

ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

March 3, 2016

3:19 p.m.

MEMBERS PRESENT

Representative Paul Seaton, Chair
Representative Liz Vazquez, Vice Chair
Representative David Talerico
Representative Geran Tarr
Representative Adam Wool

MEMBERS ABSENT

Representative Neal Foster
Representative Louise Stutes

COMMITTEE CALENDAR

HOUSE BILL NO. 227

"An Act relating to medical assistance reform measures; relating to administrative appeals of civil penalties for medical assistance providers; relating to the duties of the Department of Health and Social Services; relating to audits and civil penalties for medical assistance providers; relating to medical assistance cost containment measures by the Department of Health and Social Services; relating to medical assistance coverage of clinic and rehabilitative services; and providing for an effective date."

- BILLS PREVIOUSLY HEARD/SCHEDULED

PREVIOUS COMMITTEE ACTION

BILL: HB 227

SHORT TITLE: MEDICAL ASSISTANCE REFORM

SPONSOR(S): REPRESENTATIVE(S) SEATON

01/19/16	(H)	PREFILE RELEASED 1/8/16
01/19/16	(H)	READ THE FIRST TIME - REFERRALS
01/19/16	(H)	HSS, FIN
02/02/16	(H)	HSS AT 3:00 PM CAPITOL 106
02/02/16	(H)	Heard & Held
02/02/16	(H)	MINUTE(HSS)
02/09/16	(H)	HSS AT 3:00 PM CAPITOL 106
02/09/16	(H)	-- MEETING CANCELED --

02/16/16	(H)	HSS AT 3:00 PM CAPITOL 106
02/16/16	(H)	Heard & Held
02/16/16	(H)	MINUTE(HSS)
02/18/16	(H)	HSS AT 3:00 PM CAPITOL 106
02/18/16	(H)	Heard & Held
02/18/16	(H)	MINUTE(HSS)
02/23/16	(H)	HSS AT 3:15 PM CAPITOL 106
02/23/16	(H)	Heard & Held
02/23/16	(H)	MINUTE(HSS)
02/25/16	(H)	HSS AT 3:15 PM CAPITOL 106
02/25/16	(H)	-- Testimony <Invitation Only> --
03/01/16	(H)	HSS AT 3:15 PM CAPITOL 106
03/01/16	(H)	Scheduled but Not Heard
03/03/16	(H)	HSS AT 3:15 PM CAPITOL 106

WITNESS REGISTER

JON SHERWOOD, Deputy Commissioner
 Medicaid and Health Care Policy
 Office of the Commissioner
 Department of Health and Social Services
 Juneau, Alaska

POSITION STATEMENT: Testified and answered questions during discussion of HB 227.

MARGARET BRODIE, Director
 Division of Health Care Services
 Department of Health and Social Services
 Juneau, Alaska

POSITION STATEMENT: Answered questions during discussion of HB 227.

DUANE MAYES, Director
 Central Office
 Division of Senior and Disabilities Services
 Department of Health and Social Services
 Juneau, Alaska

POSITION STATEMENT: Answered questions during the discussion of HB 227.

TANEEKA HANSEN, Staff
 Representative Paul Seaton
 Alaska State Legislature
 Juneau, Alaska

POSITION STATEMENT: Answered questions regarding HB 227 on behalf of the bill sponsor, Representative Seaton.

ACTION NARRATIVE

[3:19:19 PM](#)

CHAIR PAUL SEATON called the House Health and Social Services Standing Committee meeting to order at 3:19 p.m. Representatives Seaton, Wool, Talerico, Vazquez, and Tarr were present at the call to order.

HB 227-MEDICAL ASSISTANCE REFORM

[3:19:40 PM](#)

CHAIR SEATON announced that the first order of business would be HOUSE BILL NO. 227, "An Act relating to medical assistance reform measures; relating to administrative appeals of civil penalties for medical assistance providers; relating to the duties of the Department of Health and Social Services; relating to audits and civil penalties for medical assistance providers; relating to medical assistance cost containment measures by the Department of Health and Social Services; relating to medical assistance coverage of clinic and rehabilitative services; and providing for an effective date."

[3:21:26 PM](#)

CHAIR SEATON opened public testimony. After ascertaining no one wished to testify, closed public testimony.

[3:22:26 PM](#)

REPRESENTATIVE VAZQUEZ moved to adopt proposed Amendment 1, labeled 29-LS1096\H.7, Glover, 2/19/16, which read:

Page 5, line 5:

Delete "**may not be less than 50**"

Page 5, lines 5 - 10:

Delete "[, AS A TOTAL FOR THE MEDICAL ASSISTANCE PROGRAMS UNDER AS 47.07 AND AS 47.08, SHALL BE 0.75 PERCENT OF ALL ENROLLED PROVIDERS UNDER THE PROGRAMS, ADJUSTED ANNUALLY ON JULY 1, AS DETERMINED BY THE DEPARTMENT, EXCEPT THAT THE NUMBER OF AUDITS UNDER THIS SECTION MAY NOT BE LESS THAN 75]"

Insert ", as a total for the medical assistance programs under AS 47.07 and AS 47.08, shall be 0.75

percent of all enrolled providers under the programs, adjusted annually on July 1, as determined by the department, except that the number of audits under this section may not be less than 75"

CHAIR SEATON objected for discussion.

REPRESENTATIVE VAZQUEZ explained that proposed Amendment 1 deleted the proposal to reduce the actual number of audits conducted. She relayed that although there were usually at least 75 audits required, but HB 227 had proposed to reduce this to 50 audits. She pointed out that, as there were between 3,000 - 4,500 Medicaid providers, maintaining 75 audits "does not appear to be a harsh imposition on the community, especially with a provision that states that we want to avoid concurrent audits," whether it was a federal or other ongoing audit. She offered her belief that historically the Department of Health and Social Services had considered whether the provider was also being audited by other agencies. The proposed Amendment 1 would return the number of audits to match existing law.

CHAIR SEATON directed attention to the e-mail response to the committee members' questions from the administration, dated February 16, 2016. [Included in members' packets.]

[3:24:15 PM](#)

JON SHERWOOD, Deputy Commissioner, Medicaid and Health Care Policy, Office of the Commissioner, Department of Health and Social Services, relayed that the Department of Health and Social Services had proposed reducing the annual number to 50 audits as, since that statute had been passed more than 10 years prior, there were now a number of other audits implemented by the federal government. The department had proposed the reduction to relieve some of the burden from the providers; however, he stated, the amendment would not pose any problem as the department would then continue to do 75 audits annually.

CHAIR SEATON referenced the aforementioned e-mail response which stated that there were currently 5,823 active Medicaid billing providers, and the proposed audit for 0.75 percent of these providers would have resulted in 44 audits. He acknowledged that the 50 audits in the proposed bill would have been closer to this figure than the 75 audits in proposed Amendment 1.

REPRESENTATIVE TARR relayed that she was more comfortable with the existing language in the proposed bill for 50 audits. She

opined that, as DHSS was currently beginning its work on some massive changes, and it was necessary to be diligent on these audits, there were also other significant efforts to address fraud and abuse.

CHAIR SEATON commented that a number of providers had stated to the committee that more regulations equaled more cost by the providers. He pointed out that although the audits might not be a problem for the department, this was a problem for the providers. He noted that the audits built more cost into the system, something the committee was trying to eliminate. He suggested that, unless the audits were "catching a lot of fraud and abuse," this was only "building cost into the system that's not being productive." He stated that he had not received any information that 75 audits were more sufficient for the cost versus benefit.

REPRESENTATIVE VAZQUEZ expressed her disagreement. She explained that, in the selection of the providers to be audited, the high risk profile was reviewed. She asked DHSS about the process for the audit selection.

MR. SHERWOOD explained that at the end of annual billing period, the claims data was taken and analyzed, and samples from different groups of sorted provider types were selected. He declared that this was not meant to be a purely representative sample, although it was intended to get a broad cross section of providers. A list of potential audit candidates and alternates was generated, which was sent to the DHSS audit committee, comprised of members throughout the department representing program integrity and quality assurance who worked with Medicaid. This committee reviewed the list and used their knowledge to sort through the providers and make recommendations to the certified auditing agency, Myers and Stauffer. He added that, generally speaking, DHSS still had the ability to target the highest risk providers when initiating 50 - 75 audits, while maintaining a degree of cross section so nothing would go unobserved.

REPRESENTATIVE TARR referenced some of her constituent providers who had been audited, at a cost of more than \$10,000 each, and she asked if 50 audits could still target the highest risk providers while not burdening some of the smaller providers.

MR. SHERWOOD offered his belief that 50 audits would still target the highest risk providers, pointing out that small dollar providers were not audited, as the cost of auditing these

providers did not justify the money recovered. He expressed his agreement that these audits could be expensive and cumbersome. He reported that preliminary findings were released in order to allow providers to dispute or correct any of the findings. He reiterated that 50 audits would allow the department "to get to the highest risk providers."

REPRESENTATIVE TARR mused that the complexity of changing regulations and expectations could be where the mistakes were made, as opposed to intentionally fraudulent behavior.

MR. SHERWOOD expressed that it was true that many of the issues uncovered during audits were not fraudulent activity, but instead were mistakes, misinterpretations of policy, or failure to execute documentation appropriately. Although these were important aspects to comply with, the department tried to strike a balance using a lower minimum threshold for audits.

REPRESENTATIVE WOOL asked about any increase in the Department of Health and Social Services workload with a higher number of audits, and who paid the cost for the audits.

MR. SHERWOOD replied that the state directly paid for the cost of the audits to the contractor, Myers and Stauffer. He reported that the recoveries from the audit process approximately offset the cost of audits, noting that the reduction in audits would be offset by a reduction in recoveries.

REPRESENTATIVE VAZQUEZ asked about the amount of money recovered in the last year as a result of the audits.

MR. SHERWOOD replied that he did not have the amount.

[3:38:58 PM](#)

MARGARET BRODIE, Director, Director's Office, Division of Health Care Services, Department of Health and Social Services, reported that she did not have the exact amount of penalties recovered.

MR. SHERWOOD offered to get that information to the committee.

[3:39:41 PM](#)

CHAIR SEATON set proposed Amendment 1 aside, awaiting more information for the amount of money recovered.

3:40:04 PM

REPRESENTATIVE VAZQUEZ moved to adopt proposed Amendment 2, labeled 29-LS1096\H.8, Glover, 2/20/16, which read:

Page 8, lines 2 - 7:
Delete all material.

Page 8, line 8:
Delete "(4)"
Insert "(2)"

Page 8, line 13:
Delete "(5)"
Insert "(3)"

Page 11, line 12:
Delete "applications for waivers and"
Insert "application for a waiver"

Page 11, line 13:
Delete "options under AS 47.07.036(d)(1) - (3)"
Insert "under AS 47.07.036(d)(1)"

Page 11, line 16:
Delete "applications"
Insert "application"

Page 11, lines 17 - 18:
Delete ", a section 1915(i) option under 42 U.S.C. 1396n, and a section 1915(k) option under 42 U.S.C. 1396n were"
Insert "was"

Page 11, line 20:
Delete "programs"
Insert "program"

Page 11, line 21:
Delete "waivers"
Insert "waiver"

Page 11, lines 21 - 22:
Delete "(A)"

Page 11, line 24:

Delete ";"
Insert "."

Page 11, lines 25 - 27:
Delete all material.

CHAIR SEATON objected for discussion.

REPRESENTATIVE VAZQUEZ referenced her lengthy reasons which she had submitted in the last meeting, as it was unclear "what we're getting into until we see the amendments actually to the state plan and the reports to the legislature will be after the fact in 2019." She offered her belief that initial research had indicated that these options may become an entitlement program, which would not allow any caps or limits. She suggested that there may not be many alternatives in a difficult fiscal situation if these options were developed.

MR. SHERWOOD expressed his agreement that, although the options for the regular Medicaid state plan would become an entitlement, the key to controlling the cost would be to establish appropriate eligibility criteria, in-service definitions, and limits which would go into the state plan for implementation, which would reduce the general fund expenditure on current services. He reported that a consultant had been hired through the Alaska Mental Health Trust Authority to help with the process and offer insights into appropriate options.

[3:42:48 PM](#)

DUANE MAYES, Director, Central Office, Division of Senior and Disabilities Services, Department of Health and Social Services, directed attention to the document titled "Home and Community Based Services Waiver and Options." [Included in members' packets.] He reported that these were the current options for the 1915(c) home and community based services program. He added that there were two other sections, one for the Medicaid option 1915(i) and one for 1915(k). He directed attention to the five documents which showed assumptions to cost savings within the general fund program and the home and community based services program.

CHAIR SEATON noted that the 1915(c) option was presented in a two page table, and the 1915(i) and (k) options were presented in the color slide package. [Included in members' packets.]

REPRESENTATIVE VAZQUEZ asked that future documents be dated, noting that she had not had time to review these documents.

MR. MAYES reported that a contract with Health Management Associates (HMA) had been signed for October, 2015 through July, 2016. This contract was in place to explore the aforementioned two options. He shared that the 1915(k) option was required by Centers for Medicare & Medicaid Services (CMS) to have an implementation council, which consisted of recipients, and/or their family members, of services within the Medicaid waiver program. He noted that the council had been in place since November, 2015. He stated that there were 12 deliverables within the HMA contract, and that deliverable number 3, a review of regulations, had been telling, as the lessons learned from the efforts of other states included the need to be very methodical in the roll out of the two options, with one service at a time, and to not overhaul the Medicaid home and community based services program all at once. He shared an example for the services by one state that were overwhelmed when trying to overhaul the system all at once. He declared that it was necessary to make sure the eligibility process was well defined and based on need, as otherwise the costs could be driven upward. He shared that it was important that the regulations and the utilization and quality controls for 1915(i) and (k) were well written. He offered his belief that the division had reduced its expenses through the home and community based services waiver program primarily because of good regulations and utilization controls. He said that it was necessary to have the ability to recalibrate the assessment tools for appropriate service levels in order to control costs. He shared that CMS allowed having soft caps in place.

CHAIR SEATON asked for a definition to soft cap.

MR. MAYES offered an example, the self-care activities of daily living which seniors often needed, that a soft cap be based on the average hours per week, and if more hours were necessary, there was a process to petition the state for additional hours. This allowed the state to manage the program, and he expressed his confidence that the program would be well managed and would not "explode in terms of cost." He directed attention to the first graph, titled "Community Developmental Disabilities Grants 1915(i) Impact" [Included in members' packets], noting that in FY15 there was general fund spending of \$11,635,800, with no federal matching funds, which served 996 individuals. He suggested that this eligibility could be refinanced as a Medicaid component under the 1915(i), which allowed for a 50

percent federal match. He moved to the next graph, titled "Senior Community Based Grants - Adult Day 1915(i) Impact" [included in members' packets], and reported that there were 13 adult day centers in Alaska, serving 423 individuals at a cost of \$1,757,000 in FY15. He opined that 114 of these individuals would meet the eligibility requirements for the 1915(i) option, allowing for a 50 percent federal match, and a general fund savings of \$236,800.

[3:53:00 PM](#)

MR. MAYES moved on to the next graph, titled "Senior Community Based Grants - Senior In-Home 1915(i) Impact" [included in members' packets], which spent \$2,917,300 in general funds for 1,371 seniors to be served in their homes with case management services to allow the seniors to remain in their homes. He offered his belief that 123 of these individuals would meet the eligibility requirements for the 1915(i) option, and thereby save the general fund about \$130,800 with a 50 percent federal match.

MR. MAYES directed attention to the next graph, titled "General Relief/Temporary Assisted Living 1915(i) Impact" [included in members' packets], which he described as a safety net for the vulnerable population. He reported that the referrals tended to come from the Alaska Psychiatric Institute or hospital discharge planning units, pointing out that the program had spent \$7.3 million in FY15 for 545 individuals. He opined that 349 of these individuals would meet the eligibility requirements for the 1915(i) option, saving the general fund about \$2.3 million [from the 50 percent federal match].

MR. MAYES announced that the last graph, titled "Senior and Disabilities Medicaid Services 1915(k) Impact" [included in members' packets], which he described as requiring a need for institutional level of care. He reported that the current personal care attendant program had 1,603 people meeting this criteria. He cited that use of the 1915(k) option would increase the federal match by an additional 6 percent, from a 50 percent to 56 percent federal match. He noted that the actual general fund savings would be about \$2.5 million. He declared the necessity to be very methodical, with a good eligibility process and good utilization controls in place, and with a well-defined eligibility process.

[3:56:27 PM](#)

CHAIR SEATON noted that a previous concern had been for the wait list, but that, as all of those on the wait list were currently getting services funded by the state, this would not be expanding the population.

REPRESENTATIVE VAZQUEZ referenced the last graph, titled "Senior and Disabilities Medicaid Services 1915(k) Impact," and questioned that there would not be any added cost to the state although it would expand services to the recipients. She asked which services would be added that the state would have to pay the balance.

MR. SHERWOOD replied that this option was intended to provide services similar in nature to the current personal care services program, which was available to any Medicaid recipient with that need. He allowed that although it might be possible for the state to design a broader service package, the intention was to focus on the assistance and maintenance activities and health related tasks instrumental to daily living similar to services already provided.

REPRESENTATIVE VAZQUEZ asked for clarification that the department would not be offering any additional services.

MR. SHERWOOD stated that the department would be offering a service similar to the current personal care services.

CHAIR SEATON stated that the 1915(i) and (k) options had been shown through Medicaid reform to be a cost saver to the State of Alaska.

CHAIR SEATON maintained his objection to proposed Amendment 2.

[4:00:30 PM](#)

REPRESENTATIVE VAZQUEZ asked about the graph titled "Community Developmental Disabilities Grants 1915(i) Impact," noting that this program did have a [waiting] list for the waiver.

MR. SHERWOOD expressed his agreement that one of the four waivers did have a waiting list for individuals with intellectual and development disabilities.

REPRESENTATIVE VAZQUEZ asked what prevented the individuals currently on the waiting list for qualification to Medicaid if they qualified for 1915(i).

MR. SHERWOOD said that most individuals on the waiting list could qualify for Medicaid if they had a need for Medicaid services. He allowed that individuals on the waiting list were often already receiving the services through the community developmental disabilities grant program. He reiterated that an issue was to establish the qualifying standards for functional impairment, and it was necessary to be judicious in setting the standard. He declared that it was necessary to be careful with the eligibility criteria and the service limitations.

REPRESENTATIVE VAZQUEZ asked what prevented the Department of Health and Social Services from simply expanding the existing waiver program which was already being reimbursed by 50 percent, in order to reduce the waiting list to zero.

MR. SHERWOOD mused that it was a possibility, as there was no statutory requirement to stop expansion for the number of individuals authorized to serve under the waiver. He shared that the current structure of the waiver offered a very wide, very generous package of benefits, targeted to people needing an institutional level of care. He stated that there were people on the wait list who did not have this need, but the 1915(i) option allowed the department to meet those needs that may not be quite so broad. He acknowledged that there could be two waivers, although it would be more cumbersome to administer. He explained that the 1915(i) option seemed to be the more expeditious.

[4:04:53 PM](#)

REPRESENTATIVE VAZQUEZ asked if there were individuals currently on the wait list who met the institutional level of care.

MR. SHERWOOD acknowledged that there probably were, although he did not know if they would be assessed by an official determination.

MR. MAYES explained that there were two types of individuals receiving services through the Community and Developmental Disabilities Grants. There were those who may meet eligibility for the (c) waiver, the institutional level of care. He said that this was not determined when people were listed on the registry, but was instead determined during an assessment at a later time. He acknowledged that some individuals on the registry did meet the definition for institutional level of care. Those individuals who did not meet this were the individuals being directed to the 1915(i) option.

REPRESENTATIVE VAZQUEZ asked what prevented the department from conducting assessments to identify those individuals needing institutional level of care and placing them into the (c) waiver.

MR. SHERWOOD replied that the expense of the assessments and the impact on the budget for the additional people could be absorbed if the legislature wanted to finance this by increasing the budget.

REPRESENTATIVE VAZQUEZ asked about the cost of an assessment.

MR. SHERWOOD replied that the assessment was done by state employees, although he was not sure if the calculation of cost was readily available. He stated that it would be necessary to take the money out of the grant program paying for services in order to do more assessments.

CHAIR SEATON asked if those individuals currently on the wait list were getting services through the community developmental grants.

MR. SHERWOOD expressed his agreement that those individuals had access to those services, although many of those individuals had very low needs, and were most likely on the registry with anticipation for a future change to those needs. He compared that the waiver for developmental disabilities which served about 2,000 people cost about \$170 million annually, whereas the grants which served less than 1,000 people cost about \$12 million annually. He declared that the package of received services under the waiver or through the grants was substantially different.

[4:09:59 PM](#)

REPRESENTATIVE VAZQUEZ addressed the graph titled "Senior Community Based Grants - Adult Day 1915(i) Impact" and, asking about the funding for the adult day care centers, questioned how a 1915(i) waiver could be fashioned to do away state funding.

MR. SHERWOOD acknowledged that the option would require the state to pay its share of 50 percent. He stated that it was not anticipated for everyone receiving these adult day services to qualify for Medicaid. He pointed out that the projection was for about 25 percent of the participants, and that DHSS would maintain the general fund match for the 1915(i) waiver, as well

as the grant program payment for those who did not qualify for that waiver.

CHAIR SEATON pointed out that of the current 423 individuals, 114 would be eligible for the waiver.

CHAIR SEATON maintained his objection to proposed Amendment 2.

4:12:17 PM

A roll call vote was taken. Representatives Vazquez and Talerico voted in favor of proposed Amendment 2, labeled 29-LS1096\H.8, Glover, 2/20/16. Representatives Wool, Tarr, and Seaton voted against it. Therefore, Amendment 2 failed to be reported out of the House Health and Social Services Standing Committee by a vote of 2 yeas - 3 nays.

4:13:07 PM

CHAIR SEATON returned attention to proposed Amendment 1, labeled 29-LS1096\H.7, Glover, 2/19/16.

MS. BRODIE, in response to an earlier question by Representative Vazquez, stated that the department had recovered \$775,330 as a result of the audits.

CHAIR SEATON noted that there had been 75 audits.

REPRESENTATIVE VAZQUEZ asked how many Medicaid providers were enrolled with Department of Health and Social Services.

CHAIR SEATON relayed that the e-mail dated February 16, 2016 [Included in members' packets] had stated there were 5,823 active [Medicaid] billing providers.

REPRESENTATIVE VAZQUEZ stated that she had wanted confirmation.

MS. BRODIE acknowledged that this was the number of Medicaid billing providers, subject to these audits.

REPRESENTATIVE TARR asked how many of these audits resulted in the assessments of overpayments.

REPRESENTATIVE WOOL asked for the amount paid to the auditing contractor for those 75 audits.

MS. BRODIE relayed that the first year of the contract had paid \$651,309 and the second year had paid \$426,380.

CHAIR SEATON reiterated that there was a question for the number of the 75 audited providers who had paid.

MS. BRODIE replied that she was researching the answer.

CHAIR SEATON set proposed Amendment 1 aside, clarifying that there had not yet been a vote.

[4:17:52 PM](#)

CHAIR SEATON moved to adopt proposed Amendment 3, labeled 29-LS1096\H.5, Glover, 2/19/16, which read:

Page 6, line 3, following "audit.":

Insert

"The department may not assess interest under this subsection if a provider

(1) identifies and reports an overpayment to the department independent of an audit conducted under this section; and

(2) repays the amount of the overpayment to the department within five months after the date the provider received the overpayment."

REPRESENTATIVE TARR objected for discussion.

[4:18:34 PM](#)

TANEEKA HANSEN, Staff, Representative Paul Seaton, Alaska State Legislature, explained that proposed Amendment 3, labeled 29-LS1096\H.5, Glover, 2/19/16, added to the audit section of proposed HB 227 and it clarified that the Department of Health and Social Services not assess interest on overpayment from the audits if the provider had identified and reported the overpayment independent of the audit and if the amount of overpayment was repaid to DHSS within five months of the date the provider received the overpayment.

REPRESENTATIVE WOOL asked for clarification that self-reporting by the provider would not result in interest or penalties.

CHAIR SEATON clarified that there was not any interest or penalty if the provider self-identified the problem and reported

it within five months. He reminded the committee that there had already been a substantial amount of testimony regarding this.

REPRESENTATIVE WOOL asked if interest and penalties would still be assessed, even as the proposed Amendment 3 only addressed interest.

MS. HANSEN relayed that Section 5 of the proposed bill did mention penalties and interest, although she deferred to the department for its interpretation.

CHAIR SEATON opined that the purpose was to avoid the conflict and he suggested a conceptual amendment adding "penalties" would be acceptable.

MR. SHERWOOD opined that the Department of Health and Social Services authority for interest was on the overpayments and that penalties was a separate authority.

[4:23:27 PM](#)

CHAIR SEATON posed that if there was an overpayment, which was subsequently self-reported, there would not be interest. He asked if there were circumstances when the overpayment would be penalized, even if it was self-reported.

MR. SHERWOOD replied that Section 6 of proposed HB 227 addressed civil penalties, and he offered his belief that the intention of the Department of Health and Social Services was that some circumstances, including failure to comply with regulations, allowed for penalties to overpayment although interest would not be charged.

REPRESENTATIVE WOOL offered his belief that there was a penalty for policy or practice failures with a separate penalty for an overpayment.

MR. SHERWOOD stated that overpayment was not considered a penalty; it was an instance whereby the department had paid incorrectly either because the service was not eligible for payment or perhaps the service was not priced correctly. He pointed out that sometimes an overpayment was because the provider had failed to do something in compliance with regulation, which could trigger the civil penalties. He noted that these were the only penalties that DHSS had the authority to issue to a provider.

REPRESENTATIVE VAZQUEZ questioned application for the five month limitation to return of the overpayment.

MR. SHERWOOD suggested that a reasonable amount of time to pay back should be based on the time of disclosure.

REPRESENTATIVE VAZQUEZ suggested the proposed amendment should read five months after discovery of the overpayment.

CHAIR SEATON reiterated the earlier discussion for a more timely review of the billings. He stated that he was in support of any reasonable timeframe which allowed a review of the records. He pointed out that receipt of payment, discovery of an overpayment, and its ultimate report to the department would not necessarily be the same.

[4:32:47 PM](#)

REPRESENTATIVE VAZQUEZ suggested a conceptual amendment for within five months after the date that the provider reports or discloses the overpayment to the department.

CHAIR SEATON suggested a conceptual amendment to line 7 of proposed Amendment 3, which would delete "receive" and insert "reported."

[4:34:06 PM](#)

CHAIR SEATON offered conceptual Amendment 1 to proposed Amendment 3, which would read: line 7, delete "received"; insert "reported"; and add "to the department" after "the overpayment."

REPRESENTATIVE WOOL suggested that someone may not report unless they saw an audit coming. He offered his belief that a business would be incentivized by a time frame.

CHAIR SEATON pointed out that was the reason for the five months after receipt of the overpayment, although it could be changed to make it simpler.

REPRESENTATIVE WOOL suggested that providers should review the payments frequently enough to catch it, and then be incentivized to report it.

[4:36:19 PM](#)

REPRESENTATIVE VAZQUEZ expressed her agreement with conceptual Amendment 1 and suggested inserting language which stated that the provider had not received notice of an audit.

CHAIR SEATON directed attention to line 4 of proposed Amendment 3, and asked if this defined the suggestion by Representative Vazquez.

[4:38:08 PM](#)

MR. SHERWOOD, in response to Chair Seaton, said the department had never had this language to use, so there had not ever been that determination. He offered his belief that an audit trigger would be determined upon notification. He reiterated that the department had never made that policy call.

CHAIR SEATON stated that "independent of an audit" meant "before you have been notified that an audit was to be conducted." He explained that this would apply when a provider was self-reporting. He directed attention back to conceptual Amendment 1.

[4:40:09 PM](#)

REPRESENTATIVE VAZQUEZ moved to adopt conceptual Amendment 1 to proposed Amendment 3, which read: line 7, delete "received"; insert "reported"; and add "to the department" after "the overpayment."

CHAIR SEATON objected for discussion.

REPRESENTATIVE TALERICO offered that this was a substantial improvement and stated his support.

CHAIR SEATON removed his objection.

REPRESENTATIVE WOOL mused that a time limit was necessary, and asked how often the department investigated older payments.

MR. SHERWOOD said that identified overpayments could go back a considerable time, and he shared that audits were conducted after a sample had been pulled from a one year period. He pointed out that the claims identified as overpayments were at least two to three years old at final determination, and that assessed interest would begin considerably after the actual overpayment.

REPRESENTATIVE WOOL asked if acknowledgement by a provider of an overpayment triggered a look into the possibility of additional overpayments to the same provider.

MR. SHERWOOD opined that the vast majority of overpayments were self-disclosed, and did not usually raise concerns, dependent on the nature of what had been identified. He shared that sometimes there was deemed a need for provider education or technical assistance. He allowed that most overpayments were considered relatively benign mistakes or incorrect systems. He said that it could lead to additional investigation, although this was not common circumstance.

MS. BRODIE relayed that each case was different, and that certain triggers could make the department look deeper, especially for any problem with policies or procedures that required education for many providers. She stated that this quick analysis was done on each audit for whether a deeper look for education or for problems was necessary.

CHAIR SEATON reminded that the purpose of the proposed amendment was for providers to investigate their books and self-report, if necessary.

REPRESENTATIVE WOOL suggested a year maximum to stimulate an annual review by each provider.

[4:47:29 PM](#)

There being no further objection, conceptual Amendment 1 to proposed Amendment 3 was adopted.

REPRESENTATIVE TALERICO asked if all audits had a pre-notification requirement.

MR. SHERWOOD replied that this was the procedure for all of these types of general provider audits; however, audits based on valid suspicion for fraud or abuse could be initiated without prior notice.

[4:49:16 PM](#)

REPRESENTATIVE TALERICO moved to adopt conceptual Amendment 2 to proposed Amendment 3, which, on line 5, added "the notice of" after "independent of." He suggested that this may inspire providers to self-audit prior to any notice.

[4:50:33 PM](#)

There being no objection, conceptual Amendment 2 to proposed Amendment 3 was adopted.

[4:50:58 PM](#)

CHAIR SEATON brought attention back to proposed Amendment 3 and asked if there was further discussion.

[4:51:16 PM](#)

REPRESENTATIVE TARR removed her objection.

There being no further objection, Amendment 3, labeled 29-LS1096\H.5, Glover, 2/19/16, as amended, was adopted.

[4:51:34 PM](#)

CHAIR SEATON returned attention to proposed Amendment 1, labeled 29-LS1096\H.7, Glover, 2/19/16.

MS. BRODIE, in response to Chair Seaton regarding an earlier question for the number of the 75 audited providers who had paid, said that, although there were 55 providers who paid, as the audits had been conducted over the last few years, only 9 of the providers were from the current 75 audits conducted.

MR. SHERWOOD, in response to Representative Tarr, explained that although 75 audits were initiated in a year, not all of these audits were completed in that year. Of the 55 providers the department recovered money from during this last year, only 9 of these were from the current audit cycle, as the other 46 audits took more than one year to complete.

REPRESENTATIVE TARR surmised that about 20 of each year's audits would be resolved annually.

CHAIR SEATON reiterated that for the past three years there had been audits of 225 providers, 75 audits each year, and the substantial portion of the recovery was from 55 of these audits, about 25 percent of those providers audited over the past three years.

MR. SHERWOOD opined that 75 audits were initiated and closed out in a given year, however, it was not necessarily all the same

audits. He pointed out that an average of 55 of those closed out audits would owe something each year.

MR. SHERWOOD, in response to Representative Wool, said that nine was the number for audits initiated and recovered in that same year.

CHAIR SEATON asked if all 55 audits had substantial recoveries.

MS. BRODIE replied that 55 audits had contributed to all the recoveries, reporting that there were only 9 providers with recoveries over \$25,000 each.

REPRESENTATIVE TARR suggested that, as only 9 of the audits evaluated had substantial recoveries, this was about 20 percent of the suggested 50 audits annually, which she deemed to be an adequate sampling.

MR. SHERWOOD acknowledged that this was reasonable logic "in terms of identifying the larger providers that would still give us an ample sample to discover." He pointed out that although each additional audit increased the chances of finding something, it was necessary to strike a balance.

REPRESENTATIVE VAZQUEZ declared that the current statute required 75 audits, out of 5,823 enrolled providers, which she deemed not to be an unreasonable burden on the provider community. She emphasized that the number should not be lessened, especially in light of the current fiscal circumstances. She stressed that it was necessary to maintain the integrity of the program and to be accountable for the money spent on these programs.

REPRESENTATIVE WOOL reiterated that 75 audits were performed each year under the current statute. In the past year, while 55 of those audits reported some payout, only 9 of those 55 audits were from the current calendar year. He surmised that, as 75 audits were completed each year, this was almost cost neutral, and the addition of more audits would only increase the money paid for the audits.

MR. SHERWOOD replied that, on average, 75 audits were completed each year, and the department was not falling behind on its audits.

CHAIR SEATON asked if the reduction in DHSS personnel would have any effect on these, noting that the audits were done by private contract.

MR. SHERWOOD replied that the cost for audits was paid as a Medicaid administrative expense. He stated that he did not recall whether that was a 50 or 75 percent federal match. He shared that there was some degree of required staff support to hire, oversee, and assist with the contracts and the Medicaid data.

[5:03:52 PM](#)

CHAIR SEATON removed his objection.

REPRESENTATIVE TARR stated her objection.

REPRESENTATIVE WOOL asked how 75 audits would affect DHSS, would it still be cost neutral, would it incur any extra work, and would more audits mean more return or hinder the department in any way.

MR. SHERWOOD replied that, as there were currently 75 audits, a return to this would not impose any additional burden, while a reduction to 50 audits would not appreciably impact the work load. He opined that it would be cost neutral for either number of audits. He declared that more audits would encourage tighter or stricter compliance, better record keeping, and better attention to regulation, although there would be a cost to the providers. He shared that, as there had now been 12 or 13 audit cycles, many of the providers had been audited more than once and had established reactions to audits. He stated that there was "no magic line" for the number of audits, and this would not provide any additional burden to the department.

[5:07:11 PM](#)

A roll call vote was taken. Representatives Seaton, Vazquez, Wool, and Talerico voted in favor of proposed Amendment 1. Representative Tarr voted against it. Therefore, Amendment 1, labeled 29-LS1096\H.7, Glover, 2/19/16, was adopted by a vote of 4 yeas - 1 nay.

[5:08:30 PM](#)

The committee took an at-ease from 5:08 p.m. to 5:18 p.m.

5:18:06 PM

CHAIR SEATON moved to adopt proposed Amendment 4, labeled 29-LS1096\H.6, Glover, 2/19/16, which read:

Page 9, line 30:

Delete "DEMONSTRATION"

Insert "PILOT"

Page 9, line 31:

Delete "January"

Insert "July"

Page 9, line 31, through page 10, line 1:

Delete "design and implement a demonstration project"

Insert "contract with a third party to establish a care coordination pilot project for approximately 500 voluntary participants who are eligible for medical assistance under AS 47.07.020(b)(14)"

Page 10, lines 2 - 4:

Delete "The demonstration project shall provide for the voluntary enrollment of approximately 500 recipients who are eligible for medical assistance under AS 47.07.020(b)(14). The Department of Health and Social Services shall"

Insert "The care coordination pilot project must focus on nutritional sufficiency and"

Page 10, line 6:

Delete "demonstration"

Insert "care coordination pilot"

Page 10, line 7:

Delete "demonstration"

Insert "care coordination pilot"

Page 10, line 9:

Delete "demonstration"

Insert "care coordination pilot"

Page 10, line 15, following "(July 2013).":

Insert "Two years after the date the Department of Health and Social Services first enrolls recipients in the care coordination pilot project, the Department of Health and Social Services shall deliver a report

to the senate secretary and the chief clerk of the house of representatives and notify the legislature that the report is available. The report shall describe the results of the care coordination pilot project, any difference in the pre-term birth rate for participants in the pilot project as compared to the pre-term birth rate for the state, and the estimated savings to the state resulting from the pilot project."

REPRESENTATIVE TARR objected for discussion.

[5:18:28 PM](#)

MS. HANSEN explained that proposed Amendment 4 removed language in the pre-term birth demonstration project, replacing "demonstration project" with "coordinated care." She reported that this had previously read that the department would design and implement the demonstration project; instead, a contract with a third party to establish a coordinated care pilot project would be substituted. She relayed that the other parameters would remain the same, to include: 500 voluntary participants from Denali Kid Care with a focus on nutrition. She directed attention to page 10, line 15, which added a requirement for a report describing the results of the pilot project and any estimated savings.

[5:19:47 PM](#)

REPRESENTATIVE TARR removed her objection. There being no further objection, Amendment 4, labeled 29-LS1096\H.6, Glover, 2/19/16, was adopted.

[HB 227 was held over.]

ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was recessed until a call of the chair at 12:30 p.m. on March 4, 2016.