

Legislative History for Connecticut Act

2005

**Act Number:** 195  
**Bill Number:** 21  
**Senate Pages:** Senate: 3443-3447, 3460-3462 8  
**House Pages:** House: 8123-8138 15  
**Committee:** Human Services: 757-761, 763-765, 765-767, 780-782, 801, 804-809, 811-817, 822-834, 843-858, 862-864, 867-872, 878-905, 907-908, 921-922, 925-926 99

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Transcripts from the Joint Standing Committee Public Hearing(s) and/or Senate and House of Representatives Proceedings

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CONNECTICUT  
GEN. ASSEMBLY  
SENATE

PROCEEDINGS  
2005

VOL. 48  
PART 11  
3255-3586

kmm  
Senate

003443  
103  
May 31, 2005

THE CLERK:

Calendar Page 24, Calendar 495, File 714,  
Substitute for S.B. 1227, An Act Concerning Fee  
Increases for Certain Vital Records and Lifetime  
Fishing and Hunting Licenses for Persons With  
Disabilities, Favorable Report of the Committee on  
Finance, Revenue and Bonding, Planning and  
Development, and Environment.

THE CHAIR:

Mr. Majority Leader.

SEN. LOONEY:

Yes, Mr. President, if that item might be marked  
Passed Temporarily.

THE CHAIR:

So noted.

THE CLERK:

Turning to Calendar Page 5, Calendar 465, File  
672, S.B. 21, An Act Concerning Audits Conducted by  
the Department of Social Services, Favorable Report of  
the Committees on Human Services and Appropriations.  
Clerk is in possession of two amendments.

THE CHAIR:

Senator Handley.

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Senate

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SEN. HANDLEY:

Thank you, Mr. President. I move acceptance of the Joint Committee's Favorable Report and passage of the bill.

THE CHAIR:

On acceptance and passage, will you remark?  
Senator Handley.

SEN. HANDLEY:

Thank you, Mr. President. The Clerk is in possession of an amendment, LCO 7183.

THE CHAIR:

Mr. Clerk.

THE CLERK:

LCO 7183, which will be designated as Senate Amendment Schedule "A". It is offered by Senator Handley of the 4<sup>th</sup> District, et al.

THE CHAIR:

Senator Handley.

SEN. HANDLEY:

Mr. President, I move the amendment and ask permission to summarize.

THE CHAIR:

On adoption, will you remark? Senator Handley.

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Senate

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SEN. HANDLEY:

Thank you, Mr. President. This amendment is a strike all amendment and will replace the entire, and would become the entire bill.

What this, what this bill will do is to provide some exclusions from the process of extrapolation in audits, which the Department of Social Services uses as a method in determining fees after an audit has found areas.

In particularly small businesses, these extrapolations are based on very, very minute numbers and have been the subject of a great deal of unhappiness and controversy in our Committee and in the providers of social services at large.

This exclusion up to \$150,000 cases will provide some relief to the smallest of the providers of social services. The bill also provides a change in the way in which the appeal process of a fine will be handled by DSS. And I move, I urge my colleagues to support this amendment.

THE CHAIR:

On adoption, will you remark? Senator Cook.

SEN. COOK:

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Senate

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Thank you very much, Mr. President. Through you,  
a question to Senator Handley, if might.

THE CHAIR:

Please proceed, Senator.

SEN. COOK:

Thank you very much. First a comment. I want to  
thank Senator Handley and the others for working hard  
to try to resolve this issue. It has been confusing  
and difficult for certain providers of social  
services.

But just for the purposes of legislative intent,  
if I may ask, is it the intention that the new system  
would be one that would also be an approved system by  
CMS in Washington?

THE CHAIR:

Senator Handley.

SEN. HANDLEY:

It would have to be, Senator Cook, because we are  
dealing with, largely with funds that are coming from  
CMS, yes.

THE CHAIR:

Senator Cook.

SEN. COOK:

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Thank you very much, and it was only really asked so that we could make sure that it was on the record that the new audit system would indeed be one that's also an approved audit system by CMS. Thank you very much.

THE CHAIR:

Will you remark further on the amendment? Will you remark further on the amendment? If not, I'll try your minds. All those in favor, please say "aye".

SENATE ASSEMBLY:

Aye.

THE CHAIR:

Those opposed "nay". The amendment is adopted.  
Senator Handley.

SEN. HANDLEY:

If there is no objection, Mr. President, I would move that this be placed on the Consent Calendar.

THE CHAIR:

Hearing no objection, this item will be placed on the Consent Calendar. Mr. Majority Leader.

SEN. LOONEY:

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Senate

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Motion is on passage of S.B. 24 as amended.

Total number voting, 35; necessary for passage,  
18. Those voting "yea", 35; those voting "nay", 0.  
Those absent and not voting, 1.

THE CHAIR:

The bill is passed. Mr. Clerk. Mr. Majority  
Leader. Mr. Clerk. Mr. Majority Leader.

SEN. LOONEY:

Yes, thank you, Mr. President. At this point, I  
would ask the Clerk to call for a roll call on the  
first Consent Calendar.

THE CHAIR:

Thank you, Mr. Majority Leader. Mr. Clerk, will  
you read those items on the first Consent Calendar.

THE CLERK:

Mr. President, those items previously placed on  
the first Consent Calendar begin on Calendar Page 1,  
Calendar 585, S.R. 28.

Calendar Page 5, Calendar 465, S.B. 21.

Calendar Page 6, Calendar 508, Substitute for  
S.B. 6881.

Calendar Page 9, Calendar 564, Substitute for  
H.B. 6838.

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Calendar Page 20, Calendar 418, Substitute for  
S.B. 1295.

Calendar Page 21, Calendar 421, Substitute for  
S.B. 1356.

Calendar Page 22, Calendar 444, Substitute for  
S.B. 1124.

And Calendar Page 25, Calendar 518, Substitute  
for H.B. 6286.

Mr. President, that completes those items  
previously placed on the first Consent Calendar.

THE CHAIR:

The Clerk will please announce a roll call vote  
on the first Consent Calendar. The machine is open.

THE CLERK:

An immediate roll call has been ordered in the  
Senate on the Consent Calendar. Will all Senators  
please return to the Chamber.

An immediate roll call has been ordered in the  
Senate on the Consent Calendar. Will all Senators  
please return to the Chamber.

THE CHAIR:

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If all Members have voted, the machine is closed.  
The Clerk will please announce the results of the roll  
call.

THE CLERK:

Motion is on adoption of Consent Calendar No. 1.

Total number voting, 35; necessary for adoption,  
18. Those voting "yea", 35; those voting "nay", 0.  
Those absent and not voting, 1.

THE CHAIR:

The items on the Consent Calendar are passed.

Mr. Majority Leader.

SEN. LOONEY:

Yes, thank you, Mr. President. Mr. President,  
the Clerk has on his desk a Senate Agenda No. 2.

THE CHAIR:

Mr. Clerk.

THE CLERK:

Mr. President, Clerk is in possession of Senate  
Agenda No. 2 for Tuesday, May 31<sup>st</sup>, 2005, copies of  
which have been distributed.

THE CHAIR:

Mr. Majority Leader.

SEN. LOONEY:

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CONNECTICUT  
GEN. ASSEMBLY  
HOUSE

PROCEEDINGS  
2005

VOL. 48  
PART 27  
8003-8302

008123

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House of Representatives

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June 4, 2005

House Bill Number 6499, as amended by House  
Amendment Schedule "A" and Senate Amendment  
Schedule "A", in concurrence with the Senate.

|                             |     |
|-----------------------------|-----|
| Total Number Voting         | 143 |
| Necessary for Passage       | 72  |
| Those voting Yea            | 143 |
| Those voting Nay            | 0   |
| Those absent and not voting | 8   |

DEPUTY SPEAKER ALTOBELLO:

The Bill as amended passes. Would the Clerk  
please call Calendar Number 609.

CLERK:

On Page 13, Calendar Number 609, Senate Bill  
Number 21, AN ACT CONCERNING AUDITS CONDUCTED BY THE  
DEPARTMENT OF SOCIAL SERVICES, Favorable Report of the  
Committee on Appropriations.

DEPUTY SPEAKER ALTOBELLO:

Representative Walker of the 93<sup>rd</sup>, you have the  
floor, Madam.

REP. WALKER: (93<sup>rd</sup>)

Thank you, Mr. Speaker. Mr. Speaker, I move for  
acceptance of the Joint Committee's Favorable Report  
and passage of the Bill.

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DEPUTY SPEAKER ALTOBELLO:

The question is on Joint Committee's, acceptance of the Joint Committee's Favorable Report and passage of the Bill, will you remark? Representative Walker, you have the floor, Madam.

REP. WALKER: (93<sup>rd</sup>)

Thank you, Mr. Speaker. Mr. Speaker, the Clerk has an Amendment, LCO Number 7183. I ask the Clerk to please call the Amendment, and I be granted to summarize.

DEPUTY SPEAKER ALTOBELLO:

Would the Clerk please call LCO Number 7183, designated Schedule "A" of the Senate.

CLERK:

LCO Number 7183, Senate Amendment Schedule "A",  
offered by Senator Handley, Representative Villano, et  
al.

DEPUTY SPEAKER ALTOBELLO:

Representative seeks leave of the Chamber to summarize. Is there objection to summarization? Objection, seeing none, Representative Walker, you have the floor, Madam.

REP. WALKER: (93<sup>rd</sup>)

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Thank you, Mr. Speaker. This Bill, the Bill establishes a statutory procedure for Department of Social Services audits of services providers.

It limits the use of extrapolations in calculating overpayments or underpayments to certain situations, and makes clerical errors (inaudible). I move adoption.

DEPUTY SPEAKER ALTOBELLO:

Question on adoption of the LCO Number 7183, designated Senate Amendment Schedule "A". Please proceed, Madam.

DEPUTY SPEAKER ALTOBELLO:

Okay, thank you, Mr. Speaker. Senate Amendment Schedule "A" replaces the original Bill. It contains many of the original Bill's provisions concerning the audit procedures, but one, eliminates the Bill's limitations that such audits cannot cover more than 100 claims, or more than a year period.

And two, deletes the Bill's administrative process for obtaining a review and appeal preliminary report by an ad hoc peer review panel.

Instead the Amendment one, requires the Commissioner to hold an exit interview with the

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provider following the preliminary report and, two, allows the provider to request a review of the final report, if he agrees by the decision in the report.

And three, specifies employees whom the Commissioner may not designate to conduct the review. The Amendment adds a condition that allows use of extrapolations based on the dollar amounts and claims.

It also adjusts several of the Bill's timeframes for notification, and issuing reports, and makes other minor changes.

The Amendment deletes the original Bill unrelated provision allowing federally qualified health centers to submit medical cost reports to DSS, and be reimbursed based on the reports, and I move adoption.

DEPUTY SPEAKER ALTOBELLO:

Question on adoption of Senate Amendment Schedule "A". Would you remark further? Representative Gibbons of the 150<sup>th</sup>, you have the floor, Madam.

REP. GIBBONS: (150<sup>th</sup>)

Thank you, Mr. Speaker. I want to just tell the Chamber that this is a Bill that the leadership of the Human Services Committee has been working on with DSS for over a year.

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This Bill has the joint approval of all the leadership and of DSS, and I think it's wonderful that we are able to bring what was potentially a very difficult issue, to a place where we've got the Bill.

For those of you who don't want to hear about audits and extrapolation, I told Representative Donovan that you could all just put your heads down.

When I tell you, just raise them, and just press the green button, because extrapolation is something very complicated.

What is essentially means is that if there is an error that is discovered in an audit, through an audit, of a provider's bill, and that error could be clerical or it could possibly be fraudulent, but generally it is clerical.

What happens is the Department then multiplies the number of times that particular drug has been sold, and extrapolates out to determine a penalty.

The penalty is frequently many, many times the size of the error, and what was happening is people who had errors in the hundreds of dollars range, were suddenly paying penalties in the many thousands of dollars range.

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We felt this was not proper and that people were, in good faith, trying to sell their products and to administer good medical aid to the recipients.

Anyway, we've been working on this for a year, we've now come up with a Bill that everybody who is connected with it will approve, and I urge adoption of this Amendment. Thank you, Mr. Speaker.

DEPUTY SPEAKER ALTOBELLO:

Thank you, Representative. Representative Caron of the 44<sup>th</sup>, you have the floor, Sir.

REP. CARON: (44<sup>th</sup>)

Thank you, Mr. Speaker. Mr. Speaker, may I ask through you a few questions to the proponent, please?

DEPUTY SPEAKER ALTOBELLO:

Please proceed, Sir.

REP. CARON: (44<sup>th</sup>)

Thank you, Mr. Speaker. Mr. Speaker, I thought I heard in the summarization, perhaps I could be corrected, has the extrapolation method been eliminated, or altered? I'm not sure I heard what that was, through you, Mr. Speaker.

REPRESENTATIVE WALKER: (93<sup>rd</sup>)

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Mr. Speaker, I'd like to yield to Representative Gibbons.

DEPUTY SPEAKER ALTOBELLO:

Well, that won't be possible at this moment, but we'll get there eventually. Representative Caron, you have the floor, Sir.

REP. CARON: (44<sup>th</sup>)

Mr. Speaker, I would be happy to point my question toward the Ranking Member of the Human Services Committee.

DEPUTY SPEAKER ALTOBELLO:

Please proceed, Sir.

REP. CARON: (44<sup>th</sup>)

Mr. Speaker, through you to the Ranking Member of the Human Services Committee, did I hear correctly in the summarization that extrapolation was to be eliminated as a method of quality control? Through you, Mr. Speaker.

DEPUTY SPEAKER ALTOBELLO:

Representative Gibbons.

REP. GIBBONS: (150<sup>th</sup>)

Thank you, Mr. Speaker. Through you, no, extrapolation has not been eliminated. What this Bill

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does do is it eliminates extrapolation for all providers who do less than \$150,000 worth of business with DSS, unless, and the two big unleses were unless DSS determines that there is fraud connected, or there could be harm to one of the people who is receiving the services of the provider. Through you, Mr. Speaker.

DEPUTY SPEAKER ALTOBELLO:

Representative Caron.

REP. CARON: (44<sup>th</sup>)

Thank you, Mr. Speaker, and how would they determine that? Through you, Mr. Speaker.

REP. GIBBONS: (150<sup>th</sup>)

If I may continue please--

DEPUTY SPEAKER ALTOBELLO:

Representative Gibbons, please.

REP. GIBBONS: (150<sup>th</sup>)

Thank you, Mr. Speaker, through you. This was one of the thornier issues that we had to work out, and DSS customarily conducts audits of all of the people who do business with them.

Sometimes an error could just be conducted with an audit, sometimes the error could be conducted

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through a whistleblower, sometimes they suspect fraud, but typically the DSS has to give 30 days notice to anybody that it is conducting an audit, in this investigation.

If they want to do an audit in less than 30 days, they have to have probable cause for conducting an audit, or an investigation in less than the 30 days time. Through you, Mr. Speaker.

DEPUTY SPEAKER ALTOBELLO:

Representative Caron.

REP. CARON: (44<sup>th</sup>)

Thank you, Mr. Speaker. Mr. Speaker, I thank the Ranking Member for her answers.

Mr. Speaker, as a Member of the Human Services Committee, when this first came to our attention, I did speak with a number of the providers, and what we found out through the public hearing process is that extrapolation is a very simplistic method of statistical analysis.

And many of the providers do provide more than \$150,000 worth of services to DSS, and in spite of the fact that they may find literally hundreds of thousands of dollars in errors, for errors that have

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never been identified, but are just assumed because they found X amount in a sample of about a couple a hundred statements.

Mr. Speaker, there are many statistical analyses, methods, for finding or maintaining quality control for finding fraud, extrapolation as I mentioned earlier, is exceptionally simplistic.

My understanding is Connecticut is the only state that currently does it. In fact, the Federal Government does not use extrapolation as a method of finding errors.

Another problem with this is that a clerical error has as much weight as a fraudulent error, and that just does not seem to make sense in terms of trying to either restrict fraud, or reduce errors.

Again, we seem to have a perverse method of trying to find and correct mistakes, and it does not really give any provider an incentive to minimize serious mistakes, because they get the same weight as a clerical mistake.

My understanding again, Mr. Speaker, is that regardless of whether an error has actually been found

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through this extrapolation, you just assume for every hundred questions you look at.

If ten have, out of that hundred you find ten errors, regardless what the errors are, you assume ten for every hundred. You have about 10,000 samples, you're going to have 1,000 errors, and that adds up very quickly.

Certainly it's gratifying that DSS has seen fit to try and negotiate this out, but the fact is, there are many methods and we have University of Connecticut that does polling, certainly they have statistic experts over there that we could utilize to find this out.

Mr. Speaker, therefore, I'm going to oppose the Amendment. I would urge the Membership as well to oppose the Amendment, until we find a more accurate method of actually controlling our errors. Thank you, Mr. Speaker.

DEPUTY SPEAKER ALTOBELLO:

Thank you, Representative Caron. Representative Mikutel of the 45<sup>th</sup>, you have the floor, Sir.

REP. MIKUTEL: (45<sup>th</sup>)

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Thank you, Mr. Chairman. Mr. Chairman, I rise in support of this measure. This issue was brought to my attention by some service providers in my area who took a day to explain what this issue of extrapolation is.

But in essence, the current DSS audit procedures, in effect, threaten many of our social service providers with shutting their doors because through this extrapolation process, very minor and innocent mistakes are treated almost as if it's fraud or intent of fraud, when in fact, many of these mistakes are just clerical mistakes. They're honest mistakes.

Under the so called extrapolation, a small fine of \$200 can be translated into a fine of \$30,000 to \$50,000 to \$60,000.

It's just ridiculous that a social service provider trying to provide services to our people, can have their doors, threaten to close their doors because of this issue of extrapolation.

I think this Bill addresses that issue, and will keep our social service providers, the doors open, and it'll keep the DSS auditors off of their backs. I

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support it, I'd urge my colleagues to support it as well.

DEPUTY SPEAKER ALTOBELLO:

Thank you, Representative. Will you remark further on Senate Amendment Schedule "A".

Representative Gibbons of the 150<sup>th</sup>, you have the floor, Madam.

REP. GIBBONS: (150<sup>th</sup>)

Thank you, Mr. Speaker, for the second time. I do recognize the comments that Representative Caron made, and I do agree that extrapolation is a way of resolving error, potential fraud with DSS that we probably don't all agree with.

But this is a big step towards resolving this issue. It is the first time that we've been able to sit down with DSS and work out an agreement that we can all accept.

My understanding is that if we haven't gone far enough, and we've only exempted those firms that do less than \$150,000 worth of business with the state, we will hold a public hearing again next year, and come back and try and remediate the law and improve upon it.

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But I urge my colleagues to accept this Amendment because I think it is an important first step, and we will go from there. Thank you, Mr. Speaker.

DEPUTY SPEAKER ALTOBELLO:

Thank you, Madam. Would you remark further on Senate Amendment Schedule "A"? Would you remark further on Senate Amendment Schedule "A"?

If not, try your minds, all those in favor please signify by saying Aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER ALTOBELLO:

Those opposed, Nay.

REPRESENTATIVES:

Nay.

DEPUTY SPEAKER ALTOBELLO:

The Ayes have it. The Amendment is adopted.

Would you remark further on the Bill as amended?

Would you remark further on the Bill as amended?

Would you remark further on the Bill as amended?

If not, staff and guests please retire to the Well of the House, Members take your seats, the machine will be open.

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CLERK:

The House of Representatives is voting by Roll  
Call. Members to the Chamber. The House is voting by  
Roll Call. Members to the Chamber, please.

DEPUTY SPEAKER ALTOBELLO:

Have all Members voted? Have all Members voted?  
Have all Members voted? If all Members have voted,  
have all Members voted properly? Please check the  
tally board to make sure your vote is properly cast.

If all Member have voted the machine will be  
locked, and the Clerk please take a tally. Would the  
Clerk please announce the tally.

CLERK:

Senate Bill Number 21, as amended by Senate  
Amendment Schedule "A", in concurrence with the  
Senate.

|                             |     |
|-----------------------------|-----|
| Total Number Voting         | 142 |
| Necessary for Passage       | 72  |
| Those voting Yea            | 141 |
| Those voting Nay            | 1   |
| Those absent and not voting | 9   |

DEPUTY SPEAKER ALTOBELLO:

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The Bill is amended, passes in concurrence with  
the Senate. Will the Clerk please call Calendar  
Number 574.

CLERK:

On Page 10, Calendar Number 574, Substitute for  
Senate Bill Number 1033, AN ACT CONCERNING SPECIAL  
POLICEMEN IN THE SPECIAL INVESTIGATION SECTION OF THE  
DEPARTMENT OF REVENUE SERVICES, Favorable Report of  
the Committee on Finance, Revenue and Bonding.

DEPUTY SPEAKER ALTOBELLO:

Representative Dargan of the 115<sup>th</sup>, you have the  
floor, Sir.

REP. DARGAN: (115<sup>th</sup>)

Thank you, Mr. Speaker. I move acceptance of the  
Joint Committee's Favorable Report and passage of the  
Bill, in concurrence with the Senate.

DEPUTY SPEAKER ALTOBELLO:

Question is on acceptance of the Joint  
Committee's Favorable Report, passage of the Bill, in  
concurrence with the Senate. Please proceed, Sir.

REP. DARGAN: (115<sup>th</sup>)

JOINT  
STANDING  
COMMITTEE  
HEARINGS

HUMAN  
SERVICES  
PART 3  
567-908

2005

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HUMAN SERVICES

March 3, 2005

JAMIE BELL: I'm sorry, lengthy waiting lists for care and extreme difficulty attracting and retaining dental personnel.

REP. VILLANO: We have your testimony.

JAMIE BELL: I just wanted to mention that actuarial and other experts we hired for our lawsuit concluded that DSS would need to spend at least three times the amount it was now spending to attract enough providers to meet the needs of Medicaid recipients.

Therefore, we urge you to support House Bill 5697, which increases provider rates across the board.

REP. VILLANO: Thank you very much, Jamie. Are there questions from the Committee? If not, thank you for your testimony.

JAMIE BELL: Thank you very much.

REP. VILLANO: Our next speaker is Roy Katz.

ROY KATZ: Good morning. My name is Roy Katz. I own The Medicine Shoppe Pharmacy in Manchester.

I am speaking today on Senate Bill 21, AN ACT CONCERNING AUDITS CONDUCTED BY THE DEPARTMENT OF SOCIAL SERVICES, which we have lived with for quite a while in the pharmacy business. It's extrapolation, and extrapolation in a nutshell is where the State comes in and audits a pharmacy, which we understand is a natural part of doing business.

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HUMAN SERVICES

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I do encourage that, however, what extrapolation does is the auditor looks at the number of claims, let's say in a two-year period.

If they find an administrative error, such as a misfiled prescription, any type of an administrative infraction, they say that they extrapolate the amount, which means that they prorate every dime that the State has paid us, including the cost of the drug and our dispensing fees for the period of two years, which is the usual audit period.

What this does in dollars and cents to the pharmacy is it takes an average prescription of \$75 where we get a \$3.15 fee to dispense that medication.

And it brings it to an average claim of \$10,000. Now that's a lot of liability to make \$3 on a prescription to risk taking a \$10,000 chance.

No one else in the industry does this. This is only a State process, where the State is the only one that does extrapolation.

If another insurance company comes in, does an audit, they find there is a problem with a claim, then they dispute the claim.

They don't assume that you are guilty and that every claim or every percentage of claims that you have done will have the same amount of errors.

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HUMAN SERVICES

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These are administrative problems. These are not fraudulent problems, and the pharmacists are being treated as if we're committing fraud.

It's just not right. We are viewed by the public as being one of the most respected people in the community, but it's just not happening.

REP. VILLANO: Could you sum up your statement?

ROY KATZ: So what we, as pharmacists, are asking is that we do away with the extrapolation. I brought my little prop with me. I don't know if you guys can read it from there, but there are so many ways of saving money.

And this is not a way for the State to save money. This is a way of putting businesses out of business, and then the State loses, the public loses, and the pharmacists lose.

REP. VILLANO: Good, thank you. Are there any questions?

SEN. HANDLEY: Good morning. How are you?

ROY KATZ: Great.

SEN. HANDLEY: When we raised this issue with the DSS, and actually with the auditors, we have been told that the extrapolation method is a legitimate method that is used.

And that, in fact, is one of the methods that the feds use in their auditing. How do we

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counteract this? I have some feelings, but I'd be curious to know how you would respond to this.

ROY KATZ: We, as pharmacists, we do have to follow federal regulations, as far as dispensing drugs go, but we don't have any programs other than Medicare.

I guess, as a federal program, but for prescriptions, generally, we are not dealing with the federal government. We are dealing with all the private insurances, and then, of course, the State.

None of the private insurances use this method. As a matter of fact, when Medicare does an audit, they audit us on a claim-by-claim basis.

Because I do process Medicare claims for some drugs, but mostly for equipment. If there is a claim that they disallow, well, they disallow that claim. They do not do extrapolation to us.

SEN. HANDLEY: So it's apparently a [inaudible] never mind, we'll go on.

REP. VILLANO: Thank you. Representative Gibbons.

REP. GIBBONS: Thank you, Mr. Chairman. We were concerned enough about this issue last year, Mr. Katz, that we wrote a letter to DSS.

I can't say we didn't come to a satisfactory conclusion between what you are complaining about and we felt was a legitimate complaint

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and what DSS felt was a problem on their side to handle the huge number of audits that they have to and to do it in a timely fashion.

I see my good friend, Matt Behren, is here, and he and I respectfully have not come to an understanding on this.

But I do think there is a problem, and I think that we will try and get a handle on it and do something that is satisfactory for both sides. So thank you for coming to testify.

ROY KATZ: Thank you.

REP. GIBBONS: Thank you, Mr. Chairman.

REP. VILLANO: Thank you. Our next speaker is Sandy Dearborn.

SANDY DEARBORN: Good morning, Members of the Human Services Committee. My name is Sandy Dearborn. I am the President of AFSCME Local 2663, representing 2,500 members in the State of Connecticut.

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And I am also a Department of Social Services, Social Worker. My apologies for being out of breath, I kind of ran up the stairs.

When I started at DSS, there were three distinct units of social work, Protective Services for the Elderly, Family Services, and Advocates for the Disabled, called the Adult Services Unit.

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Social workers have written letters to the commissioner saying that they are not able to do their job anymore. We rise in support of this bill. Thank you very much.

REP. VILLANO: Thank you very much.

SANDY DEARBORN: I will have written testimony this afternoon.

REP. VILLANO: Our next speaker is Diane Maiorano.

DIANE MAIORANO: Good morning. My name is Diane HB6275 Maiorano, and I am Chair for the Connecticut Association for Home Care's Government Relations & Reimbursement Committee.

I am here today to voice the Association's strong support of Senate Bill 21, AN ACT CONCERNING AUDITS CONDUCTED BY THE DEPARTMENT OF SOCIAL SERVICES.

This support is based on our members' deep concerns, which include the arbitrary nature of Medicaid audits and the lack of formal due process procedures.

Over a number of years, we have worked with the Department of Social Services on Medicaid audit issues.

And while we have made some progress in a number of areas, there are critical issues such as extrapolation and due process, which still remains unaddressed.

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Our experience is that audit policies tend to evolve over time, become somewhat fluid, and are inconsistent in their application leaving the providers at undue risk.

Examples of this phenomenon include, information required to document a visit and the acceptable timelines for obtaining physicians' signatures on the plan of care.

In these and other instances, even a minor paperwork transgression can result in an audit disallowance, which is then extrapolated to the whole universe of claims.

Extrapolation can compound problems with Medicaid audits by, in some cases, magnifying isolated errors into large regroupments.

As few as one or two claims might become the basis for tens of thousands of dollars being recouped with no formal appeals process.

In response to Senator Handley's question, medical auditors may use extrapolation only when there is sustained or high level of payment error or where documented educational intervention failed to correct the problem.

Given the problems stated above, we strongly believe that it makes sense for Connecticut to follow the federal government's lead and apply the Medicare audit standard to Medicaid as reflected in Senate Bill 21.

We believe that timely and clear education in advance of the application of the State's ever-

evolving audit policies will eliminate many of the troubled areas now being experienced by the providers.

Such education, we feel, should include, but not be limited to, specific examples of acceptable and non-acceptable documentations.

We also support the proposed appeals process that is detailed in Senate Bill 21.

And, lastly, in addition to the above, CAHC also strongly supports Raised House Bill 6275, AN ACT CONCERNING ACCEPTANCE OF ELECTRONIC AND PHYSICIAN SIGNATURES BY THE COMMISSION.

I ask you again for your support of Raised Senate Bill 21, and thank you for this opportunity.

REP. CARON: Thank you. So when you were talking about the extrapolation that, I guess, DSS does, if you have a couple of theirs, they just assume that every record you put in, you have the same percent of errors?

DIANE MAOIRANO: Correct. It's applied against the universe.

REP. CARON: Now does that go like week by week or month by month or for the whole year?

DIANE MAOIRANO: For the whole period that is being looked at. So, in other words, so I have been actually in an agency when we have had \$200 worth of errors that got extrapolated into a payback of \$18,000.

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And I was at a very small, not-for-profit home care agency. So definitely, it's a problem.

REP. CARON: Do they like charge you as soon as they see the errors and then just think they can make the extra extrapolation instead of just, okay?

DIANE MAOIRANO: Yes.

REP. CARON: So there is no follow up?

DIANE MAOIRANO: There is an assumption that because you have made these errors, there is not.

REP. CARON: And there is no distinction on the errors that are made? I mean, any error is as big as--

DIANE MAOIRANO: Any error can be taken, yes.

REP. CARON: So there is no small error versus a large error, paperwork, missed signature or missed check box. They all cost the same?

DIANE MAOIRANO: They all cost the same.

REP. CARON: I'm just curious. Thank you, Mr. Chairman.

REP. VILLANO: Thank you. Any other questions? Oh, I have a question. I'm sorry.

As I was hearing what you were saying, as I didn't get a chance to hear your testimony, it sounds like you have a fairly large amount of

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recordkeeping to do, and DSS wants to audit and make sure things are being done correctly.

Are there forms for you all that DSS may sponsor that you go and see the proper way to do certain paperwork with a minimum we're looking for how to avoid errors, that kind of thing?

DIANE MAOIRANO: Actually, that is what we are looking for is some standardization, so that we would know, in advance, exactly what the expectations would be and that would help enormously.

REP. VILLANO: Okay, thank you. Our next speaker is Sheila Amdur.

SHEILA AMDUR: Good morning. My name is Sheila Amdur, and I am on the Board of Directors of the National Alliance for the Mentally Ill of Connecticut. HB 5290

We are one of 51 state organizations in the country of a national membership of 220,000 people in Connecticut, 300,000 members and supporters, families of children and adults with mental illness, and people in recovery and their friends.

I gave you prepared testimony, it's very short, it's the same testimony I give you every year regarding the SSI COLA.

I guess I have been struggling when I came in here today to try to think about why for 15 years did we essentially tax the very

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Committee, and we will keep working at it, I promise you that.

MICHAEL SHAW: We're here every year, and we know you are on our side. Thank you.

REP. GIBBONS: I too want to say thank you for coming up today. Senator Handley, do you have any idea what this would cost the State? What kind of dollars we are talking about?

REP. HANDLEY: I don't know. Do you have--

MICHAEL SHAW: It's somewhere between \$3.5 and \$5 million. However, it's not new money because it's not an accrued saving.

Because they take the Social Security [inaudible] came all the way through, the State has to add no money.

It's where the State reduces the supplement by the same amount, where the State grabs some money, so it's not real new money.

REP. HANDLEY: Okay. Thank you.

REP. VILLANO: Thank you very much. Thank you for your testimony. Our next speaker is Ronald Brodie. Oh, Mr. Brodie just spoke. Marghie Giuliano.

MARGHIE GIULIANO: Good morning, Senator Handley and Representative Villano. My name is Marghie Giuliano. And I am Executive Vice President of Connecticut Pharmacists Associations.

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I am here today to speak in support of Raised Senate Bill 21, AN ACT CONCERNING AUDITS CONDUCTED BY THE DEPARTMENT OF SOCIAL SERVICES.

I first want to thank the Committee for taking the initiative for raising this most important bill.

Last year, we did bring this issue to the attention of the Committee, and we're pleased that they have decided to broaden the language this year to include all providers.

You have my written testimony. There are just a couple of things that I would like to highlight in my testimony.

We realize that audits are an important part of maintaining the State's efficiency system and making sure that we are following all of the policies and procedures, but certainly extrapolation is a way of punishing pharmacists for clerical errors.

Pharmacists sign contracts not only with the State, but with private insurers, and each of these private insurers, we deal with at least 1,000 different plans.

Each of these insurers has their own policies and procedures. So, of course, you would surmise that there might be some clerical errors along the way.

Most audits reveal clerical errors that might be performed by part-time clerks or technicians.

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In those rare instances where there appears to be fraudulent activity, a complete investigation is warranted and maximum penalty should be levied.

However, to ask a pharmacy to pay back \$25,000 to the State because it didn't have handwritten initials of the pharmacist filling the prescription is really ridiculous, especially since the Department of Consumer Protection accepts signature logs as valid signatures and documentation.

One pharmacy I know received an \$80,000 bill as a result of his combined Medicaid and ConnPACE audit, and none of this was due to fraud.

I just want to respond in summation to one of the questions that was previously asked. We do ask the Department of Social Services for what some of their common audit findings are, and we do provide that to our membership.

So we try to alert them to what the Department is finding and where some of the pharmacies might not be in compliance.

We also ask the Department this year, to do an educational program for our members. However, even with the education, it is still so punitive to take something that might have been a \$25 or \$75 error and extrapolate it out to cost a pharmacy thousands of dollars.

REP. VILLANO: Thank you, Ms. Giuliano. Are there any questions?

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This bill would expand the DCF Subsidized Guardianship Program to include guardianship arrangements approved by any court of competent jurisdiction because the parent of the child has died or is terminally ill or the child is at risk of foster care placement.

This bill provides that the amount of any temporary family assistance payment made for the child would be deducted from the subsidized guardianship payment.

However, children receiving foster care payments or subsidized guardianship payments are not eligible for temporary family assistance in Connecticut.

Therefore, there would never be an occasion to deduct the temporary family assistance payment from the subsidized guardianship payment.

And we recommend that provision be removed from that language of the bill. I would now like to ask Deputy Commissioner Starkowski to comment on some additional bills for the Department.

DEP. COMM. MICHAEL STARKOWSKI: I would like to comment on Raised Senate Bill 5693, AN ACT CONCERNING RESIDENT CARE HOME RATES.

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This bill would revise residential care home rate settings by increasing the minimum allowance for property reimbursement, increasing the allowable administrator's salary, and providing per diem add-ons on computed cost-based rates.

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Raised Senate Bill 21, AN ACT CONCERNING AUDITS CONDUCTED BY THE DEPARTMENT OF SOCIAL SERVICES, this bill, from the Department's perspective, this bill undermines our successful audit process by restricting audits to the review of only one year's worth of claims and limits the review to only 100 claims during that year.

This, coupled with the restriction, on the use of extrapolation, effectively guts the Department's ability to monitor this program and provides a license to those who would attempt to come into Connecticut to defraud the State and our Health Services Programs to defraud the State.

We have had some situations in the State already where there have been organized efforts to come in and actually defraud the State in our Medicaid Program.

Just to bring some things to your attention, we did actually have an organization that came in on, they had defrauded California. They had defrauded New Jersey.

They came into the State of Connecticut, had fraudulent activities in claims processing right across the river, in East Hartford.

They were caught leaving the country in Boston and getting on the plane with about \$.5 million in cash.

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We feel that if we start lessening our auditing standards, we are going to invite more characters like this to come into the State.

I don't think that the objective should be to lessen the standards and lessen our regulations.

It should be that we should be out there working with the industries to try to facilitate their ability to comply with the standards.

We have worked with a number of the providers, including the home health providers, the home care agencies, to try to move into an electronic venue to try to allow them to provide electronic documentation and provide electron signatures.

So I think we would rather look at the opportunity to try to ensure that they could meet the documentation demands, instead of saying the documentation demands are not going to be there because there may be a financial penalty.

I think it's been described up here that we also take a financial penalty for just about every error that we find, and we don't.

When we go out there with facilities and they have a problem with a clerical problem or they have an error in a number of situations, we will not take a financial penalty the first time that error occurs.

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But we will identify the error, work with the provider, and if that error occurs a second time or occurs repetitively, then we will take a financial penalty.

You should also know that there are a number of significant providers who really don't have a problem with the system.

We had a provider of B&A that we completed and audited recently, where the provider actually had \$20.4 million worth of claims.

We went in, we did an extrapolation audit, exactly the same as we would do with any other provider, and that provider had zero in financial penalties.

We have had a number of those providers in the millions of dollars, and we have had a number of those providers that are the smaller providers.

So even though the system may be difficult for some people to keep the proper documentation or restrict the number of errors, there are also a significant number of providers that do make the accommodations, know how to document the services.

Documentation is not only something that we would take a financial penalty for, documentation can also impact the care for the client.

As an example, on a prescription, we would like to have a diagnosis because it is not only for

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the Department's protection in an audit situation, it is also for the client's protection.

Then when the medication is given, the pharmacist understands what the medication is prescribed for.

And they have to intercept that prescription at some point because it may interact with some other medication that the individual is taking or they may already have a condition and that medication may affect adversely.

So there is a number of reasons why we would like to continue the audit process. We would like to work with the industry.

We have met with the home health providers a number of times. We have met with the pharmacists a number of times.

And it's interesting that there is a lot of opposition against extrapolation right now, but the Department of Revenue Services actually uses extrapolation in their audit process.

The home health industry was fully supportive of using extrapolation in a home health demo that we entered into with the Senate for Medicare and Medicaid Services recently, in which extrapolation in that venue took a lot of work off of the plate of the home health industry.

So we have a lot of problems with the way the bill is written right now. And we have a lot

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of problems with trying to restrict the way we audit because we think our audit process is probably one of the best deterrents from keeping fraudulent providers out of the system.

In the second section of the bill, it refers to rate setting for federally qualified health centers.

Effective January 1, 2001, Medicaid rates for FQHC's were required to be determined with federal rate-setting standards.

The law set forth a prospective rate method with annual inflation updates each October 1<sup>st</sup> based on the Medicare economic index.

The Department's method was approved by the Center for Medicare and Medicaid Services in June 2001, and the individual center rates were issued retroactive to January 1, 2001. And we ended up increasing the rates to the FQHC's on an annual basis by about \$430,000.

Since the adoption of the federal prospective rate method, FQHC's have been increased October 1<sup>st</sup> each year by the Medicare economic index.

The Medicare economic index increased their rates October 1, 2004, by 2.9%, and on October 1, 2003, by 3%.

While further review is necessary, it does not appear that the rate method under this existing bill, House Bill 21, is consistent with the

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requirements of the federally approved rate setting methodology that we have right now.

Any changes to the FQHC rate-setting methodology, of course, would have to be approved by CMS in order to continue reimbursement from the federal government. Thank you for allowing us to be here to present our--

REP. VILLANO: Thank you, Commissioner. Any questions from the Committee Members? Representative Truglia.

REP. TRUGLIA: Michael, could you help us write House Bill 5290 in the right way that we intended it to be?

DEP. COMM. MICHAEL STARKOWSKI: Is that the audit bill?

REP. TRUGLIA: That's the disregard for State funding. We seem to feel if it were in order, is there any way we could word it properly so that it would do what we want it to do?

Because you know, we have been doing this for about five or six years, and we have been putting in the same bill every year, and maybe if we had done it right in the first place--

COMM. CLAUDETTE BEAULIEU: Well, keeping in mind that the Department cannot support this bill because there are no funds included in the Governor's recommended budget, the way the bill is drafted, it would have us increase the owner and income disregard by the CPI percentage.

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So I won't comment on those because I have to read what was in your testimony. So I may be calling you at some point.

Michael, the main thing, obviously, that I am concerned about is the audit and the way in which we seem to find ourselves at loggerheads here. [Gap in testimony - microphone not on.]

We hear personal testimony this morning [inaudible] oh, I guess I better put this on, have had people in my office from a number of organizations who have talked about the way in which the auditing is done.

I would very much like us to see if we could, and I know Representative Gibbons, who is not here, has met with me. We have written letters and so forth on this.

I would very much like us to sit down and see if we cannot come to some conclusions about this.

You suggest that you're primarily interested in fraud and that the audit is [inaudible]. No.

DEP. COMM. MICHAEL STARKOWSKI: --we are not really, I mean, we're interested in fraud, but I don't know if you are aware of what is happening in recent years [inaudible].

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Federal sanctions [inaudible]. There is an initiative coming out through [inaudible] for Medicaid, and it's called the [inaudible].

What they are going to do, is they are going to come out and set the [inaudible]. They are saying right now, the federal government, that they don't intend to impose any financial sanction on the states [inaudible] cause a trend.

But based on the present budget, trying to reduce the Medicaid and federal money by 3% to 4%, it would be natural for us to assume that they are going to come after the states for a penalty on that [inaudible].

SEN. HANDLEY: Well--

DEP. COMM. MICHAEL STARKOWSKI: So it's not only fraud, it's trying to make sure that providers provide us with the right documentation.

SEN. HANDLEY: What I am hearing, you know, how, I guess I should turn this on, in case you don't know who I am.

Once again, we are hearing from the folks who are in the pharmacies and in some of the social service agencies, particularly smaller social service agencies, that much of what they are fined for, as a result of these audits, are for what seem to be relatively minor clerical errors.

Now, you said you don't do it the first time, but if there are persistent clerical errors, then it does become a fine.

And, yet, my understanding is that really what we want to make sure is to deal with issues

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dealing with fraud, with the wrong people getting, just let me finish, please.

So what I am asking is, can we not attempt to work something out in which we make some distinctions between what is a concern for fraud and a concern for clerical errors?

I know that DSS spends a lot of time worrying about what the feds are going to do and trying to foresee what is going on.

But, as you know, for example, the tariff bill, which is supposed to be written three or four years ago, is still hanging around, and a lot of the things that we did to get ready for that change still haven't happened.

While I realize you worry about it, I think we would be happier to deal with things as they are.

Can we, one of the issues that I have, can we sit down with you guys and some of the other folks who are the recipients of the audits and see if we can work out something that would make sense, at least a little bit better?

DEP. COMM. MICHAEL STARKOWSKI: Senator, I think we have criteria-- [inaudible].

SEN. HANDLEY: Well, let us talk about doing it with the pharmacy industry. You know, let's talk about that, and perhaps some of the smaller social service agencies who I have heard from, and see if we can't begin to have a conversation.

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The second issue that troubles me is the amounts of money that are collected and whether they represent a fair and reasonable amount.

Is there a process, in the process that we have right now, whereby, one, negotiations go on? If somebody is fined a significant amount, are the negotiations which follow which may reduce that amount?

DEP. COMM. MICHAEL STARKOWSKI: They have a right to appear. We give them 30 days.

SEN. HANDLEY: Who do they appeal to?

DEP. COMM. MICHAEL STARKOWSKI: They appeal to the Department. They send [inaudible]. If it goes past the 30 days, they can still provide documentation.

We had a number of those discussions and negotiations that have had a significant impact.

If they can provide some substantiation documentation, and we are not as hard as people think--

SEN. HANDLEY: I know, as people want you to think, I know, with your smiley face. I realize that, but I remain concerned about how the process goes on.

I also remain concerned and, again, in these negotiations, whether overworking down of a fine, whether the larger chain drug stores, for

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example, are in a better position to negotiate because they have the capacity to do it.

Also, the fines might be larger because their volume is larger. And, therefore, 25% of a \$1 million fine is one thing for those folks.

And a 25% reduction of a \$100,000 fine for a smaller single mom-and-pop-type pharmacy, they represent a much more serious cost to them.

It's an element of fairness that's related to the volume that, again, from my understanding, may be, is troublesome to me.

DEP. COMM. MICHAEL STARKOWSKI: If anything, Senator Handley, it may actually work the opposite because if you look at, we have a long-term care pharmacy that could potentially be merging during this year.

If those two pharmacies merge, there will be about an \$80 million entity. That's one [inaudible] for providing services for the State of Connecticut.

There volume of claims we would normally do is 100 to 200 claims. So you can imagine why the, I'm using the extrapolation on \$80 million [inaudible].

So anything on a smaller provider, the extrapolation is much more precise, much more active.

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But it's on the larger providers where we may have to adjust the way we do extrapolation because of the significant [inaudible].

Usually, when they provide documentation or negotiate a feel for the Agency, it doesn't make any difference to us whether they are a mom-and-pop pharmacy or whether they are TBS or--

SEN. HANDLEY: I didn't mean to reply that it did. I just meant that the fairness issue may be different.

What happens to the money that you collect? Do you have any idea how much you collect in audits, and what happens to it?

DEP. COMM. MICHAEL STARKOWSKI: Actually, we don't collect as much as people think we do. We collect probably about \$15 million or so.

SEN. HANDLEY: \$1.5 million?

DEP. COMM. MICHAEL STARKOWSKI: \$1.5 million understood [inaudible] and we collect about \$15 million between [inaudible] pharmacy, home care, home health, etc., which is not a significant dollar amount at the end of the day when you spent \$3 million, once we establish the receivables.

So when we establish that XYZ provider owes us \$20,000, we then automatically have to adjust our claim to the federal government to pay the federal government their portion of that \$20,000.

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So at the end of the day, the Department decided that it was going to somehow negotiate that dollar amount down. We're still out 50% of that money, if the federal government automatically [inaudible].

SEN. HANDLEY: Thank you. And I do hope we can continue this discussion.

DEP. COMM. MICHAEL STARKOWSKI: We'll continue it.

REP. VILLANO: Thank you. Representative Martinez.

REP. MARTINEZ: Thank you and good morning. I have a question on Raised House Bill 5706 and also some observations, things that I have been able to experience in our community when grandparents are raising kids, kids from this year that are foster children under grandparents' care.

There is a big disparity in the monies that one group gets over the other one. It's about \$700 per child with DSS, and per child, and it's about \$500 or maybe less for two children under DSS.

It's also, when the children are removed from DSS, okay, the priority is for the grandparents to have those children at home.

They feel that there is responsibility to get those children, and right away, they accept the children.

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The grandparents that I know, they become homeless many times in my city or we have to train and teach them to stay with foster parents so they get the money that they need. Thank you.

REP. VILLANO: It is a form of discrimination.

REP. MARTINEZ: Yes, it's horrible.

REP. VILLANO: Thank you. Representative Gibbons.

REP. GIBBONS: Thank you, Mr. Chairman. Thank you, SB 21 Deputy Commissioner, for coming to speak. As you know, we are concerned about extrapolation. I think that a few of us would love to sit in on these meetings that you have the next time.

When you talk about raising \$15 million, to me, that is real money, and that is a lot of money. If you are raising a good portion of this from \$50 million to \$80 million companies, I don't have as great a concern, but I gather that the look-back period can extend for two years.

And when small operations are being assessed a fine of \$18,000 to \$20,000, it seems to me that the fine is greater than the actual problem that they have created, and I think we need to do something to create some sort of equity in there. Thank you.

REP. VILLANO: Representative Caron.

REP. CARON: Thank you, Mr. Chairman. I don't want to take up too much time because I know we

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spent a lot of time on this, but I do want to go over the audits a little bit.

Commissioner Beaulieu, I just want to thank you for helping me many years ago, when I first entered the General Assembly, and you had a different position at DSS.

You were very helpful to me and many of my constituents, actually, and I just want to thank you for all your help way back then.

COMM. CLAUDETTE BEAULIEU: Thank you.

REP. CARON: It kept me here, I think. As we went through the testimony of the audits, many questions have come to my mind.

I don't think it's the intent of anyone, either the providers, the Members of the Committee, and certainly not DSS, to reduce the effectiveness of the audits, but perhaps to make them even more effective, that work both for the patients being cared for, the providers providing the care, and DSS.

Really, you do want to guard against all of [inaudible] obviously, but it seems that there is an assumption of guilt once an error is found.

And the people are being charged for errors they probably either may not have done or never did do with the extrapolation.

It seems like it's sort of a simplistic statistical model to be using. And I am

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wondering are there more sophisticated ways to try and gauge a more accurate assessment of what the error rates are?

DEP. COMM. MICHAEL STARKOWSKI: You know, I can't sit here and say it's the only model to use--

REP. CARON: I'm sure it's not, but it seems kind of simplistic unless I'm just not getting something.

DEP. COMM. MICHAEL STARKOWSKI: It's a methodology that you use when the resources to audit 6,000 providers just aren't there.

If you wanted to try to move from extrapolation to a methodology, where it was only claim by claim, you just wouldn't, I don't care where you were, you just wouldn't have the resources to do it.

The methodology has been challenged in the past, and, actually, was upheld in court that our extrapolation methodology was appropriate.

We do have a statistician right now looking at our extrapolation methodology to see if it could be tweaked at all.

But I think it's not the methodology as much as I think that the providers feel penalized because of errors.

REP. CARON: Well, that brings up another question that I had, and I asked the question earlier. I don't remember if you were here, but there doesn't seem to be a distinction for a gravity

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of error, you know, fraudulent error versus, say, a clerical error, seems to have the same kind of weight. That doesn't seem to make sense.

DEP. COMM. MICHAEL STARKOWSKI: You are right. I mean, a fraudulent error or a clerical error does. It means the same thing in our system, although I think that we have been much more lenient working with the providers on the front end to try to work them.

An example, we want a physician to sign a care plan, that's required--

REP. CARON: I'm sorry, what?

DEP. COMM. MICHAEL STARKOWSKI: We want a physician to sign a care plan. That's required. An agency will call a physician, and a physician doesn't send through his signature.

What we have done, initially, we would take an error, we would count that as an error. We would be included in the extrapolation.

What we have told Agencies in the past year or so, and we have worked with them very closely, is if you could document the efforts that you have tried to contact this physician, if you have contacted him more than once to get the signature on the care plan, we will take that into consideration.

We understand that the doctor may not be able to sign quickly. He may authorize the care

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plan two weeks ago, and he is into other cases right now.

REP. CARON: Unfortunately, when you do that, and I understand being receptive to some of the issues, except that, again, counting it as an error, it creates a lot of extra paperwork, lost wages, lost productivity.

And as these fines add up, even though they may be reduced at some point, we're talking sometimes a couple of salaries.

So I guess another question that came to my mind was, and, again, I asked this, are there any seminars that the Department provides on a regular basis so that we can have a little more standardized method of documenting what has to be done, what is done, and the follow up in defining?

Again, one of the reasons, the best way to have success is to have shared expectation, everyone understands what the other is expecting.

DEP. COMM. MICHAEL STARKOWSKI: I think even Ms. Guiliano referenced it. We have staff that attends the meetings of their, statewide meetings for their pharmacist association.

Our auditors attend those meetings. We have auditors that attend the Long-Term Care Financial Managers Association.

They walk through what audit exceptions are, what's going to cause an audit exception. So we try to do that by provider group.

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And we are trying to do that more lately to try to make sure that the providers understand how the system works.

We would like to try to move it to more of the electronic environment so they would file claims a little bit differently, get documentation differently, use an electronic signature, and we have been working with a number of providers.

If you can get the electronic signature in, that will eliminate a lot of the errors that are caught in an audit.

So we are trying to move down some of the, and these were some of the recommendations brought to us-- [Gap in testimony. Changing from Tape 1B to Tape 2A.]

REP. CARON: --concerning the auditors themselves, how is it that they are evaluated in their job performance? I mean, is it based on error rates found or is it just based on things, just curious?

DEP. COMM. MICHAEL STARKOWSKI: No, it's not. It's not. They are paid a standard State salary. There is usually--

REP. CARON: Not the salary, but in terms of evaluation, you know, how well were you, how well, how productive were you as an auditor? Sometimes they are rewarded for job performance for finding something.

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DEP. COMM. MICHAEL STARKOWSKI: No, they are not. No, we have a number of significant audits where there were absolutely no audit exceptions at all, and that didn't negatively impact the auditor.

And those where they have a significant finding, it doesn't positively impact their evaluation.

REP. CARON: What would?

DEP. COMM. MICHAEL STARKOWSKI: You know, the competency. Can they do the audits? Can they handle the work assignment?

Everything that are standard State evaluations and there is nothing to do with the value of the audit or the dollar amounts found.

REP. CARON: Thank you very much.

REP. VILLANO: Senator Handley.

SEN. HANDLEY: I just want one question. Actually, we were talking about finder's fees, which I think we decided we didn't think was a good idea.

One of the things that just came to my mind as we were talking again further about this with auditing small social service agencies is, following up with Representative Caron's idea of establishing for particularly new organizations that get a contract, of what expectations are and perhaps a more clear way.

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I do remember talking with a small social service agency which was audited and had some serious organizational issues because they were brand new and were not accustomed, they dealt with an immigrant population, and were not accustomed to dealing with our social service procedures.

With them, I would think, with their problems, an original meeting making clear with them, and a procedure to make clear to them how records are to be kept, and so forth, would solve some of these problems. This is the kind of thing that I think we need to sit down and talk about.

In terms of those kinds of folks, as opposed to the pharmacists who I think have a pretty clear idea, they have been in business longer than social service, DSS has.

But I think, I think we really need to talk about expectations and in the light of the audits that are going to follow.

REP. VILLANO: Thank you. Just to sum up, Mike, I find that some of the arguments you used against the audit bill look to be extreme.

I can't believe that if it has passage would gut your ability to monitor programs. I don't think so.

I think maybe it might require a little more administrative work, a little more checking, but I don't think it would simply collapse as a

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system. What is your basis for saying it will gut your ability to monitor?

DEP. COMM. MICHAEL STARKOWSKI: You know, Representative Villano, the federal government estimated that 10% of all of the Medicaid payments that go out throughout the United States are either fraudulent claims or erroneous claims.

We have not found that to be the experience in Connecticut. But we think we found that not to be the experience in Connecticut because we are out there auditing. We are out there as a deterrent.

The best thing to stop people from coming in and either filing, whether it's an erroneous claim or it's a fraudulent claim, it shouldn't be paid by the State.

Especially in these tight times, we shouldn't be having that as a liability to the State of Connecticut.

So we honestly feel that continuing our audit program the way it exists now, and we're willing to work with the providers on tweaking it, is the best deterrent from keeping people from either filing fraudulent claims or having a false expectation.

I mean, we don't want to sit here and say that if only 10% of your claims are erroneous, we are not going to take an audit exception because we all know that then that's the benchmark.

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So then the individuals that file the claims and the individuals that do the jobs are evaluating on did you exceed the 10% because it's going to cost me a financial penalty or were you below the 10%. So we think it's the best deterrent.

REP. VILLANO: And do you really believe that passage of the bill is a license to steal?

DEP. COMM. MICHAEL STARKOWSKI: I really do. I really do. I honestly do. And I'm not saying it from the providers in Connecticut now.

REP. VILLANO: I'm not pointing my finger at you. I'm talking generally about the Department. The Department must have a very low opinion of the value of the contracts.

DEP. COMM. MICHAEL STARKOWSKI: Not at all, not at all. I'm not saying that the existing providers, and I think I clarified at the beginning, what I don't want to do--

REP. VILLANO: Part of the statement ends that if we don't have the proper deterrents for theft and overpayment, the system will collapse. I don't see that we have had any serious problems in the past.

DEP. COMM. MICHAEL STARKOWSKI: Representative Villano, besides the incident that I described before, we had a second incident with a gang in Hartford that had actually worked with durable medical equipment providers to file fraudulent claims.

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Organized crime goes around the country to get into filling claims in the Medicaid Program because it's such a rich program. Once they have learned the system, then they come in.

What we don't want to be is we don't want to be the State where organized crime can come in and defraud the State of Connecticut in its Medicaid and healthcare programs. It has happened from state to state.

The example I used before about the individuals that were found in Boston, they had already done this in California, and they got out of California before they were caught. They already did this.

Then they went to New Jersey, and they did this in New Jersey, and they were not caught in New Jersey.

They came to Connecticut. We caught them in Connecticut, but they had already left the State, and they were in Massachusetts.

Organized crime looks at things like this and says, here is another way to get a revenue source for their activities, their illegal activities.

If we make it known that we are going to lessen our standards, it's an invitation for people to come in that are not the type of providers that we have in Connecticut right now and not the providers we want in Connecticut.

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REP. VILLANO: And if you did not have extrapolation, how would you do your monitoring?

DEP. COMM. MICHAEL STARKOWSKI: We would have to actually look back and see what other methods would be acceptable to still be a deterrent, still be able to keep the error rate down. We haven't looked at any other realistic methods right now.

REP. VILLANO: And how many State Medicaid Programs use extrapolation in auditing?

DEP. COMM. MICHAEL STARKOWSKI: A number of them do, but I just can't tell you. I can get back to you with a number, but in our discussions with other States--

REP. VILLANO: Not many?

DEP. COMM. MICHAEL STARKOWSKI: No, a number of them do. I just don't know how many.

REP. VILLANO: Not many or many?

DEP. COMM. MICHAEL STARKOWSKI: No, a number of them do. I just wouldn't guess. I wouldn't guess. I wouldn't guess.

REP. VILLANO: Having said that, I agree with Senator Handley that there should be discussions about the entire problem.

I concur entirely what she said. We have to discuss this because there are many, many contractors out there unhappy with the present

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situation, and it has got to change. Thank you.

SEN. HANDLEY: Thank you. No applause, please.

REP. VILLANO: Thank you, Mike and Claudette.

SEN. HANDLEY: Thank you all.

REP. VILLANO: With that, we will return, excuse me, to the public portion of the public hearing. The first speaker held over from the previous list is Alicia Zalka.

ALICIA ZALKA: Thank you.

REP. VILLANO: You made it.

ALICIA ZALKA: Sorry about that. Thank you for this opportunity to speak to you all. Good morning, Senator Handley and Representative Villano.

I apologize that I wasn't here earlier. I know earlier today, you heard from Dr. Thornquist about this bill, House Bill 5291, so I will be brief.

My name is Alicia Zalka. I am a board certified dermatologist, and I practice in Danbury. I am in private practice.

I am here today on behalf of the Connecticut Dermatology and Dermatologic Surgery Society. I am the President of that organization.

It is intended to be a toll-free hotline. It's a cost-effective way for the State to serve more than 50,000 people in the State of Connecticut who are caring for relatives. Thank you.

REP. VILLANO: Thank you, Ms. LaMorte. Questions from the Committee? If not, thank you for your testimony. The next speaker is Nancy Trawick-Smith.

NANCY TRAWICK-SMITH: My name is Nancy Trawick-Smith, and I am the Director of Community Companion and Homemaking Services, and we are a not-for-profit companion homemaker service in the Willimantic area.

We have been a provider agency for the State Home Care for Elders for 13 years. I received, I'm sorry. I'm speaking to Raised Senate Bill 21 on the Department of Social Services audit process.

I had an audit at the end of 2002 and the beginning of 2003, once again, auditing two years of my claims.

Looking over our timesheets that are submitted by our homemakers and companions, I ended up with a \$69 error, which was extrapolated to \$10,375 because of the extrapolation process.

My \$69 in errors, essentially, were 2-1/2 hours of erroneous billing, and then the rest of it was because I had an elder client who had signed with her initials and had done so consistently for three years.

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That was disallowed because they didn't find documentation that I had authorized these initial, so that was weighed as equally with my billing errors.

This was able to get rid of all the different problems I had or find documentation. It was \$455, and they had extrapolated it to \$69,000, just to show you how the extrapolation process works.

Just to mention about the documents that are being audited, these are timesheets that are submitted by homemakers and companions, and they are not written up in the controlled setting of an office with the door closed.

They fill out their timesheets while they are standing in the home of a elderly or disabled client, after they may have done two hours of work cleaning, and dusting, and vacuuming, and readying themselves to go to the next client. So you have to see how difficult it is.

I also want to mention that I have an office staff of three that handles all of the scheduling.

We schedule 500 visits a week to 200 clients, and I just want to mention, I will sum up here, that I don't feel like extrapolation is a deterrent for us or helps us with compliance.

It basically, if anything, has caused such financial damage to people, to really, really

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good provider agencies that they have decided not to actually do this kind of thing anymore.

REP. VILLANO: Thank you for your testimony. Are there questions from the Committee?

REP. CARON: Very quickly, what would encourage you to be more compliant, if this doesn't?

NANCY TRAWICK-SMITH: Well, I do want to tell you that I do have an audit every year with my books, but my accountant doesn't work this area.

And I think it can be very instructional if you have, even if you basically takes those actual errors or actually sit down with people and tell them what is expected of them.

The audit itself is something that causes you to be compliant. I don't think you need to financially damage people.

REP. CARON: Do you have an office plan of standard operating procedure to watch for fraud within your office for employees?

NANCY TRAWICK-SMITH: I'm sorry. I don't understand what you mean.

REP. CARON: Do you have an operating procedure in your office to look out for fraud?

NANCY TRAWICK-SMITH: Oh, absolutely, absolutely. We met with, we look over all those--

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REP. CARON: Do you go over that with DSS at all, get an approval or ask them their opinion on things to do, or--

NANCY TRAWICK-SMITH: No, we haven't gotten, I mean--

SEN. HANDLEY: Thank you.

REP. VILLANO: Any more discussion? If not, thank you for your testimony. The next speaker is Bob Covillion.

BOB COVILLION: I'm Robert Covillion. I am a member of the Connecticut Non-Medical Homemakers Companions' Association, and I am here to talk to you about Raised Senate Bill 21.

Basically, we are being treated for errors, as far as administrative errors go. They are not financial errors. The example would be, an employee signs an activity sheet attesting to rendering homemaking services to the client.

The client in turn, signs the activity sheet attesting that the homemaker performed those services.

On the timesheet, it shows the time that the employee started, the time the employee finished, and it also shows the date that service was rendered.

However, maybe the homemaker forgot to list down that she performed sweeping the floors, prepared a meal, and vacuumed.

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Three or four years later, we get an audit. That time slip is reviewed, and it is determined that this is in error. Therefore, it is subjective to the audit process.

Again, this is not a financial error. It's an administrative error. Extrapolation is performed.

I have some of the companies on my position statement that I submit to you. They are actual audits that were performed and numbers were extrapolated.

One company had \$166.74 found to be in error, and of that, \$95,064 had to be recouped and sent back to the State.

Another company had \$294.20 that was extrapolated to \$73,638. It's much more significant than the \$18,000 to \$20,000 that we heard earlier.

The appeal process, basically, is that we go to DSS, and we talk to Mr. Jim Wietrak, who is the Director of Quality Assurance, as to what our issues are to appeal this. It is not a third-party independent unbiased decision.

Like so many other areas in our country, our justice system allows for several appeal processes that are independent from previous ones.

Our town governments, zoning, and property, etc., have appeal processes separate than the previous people that reviewed it, and taxation,

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the Internal Revenue Services even have an appeal process.

In summary, the Director of the Department of Labor says that the service that we performed before has to be paid because those services were rendered, even though DSS says we have to reverse the money.

We pay Social Security taxes. We pay all Medicare, SUTA, FUTA, worker's comp on those services, in addition to liability worker's compensation.

REP. VILLANO: Thank you for your testimony. Are there any questions? Yes, Representative Walker.

REP. WALKER: Thank you, Mr. Covillion, for your testimony. I'm sorry I didn't hear the other testimonies.

Are you saying, just briefly, you're saying that the error doesn't necessarily have to be a financial one, it's an error in bookkeeping and it ends up being a financial burden?

BOB COVILLION: That's correct. It's a clerical error. The service was attested that it was performed by the client, and the homemaker and the State of Connecticut has attested that the service was rendered, and we must pay the homemaker and the employee.

And, therefore, because it is an administrative error, that error is extrapolated, and we must reimburse all that money.

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REP. WALKER: Back to the State?

BOB COVILLION: Back to the State. So the client was serviced, employee was paid, we paid the taxes on those services, and we get to pay back the money for rendered service to the client.

REP. WALKER: How quickly do you get the notification from the Agency about this error?

BOB COVILLION: Usually, it's within 30 to 40 days after they perform the audit on us, although the audit could be three to four years after the incident occurred.

REP. WALKER: I'm curious. How was it detected that this service was provided and it wasn't documented?

BOB COVILLION: In the audit process, the auditors come into our facility. We get a list in advance as to how many people they are going to look at and what claims they are going to look at.

We pull those claims. They come in a week later, approximately. They look at those claims, and they look at the service orders that we have, and they look at the activity sheets that we have for what we had billed.

They match them up. When they look at those activity sheets, if they find that the signature doesn't look like another signature they had before or other timesheets that are attached to that or there is not enough

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activities checked off for the time limit that the homemaker was there, then that is considered to be an administrative error.

And we are, they make copies of that, they take it back to their office, and then they write a report up and submit that report to us telling us what we have to reimburse the State.

REP. WALKER: I would like to talk to you after the public hearing. Thank you.

REP. VILLANO: Thank you. Are there any questions? Representative Thompson.

REP. THOMPSON: Yes, good afternoon. My own experience with audit reports is that auditors will often advise you where errors have been made and then make suggestions of how to avoid that in the future. Is that done?

BOB COVILLION: In the interviews that I have had with the State, they have looked at us, and they told us what those errors were. We have never received any documented written criteria as to what they are looking for.

The audit that I had the first time was audited the second time. The criteria that they looked at that time had changed.

Did I receive any notification in writing as to, oh, we changed the rules now, and this is what you are now going to reimburse us for?

No, I didn't receive nothing whatsoever on that. I had no idea that this had changed, and

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I was going to be held accountable for it, but I got to pay back the money.

REP. THOMPSON: Is that the, the numbers that have been thrown out here this morning are rather unbelievable almost.

Is there any negotiation once they have settled on a figure? Do you say, they say, you made a \$69 error, and it turns out to be a \$69,000 penalty? Is there some way that you can negotiate between \$69 and \$69,000?

BOB COVILLION: Basically, we have what is called the First Exit Interview and, basically, showing us what we, what was determined, that we have to pay back, as far as what they felt for errors.

We appeal that, and we finally end up meeting with Jim Wietrak from DSS. And in that process, we go over those errors.

And, in some cases, yes, they do reduce the amount that we have to pay back, but, again, the numbers I gave to you earlier of these companies, those were the final numbers after the appeal process.

The \$166 that had to be paid back at \$95,064 was an actual number that had to be reimbursed after negotiations.

REP. THOMPSON: After negotiations.

BOB COVILLION: After negotiations.

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REP. THOMPSON: And is there evidence that these types of figures have actually forced people out of business?

BOB COVILLION: There have been business that were in my area are not there, that were there prior to the audits. Since the audits, they are no longer in service. They are out of service.

Some companies in our organization, we had formed an organization to try to correct this process.

And some of the organizations have made a decision that they are no longer going to perform the services for the State, that they are only going to do private services from now on.

Because they cannot, this audit process is totally unfair. We are being penalized, although it's not called a penalty, for administrative errors, and the service was rendered.

REP. THOMPSON: Will the State pursue somebody who goes out of business vigorously for any, for what they extrapolated to be an overpayment? Do they sue you after a business is closed?

BOB COVILLION: I don't know to be honest with you, to answer that question. I can honestly say that we had a meeting here back on May 13, 2004. We met with Senator Roraback, and there were several other Legislative Representatives here.

It was not a hearing. It was a meeting. DSS was also here, and several other agencies and organizations.

Senator Roraback had asked the question as to how many cases of fraud had been found since 1998, 1999, since this was implemented with the Connecticut Non-Medical Homemakers Companions, and there were no cases of fraud.

REP. THOMPSON: That is interesting. There is another side of the coin in an audit report. Sometimes the auditors will inform you, and I am not an auditor certainly, but sometimes auditors will form a, well, if you did this, that or the other thing, you would have been able to charge this much more.

In other words, if instead of, if you are undercharging by clerical error or whatever, is there any extrapolation for that kind of thing?

BOB COVILLION: We don't set the pricing, if I understand your question correctly. We don't set the pricing. That is dictated to us as to what we can charge.

REP. THOMPSON: I mean, if they use your system, and the auditor comes along and says, gee, you're using the system improperly and you're not billing for services you actually provided, is there any extrapolation or any mention of that sort of situation?

BOB COVILLION: I'm not quite sure if I understand the question.

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SEN. HANDLEY: If you underpay, does it go the other way?

BOB COVILLION: Oh, no, if we underpay, I have not heard of any situations where we underpaid and that was extrapolated.

Of the people in our organization, we have approximately 105 members now, this organization is about a year and a half old, and there are 105 members.

Of them, I have not heard of anybody in that group that has stated that they had an underpayment and it was extrapolated and favorable for them.

REP. THOMPSON: It seems to me that it is more a fraud discovery system rather than an audit system that I am familiar with.

REP. VILLANO: Any other questions from Committee Members? If not, thank you for your testimony. The next speaker is Susan Esons.

SUSAN ESONS: Good afternoon. I am Susan Esons, Newt Schoenly had to leave. But Senator Handley, Representative Villano, and all Members of the Committee, my name is Susan Esons.

And I represent, I'm a member of the Connecticut Non-Medical Homemaker Companion Association, and I'm here to testify and ask for your support on Raised Senate Bill 21.

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In listening, I've written up some testimony and submitted it, and you can read that, but in listening to you this morning, I think that you have a pretty good handle on some of our concerns.

I can tell by the questions that you asked. And I think what I have to say to you is, if you do not pass this bill, and you may pass it, but it may not get passed further on, nothing is going to change.

One of the things I heard you ask was that the Department of Social Services work with us to come to some solution because we are at loggerheads.

There is another association in the State that provides home care services. They have been working on this issue for five years with DSS, and extrapolation has not gone away.

The federal government has dropped the practice of extrapolation, except in cases where there is rampant error that continues to go on and so forth.

So the State of Connecticut does need to use this extrapolation method. The other thing is, in terms of Department of Social Services saying they have sat down with us, we have had one meeting with them.

And on April 20<sup>th</sup>, we had a meeting to talk about this because you asked us, can you work out your differences with them rather than having to go this route?

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We got a response in writing the end of August, which is four months after that meeting, and the response didn't really get us any closer to resolving some of these issues.

So I guess what I'm saying is, I'm going to ask if you don't pass this, I really think nothing is going to happen.

And I really think that the, you know where we're coming from is, on some of these issues where we have had audit errors, and had to give money back.

We have been asked to provide the service. We provided the service. We paid the employee. We billed for it. We got reimbursed.

Then the State comes back and says, oh, you didn't check off that you took out the garbage and that you took the person to the doctor, so that's an error.

We are going to take that money back from you. And then not only are we going to take it back, but we are going to say that you made that same mistake in the claims we didn't look at. It just really is an insult to those of us that are trying to provide good service.

In summary, the State has a plan in 2025, to switch Medicaid dollars to be 75% community-based.

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You will not have enough community-based providers if these practices continue to meet that goal that the State has.

REP. VILLANO: Are there questions from the Committee Members?

REP. GIBBONS: Thank you for being here. I am just going to say blankly to all of you who are testifying on this bill that we have spoken with Deputy Commissioner Starkowski. I just spoke with him outside the door.

I understand it a little bit more from his point of view that he feels that if he doesn't have some practice in place, that the fraud would be rampant.

You keep saying that you have got all of these little people and smaller companies that just can't afford the fines that are doing it.

And I think that Rep Caron said it best that it's a very simplistic approach to a quite sophisticated manner of dealing with paperwork.

And whatever they are asking for DSS for reimbursement, somehow, we have to make some changes. So we are in agreement with you and will continue the conversation.

SUSAN ESONS: I appreciate your support, and you know what, we will help you find fraud. Those Agencies that are out there doing the business, we know other companies. We'll help you find the fraudulent agencies. I appreciate your support. Thank you.

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REP. VILLANO: Thank you, Ms. Esons. Monique Allard.

MONIQUE ALLARD: Good afternoon. Thank you for SB21 hearing my testimony. But I guess at this point, my name is Monique Allard, and I am here on behalf of the Connecticut Non-Medical Homemakers and Companions Association.

And at this point I guess the only think I could say is ditto. It's all been said, so I won't take up any more of your time.

But I do want to be on record as saying we are out there providing necessary services for the homebound elderly across the State of Connecticut.

Many of us have been in business for decades. We are not in the business of ripping off the State of Connecticut or the federal government.

We are in the business of taking care of your loved ones, and we want to continue to be able to do so. Thank you for your time.

REP. VILLANO: Thank you. Are there any questions from the Committee Members? If not, thanks very much for your testimony. Next speaker is Nancy Dougherty.

NANCY DOUGHERTY: Good afternoon, ladies and HB5290 gentlemen of the Legislature. My name is Nancy Dougherty, and I'm here as a representative of the Shoreline Division of [inaudible], Connecticut.

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are more closed doors, chastising social workers, and grimace-faced service providers sending mixed messages, and off on a scary roller coaster ride, the family begins.

So far, I've shared a little input at what happens with the grandparent. Now, allow me to shed some light on the grandchild.

How painful it is to hear a child to describe watching her mother being murdered right in front of her eyes.

Afraid, confused, her sense of security gone, do I have some of that evil in me too? And why wasn't I strong enough to take care of mommy?

I am asking you to please support Senate Bill 169 and House Bill 5706 because they are affecting our children here in Connecticut. Thank you.

REP. VILLANO: Thank you very much. Are there any questions from the Committee Members? If not, thanks again.

ELBY GONZALES-SCHWAPP: Thank you.

REP. VILLANO: Our next speaker is Janice Creighton.

JANICE CREIGHTON: Good afternoon and thank you for SB21 taking my testimony. My name is Janice Creighton, and I am the former owner of Helping Hands.

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I am one of the little guys that the DSS audit forced me to sell my business because I could not continue.

One of the big problems with DSS is that we have never been given any guidelines. We have asked for them numerous times.

We were told by them that they would give them to us in writing, and then when we got our response letter, it said, it's in the contract, read it.

If anyone has ever seen the regulations and the contracts that are involved in this, they are about 3-1/2" deep, and it's probably several hundred pages, most of it in language that we may not understand.

Not only do we not have guidelines, but very often the guidelines change. I was at a meeting about a month ago with an access agency, and we were told that no longer will the State of Connecticut pay a homemaker rate to transport someone to the doctor.

This has not come down. It has, no one has been notified of this. But if they decide when we are audited to take that \$.17 or whatever the difference is, \$.50 I guess is the difference, and extrapolated all of us, we will be paying hundreds of thousands of dollars for a new idea that nobody has been informed of.

In closing, I am asking you if you would please consider adding a simple statement to this bill that DSS must inform us in writing of what they

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expect of us because the quality of our paperwork is what is being audited, not the quality of the service. Thank you.

REP. VILLANO: Thank you, Ms. Creighton. Are there questions from the Committee Members? If not, thank you again for your testimony. The next speaker is Linda Clark.

LINDA CLARK: Good afternoon, Senator Handley, SB 21  
Representative Villano, Committee Members.  
Thank you for having me today.

You have my testimony before you. I can just echo what everyone else has said. I want you to know that I did not renew my State contract at the end of my audits because of the climate that we are presented with.

The Commissioner said it very clearly. We are treated like we are fraudulent people. I do not make my living stealing, and it's insulting, and it's embarrassing to be a citizen of this State and be treated that way.

It's obvious, if it continues, that's how we're thought. We are thought of that we are doing wrong before we ever provide any service. [Gap in testimony. Changing from Tape 2A to Tape 2B.]

REP. VILLANO: Our next speaker is Marilyn Hardrick.

MARILYN HARDRICK: Good afternoon, Senator Coleman, SB 164  
Rep. Villano, and Committee Members. My name is Marilyn Hardrick, and I am from the Salvation Army here in the City of Hartford,

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SEN. HANDLEY: We have met many times with your grandparents group, and I thank you for all of the work that you do and all the work that they are doing.

MARILYN HARDRICK: And in summing up, I do invite any Representative or Senator from the State of Connecticut, if you would like to come in and visit our support group, you are more than welcome to come. Thank you.

REP. VILLANO: Fatima Palais.

FATIMA PALAIS: Close enough, thank you. Good afternoon. I would just like to thank you so much for all your effort in Raised Senate Bill 21, AN ACT CONCERNING AUDITS CONDUCTED BY THE DEPARTMENT OF SOCIAL SERVICES.

We are just so heartfelt gratitude with all your efforts. There is not too much that I can add to the testimony here.

But what we want to just say is that we are in support of audits and quality control. There needs to be standards in all industries.

However, the extrapolation, it is not being a deterrent for fraud. What I think it is being a deterrent for is for us to provide our State citizens, elderly citizens, with a service.

I myself am no longer in business as well. It is just very difficult when you are paying people between \$7 to \$9 per hour, charging \$15 to have, there is very little profit margin,

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and then have to provide the service, not only for free, but at a cost to us as employers.

So, again, I just want to reiterate, there is a way that audits can be done to find fraud. Extrapolation is a valid accounting method, but it has no business in being in the home care industry.

I again thank you for all your support and hope we can continue our talks.

REP. VILLANO: Thanks very much, Ms. Palais. Are there any questions from the Committee Members?

FATIMA PALAIS: Thank you for your efforts.

REP. VILLANO: The next speaker is Mark Masselli.

MARK MASSELLI: Good afternoon, Senator Handley, Representative Villano, Members of the Committee.

My name is Mark Masselli. I am President of the Community Health Center. The Community Health Center is a federally qualified health center.

We provide primary health services to the uninsured and underinsured in Connecticut. Our health center has offices in Groton, New London, Old Saybrook, Clinton, Middletown, New Britain, and Meriden.

I'm here to thank the Committee for their work and leadership on Raised Senate Bill 21, AN ACT CONCERNING AUDITS CONDUCTED BY THE DEPARTMENT

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OF SOCIAL SERVICES, and to add my voice to the chorus of other speakers today who have talked about that.

You have heard a lot about Section 1 of the bill. I want to talk briefly about Section 2, which is specific to federally qualified health centers.

From 1988, this General Assembly passed legislation that went through the year 2000 that allowed federally qualified health centers to go to the Department of Social Services with their cost reports and annually have those costs adjusted.

That changed in 2000, but it still allowed the Department to make adjustments, but it allowed them to do it on their own accord.

This legislation would codify it and require the Department to respond responsively to any federally qualified health center who comes through.

Currently, the Department chooses its friends and supports them with rate adjustments, and rejects all the other ones that come across. We think that this is unfair. We hope that you will give consideration to this.

As you probably know, federally qualified health centers are not here just to ask for something, we have something to offer as well.

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We have been trying to work with the Department, not successfully, with costs, with reductions in pharmacy costs.

Community health centers are allowed to buy cheaper than the Medicaid Program. We have not been able to have much success with the Department.

They don't seem to respond to our calls. So we are not here just to say we need a better cost rate reimbursement.

Because of our standing, we have other opportunities that we can offer back to the State.

We just look to the Department to be fairer across the board. Section 2 really codifies that fairness. Thank you very much.

REP. VILLANO: Thank you very much. Are there any questions from the Committee Members? Senator Handley?

SEN. HANDLEY: Yeah, I have a question about the pharmaceutical part of your business. How are you incidentally?

MARK MASSELLI: Good. How are you?

SEN. HANDLEY: I'm really not sure what you were saying. Are you saying that the State of Connecticut is permitting some of the clinics to participate in this cheaper drug program and not permitting others?

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MARK MASSELLI: There certainly not communicating with all of the health centers regarding this. Certainly, our program, we have negotiated an arrangement with Walgreen's, the first in the nation where we are using a private pharmacy.

We used to use a small independent one until they went out of business, so we are using the private sector to leverage out this program. The Department just has not been interested in doing that.

They have chosen, again, their favorite of working with them, and we applaud them working with anybody.

It seems to me that when we can buy 20% lower than the Department can in the Medicaid Program, our own health center provides care to 50,000 individuals.

The great health centers in Hartford, and Bridgeport, New Haven, Waterbury. We provide care to a lot of people, and a lot of them are on Medicaid.

You know, we are willing to sit down with the Department and talk with them, but, you know, there has got to be some standards that they have in terms of dealing with people. They should deal with everyone across the board in a fair way.

SEN. HANDLEY: So you think that Section 2 here, will help the pharmaceuticals, as well as the [inaudible]?

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MARK MASSELLI: I think Section 2 will help in the pharmaceuticals as well.

REP. VILLANO: Thank you. Do you have a copy of your testimony?

MARK MASSELLI: I was not expecting to be in town today. Can I put something together and send it back to you?

REP. VILLANO: [inaudible - microphone not on]

MARK MASSELLI: I will. Thank you, Representative. Thank you.

REP. VILLANO: Theresa McGrath?

THERESA MCGRATH: Good afternoon, Members of the Human Services Committee, Senator Handley, Representative Villano.

My name is Theresa McGrath. I am the Executive Director in the Family Alliance for Children in Education. I am a grassroots lobbyist for parents to have a voice up here at the Capitol.

I'm here actually to talk on behalf of the grandparents on Raised Senate Bill 457, AN ACT CONCERNING SUBSIDIZED GUARDIANSHIP FOR RELATIVE CAREGIVERS, Raised House Bill 5706, AN ACT CONCERNING STATE PAYMENTS TO INDIVIDUALS CARING FOR THE CHILDREN OF RELATIVES, Raised House Bill 6573, AN ACT CONCERNING GRANDPARENTS CARING FOR GRANDCHILDREN AND FOSTER CARE SUBSIDIES, and Proposed Senate Bill 170, AN ACT CONCERNING THE ESTABLISHMENT OF THE KINSHIP NAVIGATOR SYSTEM.

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The Medicine Shoppe  
348 Main Street  
Manchester, CT 06040-4123  
860-649-1025

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March 3, 2005

Pharmacist or Felon?

Thank you for hearing my testimony today. I am pleading with you to take action in support of changing SB 21 to be fair.

Pharmacists serve the community. We dispense medications to you, the public in a timely manner. We catch errors made by prescribers and keep the public safe and healthy. We are not felons. Felons are criminals. They harm people. However, we are being treated like criminals. Audit regulations are to blame. Change must come from the legislature.

We understand that audits are important and a necessary part of maintaining the state Medicaid systems efficiency. However, punitive extrapolation based on administrative errors has hit pharmacies with huge fines. We must separate administrative errors from fraud and use fines for actual prescriptions not the current system of extrapolation.

Extrapolation is the practice by which an auditor examines 100 claims over a two-year period and takes any errors found then multiplies this by all of the claims paid including the cost of the drug and the dispensing fee. No one is perfect. Administrative errors happen but should be corrected and not subject to penalty. If a pharmacy filled 15,000 prescriptions during the audit period and the disputed claims totaled \$400.00 for 6 errors then one error out of 100 becomes a penalty of \$10,000.00 each for each prescription filled. This amount is for an average prescription. If the prescription was expensive then the amount goes up proportionally. That's a lot of liability for a \$3.15 dispensing fee. If a medication is dispensed and received by a patient we should be liable for the dispensing fee not the cost of the drug. If a fine is levied it should be on a per prescription basis. If an error was for an expensive prescription using extrapolation, it can lead to fines that are greater than the amount billed to the state in the first place. This is not an industry standard. The state is just about the only entity that uses extrapolation.

Brand name drug prices are going up but more and more generics are coming into the market, which will continue to lower the average dollar figure per prescription. However, the state, the federal government, drug companies, insurance companies, and PBM's (mail order companies) are all doing everything in their power to discourage the survival of community pharmacy. Dozens of pharmacies are closing in CT. every year. The crisis is happening now. As stores close there are fewer jobs available. This will lead to lower salaries for pharmacists. That in turn decreases the amount of students who want to become pharmacists.

Please help us care for people before it's too late. Once we are gone, we will not be back. I offer my services to you if there are any questions. I have included my phone up above.



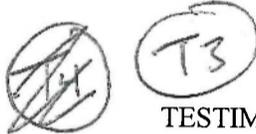
Roy D. Katz R.Ph.

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THE CONNECTICUT ASSOCIATION  
for **Home Care, Inc**

Kathryn Roby  
Chair, Board of Directors

Brian Ellsworth  
President/Chief Executive Officer



TESTIMONY CONCERNING

SB 21 – AUDITS CONDUCTED BY  
THE DEPARTMENT OF SOCIAL SERVICES  
Before the Human Services Committee  
March 3, 2005

HB 6275

Good Morning, Senator Handley, Representative Villano, and members of the Human Services Committee, my name is Diane Maiorano and I am Chair of the Connecticut Association for Home Care's Government Relations & Reimbursement Committee. The Connecticut Association for Home Care serves over 75,000 elderly and disabled Connecticut citizens.

I am here today to voice the Association's strong support of SB 21. This support is based on our members' deep concerns which include the arbitrary nature of Medicaid audits and the lack of formal due process procedures. Over a number of years, we have worked with the Department of Social Services on Medicaid audit issues and while we have made some progress in a number of areas, there are critical issues such as extrapolation and due process which still remain unaddressed.

Our experience is that audit policies tend to evolve over time, become somewhat fluid and are inconsistent in their application leaving the providers at undue risk. Examples of this phenomenon include: information required to document a visit and the acceptable timelines for obtaining physicians' signatures on the plan of care. In these and other instances, even a minor paperwork transgression can result in an audit disallowance, which is then extrapolated to the whole universe of claims.

Extrapolation can compound problems with Medicaid audits by, in some cases, magnifying isolated errors into large recoupments. As few as one or two claims might become the basis for tens of thousands of dollars being recouped, with no formal appeals process to fall back upon.

110 Barnes Road, P.O. Box 90, Wallingford, CT 06492-0090  
Telephone: 203.265.9931 • Fax: 203.949.0031 • Web: [www.cthomecare.org](http://www.cthomecare.org)

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As you may be aware, the Medicare Prescription Drug, Improvement and Modernization Act signed by President Bush in December 2003 imposes limitations on the use of extrapolation during Medicare audits to determine overpayment amounts. Medicare auditors may use extrapolation only when there is a "sustained or high level of payment error," or where "documented educational intervention" failed to correct the problem. Given the problems stated above, we strongly believe that it makes sense for Connecticut to follow the federal government's lead and apply the Medicare audit standard to Medicaid as reflected in SB 21.

We believe that timely and clear education in advance of the application of the State's ever evolving audit policies will eliminate many of the troubled areas now being experienced by the providers. Such education, we feel, should include but not be limited to specific examples of acceptable and non acceptable documentation.

We also support the proposed appeals process that is detailed in SB 21. To DSS' credit, they have developed and applied an *ad hoc* internal appeals process for audits. Many times, CAHC members have been able to provide meaningful information to reduce an otherwise unsustainable audit adjustment. Those decisions currently rest with a small handful of people who have particular vested interests. Now it is time to codify that *ad hoc* process and allow providers to have the same kind of independent review that is available elsewhere.

In addition to the above, CAHC also strongly supports HB 6275, Acceptance of Electronic and Physician Signatures by the Commissioner of Social Services. This bill will guarantee that electronic signatures will be accepted by DSS, providing the necessary assurance that home health agencies' large investments in information technology won't be negated by short-sighted insistence on adhering to paper processes.

Again, I ask you to commit your support of SB 21 and thank you for the opportunity to present our concerns to you.

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CONNECTICUT PHARMACISTS ASSOCIATION

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Website: www.ctpharmacists.org

T8

Testimony  
Before the Human Services Committee  
Tuesday  
March 3, 2005

Re: SB 21 AAC Audits Conducted By the Department of Social Services

Good Morning Senator Handley and Representative Villano. My name is Margherita Giuliano. I am a pharmacist and the Executive Vice President of the Connecticut Pharmacists Association. The Connecticut Pharmacists Association is a professional organization representing more than 1,100 pharmacists in the state. I am here today to speak in support of SB 21: AAC Audits Conducted by the Department of Social Services.

I would like to thank the committee for taking the initiative in raising this most important bill. Last year we brought this issue to you so that you would be informed about these unfair practices. We are pleased that the committee has decided to broaden the language to encompass all providers. We are here today to ask the committee to finally stop the extortion that is occurring by the audit department within the Department of Social Services. Huge deficits within DSS have the department seeking ways to balance the budget by any means possible. While we realize that audits are an important and necessary part of maintaining the state Medicaid system's efficiency, punitive extrapolation based on administrative errors is egregious and smacks of revenue-raising to fund the budget deficit.

Let me try to explain what extrapolation is. Let's say Senator Handley runs a stop sign and is pulled over by the police. The officer writes a ticket and then asks the Senator how often she passes the affected intersection. Senator Handley responds that the intersection is traversed at least once monthly. The officer, presuming a level of guilt, writes her 11 more tickets. This is what is occurring in pharmacy audits from DSS.

When pharmacists sign contracts with private insurers and DSS they agree to follow certain policies when filling prescriptions. However, pharmacists deal with over 1,000 different insurance plans, each one with their own set of rules and policies. To be perfect in all the bookkeeping "details" as well as getting the right drug to the right patient and to be able to communicate to that patient, is a challenge. Dealing with so many variables there is bound to be some technical or administrative errors.

Most audits reveal clerical errors that are performed by part-time clerks who handle the paperwork. In those rare instances where there appears to be fraudulent activity, a complete investigation is warranted and maximum penalties should be levied. However, to ask a pharmacy to pay \$25,000 back to the state because it didn't have the handwritten

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initials of the pharmacist filling the prescription on the prescription is ludicrous since the Department of Consumer Protection accepts signature logs as adequate documentation.

I can tell you that one pharmacy received an \$80,000 bill as a result of his combined Medicaid and ConnPACE audit. None of this was due to fraud. This particular pharmacist is one of the most ethical and proactive pharmacists in the state. He was punished because he "trimmed" his faxed-in prescriptions to fit into his file. It came at a cost of \$953.00. Another situation was when 2 prescriptions were filled for the same patient for the same condition, but the hard copy filed listed only one of the 2 drugs. The patient was prescribed and did receive both drugs. This was a clerical error – a filing error that when extrapolated out cost the pharmacy \$19,764.47. I could go on and on with the horror stories of pharmacies being recouped more money than they actually billed the state for during the time period audited. Sums of \$200,000 and greater are not uncommon.

No other third party payer uses their auditing system as a source of income. The above mentioned pharmacy was audited during the same period by Blue Cross and came out with less than \$3,000 in recoupment. The Connecticut Pharmacists Association supports efforts by the state to combat fraud. However, to punish innocent providers seeking to help the poor in a terribly under-funded program is unconscionable. We urge you to support this bill.

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**COMMUNITY COMPANION AND HOMEMAKING SERVICES**  
**SENATE BILL 21**

My name is Nancy Trawick-Smith and I am the Director of Community Companion and Homemaking Services a non-profit agency in the Windham Region. We have been a provider agency for Connecticut Community Care since 1992. I feel we have an excellent relationship with our Connecticut Community Care office in Norwich. We all work very hard to help keep our elderly clients in the community and out of nursing homes. Just to let you know a little about our agency we, like many of our colleagues, have a very small office staff. We have 3 people in our office doing scheduling, hiring, field staff supervision, bookkeeping, and billing. In a weeks time we serve about 200 clients. About half of those clients are CCCI clients. We schedule close to 500 visits and process approximately 300 timesheets per week. We are reimbursed \$13.52 per hour for Companion Service and \$15.24 per hour for Homemaker Service.

In 2002 I was notified by the Department of Social Services that we were to have one of their audits. We were understandably anxious because by this time these audits and their massive extrapolations had become notorious among the provider agencies, medical and non-medical alike. As someone who is responsible for a business, I had Liability Insurance to cover me if I was sued by a client, Worker's Compensation Insurance if an employee was injured, Property Insurance if someone fell in my office, but no insurance for something that could possibly render the huge financial damage that these audits were known to inflict.

Part of my anxiety stemmed from the fact that you were never sure on what basis they were going to disallow claims. Despite the fact we signed large contracts on an annual basis we had no Provider manual detailing policies and procedures. Certain rules and regulations seemed to change annually. We are told in the contract to make sure that the case manager documents in the case file if a client is unable to sign a time sheet, yet we were never told exactly how we could ensure that a case manager documented that fact. Every agency came up with their own system, their own timesheets, and their own way of doing things.

The auditor was to audit a sample of 100 of our claims and spent several days doing so. Several weeks later I received a letter with a list of possible errors. The auditor found some problem with 17 claims totaling \$ 455.56. 9 claims, involved 3 individuals who signed with initials and 2 who signed with an "x" and they had not yet found documentation in CCCI's case records that this was okayed by the case manager. On 5 claims, there was a question about whether we were charging CCCI for travel time because the clients lived next to each other and we didn't show any travel time between the two. 1 claim totaling 7.14 was actually a ½ hour overbill and 1- 2hour claim totaling 28.56 was actually billed in error. There were no missing timesheets, there were no time sheets without some sort of signature, and there was no accusation of fraud. With the Department of Social Service's methodology, if all these claims stood the amount, they informed me in their letter, that they would want to extrapolate was \$69,614. The day I received that notice was one of the most devastating I can remember. Ultimately we

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were able to prove that we had documentation that we had notified CCCI about most of these signatures. One woman who we serviced from 1997 to 1999 who was on dialysis had signed with initials. The claim for this woman was disallowed. We were also cited because we had gone from one client to the other in a senior housing complex and the auditor felt that we didn't allow enough time and disallowed 15 minutes. We were down to \$69 worth of errors. For my \$69 in errors, DSS extrapolated \$10,375.

The Department of Social Services will tell you that extrapolation is the only way to go. I can't believe that a system that turns \$69 worth of errors into \$10,000 is a good one. DSS will tell you that perfection is not too much to expect. Something important to remember is that they are not talking about perfect service they are talking about perfect timesheets, perfect documentation. Let me point out that these timesheets are not filled out in the controlled setting of an office with the door closed, they are filled out frequently after a homemaker has been working hard for 2 hours doing vacuuming, dusting, and washing the floors. They are filled out as they are standing their readying themselves to walk out the door trying to get to their next client on time, usually while their client is saying goodbye to them. It's the perfection of these time sheets that makes or breaks us. It's also being able to correctly file those 200 time sheets a week so that they can be found one to two years later at audit time. One misfiled timesheet can cost you thousands.

I feel that Senate Bill 21 is well drafted and generally a good bill. It eliminates extrapolation, except in cases of fraud or where there are high levels of payment error. It also establishes a badly needed appeals process. One thing that I feel is very important in our system is that there is always room for appeal, whether we're dealing with the judicial system or the tax system. I want to thank the Human Services Committee for taking the time to meet with us and for taking the time to draft this very fine bill.

Nancy Trawick-Smith  
Director

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March 2, 2005

Human Services Committee  
Legislative Office Building  
Hartford, CT 06106-1591

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To the Honorable Representatives and Honorable Senators of the Committee on Human Services:

Ref: Committee Bill No. 21

Subject: An Act Concerning Audits Conducted by the Department of Social Services.

The following is only one example of many examples that illustrate why there is support of Committee Bill Number 21, which basically corrects the misapplication in determining overpayments related to the non-medical Homemaker and Companion services rendered under the Connecticut Homecare Program for Elders.

**Three Actual Audits**

| Company Audited                         | <u>A</u>    | <u>B</u>    | <u>C</u>   |
|---|-------------|-------------|------------|
| Claims                                  |             |             |            |
| Total Claims                            | 54733       | 24029       | 6321       |
| Amount of claims Audited                | 96          | 96          | 95         |
| Percentage of Universe                  | 0.2%        | 0.4%        | 1.5%       |
| Claims with Errors                      | 4.00        | 5.00        | 5.00       |
| Total Error Dollars                     | \$166.74    | \$294.20    | \$135.20   |
| Extrapolated Error Amount per DSS Final | \$95,064.38 | \$73,638.87 | \$8,995.78 |

**Example of Administrative Error:**

An employee signs an Activity Sheet attesting to rendering homemaking service to the client. The client also signs the Activity Sheet attesting to the fact that the employee rendered the homemaking service. The Activity Sheet reflects the time the service began and the time the service ended. However, the homemaker did not indicate all the tasks performed, that is, the Homemaker did not indicate she vacuumed, swept the floors, and prepared a meal.

**Audit:**

Three to four years later DSS audits the company. An audit consists of comparing the DSS payments with the Service Order and the Provider's Activity Sheets for accuracy. In addition, the Activity Sheets are reviewed for completeness; did the client and the homemaker sign them, are the dates and times correct, are the tasks performed indicated on the Activity Sheets, etc. In our example, DSS would decide the above Activity Sheet (claim) is an error, because the DSS auditor judges that more tasks should have been done in the time allotted. Therefore, DSS claims an overpayment has occurred. **Keep in mind that this is not a financial error.**

**Actual Dollar Amount of Errors Found:**

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At the conclusion of the audit there were 4 of these administrative claims found. Lets assume that these 4 claims represented the claims found in the actual audits listed above for Company A. There would be a \$166.74 error, which DSS consider overpayments

**Extrapolation:**

With this information, DSS would use extrapolation to determine how much money to recoup from the company. Again, assuming Company A above, \$95,064.38 would be recouped from the company, because DSS considers this an overpayment. DSS tells us that this is not a penalty.

**Appeal Process:**

The company's only option for appeal is to Mr. Jim Wietrak, DSS Director of Quality Assurance. His decision is the ultimate decision. This is not a third party independent unbiased decision.

**Department of Labor:**

According to the Department of Labor, the service was rendered and the employer must pay the employee for performing the service. This is contradictory to DSS.

**What does it All Mean?**

It means the small business is paying the employee for the service.

It means the small business pays Medicare, Social Security, SUTA, FUTA, Workers Compensation insurance, Liability insurance, etc. on that employee's wage.

It means the client receives a service from the small business in which DSS does not have to pay for it.

It means the small business pays a ridiculous, extrapolated amount of money to DSS for a service the client received.

**Summary:**

As a member of the CT Non-Medical Homemakers and Companions Association, which is a non-paid association of small businesses, whose membership continues to grow, and has no paid lobbyists requests that Committee Bill 21 passes. Extrapolation must be eliminated, an independent third party appeal process must be implemented, and DSS must submit a written plan detailing the specific criteria that we are to meet. Keep in mind:

- Our justice system allows for several appeal processes, whether it is criminal, civil, or arbitrated; also,
- Our town governments have an appeal process for zoning, property taxes, etc; and,
- Considering taxation, there is an appeal process with the Internal Revenue Service

Note: In the above appeal processes, an individual who has an interest in the matter must recuse himself/herself. This is not the case in our current appeal process to DSS.

**A Last Note**

On May 13, 2004, at a meeting held at the Legislative Building, Senator Andrew Roraback asked DSS how many cases of fraud had been found in the non-medical Homemaker/Companion audits since 1998. The reply was none.

Respectfully,



Robert Covillion  
Member of CT Non-Medical Homemakers and Companions Association

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T19

Testimony for  
Human Services Committee Bill No. 21  
By Susan Esons  
Member of CT. Non-Medical Homemaker and Companion Assoc.

March 3, 2005

Senator Handley, Representative Villano and distinguished members of the committee.

I am asking you to vote yes and support Bill No. 21. An act concerning audits conducted by the Department of Social Services.

We providers have a responsibility to provide the service requested and to bill accordingly. Fraudulent billing should not be tolerated.

There has to be a better way than is currently practiced to find fraud and abuse and to test program integrity. Bill 21 provides that.

Currently audits are about picky paper work details and results can be financially very damaging. In our research other states do not have such a punitive approach.

DSS will tell you that paperwork is their only way of knowing if service was provided. Even if a client or family member is willing to testify that the service was provide it is not accepted. Only the 100% correct paper work.

Correct to their interpretation. There is a lack of written documentation as to what is needed to be 100% correct. This is a standard that is impossible to meet in any situation.

We have to find a way out of this mess.

We were asked to provide the service, the service was provided, we paid the employee, we were reimbursed. To then have it taken away and then extrapolated to where one so called error could cost you \$4,000 is an insult.

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It has even driven some providers to stop providing service to state clients. It is not worth the liability and is not affordable.

Extrapolation still exists today despite many talks with DSS. It is my opinion unless it is legislated the practice will not stop. The federal government has just dropped the practice of extrapolation except in an ongoing high level of error that has not corrected with time given to do so. Why can't the State of CT. drop it?

You the legislative body have asked us to try and work out our differences with DSS. This has not worked to our satisfaction. Others have tried over the years as well on these issues.

Extrapolation the killer still remains.

We have not received the rules in writing.

We are not comfortable going forward with out a neutral third party to resolve differences.

This is why you must vote in favor of Bill 21. We don't just want talk we want action.

I would like to remind you that we are only reimbursed \$13.52 per hour for Companion Service. Out of this we have to pay the Companions wage, social security and other payroll taxes, workers compensation, bonding and liability insurance plus all other overhead. Most of us have had to add administrative staff to check and double check paper work to ensure 100% compliance. We use to use this time to interact with our clients making sure we were doing what they needed to their satisfaction in a professional manner.

I have not had time to really find out the details of the proposed ad hoc peer review panel but at first glance it sounds very good and is a move in the right direction.

Please support Bill 21. Thank you.

*Jusan Coons*

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860-564-8931

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Good morning and thank you for the opportunity to speak to this committee on SB 21.

My name is Monique Allard and I am here on behalf of Quality Homemakers, Inc. and the Connecticut Non-medical Homemakers and Companions Association.

My purpose in addressing this committee is to provide you, its members, with evidence of my company's experience with the audit process, specifically item (4) and extrapolation. I have for you a series of documents, beginning with this statement. I hope to illustrate to you the cumbersome nature of the audit process and the punitive effect of the extrapolation factor in determining how companies such as mine reimburse the Department of Social Services for errors in billing/record keeping.

On the third page of your packet you will find a "Schedule of Extrapolated Error Amount." This document was part of the DSS draft report based on the department's review of my records from July 1999 to June 2001. Of the 96 records reviewed, 14 were found to contain some evidence of error—and once extrapolation took place—my error amount was determined to be \$1.423 million. Now, I want to point out to you that during that two-year period, Quality Homemakers billed for and was reimbursed \$2.648 million. Based on these figures—one can conclude that 53%—literally half of my documents were in error in some way, although only 14 "samples with errors" were identified of the 96 records audited—14%. (Note: these figures were part of the *draft* report.)

Upon further review, DSS followed the draft with report # MA-CHP-03-30 (page 4). The numbers, you will see, are significantly lower. And yes, DSS re-reviewed the records and revised the report (#MA-CHP-03-30 [r]) with the final figure for Quality Homemakers' extrapolated reimbursement at \$46.6-thousand—roughly 2% of my claims for that 2 year review period (page 5).

No doubt—I was relieved by the final figure. However, \$46-thousand is a substantial amount of money, especially when there was no allegation of fraud, misconduct or failure to provide services.

Because Quality Homemakers is headquartered midway between the northern and southern borders of Eastern Connecticut, we have been

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p. 1

fortunate enough to develop a broad base of employees and clients from Montville to Thompson. We do a large volume of business with the regional access agency, Connecticut Community Care, Inc., Eastern Office. Our company was able to provide the reimbursement to DSS. However, I would have preferred to turn that money over to my employees in the form of a pay raise or gasoline stipend. Indeed my liability, workers compensation and overhead expenses rise while my employees gasoline and living expenses are also on the increase. I shudder to think of the potential financial impact the next extrapolated audit will have on my company.

My 175-plus employees are the backbone of the Homecare for Elders Program. They are caring individuals who are often the first line of defense in keeping our elderly out of nursing homes and skilled care facilities. They are human and like anyone, can make mistakes in their paperwork. On page 6 you will find a series of comments about some of my workers as a result of a recent quality assurance audit conducted by CCCI. I hope you will find it informative. Homemaker and companion agencies like mine are providing an invaluable service to the people of this state. All we ask is that we are not punished in the process.

I will be happy to answer any questions you might have and I sincerely thank you for your time and consideration.

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**EXHIBIT II**  
**SCHEDULE OF EXTRAPOLATED ERROR AMOUNT**  
**QUALITY HOMEMAKERS, INC.**  
**PROVIDER #4081767**

|                                  |                |
|----------------------------------|----------------|
| PAID CLAIM UNIVERSE              | 48,770         |
| SAMPLE SIZE                      | 96             |
| OVERPAYMENTS                     | 14             |
| UNDERPAYMENTS                    | 0              |
| SAMPLES WITH ERRORS              | 14             |
| SAMPLE ERROR DOLLARS             | \$ 2,802.80    |
| SAMPLE ERROR DOLLARS/SAMPLE SIZE | \$ 29.195833   |
| EXTRAPOLATED ERROR AMOUNT        | \$1,423,880.79 |

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**EXHIBIT II**  
**SCHEDULE OF EXTRAPOLATED ERROR AMOUNT**  
**QUALITY HOMEMAKERS, INC.**  
**PROVIDER #4081767**

|                                  |              |
|----------------------------------|--------------|
| PAID CLAIM UNIVERSE              | 48,770       |
| SAMPLE SIZE                      | 96           |
| OVERPAYMENTS                     | 6            |
| UNDERPAYMENTS                    | 0            |
| SAMPLES WITH ERRORS              | 6            |
| SAMPLE ERROR DOLLARS             | \$ 229.70    |
| SAMPLE ERROR DOLLARS/SAMPLE SIZE | \$ 2.392708  |
| EXTRAPOLATED ERROR AMOUNT        | \$116,692.39 |

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**EXHIBIT II**  
**SCHEDULE OF EXTRAPOLATED ERROR AMOUNT**  
**QUALITY HOMEMAKERS, INC.**  
**PROVIDER #4081767**

|                                  |             |
|----------------------------------|-------------|
| PAID CLAIM UNIVERSE              | 48,770      |
| SAMPLE SIZE                      | 96          |
| OVERPAYMENTS                     | 2           |
| UNDERPAYMENTS                    | 0           |
| SAMPLES WITH ERRORS              | 2           |
| SAMPLE ERROR DOLLARS             | \$ 91.80    |
| SAMPLE ERROR DOLLARS/SAMPLE SIZE | \$ 0.956250 |
| EXTRAPOLATED ERROR AMOUNT        | \$46,636.31 |

000894

SB21

### Quality Homemakers

I would like to go to my church. I would like to go to yard sales. I would like to go to craft sales.

If I could change one thing it would be that they could apply cream on my mother's hands or legs when/where she needs it daily.

The quality is fine now. However, it took time and a lot of explaining to begin with. One is a hard worker. One is not.

Jean is a wonderful person. I wouldn't change anything.

Have a heart full of love, have responsibility, active in serving us, translates what I say and I wanted to say helped us solve difficult problems.

If I could change one thing about my companion service it would be more conscientious on the correct appointment(staffing) for the patient.

The quality of the companion service was excellent for my mother. We looked forward to their visits. A tremendous help for me.

If I could change one thing about my companion service it would be for her to leave her problems at home.

She is OK!

I would like my homemaker Paula Long to spend more time with me, so I can spend more time at the nursing home with my husband Al. She only brings me for 3 Hrs., and I would like her to take me shopping more often.

She is a very good homemaker.

Quality homemakers takes good care of me & gets me persons to give me the services I need to help me live here alone - at 87 yrs. Old it sure feels good that I can call on quality homemakers to help me out doing things I can no longer do. No matter what I call for to help me, they do find the right person. This way with the help available I'm living alone - Many thanks to your people who make this available.

Nothing it's perfect.

It's all okay the way it is. It's good. It's just what I need.

she is wonderful, very understanding.

I have found that most young people do not know much about cleaning (chores), the few that I have had.

Driver 2 hours each week. Very good.

I am quite satisfied with my caregivers. They are all great. I deeply appreciate them.

We have two homemaker providers to cover hours needed. Laura-Mon-Wed Fri, Bea-Tues-Thurs. We would like to have Bea on Saturday if possible.

They treat me like family. I love every one that comes here. Like I'm their mother with respect.

Lori, my sister's homemaker is very kind, has lots of patience and is very delicate in what she does for xxx. She keeps her trailer spotlessly clean, helps me take xxx to her doctors visits (6 of them), and even takes her grocery shopping in her wheelchair.

Because of my disability I can no longer take her myself.

The homemaker does her work as required.

I could not ask for a better person.....

000895



## CONNECTICUT NON-MEDICAL HOMEMAKERS & COMPANIONS ASSOCIATION

Two Pomperaug Office Park - Suite 203 - Southbury, Ct 06488-229 - Phone 203-264-2062

March 2, 2005

*Area T23 |*

Human Services Committee  
Legislative Office Building  
Hartford, CT 06106-1591

To the Honorable Representatives and the Honorable Senators of the Committee on Human Services:

Ref: Committee Bill No. 21

Subject: An Act Concerning Audits Conducted by the Department of Social Services.

This letter has been written in support of Committee Bill Number 21, which basically corrects the misapplication in determining overpayments related to the Homemaker and Companion services rendered under the Connecticut Homecare Program for Elders. Specifically, we support the following to correct the misapplication of overpayments:

- To eliminate extrapolation,
- To establish an appeal process to a disinterested third party,
- To adopt and distribute a set of rules and regulations so worded that they are not subject to misinterpretation.

With this in mind, and for those who have not heard of our experiences, the following information is supplied to help you understand the reasoning for our request for the raising of a bill to correct the misapplication of overpayments.

### Scope

The Department of Social Services (hereinafter referred to as DSS) Quality Assurance Group of the Medical Unit began performing audits approximately in 1998/99 to determine if overpayments had been made to Homemaker/Companion Service Providers (hereinafter referred to as Service Provider). Keep in mind DSS expects 100% accuracy, yet performs audits by taking a small sampling of the actual amount invoiced and paid to a Service Provider. An audit consists of comparing the DSS payments with the Service Order and Provider's Time/Activity Sheets for accuracy. In addition, the Activity Sheets are reviewed for completeness; did the client and the homemaker sign them, are the dates and times

Page 1 of 5

000896

correct, are the tasks performed indicated on the Activity Sheets, etc. After an audit, any errors found, including administrative errors, are deemed to be overpayments, and DSS recoups this money from the Service Providers. However, the overpayment is not recouped at the actual dollar amount billed. DSS uses an extrapolation process, to determine how much money is to be recouped based on the actual amount found to be in error. Here are three actual examples of companies audited, the actual amount of money found to be in error, and the extrapolated amount of money to be recouped from the Service Provider:

### Three Examples of Actual Audits

| Company Audited<br>Claims                      | <u>A</u>           | <u>B</u>           | <u>C</u>          |
|--|--------------------|--------------------|-------------------|
| Total Claims                                   | 54733              | 24029              | 6321              |
| Amount of claims Audited                       | <b>96</b>          | <b>96</b>          | <b>95</b>         |
| Percentage of Universe                         | 0.2%               | 0.4%               | 1.5%              |
| Claims with Errors                             | <b>4.00</b>        | <b>5.00</b>        | <b>5.00</b>       |
| Total Error Dollars                            | <b>\$166.74</b>    | <b>\$294.20</b>    | <b>\$135.20</b>   |
| <b>Extrapolated Error Amount per DSS Final</b> | <b>\$95,064.38</b> | <b>\$73,638.87</b> | <b>\$8,995.78</b> |

Note:

- **Company A had \$166.74 found to be in error and had to pay back \$95,064.38.**
- The sample size becomes less representative of the universe (Company C had only 95 claims looked at from 6,321 total claims, while Company A had 96 claims looked at from 54,733 total claims).
- **DSS wants 100% accuracy. However, DSS uses an extremely small sampling of the total claims to determine an audit error. In determining monies for recoupment, DSS applies an extrapolation process dealing with averages, which is not 100% accurate.**

Additionally, the Service Providers are required to pay back monies based on an extrapolated amount for **administrative errors, not financial errors**. Not only is this a misapplication of overpayments, but also is considered an unfair practice when the service was rendered to the client. Example would be:

- An employee signs the Activity Sheet attesting to rendering homemaking service to the client. The client also signs the Activity Sheet attesting the employee rendered the homemaking service. However, if the homemaker did not indicate all the tasks performed as a Homemaker; that is, the Homemaker did not indicate she vacuumed, swept the floors, and prepared a meal for the client to eat. DSS can claim this is an

error because the auditor makes a judgment that more tasks should have been done in the time allotted. Less may have been done at the clients' request so that something else may be attended to. This error could require recoupment of monies, which are extrapolated and to be paid back at many times the billed amount. Refer to the above extrapolation example.

- o **Note:** According to the Department of Labor, the service was rendered and the employer must pay the employee for performing the service. This is contradictory to DSS. It means the small business is paying employees to provide services to clients for which the small business must pay back monies to the State at an extrapolated amount.

#### **Recent Events**

DSS practices are questionable. The heavy handedness for picky paper work details is threatening Service Provider Agencies across the State. In 2003, several Homemaker & Companion Service Providers met to determine how best to resolve this dilemma. Our efforts have led to the formation of the Connecticut Non-Medical Homemakers & Companions Association. Membership has grown to approximately 105 Service Providers. Throughout the State there are in the neighborhood of 200 Homemaker & Companion Service Provider Agencies employing approximately 7,350 employees, serving approximately 14,000 elderly persons within our state of Connecticut, under the Connecticut Homecare Program for Elders. This non-paid association of small businesses, whose membership continues to grow, has no paid lobbyists.

**As you may or may not be aware, on May 13, 2004, at the Legislative Building,** Senator Andrew Roraback, along with other Legislative Representatives, met with DSS representative and members from the Connecticut Non-Medical Homemakers & Companions Association to discuss the misapplication of overpayments and the unfair practices related to the DSS audits. Also in attendance, were representatives from Connecticut Community Care, Inc., and The Connecticut Association for Home Care, Inc. It was apparent that legislative action was needed. At this meeting, Senator Andrew Roraback asked DSS how many cases of fraud had been found in the non-medical audits since 1998. The reply was none.

#### **Key Issues / Proposals Discussed:**

- **Key Issue:** DSS uses Extrapolation in the audit process to recoup monies for what are considered overpayments (refer to example above). DSS stands firmly behind this practice.
  - o **Proposal:** We want extrapolation stopped. Committee Bill 21 is similar to Section 935 of the Medicare Reform Bill, which passed in September of 2003. It states:
    - “(3) LIMITATION ON USE OF EXTRAPOLATION. A

Medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless the Secretary determines that –

- “(A) there is a sustained or high level of payment error; or
- “(B) documented educational intervention has failed to correct payment error.

- **Key Issue:** Our only option for appeal is to Mr. Jim Wietrak, DSS Director of Quality Assurance. When there are discrepancies, his decision is the ultimate decision. This is not an independent unbiased decision.
  - o **Proposal:** We are asking that Legislative action be taken to adopt an independent appeal process that takes it out of the sole responsibility of the DSS. Keep in mind:
    - Our justice system allows for several appeal processes, whether it is criminal, civil, or arbitrated; also,
    - Our town governments has an appeal process whether it be zoning, property taxes, etc; and,
    - Considering taxation, there is an appeal process with the Internal Revenue Service
      - Note: In the above appeal processes, an individual who has an interest in the matter must recuse himself/herself. This is not the case in our current appeal process to DSS.
- **Key Issue:** Currently any administrative errors, which are NOT fraud or financial errors and even though services were rendered, must be considered an error and subjected to extrapolation for recoupment to DSS. (Note: again DSS states this is not a penalty.)
  - o **Proposal:** We are asking for legislative action to eliminate recoupment of monies for administrative errors. In addition, we want DSS adopt and distribute a set of rules so worded that they are not subject to misinterpretation.
    - (Ex: refer to above extrapolation example.)
    - It has been found in researching other States, that there is not such a punitive approach taken. This information is available upon request.
    - The federal government does not require DSS to audit in the manner that they do.

In summary, there are many other examples that can be shown where the misapplication of overpayments have occurred and resulted in an exorbitant amount of money being recouped by DSS. At this time, we are not sure when we should present all the examples of administrative errors, but they must be considered in order to adopt and comply a set of

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rules and regulations, so worded, that they are not subject to misinterpretation. There has been a hesitancy of DSS to put this in writing.

We are forced to seek legislative action as all efforts to affect change with DSS have failed. Legislation is needed to change these heavy handed and unfair practices and to hold DSS accountable to fair practices.

We thank you in advance for your time and look forward to hearing from you.

Respectfully,

Steering Committee

Robert Covillion  
Janice Creighton  
Susan Esons  
Albert Garrido

Fatima Baptista-Palais  
Ann Radl  
Newton Schoenly  
Nancy Trawick-Smith

## Helping Hands, Inc.

000900

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Two Pomperaug Office Park, Suite 203  
Southbury, Ct 06488-2291

March 2, 2005

To: Human Services Committee  
State of Connecticut

SB 21

Re: DSS Audit Guidelines

Over the last several years, audits on the providers for the Connecticut Home Care Program For Elders have proven to be extremely frustrating to the provider agencies.

The program guidelines are often changed in the middle of a contract without notification. Example- Michelle Parsons recently told a staff member from one of the Access agencies that the program would no longer pay the homemaker rate for transportation which they have been doing for quite some time. They would only pay the companion rate. The provider agencies have not been informed about this. According to the current extrapolation process (I am using my last audit figures), the cost to me for this decision on one two hour job would be:

3.81(homemaker rate) minus 3.38(companion rate) equals 43 cents multiplied by 2 (hours) equals .86 cents. Multiply this by my field percentage (20) equals 17.20 that I will be expected to pay back on this one two hour job. I was originally paid 30.48 for this job and paid my staff person \$20.00 including taxes, unemployment and workers compensation.

There should be written guidelines as to what is expected of the providers concerning paperwork. It is important that the providers very clearly know what paperwork is required. The contract does not state what is expected. The guidelines should not be able to change within a contract period. Jim Weitrak, of DSS has promised us on two different occasions, once at the last legislative meeting, that guidelines would be provided to us but as of this date, that has not happened.

It is of great concern to the providers that the quality that is audited is not quality of service but quality of paperwork.

Alternate documentation has been accepted on some audits but not on others. There should be very clear guidelines as to what alternate documentation will be accepted.

Phone (203)264-2062 Fax (203)262-6973 E-Mail [helpinghandsinc@earthlink.net](mailto:helpinghandsinc@earthlink.net)

000901

Written Testimony  
Submitted by  
**Charter Oak Health Center, Inc.**  
21 Grand Street  
Hartford, Connecticut  
March 3, 2005

To: Senator Handley, Representative Villano and members of the Committee on Human Services

Charter Oak Health Center, Inc. writes in strong support of Committee Bill No. 21, An Act Concerning Audits Conducted by the Department of Social Services, referred to the Committee on Human Services and Co-Sponsored by Senator Handley, 4<sup>th</sup> District, Rep. Villano, 91st District; and Senator Harp, 10<sup>th</sup> District.

Community Health Centers are faced with the challenge of ensuring adequate reimbursement to support the costs of providing care to Connecticut's underserved populations. The State's ability to reimburse health centers on the federally required reasonable cost based basis has been impacted by changes in payment methodologies and eligibility requirements. In light of these factors, Charter Oak Health Center, Inc. believes Committee Bill No. 21 will assist in mitigating some of the negative impact of the cost shift to the health centers, where there is insufficient funding to support care delivery for these un- and underinsured populations. As the funding for healthcare is reduced, the affected patients become uninsured and self-pay, which places the burden for providing the care without reimbursement directly on the community health centers that can least afford to financially support the care.

Charter Oak Health Center, Inc., (COHC) is a federally qualified, 501 (C) 3, JCAHO accredited, not-for-profit federally qualified community health center, located at 21 Grand Street in Hartford, Connecticut. It was founded in 1978 and has been providing comprehensive primary health care services continuously since 1979 to un- and underserved populations from the greater Hartford metropolitan area with particular emphasis on ensuring access to affordable comprehensive health care for Hartford's residents in the southern portion of the City. Services provided include medical, dental, behavioral health services for all life cycles, women's health services, outreach, a healthcare for the homeless program, a school based health center, a nutrition program, and an in-house pharmacy. At COHC approximately 10% of total encounters are for non-reimbursable enabling services, such as Case Management, Patient Education, Outreach, and Nutrition Counseling, which are essential to bring care to the patients who would otherwise be lost to care.

According to calendar year 2004 COHC patient statistics, 35.5% of patients served were uninsured, 50.3% Medicaid and 6% were Medicare. Approximately 98% of the total population is at or under 100% of the federal poverty level.

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Inadequate funding equates to a reduction in funding, and a reduction in funding without correction results in a gradual liquidation of the community health center safety net in Connecticut that provides for those in greatest need in the State. Members of the Committee, we ask for your support of this bill to ensure services continue without interruption to Connecticut neediest populations.

Respectfully submitted,

Alfreda D. Turner  
President & CEO  
COHC

Gary A. Rhule, MD  
Vice-President of Health  
Services/Medical Director  
COHC

John Koomson  
Vice-President  
of Finance  
COHC

000903



## Southwest Community Health Center, Inc.

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BRIDGEPORT, CT 06605  
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FAX (203) 382-2954

TESTIMONY IN SUPPORT OF COMMITTEE BILL NO. 21  
AN ACT CONCERNING AUDITS BY THE DEPARTMENT OF SOCIAL SERVICES  
REFERRED TO THE HUMAN SERVICES COMMITTEE

Submitted by:  
Katherine S. Yacavone  
President/CEO

March 2, 2005

Southwest Community Health Center (SWCHC) is a Federally Qualified Health Center (FQHC) which provides comprehensive, accessible, out-patient medical, medical specialty, dental and behavioral health services to residents of Greater Bridgeport. Since 1976, SWCHC's services have expanded to meet the community's health care needs and include an HIV/AIDS and Homeless Health Care program. Care is delivered from four sites and nine homeless shelters, all licensed by the CT Department of Public Health. In calendar year 2004, SWCHC rendered services to 12,697 unduplicated persons in 63,490 patient visits. SWCHC's payor mix for 2004 indicates that 40% of all patients were uninsured, 42% have Medicaid coverage, 11% have SAGA coverage, 4% are Medicare recipients and 3% have private insurance.

SWCHC endorses Committee Bill No. 21 regarding development and implementation of proposed audit procedures to be followed by the Department of Social Services ("DSS") when auditing the Medicaid billing of federally qualified community health centers. SWCHC has had a negative experience with past DSS audits of billing for services provided to Medicaid beneficiaries and, therefore, particularly supports this bill that addresses (1.) clerical errors not being viewed as fraudulent, (2) not using the methodology of extrapolation to compute overpayment or underpayment, (3) establishment of an administrative appeal process that includes a hearing prior to any adverse action being taken, and (4) reimbursement for services to the FQHCs by the DSS at cost-based rates.

Further, SWCHC would support interpretation and clarification of Medicaid statutes relating to provider billing, "medical necessity," staff credentialing and competency, particularly in the area of out-patient substance abuse. For example, application of statutes relevant to medical care delivery is being used as standards for the delivery of behavioral health care. These medical standards are not always applicable and are often



**Joint Commission**  
on Accreditation of Healthcare Organizations

000904

in conflict with regulations of other agencies governing the provision of behavioral health (i.e. outpatient substance abuse treatment) services. Statutes that are subject to interpretation by the DSS, without a right of appeal, can lead to imposition of heavy fines to a community health center. This scenario is often caused by a difference in interpretation of the statute by the health center and DSS when the health center believed it was operating within the DSS standards.

Human error can result in clerical errors in the delivery and billing of close to 30,000 Medicaid visits per year. These clerical errors do not demonstrate an intent to commit fraud by the health center. Imposition of fines by the DSS based upon extrapolation of data based upon these errors is predicated upon an "intent to commit fraud" mind set, when in actuality an inadvertent keystroke was the root of the problem.

SWCHC fully understands that DSS has a statutory right and obligation to conduct an audit. However, an audit conducted under the parameters outlined in Bill 21 would lead to a more fair process, better communication and a better relationship between the DSS and all providers.

SWCHC also supports the use of cost reports to set Medicaid FQHC rates. The Prospective Payment System (PPS) rate setting methodology was flawed from the outset. The use of cost reports, as was done prior to implementation of the PPS, is a more accurate means to identify costs, provided that artificial caps and screens are not used in the methodology.

The sole purpose of health centers seeing Medicaid clients is to provide persons in need of health care with services to improve their health status and quality of life. Improved health status enables people to live more productive lives and become contributing members of the community.

Given the fact that FQHCs also provide services to the uninsured, for which Medicaid funds cannot be used, the idea that an FQHC can "get rich" on its Medicaid reimbursement is absurd and makes no practical business sense. SWCHC's mission is to provide care to all impoverished populations in Bridgeport, the State's largest City, whether covered by Medicaid or uninsured.

We welcome any fair and honest review of the services we provide. Audit outcomes as performance improvement opportunities are built into SWCHC's business plan in order to provide the best quality care that is possible. Adoption of Bill No. 21 will enhance the relationship between the DSS and the health centers. The DSS and FQHCs should not be adversaries but partners because we share the same mission, i.e. to ensure that Medicaid beneficiaries receive quality medical services. Medicaid services are a wonderful benefit to persons in need. Providing these services is an art and a mission – not just a business.

Thank you.

000905



**Testimony of the Connecticut Association of Not-for-profit Providers  
For the Aging**

**To the Human Services Committee**

**Submitted March 3, 2005**

HB 5693  
HB 5697

*CANPFA members serve thousands of people every day through mission-driven, not-for-profit organizations dedicated to providing the services people need, when they need them, in the place they call home. Our members offer the continuum of aging services: assisted living residences, continuing care retirement communities, residential care homes, nursing homes, home and community based services, and senior housing.*

**Senate Bill 21, An Act Concerning Audits Conducted by the Department of Social Services**

CANPFA supports this legislation, which would bring greatly needed fairness and balance to the current auditing process. Medicaid providers, and particularly smaller providers, are at a disadvantage when audited by the Department of Social Services. The actual audit can cover several years of billing and one lone bookkeeping error can be extrapolated into a major balance owed by the provider, even when there is no evidence that this error was intentional or committed beyond this one finding. Recently all skilled nursing facilities were subjected to ten-year credit balance audits that were conducted by outside firm working on a commission basis. The audits resulted in large balances owed by the providers, but larger providers who were able to expend the time and resources to review the audit results were able to reduce the auditor's findings significantly. Clearly there were flaws in the auditing process, but unfortunately, smaller providers did not have the resources to challenge it. CANPFA strongly supports this long overdue improvement to the audit process.

**House Bill 5027, An Act Concerning the Use of State Supplement Benefits to Pay for Assisted Living Housing**

CANPFA supports any and all efforts to promote community-based services and applauds the concept of using public funds to finance assisted living services.

**House Bill 5291, An Act Concerning Full Payment to Medical Assistance Providers Serving Dually Eligible Patients**

CANPFA supports the reinstatement of Medicaid funding for dual eligible Medicare patients receiving Part B Medicare services. Dual eligible patients are the 70,000 Connecticut residents who qualify for **both** Medicare and Medicaid, including many low-income elderly patients, nursing home patients, renal dialysis patients, and disabled patients of all ages. The funds were cut in 1999 when the state budget implemented a 1991 state law that eliminated the Medicaid reimbursement of the annual deductible and co-payment amounts for Medicare Part-B services provided to dual eligible patients.

Many nursing home residents rely upon medical care provided by physicians, dentists and other providers in the community. Those affected are patients who very often need comprehensive, if not intensive, medical and specialty care. The Medicare reimbursement does not cover the cost

000907

RICHARD BLUMENTHAL  
ATTORNEY GENERAL



55 Elm Street  
P.O. Box 120  
Hartford, CT 06141-0120

Office of The Attorney General  
**State of Connecticut**

*TESTIMONY OF  
ATTORNEY GENERAL RICHARD BLUMENTHAL  
BEFORE THE HUMAN SERVICES COMMITTEE  
MARCH 3, 2005*

I appreciate the opportunity to comment on Senate Bill 21, An Act Concerning Audits Conducted by the Department of Social Services (DSS).

The proposal would establish parameters for any DSS audit of certain human services providers. These parameters include written notice of the audit to the provider and a review process for the provider to challenge any audit results.

I am concerned that provisions in the legislation could weaken the state's ability to recover money fraudulently billed by a contractor and paid by the state.

For example, the proposal limits the audit to claims submitted within the previous calendar year. While initially an audit may review the most current claims, the legislation could prevent DSS from conducting a more expansive audit, if there is some irregularity with those claims or the audit raises concerns about claims submitted more than one year prior to the audit.

The proposal also prevents DSS from extrapolating payment errors over time unless there is a sustained or high level of payment error. In some cases, the contractor's failure to maintain adequate records may make such extrapolation necessary in order to ensure that all of the taxpayers' money is recovered.

DSS works with my office's whistleblower unit to uncover fraud in state contracts, in particular the billions of taxpayer dollars in human services contracts. While most of the providers are good, honest people, strict oversight is necessary to prevent contractors from wasting taxpayer's dollars or engaging in deliberate fraud.

I urge the committee to carefully consider the interest of protecting taxpayers' money in making any changes to the DSS audit process.

000908



Feb. 3, 2005

Bill #21 Hearing

Since the spring of 1998, my company has experienced DSS audits. I could hardly believe my first audit results. An auditor might find non-fraud "exceptions", and noting the dollar amount for that exception, would extrapolate that amount over the whole universe of the company's DSS clients and arrive at a sum that was hugely exaggerated relative to the noted "exception". If I contested such an exception, I would only be allowed an appeal with the head of the very department that was auditing the company in the first place. Even though I felt that the way audits were handled was unfair, I was forced to realize that I had to get into line with the audit techniques or lose my company. Since I was fearful of any further DSS "recoupments", my operational people went from being client centered to paper work centered, since the paper trail seemed all important, totally disregarding both our frail elderly clientele and workforce.

It was frustrating to realize that DSS did not care about the impact of their audits or about the service we were providing to their clients. Even after bringing legislative entities into the process to help mediate, DSS was adamant regarding the correctness of their auditing methods. It seemed that anybody other than DSS people could immediately see how unfair their auditing practices were. I became increasingly aware that DSS was recouping a lot of money from providers through their audits, even though little fraud had been uncovered. A frustrated group of provider competitors finally voluntarily gathered to try and get the attention of those who could affect audit change by legislative mandate. Finally, after many years of frustration and talk, Bill 21 has been proposed, which deals directly with our audit issues.

In an age of ever increasing paper work, passage of Bill 21, would signal that actual service of provider to client is still important. We providers know that we can provide a quality service and be accountable without the overwhelming burden of unrealistic and unfair audits.

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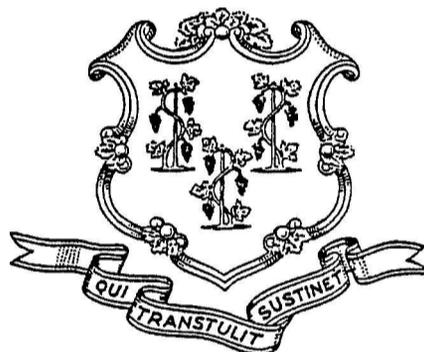
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# Department of Social Services

## Testimony Before the Human Services Committee



March 3, 2005

**Claudette J. Beaulieu**  
*Deputy Commissioner of Programs*

**Michael P. Starkowski**  
*Deputy Commissioner of Administration*  
Department of Social Services



Testimony

Good morning Senator Handley, Representative Villano and to the members of the Human Services Committee. My name is Claudette J. Beaulieu. I am Deputy Commissioner for Programs at the Department of Social Services. I am pleased to be joined by Michael P. Starkowski, the agency Deputy Commissioner for Administration. We are here this morning to testify on a number of bills on today's public hearing agenda.

HB 5290  
 HB 5699  
 HB 5706  
 HB 5693  
 HB 5027  
 SB 21

**S. B. No. 171 (COMM) AN ACT CONCERNING TREATMENT OF PAYMENTS FROM THE DEPARTMENT OF CHILDREN AND FAMILIES IN MAKING ELIGIBILITY DETERMINATIONS FOR PROGRAMS ADMINISTERED BY THE DEPARTMENT OF SOCIAL SERVICES.**

This legislation would provide for the exclusion of foster care and subsidized guardianship payments as countable income when determining initial and ongoing eligibility for any of the department's programs. Currently such payments are excluded when determining eligibility for the Medicaid program and recipients of such payments are excluded from participation in the Temporary Family Assistance program and thus these payments are not counted in that program. Federal law requires that these payments be counted when determining eligibility and benefit levels in the Food Stamp program. In addition, the bill would require the department to exclude the earned income of children for whom these payments are being made. Generally, the department excludes the earned income of children who are in school when determining eligibility for its programs. This bill would appear to require that we exclude the earnings of working 16 to 18 year olds who are not in school.

S.B. No. 171 appears to exclude foster care and subsidized guardianship payments in the Care 4 Kids child care subsidy program. This program does count these types of payments as income, although it excludes the income of the caregivers of these children. There are more than a hundred foster care families receiving Care 4 Kids subsidies and an additional number of subsidized guardianship families. This change would increase the child care subsidy for all of these families, reducing the amount of funding available for other needy families. In addition the earnings exclusion would increase expenditures in the Temporary Family Assistance program and raises questions of equity and fairness by limiting the income exclusion to such a narrow group of individuals. For these reasons, the department cannot support this bill.

**S. B. No. 762 (COMM) AN ACT CONCERNING ELIGIBILITY FOR THE STATE SUPPLEMENT PROGRAM.**

This bill would extend to the State Supplement program a provision in federal Medicaid law that provides for the exclusion of funds in a special needs trust for people with disabilities when determining eligibility for the program. Enacting this provision would result in increased costs to the state. Currently an individual receiving proceeds from a personal injury settlement typically becomes ineligible for the State Supplement program for the period of time that the proceeds are available to meet their basic needs. Under this provision there would be no such period of

**H. B. No. 5027 (COMM) AN ACT CONCERNING THE USE OF STATE SUPPLEMENT BENEFITS TO PAY FOR ASSISTED LIVING HOUSING.**

This bill would treat assisted living facilities, also known as managed residential communities, in the same manner as residential care facilities when providing benefits under the State Supplement Program. This bill raises a number of questions that would need to be answered before the department could support such a proposal. Currently the department sets rates for residential care facilities based on costs incurred. Is there an expectation that the department would do this for these types of facilities? Would the costs of providing State Supplement benefits to residents of these facilities be less than the alternative living arrangements that they currently have available to them? It would appear that the costs would exceed those of residential care facilities but would be less than skilled nursing home care. However fifty percent of the cost of skilled nursing home care is reimbursed by the federal government while State Supplement program costs are fully funded by the state. Would there be an expectation that the personal care services provided at these facilities would be covered by the State Supplement program or only the basic needs costs? Until there are answers to these questions it is not possible for the department to support this bill.

**S. B. No. 21 (COMM) AN ACT CONCERNING AUDITS CONDUCTED BY THE DEPARTMENT OF SOCIAL SERVICES.**

For the following reasons the department is opposed to S.B. No. 21.

Section 1 of the proposed bill undermines our successful audit process by restricting audits to the review of only one year's worth of claims and limiting the review to only 100 claims during that year. This, coupled with the restriction on the use of extrapolation, effectively guts the department's ability to monitor this program and provides a license to steal to those individuals that pray upon programs such as Medicaid when they see proper deterrents to theft and overpayments are not in place.

Moreover, the proposed legislation will jeopardize the state's Medicaid Federal Financial Participation (FFP) because its various restrictions on the audit process will be impossible to implement. In addition, the legislation conflicts with federal regulations relating to Medicaid program integrity insofar as Medicaid regulations require the State Plan to provide for the prepayment and post payment claim reviews that ensure proper and efficient payment of claims and management of the program.

By way of background, DSS has a staff of twenty-four auditors responsible for auditing the state's multi-billion dollar medical assistance programs. This includes the responsibility of monitoring payments to over 6,000 Medicaid providers that are paid over 16 million individual claims annually. Federal estimates of fraud and improper payments in the Medicaid program are over 10%. We believe that our auditing effort in partnership with the Office of Attorney General and the Chief State's Attorney's Office has acted as a deterrent to the rampant fraud other state's experience in their Medicaid programs. The legislation will remove the cornerstone of this important deterrent.

The present DSS audit process uses a statistically valid methodology to select samples and extrapolate the results of the audits. This is the only way to provide the necessary audit coverage of providers that bill tens of thousands of claims annually and are paid on these claims with little or no prepayment review. This methodology has been in use for twenty years and has withstood various challenges to its statistical validity.

Section 2 of the bill would increase the Medicaid rates for Federally Qualified Health Centers (FQHC) by the percentage change in allowable costs per annual cost report filings.

Effective January 1, 2001, state Medicaid rates for FQHC's were required to be determined in accordance with a Federal rate setting methodology. Section 702 of the Federal Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) required states to adopt revised rate setting for FQHC's effective January 1, 2001. The law set forth a prospective rate method with annual inflation updates each October 1 based upon the Medicare Economic Index (MEI). The law required states to base rates on, "100% of the average of the costs of furnishing services in 1999 and 2000 which are reasonable and related to the costs of furnishing services or based on other tests of reasonableness as the Secretary prescribes in regulations under Section 1833(a)(3) [Medicare method]..." The Department's method was approved in June, 2001 and individual center rates were issued retroactive to January 1, 2001 that increased state payments by \$430,000 on an annual basis.

Since adoption of the Federal rate prospective rate method, FQHC rates have been increased on October 1 of each year per the MEI update. The MEI applied to rates effective October 1, 2004 was 2.9%. The October 1, 2003 increase was 3.0%. In addition, rates for individual centers may and have been adjusted for cost increases associated with changes in scope of services. FQHC per visit rates for medical services range from \$102.08 to \$129.90 and the average is \$117.24.

FQHC's continue to be required to submit annual cost reports for the Medicaid program to the Department of Social Services' Office of CON and Rate Setting. The cost reports are not used for annual rates but are reviewed when considering requests by FQHC's for rate adjustments related to service changes.

While further review is necessary, it does not appear that the rate method under S.B. Bill 21 is consistent with the requirements of BIPA 2000 and CMS approval and federal cost sharing would be uncertain. Any changes to FQHC rate setting must be compliant with federal standards.

Again, we thank the committee for this opportunity to testify and we would be happy to answer any questions you may have.