HOUSE FINANCE COMMITTEE
FIRST SPECIAL SESSION
May 11, 2015
3:05 p.m.

[NOTE: Meeting was held in Anchorage, Alaska at the Legislative Information Office]

3:05:34 PM

CALL TO ORDER

Co-Chair Thompson called the House Finance Committee meeting to order at 3:05 p.m.

MEMBERS PRESENT

Representative Mark Neuman, Co-Chair
Representative Steve Thompson, Co-Chair
Representative Dan Saddler, Vice-Chair
Representative Les Gara
Representative Lynn Gattis
Representative Scott Kawasaki
Representative Lance Pruitt
Representative Tammie Wilson

MEMBERS ABSENT

None

ALSO PRESENT

Valerie Davidson, Commissioner, Department of Health and Social Services; Jered Kosin, Office of Rate Review; Jon Sherwood, Deputy Commissioner, Medicaid and Health Care Policy, Department of Health and Social Services; Margaret Brodie, Director, Division of Health Care Services, Department of Health and Social Services; Senator Donnie Olson; Representative Cathy Tilton; Representative Shelly Hughes; Speaker Mike Chenault; Senator Cathy Giessel;

PRESENT VIA TELECONFERENCE

Representative Bryce Edgmon
Representative David Guttenberg
Representative Cathy Munoz

SUMMARY

HB 148 MEDICAL ASSISTANCE COVERAGE; REFORM

HB148 was HEARD and HELD in committee for further consideration.

Co-Chair Thompson reviewed the agenda for the day. He indicated that he wanted to have an honest discussion concerning reform. He relayed that the House Finance Committee had held five committee hearings on HB 148. In the meetings testifiers included people from Department of Health and Social Services, health care providers, and the public. He asserted it was the job of the legislature to perform its due diligence concerning reform and expansion, ensuring that the actions that the legislature took were right for all Alaskans and protected the financial future of the state. He announced that in the current meeting two issues would be addressed; the current status of Alaska's Medicaid Management Information System (MMIS) and a provider's tax. He noted that the affidavit of Margaret Brodie, dated February 2, 2015, was provided to committee members. He also mentioned that HB 148 called for a proposal to authorize a provider tax up to the maximum extent allowed by federal law no later than January 25, 2016. The tax would offset some of the Medicaid program costs. The issue of provider taxes would be addressed first.

#hb148
HOUSE BILL NO. 148

"An Act relating to medical assistance reform measures; relating to eligibility for medical assistance coverage; relating to medical assistance cost containment measures by the Department of Health and Social Services; and providing for an effective date."

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VALERIE DAVIDSON, COMMISSIONER, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, acknowledged the two topics she would address; the Medicaid payment system and the provider tax section of HB 148. She highlighted that Margaret Brodie, Director, Division of Health Care Services, Department of Health and Social Services, was currently in the meeting.

She informed the committee about three items regarding the Medical Management Information System (MMIS). First, she acknowledged that the system had definite hurdles in the implementation process. She reported that when the system went live in October 2013 there were significant challenges which the department was transparent about. Second, she reported that the system had improved remarkably since December 2014. Director Brodie's affidavit was not a statement of the current functionality of the MMIS system in February but rather highlighted a historical problem as well as delays in the system to support a liquidated damages claim against Xerox. Third, she wanted the committee to know that the department would be ready to enroll new Alaskans under Medicaid Expansion on August 1, 2015.

Ms. Davidson moved on to address implementing a provider tax. She relayed that there were three items to keep in mind. First, the bill did not include a provider tax. Separate legislation would be necessary to implement such a tax. Second, HB 148 required the state to engage with a third-party vendor to work with stake holders to provide a recommendation to the legislature in late January 2016. Third, a provider tax was authorized in 49 other states. Alaska was the only state that did not have a provider tax. She added that most states taxed hospitals and nursing homes.

Co-Chair Thompson mentioned that Representative Tilton had joined the audience.

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JERED KOSIN, EXECUTIVE DIRECTOR, OFFICE OF RATE REVIEW, explained that his office was responsible for setting the reimbursement rates for Medicaid services for providers and facilities. He indicated he would be discussing the provider tax provision within HB 148. He relayed that HB 148 directed the department to do two things; analyze provider taxes and bring provider tax legislation to the legislature for final consideration. House Bill 148 did not create or implement a new provider tax. Instead, it directed the department to analyze provider taxes with the assistance of an independent contractor and to bring legislation forward. He reiterated that Alaska was the only state that did not have a provider tax. He reported that two thirds of all other states had at least one or more

provider tax on their books. He proceeded to explain the definition of provider taxes and how they work beginning with the legal framework. He informed the committee that federal law specified how providers should work as outlined in the Code of Federal Regulations (CFR) (42 CFR 433). He detailed the code. He suggested that if the state wanted to tax providers it could tax 19 possible classes. The most common provider tax applied to nursing homes and hospital inpatient services. He reviewed that most states tax the mentioned categories. He relayed that most small providers were not taxed under the provider tax system.

Co-Chair Neuman stated that he had heard a provider tax described as a tax on Medicaid recipients in which a tax was passed on from providers to patients. He wondered whether a provider tax would apply to small clinics with only one or two physicians or to large hospitals. He asked about the sideboards of a provider tax.

Mr. Kosin replied that there were specific classes of providers or services that could be taxed. He reiterated that the most common providers taxed were nursing homes. A facility was specifically taxed based on net patient revenue. A facility might collect revenue from a variety of sources all of which would be considered. Most states took a percentage of expected revenue. The provider tax was not a tax on individuals or on recipients of services. He suggested that the tax could be modeled through a variety of structures such as the discharge days at a hospital. He explained that a formula could be generated from a pool of data. He mentioned that there was an opinion from the attorney general that indicated that taxes could only be used for a general purpose. The legislature, being in charge of fund appropriations, would be responsible for deciding about the budgeting of provider taxes if they were approved. The tax could not be specifically earmarked for Medicaid but could be appropriated to it.

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Co-Chair Neuman commented that many of the questions his office received had to do with how a provider tax would affect individual doctors.

Co-Chair Thompson added that the questions were from small providers.

Mr. Kosin stated that the department sought to hire an independent contractor to analyze other provider tax categories. However, he maintained that the most common provider's tax was on hospital and nursing home facilities. He expressed that, based on preliminary research, his office did not anticipate proposing a tax on individual providers such as doctors. He suggested that the most likely tax proposed would apply to hospitals or nursing homes. He concluded that small providers would likely be excluded from his office's provider tax proposal.

Co-Chair Neuman asked if the provider tax was a pass through tax to Medicaid recipients.

Mr. Kosin responded that in reviewing the tax structure of other states he found examples such as in the state of Tennessee where specific provisions were included in their tax structures that stated that hospitals could not pass the cost of the tax onto charges for general services. The reason his office wanted to use an independent contractor was due to 49 other states already having a provider tax in place. His office wanted to take advantage of outside expertise in order to do what was best for Alaska. He relayed that the department did not want to see an increase in charges for healthcare. The state wanted a more efficient system.

Co-Chair Neuman was unsure whether Mr. Kosin answered his question. He suggested that maybe someone else could address the question.

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JON SHERWOOD, DEPUTY COMMISSIONER, MEDICAID AND HEALTH CARE POLICY, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, clarified that federal law limited what could be charged to Medicaid recipients for the cost of their care. He did not believe that there was any direct way to pass the cost of the provider tax onto Medicaid patients. He suggested that as Mr. Kosin continued with his presentation he would be pointing out other practical considerations that would not permit passing on the cost. He explained that generally the tax structure was arranged such that Medicaid reimbursements could be used to offset some of the impact of the tax. However, he was speaking of Medicaid reimbursements from the state, not from a recipient.

Co-Chair Thompson asked about the impact of a provider tax on the insured and expressed concern about costs being shifted to the privately insured patient.

Mr. Kosin responded that the payer of the tax was the facility being taxed. For instance if a hospital was taxed, the hospital would be responsible for paying the tax. He stated that the state of Tennessee had provisions to preclude hospitals or the tax payer from increasing charges, thereby, shifting liability to private patients. The state would need expertise to craft its legislation to protect private patients.

Co-Chair Thompson asked if non-profit tribal health providers could be included in the provider tax structure.

Mr. Kosin differed to the attorney general's office and to council for an answer to Co-Chair Thompson's question. He was unclear whether the state could tax a tribal entity. He indicated that the state set rates for 19 different hospitals, 12 of which were combined with nursing homes and 6 stand-alone nursing home facilities. All of the facilities, with the exception of 4, were non-tribal entities. He continued that if he was correct in assuming that tribal entities could not be taxed by the state, other hospitals should be able to be taxed including non-profit entities.

Vice-Chair Saddler asked about the 19 different providers eligible to be taxed. He wondered which category generated the most revenue for the state. He asked Mr. Kosin to recite a list.

Mr. Kosin responded that his office had not ranked the classes. He wanted to operate in good faith to indicate to providers that his office was not targeting a certain class or specific providers. His office performed the primary rate function for hospitals and nursing homes. He explained that part of the reason that hospitals and nursing homes were some of the common provider tax candidates was because they often received Medicaid reimbursement. He furthered that there were very specific limitations. There was a mechanism in which the state could draw down federal funds with a certain amount of generated tax revenue, essentially matching funds and offsetting liabilities. The reason the

provider tax was palatable because the state could offset some of the liability with enhanced payments for Medicaid.

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Vice-Chair Saddler asked Mr. Kosin for a general ranking of facilities that generated the most patient revenues. He wanted a list of the top three or four.

Mr. Kosin reported that for the FY 15 authorized budget physician services made up the largest Medicaid expenditure. Inpatient hospital services, outpatient hospital services, nursing homes, mental health services, personal care services, followed in the ranking. He reiterated that for the purpose of looking at a provider tax hospitals and nursing homes rose to the surface. Currently he was unable to say where the state would apply a provider tax. He wanted to operate in good faith which was why he would be bringing in a contractor with expertise.

Co-Chair Thompson acknowledged Representative Hughes in the audience and Representative Pruitt at the table.

Vice-Chair Saddler wanted to clarify that if the state sought to impose a provider tax that it would make sense to investigate the top payers. He wanted to make sure that Mr. Kosin provided a ranking of Medicaid billing.

Mr. Kosin asserted that he provided a list of Medicaid expenditures. He stressed that based on HB 148 and the provider tax provision the state had already issued a request for proposal (RFP) for a contractor. His office requested a specific provision that the independent contractor would focus primarily on reviewing every type of class of provider tax as an act of good faith. He emphasized that he anticipated any proposal would include hospitals and nursing homes.

Vice-Chair Saddler wanted to hear additional details about fees, time, and costs. He wanted to know about patient revenue in each of the classes of providers. He understood there were some limitations as to what the provider tax would be able to collect. He mentioned 6 percent of net patient revenue. He wondered about access to the data.

Mr. Kosin responded that a consultant would have to compile the information. He indicated that his division collected Medicare cost reports from hospitals and nursing homes and were able to determine different revenue and other financial information.

Mr. Kosin addressed the safe harbor provision of a provider tax. He relayed that it was often thought of as a 6 percent tax. The federal government said that the state could not hold its providers harmless. In other words, the federal government did not want states to impose a tax that would keep everyone harmless. The federal government did not want any state to levy a tax, collect the revenue, draw down federal funds, and then pay the provider back in full. There were certain caps in place including the safe harbor provision. The safe harbor provision was a 6 percent cap that held entities harmless as long as their tax was less than or equal to 6 percent of net patient revenue.

Vice-Chair Saddler clarified that the 6 percent tax was not a 6 percent provider tax but a tax cap in which the state could collect no more that 6 percent of net patient revenue for a class of provider. Mr. Kosin responded, "That is correct."

Vice-Chair Saddler remarked that the tax could be .5 percent, 1 percent, or 5 percent depending on the net revenue.

Mr. Mr. Kosin elaborated that in theory the state could go over 6 percent. However, there was an additional test. The test was referred to as a 75/75 test. He qualified that the test stated that if the tax collected exceeded 6 percent, the tax remained valid unless 75 percent or more of providers in the same class received 75 percent or more of the total tax cost through enhanced Medicaid payments. This was another measure to prevent drawing down federal funds to make providers whole.

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Representative Gara asked about the administrative costs for a provider tax. He referred to the department hand-out. He suggested that in the first year of Medicaid expansion the state savings in its budget equaled $6.6 million and rose every year until 2021 to $24.5 million. He relayed that the administrative costs were less than $2 million. He

suggested that the state could save money without a provider tax by accepting Medicaid expansion. He wondered if he was correct.

Mr. Sherwood responded affirmatively. He elaborated that Medicaid expansion would offset funds that were currently being paid through the state's GF. He anticipated that the offsets would exceed the administrative costs of the expansion and would ultimately be equal to 10 percent of the cost of the actual services provided.

Co-Chair Neuman commented that the numbers Mr. Sherwood shared with the committee came from a report conducted by Evergreen Economics. He relayed that three different reports were completed by three different contractors, the results of which varied. He warned that there was nothing substantiating the findings in Evergreen's report. A previous report by The Lewin Group claimed that Medicaid expansion would cost the state up to $44 million. He suggested that the numbers from the Evergreen report were not necessarily accurate.

Mr. Sherwood agreed that the department's numbers were estimates based on Evergreen' report. He informed the committee that Evergreen Economics had been doing DHSS's long-term care forecasts for approximately 10 years. Originally the company was a subcontractor of The Lewin Group. He emphasized that Evergreen's forecast was more recent than that of The Lewin Group. He also pointed out that some of the previous forecasts included the estimated cost of more people applying for Medicaid as a result of the Affordable Care Act which required a person to show proof of health insurance or to pay a tax penalty. He stressed the importance of making an apples-to-apples comparison when looking at the numbers. He stated that DHSS thought the Evergreen numbers were reasonable and based on Alaska-specific information, information not considered in some of the other forecasts. He noted that there was always a degree of uncertainty in forecasts and projections.

Co-Chair Neuman emphasized that the numbers were estimates rather than factual numbers.

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Mr. Mr. Kosin communicated that in the process of his analysis he typically started with reviewing federal law.

He suggested things were pretty straight forward because many other states had a provider tax. He believed that in order to determine what was best for Alaska he needed to better understand and learn from the expertise of an independent contractor. He added that all provider taxes had three requirements. First, the tax had to be broad-based for all providers within a class, uniformly imposed at the same rate or amount for providers within a class, and providers could not be held harmless using Medicaid reimbursement to effectively make them whole with federal funds. He spoke of the RFP that DHSS issued on April 30, 2015 in order to be proactive. He highlighted the purpose of the RFP was to perform a feasibility study, and if viable, put together a tax proposal to bring to the legislature for final approval. He anticipated that the contract would be awarded by June 30, 2015. He concluded his presentation by offering to answer any questions from members of the committee.

Representative Wilson asked if a fee could be applied rather than a tax. She suggested that a fee would likely affect more providers. Mr. Kosin responded that he did not feel knowledgeable enough to distinguish between a fee and a tax. He noted that other states collected licensing fees based on the number of beds that an entity had or based on something structural for the facility. In terms of a tax versus a fee, generally what he had seen was a tax for the 19 classes of providers.

Mr. Sherwood added that he had seen some examples of states that referred to their revenue as fees such as a bed fee. However, he believed that a higher level of analysis by a contractor was necessary to better understand federal requirements.

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Representative Wilson wanted to know why the provider tax was not included in the bill. She suggested that the bill was crafted not only because of Medicaid expansion, but also due to the growth in costs for Medicaid. She believed that the bill was about all healthcare costs to the state. She opined that it was an integral part and wondered why it was not included in the legislation.

Mr. Sherwood responded that commonly states had enacted provider taxes to avoid rate reductions or in times of

budget stress. The department's understanding and the advice from the Department of Law was that any taxing authority that the state had needed to be very specific. The taxing authority could not be open-ended. Department of Health and Social Services was not comfortable with putting a proposal together until it conducted more research and brought in experts to evaluate the different considerations and potential implications to health care providers.

Representative Wilson asked about how to determine whether a provider had folded a tax into the cost to patients.

Mr. Kosin affirmed that his office had the same question. He explained that, specifically for hospitals and nursing homes, the way in which Alaska reimbursed through Medicaid and the way it set reimbursement rates included a rigorous financial analysis using Medicaid cost reports. He contended that his office could track numbers very effectively. He suggested that not only could the legislature include language prohibiting the passing on of fees, the Office of Rate Review could do effective oversight through the state's Medicaid cost reporting and through the reimbursement of rates by tracking dollars.

Representative Wilson wanted to make sure that people were aware that a Tennessee hospital was one of the highest charging providers. The entity charged a total of $286 million in 2009 and 2010. She found it difficult to believe that some of those charges were not pass-through charges.

Mr. Kosin responded that there were other states that could be used as examples other than Tennessee. He suggested that perhaps Tennessee was not the best model.

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Vice-Chair Saddler asked about Mr. Kosin's reference to an RFP. He was specifically looking at an RFP entitled "Medicaid Redesign and Expansion Technical Assistance." He wondered if the RFP that Mr. Kosin was referring to was a different RFP. Mr. Kosin responded that he was referencing a different RFP.

Vice-Chair Saddler asked for more details of the contract such as the duration of the contract and the expected cost. Mr. Kosin relayed that the state was seeking to award the contract by June 30, 2015 for the term of approximately one

year in the amount of $175 thousand. He added that the scope of the project focused on three specific deliverables with iterations of the items. He offered to provide a copy of the RFP to the committee upon request.

Co-Chair Thompson indicated he wanted a copy of the RFP.

Mr. Kosin continued to detail the three deliverables; a feasibility and recommendation, a draft tax proposal, and public presentation and subject matter expertise. The RFP outlined definite timelines and milestones.

Vice-Chair Saddler asked Mr. Kosin to repeat the three deliverable items of the contract.

Mr. Kosin reiterated that the first deliverable item was a feasibility study and recommendation. He indicated that a draft tax proposal would then be crafted with the intention of it being presented to the legislature. The tax proposal was the second deliverable item and would be shaped with the help of the Department of Revenue (DOR). The third item was public presentation and significant stake-holder input in regular meetings with providers and the general public.

Representative Kawasaki commented that many doctors had come to him with their concerns about losing their practices upon the implementation of a provider tax. He wondered if separate legislation was necessary prior to a provider tax taking effect. Mr. Kosin responded affirmatively.

Representative Kawasaki asked if he was currently working on an RFP outside of the context of the Medicaid reform bill. Mr. Kosin replied, "Yes." He explained that the department wanted to make sure a proposal was crafted properly.

Representative Kawasaki asked whether HB 148 had any provider taxes within the legislation. Mr. Kosin made it clear that HB 148 did not propose, create, or implement a provider tax. The bill directed the public to study a proposal for the legislature.

Co-Chair Thompson interjected that what Mr. Kosin had stated was cited in the bill.

Representative Kawasaki asked if the department was doing the RFP. Mr. Kosin replied that the RFP had been issued and the department was reviewing it.

Representative Kawasaki asked if Section 1 of HB 148 was necessary for the RFP to go out. Mr. Kosin deferred to the Department of Law and the deputy commissioner.

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Mr. Sherwood believed DHSS had the authority to pursue the RFP whether it was contained in the bill.

Representative Pruitt was trying to understand why the provider tax was written into HB 148. He suggested that if, in the department's view, Medicaid expansion covered itself there was no reason to discuss authorizing a provider tax to the maximum extent allowed under federal law. He wanted to know why it was included in the bill, whether it would have been included no matter what the circumstance, or whether it was included because the current Medicaid system was significantly broken. Mr. Sherwood reported that the legislation included a proposal for expansion and a proposal for reform. He added that it was the intent of the department to be open and transparent about looking at expansion and reform.

Representative Pruitt asked if it was accurate that the state would not be able to cover the cost of Medicaid because of the fiscal challenges it was facing. He continued that the provider tax would help offset some of the state's costs. Mr. Sherwood replied that in periods of revenue shortfalls states typically analyzed whether a provider tax system could help support GF expenditures for the Medicaid program. Alaska was facing a time of revenue deficits. He also mentioned that Medicaid expansion could reduce charity care. The question was asked whether it was an opportune time for providers who shoulder the burden of charity care to look at a provider tax. He believed that these considerations brought the issue to the forefront.

Representative Pruitt asked how the state would proceed with an expanded population if reimbursement fell from 90 percent to 50 percent. He wondered if the state would consider an additional tax in the future to cover expenses for an increase in Medicaid population. Mr. Sherwood responded that the current legislation included a provision

that if the revenue fell below 90 percent, the state would not cover the expanded population.

Representative Pruitt asked Mr. Sherwood if he thought the state would start off providing Medicaid to certain people then halt providing it to the same group if the federal government's portion fell below 90 percent. He suggested that if the government's portion fell, for example, to 88 percent, he anticipated an argument that it was only 2 percent below 90 percent.

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Commissioner Davidson explained that when the governor included federal receipt authority in the original budget bill at the beginning of the year, the House Finance Committee asked if a provider tax had been considered since all other states had provider taxes. At the time the committee wondered if providers had or should have skin in the game. As the governor and the department were considering introducing a stand-alone bill, in the interest of transparency, they included at least a thorough study of the issue prior to considering a provider tax. She pointed out that HB 148 specifically stated that the participation for the expansion population was contingent upon a federal match of at least 90 percent.

Representative Pruitt was concerned with whether Alaska would actually pull out of expansion if federally matching funds dropped below 90 percent. Commissioner Davidson responded that she would expect the department to follow the law. The law that was currently being proposed outlined that if the federal match went below 90 percent the state would discontinue its participation.

Representative Gara commented, "Congress will do what Congress will do." He suspected that if the federal government went below 90 percent, as the current law promised, there would be many states up in arms. He asked how many states were signed up for Medicaid expansion at present. Commissioner Davidson responded that there were approximately 27 states enrolled. She added that almost 30 states had participated in Medicaid expansion.

Representative Gara referred to one of the pamphlets provided by DHSS. He asked about proposals between Medicaid expansion and Medicaid reform which the department

projected a state savings of $580 million over the following 6 years. He asked if there was a need for a provider tax for the Medicaid and expansion portion given the potential savings. Commissioner Davidson responded in the negative. She elaborated that there was not necessarily a need for a provider tax. However, since Alaska was the only state without a provider tax it was unusual and something to consider moving forward in financing the state's healthcare delivery system.

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Representative Gara summarized that the state would save approximately $580 million over the following 6 years. He asked if the regular Medicaid program cost money to the state. He opined that the provider tax would help to offset some of the costs of the regular Medicaid program. He wanted to know if the commissioner agreed. Commissioner Davidson responded affirmatively.

Vice-Chair Saddler understood that states that had provider taxes could collect no more that 25 percent of its Medicaid revenue, an imposed cap. For example, if the state spent $800 million on Medicaid the state could collect a maximum of $200 million in provider taxes. He wanted to make sure he was understanding the calculation correctly. Mr. Kosin believed that the cap applied to each class of provider. He restated that it was 25 percent of expenditures per class of providers or services. He thought the cap was based on classes. He would find out and provide a written answer to the Representative's question.

Co-Chair Thompson asked that the answer be provided to his office. He would see to it that committee members were provided with a copy.

Vice-Chair Saddler noticed, after doing some research on provider taxes, that there had been proposals by the federal government to reduce the cap from 6 percent to 3.5 percent of patient revenue. He wanted to know if the department had considered what kind of effect such a change would have on the state's calculations. Mr. Kosin confirmed that the department had considered the change and its effects. He clarified that Representative Saddler stated that the federal government had considered lowering the Safe Harbor provision to 3.5 percent. He emphasized that the department would be asking the contractor to do a

separate analysis on the issue. It would be included in the tax proposal.

Vice-Chair Saddler noted that the federal budget projected the federal Medicaid costs to jump 62 percent by 2026 to approximately $567 billion. There was a strong likelihood that the federal government would consider rolling back its caps. Mr. Kosin relayed that the federal government had had a deficit for a long period and had never taken action to-date. He could not confirm with a "yes" or "no".

Representative Wilson wanted to verify a couple of items. First, she inquired whether the provider tax could be passed to patients or any entities. Mr. Kosin remarked that he had heard that other states had protocol in place to prevent it from happening. He added that he would look into it with the contractor. He stressed that the analysis would be included in any tax proposal presented to the legislature.

Representative Wilson asked if other states shared the same challenges of attracting providers. She mentioned the Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) program to entice providers to Alaska. She also noted other incentives such as loan forgiveness. Commissioner Davidson responded in the affirmative. She elaborated that there were a number of other states that were considered health professional shortage areas that had to undertake measures to attract providers.

Representative Wilson wondered about which states were included. Commissioner Davidson indicated that she would provide the committee with a list.

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Representative Wilson wondered if the state could proceed with implementing a provider tax whether or not Medicaid was expanded. Commissioner Davidson stressed that HB 148 did not implement a provider tax. However, it did require the state to engage a contractor to recommend a provider tax to the legislature. She added that it would be up to the legislature to act on the recommendation.

Representative Wilson restated her question. She wondered if, following the study, the department would bring legislation forward to implement a provider tax even if the

state did not opt to participate in Medicaid expansion. Commissioner Davidson restated that the department would provide a recommendation to the legislature on whether the state should institute a provider tax. She suggested waiting for the third-party contractor recommendations before making any speculations.

Representative Pruitt asked about pass through and tax. He wondered if the department would be able to identify a pass through fee to an individual payee or an insurance payee. He wondered if the department would be able to see all elements concerning payees. Mr. Kosin was uncertain. He thought it was possible to conduct the necessary analysis but needed to consult with a contractor. He opined that at the state did not want to see costs passed on to patients or a rise in health care costs.

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Vice-Chair Saddler followed up regarding the hold harmless cap. He wondered if the state would be obligated to backfill the difference through the state GF. Mr. Kosin appreciated the representative's question. He suggested that he would refer to the contractor's analysis. He was unsure of the answer. He was aware that the department did not want to put the governor or the State of Alaska in the position of repayment. The department wanted to do things correctly and responsibly.

Vice-Chair Saddler commented that a consultant would do a better assessment. However, he wanted to know how likely it was that the government would change the hold-harmless rate. Commissioner Davidson responded that in order to change the cap the federal government would have to change the federal law requiring consent from both bodies of congress as well as the consent of the president. Mr. Kosin also suggested that regulation could be changed and was aware that the president had looked into it.

Vice-Chair Saddler pointed out that the president had a pen that he could use.

Representative Gattis wanted to make sure that the study considered the concerns of providers from her district regarding non-profits earning huge profits on the backs of small providers. Mr. Kosin responded that the governor had made it very clear that he did not intend to put any proposals forward that would affect small providers to the

extent that the state would lose healthcare providers. The department would be looking into the fairness of a proposed tax.

Co-Chair Thompson announced that the committee would hear the next section of the day's presentation.

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AT EASE

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RECONVEYNED

MARGARET BRODIE, DIRECTOR, DIVISION OF HEALTH CARE SERVICES, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, introduced herself and explained that she would provide a status update on the Medicaid Payment System (MMIS) as it related to her affidavit she filed on February 2, 2015 in the lawsuit against Xerox.

Ms. Brodie turned to slide 2: "Background":

> October 2013: Alaska Medicaid program deployed a new claims payment system developed by Xerox Corporation to replace the old system.
>
> These systems are known as Medicaid Management Information Systems (MMIS).
>
> The new system had significant performance problems; many claims suspended or denied in error, causing providers to experience serious difficulties getting paid.

Ms. Brodie explained that in October 2013 the State of Alaska replaced its 30 year-old legacy MMIS with the Xerox enterprise system. She reported that the new system had immediate and significant performance problems on the first day of its initialization. She elaborated that there were claims suspended or denied in error as well as claims being paid to the wrong provider.

Ms. Brodie moved to slide 3: "Background, Cont.":

> While Xerox worked to fix the system, the State issued advance payments to providers on request.

The State has made over $165 million in advance payments. Of that, the State has recouped $70 million as of May 1, 2015.

Ms. Brodie explained that Xerox and the state worked to fix the problems with the system. She relayed that in order for providers to continue providing services to Medicaid recipients the state had to help by advancing payments to providers per their request. The state had to evaluate the claims that had been submitted into the system. The state analyzed whether the claims had been denied, suspended, or paid inappropriately. If providers had submitted valid Medicaid claims for payment the state paid the claims in the form of advanced payments from GF dollars.

Ms. Brodie reported that the state had made over $165 million in advance payments at present. The state had recuperated over $70 million of those dollars currently.

Ms. Brodie continued to slide 4: "State Holds Xerox Accountable":

August 2014 – State finds Xerox in breach of contract due to performance problems.

October 2014 – Xerox agrees to corrective action plan.

February 2015 – Administrative hearing on liquidated damages. Decision pending; next hearing scheduled for August 2015.

May 2015 – The system is processing new claims at greater than 90 percent accuracy. This is better performance than the old legacy system.

Ms. Brodie continued to explain that as of August 2014, after 11 months of attempting to resolve claims, the state filed a breach of contract against Xerox. In October of 2014 Xerox agreed to a corrective action plan that included certain changes that would resolve the payments problems. She added that the corrective action plan was not intended to fix the entire system. Its purpose was to fix claims pricing and payments which were the items that most affected providers. There were also other items within the system that needed correction.

Co-Chair Thompson asked Ms. Brodie to make sure to announce any slide changes for proper record keeping. He also indicated that Speaker Chenault had joined the audience.

Ms. Brodie reported that in February 2014 the state formally accepted Xerox's corrective action plan and had its first hearing in front of an administrative law judge. She added that the next hearing was scheduled for August 2015. She specified that the completion of the corrective action plan was scheduled for the end of March 2015. It took until the end of April 2015 to complete all of the tasks specified in the corrective action plan. However, while addressing the initial items more defects were identified. She asserted that even with the remaining defects the state was processing 90 percent of the claims accurately.

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Ms. Brodie advanced to slide 5: "System Improvement":

> Xerox and the State agreed to a Correction Action Plan requiring correct claims pricing and correct claims payment by certain timelines.
>
> Xerox is required to make 17 system corrections, called Design, Development & Implementation (DDI) deliverables.
>
> Xerox has submitted all deliverables. They have not been fully accepted by the State.

Ms. Brodie reiterated that the state had agreed to a corrective action plan. She also reported outstanding design, development, and implementation (DDI) work on the enterprise system. She relayed that Xerox had submitted all of the corresponding deliverables but the state had not fully accepted them to-date. The state contended that if the system had been fully tested, as it should have been, the state would not have had the number of defects that it was currently experiencing. She clarified that a large system like the one the state had would never be completely free of defects. She added that the enterprise systems in the country were not without a dozen or more ongoing defects. She claimed that the state's legacy system also had many defects.

Ms. Brodie advanced to slide 6: "System Improvement, Con't.":

State outlined 38 items that needed to be completed for the corrective action plan.
- 16 effect claims
- 4 have already been resolved

For system acceptance the State outlined:
- 19 deferred items
- 13 DDI deliverables

Ms. Brodie highlighted that Xerox had completed the corrective action plan. A few items remained that needed to be addressed because they were not working as intended. She clarified that these items were problems arising from of changes in regulations and new federal mandates. Xerox approached the state about being released from the corrective action plan. The state reviewed the system and generated a list of 38 additional items that Xerox had to address to be released from the corrective action plan. In comprising its list the state took a look at the broad functionality of the system. The state identified 16 items that needed to be fixed affecting claims, 4 of which were resolved. The state anticipated that Xerox would have the remaining items affecting claims processing dealt with within 3 months. She relayed that the state had a schedule of all deployments through January 2015.

Ms. Brodie informed the committee the state was identifying any item that would prevent it from accepting the system before releasing Xerox. She relayed that in order for the state to accept the system it needed the 19 deferred items completed. She claimed that some of the 19 items no longer existed. She relayed that some of the enhancements had to do with something called "smart PA" which the state no longer used. Smart PA was the state's prior authorization, also known as a service authorization system. Its function was to obtain permission to perform a service prior to the performance of the service. Currently, service authorizations were done through the enterprise system. She shared that over the course of the following month the state would be negotiating with Xerox about what function the state would receive in lieu of the Smart PA. The state was not interested in receiving a dollar amount in place of adding a different function.

Ms. Brodie reiterated that the conditions of Xerox's release included addressing 19 deferred items, 13 DDI deliverables, and acquiring certification.

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Ms. Brodie continued with slide 7: "System Improvement, Con't.":

There are three components to the system:
- Claims processing
- Financial accounting
- Reporting

Claims processing has dramatically improved. Claims are now processing timely and with over 90 percent accuracy.
- Acceptance by the State depends on:
  - Additional fixes to financial reason codes
  - Further improvements in reporting

Ms. Brodie explained that there were three components within MMIS. The corrective action plan focused on the claims processing system. The majority of the work left to complete had to do with the financial accounting and reporting portions of the system, both of which affected the state rather than providers. She reported that the state had had a temporary system in place for the previous 20 months.

Ms. Brodie noted the vast improvement of claims processing in the previous month. She relayed that her office had been inundated with calls on Tuesdays and Wednesdays after a cycle ran and people could verify the status of a claim. She observed that calls had ceased with the implementation of improvements. She also mentioned a reduction in staff time addressing claim issues. She highlighted that her office had had difficulties processing a particular provider's claims about 50 percent of the time. Currently, the office was able to process all claims for this provider within a cycle.

Ms. Brodie made it clear that acceptance of the system was also contingent on fixing the financial reason codes. The codes identified the reason for a claim such as overpayment. The reason codes had not worked until the

month prior. She reported that they were currently working and that only one or two more codes needed to be fixed.

Ms. Brodie emphasized that the most important area to improve was reporting. The major report that was currently missing was the cost report that enable the state to set rates for providers.

Ms. Brodie detailed the graph on slide 8: "System Timelines." She explained that the slide showed the state's current timely processing of claims. She offered that claims were, "flying through the system." The claims were no longer needing manual intervention, it was all auto adjudication.

Ms. Brodie advanced to slide 9: "Defects." She explained that the chart showed the number of defects from July 2014 through the present and noted the substantial decrease in the numbers. She reported that the number for the current day was 80 the majority of which had nothing to do with claims payment and pricing.

Ms. Brodie moved to the chart on slide 10: "System Performance." She pointed out that since initiating the corrective action plan the state had been successful in getting more claims paid with less new claims being suspended. She noted that the gray bars on the chart were claims being reprocessed; old claims that had been paid, denied, or suspended incorrectly were given a suspend status to be reprocessed.

4:16:58 PM

Ms. Brodie turned to slide 11: "Payment Processing." She pointed out that the blue horizontal line represented the state's historical payment level. The state had been paying above the historical level. She explained that the encounter rates were paid using the new system. However, previous encounter rates had to be paid outside of the legacy system. She expected the new normal to be $27 million to $28 million.

Co-Chair Thompson announced that Senator Giessel had joined the audience.

Ms. Brodie observed that the last few slides showed marked improvement in every area of the enterprise system.

Ms. Brodie detailed slide 12: "February 2015 Affidavit":

> A February 2015 affidavit signed by Margaret Brodie, Director of Health Care Services, outlined the problems the State had with Xerox's system since its October 2013 deployment.
>
> Since that time, many of the defects identified have been corrected or significantly improved.

Ms. Brodie informed the committee that she filed an affidavit on February 2, 2014. The affidavit was in response to the Xerox litigation claiming harm to the state as a result of Xerox not performing its job. Since the filing the state had seen significant improvement on the part of Xerox to correct its performance defects. The number of defects had been reduced significantly. The company had fixed most of the claims payment and pricing issues. She mentioned that she would review her comments made in the affidavit and provide the committee with a current update. She maintained that at present not everything was fixed.

Ms. Brodie read from slide 13: "Item Number 7: Defects":

> Affidavit: System unable to accurately balance claims as a result of an embedded rounding error
> Current Status: CORRECTED, April 2015
>
> Affidavit: Slow system performance on medical service authorization – authorizations were taking 30 minutes
>
> Current Status: IMPROVED: Authorizations are taking 5 to 10 minutes. Xerox has committed to continuous improvement.

Ms. Brodie indicated that the state wanted to see further improvement in reducing the time it took to process an authorization request. She noted that in the legacy system the most expeditious people could complete an authorization within two minutes.

Co-Chair Thompson asked, "How many minutes?" Ms. Brodie responded, "Fourteen."

Vice-Chair Saddler read from Ms. Brodie's affidavit that Xerox had committed to continuous improvement. He opined that based on her affidavit Xerox had been "shinning the state on for the four years." He wondered if Xerox could be trusted currently.

Ms. Brodie pointed to Xerox's performance since the implementation of the corrective action plan in October 2014. She felt the state was getting results from Xerox.

Vice-Chair Saddler asked Ms. Brodie again if she trusted Xerox. Ms. Brodie relayed that she trusted their performance because of significant improvements.

4:20:36 PM

Ms. Brodie detailed slide 14: "Item Number 7: Deficit Con't":

> Affidavit: System does not price claims correctly (12.4 percent of all claims are not pricing correctly):
>
> Current Status: CORRECTED, March 2015.
>
> Affidavit: System fails to pay certain categories of claims (e.g. hospital stays longer than three days)
>
> Current Status: CORRECTED with minor exceptions:
>
> TEFRA - solution ready to go (few claims)
>
> Hospital stays where Medicaid is secondary payer primary (low dollar amounts)

Ms. Brodie explained that the 12.4 percent reported in the affidavit applied to claims that were priced incorrectly from October 2013 through September 2014. Currently, the system was paying claims at an accuracy rate of more than 90 percent.

Ms. Brodie discussed the statement made in the affidavit about the failure to pay certain types of claims. She clarified that the system was not paying many claims associated with behavioral health and with hospital stays greater than three days. She relayed that there were only a small number of these challenging claims and indicated that the state had mapped out solutions for Xerox. She added

that the state had problems with claims having to do with hospital stays where a commercial insurance company or Medicare was the primary payer and Medicaid was the secondary payer. It really came down to low dollar amounts due to co-pays and deductibles that only Medicaid paid.

Representative Wilson referred to slide 14. She asked when Medicaid was a secondary versus a primary payer. Ms. Brodie responded that she would need to get a percentage of the number of recipients that had other health care. She gave an estimate of 20 percent to 25 percent of the state's recipients. She would provide Representative Wilson with the exact figure. Mr. Sherwood also indicated that Medicaid was the payer of last resort for all payers except for services covered by Indian Health Service (IHS). Medicaid was a secondary payer behind Medicare, Veterans Insurance, Tricare, private insurance, and any other liable individual such as worker's compensation. He reiterated that Medicaid was secondary.

Ms. Brodie moved to slide 15: "Item Number 7: Deficit Con't":

> Affidavit: System inappropriately denies claims; many remain wrongly denied and outstanding for over a year
>
> Current Status: CORRECTED. New claims are processing correcting.
>
> > Backlog: Old claims wrongly denied have been identified and are being reprocessed. Many providers have resubmitted claims and been paid. September target for completion.

Ms. Brodie informed the committee that her office had a plan for old claims that had been processed in error. Claims had been identified, a work plan had been drafted for reprocessing claims, and claims were sorted into three categories. The categories included claims resulting in payouts to providers, claims resulting in paybacks to the state from overpayments to providers, and claims without any monetary changes.

4:24:45 PM

Ms. Brodie advanced to slide 16: "Item Number 7: Deficit Con't":

Affidavit: System is unable to process many claims, causing the claims to incorrectly suspend.

Current Status: CORRECTED.

Some claims suspend because they require manual review:

School-based services suspend pending payment of the school district's state match.

Durable medical equipment claims suspend for manual review of the invoices.

Claims that require medical necessity justification suspend until payment is authorized.

Claims that were first billed to insurance suspend until any insurance payments are reviewed.

Ms. Brodie indicated that the slide applied to claims that were suspended inappropriately. She highlighted that incorrect suspensions had been corrected and that any claims that remained in suspension status were supposed to be suspended.

Ms. Brodie informed the committee that there were two categories of claims intended to be suspended. The first was the school-based services claims in which school districts billed Medicaid for services they provided to children in their districts. The state had an agreement with the participating school districts where they paid the state match portion of the services. She elaborated that three years prior the state had been able to pay the claims and subsequently collect the money from the school districts. However, the federal government mandated that once a claim was paid a state could not go back and collect money from a school district. Therefore, the state had to receive the match up front. Currently, the state suspended claims, the school district paid the claims to the state, and then the state released the claims for payment. She reported that there were other types of claims such as durable medical equipment claims that were suspended in order to attach an invoice prior to submission. She added

that someone had to manually inspect the invoices and price the claims.

Ms. Brodie presented slide 17: "Item Number 7: Deficit Con't":

> Affidavit: System lists claims as being paid, but links no provider to the claim, so checks can’t issue and the claims aren’t paid.
>
> Current Status: CORRECTED.
>
> Affidavit: System pays wrong provider.
>
> Current Status: CORRECTED.

Ms. Brodie reported that claims listed as being paid but without a link to a provider were referred to as "ghosted claims" because of the difficulty in tracking them. The deficit had been corrected five months previously. Another deficit that had been corrected was the system paying the wrong provider due to provider identification numbers being mapped incorrectly to the wrong provider. She continued to explain that providers had several different provider numbers. If the system did not match to the correct provider identification number it was possible that an incorrect provider could be paid.

Ms. Brodie continued with slide 18: "Item Number 7: Deficit Con't":

> Affidavit: System is not able to produce cost-based reports needed to change provider rates
>
> Current Status: Xerox correction target date June 2015
>
> Affidavit: Error with third-party liability insurance
>
> Current Status: CORRECTED.

Ms. Brodie relayed that there was one report that had not been able to be produced and Xerox hoped to resolve the issue in June 2015. She stated that the problem was not necessarily the report that was incorrect, but the way in which information had to be loaded into the decision support system to run the report correctly.

Ms. Brodie briefly stated that the third-party liability insurance error had been corrected.

4:28:13 PM

Ms. Brodie slide 19: "Item Number 10: Responding to Providers":

> Affidavit: Xerox is not adequately responding to provider calls.
>
> Current Status: The number of calls being abandoned has decreased significantly. This means Xerox has increased its capacity to handle provider calls.

Ms. Brodie stated that upon the initialization of the system the number of calls abandoned often reached 50 percent, a problem that Xerox had since rectified. She clarified that an abandoned call was a call in which a caller got tired of being on hold and hung up. Mr. Sherwood added that there was always a certain percentage of call abandonment expected. He never expected the percentage to equal zero, but wanted to see the number decrease as it had.

Ms. Brodie turned to slide 20: "Item Number 11: State Staff Time":

> Affidavit: Xerox system problems are requiring State time and resources.
>
> Current Status: State staff time spent working with providers on claims problems has decreased considerably in the last three months.
>
> > DHSS has one dedicated FTE remaining through December 2015.

Ms. Brodie explained that as Xerox continued to work on the corrective action plan and amended the defects that affected claims payment and pricing, the call volume decreased on a weekly basis.

Ms. Brodie detailed slide 21: "Item Number 12: Loss of Federal Match":

Affidavit: Xerox problems are delaying enhanced federal reimbursement to the State for the MMIS project.
Current Status: When the system is certified the State will receive the 25% enhanced match. There is no loss of federal funds.
CMS letter: "Upon certification….the state may retroactively claim the remaining 25%"

Ms. Brodie offered that there had been problems with delayed enhancement federal reimbursement to the state for the MMIS project. She offered that the state typically received an enhanced federal medical assistance percentage rate of 75 percent for the operations of the MMIS project. However, because the system was not certified the federal government notified the state that it was dropping its federal participation rate to 50 percent. The state received its notice nine months after the state went live with the system. She stressed that the state had a letter from the Centers for Medicare and Medicaid Services (CMS) that upon certification of the system the state's federal match percentage would resume at 75 percent retroactively.

Co-Chair Thompson clarified that the federal match percentage of 75 percent would be retroactive from the initiation of the system. He asked if there was a compliance cutoff. Ms. Brodie responded that there was not a cutoff for certification of an enterprise system but that it typically took between 24 to 30 months for a system to be certified.

Co-Chair Thompson wanted to confirm that that it took 24 to 30 months to get a system certified. Ms. Brodie responded affirmatively.

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Ms. Brodie explained the chart on slide 22: "Item Number 13: Advantages to Providers":

> Affidavit: The State is having to advance payments to providers due to Xerox system problems.
>
> Current Status:
>
> > $165 million in advance payments have been issued

$70 million has been recouped from providers; collections are ongoing.

Ms. Brodie emphasized that the level of advance payments was not increasing. She suggested that if the state was having problems with payments to providers the amount would be increasing. Providers were willingly repaying advances they received.

Ms. Brodie scrolled to slide 23: "Item Number 14: General Fund Shifting":

Affidavit: Legislative Audit disallowed manual adjudication of advance payments, delaying State's ability to receive federal match FY 2014.

Current Status: Correction in progress. As we process these claims though the MMIS system, the State will be able to receive federal reimbursement in FY 2015 and FY 2016.

There is no loss of general funds.

Ms. Brodie relayed that the state had worked with CMS to claim the advance payments that it had made in FY 14. The state had taken care to review and document each claim in which it paid out an advance to a provider. The federal government was comfortable with the state seeking reimbursement for the advance payments and drawing down the state's federal match because of the thoroughness with which the state took with each claim. She reported that Legislative Budget and Audit disallowed the state's action following the state's reappropriation period. Currently, many of the claims had already processed through the system and federal dollars had been drawn down. There were approximately $95 million outstanding. She added that the division was hoping to collect the bulk of the reimbursement monies by June 30, 2015 and complete collection by December 31, 2015.

Ms. Brodie continued to slide 24: "Item Number 15: Loss of Insurance Payments":

Affidavit: System did not produce clean data to allow state to bill third-party payers.

Current Status: CORRECTED.

Going out this week:

Commercial insurance billing: $37 million
Commercial insurance billing: $200 thousand
Medicare billing: $48 thousand

Going out next week:

Medicare B billing: $25 thousand

Ms. Brodie clarified that the second line should read, "Commercial insurance recoupment: $200 thousand."

Ms. Brodie moved to slide 25: "Item Number 16: Xerox

Affidavit: Xerox did not sufficiently staff its Alaska project.

Current Status: Xerox continues to recruit for these positions. State is monitoring closely.

Mr. Brodie relayed that Xerox had provided additional staff from other locations to assist with the Alaska project. The state had been able to work with the temporary staff Xerox provided and significant progress had been made. The state continued to monitor the recruitment process closely.

4:35:26 PM

Ms. Brodie advanced to slide 26: "Item Number 17: Liability of Audits":

Affidavit: We anticipated Xerox problems would cause the State to have high error rates in federal Payment Error Rate Measurement (PERM) audits

Current Status: Preliminary results from the PERM audit in March, April, and May are very positive, with lower-than-expected error rates.

Affidavit: Xerox's processing of editing claims does not meet federal criteria.

Current Status: Xerox is working on it. This problem is not unique to Alaska and exists throughout Xerox's MMIS legacy and new systems.

Affidavit: State concerned about federal Office of Inspector General (OIG) audit of IHS payment.

Current Status: Audit not finalized yet.

Ms. Brodie explained that six years prior the state had the best PERM rating in the nation and three years prior Alaska had the second-best rating. She supposed that the state would be rated the worst in the nation due to the period of time in which the PERM auditors were focused. She conveyed that the auditors reported finding discrepancies and associated dollar amounts much lower than the state anticipated. The auditors reported finding a total of $18.3 thousand in discrepancies for 29 claims. More information was forthcoming from the auditors. She was surprised and encouraged by the correspondence the state had received from the auditors to-date.

Co-Chair Thompson asked if the state had received any penalties related to past errors in billing or if there were potential penalties the state might receive. Mr. Sherwood responded that the state had never received any penalties related to the PERM audits that assess the state's overall accuracy. Generally speaking in other audits, the state simply had to repay any error amounts. He clarified that the PERM audit was conducted in each state every three years. He purported that until the current year the state had been ranked number one or number 2 each time it had been subject to a PERM audit. The state had very high rates of accuracy regarding Alaska's claim payments.

Vice-Chair Saddler relayed that in Ms. Brodie's affidavit the PERM rate for Alaska was 6 percent to 12.4 percent. He wondered what rating Ms. Brodie anticipated from the audit that was in progress. Ms. Brodie responded that the 6 percent to 12.4 percent was based on a study conducted by Kevin Quinn of Xerox. She believed the state would receive a rating between 5 to 8 percent.

Vice-Chair Saddler asked how a rating between 5 to 8 percent compared to previous ratings before the implementation of the enterprise system. Mr. Sherwood stated that for FY 08 the PERM rate equaled .47 percent. In FY 11 the PERM rate was 1.4 percent.

Vice-Chair Saddler concluded that the state was looking at a possible rate 10 times the rate the state had previously. Ms. Brodie stated yes. She explained that the rate was determined based on how a claim processed in its first attempt. The rating had nothing to do with rectifying errors. The period of time that the PERM audit reviewed was from October 2013 through September 2014, a time when there were many errors.

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Vice-Chair Saddler asked about potential financial impacts of an error rate. Ms. Brodie answered that if there was an error on a claim, the state had to reprocess the claim and pay it correctly. If a claim was paid when it should not have been paid, the state would be obligated to repay the amount. If a claim paid incorrectly with the wrong dollar amount, the claim would have to be reprocessed and either the state would end up paying more or recouping funds from a provider. She elaborated that any time a provider was overpaid there was no limit on the amount of time for the state to receive the money back from a provider.

Vice-Chair Saddler read page 11, lines 6 through 10 of Ms. Brodie's affidavit:

> 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 percent and 12.4 percent of the total amount of Medicaid claims paid, which is approximately $1.2 billion.

Vice-Chair Saddler wondered about how much the state would have to repay if the rate was 5 percent to 8 percent rather than 6 percent to 12.4 percent. Ms. Brodie explained that what the affidavit stated was of the $1.2 billion in claims paid, the state had documentation from Xerox indicating that 6 percent to 12.4 percent of the claims were paid in error. Xerox's report looked at the end result of the claim including any reprocessing of claims. The PERM only looked at the initial processing of a claim. She offered that processing incorrectly meant that a claim was either overpaid or underpaid. She was not able to provide a dollar amount because some were overpaid and some were underpaid claims.

Vice-Chair Saddler suggested that the language was damning and wanted to give Ms. Brodie an opportunity to clarify. He stated that since the state had to pay back a substantial sum he wanted to know if the amount was $60 million. Ms. Brodie indicated that the division expected a very high PERM error rate due to the period of time being evaluated. However, she expressed her confidence in new date claims. She furthered that claims found in error would be reprocessed and literally the money would come from or to the providers.

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Representative Pruitt referred to Ms. Brodie's estimate of a 5 percent to 8 percent PERM error rate. He wanted to understand the PERM error compared to her earlier discussion about the system processing at greater than 90 percent accuracy. Ms. Brodie answered that the PERM error reflected looking back in time. Whereas, the 90 percent represented present day, new day claims. The presentation slide showed that there were a significant number of errors in claims since October 2013 through October 2014. Since the state began working with Xerox on the corrective action plan to address defects in the system and to implement the change requests, claims were currently processing expeditiously through the system. She reported a maximum of 9 days to process a claim currently and with accuracy.

Representative Pruitt wanted to understand how a 10 percent error rate was an improvement to a PERM error rate of 5 percent to 8 percent. Ms. Brodie noted that the state actually thought the claims were being paid at 95 percent but did not have the resources to calculate a specific percentage. She furthered that it would take an analysis of every claim that went through the system. The state had requested that its contractor perform such an analysis. However, the contractor provided a similar figure to the state's number. She relayed that she did not want to get anyone's hopes up when there were issues still remaining in the system.

Mr. Sherwood interjected that the PERM error measured against the dollar value of the errors. He supposed that relatively small errors counted against the state, but looking at the payment accuracy it was small. He furthered that when looking at the volume of claims the state considered that there might be a number of errors but small

in value. The small value items did not get the priority the big volume errors received. PERM was a very specific error rate and auditors looked at more than just claims processing. They actually evaluated policy and the documentation of claims. Adequate documents were required in order to support the claims.

Ms. Brodie revealed that the state knew that a number of claims processed in the time period were paid a fraction of a cent off and counted as an error against the state.

4:47:44 PM

Representative Pruitt supposed that if the state were to have another perm audit done presently it would have a 95 percent accuracy rate or a 5 percent error rate. Ms. Brodie responded affirmatively.

Representative Pruitt thought the 5 percent was close to the rates listed in the affidavit. He felt that the update concerning the system was more glowing than in the affidavit. He wondered how the state would argue its case to get restitution. Mr. Sherwood pointed out that the affidavit reported that in the last PERM cycle in 2011 the national error rate was 3.3 percent and was comprised of approximately one third of the states in various stages of maturity. He opined that with a very mature system in which the state had 25 years to work out various issues it would be operating at a very high level of accuracy. He continued that a system tested within its first year of operation would likely have a greater error rate than the national average because of the time needed to identify and address problems with a large system. He was encouraged by the fact that the state's new system, in operation for only about 12 months, had an error rate close to that of a system in operation for 20 years.

Representative Pruitt commented that part of the argument in the state's case appeared based on estimating the state's error rate. He thought that Mr. Sherwood was contradicting the argument by indicated that the error rate was anticipated because the system was new. He asked if the state's case was harmed with such a contradiction.

Commissioner Davidson replied in the negative. She pointed out that the affidavit was not a statement of the current functionality of the MMIS system. Rather, it highlighted

historical problems that documented problems as well as delays in the system to pursue a liquidated damages claim against Xerox. She explained that the claim was for past damage and past harm to the state. Similar to all litigation, damages were assessed for a historical point in time.

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Representative Pruitt understood Commissioner Davidson's point. However, he felt that the state was more comfortable, currently, with the original issue. He found it interesting that currently the state did not have the same challenges with the system that it did at the time it filed litigation against Xerox. He remarked that what was a problem previously was not a problem presently. He opined that the state had a different standard currently than it did prior.

Commissioner Davidson stated that she disagreed with Representative Pruitt's characterization.

Ms. Brodie continued with slide 26. She reported that Xerox' process editing claims was not firing in the proper sequence. Xerox was working on a corrective action. She added that any state using Xerox's MMIS legacy and new systems were experiencing the same issue. She explained that the state had an audit of the Indian Health Service payment conducted by the federal Office of Inspector General. The state was waiting for the audit to be finalized before it would know its status.

Co-Chair Thompson asked if the state was still accessing damages against Xerox. Ms. Brodie replied that the state had been withholding payments from Xerox and applying them to the liquidated damages.

Ms. Brodie continued to slide 27: "Items 18 and 19: Mandates and Regulation:

> Affidavit: Concern Xerox system would hamper State's capacity to comply with Medicaid mandates and regulation projects
>
> Current Status: Capacity has improved and we are addressing the mandates and regulation projects:
>
> ICD-10 is on schedule.

Xerox provided T-MSIS proposal - currently negotiating

HIPAA Operating Rules is in progress.

Mandates were prioritized and the remaining will follow completion of the above.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) in progress.

Free Standing Birth Center in progress.

New Waiver Regulations in progress.

Last EPSDT regulations in progress.

Ms. Brodie explained that the items listed on the slide were all of the things listed in the affidavit that the state had not addressed. Since the affidavit had been written some items had been addressed including the ICD-10 which was on schedule. She indicated that progress had been made on most of the items on the list since February 2015. Prior to February no work had been done on the items.

4:54:05 PM

Ms. Brodie turned to slide 28: "Item Number 21: Future Costs":

Affidavit: Built-in system problems may create more costly maintenance.

Current Status: Xerox and the state are taking steps to work cooperatively to reduce costs as much as possible.

Ms. Brodie believed that some things were built into core that belonged in relational tables. She relayed that Xerox had agreed to review the items and make the necessary adjustments. She was hoping to mitigate increased costs going forward.

Ms. Brodie pointed to the last slide 29: "Reprocessing":

230,371 claims to be reprocessed that will result in a payout

Have been prioritized and work is on-going

Can reprocess approximately 20,000 claims an hour

226,000 claims to be reprocessed that will result in recoupment

Letters went out to these providers on May 1st

5,436 claims to be reprocessed – no financial impact

Ms. Brodie concluded that the amount of work that remained in cleaning up the system was significant. However, much progress had been made since October 2014 and particularly from February 2, 2015 when she filed the affidavit. She admitted that the system was not perfect, there were still items to resolve, and issues could result from the audit. She expressed surprise about the results of the PERM audit indicating a small number of claims with small dollar amounts that had problems. She stated that she had been shocked at the results.

Co-Chair Thompson asked the director to come back the following day to answer further questions.

Representative Gara wondered, after all of the fixes, if the system was processing claims at a better rate than the state's old system. Ms. Brodie answered positively. She furthered that the system could actually process more claims than the previous system. The legacy system was limited to a number of claims that it was able to process each week.

Co-Chair Thompson asked the age of the previous system. Ms. Brodie stated that the system was 30 years old.

Representative Gara asked if the system was processing claims more accurately. Ms. Brodie responded that the system was not necessarily processing claims more accurately. However, the system was processing claims at higher-than-historical levels. The state was aware that the accuracy was greater than 90 percent.

Representative Gara asked about the $1.2 million of federal reimbursement mentioned in the affidavit and the error in payments. He asked how the error rate compare to the amount Representative Saddler asked you about currently versus prior to January 2014 when the administration took over. Ms. Brodie stated that the error rate that the department had seen had declined from October 2014 to the present. In the course of correcting the claims processing, the payment, the pricing, and the processing had been reduced significantly.

4:58:12 PM

Representative Wilson wanted to know if the state was forward funding providers as a result of errors. Ms. Brodie stated that the department had one or two providers that the state had issued advances to in the previous two weeks. These providers had specific issues associated with their claims which were being address to expedite their processing.

Representative Wilson wanted to hear more about advances to providers due to errors. She also wanted to address the topic of lost providers resulting from issues with the MMIS.

Vice-Chair Saddler remarked that the new system was not more accurate than the previous system. He stated that she had testified earlier that the error rate was twice the national average and that it was up to 10 times the accuracy of the previous system. He concluded that the new system was not processing claims more accurately than the old system and asked her if he was correct. Ms. Brodie contended that currently the system was paying claims with approximately 95 percent accuracy. She clarified that she was reporting over 90 percent until she could verify the percentage. She continued to respond that the accuracy rates were similar from the legacy system at 96.4 percent to the new system.

Vice-Chair Saddler commented that his math was off because he had seen an error rate of .47 and now an error rate of between 5 percent and 8 percent. Ms. Brodie explained that the numbers were from letters that she had received regarding the PERM audit to-date. More information was forthcoming. It appeared from the information she had received through the current day the state's error rate

would be lower than originally anticipated. Mr. Sherwood clarified that the rate he was referring to was for federal FY 14 which was October 2013 through September 2014 and not the current period of time being addressed

Vice-Chair Saddler stated that at a rate of 95 percent accuracy the state had an inaccuracy rate of 5 percent. Mr. Sherwood responded that Representative Saddler was correct. The PERM not only looked at the accuracy of the claims payment system but assessed all possible errors that occurred from the delivery of the service through the payment of the service. Perm auditors also considered whether a service was actually delivered, the service was delivered in an appropriate way, whether there was adequate documentation for the service, and whether the claim was processed and paid correctly in the system after submission.

HB 148 was HEARD and HELD in committee for further consideration.

5:01:23 PM

Co-Chair Thompson reviewed the agenda for the following day.

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ADJOURNMENT

5:01:48 PM

The meeting was adjourned at 5:01 p.m.