BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL BY THE COMMISSIONER OF ADMINISTRATION

STATE OF ALASKA, DEPARTMENT OF HEALH AND SOCIAL SERVICES v. XEROX STATE HEALTHCARE, LLC	OAH No. 14-16-CON Agency No. 060706

AFFIDAVIT OF MARGARET BRODIE

STATE OF ALASKA)
) ss.
THIRD JUDICIAL DISTRICT)

I, Margaret Brodie, being first duly sworn, upon her oath, deposes and says:

Factual Background

1. I am the Director of the Division of Health Care Services (DHCS) for the Department of Health and Social Services (DHSS) and have acted in this position since June 2012. The duties of my position include the supervision of the Enterprise Project Design, Development, Implementation (DDI) Manager and the Medicaid Medical Director.

2. Alaska's Medicaid Management Information System ("MMIS") was established in 1987 to process and pay Medicaid claims. Since then, the number of Alaskans enrolled in medical assistance programs has grown to more than 140,000. Today, Alaska's MMIS pays about $1.5 billion annually in state and federal money to doctors, hospitals and others who care for Medicaid and Denali Kid Care patients.

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3. In late 2006, DHSS issued a Request for Proposals ("RFP") to replace the old, legacy MMIS. The legacy system had been in place since 1987 and was not Internet-dependent and did not comply with changing federal requirements, including the Affordable Care Act. The RFP sought a new system flexible enough to support a variety of health care delivery systems and capable of processing claims and data from multiple programs and multiple plans. Importantly, the MMIS has to be certifiable by the Centers for Medicare and Medicaid Services ("CMS"). CMS is the federal agency responsible for administration of several key federal health care programs including Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Portability and Accountability Act. CMS provides 90% of the funds for the design, development and implementation of the MMIS (DDI), and 75% of the funds for the operation of the MMIS, once it has been certified.

The delay in providing acceptable DDI Deliverables 6, 7, and 8

4. The DDI portion of the contract was divided into eight deliverables:

Milestone	Contract Price	Contract Completion Date	Actual Delivery Date
Project Initiation (DDI 1)	$1,617,333.90	12/31/2007	6/18/2008
Requirement Verification (DDI 2)	$6,469,335.60	8/31/2008	3/1/2009
System Design (DDI3)	$3,234,667.80	10/31/2009	5/13/2010
Conversion (DDI 4)	$3,234,667.80	5/31/2010	12/7/2012
MMIS Development (DDI 5)	$3,234,667.80	10/31/2009	12/1/2012
Testing (DDI 6)	$3,234,667.80	10/31/2009	11/30/2013*
Acceptance Test (DDI 7)	$3,234,667.80	4/30/2010	11/30/2013*
Implementation (DDI 8)	$8,086,669.50	5/31/2010	5/20/2014*

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DHSS has not yet accepted DDI 6 or 7: Testing (excluding acceptance testing) and Acceptance Testing. And Xerox did not complete DDI 8: Implementation.

5. Prior to "go live" on October 1, 2013, Xerox represented to the State that it performed extensive "system testing" on the MMIS, allegedly running over 13,000 test cases to confirm that the system met the essential requirements necessary for Go Live. The State understood, based on Xerox's statements, that approximately 90% of the functionality was to be implemented and that the system was ready to Go Live. Wanting to get at least part of the long-delayed MMIS up and running, the State agreed to allow Xerox to "go live" on October 1, 2013 on the portion of the MMIS that Xerox said was "completed". The State did not give its acceptance of the MMIS. Acceptance was withheld because of the then-known defects in the system and because the development and implementation of other parts of the system were deferred. To date the system has not been fully implemented.

6. As a result of Xerox's testing and representation that the Enterprise MMIS was ready, the State allowed Xerox to "go live" with Enterprise on October 1, 2013. At the same time, the State stopped using its existing legacy system to pay providers. Once operations were shifted to Enterprise, it was not possible to restart the legacy system. Although the State was aware that Enterprise had defects, the State relied on Xerox's representations and the provided schedule of fixes in making the decision to cut over from its old legacy system to Enterprise. Xerox's defective testing,

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failure to fully implement Enterprise, and failure to cure has caused the state to suffer devastating harm that is difficult to fully quantify.

7. **Defects in the MMIS:** The following are defects in the Enterprise system that directly result from Xerox's failure to meet the DDI milestones. In particular, these defects arise from Xerox's failure to provide a fully tested and accepted deliverable for DDI 6, 7, and 8.

- System is unable to accurately balance claims as a result of a rounding error imbedded within the system;
- Extreme slow system performance surrounding medical service authorization functionality;
- System does not price claims correctly (12.4 percent of all claims are not priced correctly);
- System fails to pay certain categories of claims (e.g. hospital stays longer than three days);
- System inappropriately denies claims (many remain wrongly denied and outstanding for over a year);
- System is unable to process many claims, causing the claims to suspend;
- System lists claims as being paid, but links no provider to the claim, so checks can't issue and the claims aren't paid;
- System pays wrong provider; (also problematic because the checks go to the wrong provider with an EOB – this is protected health information);
- System is not able to produce the cost based reports needed to change the provider rates;

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- System is unable to correctly process third party liability insurance (situations where private insurance pays share of claim prior to Medicare).

Harm to the State

The following paragraphs further describe the defects in the system and describe the harm to the State arising from the defects.

8. **Failure to financially balance claims:** The first claims payment cycle in Enterprise MMIS was completed on October 4, 2013, but the claims failed to financially balance. Financial balance of claims is a fundamental tenet of MMIS claims processing and had never been an issue for the State of Alaska. Several DHCS staff spent the weekend working with a team from Xerox to attempt to isolate the issues that resulted in the off balance cycle. We were eventually able to identify to the exact penny where the reports did not match the processed claims and this led to the discovery of a rounding error within Enterprise. Due to this rounding error, additional ad-hoc reports had to be developed for the weekly cycle so that we could pay providers. The additional workload of having to identify discrepancies rather than rely on system-generated reports that balance each weekly cycle takes an extensive amount of state staff time and resources. This has remained as an ongoing issue under Enterprise. There has not been a single instance where the claims have balanced correctly under Enterprise.

9. **Problems with Service Authorization Functionality and User Input Screens:** There were the expected issues with new system stability at first and some things did improve daily. However, a major early problem was the new

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service authorization functionality and user input screens. Legacy included a portal for service authorization entry and management called SmartPA which was user-friendly for State and Xerox staff. The new Enterprise screens were so cumbersome and operationally slow that an activity previously performed in 60 to 90 seconds in Legacy, now took almost 30 minutes to accomplish in Enterprise. All travel, waiver, hospital stays, durable medical equipment orthotics, and behavioral health services are service authorization dependent. This translated into providers being unable to obtain service authorization to provide services to our recipients and ultimately, not being paid timely.

10. **Responding to Provider Complaints:** The Xerox command center was not prepared to deal with the overwhelming number of service authorization calls and complaints from providers arising from Enterprise problems. Attached hereto as Exhibit 2-A are true and correct copies of correspondence from providers to DHSS and/or its counsel surrounding problems with Enterprise. The State has been forced to field a huge increase in calls every day which was overflow from providers being unable to get through to Xerox. The Enterprise system immediately and completely overwhelmed Xerox staff, state staff, and providers.

11. **State staff time performing Xerox's work and Responding to problems with Enterprise:** Due to the enormous number of issues since this system has gone live, the State began tracking the amount of time its staff spends performing work that belongs to Xerox under the Contract and has calculated those costs at $4.5 million to date. In addition to the fiscal agent work that state staff is doing, DHCS has

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had to hire additional staff to keep up with the additional workload. We have also had to maintain the DDI State staff in order to address defects and change orders that still have not been completed. This additional staff to date has cost the state $640,385 and will continue to cost at least an additional $211,779 each year as long as we are using the Enterprise system.

12. **Loss of federal matching funds:** In order for the State to receive financial match from CMS (ranging from 50 to 90 percent of the share of the costs to design, implement, and operate), the system must be certified. The certification process consists of a number of steps that include filing an advance planning document (APD), a description of the costs and benefits of the proposed project; and an account of the activities and costs covered by the request. The prior approval process occurs before the initiation of any work. Once the system is complete, CMS conducts an onsite review to validate that all system requirements are met. As a result of the continued delays in fixing defects and completing implementation, CMS has dropped the State's reimbursement rate from 75% FFP (Federal Financial Participation) to 50% for the administration of the new system. [SOA Bates Nos. 1163-11638] This has resulted in the State paying back **$2,909,341** to the federal government. Significantly, this lack of funding crosses fiscal years. The state has to make up the difference, which diverts state funds from other important projects, resources, opportunities.

13. **Advances to Providers:** Prior to Enterprise going live, DHCS worked with Xerox to identify providers that rely heavily on Medicaid payments for their

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business. The State predetermined an amount to advance each of these providers equal to six weeks of their usual Medicaid payments so that they would not be harmed by the two week shut down of Legacy and the start-up period of Enterprise. Many unforeseen issues caused these and other providers' claims to not process through the system, so we had to expand these "advance" payments to "interim" payments and also make them available to additional providers.. We have now issued a total of **$164,633,356.00** in "advances" to providers. These were payments for valid claims that providers had submitted or attempted to submit to Enterprise for payment, but the claims suspended, denied, or paid inappropriately. Of the $164 million issued, we have collected back $60,476,117. Our current outstanding balance is **$104,157,239.** This amount will likely never be fully recovered due to crossing fiscal years, the inability of Enterprise to provide accurate records, and providers going out of business. Even if we are allowed to claim these monies in the future, it will be within a different fiscal year and the State may not have authority to utilize the funds. A total of 18 providers have gone out of business after taking advance payments. The total amount of advances that we will recover from these providers is $1,425,520 to date and could increase as we are still dealing with Enterprise issues that are adversely affecting certain providers. Had Enterprise been working properly, these advances would not have been necessary.

14. **Loss to the general fund:** In an attempt to mitigate the damage, the State asked CMS for permission to manually adjudicate these claims and draw down the federal dollars associated with them. CMS granted permission and in June 2014,

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we moved these expenditures to codes that would allow us to federally claim them. The federally claimed dollar amount associated with these claims is $78,653,426. The funds were drawn down in June 2014, but this was subsequently overruled by Legislative Audit, and we have had to pay back the federal funds. Due to the inability to draw down this amount, the general fund for state fiscal year 2014 was shorted the **$78,653,426** which could have been re-appropriated for other purposes.

15. **Loss of insurance payments:** DHCS contracts with a third party liability ("TPL") vendor that recovers Medicaid expenditures from recipient insurance policies. Since go-live, Enterprise had adversely affected our TPL contractor's ability to fulfill their contractual obligations. For example, the contractor has been unable to get a reliable data interface from Enterprise since go live resulting in the TPL contractor being unable to collect on claims that should have been billed to a private insurance company rather than to Medicaid. The contractor typically collects on average $12 million per year for this task. In fiscal year 2014 they collected $6,257,935 which is more than **$6 million** short of the previous year's collections. They also collect for claims that should have been billed to Medicare rather than Medicaid. Medicare has strict time limits under which a claim for these services can be made. As of July 2014 the State lost the ability to Claim $731,337 in Medicare payments. Another six months have passed so that number is now estimated to double or **$1,462,674.** Since go-live, In addition, Enterprise has not been able to process third party liability insurance

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correctly. This is where commercial insurance companies pay their share before Medicaid pays considers payment.

16. **Harm Caused by Xerox subcontracting to Cognizant for DDI and failing to fully staff the project:** After Enterprise went live, the State was informed that Xerox had subcontracted the development piece to a company known as Cognizant back in August of 2013. Cognizant staff that Xerox assigned to interface with the State team were given Xerox email addresses so the State had no way of knowing that they were working with an entity other than the contracted fiscal agent, Xerox. From October 9, 2013 through to present day, Xerox has steadily taken manpower and expertise away from the Alaska Enterprise project. The State was not informed that the command center was disengaged from the project, that certain individuals were transferred to Cognizant, that some quit, and that others had asked to be transferred from the project as they were being overworked. Originally, two high level managers were assigned by Xerox to manage the tasks of DDI and Operations. Now, only one manager remains. Xerox has left the most critical of all positions, the Systems Manager, vacant for seven months as of this date. Another critical position, the Service Utilization Reviews ("SURS") manager, has been vacant since last May. These are all vital positions identified specifically in the contract.

17. **Potential liability to the State resulting from audits:** In fiscal year 2008, Alaska Medicaid had a Payment Error Rate Measurement (PERM) of 0.47% while the national average was 2.62%. In fiscal year 2011, the Alaska Medicaid PERM

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rate was 1.4% with a national average of 3.3%. We are currently mid-cycle of the third federal PERM audit, so it has not yet been determined what our error rate will be, but according to a recent payment review report completed by Kevin Quinn at Xerox, Alaska can expect anywhere from 6% to 12.4% PERM error rate.[1] PERM errors are extrapolated over the entire population of claims paid in FFY2014. We are expecting to have to pay back to the federal government substantial sums. While DHSS can't know what this number will be with certainty, it will likely be between 6% and 12.4% of the total amount of Medicaid claims paid, which is approximately $1.2 billion.

In addition to the PERM audit we have four other audits occurring right now:

- The National Correct Coding Initiative (NCCI) audit which is problematic because Xerox has not been able to produce the NCCI mandatory quarterly reports since go-live. We do not know what the penalty for non-compliance will be.

- The Office of the Inspector General (OIG) has just initiated an audit on Indian Health Services (IHS) claims. This audit does incorporate the first quarter of go-live where we know that Enterprise paid fee for service plus the encounter rate rather than just the encounter; that it did not apply third party liability cost-avoidance correctly; and it only paid for the first three days of hospital stays regardless of the length of authorized stay. This audit will not be finalized until July 2015. There is no way to determine what the damage will be to the state at this time. This type of audit also uses the extrapolation method so it is likely that it will result in a significant dollar amount.

- Legislative Audit just completed its Single State Agency audit. As a result of the state of Enterprise, the Commissioner of the Department of Health and Social

[1] On January 29th Xerox made a presentation to the Governor's Chief of Staff and the Commissioner of DHSS at which it represented that the payment error rate was 1.2%. DHSS strongly disagrees with this percentage and believes the actual percentage is between 6% and 12.4%

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Services has received two management letters from Legislative Audit. One formal recommendation is that the "DHSS Commissioner should work with Xerox to correct defects in the Alaska Health Enterprise (AHE) system."

- The final audit is currently underway is House Bill 30. We do not know when Health Care Services will be addressed in the Department's audit. We are sure that Enterprise will be an issue in the State's ability to provide the required information needed to complete the audit.

18. **Inability to comply with Medicaid mandates, regulations and requirements since Enterprise went live:** Currently the State is out of compliance with the following federal mandates as a result of the defective deliverables:

- HIPAA Operating Rules
- T-MSIS
- Hospital Presumptive Eligibility (CMS made the state come up with a manual work around)
- Referring/ordering provider
- ICD-10 (The state was placed on a corrective action plan)
- Cost Sharing

19. **Inability to move forward with regulation projects**: due to delays and defects in implementation of Enterprise, the State has been unable to move forward and complete the following regulations projects:

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
- Free Standing Birth Center
- New Waiver Regulations
- Last EPSDT regulations
- Last waiver regulations
- Behavioral Rehabilitative Services regulations
- EMAR reports

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20. **Lost opportunities; inability to implement State initiatives:** We have not been able to implement any state initiatives that would result in savings to the state. We had intended on implementing the Division of Juvenile Justice Medicaid program in March 2014 which would have saved the State approximately **$1.5 million a year**. Senior and Disabilities Services Telemedicine is not implemented, which would have saved state travel costs and streamlined the assessment process for the home and community based waiver program. This was ready to go in October 2013. The last item is for the Division of Behavioral Health's Behavioral Health Aides. This was intended to save state funds by not having to travel individuals from villages into regional hubs to receive treatment. We have not completed the regulations as there is no specific timeframe for when Enterprise will be able to accommodate this change. These losses in savings are very difficult to estimate.

21. **Additional Development Costs:** In addition to these lost opportunities, the State will end up having to pay development costs in the millions of dollars because many items that are typically configurable in an MMIS, were hard coded by Xerox into the core. Things such as new benefit plans, and provider rate changes should normally take just a few minutes to update. But because they were built into core and not in relational tables, the state has to pay for the coding changes and programmers hours in core. The cost to the State for these items being will be millions of dollars per year.

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I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Margaret Brodie

SIGNED AND SWORN TO before me on February 2 2015, in Juneau, Alaska.

STATE OF ALASKA
OFFICIAL SEAL
James Chennault
NOTARY PUBLIC
My Commission Expires With Office

Notary Public in and for Alaska
My commission expires: with office

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