

HOUSE FINANCE COMMITTEE  
FIRST SPECIAL SESSION  
May 12, 2015  
1:11 p.m.

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

1:11:30 PM

CALL TO ORDER

Co-Chair Thompson called the House Finance Committee  
meeting to order at 1:11 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

Margaret Brodie, Director, Division of Health Care  
Services, Department of Health and Social Services; Valerie  
Davidson, Commissioner, Department of Health and Social  
Services; Jon Sherwood, Deputy Commissioner, Medicaid and  
Health Care Policy, Department of Health and Social  
Services.

PRESENT VIA TELECONFERENCE

Representative Bryce Edgmon  
Representative David Guttenberg  
Representative Cathy Munoz

SUMMARY

HB 148 MEDICAL ASSISTANCE COVERAGE; REFORM

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

#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."

1:11:50 PM

Co-Chair Thompson discussed the meeting agenda. He shared that the committee would continue to address the Medicaid Management Information System (MMIS). He noted that committee members had been provided with the Affidavit of Margaret Brodie [Director, Division of Health Care Services, Department of Health and Social Services] dated February 2, 2015 (copy on file). He listed various department staff available for questions. He had reviewed the PowerPoint from the prior day and was concerned that it did not consistently match the affidavit.

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Representative Wilson pointed to pages 2 and 3 of the affidavit related to the delay in providing acceptable design, development, and implementation (DDI) deliverables. She asked if deliverables 6 through 8 had been paid and accepted by the department.

MARGARET BRODIE, DIRECTOR, DIVISION OF HEALTH CARE SERVICES, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, replied that the DDI deliverables mentioned by Representative Wilson had not been paid for.

Representative Wilson asked what the acronym DDI stood for. Ms. Brodie replied that DDI stood for design, development, and implementation.

Representative Wilson asked about the status of the specific deliverables and why they had not yet been paid.

Ms. Brodie answered that DDI deliverables 6 through 8 were testing packages for the different types of claims. The state had determined that if adequate testing had been done for the deliverables, claims would have been paid correctly from the beginning.

Representative Wilson wondered if the state did not plan on paying for the items. Ms. Brodie answered that the testing had been done with the defect fixes and change requests that had been underway for past 19 months (since "go live" on October 1, 2013).

Representative Wilson understood that the division was still working on the testing. She was trying to determine if the deliverables were out of the contract or whether there was still more work that had to be done. Ms. Brodie replied that it was the state's contention that the Xerox contract was still in the DDI phase.

Representative Wilson asked if the items would be determined later down the road. Ms. Brodie replied that Xerox had submitted its testing documents for the division's approval; it had not yet given the approval.

Representative Wilson pointed to a list of defects in the MMIS on pages 4 and 5 of the affidavit. She wondered about the status of the items on the list.

Ms. Brodie answered that the list included defects for item 7, which had been mentioned on slide 13 of the division's PowerPoint from the previous day ["Medicaid Payment System Status Update" dated May 11, 2015 (copy on file)]. The first two items of the list had been corrected:

1. System is unable to accurately balance claims as a result of a rounding error imbedded within the system
2. Extreme slow system performance surrounding medical service authorization functionality

Ms. Brodie elaborated that the time it took to submit a service authorization had decreased from 30 minutes down to 5 to 10 minutes. Item 3 had been corrected; item 4 had been corrected by about 97 percent. There were a few minor claims that still did not pay including TEFRA [Tax Equity and Fiscal Responsibility Act]; the division was also working on an issue with hospital stays for cesarean sections exceeding three days.

3. System does not price claims correctly (12.4 percent of all claims are not priced correctly)
4. System fails to pay certain categories of claims (e.g. hospital stays longer than three days)

Ms. Brodie continued addressing the defects listed on pages 4 and 5 of the affidavit. Items 5 through 8 had been corrected:

5. System inappropriately denies claims (many remain wrongly denied and outstanding for over a year)
6. System is unable to process many claims, causing the claims to suspend
7. System lists claims as being paid, but links no provider to the claim, so checks can't issue and the claims aren't paid
8. System pays wrong provider; (also problematic because the checks go to the wrong provider with an EOB -this is protected health information)

Ms. Brodie relayed that item 9 had not yet been corrected. Item 10 had been corrected:

9. System is not able to produce the cost based reports needed to change the provider rates;
10. System is unable to correctly process third party liability insurance (situations where private insurance pays share of claim prior to Medicare).

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Co-Chair Thompson wondered if the corrected items had been corrected 100 percent and why they had not been paid if they were complete. He had asked the division in the previous meeting if there were items the state had not yet paid. He recalled that the division had responded that many things had not yet been paid. He remarked that Ms. Brodie had just reported that all but one of the items on the defects list had been corrected; therefore, he wondered why deliverables 6 through 8 were still open.

Ms. Brodie replied that the division had identified 38 items for Xerox to fix in order for all claims to pay correctly.

Co-Chair Neuman asked for verification that the division was able to pay 90 percent of all claims submitted. Additionally, he asked if the defects listed on page 4 were all corrected by 97 to 100 percent. Ms. Brodie replied in the affirmative related to new claims. There was still cleanup work underway for claims that had been suspended or denied inappropriately in the past. The division was currently working on reprocessing the claims; it was prioritizing by dollar amount and provider type.

Co-Chair Neuman asked how many claims the division was reprocessing and what the total dollar amount was. Ms. Brodie did not have a dollar amount associated with the 230,371 claims that would result in a payout to providers. The majority would be a fraction of one cent. She explained that when the system had first gone live for professional providers, the payment rate went out four decimal places; however, the system had been built with only three decimal places. She elaborated that there were 226,000 claims for reprocessing that would result in a recoupment by the state from providers. By regulation the division had to give providers notice at least 60 days in advance; the letter had been mailed to providers on May 1 [2015]. There were 5,436 claims for reprocessing that had no financial impact.

Co-Chair Neuman emphasized that there were 228,000 claims the division was experiencing problems with.

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Representative Gara stated that the costs and benefits needed to be weighed. He stated that Commissioner Davidson had provided a chart in the past showing that under the legislation the state would save over \$250 million in the following six years.

VALERIE DAVIDSON, COMMISSIONER, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, replied in the affirmative.

Representative Gara remarked that the legislature had asked the department to engage in reforms. He asked for verification that the reforms the department was pursuing without the bill would save the state an additional \$300 million over the next six years. Commissioner Davidson replied in the affirmative.

Co-Chair Thompson asked if the numbers were estimates. Commissioner Davidson answered in the affirmative.

Representative Gara highlighted that the state would receive \$145 million in federal funds the first year, which would grow. He asked for verification that the department estimated an additional 4,000 jobs would be created in Alaska. Commissioner Davidson replied that in the first year of Medicaid expansion \$146 million in new federal revenue was expected. The total new federal revenue in the first six years would be slightly over \$1 billion. She explained that the 4,000 new jobs figure had come from an economic study conducted by Northern Economics, which looked at the multiplier effect in the economy and how many jobs the new dollars would generate. She detailed that while some of the jobs would be related to healthcare others would be related to items like food, clothing, furniture, kids' things, and other that were associated with increased medical personnel.

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Representative Gara understood there was an issue of old and new claims. He addressed the consideration of whether the state would have the ability to pay the new claims if Medicaid expansion and reform were accepted. He remarked that the department estimated the accuracy rate on new claims was somewhere around 95 percent. He asked for verification that the remaining 5 percent were still processed within two billing cycles. He reasoned that the money did not just disappear.

Ms. Brodie replied that the division worked to determine why a claim did not pay and to correct the defect or error within a couple of billing cycles; if the cause of the error could not be determined the division implemented a workaround to allow payment of the claim.

Representative Gara asked for verification that under Medicaid expansion and reform the providers would be paid either in the first billing cycle or within several billing cycles. He asked for verification that providers would not be denied their money. Ms. Brodie replied in the affirmative; providers would be paid within the 30 days that the state was mandated to pay them.

Representative Gara believed the department had done great work to get the "mess in order" over the past several months. He referred to businesses claiming they had gone out of business due to a system implemented in 2013. He asked for verification that the businesses were referring to problems that occurred before the new commissioner [Commissioner Davidson] started solving the problems. Ms. Brodie replied in the affirmative.

Representative Gattis commented that Representative Gara had indicated that MMIS was a bum system. She stated that in business when a new program was started (e.g. an accounting program, new software, or other) the old program was not discontinued until the new program had proven to be successful. She opined that it was not the wisest thing for the department to discontinue the old system and start a new program before its success had been determined. She continued that the division was currently trying to fix the system piece by piece. She wondered if the system was still providing draws or advances to anyone.

Ms. Brodie replied that in the past three weeks the division had given two advances. One had been given to a provider because a system error had resulted in an issue with their claims being paid. The issue had been corrected the past weekend.

Representative Gattis interjected that the system was still a bum system. She continued that it was not doing what it was intended to do. She reiterated her prior comment that the division should have continued its former accounting system until the new program was working properly. In reference to the consideration of expanding the system, she remarked that the state was still not finished with cleaning up the old system. She relayed that in the past her constituents had complained about getting nothing and then getting advances. Some individuals did not want to take advances. She had also heard that some individuals did not want the government to have a "stranglehold" and to be subject to the continued mistakes. She had attended her city council meeting the prior evening and relayed that people had asked her to "stop this; it's madness." She believed the system continued to have glitches that were not ready to go forward.

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Vice-Chair Saddler relayed that he had heard from several providers that the delays in providing Medicaid reimbursements had been a significant hardship to their businesses. He pointed to page 8, lines 17 and 18 of the affidavit, which stated that a total of 18 providers had gone out of business after taking advance payments. He asked if the department was asserting that it was the providers' fault for going out of business and that the absence of reimbursements for Medicaid services played no part.

Ms. Brodie answered that several of the 18 providers had changed their tax identification (ID) numbers and had opened under new provider ID numbers. She believed 3 providers would claim that Enterprise put them out of business; 2 of which had been prosecuted for fraud and the other had sold their business.

Vice-Chair Saddler turned to page 5, number 8 regarding the failure of the Enterprise system to financially balance claims. He asked how important the financial balancing of claims was. Ms. Brodie replied that the balancing was imperative.

Vice-Chair Saddler pointed to the last sentence under number 8, page 5: "there has not been a single instance where the claims have balanced correctly under Enterprise." He asked for verification that Ms. Brodie had made the statement on February 2, 2015. Ms. Brodie replied that it had been correct at the time. She elaborated that the system did not balance, but the division was able to run reports to show what the differences were in order to bring it into balance.

Vice-Chair Saddler referenced Ms. Brodie's statement that financial balancing was essential. He noted that Ms. Brodie had stated that the system did not operate properly when it was implemented on October 4, 2013 and as of February 2, 2015 it did not operate correctly. He continued that Ms. Brodie had testified during the current and prior meetings that the system was fixed. He wondered when claims began balancing correctly.

Ms. Brodie answered that financial balancing had been accomplished in March 2015. Claims balancing, which was equally important, had been accomplished in April 2015. Vice-Chair Saddler asked for clarification on what

balancing had occurred in March. Ms. Brodie answered that financial balancing had occurred in March 2015 and claim balancing had occurred in April 2015.

Vice-Chair Saddler asked what had occurred in the past six weeks that had caused the balancing to work correctly. Ms. Brodie answered that the division had been working with Xerox on a corrective action plan since October [2014]. Xerox had devised a plan on how it would fix all of the defects and change requests that it thought effected claims processing and payment; it had worked through and corrected all of the defects and had implemented the change requests. After the work had been done the division had found that there had still been 16 items that impacted claims payment (during the period of October through March).

Vice-Chair Saddler spoke to delays of a couple of years in terms of manual workarounds and additional delays. He referred to articles in the Peninsula Clarion and the Juneau Empire that had referenced significant overtime expenses. He asked what it had cost the division to provide the manual workarounds. Ms. Brodie responded that there were no overtime costs; division staff was not overtime eligible.

Vice-Chair Saddler asked if Ms. Brodie had absolute confidence that the claims and financial balancing would continue to occur properly going forward. Ms. Brodie replied in the affirmative.

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Commissioner Davidson added that the corrections had occurred due to department staff who had worked tirelessly to fix the problem. She explained that the department recognized it had not created the problem, but it was a problem it owned and was bound and determined to fix. She referenced an earlier question by Representative Gattis and explained that the advance payments had been made because the staff in Ms. Brodie's office had worked very hard to ensure that the estimates could be assessed based upon the former 25-year old system to estimate the claim amounts that could be made. She emphasized that the affidavit had been written at a point in time in order to document the past damage and harm caused by Xerox to the state; it did not reflect the current state of the system as indicated in Ms. Brodie's PowerPoint presentation to the committee the

preceding day. She emphasized that Ms. Brodie and her team had worked very hard to bring the system up to where it should be. She remarked that where she was from it was important to stop and say thank you when people worked hard to turn things around. She emphasized that "where we are today is not where we were in February; it's certainly not where we were in October of 2013." The department recognized that the system was not perfect, but she believed it was cause for celebration that the new day claims were paying with over 90 percent accuracy and timeliness.

Commissioner Davidson completed responding to a question asked earlier by Representative Gattis. She explained that two advance payments had been made [recently]. One payment of approximately \$16,000 had been made to fix a problem. The other payment had been made to another provider. She explained that billing errors happened for a variety of reasons. She elaborated that the provider had confused two different fields and had incorrectly entered numbers when submitting the information. The department could have asked the provider to redo their claim, but thought it was more responsible to advance a payment; the provider would be required to reprocess the claim at a later time. The state had always worked to ensure advance payments could be made when possible and when justified, including going back to look at what the former system was able to process and to make sure providers could continue to operate as a business. She elaborated that the priority going forward had been placed on ensuring that new claims were able to process in an accurate and timely manner, which was currently occurring at a rate of 90 percent. She reasoned that medical providers had to be able to predict what kind of revenue they would have coming in; therefore, prioritizing the new claims was an issue the department had worked on with Xerox.

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Vice-Chair Saddler thanked Ms. Brodie for her work. He commented that she had been the director of the Division of Health Care Services for three years and he understood the system problem had not been fun. However, he stressed that the system had exposed the State of Alaska to some very significant financial penalties for years; it had also made the single largest expenditure of state government an unreliable program, which the administration was proposing

to expand. He found the issue troubling. He noted there had been a lack of performance by Xerox and the situation had existed for years. He questioned the department's claim that most of the problems had been fixed. He stressed that the system needed to be trustworthy in order to consider expansion. He stated "thank you for the hard work, but there's much hard work to be done."

Co-Chair Neuman noted that the committee seemed to be receiving mixed answers [from various sources]. He referred to an April 26, 2015 article in the Juneau Empire that discussed the MMIS and some of the problems. The article stated that staff had logged 100,000 hours in overtime thus far in 2015. He acknowledged Ms. Brodie for her hard work, but he was concerned that she was spending the majority of her time working on Xerox's problem. He continued that instead of working to supervise their employees, department heads were spending their time on fixing the Xerox problem. He believed things were not adding up and wondered about the source of the confusion.

Commissioner Davidson answered that the overtime mentioned in the [Juneau Empire] article had pertained to the Division of Public Assistance related to processing public assistance applications for a variety of services. She agreed that while Ms. Brodie had spent a considerable amount of time dealing with Xerox, she did not believe Ms. Brodie had done Xerox's job for them. She addressed that providers had to get paid for services if the state wanted to continue to provide a Medicaid benefit.

Co-Chair Neuman understood. He shared that he had spent many hours working with Ms. Brodie on the issue prior to Commissioner Davidson's tenure as commissioner. He highlighted the work they had done to figure out how to cover costs for all of the personnel time. He countered that the overtime had included Ms. Brodie as well. He believed Vice-Chair Saddler had been trying to make the point as well and he stressed that it was the same point made in the affidavit.

Representative Gara stated that if the state accepted Medicaid expansion and reform it was a given that the state would have to pay claims. Based on the department's testimony he surmised that the accuracy rate was over 90 percent and if a mistake was made it was fixed within a couple of billing cycles. He wondered if the department was

ready (given the system improvements) to process claims in a way that kept providers in business if Medicaid expansion was accepted. Commissioner Davidson replied in the affirmative to each question.

Representative Gara asked Commissioner Davidson to elaborate on why she believed the state was ready to accept Medicaid expansion under the billing system improvements.

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Commissioner Davidson replied that as drafted the bill would have a start date of August 1 [2015], which was an amendment made by the House Health and Social Services Committee. New claims accepted by the department would need to be new day claims, which were paying at a minimum of 90 percent accuracy for timeliness and dollar amount. She relayed that the department believed the system was prepared to handle the additional volume of new claims coming in.

Representative Gara asked if the new system processed significantly more claims than the former system. Ms. Brodie answered that the system was able to process 200,000 claims per week compared to 100,000 claims.

Vice-Chair Saddler remarked on Commissioner Davidson's statement that department staff were not doing Xerox's work. He pointed to page 6, line 23 of Ms. Brodie's affidavit that read: "...the State began tracking the amount of time its staff spends performing work that belongs to Xerox under the Contract and has calculated those costs at \$4.5 million to date." He asked the department to reconcile the discrepancy.

Commissioner Davidson replied that the statement had been true at the time the affidavit had been written; however, it was no longer the case. She reiterated her prior statement that currently over 90 percent of the new day claims were adjudicating automatically through the system.

Representative Wilson wanted to understand how the state was planning for the system to go live on August 1. She had been told that the group of individuals [who would receive healthcare] under Medicaid expansion were employed single men and women. She wondered if the plan under Medicaid expansion would be identical to the current Medicaid plan.

Commissioner Davidson replied in the affirmative. She elaborated that the Medicaid expansion plan included in the bill would mirror the current Medicaid program. She relayed that the department had issued an RFP [request for proposal] and she believed the contract would be awarded in the near future. The RFP had asked candidates to identify Medicaid reform opportunities existing in other states for the entire Medicaid program. The administration recognized that Medicaid in its current form was not sustainable; however, the administration wanted to accept Medicaid expansion quickly in order to take maximum advantage of the 100 percent federal match including the additional new federal revenue.

Representative Wilson noted that the administration acknowledged that the current Medicaid system needed reform, yet it was willing to add additional people to the system. She referenced that the RFP sought to determine what other states were doing, what managed care looked like, and other. She asked why the department would not wait for the RFP to come back to get suggestions on what a more efficient system would look like.

Commissioner Davidson replied that the administration did not want to wait because there were 20,000 Alaskans needing healthcare who would be covered under Medicaid expansion.

Representative Wilson interjected that the administration was claiming that there were 20,000 Alaskans who had no access to healthcare. In the past, she had been told that the state did not need more providers because most of the population was receiving healthcare benefits. She remarked that the question was related to who was really paying for the healthcare.

Commissioner Davidson replied that approximately 42,000 Alaskans would be eligible under Medicaid expansion; the administration expected that about 20,000 individuals would sign up in the first year (increasing to 26,000 in later years). In terms of access to healthcare, it was true that some individuals did have access through the emergency room because they waited until they were sick enough that they were required to go. However, individuals were not receiving prevention exams including mammograms and prostate cancer screening; a whole host of services were not being provided to Alaskans because they were not

emergency room services. She stated that contrary to the belief that Medicaid was broken, Medicaid continued to provide critical health benefits to Alaskan citizens. She detailed that over 11,000 children received immunizations in the first three months of 2015. She continued that thousands of Alaskans received mammograms, cancer screenings, and other. She stressed that Alaskans were receiving healthcare access through Medicaid.

Representative Wilson countered that it had been Commissioner Davidson who had said the system needed reform. She stressed that she had not been the one to say the system was broken. She remarked that the final report resulting from the RFP was not scheduled for completion until May 16, 2016. She wondered why the state would not implement reforms and look at managed care [prior to accepting expansion]. She detailed that state employees with insurance were under managed care with preferred providers and other. She wondered why the state would not wait for the RFP results prior to accepting expansion. She pointed to studying what other states were doing in order to avoid mistakes that had already been made. She believed everyone wanted to ensure that Alaskans were healthy. She discussed that there were behavioral grants that were issued to care for people without insurance. Additionally there were sliding payment scales to help individuals without much money. She wondered why expansion would be accepted to cover a large group of individuals (i.e. working men and women) before the RFP results had been received. She did not believe it made sense to start the individuals under a program that may be shifted depending on reforms that were recommended by the RFP.

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Representative Wilson continued. She asked if the system could handle paying groups differently given that employed individuals with income may have deductibles.

Commissioner Davidson replied that she had not heard the first question.

Representative Wilson wondered why the administration had issued an RFP that was not due until May if it wanted to start Medicaid expansion at present. Second, if it was better to put the new registrants into a managed care unit

with co-pays, deductibles, and caps, she wondered if the Xerox system could handle it.

Commissioner Davidson clarified that the preliminary RFP results were due in January; the date had been moved up in order for the administration to provide information to the legislature (the legislature had communicated that a March due date would be too late) and to get feedback on reform. The administration did not want to wait to expand Medicaid given that individuals in the expansion category did not have access to healthcare. She elaborated that the state had the opportunity to make Alaskans as healthy as possible with 100 percent federal funds, but the opportunity would end in December 2016. She added that reform was a process that happened over time; it was not like switching on or off a light switch. She further explained that as the administration envisioned reform in Medicaid, individuals in the expansion category would be in a similar benefit package to existing beneficiaries and therefore would move along with existing recipients as reforms took place.

Representative Wilson stated that individuals under expansion were not in the same situation as existing recipients. She elaborated that current recipients did not have jobs, were disabled, elderly, and would not be working. She opined that it not make sense to put the two groups together. She asked whether the Xerox system could handle it if the new registrants were put into a managed care unit with co-pays, deductibles, and caps.

Commissioner Davidson replied that the existing Medicaid system did have cost sharing and co-payments for certain kinds of medical procedures. She detailed that the system included co-payments for out-patient and in-patient services and for pharmaceuticals. She confirmed that the system was capable of addressing the situation.

Representative Wilson emphasized that there was currently access to healthcare. She stated that there may not be coverage for everything (she noted that she and other state employees had to pay for certain things out-of-pocket). She commented that the state had spent over \$30 million per year for women's healthcare. She did not want to send the message that there was no healthcare. She stated that there was healthcare available, but it may not be to the extent allowed under expansion.

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Commissioner Davidson answered yes, there were currently people without health coverage accessing healthcare through the emergency room, which was the most expensive healthcare delivery system.

Representative Wilson stated that individuals were also using a sliding payment scale. She opined that part of the problem was that the state had not helped people understand other ways of getting care. She was concerned that the state was not "going to do the managed care before, so that we help those understand the process."

Representative Pruitt referred to the discussion on whether the system could handle additional people. He recalled a recent statement related to how changes to the system would impact other areas in the system. He asked what effect change had on the system overall. Ms. Brodie replied that it depended on the scope of the change. Some changes were very easy, such as updating a provider rate. Likewise, there were difficult changes such as building an entirely new benefit package. She elaborated that part of the reason the state was putting forth the same benefit package was due to the difficulty building a new package would entail and to save the state millions of dollars in development costs.

Representative Pruitt discussed his understanding that the current system handled 14,000 medical codes. He believed a substantial amount of new codes would be utilized due to the Affordable Care Act (ACA). He remarked that there had been challenges with the 14,000 codes; therefore, he wondered how the system would react to a substantial increase in codes.

Ms. Brodie replied that the ICD-10 had approximately 77,000 diagnostic codes. The division had already mapped the current codes to the future codes; it was currently in testing in the Enterprise system. She elaborated that the state was currently in the process of testing with providers; the work was not complete, but the department was anticipating it would be ready on October 1 [2015].

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Representative Pruitt referred to Ms. Brodie's testimony that changing the benefit package could have a substantial impact on the system, which was why the administration proposed that the expansion population would look similar to the current system. He believed reform would mean a substantial change to the overall benefit package. He observed that reform implemented by the legislature or the department would mean a change to the benefits. He surmised there would be challenges with the implementation if the state moved forward with one package and decided to change it later on.

Ms. Brodie agreed that making changes in the system required development work, but the department believed it was possible through the process defined in the corrective action plan. Additionally, the department had the ability to conduct the proper testing to ensure that anything deployed into the system would not break the system or impact any claims payment. She added that the department had a very good process in place due to the corrective action plan.

Representative Pruitt wondered if it would be more prudent to begin with a system that was ready than to add or fix something later on. He wondered about costs and other challenges associated with making changes later on.

Ms. Brodie responded that the department currently had the processes in place, including scoping of work needed and development time. Additionally, the proper testing time was in place for the state and Xerox to ensure the accuracy of anything deployed into the system.

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Representative Gattis asked about what had "bogged down" the system in the past. She believed that whoever had started the system had probably thought they had everything in place. She wondered if the high number of codes or a particular number of providers or beneficiaries had bogged the system down.

Ms. Brodie stated that it was a host of issues that had bogged the system down. She explained that when the new system went live, the department had been told that it had the legacy system as a backup. She detailed that the department had been told that if something did not work in

the new system, claims could be loaded into and paid under the legacy system. However, it turned out that because the claims were so different in the Enterprise system, they could not be loaded into the legacy system. She addressed what had bogged the system down and detailed that claims had not been paying correctly.

Representative Gattis interjected that she understood what the problem had been. She questioned what had put the initial kink in the system. She wondered how not to bog down the system moving forward. She remarked that the department was currently saying that things were in place, but things were thought to have been in place when the old system had been implemented. Separately, she believed reform could be a light switch that was turned on. She reasoned that it was a "huge light switch that we know there are areas that we have to do better." She acknowledged that the possibility of getting the information working correctly in the system was another part of the equation. She reiterated that she knew that "we can do our job and do it better" in Medicaid and in how business was done in the state.

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Commissioner Davidson believed that states doing Medicaid reform well and delivering good healthcare systems saw reform as a constant process. The administration believed that reform and expansion could go hand in hand; the department was building on reform that it had already undertaken. She expounded that the department had identified a number of reforms through the budget process and in the current legislation.

Representative Gattis opined that reforms should have occurred already. She was exasperated by the "slow go of government." She stated that there was no reason for a hold up on implementing reforms. She expounded that it should have been possible to get the reforms done already through regulations, not legislation.

Representative Pruitt addressed that there were many reforms needed. He spoke to the issue from a policy perspective. He pointed to the implementation of reform including pro-pay discussions and an insurance exchange-type scenario. He wondered whether it would be complex to enforce the changes impacting individuals. He elaborated

that recipients would become used to the program, but would be asked to shift in some capacity later on (e.g. more money out of pocket or other). He wondered if the department saw the issue as a complex series of events or as a switch that could just be flipped.

Commissioner Davidson replied that it was a bit of both. She agreed that everyone, including legislators and Alaskan citizens, had their own idea about what reform should look like. Consequently, the department had created the RFP to look at what other states were doing and at some of the best practices. Additionally, the goal was to engage with stakeholders (members of the public etcetera) to look at which healthcare delivery models would work for Alaska. She elaborated that what may work in one region of the state may not work in another region (e.g. what worked in Mat-Su may not work in Bethel).

Commissioner Davidson addressed educating people in terms of how they received healthcare. She found it frustrating when she saw a medical provider for an ailment and they did not also ask what about her health she would like improved over the next year and how they could work together to help improve her health. She explained that one reason providers did not ask the question, was because they were paid per incident, not to address overall health. Related to payment reform opportunities identified in the legislation, the department wanted to look at innovations other states had undertaken. She elaborated that the committee had heard from PeaceHealth in Ketchikan about an innovation grant it had received from the Centers for Medicare and Medicaid Services. She detailed that it had cost the entities about \$700,000 to lose \$1.5 million in reimbursement opportunity. Additionally, the committee had heard from Central Peninsula Hospital, which had been interested in reform efforts, but needed the resources from expansion to fund the reform effort. She furthered that many hospitals had uncompensated care and were not able to spend money to lose money.

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Representative Pruitt appreciated the conversation related to providers, but wondered about the public. He remarked that there could be pushback on making changes, especially ones that have an impact financially. He noted that a recent legislative vote to add one penny to a fuel tax had

been very close. He continued that it had been a very contentious issue. He asked whether the department believed that starting off with one system and potentially making changes later would be acceptable to the public. He remarked that it was possible to incentivize or almost force some of the discussions with providers, whereas it was a different conversation related to the public.

Commissioner Davidson replied that engaging with the public and having a conversation about how the transition would occur would be critical to success. From her perspective, they were talking about individuals who did not currently have health coverage. She believed the individuals would be open to recognizing that to receive healthcare they would have to pay copay (already existing under the current Medicaid program) for pharmaceuticals, hospital inpatient and outpatient treatment, and other services. She elaborated that copay was not allowed for certain Medicaid beneficiaries. She discussed that the department planned to work with the public to ensure that they understood that health coverage was a benefit they would have that they did not previously have. She detailed that the department would work to educate recipients that the new coverage would enable individuals to receive care in a more efficient and patient friendly way. She believed individuals would welcome the idea, which was why 65 percent of Alaskans had voiced support for Medicaid expansion and reform.

Vice-Chair Saddler addressed Commissioner Davidson's testimony about individuals without health coverage. He noted that she had implied that the emergency room was the only alternative to receive healthcare. He pointed to a distinction between health coverage and health insurance. He referred to the distinction made by Commissioner Davidson that individuals qualifying for treatment through the Indian Health Service (IHS) had healthcare, but not health coverage (defining coverage as insurance).

Commissioner Davidson replied in the affirmative. She elaborated that it did not qualify as health insurance if an IHS beneficiary had access to an IHS facility because it was not a portable health benefit.

Vice-Chair Saddler made the distinction that healthcare was not the same as health insurance. He explained that maybe half of the 43,000 people who had been represented as not

getting healthcare actually did have healthcare, but not health insurance or coverage.

JON SHERWOOD, DEPUTY COMMISSIONER, MEDICAID AND HEALTH CARE POLICY, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, replied that individuals who did not have health insurance may have access to some degree of healthcare. For example, they may be able to access healthcare in an emergency room or through a community health center, which may provide some level of care, but did not necessarily adequately meet all levels of need. For instance rehabilitative services for a traumatic brain injury would probably not be available through emergency rooms, a community health center, or another provider. He noted that a person may be able to make some type of payment arrangements or charity care eventually. Additionally, people with cancer frequently could not receive treatment through the emergency room until they were very ill; at which time treatment would be much more substantial and could include heroic or palliative care. He explained that the situations were examples of incidents where individuals may not have access to adequate treatment if they lacked health insurance or some means of paying for care.

[2:22:20 PM](#)

Vice-Chair Saddler explained that maybe half of the 43,000 people who had been represented as not getting healthcare actually did have access to health coverage through IHS. He asked for verification that the care may not be adequate in the department's terms or provide for every specialty, but there was access to healthcare.

Commissioner Davidson replied that more than 70 percent of the individuals eligible for expansion did not have portable healthcare coverage. She relayed that 43.3 percent had no coverage at all.

Vice-Chair Saddler asked if coverage was defined as access to health insurance or access to healthcare. Commissioner Davidson replied that 29.3 percent of the 42,000 individuals had partial access, which included IHS limited benefits, veterans' benefits, or access to community health centers.

[2:23:28 PM](#)

Representative Gara provided a scenario about a person with prostate cancer earning less than 100 percent of the poverty level who had no health coverage. He wondered where the individual would go for cancer treatment.

Mr. Sherwood replied that there may be some limited options for people with an extremely low income; individuals may be able to receive some care through the chronic and acute medical assistance program. However, a person in the situation may be in something of a "no man's land" where they had to find providers willing to provide charity care. Additionally, the individual would be faced with identifying the various providers needed, with lining up the care, and with getting agreements to accept deferred payment in place. He stated that the person may or may not be successful.

Representative Gara stated that as a prostate cancer survivor he did not believe he was entitled to better treatment than someone else. He addressed the issue of copays. He relayed that the previous DHSS commissioner had been hesitant on the copay issue because in many cases copays cost more to administer; therefore, some had been excluded from the system. He asked for verification that sometimes copays cost more to administer than money they brought in.

Mr. Sherwood responded that there was a cost to administering copays in Medicaid that was different than conventional insurance given the specific federal limits on what could be charged. He elaborated that it was necessary to monitor the copays to ensure that limits were not exceeded. There were situations where the cost of monitoring and adjustments would exceed the money coming in from copays.

Representative Gara thanked Commissioner Davidson for all of her hard work. He pointed out that she had identified over \$500 million in reform savings. He discussed that he had served on the House Finance Committee for a number of years. He continued that there had been six years where the Parnell Administration did not adopt the reforms and now Commissioner Davidson was being asked why the reforms had not yet been adopted. He remarked that the legislature had not adopted the reforms and was asking the department why the reforms had not been adopted. He believed the situation was a double standard. He was impressed that the

commissioner had identified over \$500 million in reforms over a six-year period. He did not understand why the legislature would not want to save the money and why it was accusing the current administration of not doing what the prior administration never did. He did not understand the sudden outrage of the lack of reforms that no one had adopted before.

[2:27:59 PM](#)

Vice-Chair Saddler commented that Mr. Sherwood and Ms. Brodie had both been in their current positions for at least three or more years.

Mr. Sherwood replied that he had been deputy commissioner for the past 6 months; prior to that he had been the deputy director of the Division of Senior and Disability Services for 1.5 years and a senior policy manager for the Division of Healthcare Services and its predecessor the Division of Medical Assistance.

Vice-Chair Saddler asked about Ms. Brodie's history working for the department. Ms. Brodie replied that she had been deputy director of the Division of Healthcare Services for a 3-month period; prior to that she had been the head of the finance and recovery section for 2.5 to 3 years. She shared that prior to her work at DHSS she had been chief of administration in grants for the Department of Natural Resources.

Vice-Chair Saddler thought that there was not much justification in adding to the system until a switch was flipped and the Enterprise system was successful in qualifying people for Medicaid and processing applications for payment. He pointed to page 13, item 20 of Ms. Brodie's affidavit. He stated that the document read that because the department had been unable to rely on the Enterprise system it had forgone the opportunity for several other reform efforts including the Medicaid program for the Division of Juvenile Justice that would have saved \$1.5 million, Senior and Disabilities Services Telemedicine that would have saved state travel costs, and the Division of Behavioral Health's Behavioral Health Aides. He remarked that the reforms had not happened because the switch had not been flipped to have an effective Medicaid system. He quoted from the paragraph "We have not completed the regulations as there is no specific timeframe for when

Enterprise will be able to accommodate this change. These losses in savings are very difficult to estimate." He asked if his understanding was accurate.

Ms. Brodie reiterated earlier testimony that the affidavit reflected only a point in time.

Vice-Chair Saddler asked if the statements had been true in the past. Ms. Brodie replied in the affirmative.

Co-Chair Thompson noted that the committee was trying to do its due diligence for the state. He remarked that the bill reflected a huge policy change that the committee wanted to make sure was not rushed into too rapidly. He stated the committee wanted to make sure Medicaid expansion was done right. He did not want to end up in a situation like some other states that had accepted Medicaid expansion; some states needed to make changes after accepting expansion, but the federal government would not allow the changes. He opined that significant due diligence remained before Alaska accepted Medicaid expansion.

[2:31:49 PM](#)

Representative Guttenberg observed that there seemed to be a situation where the state wanted to look back on its computer program that had dubious origins. He believed the issue had been addressed considerably. He addressed that the cost of healthcare was one of the largest drivers in the state. He pointed to healthcare costs associated with the state's unfunded retirement liability and contracts with public employees. He asked about the ability to get healthcare costs under control if expansion was not done. He wondered about the ability to wrangle and take control of the rising healthcare costs. He stressed that healthcare costs were out of control and opined that no one seemed to have a handle on the situation. He wondered if the state could start to get the rising costs under control without Medicaid expansion. On the flip side, he wondered about the chance of controlling the costs if Medicaid expansion was accepted. He asked about the mechanisms under expansion that would be utilized to successfully control the costs.

Commissioner Davidson referenced public testimony from Central Peninsula Hospital and PeaceHealth; the hospitals had communicated that reform was very challenging without a cash infusion to offset losses that would come while

payment reform options were tested. Currently, as the Alaska State Hospital and Nursing Home Association had testified, about \$100 million in uncompensated care was provided annually by hospitals in Alaska. She explained that as a result, costs were spread to everyone else. One way to reduce the cost was to have revenues to offset the uncompensated cost; the biggest opportunity available was Medicaid expansion.

[2:34:47 PM](#)

Co-Chair Thompson moved to item 9 on pages 5 and 6 of the affidavit. The item identified that there were problems with service authorization functionality and user input screens. He noted that the issues had not been addressed in Ms. Brodie's PowerPoint the previous day; he asked if the issues had been corrected.

Ms. Brodie answered in the affirmative. She detailed that the time it took to submit a service authorization had been reduced from 30 minutes down to 5 to 10 minutes. She elaborated that Xerox was working on increasing the functionality with the hope of reducing the timeframe even more.

Co-Chair Thompson opined that the problem had not been completely corrected given that it had taken between 60 and 90 seconds under the legacy system. He asked for verification that submitting a service authorization took 5 to 10 minutes at present. Ms. Brodie replied that the problem had been corrected to the specifications outlined in the Xerox contract. She was asking for even better functionality going forward.

Co-Chair Thompson asked if the correction also applied to the following language under item 9:

All travel, waiver, hospital stays, durable medical equipment orthotics, and behavioral health services are service authorization dependent. This translated into providers being unable to obtain service authorization...

Ms. Brodie affirmed that the item had also been corrected.

Co-Chair Thompson asked for verification that the applications were processed in an efficient manner. Ms.

Brodie affirmed that the applications were processed in a timely manner.

Representative Gattis shared that she had spoken with a chiropractor the prior evening about provider tax and Medicaid expansion; the chiropractor had relayed that there had to be a pediatrician referral in order to provide treatment for kids. She relayed that chiropractors could not get approval to receive payment for services when the patient was on Medicaid. She stated that trying to get the authorization was near impossible. From a chiropractic standpoint there were some glitches in getting authorization.

Ms. Brodie answered that the specific issue was outside of the Enterprise system. She asked members to refer anyone having a difficult time with the issue to Cindy Christensen the division's chief of operations, who would get it taken care of immediately.

[2:38:42 PM](#)

Representative Pruitt needed clarification on a couple of components related to department staff costs. He pointed to the statement in Ms. Brodie's affidavit that "additional staff to date has cost the state \$640,385 and will continue to cost at least an additional \$211,799 each year..." (page 7, lines 4 and 5). He wondered if the system would cost the state more because it switched to Xerox, because of the problems associated with the system, or because the state was doing some of the work Xerox should be doing.

Ms. Brodie answered that because testing protocols had not been followed in the beginning when deployments had been put into the system, addressing the issues providers had with trying to ensure recipients could continue receiving services had overwhelmed the Xerox and staff. Therefore, state staff had been working directly with providers on their specific billing issues, which was a function of the [Xerox] fiscal agent, not state staff time. Department staff still did a small portion of the work (a few hours per week), but nothing like at the beginning. She added that some of the providers had chosen to work with the department due to the relationship it had built with them since Go Live; the providers trusted the department more.

Representative Pruitt wondered if challenges in the system would be on the state or Xerox to deal with. For example, related to additional codes or a change to the benefits package. Ms. Brodie answered that changes could occur as a standalone project where the state would get 90 percent federal match. Alternatively, the department had a bank of 600 hours of work that Xerox was required to do and the department would put in a change order. She detailed that if a change order was put in, the department would monitor every step and would get the test results. Under the standalone project scenario the department would use protocols implemented in October 2014 to conduct monitoring and testing. Additionally, the department would watch the change through three different environments before it got to the system.

[2:42:35 PM](#)

Representative Gattis pointed to page 7, item 12 in the affidavit related to loss of federal matching funds. She asked when the department expected the MMIS to be complete, how the Center for Medicaid Services (CMS) validated that system requirements were met, and how long the process took.

Ms. Brodie replied that the department was anticipating notifying CMS that the division was ready for certification at the end of the calendar year [2015]. She detailed that CMS typically came in during the next quarter; it had a complete certification checklist to ensure the system met the CMS requirements. She furthered that the department had a copy of the checklist and was working the checklist prior to asking CMS to conduct the validation.

Representative Gattis asked if Ms. Brodie had testified that the process would take 24 to 30 months. Ms. Brodie affirmed that it appeared to be taking Enterprise systems 24 to 30 months to get certified.

Representative Gattis asked how much funding the state currently had to make up. Ms. Brodie would follow up with the figure. She added that because the state had not been paying Xerox the figure was 25 percent of nothing.

Representative Gattis wondered how much state funds had been lost due to the funding crossing over the fiscal years. Ms. Brodie replied that the state funding had not

been lost, but had shifted from one fiscal year to the next. What the department had identified as a loss in FY 14 would be primarily realized in FY 15 (with the final amount realized in FY 16).

[2:45:04 PM](#)

Representative Gattis referred to the committee's discussion on penalties the previous day. She wondered if the state was exempt from penalties. Additionally, she asked if the state had not been subject to paying penalties back because it was a pilot program.

Ms. Brodie answered that the discussion on penalties had been specifically related to the PERM [Payment Error Rate Measurement] audit. The department had anticipated that its payment error rate would be much worse than the current reality. The department had preliminary results for three months, which included 29 claims for \$18,000; the department had expected it would be much higher.

Representative Gattis asked if the state was exempt from penalties. Mr. Sherwood answered that penalties did not attach to PERM audits. He detailed that the department needed to correct any payment errors that were found in either direction; the state was responsible for repaying the federal government if it had claimed money improperly. To date there had been no additional financial sanctions imposed with the PERM audits. The department was responsible for developing a corrective action plan addressing how it intended to reduce the error rate in the future.

Representative Gattis asked for confirmation that there had been no penalties to date. Mr. Sherwood answered that to date PERM had not been subject to penalties; there was no federal authority to levy a penalty around a PERM finding. He elaborated that the federal government had general authority to impose certain sanctions on state Medicaid programs, but there was nothing specific to PERM.

Ms. Brodie added that the division had been anticipating a much higher error rate than it was seeing. She expounded that if an error resulted in an additional payout to a provider, the state had to claim it with CMS within eight quarters in order to receive federal funding. The state had not anticipated being able to claim some of the payouts

within the eight quarters, which was addressed in the affidavit.

Co-Chair Thompson asked if the state was subject to another PERM audit in the near future. Mr. Sherwood answered that states underwent a PERM audit every three years; Alaska's next audit would be in FY 17.

Ms. Brodie elaborated that changes were underway with the PERM audit process, which would begin to take place on an as needed basis instead of every three years.

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Vice-Chair Saddler referred to an earlier question pertaining to how much money had been lost due to reimbursements crossing fiscal years. He referenced Ms. Brodie's answer that there had been no state funding lost; it had shifted to a different fiscal year. He referred to another statement by Ms. Brodie that if claims were not submitted within eight quarters the state lost its chance to receive reimbursement. He asked if his understanding of the statements was correct.

Ms. Brodie replied in the affirmative; claims were submitted well within the eight quarters.

Vice-Chair Saddler read from page 7, lines 16 through 22 of the affidavit:

...in fixing defects and completing implementation, CMS has dropped the State's reimbursement rate from 75 percent FFP (Federal Financial Participation) to 50 percent for the administration of the new system. (SOA Bates Nos. 1163-11638] This has resulted in the State paying back \$2,909,341 to the federal government.

Vice-Chair Saddler asked if the state would get the money back. Ms. Brodie affirmed that the state would get the money back at certification.

2:52:00 PM

Vice-Chair Saddler voiced his understanding that the process for getting a system like Enterprise certified was not instantaneous and took an application process and other. He asked for verification that the department

expected certification by CMS by March 30, 2016. Ms. Brodie answered replied in the affirmative.

Vice-Chair Saddler asked a question about the department's confidence related to the implementation of the system [audio indecipherable]. Ms. Brodie replied in the affirmative.

Co-Chair Thompson spoke to the requirement of federal certification for the state's MMIS. He remarked that there had been no discussion on what the certification amounted to and what it would do. He noted that some other states (e.g. Indiana) would not accept Medicaid expansion until they received federal certification of the MMIS; the states reasoned that they would not receive federal funding until the MMIS was certified. Given the expected certification date of March 30, 2016, he wondered if Alaska would be responsible for paying for Medicaid expansion until that time.

Commissioner Davidson replied in the negative. She explained that the certification did not impact the system's ability to pay. She elaborated that the new day claims were currently paying at over 90 percent accuracy in terms of timely payment. She relayed that the certification process required by CMS would enable the state to be reimbursed at the enhanced match of 75 percent for the MMIS.

Co-Chair Thompson asked at what rate the state was reimbursed excluding certification. Commissioner Davidson replied that currently the state was reimbursed at a 50 percent rate.

Co-Chair Thompson asked if the state would pay the remaining 50 percent until certification. Ms. Brodie answered that the state received administrative payments and claims for services payments from CMS. The expansion population would fall under the claims for services and would be reimbursed at 100 percent as soon as the state's plan amendment was approved.

Co-Chair Thompson asked for verification that reimbursement would occur as soon as it [the state's plan amendment] was approved. Ms. Brodie affirmed. She explained that the 50 percent match was the administrative cost of running the

Enterprise system, which was the only cost affected by the reduced match.

Co-Chair Thompson surmised that the 100 percent reimbursement was dependent on the MMIS certification. Ms. Brodie replied in the negative. She clarified that the 100 percent reimbursement was based on CMS's approval of the state plan amendment; it was unrelated to the MMIS certification.

[2:55:18 PM](#)

Co-Chair Thompson addressed the PERM audit. He referred to the department's PowerPoint presentation showing 230,371 claims to be processed that would result in payouts and 226,000 to be processed that would result in recoupment. The presentation also indicated that the department had mailed letters on May 1 requesting the recoupment from providers. He wondered if the 456,000-plus claims had been involved in the PERM audit and what the results had been. He believed the number was high.

Ms. Brodie answered that the claims were part of the PERM review, whether the review selected these specific claims or not. She had been surprised because when the new system had gone live it had paid all professional claims a fraction of a cent off. She elaborated that to a PERM auditor a claim that was off by 0.0001 constituted an error albeit financially the dollar amount was insignificant.

Representative Wilson clarified that an audit did not check everything. She remarked that the claims the auditors chose could have been more accurate than another random sample. Ms. Brodie replied that the audit selected a good representation of the claims for a period of time; therefore, it was a statistically valid sampling of the claims.

Representative Wilson understood, but stated that the audit had not checked every single claim. She surmised that if the audit had sampled all claims the error rate may have been closer to what the department had anticipated. She stated that the selection may have picked the claims that had no errors. She noted that an audit was a random selection, but it did not necessarily represent the entire system. She pointed the issue out because she used to think that an audit checked everything.

Mr. Sherwood agreed that there was a possibility that the findings of the audit were not representative [of the claims as a whole], but statistically the probability was very low. He explained that the chosen sample size and statistical methodology went to ensure that the probability of a substantial variation between the audit findings and the entire group of claims was very low.

Representative Wilson had heard from many small providers on errors that still existed.

[2:58:58 PM](#)

Co-Chair Neuman referenced an earlier question by Representative Gattis related to how many providers had gone out of business [after taking advance payments]. He pointed to page 8, line 17 of the affidavit, which specified that 18 providers had gone out of business after taking advance payments. He believed Ms. Brodie had replied earlier that only 3 providers had gone out of business [after taking advance payments]. He addressed the cost to the state. He remarked that the state had issued advance payments of over \$164 million to providers; however, it had only recouped \$60 million, which left a balance of \$104 million [page 8 of the affidavit]. He read from lines 12 through 17 of the document:

This amount will likely never be fully recovered due to crossing fiscal years, the inability of Enterprise to provide accurate records, and providers going out of business. Even, if we are allowed to claim these monies in the future, it will be within a different fiscal year and the State may not have the authority to utilize the funds.

Co-Chair Neuman highlighted the inability to recover \$104 million. He spoke to losses to the general fund due to the inability to draw down another \$78 million. He wondered how to account for the difference between the numbers provided in the affidavit and the numbers Ms. Brodie had given earlier in the meeting.

Ms. Brodie answered that statistics had been updated. The state had recouped over \$70 million in advance payments; there was approximately \$95 million outstanding. She detailed that numerous providers were on repayment

schedules. For example, at the time individuals received an advance the state had asked how and when they would pay the money back (i.e. check or a certain percentage of claims withheld). Therefore, the department was recouping more every week. She elaborated that the department would collect money from the remaining providers by December 31, 2015. She relayed that it would not be possible to collect the entire amount given that some providers had gone out of business. The state was pursuing collection of those monies through other provider IDs the individuals had opened; the department was also looking at garnishing Permanent Fund Dividends as an option to recoup money.

Mr. Sherwood clarified that the 18 providers listed in the affidavit included providers that had gone out of business for any reason (e.g. moving out of state or retiring). However, it did make recoupment more difficult for the state if the individual was no longer an enrolled Medicaid provider.

Co-Chair Thompson stated that the Office of Management and Budget had provided the committee with a recent report showing that in 2010 there had been 4,500 providers participating in the Medicaid program. He relayed that by 2014 the number had dropped to 3,500. He stressed that the state had lost 1,000 providers that had been participating in Medicaid program. He believed the loss was substantial and asked for the department's comment.

Ms. Brodie addressed the change in the number of providers and explained that the state now enrolled rendering providers. She detailed that whenever a provider went from one agency to the next their enrollment had to be ended and restarted under the new agency. She elaborated that the department had reenrollment of all of its providers in anticipation of the Enterprise system; there had been providers that had not reenrolled or had any activity for an extended period of time.

Co-Chair Thompson extrapolated that in other words the providers [that had not reenrolled] did not care to participate in the Medicaid program. Ms. Brodie answered that there were providers nationwide enrolled in Alaska Medicaid in order to provide services to a specific recipient who may be in their state. She furthered that in the past those providers did not automatically end their enrollment; however, when the department conducted the

reenrollment it had automatically ended the enrollments of providers that had not participated for an extended period of time.

[3:04:23 PM](#)

Vice-Chair Saddler asked for clarification that 1000 providers did not reenroll when all providers had been moved from the former system to the new system. He asked what accounted for the reduction in the number of providers.

Ms. Brodie replied that providers were not taken from the old system to the new system; providers had the choice to enroll in the new system if they wanted to provide services to Medicaid recipients. She reiterated her prior statement that there had historically been providers from across the country that had enrolled one time to provide services to one recipient at that time; their enrollment had remained open in the legacy system. She elaborated that those providers had all been terminated when reenrollment for the new system took place.

Vice-Chair Saddler asked for verification that there had been 4,500 providers under the former system, but that some had been inactive and did not reenroll in the new system. Ms. Brodie replied in the affirmative.

Vice-Chair Saddler asked how confident the department was that the 3,500 providers currently in the system were actively providing services in Alaska. Ms. Brodie replied that the number of providers offering services to Medicaid recipients had increased in FY 14 by 6.4 percent.

Vice-Chair Saddler asked for detail on the increase. Ms. Brodie replied that there had been 3,356 providers in FY 13, which had increased to 3,572 in FY 14.

Vice-Chair Saddler wondered how the department measured the providers as actively providing service to Medicaid recipients. Ms. Brodie replied that the numbers reflected providers paid by the department during the fiscal year. Vice-Chair Saddler asked Ms. Brodie to repeat the FY 14 number. Ms. Brodie replied that the number was 3,572 for FY 14.

[3:06:58 PM](#)

Representative Gara referred to past providers who had been over or under paid. He remarked that the situation would be different for future providers given the fixes the department had made. He asked for verification that the department was more accurate on paying future claims than on fixing the outstanding over or under payments.

Ms. Brodie replied that the department was more accurate at present day and going forward.

Representative Gara spoke to payments that had been withheld by the federal government for the Enterprise system (the state should qualify for 75 percent reimbursement upon certification; in the meantime it was reimbursed at a rate of 50 percent). He believed the department may have referred to another category of claims that the department would get full reimbursement for, but had not yet received. He wondered how much money the state may still be due. He asked for verification that the money did not disappear, it was just paid late.

Ms. Brodie replied in the affirmative. She added that the dollar amount was the amount included in her affidavit because the state had not been paying for the system since that time.

Representative Gara believed that the state was receiving 50 percent payment reimbursement from the Enterprise system that it was no longer paying. He asked for verification that the state would receive 75 percent when it received certification; however, the figure would be zero given that the state was no longer paying for the system. Ms. Brodie replied in the affirmative.

Representative Gara wondered if the state had received a lower rate for any claims outside of the Enterprise system that it would retroactively receive a higher rate for. He wondered if there was money due to the state for the claims. Ms. Brodie replied in the negative; the state had reprocessed these claims.

Representative Gara asked for verification that if the state applied for certification to enroll in Medicaid expansion, the expansion would not occur until the federal government provided its approval. He asked for confirmation

that the state would receive the higher federal reimbursement rate once approved.

Mr. Sherwood answered that Alaska had to submit a state plan amendment to be eligible for expansion, which could be done at any point during the first quarter the state began Medicaid expansion. He believed the department would submit the document before the end of the prior quarter. He elaborated that the state could continue to draw money and would send in its report of expenditures at the end of the first quarter. Any settling up was expected to occur at that point; the state plan amendment should be approved at that time and Alaska would receive full funding.

[3:10:41 PM](#)

Representative Gattis asked what the state expected to write off as a result of some providers going out of business. Ms. Brodie replied that at the time the affidavit had been written the money owed to the state had been \$1,425,520. However, at least one-third of the providers had reenrolled under a new provider identification number; therefore, the state was able to attach any debt to the new ID number.

Representative Gattis asked for verification that the rough figure was over \$1 million at present. Ms. Brodie replied that she would have to follow up with the information.

Representative Gattis asked how many out-of-state providers there were compared to in-state providers. She referred to Ms. Brodie's testimony regarding out-of-state providers who had registered in Alaska for one particular patient and had dropped off the provider list when the new system began. Ms. Brodie would follow up with the information.

Vice-Chair Saddler asked about the average time it took to have a state plan amendment approved by CMS. Mr. Sherwood responded that the regulatory approval timeframe was 90 days; the timeframe could be extended if CMS requested additional information. He did not have a precise average of all of the department's state plan amendments, but based on his experience some could be approved in 45 days. He elaborated that a relatively straight forward amendment could be expected to receive approval within the 90-day timeframe; however, there were some state plan amendments that had taken substantially longer. He indicated that the

amendment under discussion was a "check the box" type of amendment, which the department expected would receive approval within the 90-day timeframe.

Vice-Chair Saddler asked what "substantially longer" meant. Research he had done on the issue indicated that a state plan amendment could take 1 year to 18 months or more. Mr. Sherwood answered that some issues had taken that long; usually amendments of this nature pertained to coverage and reimbursement rather than eligibility.

Vice-Chair Saddler asked if it was fair to assume that expanding Medicaid in Alaska may have one of the longer approval times. Mr. Sherwood responded that he did not believe the expansion portion of the state plan amendment would have a longer approval time, which would be distinct from most of the state plan amendments for reform.

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Vice-Chair Saddler thought that something as complex as the reform envisioned by the state would take longer than the statutory minimum of 90 days. Mr. Sherwood responded that the state expected some of the other pieces in the bill to take longer. For example, state plan amendment involving the 1115 waivers could be a lengthy negotiation process. However, he was not aware of an eligibility state plan that had taken substantially over 90 days to approve.

Vice-Chair Saddler believed CMS would like to see more states expand Medicaid; however, he did not know how receptive the federal administration would be to reform or how long the reform component process would take. He asked for verification that approval for reform and waivers could take 1.5 to 2 years or more.

Mr. Sherwood believed it was possible, depending on the specifics included in the state's reform, that there could be a lengthy approval time for one or more components; however, he did not believe it would be the average.

[3:15:54 PM](#)

Co-Chair Neuman noted that part of the problem had been trying to get the certification process done. He stated that Ms. Brodie indicated that once some of the problems were fixed the reimbursement rate would increase from 50

percent up to 75 percent, but CMS had previously dropped the state's reimbursement rate from 75 percent as a result of continued delays in fixing deficits and completing implementation. Therefore, the state had to pay back close to \$3 million to the federal government. He pointed to technical difficulties that had occurred in the certification process. He stated that the reimbursement rate for the state's share of design and implementation had increased from 50 to 90 percent. He reiterated his remarks about the drop from 75 to 50 percent related to certification.

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Representative Wilson stated that if the state accepted Medicaid expansion on August 1 it would be one plan. She asked for verification that the state would have to ask the federal government for approval if it wanted to change to management care or other.

Mr. Sherwood replied in the affirmative. He elaborated that a state plan amendment or a waiver request would be required for other kinds of reforms that would implement managed care or substantially change the benefit package.

Representative Wilson asked for verification that there would be no guarantee the state would be able to do all the reforms; it would be up to the federal government. She thought the state may be gambling on what the federal government would or would not accept.

Mr. Sherwood answered that there was always some uncertainty about the exact design of some of the proposals; they may or may not be approved. In many cases there was established precedent for federal approval of reforms that were very similar to reforms discussed by the department.

Representative Wilson noted that the state's recent transition to Aetna [for state employees] from the prior insurance company had not been smooth. She remarked that the department had testified that there had been two glitches in the past few months related to state payment to

[Medicaid] providers. She assumed one of the cases was in Fairbanks (a provider had not been paid due to the glitch). She communicated that the provider had received a draw, which was supposed to take about six weeks. She wanted to verify that there had only been two glitches related to provider payment in the past few months.

Ms. Brodie clarified that there had been two requests for advanced payments. One was related to an entity in Fairbanks; the issue pertained to the need for a valid supervisor to be connected to the claim. The issue had been fixed as of the prior weekend. The other issue had resulted from a provider entering the billing provider in the rendering ID field in the claims system.

Representative Wilson remarked that maybe other providers had experienced problems, but had not applied for an advance payment. She explained that her question was not limited to providers that had asked for an advance.

[3:33:45 PM](#)

Ms. Brodie affirmed that since the implementation of Go Live some providers had chosen to just wait until the issue was fixed.

Representative Wilson clarified that she was only interested in the time period between January 1, 2015 and present. She reiterated her prior question. Ms. Brodie replied that there had been one payment issue that was causing claims not to pay (of the individuals who received advances). The payment error had been fixed. She relayed that the department was not aware of any other problems, but it was possible a provider had just not submitted a claim yet.

Representative Wilson addressed a discussion the previous day related to IHS. She noted that IHS had been the only instance discussed by the department where Medicaid was the primary payor (IHS was secondary). She elaborated that Medicare, Tricare, Veteran, and private insurance paid first, while Medicaid acted as the secondary payor. She cited statistics that approximately 40 percent of individuals eligible for IHS utilized the service, but 60 percent had elected to use other services. She wondered why Medicaid would be the secondary payor and not the first

(unless the federal government was not doing its part to pay).

Commissioner Davidson replied that the IHS was the "payor of last resort" as required by federal law. She discussed that by law Medicaid beneficiaries who were also IHS beneficiaries were allowed to have a choice of provider. One of the reasons the state was pursuing the 1115 tribal waiver was to work with tribal providers to enhance their ability to provide care to IHS beneficiaries. She relayed that IHS did not historically pay for long-term care services. One of the reasons for this was that in the past people did not live long enough. She elaborated that IHS historically provided limited healthcare services and did not provide long-term care, behavioral health, hospice, disability, or home and community based services. She continued that historically IHS beneficiaries would receive the services outside of the IHS system. As IHS and tribal health providers in Alaska had enhanced their ability to provide care, much of the services had transitioned over to tribal providers, which allowed the state to recoup 100 percent federal match. She expounded that the state could claim 100 percent federal match for IHS/Medicaid beneficiaries seen in an IHS facility including the tribally operated facilities in Alaska. Over the years the legislature had worked with tribes and the department on efforts to enhance the capability in the tribal health systems, specifically in long-term care opportunities and on a patient housing facility that was under construction at the Alaska Native Medical Center. The facility would allow more IHS/Medicaid beneficiaries to be seen in Alaska tribal health facilities, which would bring the state 100 percent federal reimbursement.

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Representative Wilson asked for verification that the state would not receive 100 percent reimbursement if an individual elected to go to Medicaid provider instead of a non-tribal facility.

Commissioner Davidson answered that if an IHS/Medicaid beneficiary did not receive their care in an IHS or tribally operated facility they were subject to the regular federal match of 50 percent. She noted that the match was higher for children and pregnant women.

Representative Wilson wondered if there was an incentive for a single male or female without Medicaid to go to a tribal health service instead of the emergency room. She noted that a person without any money would not pay for service. She thought there may be no incentive to choose one option over the other because they were not personally paying for the service.

Commissioner Davidson asked for clarification. She wondered if Representative Wilson was asking about an IHS beneficiary using the service of a private emergency room.

Representative Wilson wondered what would direct a person towards receiving services in one way or another [from IHS versus the emergency room]. She remarked that the services would be paid 100 percent [if a person received treatment at an IHS facility] or not at all [if a person went to the emergency room].

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Mr. Sherwood replied that if an IHS beneficiary who was ineligible for Medicaid received services from a provider (a non-tribal facility), the provider could charge whatever they charged the general public. However, the individual would not be charged for care if they received treatment at a tribal facility.

Commissioner Davidson added that IHS did charge for certain services. For example, tribal health facilities typically would provide eye exams, but did not pay for glasses or contacts. Additionally, tribal health facilities provided preventative dental exams, but would not pay for a root canal, crown, or bridge.

Representative Wilson was interested in understanding uncompensated care. For example, a person may have Tricare coverage, but it was not enough to pay all the bills. She elaborated that IHS may pay for some services but not others. She had recently heard from a couple of people who had gone to IHS for a doctor appointment. She had been concerned to find out that the individuals had been approached with a \$25 gift card to sign up for Medicaid. She wondered why a service that was paid 100 percent by the federal government would be encouraging individuals to register for Medicaid. She referred to beautiful IHS facilities available to beneficiaries.

Commissioner Davidson answered that IHS was the payor of last resort. She explained that if IHS beneficiaries were Alaska residents, they could not be categorically excluded as a class from enrollment in a state benefit.

Representative Wilson replied that she did not want to categorize anyone. She was trying to determine the benefit of IHS. She wondered why IHS providers would start the discussion with beneficiaries about registering for Medicaid.

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Commissioner Davidson replied that according to IHS's calculation on costs, Alaska tribal health providers actually received between 50 to 60 percent of the funding required to provide the most basic care for an individual, which was why they were a payor of last resort. She detailed that if a visit cost \$1,000 and the IHS provider received \$500 reimbursement for the service, the provider had to make up the difference in cost. She furthered that for this reason, Congress had authorized IHS facilities (including tribally operated facilities in Alaska) to seek reimbursement from third parties including private insurance, Medicaid, and Medicare.

Representative Wilson thought the federal government was supposed to provide 100 percent reimbursement for IHS services. She surmised that the federal government was getting out of making the full payment by requiring the state to pay the difference. She asked if the federal government had funded IHS services at 100 percent at some point in time.

Commissioner Davidson replied that the federal government had never paid 100 percent of healthcare for Alaska Natives and American Indians.

Representative Wilson asked if the federal reimbursement rate had been the same over time. Commissioner Davidson believed that the reimbursement percentage had actually increased. She discussed that prior to the Department of Interior healthcare services had been provided to Alaska Natives and American Indians on a very limited basis. She elaborated that when immunizations were first started in rural communities volunteers had traveled throughout Alaska

by boat to provide the service. She noted that many of the individuals had become community health aides or practitioners.

[3:49:00 PM](#)

Representative Wilson believed that about 47 states had managed care. She wondered if managed care would be done by Medicaid or would the state work on an agreement with IHS to provide managed care.

Commissioner Davidson responded that under the RFP the department would look at options. She detailed that some states had Medicaid manage the program, while other states contracted with a third-party provider. She stated that Alaska could look at doing contracting with the tribal provider. She relayed that one of the things the state was doing with the 1115 waiver it was pursuing was making sure it had maximum opportunity for 100 percent federal match. She elaborated that the state currently had opportunities it was pursuing with long-term care and behavioral health services; however, it could not currently waive choice (waiving choice would require an 1115 waiver). The 1115 waiver would allow the state to require IHS beneficiaries to receive their care in an IHS facility.

Vice-Chair Saddler asked if a person would be able to receive IHS services if they qualified for Medicaid. Commissioner Davidson replied in the affirmative; the services were not mutually exclusive.

Vice-Chair Saddler referred to the time it would take to approve a waiver. He addressed the department's assurances that it could make Medicaid expansion and reform happen by August 1, 2015. He wondered about costs the state may be exposed to if expansion occurred on August 1, but it took CMS up to two years to approve reforms or waivers. He wondered if the department had calculated what it would cost the state to provide services at less than 90 or 100 percent Federal Medical Assistance Percentage (FMAP) for the two years it could take to receive final approval.

Mr. Sherwood answered that the department had not calculated the cost of adding expansion with no federal reimbursement during the time period because it did not anticipate that the state plan amendment for expansion would take that long. He elaborated that the legislation

identified various reforms that would be phased in. The department did not necessarily anticipate savings from the reforms to incur in year one.

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Vice-Chair Saddler asked for verification that the department believed approval for expansion would be close to instantaneous. Mr. Sherwood answered that the department expected expansion to be approved in a couple of months (the approval timeframe of a typical eligibility amendment).

Vice-Chair Saddler asked which of the plan amendments had been changed in only a couple of months in the past 10 years in Alaska. Mr. Sherwood would provide information on the department's eligibility state plan amendments.

Vice-Chair Saddler asked about the cost to provide services to an expanded population. He elaborated that the state would receive reimbursement at 50 percent until CMS approved the waivers or certain reforms. He wondered if the department had calculated the costs. Mr. Sherwood responded that the 100 percent funding for Medicaid expansion was not contingent on approval of any reforms in the bill; it was simply related to the submission and approval of the state plan to add expansion.

Vice-Chair Saddler remarked that the department's RFP envisioned going through a thorough evaluation process to consider other plans' amendments, Alaska's special circumstances, and how a reform package may be best crafted to make the most effective and efficient use of the state's resources. He stated that the results were not expected until after the department envisioned expansion would take place. He believed the situation was a matter of "ready, fire, aim." He did not think it sounded like good planning.

Commissioner Davidson answered that the RFP would look at the entire Medicaid program.

Vice-Chair Saddler restated that the RFP results would be received after expansion. He equated the situation to putting the cart before the horse. Commissioner Davidson replied that since the passage of ACA five years back, the state had been given substantial time to look at available reform options for Medicaid. She relayed that the

department had spent a tremendous amount of time since December [2014] looking at options for accepting expansion as quickly as possible in order to take advantage of 100 percent federal match, which started in January 1, 2014 and would end December 2016. She expounded that the match would decrease to 95 percent in 2017, 94 percent in 2018, and 93 percent in 2019.

Vice-Chair Saddler countered that the Supreme Court's decision that mandating Medicaid expansion was unconstitutional had only occurred in the past year or so. He stated that there had not been five years to consider expansion.

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Commissioner Davidson replied that it had been three years since the Supreme Court's decision. Prior to that Medicaid expansion had been mandatory after the passage of ACA. Therefore, she would have expected more activity to occur, not less; however, she could not speak for the past administration.

Vice-Chair Saddler added that only about half of the states had considered accepting Medicaid expansion. Commissioner Davidson answered that 29 states plus the District of Columbia had accepted Medicaid expansion.

Co-Chair Thompson read a statement from Ms. Brodie's February 2 affidavit on page 10, lines 4 and 5: "harm caused by Xerox subcontracting to Cognizant for DDI and failing to fully staff the project." He thought it appeared that Xerox had not yet fully staffed the project. He wondered about the status.

Ms. Brodie replied that Xerox still needed to hire a systems manager and a Service Utilization Reviews (SURS) manager.

Co-Chair Thompson referred to an article he had read in a newspaper that morning. He reported that it looked like Xerox State Health Care LLC was currently looking for individuals to provide various services such as accounting assistance, business analysis, surveillance utilization review managers, operations manager, and other. He wondered why it appeared the company was just starting to staff an

office when they were already supposed to be up and running. He expressed confusion about the situation.

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Ms. Brodie replied that some of the positions were being recruited to be in support of the state system staff. Xerox was hiring people to specifically work with the state's system unit to learn the "ins and outs" of Alaska Medicaid, which would enable the individuals to go back to Xerox and Cognizant with knowledge of the rules. The process would help ensure more efficiencies in the future. She explained that the other positions were actually being staffed out of other offices at present. She furthered that people had been placed in acting status in the positions, but they were not necessarily physically in Alaska.

Co-Chair Thompson asked if Xerox was utilizing its employees throughout the country. Ms. Brodie replied in the affirmative.

Vice-Chair Saddler pointed to Ms. Brodie's statement on page 10, line 18 that "Xerox has left the most critical of all positions, the Systems Manager, vacant for seven months." He also noted her statement that the SURS manager, another critical position, had been vacant since the previous May. He had seen the advertisement in the newspaper as well. He asked if there were currently systems and SURS managers in the office.

Ms. Brodie replied that the managers were not in the Anchorage office. There was an acting SURS manager in the Anchorage office, whereas an individual from Xerox corporate was currently acting as the systems manager.

Vice-Chair Saddler asked which office the systems manager was working out of. Ms. Brodie replied that the systems manager was working out of the corporate office in Texas.

Representative Gattis had not been impressed at how the Xerox MMIS system had worked in the past. She wondered if people could operate the program worldwide. Ms. Brodie replied that people could work in the system anywhere.

Representative Gattis wondered why the person's location mattered. Ms. Brodie answered that the employees did not have to be face-to-face with the department, but the

department did require the employees to meet with them in person every four to six weeks to ensure the state's needs were being met.

Representative Gattis noted that the great thing about technology was that a person did not have to be physically present to provide the work.

[4:03:17 PM](#)

Co-Chair Neuman drew attention to the fiscal notes. He discussed that the committee had received some information on the amount of federal funds that would come back into the state. He mentioned to Commissioner Davidson's testimony that the federal government would reduce reimbursement to the state from 100 percent down to 90 percent over the years. However, the fiscal note related to Health Care Medicaid services (OMB component 2077) showed increasing funds reimbursed to the state. He observed that the figure was up to \$278 million in FY 20. He stated that the money was projected at \$309 million in FY 21. He discussed that the federal government was \$16 trillion in debt. He wondered if there was a system that could accept up to 40,000 more people. He noted that provisions in the legislation would change federal reimbursements from 175 to 203 percent of the federal poverty level. He expounded that the bill expanded the "donut hole" (people under 65 years of age who were not pregnant). He stressed that the legislation would add a tremendous number of Alaskans into the program. He remarked that according to the department's estimate, a considerable number of federal funds would be added to the reimbursement amount coming in to Alaska. He wondered what assurances the state had that the federal government would continue to provide the increases to the state. He believed many people were concerned about the issue. He opined that nationally people were concerned about the federal taxes coming out of their paychecks. He remarked that many other states had accepted Medicaid expansion and had populations in the millions. He believed it was a "scary proposition" that the federal government would owe such a considerable sum to states. He spoke to expanding eligibility for up to 40,000 more Alaskans. He asked how the state would afford its portion of the costs. He wondered what would happen if the federal government could not uphold its reimbursement.

Commissioner Davidson replied that current federal law required the federal government to reimburse the state at 90 percent beginning in 2020 and beyond. She explained that a change to the reimbursement rate would require an act of Congress and consent of the president. The bill required participation to be contingent upon the match remaining at 90 percent. The department would expect to follow state statute, which only authorized the state's participation in Medicaid expansion as long as the match remained at a minimum federal match of 90 percent.

Co-Chair Neuman discussed that the state's budget was getting tighter every year. He stated that the federal government could not continue to spend money given its \$16 trillion in debt. He remarked that in Alaska alone, it was doubling the amount of money it expected from the federal government in a 10-year period in order to expand Medicaid. He believed the issue should be of great concern to everyone.

Representative Gattis was concerned about incentivizing people to find new Medicaid clients. She referenced businesses handing out \$25 gift cards to incentivize people to sign up for Medicaid. She did not believe it was fundamentally the right way to go. She was concerned about adding individuals to a program that she did not believe the federal government could afford.

Commissioner Davidson replied that one of the reasons the administration was interested in expanding Medicaid was because it provided the opportunity to extend coverage to Alaskans without health insurance and to save the state in what it currently paid with 100 percent general fund dollars. Savings would be about \$6.6 million in the first year; cumulatively the savings totaled \$107.8 million in the first six years; the amount did not include the other reform efforts identified in the bill.

Representative Gattis disagreed that it was a savings if the money came from the federal government. She did not believe a savings took place when the money was paid by another party.

[4:11:46 PM](#)

Representative Pruitt remarked that the projected general fund savings were based on the 90 percent federal

reimbursement. He asked if the department could alter the projection to illustrate state savings that would occur if the federal reimbursement rate was reduced to 50 to 80 percent.

Commissioner Davidson asked for clarification on the request. She restated the request provided by Representative Pruitt. Representative Pruitt replied in the affirmative.

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

Co-Chair Thompson discussed the schedule for the following day.

#  
ADJOURNMENT

4:13:58 PM

The meeting was adjourned at 4:13 p.m.