

ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

February 4, 2014

3:05 p.m.

MEMBERS PRESENT

Representative Pete Higgins, Chair
Representative Wes Keller, Vice Chair
Representative Benjamin Nageak
Representative Lance Pruitt
Representative Lora Reinbold
Representative Paul Seaton
Representative Geran Tarr

MEMBERS ABSENT

All members present

COMMITTEE CALENDAR

HOUSE BILL NO. 263

"An Act extending senior benefits."

- MOVED CSHB 263(HSS) OUT OF COMMITTEE

PRESENTATION: MMIS~ DEPARTMENT OF HEALTH AND SOCIAL SERVICES

- HEARD

PREVIOUS COMMITTEE ACTION

BILL: HB 263

SHORT TITLE: EXTEND SENIOR BENEFITS PAYMENT PROGRAM

SPONSOR(S): REPRESENTATIVE(S) HAWKER

01/21/14	(H)	READ THE FIRST TIME - REFERRALS
01/21/14	(H)	HSS, FIN
02/04/14	(H)	HSS AT 3:00 PM CAPITOL 106

WITNESS REGISTER

REPRESENTATIVE MIKE HAWKER
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: Presented HB 263 as the sponsor of the bill.

RON KREHER, Director
Director's Office
Division of Public Assistance
Department of Health and Social Services
Juneau, Alaska

POSITION STATEMENT: Answered questions during discussion of HB 263.

WILLIAM STREUR, Commissioner
Office of the Commissioner
Department of Health and Social Services (DHSS)
Juneau, Alaska

POSITION STATEMENT: Answered questions during a discussion of the Medicaid Management Information System and the Department of Health and Social Services.

DAVID HAMILTON, Group President
Government Health Care Solutions
Xerox Corporation
Lexington, Kentucky

POSITION STATEMENT: Testified and answered questions during the discussion on the Medicaid Management Information System (MMIS).

CRAIG STEFFEN, Managing Director
SVP Health Enterprise Operations
Government Health Care Solutions
Xerox State Health Care, LLC
Atlanta, Georgia

POSITION STATEMENT: Testified and answered questions during the discussion on the Medicaid Management Information System (MMIS).

LISA SMITH, Acting Executive Director
Choices, Inc. & Soteria-Alaska
Anchorage, Alaska

POSITION STATEMENT: Testified and answered questions during the discussion on the Medicaid Management Information System (MMIS).

KAREN PERDUE, President and CEO
Alaska State Hospital & Nursing Home Association (ASHNHA)
Anchorage, Alaska

POSITION STATEMENT: Testified and answered questions during the discussion of the Medicaid Management Information System.

CHERYL CAMPBELL
Alaska Speech and Language Depot, Inc.
Anchorage, Alaska

POSITION STATEMENT: Testified during a discussion of the Medicaid Management Information System.

JULIE DYER
Catholic Community Service
Juneau, Alaska

POSITION STATEMENT: Testified during a discussion of the Medicaid Management Information System.

NANCY LOVERING
Anchorage, Alaska

POSITION STATEMENT: Testified during a discussion of the Medicaid Management Information System.

ROSALIE NADEAU, CEO
Akeela

Anchorage, Alaska

POSITION STATEMENT: Testified during a discussion of the Medicaid Management Information System.

SUSAN GARNER, Finance Director
Mat-Su Services for Children and Adults, Inc.
Wasilla, Alaska

POSITION STATEMENT: Testified during a discussion of the Medicaid Management Information System.

MALANE HARBOUR, Executive Director
Primrose Retirement Community
Wasilla, Alaska

POSITION STATEMENT: Testified during a discussion of the Medicaid Management Information System.

TOM CHARD, Director
Alaska Behavioral Health Association
Juneau, Alaska

POSITION STATEMENT: Testified during a discussion of the Medicaid Management Information System.

THERESA SABENS, Occupational Therapist
Building Blocks Rehab
Fairbanks, Alaska

POSITION STATEMENT: Testified during a discussion of the Medicaid Management Information System.

SANDRA JAMISON, Owner
Talkabout, Inc.
Fairbanks, Alaska

POSITION STATEMENT: Testified during a discussion of the Medicaid Management Information System.

ACTION NARRATIVE

[3:05:28 PM](#)

CHAIR PETE HIGGINS called the House Health and Social Services Standing Committee meeting to order at 3:05 p.m. Representatives Higgins, Pruitt, Nageak, Keller, Seaton, and Reinbold were present at the call to order. Representative Tarr arrived as the meeting was in progress.

HB 263-EXTEND SENIOR BENEFITS PAYMENT PROGRAM

[3:06:44 PM](#)

CHAIR HIGGINS announced that the first order of business would be HOUSE BILL NO. 263, "An Act extending senior benefits."

[3:07:11 PM](#)

REPRESENTATIVE MIKE HAWKER, Alaska State Legislature, as sponsor of HB 263, offered an overview of the bill. He explained that this proposed bill would extend the termination date of the Senior Benefits Payment Program from June 30, 2015 to June 30, 2021. He shared that the program had been established in 2007, in response to the recognition for the unsustainability of the original Longevity Bonus Program, which was not a needs based program. He reported that there was still a need and a desire to address the expenses of living in Alaska for low income seniors. He explained that this was a three tiered program for benefit payments of \$125, \$175, or \$250 each month, based on household income relative to the federal poverty level index. He declared a desire to help Alaskan seniors with the proposed bill, which would extend the program for six years through 2021.

[3:10:40 PM](#)

REPRESENTATIVE PRUITT asked for an explanation to the program extension being presented this year, as it would not expire until next year.

REPRESENTATIVE HAWKER, in response, said that the program was a "life-safety security for these seniors." He explained that waiting until next session would create greater angst for

seniors, while this proposed bill would let them know in advance that the program was being extended. He declared that the average age of the recipients was 75 years, and he said "quite frankly, those are folks I don't want to cause trauma and concern for over the course of the coming year."

[3:12:17 PM](#)

REPRESENTATIVE SEATON expressed his agreement with bringing this issue forward early, although he stated concern for the six year length of the proposed extension. He pointed out that the current rate of deficit spending had reduced savings, which were projected to run out sometime in the not too distant future. He suggested amending the proposed bill to a three year extension, as this would not put fiscal constraints on a future legislature.

[3:13:59 PM](#)

REPRESENTATIVE HAWKER offered his opinion that the values of the elected representatives to the State of Alaska should prioritize programs which benefited all low income seniors across the state. He asked to give low income seniors this additional surety that the program had endorsement from the legislature for more gravitas in the future. He allowed that the program would always have to compete in the budget process for adequate funding, although it should not have to "fight for its very existence in a subsequent reauthorization." He declared that this was the right thing to do, and the best thing to do, for our seniors, and that it was possible for this to be done right now.

[3:16:22 PM](#)

CHAIR HIGGINS expressed agreement with Representative Hawker, although he stated his agreement with Representative Seaton for fiscal conservatism. He declared that elders and children were valuable resources in Alaska, and this value should not be questioned. He endorsed the proposed bill in its current form.

REPRESENTATIVE HAWKER indicated AS 47.45.301(c), which stated that program funding could be reduced or eliminated in a fiscal year by the Department of Health and Social Services (DHSS) if it estimated that appropriations for the program were insufficient to meet the demands of the program. He declared that there was an expansion and contraction mechanism in the program, which would accomplish the same goal as intended by

Representative Seaton, without prematurely terminating the program.

[3:18:17 PM](#)

REPRESENTATIVE SEATON asked if the current statute allowed the department to shift payments to the most economically challenged, as opposed to a pro rata reduction.

[3:19:08 PM](#)

REPRESENTATIVE HAWKER directed the question to DHSS for its interpretation of the statute and its intentions. He reported that low income seniors were not funded if in prison, in state nursing homes, in veterans or Pioneer homes, or in public or private institutions for mental disease. He declared that the state was "very prudent with our spending of the money for this program."

[3:20:18 PM](#)

RON KREHER, Director, Director's Office, Division of Public Assistance, Department of Health and Social Services, said that generally a pro rata reduction to balance across the groups served would be followed, but ultimately DHSS desired to ensure that those at greatest risk with the lowest income would be ensured of the benefit.

[3:21:14 PM](#)

REPRESENTATIVE SEATON asked if the statute would require a pro rata approach, or could the majority of payment be directed to the most economically challenged group.

[3:21:39 PM](#)

MR. KREHER offered his belief that the statute allowed flexibility for either approach, as this specific program was not heavily regulated.

[3:22:15 PM](#)

REPRESENTATIVE NAGEAK clarified the income limits for benefits.

REPRESENTATIVE HAWKER pointed out an inconsistency regarding the income limits of the federal poverty level in the sponsor statement. Since it was written, there had been an adjustment

of the federal poverty level and he said he would revise the sponsor statement. He stated that the smallest payment, \$125 per person per month, applied to an individual senior with a personal annual income of less than \$25,515, or a married senior couple with annual income less than \$34,405. He said this was bench marked to 175 percent of the federal poverty level. He reported that the \$250 per person per month payment went to individual seniors with a personal income of \$10,935 or less, or married senior couples with an income of \$14,745 or less, which was 75 percent of the federal poverty level. He emphasized the difficulty for these elders with the costs of living in Alaska. He reflected that a lot of time had been spent creating these tiers on the original bill, and that the program has proven its importance and its durability and workability for the state. He declared that DHSS had wide latitude to determine equitable funding for the program, if it could not be fully funded.

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CHAIR HIGGINS closed public testimony.

[3:26:31 PM](#)

REPRESENTATIVE KELLER moved to adopt Amendment 1, labeled 28-LS1256|A.1, Mischel, 1/31/14, which read:

Page 1, line 1:
Following "**extending**":
Insert "**the Alaska**"
Following "**benefits**":
Insert "**payment program**"

There being no objection, it was so ordered.

REPRESENTATIVE HAWKER, as the sponsor of proposed HB 263, expressed his support for Amendment 1.

The committee took a brief at-ease.

[3:28:16 PM](#)

REPRESENTATIVE SEATON referenced his earlier concern for the six year extension in proposed HB 263. He moved to adopt conceptual Amendment 2, "which would be to change on line 6, page 1, 2021 to 2017."

[3:29:11 PM](#)

REPRESENTATIVE KELLER objected for discussion.

REPRESENTATIVE SEATON offered his belief that the department [DHSS] would pro rata everything down, and he offered examples to these payments. He opined that the legislature should determine the payments. He expressed his concern for extending a \$25 million annual program for six years, when a budget deficit was projected in the near future.

3:30:45 PM

REPRESENTATIVE PRUITT, referencing the proposed conceptual Amendment 2, asked if Representative Seaton had intended the proposed expiration date to be 2018, instead of 2017, as that would be three years after the current expiration.

3:31:17 PM

REPRESENTATIVE SEATON asked to restate the expiration date in his proposed conceptual Amendment 2 to be 2018.

3:31:45 PM

REPRESENTATIVE NAGEAK noted that the value of income levels was dependent upon the cost of living in various areas of the state.

REPRESENTATIVE HIGGINS reminded committee members that discussion should be limited to proposed conceptual Amendment 2.

REPRESENTATIVE KELLER expressed his support for the Senior Benefits program, as it was an Alaska program, and was not initiated through a federal matching program. He explained:

It's one we saw the need, we see the need, and we're addressing it, and the reason that is significant to the amendment, is that I personally prefer to give the seniors a leg up on this one, because, if we get in, like we are all very concerned about, the legislature, if we get into this boat of looking for ways to cut, this is going to be low hanging fruit, because its dollar for dollar; in other words, they cut a dollar out of spending for senior programs, it's a dollar more in general funds; whereas a lot of the Medicaid stuff, you know, we have to cut twice as much in the spending in order to get the same savings.

REPRESENTATIVE KELLER expressed his desire to pass the proposed legislation, and declared his opposition to proposed conceptual Amendment 2.

[3:34:08 PM](#)

REPRESENTATIVE TARR expressed her opposition to proposed conceptual Amendment 2, stating that a longer term commitment promoted better planning and encouraged seniors to stay in Alaska.

[3:35:11 PM](#)

REPRESENTATIVE SEATON withdrew proposed conceptual Amendment 2. He declared his support for the program, and suggested that the legislature, and not a department, should have the latitude to make any changes to the program.

[3:35:37 PM](#)

The committee took a brief at-ease.

[3:36:03 PM](#)

REPRESENTATIVE KELLER moved to report HB 263, as amended, out of committee with individual recommendations and the accompanying fiscal notes. There being no objection, CSHB 263(HSS) was moved from the House Health and Social Services Standing Committee.

[3:36:39 PM](#)

The committee took an at-ease from 3:36 p.m. to 3:40 p.m.

Presentation: MMIS, Department of Health and Social Services

[3:40:31 PM](#)

CHAIR HIGGINS announced that the next order of business would be a discussion regarding the Medicaid Management Information System (MMIS) and the Department of Health and Social Services.

WILLIAM STREUR, Commissioner, Office of the Commissioner, Department of Health and Social Services (DHSS), declared that responsibility for the implementation of the MMIS rested with him and with Xerox. He said that although DHSS did not have the technological capabilities for this system, it would ensure that the system worked as advertised. He relayed that the contract

with Xerox and ACS was \$32,487,982, of which the state commitment for development of the system was 10 percent, between 2007 and October, 2013. He clarified that there had been \$146 million spent for development and seven years of operation with 130 Xerox employees. He reported that there had been a lot of training for state and Xerox staff since July, 2013. This training was conducted on the new platform to provide availability 24/7 from any internet connected computer. He noted that there were 37 courses available for internal system users, with 130 classes scheduled to assist and enhance the capabilities for provider use of the system during the first three months of 2014. He acknowledged that a glaring weakness had been a lack of sufficient advance communication, and that DHSS would work closely with Xerox, as well as the provider community, to fix the challenges to the system. He said that there had been \$118 million in advance payment to the providers to assist with payment of claims for services. Directing attention to the requirement for timely filing, he stated that this had been temporarily suspended. He stated that allowances would be made for other issues, including Medicare cost reports.

[3:46:36 PM](#)

CHAIR HIGGINS established that he was a dentist, and his offices had felt the "domino effect" as this affected operations and overhead. He declared that there were many questions, and that people wanted information and transparency. He stated that the system was three years late in the coming, and "it just simply didn't work."

[3:47:55 PM](#)

DAVID HAMILTON, Group President, Government Health Care Solutions, Xerox Corporation, confirmed that he was the Xerox senior executive responsible for all of its government programs. Reading from a prepared statement, he noted that Xerox had had the fiscal agent contract since 2008 for both processing the daily operation and implementing the new system. He reiterated that there were 130 Xerox staff working day to day operations, and including the project team, there were almost 400 people working on the program. He declared a commitment to the state and the providers for a rapid resolution. He shared that the copy business was now the smallest piece of Xerox, whereas the largest pieces were business and industry services, which included public and private health care processing. He offered that Xerox had worked with Medicaid since shortly after the program was created in 1965, and that Xerox processed for nine

other states. He explained that the technology program in Alaska "was our latest and greatest solution, it is one where we have been up and running for roughly 9-10 months in New Hampshire, both in terms of their claims programs and managed care programs." He declared that this was a product and program to which Xerox was very committed. He reported that this was a large system, with about 7 million lines of code conforming to more than 10,000 business requirements in Alaska. He declared that this program replaced a 25 year old system which could not accomplish all the mandates from health care reform. He acknowledged that the program was "not where we want to be, but signs of progress are beginning to show through." He referenced key information from the claims and service authorization processing for accessibility and turnaround times, which reflected significant progress. He pointed out that the old system processed about \$25 million in claims per week, whereas this system was better than that, processing over \$30 million in claims for the previous three weeks, while currently working down the backlog of claims from the fourth quarter of 2013. He stated his regret that the service authorizations had had periods of 40-60 minutes for access. He stated that currently the wait time was under 5 minutes, and would be sustained with the addition of staff and system improvements. He acknowledged the variation between processing paper and electronic claims, as clean electronic claims were adjudicated very quickly, whereas paper claims required manual processing. He offered his belief that, as they were processing almost 8,000 claims each week, the paper backlog would be cleared during the next three to four weeks. He offered his belief that progress had been made and extended his apologies for the disruptions, stating that Xerox was escalating its response toward rapid completion.

[3:55:13 PM](#)

CHAIR HIGGINS asked if Alaska, as the second state to institute this program, was used as a learning curve for Xerox.

MR. HAMILTON, in response, acknowledged that "there is a bit of a learning curve that products in general mature in the market place." There was a benefit of lessons learned for later versions.

[3:55:53 PM](#)

REPRESENTATIVE KELLER asked how the 10,000 business considerations in Alaska compared to the other states.

3:56:22 PM

CRAIG STEFFEN, Managing Director, SVP Health Enterprise Operations, Government Health Care Solutions, Xerox State Health Care, LLC, replied that, although every state was complex, unique, and required tailoring around its policies, the number of Alaska requirements were similar to those in New Hampshire. He stated that although the core system did most of the day to day managing and handling of claims from providers and recipients, the specific policy of each state required complex tuning, as each state was different. He declared that Alaska was not a test site, and that the system was specific to the needs of Alaska.

3:58:01 PM

REPRESENTATIVE SEATON, offering an anecdotal account from a constituent regarding expiration dates on the insurance cards, asked if this was a concern throughout the state and if there was an update on the status.

3:59:03 PM

MR. STEFFEN replied that, although a year of eligibility was printed on the cards, eligibility was issued on a monthly basis. He established that Xerox received daily eligibility updates from the Division of Public Assistance to post on the system. He considered that the eligibility issue could have been either with the system or with the individual member. He acknowledged that there had been issues with timely eligibility transfers into the system, and with communication to the pharmacy system. He stated that whenever this had occurred, they had contacted the pharmacy benefits administrator with appropriate eligibility information.

4:00:24 PM

REPRESENTATIVE SEATON asked for clarification regarding the dates on the benefit cards.

MR. STEFFEN offered his understanding that this was a policy of the State of Alaska, and was not a Xerox protocol.

REPRESENTATIVE SEATON expressed concern for his constituents' ability to obtain medication, and suggested there be a notification process.

[Chair Higgins passed the gavel to Representative Pruitt.]

[4:03:02 PM](#)

MR. STREUR requested more details regarding the specific instance, offering his belief that there was 24/7 access to pharmacies.

REPRESENTATIVE SEATON observed that more communication was necessary.

REPRESENTATIVE SEATON asked for assurance that the outstanding money due to the large providers in Homer would be paid in a timelier manner.

MR. STREUR, in response, said that there were advances available for almost 100 percent of the billing amounts; however, the larger providers were most reluctant about accepting an advance with concerns for any future adjudication. He offered his belief that no one had been denied an advance, especially to "keep the doors open, to keep their staff working, and to ensure that services continue." He offered to provide more details for the availability of the advances.

REPRESENTATIVE TARR shared that the delay had affected the ability for day to day operations with one of her constituent providers. She questioned whether the availability for advances had been communicated to all the eligible organizations.

[4:06:33 PM](#)

MR. STREUR, in response to Representative Seaton, said that Medicaid Fair Hearings were not related to MMIS, and it was primarily for claims and authorizations which had been disputed. He offered to forward more information.

[4:07:37 PM](#)

REPRESENTATIVE PRUITT opened public testimony.

[4:08:02 PM](#)

LISA SMITH, Acting Executive Director, Choices, Inc. & Soteria-Alaska, stated that her organization had received very little communication once the new MMIS site went on-line in October, although they had a backlog of Medicaid billings. She explained that it had been necessary to draw from reserves for the

following month and a half. Neither she, nor the Medicaid billing service they used, was able to access on-line. She explained that it was now very difficult to meet the required state matches to grants. She shared that she had twice requested advances from the Division of Health Care Services, but had yet to receive any response. She declared that the current system was not working, and she had heard that all Medicaid billing had been suspended for the next four to six weeks. She predicted they would need to close business, if this was not corrected. She detailed that this would affect both the beneficiaries and the staff members.

4:10:09 PM

REPRESENTATIVE SEATON asked for more specifics about the request for an advance.

4:10:51 PM

MS. SMITH, in response to Representative Tarr, explained that Choices, Inc. was an outpatient service for adult behavioral health, except for medication management. Through Choices, Inc. they had Soteria-Alaska, which was an alternative residential facility for people who wanted to make decisions on their own. She reported that the organization had been pressured toward a medical model in which beneficiaries apply for Social Security and Medicaid.

4:12:22 PM

KAREN PERDUE, President and CEO, Alaska State Hospital & Nursing Home Association (ASHNHA), sharing that she was representing the 30 members of ASHNHA, reported that ASHNHA had surveyed its members in the last week regarding the MMIS implementation. She directed attention to the survey results [Included in members' packets]. She highlighted some of the issues and suggested solutions. She reported that most facilities were showing unusually high balances for Medicaid accounts receivable, with a total for receivables of \$198 million. She stated that the status of the denials and re-submittals changed weekly, making it more difficult to accurately report. She expressed a need for benchmark statistics to better track over time. She acknowledged the support from State of Alaska and Department of Health and Social Services staff, although there was still a feeling of frustration as the providers did not perceive the improvements in the system which Xerox had described. She reported that timeliness and accuracy were all rated poorly in

the survey. She offered to run the survey again in a few weeks to gauge any improvement. She established that 62 percent of the survey respondents stated that the system had not improved since November, pointing out that the provider inquiry line with its 30 minute waiting time was a huge source of frustration. She reported that many providers had quit calling the inquiry line. She mentioned that half the ASHNHA members had received advance payment, although it was difficult to reconcile to individual payments. She pointed out that the administrative burden was high, as claims needed to be re-processed. She endorsed support for the timely filing exemption, asking that it be in writing, and for the tracking provided by Xerox. She asked about metrics for solutions to ensure solutions were attained. She emphasized the need for a focus on long term care in the small hospitals, as these institutions were not able to sustain the large accounts receivable debt. She declared that transparent metrics for better tracking would raise provider confidence.

[4:17:44 PM](#)

REPRESENTATIVE SEATON expressed his appreciation for the survey. He asked if advances could be tied to specific claims and whether this would solve the problem for those people wanting the advance.

MS. PERDUE, in response, explained that it would be helpful if the advance payment was a lump sum and did not have to be reconciled similar to each individual advance payment.

REPRESENTATIVE SEATON expressed his agreement that this was a short term solution for, hopefully, a short term problem. He offered his belief that this would work for the providers, as well as Department of Health and Social Services and Xerox.

MR. HAMILTON relayed that DHSS had made several recent attempts to change the policies, and he offered to work with them for a solution.

[4:20:27 PM](#)

REPRESENTATIVE TARR asked if the timely filing exception was an already in-place remedy that would address this need. She asked if these administrative issues were preventing any of the health care providers from serving patients. She asked how the organizations were taking on this additional burden for processing.

MS. PERDUE, in response to Representative Tarr, offered her belief that Department of Health and Social Services had extended the timely filing requirement for one year. She declared that the burden to small hospitals did not affect direct patient care, although it did create more work for the business office. She opined that it was an even greater impact on the small community agencies.

REPRESENTATIVE TARR asked if there had been any decisions to not provide care because of this processing problem.

MS. PERDUE opined that this was not the case.

[4:22:43 PM](#)

CHERYL CAMPBELL, Alaska Speech and Language Depot, Inc., relayed that she was a speech language pathologist, and, as a sole proprietor, she provided direct patient care and prepared the billing. She declared that her biggest issue was for patients with Medicaid as second insurance. She submitted these as paper claims, in order to attach the third party insurance information directly to the claim. She declared that she had not yet received payment for any services to these clients since the Xerox transition, and that Xerox would not offer any timeline for reimbursement. She had not received any payment for these clients since early September, 2013, with more than \$13,000 in outstanding claims for two clients. As of January 1, 2014, the Centers for Medicare and Medicaid Services (CMS) had changed the procedure codes for speech language evaluations from one to four codes. She reported that she had discussed the procedure code changes with Xerox in December, and had been informed that the new codes would be valid on January 1. Her first claim was denied by the electronic billing system on January 17, 2014, and, when she called, she was informed that there was no timeline to the availability for use of the codes. She was advised not to bill any evaluation services until the new procedure codes were available. She had, to this point, only received minimal reimbursement, and her business was quickly approaching a critical financial point. She noted that the call time to provider inquiry was a minimum wait for 30 minutes, no matter the time of day.

[Representative Pruitt returned the gavel to Chair Higgins]

MR. HAMILTON, in response, said that the Xerox staff would follow up with DHSS in the next 48 hours.

4:28:38 PM

JULIE DYER, Catholic Community Service, stated that Catholic Community Service (CCS) had a behavioral health division, a senior services division, and a hospice and home health agency. She reported that CCS was being reimbursed, which she opined was due to its narrow code set. She declared that prior to October 1, 2013, there was a three week turnaround for a prior authorization to Xerox, whereas now it was a three - four month turnaround. For its waiver program, they had not received any authorizations since the transition. She explained that they were not the provider submitting the plans for care, however, without an authorization, she did not know anything about each waiver status. She offered her belief that discussions regarding the viewing of authorizations were ongoing between the state and Xerox. She declared that waiver claims would be at a negative collection rate by the end of March, if authorizations were not put in place. She directed attention to a suggested fix that Xerox mail authorizations to providers, which was the method under the previous system; however, the state had refused as they believed that "providers should be able to see them on the new system." She opined that this "seems like a really simple fix to a very big problem." She expressed her appreciation for the statement by Commissioner Streur that the system will run as advertised; although, she pointed out, the providers should not be the ones penalized in the meantime.

CHAIR HIGGINS asked where was the hold up for the waivers.

MR. HAMILTON, in response, stated that DHSS and Xerox can work out a solution for the print copy.

MR. STREUR opined that the problem was with both DHSS and Xerox, and he would investigate this problem.

4:34:32 PM

REPRESENTATIVE SEATON, reflecting on the authorizations, asked if these were for new waivers.

MR. STREUR explained that eligibility for public assistance and Medicaid came every month, while new authorizations for services to be rendered to an individual were renewed annually.

REPRESENTATIVE SEATON asked if the monthly authorization was a new procedure and if this was complicating the system.

MR. STREUR replied that this was not a new procedure. He stated that an advantage of the healthcare reform was greater flexibility in that area.

4:36:10 PM

NANCY LOVERING, expressed concern with the difficulty for receiving reimbursement, as she was a sole proprietor with a single employee. She was cautious regarding the proposed advances for fear of audit. She reported that claims were denied and no secondary claims were paid. She stated that Xerox told her that the claims filed prior to the shutdown would have to be re-filed, and she emphasized how costly multiple filing was for a small business owner. She observed that the Xerox system would often shut down in the middle of processing. She lauded Darren Culp, a Xerox employee in Anchorage, who had been extremely helpful and diligent.

ROSALIE NADEAU, CEO, Akeela, explained that Akeela was a behavioral health program throughout Alaska. She shared that most of the funding problems had been with mental health claims. She confirmed that Akeela was having the same problems as those listed by previous testifiers. She added that Xerox had no code for an eligible Medicaid service. She stated that there was major concern for a non-profit to take an advance, as it was incumbent upon them to prove the claims against those advances which created problems for audits and it cost a lot of extra money for clerical staffing. She observed that Akeela had to prove its legitimate billings against the advances, and she opined that a better way would be to treat this as a loan against the billings. She suggested that some smaller providers would not be able to stay in business with this system.

CHAIR HIGGINS offered his belief that audits for this time period would be a "nightmare," as any irregularities created an issue.

MR. STREUR, in response, said that this was another example of the need for better communication. He acknowledged that he had previously worked in the private sector, and he declared the necessity for separating advances from the billings. He specified that DHSS would pay an amount against the submitted claim. He pointed out that the recovery would be in consort with the provider, as repayment would be against the advance, and it would be treated as a loan. He declared that he would

keep these as separate processes, and not let the recovery of the advance go against a remittance advice (RA).

4:46:51 PM

SUSAN GARNER, Finance Director, Mat-Su Services for Children and Adults, Inc., reporting that she was representing the Alaska Association on Developmental Disabilities (AADD), stated that the system would have avoided a lot of these challenges had it been tested prior to going live. She declared that a delayed implementation would have been preferable to the current situation. She shared that AADD had had a 97 percent claim recovery rate in the final Medicaid processing under the previous system on September 17, 2013, which was similar to most other AADD agencies; however, the October recovery rate was zero percent, with a subsequent increase to 61 percent. She shared that her organization had experienced the same challenges as others had already reported. She explained that it was difficult to bill for services without authorization. She declared that there had not been any reimbursement for new group services or for code changes to ongoing services. She stated that her group was currently owed \$1.4 million in accounts receivable, and its cash reserves were rapidly depleting. She lauded the bi-weekly tele-conferences with the department which had also allowed direct contact with Xerox.

4:50:12 PM

MALANE HARBOUR, Executive Director, Primrose Retirement Community, reported that there had been between 13 to 16 Medicaid choice waiver residents in its community since September, and she echoed the previously stated concerns. She shared that Primrose had more than \$300,000 for care already provided due in accounts receivable billing. She noted that the Primrose billing claims were not being received in the new system, hence payment had stopped on September 15, 2013. She reported that her organization had averaged 16 hours for billing time every two weeks. She listed a variety of excuses she had heard, including suggestions to continue to re-bill with the hope that some will go through. She stated that they were now receiving payment, sometimes duplicate payment, with no RAs, and Xerox had stated that it did not know what service billing each check was covering. She declared the necessity for prompt payment, as Primrose had operating and payroll expenses. She reported that a new staff member had been hired to primarily work on these outstanding billings and that payments were being

posted as a credit until this could be straightened out. She pointed out that it ultimately affected the Medicaid recipients.

[4:54:41 PM](#)

TOM CHARD, Director, Alaska Behavioral Health Association, stated that the association had more than 50 business members, many of which operated "at the margin, not profitable," and when a large payer was behind in payments, the accounting nightmare and audit risk was increased. He lauded the help from the staff of the Division of Health Care Services. He expressed concern that the providers would be "left cleaning up the mess."

[4:56:52 PM](#)

THERESA SABENS, Occupational Therapist, Building Blocks Rehab, declared that its receivables were over \$250,000. She shared that the company employed 17 staff. She reported that the wait time with Xerox was close to an hour, and that they had been told to wait for eventual payment and not to re-submit claims because "boxes and boxes are filling our rooms and we don't need more boxes." The wait for payment had now extended to five months, and they were not able to hire more staff or add more equipment. She acknowledged receiving a call from Medicaid regarding payment, however these payments were for people her business had not served. She lamented that there were not any repercussions for Medicaid and "we have to suffer for their screw-up."

CHAIR HIGGINS said that the Department of Health and Social Services would contact her.

[4:59:39 PM](#)

SANDRA JAMISON, Owner, Talkabout, Inc., acknowledged help from Xerox, as well as receipt of some payments; however, the majority of payment requests "are not even showing up in the system at all."

[5:01:10 PM](#)

CHAIR HIGGINS said that everyone on the witness list would be contacted.

CHAIR HIGGINS closed public testimony.

MR. HAMILTON expressed a continued commitment from Xerox to "follow through not only the specific issues that have been mentioned today, but continuing to knock down this backlog and any of the issues that have been raised over the course of the last few months." He declared that there would be progress, discrepancies would be investigated, and there would be transparency in sharing, clarity, communication, and resolution.

[5:02:31 PM](#)

ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 5:02 p.m.