

HOUSE FINANCE COMMITTEE
FIRST SPECIAL SESSION
May 13, 2015
1:09 p.m.

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

1:09:58 PM

CALL TO ORDER

Co-Chair Thompson called the House Finance Committee
meeting to order at 1:09 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 Cathy Munoz
Representative Lance Pruitt
Representative Tammie Wilson

MEMBERS ABSENT

None

ALSO PRESENT

Stacey Kraly, Chief Assistant Attorney General, Department
of Law; Rachel Witty, Assistant Attorney General,
Department of Law; Valerie Davidson, Commissioner,
Department of Health and Social Services; Andrew Peterson,
Assistant Attorney General, Department of Law; Speaker Mike
Chenault; Representative Liz Vasquez; Representative Kurt
Olson; Representative Neil Foster; Representative Andy
Josephson.

PRESENT VIA TELECONFERENCE

Representative Bryce Edgmon
Representative David Guttenberg

SUMMARY

HB 148 MEDICAL ASSISTANCE COVERAGE; REFORM

HB 148 was HEARD and HELD in committee for further consideration

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Co-Chair Thompson discussed the agenda for the day.

#hb148

HOUSE BILL NO. 148

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

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STACEY KRALY, CHIEF ASSISTANT ATTORNEY GENERAL, DEPARTMENT OF LAW, placed herself on record.

RACHEL WITTY, ASSISTANT ATTORNEY GENERAL, DEPARTMENT OF LAW, introduced herself.

Ms. Kraly explained that as the Chief Assistant Attorney General she represented the Department of Health and Social Services (DHSS) and supervised a section of 10 attorneys including herself. Her section provided all of the legal representation for DHSS except for Child-In-Need-Of-Aid proceedings. Her section did a small amount of work for the Office of Children's Services (OCS) but did not handle day-to-day proceedings. At any given time her section had 4 to 5 fulltime attorneys working on Medicaid-related matters; one fulltime attorney specifically dealt with Medicaid audits and sanctions relating to provider relationships. Her section also had a dedicated attorney that handled Medicaid recovery including third-party liability and trust and estate recovery. The hours equivalent of 2 attorneys spread amongst 2 to 5 attorneys, were dedicated to working on representing and advising the department on various matters related to the Medicaid program. The work encompassed dealing with regulations, advising on

legislation, representing the department in administrative hearings, civil litigation, and Supreme Court appeals.

Ms. Kraly relayed that in preparing for her presentation she was asked to discuss three topics; Xerox litigation, other litigation related to DHSS, and efforts of the Medicaid Fraud Control Unit. She would be inviting Mr. Peterson to join her when talking about the third item. In talking about some of the litigation she would try to be as responsive as possible to the questions posed by the committee. However, she wanted to remind the committee she would be talking about active litigation including the Xerox case and would provide as much information as possible but some answers might have to be answered at a later time. She reiterated that she would try to be as responsive as possible.

Ms. Kraly introduced the PowerPoint "Department of Law's Presentation on Medicaid Issues."

Ms. Kraly began with slide 3: "Xerox Contract":

- In 2007, DHSS contracted with Xerox to develop and operate a new Medicaid Management Information System for the State of Alaska.
- There are two major parts of this contract:
 - The design and development of the system
 - The operation of the system

Ms. Kraly indicated that once the Xerox system was certified Xerox would continue to do the day-to-day operations of the program. The contract encompassed both components.

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Ms. Kraly continued to slide 4: "Purpose of Litigation":

- The claim filed in September 2014 focused on getting Xerox to provide a fully operational system. DHSS did not terminate the contract and has continued to work closely with Xerox to fix the system.

- The litigation appears to have motivated Xerox to prioritize its Alaska project and has resulted in significant improvements. As Ms. Brodie testified, since the claim was filed, Xerox has developed and implemented a corrective action plan to improve claims processing and resolve system defects.

Vice-Chair Saddler wanted to confirm that there were a couple of different avenues of redress the State of Alaska had against Xerox. He mentioned civil litigation and hearings before an administrative law judge. He wanted to know if litigation meant in court or an administrative law judge.

Ms. Kraly relayed that the case was filled in front of the Office of Administrative Hearings. The state did not file a case in Superior Court.

Vice-Chair Saddler clarified that it was considered litigation before an administrative hearing. Ms. Kraly stated that Representative Saddler was correct.

Ms. Kraly relayed that as Ms. Brodie testified previously that since the claim was filed Xerox had developed and implemented a corrective action plan for claims processing and was working on resolving system defects.

Ms. Kraly turned to slide 5: "Status of Litigation":

- As noted above, Xerox and DHSS agreed to a "go live" date of October 1, 2013.
- As noted by Ms. Brodie, significant problems were identified immediately. DHSS worked with Xerox over the ensuing year to achieve improvement but to little or no avail.
- Per the contract, the parties engaged in a two- day mediation in September 2014. This mediation was not successful.

Vice-Chair Saddler asked if the state decided to go live on its own volition or if relied solely on Xerox's representations that it should. There was a question as to whether the state should have or could have continued the old system. He asked if it was clarified as to whose

decision it was to go live without the legacy system continuing in a parallel fashion.

Ms. Witty responded that in the claim DHSS alleged that based on representations by Xerox the new system was ready to engage. It was her understanding that, at a certain point, running both systems simultaneously had to end. In the state's claim the decision to cease the operation of the old system was based on Xerox's representations.

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Vice-Chair Saddler clarified whether the decision was solely going live while concurrently ending the use of the old system. Ms. Witty answered that it was the state's decision to go live without the legacy system remaining in operation.

Co-Chair Thompson acknowledged Representative Josephson in the audience.

Ms. Kraly continued to explain that in the previous year in August and September the Department of Law (LAW) and DHSS evaluated its many options under the state's contract with Xerox and determined that the contract required that the parties engaged in alternative dispute resolutions. Department of Law initiated provisions of the contract that required a mediation. The parties engaged in a two-day mediation held in Anchorage in September 2014 held in Anchorage. Although the mediation highlighted and addressed a number of significant issues, it was ultimately unsuccessful.

Ms. Kraly advanced to slide 6: "Status of Litigation":

- On September 22, 2014, DHSS filed a contract claim with the Commissioner of Administration which was referred to the Office of Administrative Hearings. The claim sought the following relief:
 - Development of an acceptable corrective action plan
 - Completion and correction of deliverables necessary for a fully operational system that can be certified by the federal government

- Payment of liquidated damages and other damages resulting from the delays and lack of functionality

Ms. Kraly advanced to slide 7: "Status of Litigation":

- A hearing on the liquidated damages was held on February 18 and 19, 2015.
- A hearing on the breach of the contract was scheduled for August 2015.

Representative Gara did not understand why the committee was rehashing the litigation information rather than debating the bill.

Ms. Kraly continued with slide 7:

- On April 2, the administrative law judge stayed the case. The parties agreed to stay the case until August 24, 2015 to allow Xerox to complete its work under the corrective action plan and other deferred work, and to allow DHSS to evaluate the system for acceptance.

Ms. Kraly indicated that if the system was acceptable to DHSS then the hearing in August would be removed from the calendar.

Ms. Kraly reported that the parties were in an acceptance phase of the contract negotiation as detailed in slide 8: "Acceptance":

- On or before July 31, 2015, the parties are to meet and establish whether the system is acceptable to DHSS, meaning that all major defects have been resolved, all deliverables are complete, and Xerox can be released from the implementation phase of the contract and allowed to focus solely upon operations.
- This means that DHSS will have to determine that the system is functioning at a level and degree that meet its core business needs. But this does not mean that DHSS is the sole arbiter for acceptance—DHSS is in contact with the federal government to assure

that their determination of acceptance meets the federal standard so that the system will be certified.

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Co-Chair Neuman referred to the slide indicating that the department would have to certify that all major defects were resolved. He suggested that the department would not know for a while whether the program was working properly. He mentioned new coding requirements from the federal government. He wondered how the state could certify that all major defects were resolved having experienced so many problems with the system.

Ms. Kraly stated that there was a likelihood that there would always be issues with the systems, functionality and improvements that would have to be addressed. The concept articulated in the slide had to do with the idea there had been a list of correctable defects in the corrective action plan. Issues encountered with the new International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD 10) codes were not part of the consideration currently. There would be constant improvements and additions that would need to be made as long as the program was operational.

Co-Chair Neuman asked whether Xerox would be held liable for any complications in the future after July 31, 2015 if the state signed off on everything the company had done to-date.

Ms. Kraly responded in the negative. She informed the committee that there was a contract in place that addressed both the design and development of the system and the operations of the program including additional change orders requested in the future. Xerox would be held accountable for the changes as they occurred in the future.

Co-Chair Neuman asked about the possibility of having an independent auditor or analyst that could advise the state on the signing off of the system.

Ms. Witty relayed that the state had a technical assistance contractor under contract known in the industry as an independent verification contractor; a third party

assessing the system that determined whether Xerox was complying with the corrective action plan. In addition, the state had the check of the federal government, the Centers for Medicare and Medicaid Services (CMS). If the system did not do all that it was expected to do, there was a way to check against DHSS's assessment.

Co-Chair Neuman asked for a specific list of items being addressed by Xerox.

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Representative Munoz asked about the 38 items that needed to be fixed subject to the corrective action plan. She wondered if all of the actions were consistent with federal requirements. She wondered if there would be an additional list of demands.

Ms. Kraly communicated that the two items were not mutually exclusive. The items the DHSS list identified were items that had to be addressed in order to reach the acceptance phase. As part of the acceptance phase the department would be engaging with the federal government, CMS, and with the technical assistance contractor mentioned earlier to ultimately ensure certification. She was unclear whether the items would be the same ones the federal government would be focusing on. She did not believe they were mutually exclusive of each other. They went hand-in-hand.

Vice-Chair Saddler wanted Ms. Kraly to elaborate on what was at stake for the state in terms of finances, the operations, fines, and penalties. He wanted to know why the case was important to Alaskans

Ms. Kraly responded that a functioning Medicaid Management Information System (MMIS) was critical to the administration of the Medicaid program. She opined that it had been testified to by the commissioner and Ms. Brodie over the past two days. It was necessary to operate the Medicaid program. With respect to getting acceptance and certification the two functions lead to federal dollars for the development and operation of the program. In order to get certification from the federal government they had to approve the system. Once approved, the federal government would pay 50 percent of the cost. Upon certification, the federal government would backfill the additional 40 percent covering 90 percent of the program.

Ms. Kraly continued that, in terms of the operation phase and the functionality going forward, the federal government would pay 75 percent of the operation of the program. Certification lead to enhanced federal funding for the operation of the program.

Vice-Chair Saddler asked Ms. Kraly to confirm that the reason why the administrative investment rate went from 75 to 50 percent. He wondered if it was due to some error on the part of the state.

Ms. Kraly did not believe it was based upon an error. She thought it was a functionality of not getting paid the enhanced rate until certified.

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Vice-Chair Saddler wondered about the finances. He heard that the state was on the hook for a payback to the federal government with some potential fines and error rates. He wanted to know the financial implications.

Ms. Kraly communicated that as was testified previously the intent was for the state to eventually become whole. If the state had either over paid providers in error then the state had to pay back the federal government the additional payment. If the state had underpaid, once reconciled, the federal government would give the money back. There were no penalties or sanctions, per se. There was the ultimate accounting reconciliation at the end of the day that the federal government was not overpaid or underpaid for billed services.

Vice-Chair Saddler asked if the state would ever recover some of the money. Ms. Witty prefaced by saying that it was important to put Ms. Brodie's affidavit into context. It was not only a point in time, but it was filed in response to a motion by Xerox saying that the state's liquidated damages clause was unenforceable. Xerox claimed that the state's actual damages were minimal compared to the amount of damages the state had said it accrued through the liquidated damages clause. Xerox suggested that it should be struck from the contract as unenforceable. The affidavit of Ms. Brodie was to support the state's position that the damages were difficult to calculate and under the law the

state's situation was the reason why a liquidated damages clause would be included in a contract.

Ms. Witty added that although the state was uncertain of the ultimate value of the damages, it could still go after Xerox for its costs. Accounting reconciliation issues and repayment issues were causes for damages.

Vice-Chair Saddler pointed to page 8 of the affidavit where it referenced the state's current outstanding balance of \$104 million. On page 7 it also stated that CMS had dropped the state's reimbursement rate from 75 percent Federal Medical Assistance Percentages (FMAP) to 50 percent as a result of continued delays in correcting defects. He remarked that Ms. Witty was correct.

Representative Gara wanted to be clear that the reimbursement rate that Vice-Chair Saddler mentioned had to do with the reimbursement rate of the cost of the system, not the reimbursement rate for health care services. He said it had gone down from 75 percent to 50 percent but it would retroactively go back to 75 percent once the system was certified. He wanted to make sure he was correct. Ms. Kraly responded in the affirmative.

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Representative Gara asked that once the system was certified and the retroactivity was activated, it would be as if it had been 75 percent the entire time in terms of reimbursements to the state. Ms. Kraly responded, "That is correct."

Representative Gara noted was that with all of the improvements that were enforced through litigation, which he appreciated, the system was up to about a 95 percent billing accuracy. Ms. Kraly responded that that was her understanding.

Representative Gara commented that not only was the system up to 95 percent accuracy, the remaining 5 percent of claims were paid within the following one or two billing cycles. He recapped that the billing performance was essentially 100 percent accurate. Ms. Kraly responded that was her understanding.

Representative Gara asked, with the improvements that had been made, if there was any reason why the state should not proceed with Medicaid expansion at present. Ms. Kraly responded, "Through the chair, Representative Gara, I do not."

Representative Gattis added to the comments made by Co-Chair Neuman. One of her concerns was that she was not hearing from both sides of the litigation. She wanted to hear what the other side had to say.

Representative Pruitt wanted to discuss the money. He asked Ms. Kraly about her understanding of the system as she had gone through the litigation process. He wondered if she considered herself very capable of understanding the full ramifications of the system.

Ms. Kraly responded that she had been representing DHSS for fifteen years. In that time she had represented the Medicaid agency in its various iterations. She reported working very closely with all of the divisions and the commissioner's office on a myriad of Medicaid problems. She had been actively involved in the litigation, although, she was not one of the attorneys who had entered an appearance in the litigation. She was very comfortable with discussing the impact of the MMIS system on the operations of the department as well as the impact to litigation related to the Medicaid system.

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Representative Pruitt asked about additional discussions concerning payments or penalties the state might have to pay. He wondered what the ramifications of a recuperation the state could have on the litigation from Xerox's faults. He wondered what the clause covered. He asked if it was just the money that the state would otherwise receive from the federal government, labor costs, or other things.

Ms. Kraly wanted to make sure she understood Representative Pruitt's question. She wondered if he was asking about the damages the state could potentially recover from Xerox.

Representative Pruitt responded affirmatively and added that he also wanted to know the scope of the damages. He wondered if the state would be recouping money lost with the federal government and future financial actions. He

wanted to make sure the state would be whole again at the end of the litigation.

Ms. Kraly responded that the purpose of the litigation as filed was to ultimately get a functioning system. As part of the litigation the state raised a number of claims in the accusation including a claim for liquidated damages. Under the contract there was a provision that allowed for liquidated damages. Xerox was contesting that provision and had argued that damages should be held unenforceable. Xerox's argument was that the damages the state was assessing were so large in comparison to the actual damages the state was suffering. As a result, she continued, Ms. Brodie drafted the affidavit responding to the claim identifying that the damages that the state suffered were large and significant but difficult to quantify for a variety of reasons. The state would not actually know the dollar amount in damages for quite some time well into the future. The purpose of a liquidated damages provision under the law was to identify a penalty. The provision was initiated because of Xerox's failure to perform and an inability of the state to quantify damages. It was her expectation at the conclusion of the litigation that the state would have a functioning system and there would be some form of remuneration from Xerox related to some of the damages. Currently, she was unable to provide an exact amount. Part of the litigation that was currently in front of the administrative hearing office was how to quantify and calculate the amount for damages. The numbers that needed to be reconciled would be determined once all of the pieces were in place.

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Representative Pruitt asked whether Xerox would make a profit from the system. Ms. Kraly relayed that there were two parts to the contract. The first was the design and development and implementation phase. The operations was the second part of the contract. She furthered that once the system was operating and certified by the federal government the state would be in a contractual relationship with Xerox and receiving payment, as they would continue to manage and operate the program. She supposed that it would be better to ask Xerox about potential profits.

Representative Pruitt understood that the state was going to pay Xerox. However, if the state was awarded liquidated

damages exceeding what the state paid for the system, he wondered at what legal opportunity could Xerox end its business relationship with the state. He was concerned with being left with a system without support. He wondered if Xerox would cut its losses and whether the state would have any recourse.

Ms. Kraly responded that should Xerox determine it no longer wanted to participate there would be a breach of contract. The state would then litigate a breach of contract action against Xerox. She furthered that unless there was a mutual termination the state would have additional claims. The current litigation was the one remedy the state had with respect to Xerox. It was not the exclusive remedy, there were additional remedies under the contract up to and including the termination of the contract. The state did not want to terminate the contract, rather, it wanted an operational system. If Xerox were to walk away from the state unilaterally then the state would evaluate and pursue all of its remedies under the contract.

Representative Pruitt asked about the maintenance contract duration. Ms. Witty believed the contract ran through 2019 with options to renew. She would get back to the committee to confirm her answer.

Representative Pruitt mentioned that the state had used the previous system for 26 years. He expressed further concern with being stuck with a very large and expensive system after 5 years if Xerox potentially did not want to support it down the road. He asked about the state's recourse at that point.

Ms. Kraly indicated that the state could choose to litigate with Xerox. She also noted that the system belonged to the state. The state could bring in a new operator as another option.

Ms. Witty clarified that the contract expired September 2017.

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Co-Chair Thompson suggested that the contract was renewable for up to 25 years.

Vice-Chair Saddler stated that the enterprise system went live in October 2013, 4 years behind schedule according to what Xerox promised the state. Xerox was currently 2 months into a corrective action plan and there was nothing regarding the enterprise system that stood in the way of expanding Medicaid at present. He asked if the enterprise system was currently certified. If not, he wondered if the state would receive any FMAP if it expanded Medicaid today.

Ms. Kraly answered that the system was not certified. However, certification would not impact the enhanced federal match for the expansion population. The state would still receive the 100 percent federal match in 2016 if it expanded as indicated in HB 148 on August 1, 2016.

Vice-Chair Saddler asked why the state would need to certify the system. Ms. Kraly responded that certification had to do with the functionality or the operation of the system. It had nothing to do with the federal match for the reimbursement from the federal government for services that were provided. Certification had to do with whether the MMIS met certain protocols set by the federal government. It did not impact payment. She provided an example. She suggested that the state was receiving its 50 percent match for all of the services that the state was currently providing. The state was receiving a little more for certain children and pregnant women. The matching dollars were coming in from the federal government every day, week, or month.

Ms. Kraly briefly discussed slide 9: "Certification":

Once the system is accepted, DHSS will seek certification for the system. Certification relates to the federal matching for the development and operation of the system, not to the federal match for the payment of services.

For example:

For development of a new MMIS system, the federal government pays 90% of that cost, the state pays 10%

For operation of the MMIS system, the federal government pays 75% of that cost and the state pays 45%

Ms. Kraly stated that the slide discussed the certification, the concept of certification, and its related funding from the federal government.

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Ms. Kraly outlined slide 10: "Certification":

Currently the federal government is only paying 50% of the cost of the development and is paying 50% of the operation. Once the system is certified the federal government will reimburse the state to the full match noted above, e.g., the additional 40% for design and 25% for operation. And this payment is retroactive.

Thus, certification relates to funds expended by the state to build and operate the new system and does not impact provider payments for federal match related to those payments.

Ms. Kraly summarized that slide 10 discussed more about certification.

Representative Wilson asked about page 9. She wanted to know if what was listed for the federal government's operational costs for the MMIS of 75 percent and the state's portion of 45 percent was accurate. Ms. Kraly responded that it was a typographical error.

Co-Chair Thompson clarified that the number should have been 25 percent.

Representative Wilson asked about the coding in October. She wondered why the state did not wait to pursue litigation with Xerox until the next large test of the system occurred or until certification was completed.

Ms. Kraly indicated that she was not qualified to answer Representative Wilson's question. She pointed out that the commissioner and Ms. Brodie spoke on the topic the previous day. As far as her second question, certification was not the trigger for reimbursement from the federal government for the provision of services. In her opinion, waiting for certification to expand did not make sense. The state would receive money from the federal government regardless of certification.

Representative Wilson indicated she was only referring to the state's agreement with Xerox. She wondered why the state would not wait to take care of the litigation following the certification for Xerox. She was not looking at expansion. She was looking at whether other states waited until they changed over.

Ms. Kraly relayed that if she understood Representative Wilson's question correctly the state was in a status quo position with Xerox currently. The state had not withdrawn the litigation or the claim for liquidated damages. The state was able to reinstitute or go back off the stay or address additional claims should there be additional problems in the future. The state did not intend on releasing Xerox from performing under the contract in the future. There was really no need to wait until the two milestones were reached. The state was moving forward on a day-to-day basis.

Representative Wilson suggested looking again during the interim at whether other states in converting to a new system, used certification as a stamp of approval.

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Co-Chair Thompson commented that, in terms of the whole system, when it initially went live it seemed to work. However, when the big load was initialized there was a significant problem. The system currently appeared to be working, but the state would be adding 20 thousand to 40 thousand new people and 70 thousand NCCI [National Council on Compensation Insurance] codes into the system simultaneously. He was concerned whether the system could handle the additional load.

Ms. Kraly moved to slide 12: "State Litigation":

Filipino American Assisted Living Providers Association v. DHSS:

This class action complaint for injunction, damages, and declaratory relief related to DHSS' efforts to engage in cost-based rate setting for assisted living home operators.

Ms. Kraly reported that the committee requested that the topic of ongoing litigation within DHSS be included in the presentation as well as to discuss a couple of federal cases. She reported that the Filipino American Assisted Living Providers Association v. DHSS was currently in a lull. The state had prevailed on all motions [Secretary's note: Audio cut out briefly].

Ms. Kraly turned to slide 13: "State Litigation":

Putnam and Brown v. State of Alaska, DHSS, DSDS:

Litigation filed on behalf of two Medicaid nursing home recipients, requesting a preliminary injunction, and declaratory and injunctive relief arguing that the notices sent by DHSS violated due process because they did not engage in a material improvement analysis/process similar to what is done when terminating a person from home and community-based waivers under AS 47.07.045.

Ms. Kraly relayed that the litigation was filed by two Medicaid recipients who were challenging the state's determination that they no longer met nursing facility level of care conditions and could no longer have their services paid for in a nursing home. The allegations raised were that the state should use the same process that was used for home and community-based waivers establishing that recipients had materially improved.

Vice-Chair Saddler asked for details about the case on slide 12. Ms. Kraly responded that 4 or 5 years prior the legislature and the department discussed a variety of issues concerning consistency within the assisted living home arena. The discussion included moving to cost-based reporting required by the federal government. Department of Health and Social Services engaged in a regulatory proposal to require assisted living homes to engage in cost-based reporting which was a fundamental shift in how rates were established previously. A number of assisted living homes participated in providing cost-based reports and certified accounting records. Other homes did not like the new plan and filed the litigation arguing that the system the state was engaging in through regulations was too extensive and ineffective. The state presently prevailed on all claims at present.

Vice-Chair Saddler thanked Ms. Kraly for the helpful information.

Ms. Kraly continued to explain slide 13. She reported that the case remained active and an oral argument was scheduled at the end of June [2015].

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Ms. Kraly pointed to slide 14: "State Litigation":

Henderson v. DHSS, DHCS:

Litigation related to the DHSS' protocols regarding the approval for prior authorization for the hepatitis C drug Sovaldi violated federal and state law. The drug in question is Sovaldi, a relatively new treatment for hepatitis C with a high rate of success in patients with the disease, along with a cost of \$84,000 for each course of treatment. At issue is whether the criteria were properly adopted under the Administrative Procedures Act, whether the policy unjustly discriminates in violation of 42 CFR 440.230(c), and whether the notice of denial comports with due process.

Ms. Kraly indicated that the state had been sued. The argument was that the state's protocols were in violation of the Administrative Procedures Act; they discriminated under the federal rules related to the Medicaid Act and that the state's notice violated due process. She reported that the case was in its infancy in the discovery and motion practice.

Ms. Kraly detailed the case on slide 15: "State Litigation":

Nafalhu v. SDS:

Litigation related to the Division of Senior and Disabilities Services (SDS) alleging that the process used by SDS to determine eligibility for personal care services violates due process because eligibility is not based solely upon the assessment but is put through a quality control system to assure the accuracy of the assessment in light of all other

factors, such as medical diagnoses and medical records.

Ms. Kraly relayed that the case was filed within the previous month regarding how the division determined needs of patients for personal care services.

Ms. Kraly clarified that the four cases that she had presented she would highlight. They were active litigations. The department had a myriad of additional cases it dealt with at the Office of Administrative Hearings, which dealt with Medicaid provider audits and recipient fair hearings with respect to the denial, suspension, or termination of Medicaid benefits.

Ms. Kraly moved on to slide 16: "Federal Litigation":

King v. Burwell:

The issue is whether a person who purchases insurance on an exchange established by the federal government, instead of on an exchange established by a state, is authorized to get tax credits under Obamacare.

Only 16 states have their own exchange; the remaining states have relied upon the federal exchange. It is estimated that at least 5 and maybe as many as 8 million people will lose their tax credits, if the Court finds that the tax credits do not apply to insurance purchased on the federal exchange.

Ms. Kraly relayed that the case was before the United States Supreme Court. She provided case details regarding the Affordable Care Act. Individuals who purchased insurance through the exchanges had been provided with tax credits. The question in front of Burwell was whether the tax credits could be provided if a person had purchased the insurance through the federal exchange. There was a provision in the Affordable Care Act that indicated that a person could only receive a tax credit if they applied through a state exchange. The litigation was asking whether the tax credits were available through the federal exchange.

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Vice-Chair Saddler asked if the state was at issue in the case being that it did not have its own exchange relying on the federal exchange. Ms. Kraly responded affirmatively.

Vice-Chair Saddler asked about the potential impact if the Burwell case went against the federal administration's position. Ms. Kraly explained that the ultimate impact would be that those individuals that received tax credits through the federal exchange would no longer be eligible to receive them.

Vice-Chair Saddler asked if Alaskans would be required to repay the tax credits. Ms. Kraly did not know the answer to Vice-Chair Saddler's question. She assumed not.

Vice-Chair Saddler wondered if the State of Alaska would be required to step in for the people affected. Ms. Kraly responded that the State of Alaska could certainly step in, but currently the questions and answers would be hypothetical. She reiterated that the state could step in to provide fixes.

Vice-Chair Saddler asked if the state would be obligated to step in. Ms. Kraly did not believe so.

Co-Chair Neuman commented that when he had spoken with many Alaskans around the state who had received the credits and expressed their concerns. He suggested having something in HB 148 that addressed the needs of Alaskans who would be subject to losing the credits. He mentioned Obama Care. He suggested that the Department of Law come up with options for the legislature to consider to make sure that the state did not lose the 21 thousand Alaskans that were currently covered. He also did not want the same people to incur additional costs just because the state decided to expand Medicaid.

Representative Pruitt asked about the income level for people who would qualify for tax credits. Ms. Kraly stated that roughly speaking insurance was made available to those with an income of 133 percent to 400 percent of the federal poverty line. An individual making approximately \$16 thousand to \$47 thousand would be required to purchase coverage but would no longer receive any help should the court rule against the administration. She suggested that the department might have more accurate information.

Representative Pruitt asked about the numbers. Ms. Kraly answered 133 percent to the 400 percent of the federal poverty guideline.

Representative Pruitt did not believe the income levels matched the percentage levels. He wanted to hear from the commissioner if possible.

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VALERIE DAVIDSON, COMMISSIONER, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, responded that the subsidized insurance available on the federally facilitated market place in Alaska was based upon an individual falling between 100 percent and 400 percent of the federal poverty level. In terms of state versus federal-based exchanges, every state had the opportunity to develop their own state-based exchange by a certain date. She relayed that there were federal grants available for states to take advantages of building the exchanges. She continued that for states unable or chose not to develop their own state-based exchange were subject to the federally facilitated market place. Previously, the issue was addressed by the department in a letter to Senator Coghill addressed by the commissioner of insurance in a memorandum. She could make the letter dated April 14, 2015 available to the committee.

Commissioner Davidson relayed the exchange options for the state. The first was to do a traditional state-based exchange which Alaska no longer had the opportunity to pursue due to federal dollars no longer being available. The second option was to build a state designated exchange in which the state basically designated the federal exchange to serve as the state-based exchange in order to comply with the rules. The third option was to establish a supported state-based exchange. The fourth was where Alaska could contract with another state. The fifth option was to build a regional exchange where a number of states could work together to develop an exchange. The sixth option was a state private exchange. She relayed that based upon Alaska's situation, the most cost-effective systems available and being pursued by the Division of Insurance were the state-designated exchange or the contracted state-based exchange. The federally facilitated market place would be designated as Alaska's exchange or the state could contract with another state to provide the service for Alaska.

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Vice-Chair Saddler asked that the information be provided in writing. He suggested that the Commissioner was saying that if there was a reduction through federal litigation in health care benefits to some Alaskans that the state would consider several options to maintain that [health care benefits]. Commissioner Davidson responded that the department would be happy to provide the information.

Representative Pruitt assumed that the closer a person was to the poverty the higher the subsidy or tax credit. He wondered if he was correct in his assumption. Commissioner Davidson responded affirmatively.

Representative Pruitt wanted to know how many people within the expansion population could potentially be impacted. Commissioner Davidson would try to provide the information Representative Pruitt was requesting.

Representative Gara asked a question about the donut hole. He suggested when Governor Parnell and other governors sued to stop the Affordable Care Act the ruling resulted in what was commonly referred to as a donut hole. He wanted to better understand the circumstances for those people who would have received insurance subsidies but currently did not receive either insurance subsidies or Medicaid. He wanted to better understand the gap and wondered how many people were affected.

Commissioner Davidson stated that she could provide some specificity on the exact number of Alaskans that fall within the gap Representative Gara was talking about. She explained that in terms of the donut hole created by the Supreme Court it resulted because under the original Affordable Care Act that was drafted Medicaid expansion was required of all states. As a result some states sued including Alaska. The Supreme Court determined that while the Affordable Care Act was constitutional states could reject Medicaid. Individuals that are at less than 100 percent of the federal poverty level did not qualify for a subsidized insurance plan in the marketplace.

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Representative Gara asked if there was a group of people below 100 percent of the federal poverty line that were also not eligible to receive Medicaid even with expansion.

Commissioner Davidson responded in the affirmative. She pointed out that people in the expansion populations that were newly eligible between the ages of 19 to 64 in 2016 of the almost 42 thousand Alaskans who would be eligible under the expansion, 23,344 were below 100 of the federal poverty level, ineligible for a subsidy on a federally facilitated marketplace.

Representative Munoz asked about how many people were purchasing subsidized insurance that would transfer to Medicaid with expansion. Commissioner Davidson would get back to the committee with the information Representative Munoz was requesting.

Ms. Kraly pointed to slide 18: "Federal Litigation":

Scott v. DSS:

On April 29, 2015, Governor Rick Scott, filed suit against the federal Government related to its decision to defund the Low Income Pool, a grant program authorized by the federal government to assist in offsetting cost of care for persons who do not qualify for Medicaid.

Florida receives 1.3 billion to help hospitals cover the cost of care for uninsured persons. The federal Government decided not to re-issue the grant that paid for the Low Income Pool arguing that those persons should be covered by Medicaid expansion.

Governor Scott filed suit arguing that this reduction of the grant was akin to the coercion argument that was struck down by the US Supreme Court in the Sebelius case in 2010.

The federal government stated that the program was temporary and had been previously set to expire in June. The pool funding shouldn't be used to pay for costs that would be covered by an expansion of Medicaid

Ms. Kraly concluded her portion of the presentation.

2:15:13 PM

ANDREW PETERSON, ASSISTANT ATTORNEY GENERAL, DEPARTMENT OF LAW, introduced himself indicating that he was the supervisor of the Medicaid Fraud Control Unit. He would be discussing a number of things including the unit's mission and how it had been fulfilled through collaborating with other state and federal agencies. He would be pointing out some of the results of the enhanced collaboration and the effectiveness it had provided the unit and the resulting cost savings. He would also talk about some of the reforms his office and Ms. Kraly's office recommended to DHSS. He noted that he would be summarizing the first few slides to save time.

Mr. Peterson started with slide 20: "Introduction":

Omnibus Budget Reconciliation Act 1993

Requires states to establish Medicaid Fraud Control Units (MFCU)

Sets performance standards and guidelines

Minimum personnel requirements

Federal Financial Participation (FFP) grant

Funds 75% of MFCU costs

Mr. Peterson explained that the Medicaid Fraud Control Unit was established in 1993 by federal regulation. Essentially the regulation required that all states had Medicaid Fraud Control Units (MFCU) nationwide. Currently, there were 49 states and the District of Columbia that had MFCU. North Dakota was the only state that did not have a MFCU presently. The federal government set forth certain performance standards and guidelines that had to be followed similar to DHSS. The unit was audited on a regular basis to back sure it is being a good steward of federal resources being received. As a result, the unit had a 75 percent federal financial participation match.

Mr. Peterson advanced to slide 21: "Medicaid Fraud Control Unit [MFCU]"

MFCU investigates and prosecutes:

Medical Assistance Fraud

Allegations of abuse or neglect

Financial exploitation or misappropriation of patient assets

Mr. Peterson indicated that MFCU was responsible for investigating and prosecuting medical assistance fraud, allegations of neglect and abuse, and financial exploitation or misappropriation of patient assets. The unit had statewide jurisdiction to prosecute any crime in the State of Alaska. The way he described it was that if the unit had Medicaid fraud or abuse allegation of hook the unit would prosecute any other crime involved in the case. If a Medicaid hook was not part of a case the case would move to another prosecutor such as the District Attorney's office or the Office of Special Prosecutions. He mentioned having a couple of limitations.

Vice-Chair Saddler asked how many staff he had and about the division's budget. Mr. Peterson answered that there was a total of 10 staff in the MFCU. He expounded that there were two prosecutors, himself and another. There were 6 criminal investigators, one of whom was in a supervisory role. The other staff member was the only forensic auditor in the state.

Mr. Peterson discussed the unit's budget. He relayed that in federal FY 2015 totaled \$1,105,990. Ms. Kraly interjected that the number was on slide 28.

Co-Chair Neuman recollected DHSS moving over about \$6 million from its budget to help with fraud control. He asked Mr. Peterson to clarify. Mr. Peterson speculated that Co-Chair Neuman was likely referring to funds designated for the fraud control unit within the Division of Public Assistance. One of the specific requirements of establishing MFCU was that they be entirely independent from DHSS. Twenty-five percent of MFCU's budget came from the Attorney General's budget. The remaining 75 percent of funds came from a federal match.

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Mr. Peterson detailed slide 22: "MFCU Limitations":

Non-Medicaid cases

Investigating or prosecuting recipient fraud

Data mining

Mr. Peterson mentioned that MFCU had some limitations on what the unit could prosecute. In a recipient case in which there was a collaboration with a doctor or provider the unit would charge both together. The last limitation was doing any kind of data mining. Instead the unit took a referral from any source, primarily from DHSS. The referral could come from a citizen or a physician. When the unit received a referral it opened the door to initiate an investigation.

Mr. Peterson advanced to slide 23: "NFCU Collaboration with DHSS":

Coordination Between

Program Integrity

Quality Assurance (SDS)

Health Care Services QA

Behavioral Health QA

Department of Law - Civil Division

Identify Problems or Limitations

Criminal vs. Civil Action

Regulation modification

Mr. Peterson talked about the way MFCU had been able to enhance the unit's ability to investigate through collaboration, primarily with DHSS. In meeting with other directors from MFCU nationwide, Alaska's unit had one of the best relationships with a DHSS than any throughout the nation. It was bearing fruit which he would demonstrate when

he discussed results. The Medicaid Fraud Control Unit had a close relationship with DHSS and with the civil unit. He relayed that when DHSS sent over a referral Mr. Peterson's unit could work closely to collaborate on the best way to handle a case. If neither MFCU nor the criminal division were able to prosecute, the next discussion needed to be about some type of regulatory reform or a request for statutory reform. If Department of Health and Social Services wanted to address a problem the unit had to figure out a way to approach it.

Mr. Peterson scrolled to slide 24: "Collaboration with other Agencies":

Office of Inspector General (OIG) Agents

FBI

Immigrations and Customs Enforcement

Other Federal Agencies (SSA, DEA, USPS)

Alaska State Troopers

Municipality of Anchorage & APD

Dept. of Labor

Dept. of Commerce

Dept. of Corrections

Mr. Peterson pointed to the extensive list of additional agencies that MFCU worked with on a daily or weekly basis. He reported the unit worked closely with many different federal agents and state law enforcement officers. He reported that in the previous three years MFCU had entered into memorandums of agreement with the Department of Labor and Workforce Development, the Department of Commerce, Community and Economic Development, and the Department of Corrections. The agreements had allowed the sharing of information. The data that was exchanged helped the unit to fulfill its mission of prosecuting waste, fraud, and abuse within the system.

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Mr. Peterson revealed slide 25: "Results":

102 Criminal Cases Filed since FFY 2012
80 Criminal Convictions

Suspension from providing Medicaid services

8 civil resolutions - limitation on providing services

Restitution Judgments totaling \$2,806,369.70

Pending Cases:

Number of pending and ongoing investigations

Potential Restitution: \$4 million in pending criminal cases

Mr. Peterson affirmed that those individuals who received a criminal conviction were suspended from providing Medicaid services for 10 years typically, and faced a possible extension of 10 years which was determined by the commissioner of DHSS. The unit had secured 8 civil resolutions that had not risen to the level of a criminal charge or a negotiation had been agreed upon.

Vice-Chair Saddler asked about the \$2.8 million in restitution judgements. He wonder about the loss percentage. Mr. Peterson assumed Vice-Chair Saddler had heard about audits within DHSS and how it looked at statistically valid samples. In terms of criminal prosecution Mr. Peterson had to have a verifiable loss. He furthered that what the unit could prove in court was equal to what the restitution judgements would be. The \$2.8 million in judgements were criminally court ordered restitution judgements based upon the prosecutions.

Vice-Chair Saddler asked if it equaled 100 percent of the proven loses. Mr. Peterson speculated that it was never 100 percent of the proven losses. It was what the unit could prove in court. He relayed that there were often times situations where the unit believed that there was more lost than could be proven. He was referring to what could actually be proven.

Vice-Chair Saddler remarked that he was not completely clear about Mr. Peterson's remarks. He rephrased his question. If the unit was recovering \$2.8 million, he wondered about the amount being lost. He wanted a percentage provided.

Mr. Peterson commented that the Federal Bureau of Investigations (FBI) had statistics estimating what the percentage was for fraudulent health care billing. He added that it was 100 percent of what the unit had been able to prove in its criminal cases.

Vice-Chair Saddler was still unclear about the percentage. He appreciate any information Mr. Peterson could provide on the subject. Mr. Peterson responded that the FBI statistics suggested that 3 percent to 10 percent of all health care billing was fraudulent. If the 3 percent FBI statistic was applied to the Medicaid system of the state of Alaska then potentially \$45 million per year could be determined to be fraudulent.

Co-Chair Thompson asked if judgements were different from collections. He cited that the state had not collected the amount it just reflected the amount the state had received in judgements. He wondered if he was correct.

Mr. Peterson stated that Co-Chair Thompson was correct. He relayed his surprise at the amount that had been collected. He also mentioned that MFCU had recently received a fairly significant judgement. One of the benefits was that once a potential fraud was identified the federal government essentially reached into the state's coffers and took the fraudulent amount of the federal share back from the state, a sign that the state had been a poor steward of the state's resources. Once a conviction was obtained against a defendant and the state proved the judgement was not collectable the state would then be able to get the money back from the federal government. Although the state might not collect 100 percent of the funds that the state received in restitution judgements there was clearly a financial benefit back to the State of Alaska.

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Representative Gara discussed a comment made by fraud investigators that it would be cost effective to hire additional investigators in order to recuperate money by

discovering fraud. He furthered that they had suggested that money spent on hiring additional investigators would be less than the money returned. He asked for Mr. Peterson to comment.

Mr. Peterson relayed that, based on statistics he would be reviewing, Representative Gara's statement was accurate. He reported that prior to 2012 the MFCU had 3 investigators and was prosecuting on average zero to 3 cases per year. In 2012 MFCU expanded its number of investigators to 6 which greatly enhanced the unit's ability to look at a larger number of cases. Since then, the unit had dramatically increased both the amount of restitution and the number of prosecutions secured for Medicaid fraud.

Mr. Peterson advanced to slide 26: "Results Cont.":

121 suspensions of Medicaid providers based on credible allegation of fraud

114 Individual PCAs

4 PCA agencies

Transportation service provider

Two medical practices

Mr. Peterson acknowledged that there had been 121 suspensions of Medicaid providers which included the 102 prosecutions mentioned earlier in the presentation.

Mr. Peterson advanced to slide 27: "Cost Savings":

Estimated Savings: \$30 Million

FFY 2013: \$461,805

FFY 2014: \$18,089,187

FFY 2015: \$12,154,541

Mr. Peterson conveyed that the number had been provided to the unit by DHSS's Program Integrity Unit. The way the number was estimated was based on the number of suspensions in each year. The cost savings were estimated going forward

based on the suspensions. The estimated savings was \$30 million since federal FY 2013.

Vice-Chair Saddler asked what the number was based on. Mr. Peterson replied that it was the Program Integrity Unit's best estimate.

Mr. Peterson detailed slide 28: "Funding," pointing out that the chart showed the total expenses for MFCU each year in 2012 through 2014. The third line down was the state's 25 percent share. On the fourth line the fines were shown and in each year starting in 2012 through 2014 the unit had increased the amount of fines ordered by court order judgements. He mentioned that the two cases in which the defendants had already entered plea agreements, but sentencing was pending for the following summer, would result in \$450 thousand in additional fines being paid to the state. Similarly, with restitution, the slide indicated an escalation in the amount of restitution the unit had been collecting as part of the prosecutions. Additionally, with the two pending cases that should be sentenced the following summer the unit anticipated an excess of \$1.5 million additional restitution ordered to the state.

Mr. Peterson discussed the national civil cases was that one of the benefits the state received by having a MFCU was that the state was able to participate in National Association of Medicaid Fraud Control Unit cases. The cases are national cases against health care providers or pharmaceutical companies. The State of Alaska was able to join in the civil litigation without having to fund the litigation itself. The amount of money on the chart were civil judgements that had come in to the MFCU as a result of Alaska's membership in the national association.

Mr. Peterson pointed a few other items on the slide. He noted the return on investment, a return on the state's investment of the 25 percent share on the amount of money the state was getting back. Each year with the additional investigators additional funds had been collected. The bottom line of the chart reflected the number of convictions each year since 2012.

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Ms. Kraly continued to slide 29: "Civil Recoveries: 2 Attorneys and 1.5 Paralegals." She explained that the slide

reflected a calculation of the recoveries that her section had achieved over the prior 4 calendar years. The numbers represented actual recoveries the Human Services Section had obtained as a result of the estate recovery, trust recovery, third-party subrogation, and audits. She added that she had two attorneys and 1.5 paralegals dedicate to civil recoveries, a good return on investment overall.

Mr. Peterson concluded with slide 30: "Reform":

Collaboration to achieve/implement reform:

Interest Penalties on Overpayments (HB 148)

Civil fines on providers for regulation violations (HB 148)

Revisions to Personal Care Attendant Program (draft regulations pending)

Revisions to durable medical equipment program (regulations pending)

HB 161, pending transmittal to Governor for signature

Mr. Peterson began at the bottom of the slide. He stated that in the unit's meetings with DHSS identifying reform was an important component. He conveyed his support of HB 161 [Short Title: Medicaid: Used Durable Medical Equipment], a reform in an area that the MFCU had been looking at with respect to durable medical equipment. At the top of the list on the slide he stated that HB 148 had several reforms that had been proposed by both the criminal and civil divisions of the Department of Law and of DHSS with respect to interest penalties for providers that had been either potentially billing Medicaid for services that were not allowed or not keeping proper paperwork and imposing civil fines. The reason he felt it was so important was that currently if a provider was billing Medicaid in a manner that maybe was not appropriate and was caught, the only penalty was a mulligan; return the money and start over. They had the opportunity to litigate in the administrative hearing process of the state's claim that the provider owed the state money which could take years. In all of the time there was no loss to the provider. There

was no interest charged on the money that the state paid out. One of the ideas was to make sure that providers had some skin in the game. The two proposals would ensure that providers had skin in the game. If providers were billing Medicaid inappropriately and receiving funds they were not entitled to they would be entitled to appeal or challenge the state's findings. However, in the end, if the providers were determined to be wrong they would likely have to pay interest on the monies improperly received. Currently the only way to address providers that were doing something wrong was with a criminal charge which came with significant consequences. The civil fines that the unit was asking the legislature to consider would provide the option to remedy potential waste, fraud, or abuse without having to potentially put a provider out of business.

Mr. Peterson concluded that some of the revisions the unit had worked with both on the criminal and civil sides had been addressing revisions in the personal care attendant program. The unit had implemented a number of revisions in past years. He intimated that the committee had heard from the director of Senior Disability Services (SDS) as to the amount of money that had been saved, some of which were due to prosecutions but most of it was due to reforms implemented by SDS.

Co-Chair Thompson asked that any written responses to the questions be directed to his office.

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

ADJOURNMENT

2:35:20 PM

The meeting was adjourned at 2:35 p.m.