Faye Morrison went to the witness table. Chairman Ivey asked them to share their process for handling the data received from LDH to get it to the hands of the EOCs (Emergency Operations Centers).

Colonel Reeves thanked him for the invitation to appear before the Council to provide additional insight on the COVID-19 first responder report and the state police's role. He explained this initiative came to be during the early days of COVID-19 pandemic, as we were all anxious for information to ensure the safety of the public as a whole. As public safety leaders, we were equally concerned for our employees as they were duty bound to go into these environments and answer calls and provide their public safety services to the public and that involved interactions, sometimes close interaction. As we discussed ways to protect our employees beyond the obvious mitigation efforts of masks, gloves, routine sanitation, and social distancing, we discussed options that would provide situational awareness for first responders who were required to enter these COVID-19 environments and interact with the public. Through much discussion with health officials at LDH and public safety officials of the importance of providing this awareness to boots on the ground responders, but we also wanted to protect the rights of those in whom we were interacting with. It was determined that the most appropriate method was for LDH to provide a list of COVID-19 positive persons and addresses to public safety agencies for entry into computer aided dispatch systems (CADS). At the local level with this information residing in the CAD, dispatchers are able to notify responders when a call comes in at a particular residence that there's a potential for

a COVID-19 exposure there. The process eventually agreed upon was for LDH to send the file of state COVID-19 cases to state police each day. State police would separate the data by parish, secure the files and send to key individuals for distribution to each parish for inputting into their local CAD systems.

After receiving the data from LDH and formatting it, state police would send the data to the Louisiana Sheriff's Association, the Governor's Office of Homeland Security and Emergency Preparedness (GOHSEP), and LDH Bureau of Emergency Medical Services (EMS) for dissemination to local CAD representatives. State police did not add, remove, or in any way manipulate the data other than to organize an Excel spreadsheets tabs by individual parish or the no-parish if none was indicated in the patient data. As state police does not yet have an operational CAD system, our role in this initiative was simply as a liaison and facilitator of data between the LDH health officials and our partner public safety representatives. Our involvement recently came to an end as LDH and local public safety officials are now working together directly in the sharing of that related data. From the earliest discussions regarding this initiative, it was made clear that we had an obligation to protect the data as it relates to HIPAA and our citizens' privacy rights. As was stated by the Louisiana legislative auditor, the data was never intended to be used for case counting purposes but only to provide situational awareness to our first responders and assist them with protecting themselves from exposure to COVID-19 while providing their critical public safety services to our citizens. So with that said, I'll certainly open to answer any questions that you may have.

Chairman Ivey asked LSP legal counsel to expound the measures LSP took when distributing the data further down the line to address the HIPAA issue. Ms. Morrison explained that LSP relied on LDH with regard to the necessity to protect that information. They released it to us via an exception to the HIPAA law for a public emergency for the first responders. Dr. Alexander Billioux (Assistant Secretary for Office of Public Health at LDH) communicated with Colonel Reeves and representatives from the Sheriff's Association and GOHSEP what the parameters were going to be and he indicated in that communication, there was no official data sharing agreement at the time, but the parties who had been working towards getting that information agreed that the information was going to be protected. The goal as Colonel Reeves said was to go into a CAD system. So if your parish did not have a CAD system, there was really no reason for you to be getting that information because you did not have the proper program. Chairman Ivey said the list was not useful at that point.

Ms. Morrison said the list was not to be shared to give everybody in the head of government a list so they knew who was on it in their parish. It was to go directly into the CAD system. Like Colonel Reeves said, we did not even have a CAD system so we could not use that information for our people, but it was to be used for all of the locals who do have CAD systems. So daily LDH sent state police their report and it was a very simple information in the email itself and it had an attachment of an Excel spreadsheet. The email said "Attached please find the cumulative data for today." and then it had the warning that said "The protected health information is being shared for the purpose of first responder notification. Further distribution of this information for any other purpose is prohibited by law." And that's the information that was provided by LDH to state police. And we used the same one daily when we sent it out to our limited contacts in the Sheriff's Association and GOHSEP stating, "The attached document contains protected health information that is being shared for the purpose of first responder notification. Further distribution of this information for any other purpose is prohibited by federal law."

Chairman Ivey asked about duplications or if the data may have had multiple entries for a positive test, with respect to the purpose of the first responder report was it even relevant. Colonel Reeves responded no, it was not relevant to us at all if someone appeared multiple times on the list, because all that we were interested in was allowing the first responders to know that someone or an address was on the list. Chairman Ivey asked if it would be safe to say that if someone brought that to the attention for purposes of using the report itself, it was not consequential because if it showed up in the system then it would not show up more than five times once the address is identified. Colonel Reeves agreed.

Senator Luneau said he certainly understood the need, especially early on in this pandemic for the first responders having this information. But your office never used it to compile any other information, like the number of positive tests or anything like that. Colonel Reeves answered no, not at all, we were just a gateway for the information. Senator Luneau asked if parish GOHSEP offices typically have a CAD system. Colonel Reeves responded he did not believe they do but understands that in some cases they do. This information was given to me, that some GOHSEP offices manage those systems for the entire public safety services for a parish. Senator Luneau asked if that was the case in Red River Parish. Colonel Reeves did not know.

Colonel Reeves shared an incident that he personally witnessed of a local law enforcement officer in another parish where he heard over their portable radio unit dispatched to a location. The dispatcher came over the air when dispatching the unit for the specifics of the call and said, "I have a COVID alert on the CAD system. Let me check to see if it's still valid. If it's not, we'll remove it from the system." So I know that a lot of our public safety partners are doing their best and their due diligence to vet those lists as they expire.

Senator Mizell asked at what point did you all feel that you had the PPE sufficient to treat everybody as a possible COVID patient. Colonel Reeves said he would be hard pressed to give a specific on that, but I know that early on we were struggling with garnishing masks and other PPE to send out to all of our troops and all public safety officials including law enforcement, firemen, EMS and all that. So it took us a while in interacting with GOHSEP and the National Guard to build up that stockpile to where we could adequately send it out to everyone.

Senator Mizell asked if they are all wearing masks in contact with the public consistently now. Because the whole point is your people on the front line are getting hazard pay because you have to be prepared for the hazard you are facing every day. So when did you feel that you had all get the supplies you needed. Colonel Reeves said he does not have that exact date. Senator Mizell asked if LSP was referring to a list before putting on masks. Colonel Reeves explained that he instructs all their state police personnel that it is recommended to wear masks whenever interacting with the public as soon as masks were available.

Chairman Ivey commented that resources and availability across the state took a while to get enough supplies in one location. He asked if LSP is working with local law enforcement and other local public safety agencies around the state to help be that conduit for the supplies right now, or are they required to procure those things on their own. Colonel Reeves explained that there is a close correlation and cooperation between GOHSEP, state police, the national guard, the sheriffs and local police departments, along with EMS and fire, to make sure that we share those resources between us all so that everyone is adequately protected.

Chairman Ivey asked the representatives from the Sheriffs' Association to the witness table. Michael Ranatza, Executive Director for the Louisiana Sheriffs' Association (LSA), introduced himself and former sheriff Ricky Edwards from Jefferson Davis Parish, who served on LSA staff for about the last eight years.

Mr. Ranatza testified that the association was very thankful for LDH providing the information to us initially which we made a request through our in house counsel, Shannon Dirmann, providing that exception whereby we could receive the information for public safety purposes. And we did stipulate to Mr. Russo, to LDH, to the governor's office who played a role in this and we're thankful for LSP and GOHSEP. We all worked together to get this information for our members.

In the beginning of this pandemic there was not a lot of PPE or much information but there was substantial fear in the community pertaining to how to deal with this issue. So on behalf of our members, we sought the information and worked with the responsible parties and did stipulate to the HIPAA laws pertaining to the vital security of these issues for all of our citizens, because we didn't want to harm anyone with this information at

all, but only we wanted to safeguard our deputy sheriffs and our employees. So that was the involvement. I do mean our sincere thanks of all that work with us. During the course of time, there have been situations that sometimes were discussed with us and sometimes not about violations committed by individual parishes. We were not asked to specifically address those issues, but we did have subsequent general conversations with sheriffs, again emphasizing the importance of the security of the information. That has been throughout the pandemic, our desire to have the information only for public safety purposes. At this time, I'm going to ask Sheriff Edwards to describe to you the pain staking methods in which we delivered the information to our members.

Mr. Ricky Edwards explained that LSP would send him a file that was a password protected containing the list and then it was parsed out by each parish as well as the no parish information. I would then take each one of those tabs they gave me, and instead of sending the whole statewide list, which I believe is what GOHSEP was doing, I would send the sheriff only the information for his parish. I would take that tab and make a new password for 64 times and send it out to 64 sheriffs daily. In that specifically we wrote this is the emails, "The attached document contains protected health information that is being shared for the purpose of first responder notification. Further distribution of this information for any other purpose is prohibited by federal law. It is given to us to use in this emergency and should be protected as per HIPAA guidelines." So we made it clear that this information was to be used by first responders.

Chairman Ivey said the reason that I had you all come up in this order is to establish the chain of custody of the data and its transmission and the communication with regard to the responsibility of complying with HIPAA. Thus far it sounds like that specific mandate on the use of the data has been maintained consistently from LDH through LSP and now LSA.

Senator Luneau expressed his appreciate for their attendance and understood the need early on the pandemic to have this specific information, but apparently the DeSoto Parish Sheriff's department violated your own requirements to participate in this. He asked if they had discussions with them about them using the information for a different purpose than mandated and that it was problematic. I am sure they are here and will ask them the same questions. Mr. Edwards responded that he had not. Mr. Ranatza answered that he had not nor was he ever the recipient of information from LDH pertaining to an infraction on their part.

Senator Luneau said that is problematic because if these parishes put messages on social media using this information that you gave them guidelines about how they could use it and they violated those guidelines, I think you ought to have a discussion with them and tell them that they cannot do it. He recommended that LSA have a discussion with all 64 sheriffs and somebody apparently did this. Not to castigate these other people who did not inappropriately use the data but they all need to understand that this is not the purpose of this information. Certainly the point is not to put it out on social media where it jeopardizes the health and welfare of all of the citizens in the state. The irony of this whole thing is that LDH has been accused of exaggerating these numbers and we had to wait until somebody violated the rules to say that their numbers are accurate.

Senator Luneau strongly encouraged LSA to have conversations with the sheriffs. I want to ask the parishes directly what their plan is going forward because we can't have this happening. Mr. Ranatza said that he certainly will at Senator Luneau's request and that LSA's perspective was with deep gratitude on behalf of the remaining sheriffs' offices that obviously abided by those regulations and far be it for me to say that they erred in this regard. I have not seen or heard actual infractions, but I would be happy to report to them your concern and we will do so today.

Senator Luneau said he understands why they needed this information and think it was right to share that information with first responders. His complaint was the information was misused if in fact it was put out on

social media to dispel or to create this rumor that the numbers being reported were not accurate. And that is what we want to make sure does not happen again.

Chairman Ivey asked about the current process that LDH is utilizing and no longer going through LSP, and if LDH is signing agreements with LSA or with the members directly. Mr. Edwards explained on July 15th LSA handed out data sharing agreements to all the sheriffs and we have since received those. Then on July 24th, we had a conference call about the data sharing agreements with GOHSEP and everything changed on that day. Now the data is put in a portal. I receive the data from the portal and instead of GOHSEP sending out the data, I send the data out to both the sheriffs and the OEP directors. I am only the conduit. LDH puts it out there and I put the password in and it makes all of the different folders. The folders are all encrypted with their own individual passwords that LDH does instead of me now. And then I sent those directly to the sheriff and the Office of Emergency Preparedness (OEP) director. Chairman Ivey asked if there are data sharing agreements from every agency or whoever's responsible for seeing the data. Mr. Edwards said he has data sharing agreements for sheriffs but do not know anything about the directors.

Chairman Ivey asked if anyone from Red River Parish or DeSoto Parish was present who could give testimony. No one came forward to testify. Chairman Ivey said for the record that invitations were sent so they could come and participate in this process. Senator Luneau commented that this is very troubling that these folks are not here to discuss with us and find out what's going on. I hope that we can take the right steps I don't know if it would be the prerogative of this committee or what committee we would need to look at, but we need to have some discussions with these folks. This cannot happen again. This is of primary importance as far as I'm concerned when you talking about public health issues like this, especially when we're looking at offices of homeland security. I do not think this should just go away because they did not bother to show up today. I think we need to have some communications with them in some facts.

Chairman Ivey said that is duly noted. I want to also thank the legislative auditor for the fine work you did to really cut through the noise that run so rampant on social media and really get to the bottom of this. My biggest concern from this report is that we have public officials who have effectively undermined public safety and public health for the communities they serve when they went on social media and provided misinformation. Anyone acting on that misinformation could have been infected, could have infected a family member and this is why it's important. I know that testimony was already given that additional auditing and research will be done to do a more thorough analysis and audit of the data. If we expect our constituents to be able to make informed decisions, what we must do is provide a high degree of confidence that the data that is being reported is accurate. Based on the limited investigation of this particular report, it would appear that LDH has done a very good job at providing almost entirely accurate data. We did hear some of the reasons why some of the data may not be quite so accurate just based on the laboratories and reporting.

Senator Bernard asked them to reserve judgement for the officials in Red River and DeSoto Parishes. I have been to 473 million meetings in my life, and I bet you half of them, I didn't know they were having, because I didn't get notice. Now somebody probably did get notice but I have it on good authority that the DeSoto sheriff was informed, but the GOHSEP individual was not and had no idea about the meeting. Now whether he did not receive the notice or his secretary did not show it to him, I do not know. I don't think on some of these people's part, there was an attempt to purposely avoid this meeting. Maybe in some future meeting they would be able to come and offer whatever commentary they would have on some of these circumstances.

Chairman Ivey said that is duly noted. I do believe that everyone who was identified in the report was sent an invitation. I don't know if the GOHSEP folks were a part of the public dissemination of the accuracy as they perceive it to be. But I do believe we need to need to have a further follow-up conversation on this and accountability. Part of the responsibility of this committee is accountability in public service and a HIPAA violation is no small thing. And then when you compound the fact that some of these officials violated the

HIPAA policy and publicly went out and made their own assertions effectively to the entirety of LDH data and whether or not it could be trusted, I believe is an extremely egregious violation because of the impact that it has on our constituents and their decisions they make with that data. So we will be having additional conversations and certainly will allow them to speak and send them additional invitations on that. Chairman Ivey asked if any further discussion on this topic and no one had additional comments.

Louisiana Department of Health – Behavioral Health Provider – New Horizon Counseling Agency, LLC – Audit Issued June 17, 2020

Mr. Magee explained that Cortrinia and Tyler Price are the owners of the New Horizon Counseling Agency (New Horizon).

Mr. Magee explained that he and Mr. McDougall are part of the performance audit data analytics unit and similar to performance audits which attempt to find ways to improve programs through more efficient and effective processes, what drives the data analytics part is analyzing data to find the issues that exist. We use data to drive the audits that we conduct. Specific to the behavioral health program, our performance audit section has conducted a variety of audits over the last few years, looking at the various facets within the behavioral health program. Our first audit from a few years back looked at the provider networks and tried to determine whether or not there are an adequate number of providers out there for the behavioral health program. We then looked at access to comprehensive and appropriate specialized behavioral health services. As behavioral health issues become more prevalent in society it is important to make sure that we have the services there to address those issues. More recently we have been focused on looking at improper billings and improper payments or potential ones through either various bills that have been passed by the legislature such as Senator Luneau's National Provider Identifier (NPI) bill. Representative Horton had a bill about 12 hours of services in a day recently. Looking at just the data itself and trying to understand if you can manage and see what is going on in the program based on the data that these providers and managed care organizations (MCOs) are presenting.

Based on this knowledge of the program that we have learned over the last few years, and the fact that over the last few years the Attorney General's Office and the MCO's special investigative units have identified the behavioral health program and specifically mental health rehab providers as the biggest issue or provider group in the Medicaid program for these potential actions. We decided to look further into this to try to fill in a void that may exist in ensuring the integrity of the program. To do that we created what we call our risk matrix. So based on our knowledge of looking at the behavioral health program in the past and based on some laws and rules that exist out there already, we are analyzing behavioral health providers on a quarterly basis across 15 to 20 dimensions to try to determine which ones are the riskiest providers out there and what should happen next with those providers. The good thing is that the majority of the providers at the top of our list are already under state or federal investigation. However the provider that we are going to discuss today, New Horizon was not under a current active investigation at the time that we identified them as acting like the other providers that were high on this risk matrix. Therefore to see if this risk matrix could add value to the integrity of the program for Louisiana taxpayers, we initiated an audit to determine how to improve the matrix and to see how things were going at New Horizon. We also attempted to look at it a slightly different way, not just using the Medicaid data, but also other data sets that our office has access to so we could try to get a complete picture of what was happening at this provider.

We used various data sets such as Louisiana Workforce Commission (LWC), vital records to determine if any of the people providing services were deceased, OMV driver's license records to try to figure out where these recipients and the people providing services lived and then share note data which Brent will get into more. That really gives a much more detailed and complete picture of the services that are being provided than just the Medicaid data. For a little bit of background New Horizon was registered with the Secretary of State in 2015

and within two years had been paid in 2017 over $4 million for behavioral health services. Over the scope of our audit New Horizon billed and was paid over $8 million of services for 77,000 encounters. There were also an additional 8,000 progress notes, which we will explain further, that were billed but maybe not paid for by LDH or the MCOs.

Mr. McDougall explained that the report had three main findings in it and each had sub-findings that I will give a couple of examples. But one of the most important things before getting into the report in regards to our work on this is that for these behavioral health services, the Medicaid data that is received by LDH does not contain the time information for when the services are provided. It only contains the date that the services were provided. So you can have information come in that shows that a person is providing 12 hours of services in a day, but you don't know when during that day those services were provided. So the first thing that we did to try to work from an efficiency perspective is we obtained the actual information for each of those claims from the billing company. Now, every claim has to have what's called a progress note. That is the documentation to show the service that was actually provided and how the recipient responded during the surface itself. That progress note contains the name of the person that actually provided the service, the time of the day that the services were provided, the procedure that was provided as well as any additional information such as the age of the recipient, the education level of the person providing the service and other information. So the key when analyzing the services is to know when the services were provided and by whom. Since January 2019 that information regarding the person providing the service is now available in the Medicaid data, but prior to that date it was not.

Mr. Magee explained that analyzing the data that way allowed us to instead of trying to follow allegations or paper, we instead were able to identify those claims and encounters that appeared to be improper such as occurring from 1 am to 3 am or for spanning many hours. We were also able to look at things such as phrasing of the recipient wasn't present for the service while the recipient needs to be present for the service. Again, this data set gives such a more comprehensive view of what is happening than what currently exists in Medicaid.

Mr. McDougall said we obtained that detailed information regarding New Horizon so we could actually see the times of the services and the individuals providing it. We matched that together with the claims and encounter data for Medicaid as well as other data sets for the different findings. The first of three findings has to do with $211,000 of services that do not appear to have been provided by New Horizon between December 2015 and January 2020. There were also multiple sub findings for this, but I will just go over two of them and give some examples of it. The first has to do with New Horizon being paid $30,000 for services provided by its owner, Cortrinia Price, which does not appear to have been provided because they overlap with her personal activities and interviews with legislative auditors. What I mean by this is that Ms. Price’s Facebook data and banking records place her at other locations when the information from the progress notes state that she's providing services to individuals in their homes. He referenced page seven of the report that documented her billing for services when she was actually in New York and another time at a restaurant. Another example was Ms. Price billing for providing services during times when she was meeting with the auditors on June 13, 2019, and January 29, 2020.

Mr. McDougall continued providing the second sub-finding regarding New Horizon employees falsifying their billing times based on comparing to LWC data to progress notes and Medicaid data. We did interview employees of New Horizon and a few admitted that they did bill for services that they did not provide. The third sub finding has to do with New Horizon being paid $1,200 for services that the billings indicate were provided by its clinical director while she was hospitalized or after she was deceased by matching information to vital records. The second finding has to do with New Horizon improperly billing Medicaid services. New Horizon appears to have improperly billed and paid for $656,000 of services between November 2015 and 2019. He referred to examples documented in the report.

Mr. Magee pointed out that the only way that you can look at this is by going to the progress note level. Now there are other Medicaid programs who have electronic visit verification, and that does capture the time information. If time information was available for the behavioral health program, you could run these analytics on the entire program. It does not exist right now. So what has to happen is an audit or investigation has to be started. Those records have to be gotten from the provider or whatever contractor it is that does the billings. And then you can look at it on an individual provider basis. But if you could look at it globally for the entire program, like we're trying to do with what Medicaid data exists right now, you could identify a lot of these instances globally.

Senator Mills referred to the management's response and the provider's response. He served on the Medicaid Task Force which Mr. Purpera chaired for several years. One of the statements made at a task force meeting by people at a big level was that Medicaid fraud and abuse was going to be more on a provider side than individual Medicaid recipients. I think this is really timely that we talking about this. The first question I would ask is I see right here that the provider is coming back with a rebuttal of certain things. He pointed out Ms. Price's response that she did not agree with the findings and need more documentation. Then LDH's response is they don't really have the analytics because much of the data and information utilized goes beyond the scope of Medicaid encounter data and medical records typically available to LDH. It looks like a lot of information but the provider refuting and LDH says they do not have the data. It looks like a lot of lawyers and disagreements.

Mr. Magee said LLA worked with the Attorney General's Office (AG) which was instrumental in our case and it is working through the legal process right now. There is a representative from the AG here but not sure how much they can divulge. Senator Mills asked how can LDH and LLA partner up where it is not this far down the line and more real time because a lot of money has already gone through the door. Mr. Magee explained that LLA's role is to identify ways that processes can be improved. As a part of that we had our standard audit meetings about this report to talk about the results. We also had a separate meeting with LDH's analytics groups to discuss some of the analyses that we ran so they could see if some of them could be incorporated into what they are doing. We have also recommended in the past, specifically in an eligibility report, where we identified some people who may be earning too much. One of the things that we used was LWC data. So LDH was able to enter into a data sharing agreement to get access to that data for that purpose. The same type of thing could happen here because it is two executive branch agencies who are trying to do the same thing - run government efficiently and effectively. We would always encourage agencies to try to reach out and get more data that exists to help you do your job. The more resources and more information the better they can do their job.

Senator Mills said maybe both departments can get a report back to this committee but when LDH acknowledges in their response letter that LLA has more analytical information than they have it just seems that there has to be a solution within LDH. At the end of the day when there is say there is major provider fraud in any case, which entity should be eating this – the MCO or the taxpayers. He asked what liability the MCO has to be monitoring this data. Mr. Magee responded that the MCOs definitely have a responsibility to determine what is happening within their network. One of the issues we have seen whether it's in the 12 hour report that we recently released or in looking at this, often these providers bill for multiple MCOs. So the MCOs do not have a complete picture of what is always happening in the entire Medicaid program. There are really three entities which have access to all the data: LDH as the administrator of the program, our office and the AG. There are a lot of players involved but the MCOs can manage what's happening in their network. If a lot of these claims and encounters are happening in their network, they can see that and it is their responsibility of their special investigative unit to identify that. They are constrained in the sense that they cannot see everyone else's data.

Senator Mills asked if the auditors look at the contractual obligations of the MCOs and if any of those contracts and obligations have been violated do they have some exposure financially. Mr. Magee responded that LLA does look at the performance metrics that they are supposed to meet but not sure about the dollar component of

your question. Senator Mills questioned duplications of billing, giving the example of three prescriptions filled on the same day for the same person at three separate pharmacies then someone is not getting paid. If somebody went a physician and had three or four services, somebody is not getting paid because it's a capitated rate. In this case, if they did have duplication of billing then what is the contract responsibility of the MCO. Mr. Magee responded that LDH may be able to speak more specifically to those contractual obligations.

Representative Jordan said it seems to be some software issues. In your experience, have you found that some software programs or are better suited for this line of work? Mr. Magee responded this is our first foray into behavioral health providers specifically, but what I will say is it often comes down to controls around the program. Our understanding that the controls that are spoken to here can be turned them off. So if the control exists, but it's able to be turned off, is it really a control. In this case for this provider, we saw the progress notes showed the times did overlap. Therefore those permissions must have been turned off or the software wasn't working correctly, but either way what was happening appeared to be improper.

Representative Jordan asked if LLA has someone that can through those parameters and those permissions to see if the software, for lack of a better term, adequate for the purposes being used for. Mr. Magee answered that LLA has a section that does look at controls. The complexity with this is that the provider is contracted with an MCO to deliver services and then that provider has a contractor who's doing their billing. So it gets further and further away from being directly accessible by us. We were able to obtain the data but we really were unable able to ask a lot of questions about those types of controls that you're alluding to.

Representative Jordan saw that the encounters required face to face and it was done over the telephone or something like that. Because of the COVID environment, there has been an expansion of telehealth and telemedicine, so would some of those things that were previously not permitted now be permitted in this environment. Mr. Magee responded the Office of Behavioral Health (OBH) is here and they can answer more specific about it. But I do know that there has been an expansion of providing services through teleconference or over the phone because of the environment that we have been placed into. As far as documentation are they requiring more documentation? Are they requiring any type of IP address information or anything like that? When the phone call happened, are they keeping telephone logs? That's not information that we know, but those are data points that could help to keep the integrity of the program as you move it from in-person to virtual.

Chairman Ivey asked about the overlapping data and their response was it that they were overlapping to bill for the same into a patient during the same time period or were they overlapping in the sense of multiple patients over the same time period. Mr. McDougall answered kind of all of the above. There were situations where two providers billed for the same patient or at the same time and situations where one provider billed for seeing two patients individually at the same time. Also an individual was listed as an inpatient in a hospitalized situation was being billed for as being seen at home by a provider. Usually we found two patients being seen at the same time. Mr. Magee explained a typical situation that we would see is maybe individuals who live in the same household who were delivered individual services. Now they could be delivered group services and you could deliver those services at the same time, but that's not what we're talking about here. There would be individual services say from 10AM to 12PM for one person and 11AM to 1PM for the other person. That hour of overlap is what we're capturing here in our report.

Chairman Ivey asked how many instances were found. Mr. McDougall said that was $6,400 worth of services. Mr. Magee further explained that the majority of those instances were two workers providing one-on-one services to the same recipient on the same day but at overlapping times. So we would see one of the individual providers would bill as though they were seeing the person in the office and the other person would bill as though they were seeing the person at home. The recipient cannot be in those two locations at the same time.

Senator Luneau referred back to the MCO portion of this. These providers contract with the MCOs that are paid to do the service for LDH. Is that the kind of the chain of command? If the MCOs cannot properly have a set of checks and balances to see if these people are actually providing the services then who can? Apparently you did a crackerjack job on this audit, but that's a small snapshot. Shouldn't these MCOs who are paid a hell of a lot of money be catching this?

Mr. McDougall commented that LDH could speak more to this, but having the time information is the key and that is something that is not contained in the Medicaid claim data that the MCO is receiving. It's not contained in the encounter data that the MCOs send to LDH. Senator Luneau asked if the MCO has ever told anybody that if they do not have this information then they cannot check this. Mr. McDougall responded that when an MCO has concerns regarding specific providers, they have to go to the provider themselves and request the progress note information containing the time information or they have to get it directly from the billing company. Senator Luneau said apparently that doesn't work very well because they told you they were providing services when they were meeting with you. So that doesn't work too well. Senator Luneau said he did not understand why pay MCOs to do this if they are not doing it.

Mr. Magee commented that if data exists, it should be looked at comprehensively and that's what we have attempted to do here for one provider. But that goes to your bigger issue. If this data which exists out there with a contractor of the provider who is contracting with the MCO was gathered and captured, you wouldn't just run an analytic to say does this person not have an individual attending NPI, or is this person billing for more than 12 hours a day? You could do that. But then you could also see when they are billing and you could run checks for times that are outside of the norms of providing these services and so forth. More information would allow much better informed decisions and oversight.

Senator Luneau said that was part of the reason why I brought that legislation. We passed it because we knew that there were problems here. For some reason the state of Louisiana wanted to focus on recipient fraud and that's not where the dollars are. Is there some recipient fraud? Yes. We know that there's always going to be, there are going to be bad actors in everything. Is there provider fraud? Yes. We know that for the same reasons, but the numbers are incredibly higher on the provider side. We have got to talk to the MCOs about this, but for the life of me, I can't understand why we're paying them to provide this service and they're allowing these blatant things to go on. There is a disconnect somewhere that we have to find, but you guys did a great job and I appreciate your work in this area.

Mr. Magee said in the end this is about the recipient receiving the services that they need. The last finding speaks to the fact that of all the progress notes that we looked at over 81% of the time the recipients made no progress or even regressed. That is not an indication of the entire behavioral health program. That's an indication of the services being provided by this provider. Either they were not filling out the paperwork properly and maybe people were making progress and they just weren't denoting it that way or the people were really regressing. We saw in one case that for 352 progress notes for one individual, 351 of those showed regression or no progress. So why was this person receiving services for almost two years from the same provider whenever there appears to be a lack of quality of those services.

Senator Luneau said in some instances it is quantity. For example, in Grant Parish that I represent, we now have one provider that just got licensed. We had none in the entire parish and that is the only services they have so they are very needed, but it's like you said, there's something wrong when you have that many sessions and not showing any progress.
They need some other help or something's not working there. Mr. Magee noted that sometimes the service intervention keeps someone from regressing and I'm sure that OBH will talk about that. So making no progress is actually a win in that sense. But for these 351 progress notes it cost almost $40,000 for those services. This is really the managed care portion of the MCO name. If these services are not working, maybe there are other

more evidence based services that could be provided for the individual to receive the care that they need. Senator Luneau commented that there does not seem to be much management going on in that managed care in this instance. So we definitely need to look at that.

Representative Hilferty asked about the issue that LDH, LLA and AG can see the full picture of what services are being provided. Are there software based solutions that we could require the MCOs to adopt that would give them that picture while providing that protection from identifiable information on the patient? Mr. McDougall responded that each MCO can only see their own encounters and claims information. They can't see other MCOs information. Only LDH, LLA and AG can see all this information across the board. Representative Hilferty asked if there was something that LDH could adopt then that would allow them to flag that from a software based perspective to find work outside of the normal hours or maybe the same patient receiving the same treatments at the same time, or find any such anomalies. You guys did an amazing job on this, but this is happening right now with other providers that we do not even know about. So while your system is great and that it uncovered it, but is it necessarily a scalable system. Mr. McDougall explained that obtaining the time information for each service is the key and knowing when it was provided.

Chairman Ivey asked if the MCOs require that data. Mr. McDougall said LDH would have to respond. I know that there are some constraints in what is required to be reported for Medicaid claim and they can go into more detail on that. Mr. Magee added that federal requirements just require certain things to be reported and this is outside of those requirements. Therefore additional work will have to go into it to get this data.

Representative Hilferty asked if just because it's not required that wouldn't preclude us from requiring it on the state level. Mr. Magee answered not to my knowledge, but I believe LDH can speak to that. Representative Hilferty noted that the children were not receiving these behavioral services. So not only do we have the economic loss that I assume will come down to the State of Louisiana taxpayers paying for. But also this child lost two years on services that were potentially going to benefit them. Mr. Magee said OBH can speak to this more with their expertise. Patients receive a certain number of hours of these services over a certain amount of time, and then the provider and those recipients need to prove that they continue to need those services. If the services were not provided and then the MCO may say that they are not getting any better with these services and they may not be approved in the future.

Representative Hilferty asked why the MCO continued approving it when there was no progress. Mr. Magee answered that he was not sure they were getting the required paperwork to approve it. But as far as what they were looking at quality metric wise, I cannot speak to that. Representative Hilferty said it just seems like the system keeps rolling and there's never anything to stop it to say let's look at what we're actually doing, which is trying to provide better health outcomes and behavioral health outcomes for our citizens. The MCOs are just spinning off these contracts and then people are taking advantage of the fact that there's no oversight.

Mr. Magee added that LLA can always look at things but audits are always by their very nature looking in the past. But if there's anything that you can put in place to catch it earlier on and potentially prevent those dollars from going out the door, then that's typically what we recommend in our audits. This is not on the agenda, but this past week we did release a report on the 12 hour legislation and the dollars that we found in there are simply because edit checks do not exist. So we saw of the 323,000 or so in potential improper payments about 140,000 of those were instances where an individual person was billing more than 12 hours to just one MCO. So like we said earlier, the MCOs cannot see each other's data, but instances where the individual bills more than 12 hours to one MCO should not happen.

Representative Hilferty said that problem is fully in the MCO’s court and should be able to find and stop it. Mr. McDougall added that the time information would have been extremely helpful when looking at the data for that report, because we had instances where individual providers are billing for providing more than 24 hours in

a day. Now, obviously you can't provide more than 24 hours in a day, but having the time information, you would be able to go in and obviously find overlaps between services. So without the time information, we don't know when they're claiming services. Representative Hilferty remarked that LDH needs to request more information from the MCOs on the services being provided in a more real time sense they can find these things. Mr. McDougall said they actually need to get the time information from the actual provider or from the billing company because the MCOs don't even receive the time information. The only people that see the time information is the provider and the billing company if they use a billing company but they can bill the MCOs directly. That is why we keep saying it over and over again that the time information is significant. Representative Hilferty asked why the MCO would not ask to see the time information. Mr. McDougall answered that it is not required as part of the Medicaid claim. Mr. Magee said this report identified multiple instances where a person billed 15 and 18 hours in one day. But one instance on a progress note, it said that the services were provided from 1PM to 4AM. That's most likely - being in a very conservative nature of looking at it - a data entry error and they meant to put 4PM. So it looks like an improper billing but it was probably just an error in entering the data. But again, that's speculation until you actually get the progress note time data, and see what happened.

Senator Mills said I think the key question is we see so many audits come about and this one is extremely productive. I would question everybody from the MCO level to LDH, what did you learn from this audit and how can it be corrected so it doesn't happen again. From Representative Hilferty and Senator Luneau's questions we can ask what are the MCOs managing besides the per-member-per-month (PMPM). I would also challenge LDH to consider and all of us to consider these new RFPs which the MCOs are competing for such precious contracts. We need to consider how to shore these contracts up that there's some clawback provisions that if an MCO does not do what they supposed to be doing this major financial penalties involved. Every time I hear these hearings, it's always somebody dropped the ball, but the only consequence can be a monetary consequence. I ask everybody to consider taking this report and maybe not diving into specifics of that provider, but the systemic problems shown in the audit.

Senator Bernard complimented this great report and commended the thoroughness of the report. In my previous work, I used to tell people if we make a mistake, we're going to admit it and we're going to put something in place to keep it from happening again. So I appreciate Senator Mill's questions. I share the frustration because if the people send us here for anything, they sent us here for to ensure accountability. Where does the buck stop here? It's either with the MCOs, but there's a fog around the accountability of this and that's disturbing to me. I guess it's remedied partly by what Senator Mills just suggested. Let's find out what we had in it, should have had in it, and make that a requirement the next time so that there is specific accountability that we can have for this. It's discomforting to think that this is one report but how many more are out there out like. I am a new member of this committee, but I would have thought that there was a more definitive accountability for funds but it seems to be a little foggy about where the buck stops. I hope we can remedy that.

Mr. McDougall continued presenting the report findings regarding the improperly billed Medicaid services and the second sub findings. According to the progress note itself, it says the recipient of the service was not present when the service was provided. In the majority of these situations the recipient was a child and the progress notes said that they were at school at the time the service was provided so they just ended up speaking with a member of the family. Essentially the person receiving the services was not even present when it was provided.

Mr. Magee further explained that for these services, the provider prescheduled the services and visits and do not just show up. So for a school aged child that should be factored into the decision of whether or not to deliver a service at during the school day. It said in the progress notes that the child was at school. If that data were captured electronically they could run a keyword search to identify those instances.

Mr. McDougall shared the third and final finding dealing with the inadequate documentation of the services provided. Although LDH requires that all documentation supporting the service be unique for each service provided, New Horizon's workers appeared to have duplicated the same information from an entire progress note or a portion of one progress note to create a new one. We identified almost 26,000 progress notes, which is about 30% of all of the progress notes for the business for which all or a portion of the progress note was used to create six or more progress notes. He provided several examples of this practice which showed the notes could not apply to children because about jobs and was word for word the same. We found that 81.9% of the progress notes indicated that the recipients regressed made no progress or made minimal progress.

Representative Hilferty asked if the providers are required to use evidence based practices. Mr. McDougall responded that these services are non-evidence based services. Mr. Magee added that these are these two services primarily are known psychosocial rehabilitation (PSR) and community psychiatric support and treatment (CPST). Those are not evidence based services. Our report a few years ago on the service delivery model showed that the evidence based services were not being used nearly as comprehensively as these services. Representative Hilferty asked if that is because they are less expensive to administer. Mr. Magee responded that LLA's report found that the evidence based services were not necessarily more expensive than these services, especially since these services are being billed at such a high rate.

Representative Hilferty asked who picks the service for the child and if it is the provider and then it gets approved by the MCO. Mr. Magee responded we will let OBH get more detailed into it. Mr. McDougall said each provider has a clinical director or a physician that diagnoses the recipient and that diagnosis is then submitted to the MCO for approval. The units that are available to be used for that recipient are then assigned to them and the provider can draw from it. Mr. Magee added that the provider makes a treatment plan of what interventions and what services they're going to be providing to address the issues that were identified. Representative Hilferty said she does not understand why we would not require they be evidence-based, but that's not a question that's just more a statement.

Chairman Ivey asked LDH if they would like to respond and answer questions from members. Ms. Ruth Johnson, Executive Director of Medicaid, and Ms. Karen Stubbs, Assistant Director of the Office of Behavioral Health went to the witness table to answer questions.

Ms. Johnson shared that for this particular provider the MCO actually did refer them to LDH's Medicaid Fraud Investigative Unit based on some suspicious activity that they did see. So the MCOs are responsible for doing that. In the last three years, the MCOs have referred 720 behavioral health providers for further investigation. So I did not want the impression to be that it does not occur. Chairman Ivey asked for this particular example is there a date where they became aware of the suspicious behavior. Ms. Johnson responded that she could get that information for him. Chairman Ivey said he would appreciate it to see how the dates fall. Ms. Stubbs pointed out LDH's response where they referenced in 2016 and in 2018 there was some suspicious activity identified, one time by the MCO.

Senator Mills asked for the procedure when a report is turned in from the MCO that there is either suspicious activity or there's something going on. What is kind of the parameter to cut the meter off and not just keep it running until all the due process takes place. What is LDH's process? It would be like a hospital taking out of somebody's appendix eight times.

Ms. Virginia Brandt, LDH Compliance Director, explained their process. When we receive a complaint from MCO, those complaints are all referred also directly over to the Medicaid Fraud Control Unit (MFCU). Generally nothing further is done by LDH. If the MCO has looked at the provider because we have to do something called audit coordination. We can't audit the same thing that the MCO has audited. It would be particularly burdensome on the providers if we did that every time. So when we receive a complaint like that we

ensure that it is forwarded on to the AG for their investigation. If we receive any complaints or discover anything in our own audits that we determine is suspicious of fraud, we also make those referrals to the AG.

Senator Mills asked from a financial standpoint, if the meter is really running and there's becoming a tremendous amount of expenditures and there could be some fraud what are the stop gaps from just this whole process. Ms. Brandt responded that the MCOs will often place a provider on prepay review if they believe that there is suspicion of fraud without going through all of the appeals that are guaranteed to a provider, we cannot terminate their payments. Senator Mills asked if there is no process that you can take immediate action if you suspect fraud. And there's a tremendous amount of expenditures. Let's say you had a major provider and a tremendous amount of money being spent do you have to let the process go on. Ms. Brandt explained that LDH has to allow the provider to have due process and can't just terminate their ability to receive funds.

Senator Mills requested LDH to share what lessons were learned from this audit to shore up your procedures and shore up future contractual obligations. Ms. Brandt answered there is no doubt that we can do a lot more with risk based analysis of the providers. We have a limited software capability right now. Our data analytics software is not particularly robust. We have been trying in house to develop a risk based analysis on our providers but that is difficult to do it the way that we're doing it without a fully integrated software package that will allow us to do that.

Senator Mills said they could talk later and do not want to monopolize the time, but it seems like you could do a return on investment analysis of what it's going to take and what's going through the door. He asked if there is any urgency on everybody's part on this, or is this just a routine audit from LDH's standpoint. Ms. Brandt said this audit in particular is very disturbing. But even if we had the data analytics, there is a lot of stuff that is not available to us now. As the legislative auditor mentioned the time data is not a standard field on a claim. It would be required to be collected through another mechanism and we can't just change the claims system that we use because that is a national standard for the claims. It takes years to get CMS to change the claim format. It would have to be collected through an alternative system outside of the claim system.

Senator Mills questioned if these people are convicted and not a way to pay it back, then who eats the cost of this. Is it the MCO or the taxpayers? Ms. Brandt said she would have to defer to someone who's more knowledgeable about the MCOs but it's my understanding that the anything that is determined to be fraud those claims are reversed for what the MCO costs. It is not reversed out of the PMPM. It goes into the calculation of their medical loss ratio and if they don't meet that medical loss ratio, because there's so much fraud in their system, then it would affect the amount of money that they would draw. There is some calculation for fraud in the determination of the PMPM but we would really need to have somebody from the actuary to testify how that works that's way beyond my knowledge base. Senator Mills said we will discuss this further later.

Chairman Ivey asked about the process this specific case if LDH sent this case to the AG for investigation. Ms. Stubbs said contact was made in 2016 and 2018. I should say we work closely with both the LLA and the AG. As recently as two or three weeks ago, we had a conversation with the AG about another case, advising them when they have questions, asking details about the program. So it's not done in silos. They are the investigative and prosecutorial arm, and so we assist them when they need that help. The LLA and I meet regularly and they ask questions about the program. We do not ask them why they are asking questions. It's very specific. Like, hypothetically, if we had this progress note said this, what would you think? And we answer and know that they have a job to do. We help in any way we can and we have done it, and there is proof of that. It is not two branches working in silos.

Chairman Ivey asked how the MCOs are compensated. I am not so familiar with some of the ins and outs, as well as some of our new freshmen colleagues may not also be so aware. Ms. Johnson responded they are paid a PMPM fee for individuals enrolled in the program, and then there's a portion of their contract that covers their

administrative costs. Chairman Ivey asked how fraud impacts MCOs. Ms. Johnson explained that fraud impacts their medical loss ratio. There are also performance incentives that could be affected depending on what the situation is. Chairman Ivey asked if it effectively reduce their base rate of compensation. Ms. Johnson said it would depend on the situation. The PMPM is actuarially set based on the expenses that are incurred.

Representative Schamerhorn asked if New Horizons out of business right now or are we still sending them business. Ms. Stubbs responded that they are not part of the managed care network right now. Representative Schamerhorn asked if everybody that is employed in these counseling agencies are they trained and licensed or just employees under a licensed counselor. Ms. Stubbs explained that these providers are mental health rehab providers. They are one singular behavioral health provider type among many different behavioral health provider types. And they provide three specific behavioral health services among dozens of behavioral health services. So the agency like New Horizon is licensed by LDH. They employ both licensed and unlicensed staff depending on which component of the programming is being delivered. So the people under them might be a licensed clinical social worker, but it also might be a peer such as someone with lived experience who is also providing a certain component of the service. A peer is a national model and is evidence based. But to answer your direct question, the individual employees may be licensed or unlicensed depending on the component of what they're delivering. The entire entity is licensed.

Chairman Ivey inquired if the unlicensed individuals are registered with LDH. Ms. Stubbs said thanks to Senator Luneau, they all have now an individual rendering NPI number. So we are able to very specifically identify in an encounter which unlicensed employee delivered that service to that Medicaid participant. Representative Schamerhorn referred to the earlier report with 300 or so visits. I am curious if that was a licensed counselor that was actually doing the reporting. Ms. Stubbs explained that the time period that these services occurred in were likely prior to implementation of the individual NPI number. I have not seen the records and not sure if the LLA knows if the individual claiming to provide the services were licensed or unlicensed. But at this point in time we would be able to determine that if someone were delivering services in 2019 - 2020.

Senator Mizell thanked LDH for bringing their whole team. This is not like just taking money right out of taxpayers. It's giving people much less than they think they're going to get in the way of services. She asked Ms. Brandt about her comments about a complaint had to reach a certain point. Ms. Brandt said that due process is allowing the provider to appeal. We cannot just terminate them as a provider. We have to go through the process and our case has to be sufficient that it will stand up to the administrative law review and potentially into the district court, if the provider appeals all the way. Senator Mizell asked when we look at the red flags that the auditor laid out so nicely, if it because of a red flags that came through LDH's system. Ms. Brandt explained about the complaints LDH received from the MCOs. The MCOs did their own internal review of claims that had been submitted to them and based on their review they felt that it was indicative of fraud. So a referral was made to the AG in that case. Senator Mizell asked if the referring physician ever gets an update to see that no progress is being made.

Ms. Stubbs explained the initiation of a service like a Mental Health Rehabilitation (MHR) service can happen in a number of different ways. A Medicaid participant might call their managed care company and say, I need to find a provider and need XYZ service. The MCO may say here's your list of 250 MHR providers in Baton Rouge, and you can choose. At that point the mental health rehab provider would contact the MCO to receive prior authorization. It could be a referral so maybe now again the population we are dealing with are serious mental illness (SMI). So all of these Medicaid recipients, they are chronically mentally ill. It could be that they are being seen by a psychiatrist who is recommending that between the psychiatrist visits, they also receive these MHR services. So in that case, it could be kind of a physician referral. There are multiple ways you can connect to an MHR provider. The MHR services CPST and PSR are required to be prior authorized so the managed care company is looking periodically to reissue prior authorizations. I will say that with this

population there is some times where no progress is progress. This is a serious mental illness and a chronic mental health challenge. I do not know the exact case in this specific provider. The LLA made specific comments about these progress notes and making some assumptions and connections that is absolutely allegedly not the case. I am not sure what terminology I'm allowed to use while it's under investigation. In another provider situation because I don't want it to appear that I'm in any way defending the allegations of this provider audit, but in other provider situations and recipient situations, no progress might happen for a while. It might be their success. Their level of functioning may never meet the type level of functioning that you and I experience. In this situation, it appeared that they were copying and pasting progress notes that were literally incorrect and not applicable to the patient at hand.

Senator Mizell said she wonders whoever sends the patient in the first place if there is ever a check in to see the status of that patient that was sent in that we have made this investment of time and trust to. Ms. Stubbs responded that the MCO is checking in every time they do that prior authorization. I am not sure how many numbers of sessions, but they would be approved in a group of sessions. And then when that is over, they would re-prior authorize. So at some point when no progress is made which for some people that might be at the expiration of the initial group of sessions. For some people, it might be nine months or a year later when they see no progress, the MCOs care case managers would say maybe this isn't the best service for this member, let's see what else is out there and try another service. Or they might say (again, not talking about this case) that the progress hasn't changed, but they haven't ended up in an inpatient setting or emergency room. And when we see their history - because we've had them as a member for years - they were going once a month to the ER. So that might be progress for them. It's just very gray. It's very specific to the individual, but yes, the MCO should be checking in. Hopefully that member does have like a psychiatrist or another healthcare provider that is caring enough to check in and look, but at a minimum the MCO would be at that prior authorization time.

Chairman Ivey questioned the due process afforded to the providers. What authority do the MCOs have to suspend or remove providers from their network? Ms. Brandt said the MCOs are not required to contract with any provider that they don't wish to so they can terminate their contract with the provider. As I mentioned before the MCOs have the authority to place a provider on prepay review which would involve them requiring the provider to submit their claims sometimes they submit documentation with the claims and the MCO reviews that documentation before paid. There is an additional level of scrutiny on the claims before they are paid.

Chairman Ivey asked if she is aware of how many providers of this nature had their contracts terminated Ms. Brandt responded that LDH can get that information. Chairman Ivey said he would appreciate it and also asked about claim rejection in general because documentation is not provided completely or it is inaccurate or false. Do you have any data on claim rejection rates from the various providers on these services? Ms. Johnson responded they can provide denial rates information.

Representative Hilferty expressed her appreciation for LDH working with the other departments, the AG and LLA. However we are only seeing a small sliver of it two years after the fact with no real information on how the losses will be recovered. This is not an ideal scenario for the patients that were supposed to receive the services as well as for the taxpayers of Louisiana. So I guess the question is what additional information would you need to assist you in ferreting this out on the front end? Because LDH is the keepers, as I understand it, of the information across the spectrum and across the MCOs. Ms. Johnson responded there would be additional information as far as the auditor mentioned of the time that the actual service occurs. That is not something that we are currently getting, as we mentioned that's not something that CMS requires to be submitted. So we would need to get that information through a separate system outside of our current claim system. Representative Hilferty asked how difficult would it be to ask the providers to provide that information? Ms. Johnson explained in addition to that we would need some place to store it. So we would need a system to store that information, then we would have to build the analytics around it. You are asking what we would need to do the same job that the auditors did. There is some information that they had that we would have to get access to. I

believe they mentioned before that they actually went not the MCO, not the provider, but the provider's billing company. We would have to look into how we could access that because we don't have the right to subpoena like the AG.

Representative Hilferty said she would think that an app could be possible to clock in and clock out for providers. Ms. Johnson said we have visit and verification available for some providers but we would have to look at how to institute that for this group. Ms. Stubbs explained that the capability exists for an electronic medical record or electronic health record and that is happening. It costs a provider to then take that information and send it to the MCOs to build their encounters. I know I often hear that every additional piece of information the provider sends over cost them an additional amount of money. So I think those are all just barriers that you would have to get over with the tens of thousands of providers and the dozens of different electronic health records in addition to building this system.

Representative Hilferty commented that she is hearing that it is going to be tough and we cannot do it, but the reality is we are just looking at one example of multiple fraudulent visits, some of which are obviously fraudulent, where the provider was of town and others are maybe dubious at best. All we are getting back from LDH is it is very difficult or not possible. Ms. Johnson said I am not saying that it's not possible and I don't want that to be the impression. These things are possible. There are always ways to do something, but you have to weigh our ability to staff up to do that, plus the cost of doing it and then the return. So like Senator Mills had mentioned before, that is something that the department does need to look into and we commit to look into that and to report back to this committee. But I can't tell you sitting here today that I can put these nine things in place and they are going to make all fraud disappear.

Representative Hilferty said she does not think anyone is under that false impression. I certainly wouldn't want to put you in that box. But in one year from now we may look at a very similar report about a different provider that may still occur but we can see the steps put into place and hopefully this will not happen in the future. She asked if it is common practice that the MCOs pay in advance for these services since prepay review was mentioned. Ms. Brandt explained that prepay review is not paying for the service in advance. The systems process millions of claims. There are certain edits that are on those claims, but they don't require the provider to submit documentation outside of the normal claim fields in a normal environment. And they process based on what's on that claim form. In a prepay review, the MCO requires additional documentation, or they do an additional level of review of the services prior to paying that claim. But it's not paid before the services are provided. It's just the matter of whether the analysis of the claim is done before payments are made or if there is a more intensive analysis. We refer to it as retrospective review. We do many different types of retrospective reviews where we might look at claims for inpatient and outpatient services, but we do that on a retrospective basis because if we did that prior to the payment of the services then what we would most often be denying would be the claim for the hospital service because the hospital claims tend to come in later than the outpatient claims do.

Senator Luneau asked about the prepay review if there are some kind of standard criteria that they have to get to. Based on what was found in this audit looks pretty egregious. I am wondering why these people weren't put on prepaid review or maybe they were. Ms. Brandt answered that she does not believe that New Horizon was placed on prepaid review. That is generally at the discretion of the MCO to put a provider on prepaid review. What the individual MCO requires as part of their prepay review can vary. They may only review a sample of the claims that come through when they put a provider on prepay review or they may review a hundred percent of the claims that come through.

Senator Luneau asked if LDH mandates any criteria for all MCOs to use in this regard. Ms. Brandt responded to her knowledge, LDH does not. Senator Luneau asked in general do we believe that fraud is more or less now that we currently have five MCOs than we had just one insurer. Ms. Brandt asked if he meant when we had just

fee for service. She said she wished she could tell the level of fraud but unable to. If we could look at the claims data and tell you just from the claims data which claims are fraudulent and which ones were good, we would never pay the fraudulent claims in the first place. It takes more scrutiny than just review claims. And for that reason, it is very difficult to estimate the percentage of the services that are fraudulent. Senator Luneau said there is probably some data out there because what was proven to be fraudulent. Ms. Brandt said she has heard everything from 4% to 25%. I think the 25% is definitely too high. I think the 4% is probably too low.

Senator Luneau referred to earlier discussion about evidence-base healthcare. His appreciation is that evidence-based healthcare is more expensive because you have psychiatrist and psychologist generally doing this rather than a lesser educated person for lack of a better way to put it. Is that generally the way you see it? Ms. Stubbs answered that she would not necessarily agree. We have a lot of evidence based practices within the behavioral health component. In fact the audit that the auditor referenced around access to care and evidence-based and just a couple of weeks ago we had to give them an update. They were going to close that out because LDH has come so far. Our evidence based practices are not necessarily completely made up of licensed practitioners, even though most of the EVPs have more licensed practitioners than MHR, but some costs more because they're more intensive and some do not. There are evidence-based components you can incorporate. Generally licensed services are more expensive. Senator Luneau noted that a psychiatrist should cost more than a social worker, but if that is not true then we have more problems because there has to be a pay scale in there. Ms. Brandt agreed and explained the level of academic training definitely has a pay discrepancy. But our evidence-based services aren't necessarily provided by our psychiatrist. They are by our licensed social workers, which of course are different than a non-licensed clinician.

Senator Luneau asked when the MCO identifies fraud especially if it's a large amount of money, it could potentially cost them a lot of money and also lose a lot of money. So we have the people that are supposed to be identifying the fraud also being the same ones that are going to lose money if they identify the fraud. Is that in short how this works? We need to have some answers for that at some point in time and let’s come back to it next time. Ms. Johnson responded that the MCOs are contractually responsible to do that. LDH has a responsibility to have measures and controls in place to identify fraud and to make reports of that information to the AG in referrals. So I would say it is not solely the responsibility of the MCO to do that. Senator Luneau said it is part of their responsibility. Ms. Johnson said they should be held accountable for that as part of their responsibility in managing the program. Senator Luneau agreed with Senator Mills that we need to look at that a little bit more and might be a good discussion topic for our committee. It seems like we got the foxes guarding the hen house.

Chairman Ivey asked if Senator Luneau is suggesting that there may a financial incentive to maybe look the other way. Senator Luneau said it may be a conflict there and I think we have to do something different there. Chairman Ivey asked if certain MCOs are more proactive and do a better job at identifying potential fraud than others or all they about the same. Ms. Brandt responded they all seem to be about the same but more fraud referrals do come from the MCOs that cover more lives because a larger MCO. Chairman Ivey said that is expected. He would like to see a report identifying from a ratio perspective the MCOs that are more proactive at identifying potential fraud concerns. Ms. Johnson responded they would get that information to him.

Chairman Ivey asked if anyone representing an MCO who would like to provide testimony or answer questions and no one came forward.

Mr. Magee addressed Senator Luneau's questions about the evidence-based services and pulled up LLA’s previous report that Ms. Stubbs referenced. That was of course older data but one of the evidence based services is known as assertive community treatment which cost $1,100 to receive that service for a month. To receive psychosocial rehab service, which is what we're primarily talking about in this current report, cost over $3,100 for one month. Also to be in a state hospital for a month it would cost over $17,000. So of course there's

the move away from institutionalization or receiving services in the community. But it does seem depending on the evidence based service, sometimes they can be less expensive and then sometimes they can be more expensive. So I think it just depends on the evidence based service.

Senator Luneau agreed and said inpatient hospitalization obviously is much more expensive. One of the problems with evidence based treatment is that in numerous parishes in the State of Louisiana, we don't have a single psychologist or psychiatrist. All we have are social workers in those instances. So it's either this or nothing. The point I was trying to make is evidence based is not always best. It depends on the circumstances of the area and what they're trying to do.

Chairman Ivey asked if LLA or the AG was aware of this particular provider prior your data analytics model determining that they should be investigated. Mr. Magee said they were not being investigated at the time. I believe based on what LDH stated that there had been some work done by the MCOs on them but I am not sure what the end result of that work was. So they may have potentially been on the radar but they were not being actively investigated by the AG. Mr. Magee explained how LLA obtained a list of who the AG had an active case on and who LDH's program integrity section had an active case on. We compared the active cases with our list of identified concerns, and the majority matched which is good. The majority of the providers who appeared to have behavior similar to what we identified were being looked at except for New Horizon. We were able to kind of validate the model.

Chairman Ivey asked if LDH could establish were the failure was and if the MCO did alert LDH and be sure of the process to ensure that LDH did turn this entity over to the AG. Did the AG look at the limited data set and determine not worth their time? If you all could provide a timeline on this entity because I am not clear on exactly what happened in this process for New Horizon.

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Mr. Magee said they would briefly present what was found in the eligibility component of this report. We started an audit of a Medicaid provider (Business Entity No. 1) and through that work happened to find this eligibility issue. It was not one that we were really actively seeking.

Mr. McDougall provided the details on the one finding in this report. Individual A.B. may have provided incomplete and inaccurate information to obtain Medicaid benefits for her dependent children. During our analysis of Business Entity No. 1, we identified that A.B.'s children were on Medicaid. We found that she appeared to have provided incomplete or inaccurate information to LDH in order to obtain her benefits. That type of inaccurate information is she did not disclose all of her income. She did not disclose that she was married and lacked the number of member household on her application as well as lack of her income on the application. We found from January 2012 to December 2018 LDH pay the MCOs just under $28,000 for PMPMs and other benefits and LDH paid providers, $6,600 directly for Medicaid services for A.B.'s children. In addition, MCOs paid just under $80,000 to providers for services for A.B.'s dependent children. One of the key factors of this is that $49,000 of that $80,000 was paid to Business Entity No. 1 for services provided for A.B.'s children. According to LWC wage data and Business Entity No. 1 payroll and contract payment records during the time period that their children were on Medicaid, A.B. and her husband, C.D. had wages and contractor payments totaling $1.1 million of income. In addition, they used $2.8 million of Business Entity No. 1 funds make personal purchases, real estate transfers, and A.B.'s personal credit cards. During this time period, A.B. failed to identify all the household members or disclose all the income earned by the members of her household. Had A.B. provided complete and accurate information to LDH her dependent children may have been ineligible to receive the services and Medicaid benefits. We had one recommendation in this report that LDH seek legal counsel regarding the recovery of the benefits and for LDH to compare Medicaid applicants and recipients to LDH's Medicaid provider database.

Mr. Magee said over the past few years LLA had various audits on the eligibility component. LDH has made changes to the way that they determine eligibility, whether it's looking at LWC wage data quarterly instead of annually, changing various percentages and formulas that they use. Still missing is those individuals who are not classified as employees, but are instead classified as contractors. Without the tax data they are reliant on the person to tell the truth about the wages and the contractor payments. In this case, they were able to look at LWC and see no wages. According to the application, either the wages weren't told, or they were very severely under reported. In the past, there hasn't been anything to verify that against. While she was receiving approximately $10,000 every two weeks as a contractor for Business Entity No. 1, that was not visible to LDH at the time. So it is really that one last component of the complete picture that LDH needs for eligibility purposes.

Chairman Ivey commented this report predates this administration and Medicaid expansion so these failures and process and controls and really the ability to identify people who were claiming eligibility when clearly they don't goes back much further. Mr. McDougall said this report covered 2012 through 2018 so it was an ongoing process. One of the ways that they were able to maintain their eligibility, in addition to the fact that she was not reporting herself to LWC for wages, is that the children were being auto-enrolled and auto renewed, rather than the mother having to fill out an application every year. But this continued over a span of at least six years.

Chairman Ivey asked if the children qualified originally in 2012. Mr. McDougall answered that based on the income of both parents, the children did not qualify. Chairman Ivey commented that A.B. identified the blind spots and then exploiting them in the system. Mr. McDougall noted that since Business Entity No. 1 was a Medicaid application center then A.B. would know how to apply and be eligible for the program. Chairman Ivey asked if A.B. was the provider of the services for her own children. Mr. McDougall said they found only three instances where she was listed as the provider of her children's services.

Mr. Magee said this is an interesting point because there is no regulation that prohibits you from providing services to your family member. There is a regulation that I believe says you need to establish safeguards if you are going to provide services in that instance. What the definition of safe guard means there I am not sure but a provider can currently provide services to family members.

Chairman Ivey asked if the services were actually provided or were they fraudulent claims. Mr. McDougall said some of the services to the children were included in some of the findings where we questioned whether services were provided or not or that they were improperly billed. It's not a clear situation because some fall into different categories.

Senator Luneau asked in this instance what benefit does it give the recipient to do this unless it was through her company where she made money. Mr. McDougall responded that the children would be receiving free healthcare. Senator Luneau asked if they needed it. I guess if you need it that's a benefit but if you don't need these services why would somebody want to do that. Mr. Magee explained that the children received $79,000 worth of services of which $49,000 were paid to Business Entity No. 1. So there was $30,000 in benefits for other types of services that they received.

Senator Luneau said it kind of gets to the point of recipient fraud is just not worth much unless you're just trying to defraud the state to get some services that you really need. But it seems like to me the provider side of it is more important again. In this instance, the only way the recipient profited was she had money paid to her own company. Mr. Magee said in this case, they received the free health care and also $49,000 did go back into her company. Senator Luneau said the point I'm trying to make is if they really needed the services, I can understand that, but if they really didn't need the services, they don't profit anywhere from that. Mr. Magee said

if the persons are not receiving services then just the MCO is receiving the monthly PMPM, but the individuals are not receiving any benefits.

Representative Schamerhorn asked about the four dependent children. The monthly premium is almost $27,826 paid to MCOs from LDH as a snapshot of the whole deal over six years. Mr. Magee explained that the PMPMs range from $500 to $600 per month depending on the different risk categories.

Representative Freiburg asked what kind of documentation is needed for a person to acquire services. Mr. McDougall explained briefly explained that a person has to go through the eligibility process and would have to be diagnosed by a psychologist or a physician. They would have to have a treatment plan made that would then be approved by the MCO to begin receiving the services. Representative Freiburg asked if the four children had that documentation and referral approved by the MCO. Mr. McDougall clarified that only two of the children receive services from Business Entity No. 1. Mr. Magee added that all four children had Medicaid coverage that they potentially didn't qualify for. Mr. McDougall said from his recollection the documentation was done by employees of Business Entity No. 1 but did not recall there being a referral from another doctor.

Representative Freiberg asked if the same group that can diagnose it can also treat it. Mr. Magee said correct because most providers have a clinical director that they contract with that makes the determination and then that goes to the MCO for approval. Then various people, whether licensed or unlicensed, actually begin to provide the services. In the end they all work for the same provider which in this case was Business Entity No. 1. Mr. Magee pointed out one recommendation that LDH use the provider list. If LDH would have compared the Medicaid recipient list or the parent of the children to the provider list to see that they were on both. Business Entity No. 1 billed $8 million over the four years. That would just be another tool in their process to make sure that everyone qualifies. Chairman Ivey pointed out LDH already had the data and could compare providers with Medicaid beneficiaries. Mr. Magee said LDH agreed with that recommendation and are looking into how they would implement it.

Senator Mills suggested that on the Medicaid application if for a minor that the person filling it out could proclaim whether they are a provider. That could have the dual check on it. Mr. Magee deferred to LDH to answer but again the more information the better. Mr. McDougall mentioned that there is a CMS database for the national provider identification (NPI) registration number that does contain personal identifying information, such as tax ID numbers and social security numbers. It is not something that we have access to, but it's something that LDH can access and could provide us access to if they chose to. Senator Mills mentioned when applying for a gaming license there is so much disclosure that takes place on those types of things when you're doing that due diligence. It just seems that that would be one thing that you could basically ask on the application for a minor child.

Ms. Tara LeBlanc, Medicaid Deputy Director for Eligibility Division said she was there to answer any questions. Ms. Brandt said the only comment I have is that we have followed through with the recommendation that was made by the legislative auditor that we compare our provider database to our recipient database and we are actively engaged in that now. Chairman Ivey asked if they found any other instances as a result of the checking. Ms. Brandt responded that it is a time consuming process to review them. Because of the nature of the way that we received the application we can't do anything on the fraud side. For instance, if an application comes to us from the federal marketplace, we don't do a full review on them, and I also don't have an application that that individual provided to Louisiana Medicaid. So the making of a fraud case where intent is an element of it would be difficult, if not impossible in those instances. We have identified 102 potential providers who were also Medicaid recipients. We still have about 85 of those left for a review. We have identified that some of them were not Medicaid recipients at the time that they were receiving income from the Medicaid program. Their business may have closed and then they became a recipient or vice versa. Some of them, their income from Medicaid was low enough that they still qualified as recipients. Then there were a

handful that came in through the federal marketplace. There are other criteria that allowed them to continue to be eligible.

Chairman Ivey thanked the members for their diligence on these subject matters and some we will continue reviewing particularly COVID data. I know that the legislative auditor is working on an investigation on the unemployment claims and some potential fraud in that. That's obviously a big item right now and we want to make sure that we're mitigating our risk in that process.

Other Business

No other business was discussed.

Adjournment

Senator Bernard offered the motion to adjourn and with no objection, the meeting adjourned at 1:45 p.m.

Approved by LAAC on: September 14, 2020

The video recording of this meeting is available in House Broadcast Archives:
https://house.louisiana.gov/H_Video/VideoArchivePlayer?v=house/2020/aug/0817_20_LegisAudit