

PA10-116

SB283

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**CONNECTICUT
GENERAL ASSEMBLY
HOUSE**

**PROCEEDINGS
2010**

**VOL.53
PART 16
4949 – 5314**

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HOUSE OF REPRESENTATIVES

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May 5, 2010

Those voting Yea	146
Those voting Nay	0
Those absent and not voting	5

DEPUTY SPEAKER ALTOBELLO:

This bill passing, in concurrence with the
Senate.

Will the Clerk please call Calendar 505.
Representative Olson.

REP. OLSON (46th):

Thank you, Mr. Speaker.

Mr. Speaker, I rise for -- to move for a
suspension of the rules for immediate consideration of
House Calendar Number 505.

Thank you.

DEPUTY SPEAKER ALTOBELLO:

Suspension of the rules for a transmittal.
Seeing no objection, so ordered.

Will the Clerk please call Calendar 505.

THE CLERK:

On page 27, Calendar 505, Senate Bill Number 283,
AN ACT CONCERNING AUDITS BY THE DEPARTMENT OF SOCIAL
SERVICES, favorable report of the Committee on
Judiciary.

DEPUTY SPEAKER ALTOBELLO:

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Representative Lyddy, you have the floor, sir.

REP. LYDDY (106th):

Thank you, Mr. Speaker.

Mr. Speaker, I move the joint committee's favorable report and passage of the bill.

DEPUTY SPEAKER ALTOBELLO:

The question before the Chamber is acceptance and passage.

Please proceed.

REP. LYDDY (106th):

Thank you, Mr. Speaker.

This bill addresses a concern that the Human Services Committee heard from a number of community providers, such as the Community Providers Association, the Connecticut Pharmacists Association, as well as Companions and Homemakers, among many, many others, in relation to the audit process with DSS.

As a member of the Human Services Committee as well as the working group on human services, we heard from these providers that this was a very burdensome process and costs them thousands of dollars for a very simple, clerical issues.

Mr. Speaker, the Clerk is in possession of an amendment. The amendment is LCO 4431. I ask that the

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Clerk please call the amendment.

DEPUTY SPEAKER ALTOBELLO:

Will the Clerk please call LCO 4431, previously designated Senate "A."

THE CLERK:

LCO Number 4431, Senate "A," offered by Representative Walker and Senator Doyle.

DEPUTY SPEAKER ALTOBELLO:

The Representative seeks to leave the chamber to summarize.

Seeing no objection, please proceed, sir.

REP. LYDDY (106th):

Thank you, Mr. Speaker.

Mr. Speaker, this amendment just makes a number of technical changes. It strikes line 32, a "shall" clause.

Mr. Speaker, I move adoption of the amendment.

DEPUTY SPEAKER ALTOBELLO:

The question before the Chamber is adoption of Senate "A."

Representative Gibbons, do you care to comment on Senate "A?"

REP. GIBBONS (150th):

Thank you, Mr. Speaker.

Yes, I strong -- stand in strong support of Senate "A," which really reflects the changes that we've been discussing for the past three months in the whole audit process.

As Representative Lyddy says, this has been a work in progress for a couple of months. We've heard from many of the nonprofits. We discussed this with the Commissioner of DSS. We've discussed it with everybody who is concerned. And it take a while to sort out what is actual in evidence and in reality today and what we need to do to make an audit process that is essential for DSS workable for the nonprofits.

I think this amendment works very well. It adds an appeal process, which we need. It requires a 30-day notice, a notification to the nonprofits of what they are going to be audited on, which once again is an essential part of the -- of any audit bill going forward.

This has been a great collaboration of both sides of the aisle and the departments, and all the people involved.

And I urge strong support.

Thank you, Mr. Speaker.

DEPUTY SPEAKER ALTABELLO:

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Thank you, Representative Gibbons.

Further on Senate "A?"

If not, I'll try your minds. All those in favor,
please signify by saying aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER ALTOBELLO:

Opposed?

The ayes have it.

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.

THE 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. The House
is voting by roll call. Members to the chamber.

DEPUTY SPEAKER ALTOBELLO:

Have all members voted? Please check the board,
make sure your vote is properly cast. If all members
have voted, the machine will be locked. Clerk, please
take a tally.

Representative Urban, for what purpose do you

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rise?

REP. URBAN (43rd):

To be recorded in the affirmative.

Thank you --

DEPUTY SPEAKER ALTOBELLO:

Representative Urban --

REP. URBAN (43rd):

-- Mr. Speaker.

DEPUTY SPEAKER ALTOBELLO:

-- in the affirmative. Thank you, Mr. Clerk.

The Clerk please announce a tally.

THE CLERK:

Senate Bill Number 283 as amended by Senate "A,"
in concurrence with the Senate.

Total Number Voting	145
Necessary for Passage	73
Those voting Yea	145
Those voting Nay	0
Those absent and not voting	6

DEPUTY SPEAKER ALTOBELLO:

This bill as amended passes.

Representative Olson, do we have anything from
you right now? I think not, actually. Nice having a
conversation, always, always fun.

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Those Absent, Not Voting

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THE CHAIR:

The bill is passed.

Mr. Clerk.

THE CLERK:

Calendar page 32, Calendar Number 230, File 344,
Senate Bill 283, AN ACT CONCERNING AUDITS BY THE
DEPARTMENT OF SOCIAL SERVICES, favorable report of the
committees on Human Services and Judiciary.

THE CHAIR:

Senator Doyle.

SENATOR DOYLE:

Thank you, Mr. President.

I move acceptance of the Joint
Committee's favorable report and passage of the bill.

THE CHAIR:

Question before the chamber is
acceptance and passage. Do you care to remark
further?

SENATOR DOYLE:

Yes, thank you, Mr. President.

What this bill does it deals with an issue that the
Human Services Committee spent a lot of time on this

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session and the -- the Human Services off session had a non-profit public hearing process and this issue was raised basically -- at issue here is that DSS processes and audits the non -- the non-profit providers who the DSS contracts with.

But before I get into the context, the Clerk has an amendment that's pertinent to the overall bill. Will the Clerk please call LCO 4431 and I be allowed to summarize.

THE CHAIR:

Would the Clerk please call LCO 4431 to be designated Senate A?

THE CLERK:

LCO 4431, which has been designated Senate Amendment Schedule A, is offered by Senator Doyle of the 9th district.

THE CHAIR:

Senator Doyle.

SENATOR DOYLE:

Thank you, Mr. President.

I move adoption of the amendment.

THE CHAIR:

The question before the chamber is the adoption of Senate A. Senator Doyle has requested permission to

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summarize. Is there objection? Seeing none, you may proceed Senator Doyle.

SENATOR DOYLE:

Thank you, Mr. President.

The amendment before deletes Sections 2, 3 and 4 from the file copy and so with -- which are provisions regarding -- limiting the -- the two -- the -- the scope of the audit two years and the extra -- extrapolation projections percent matter and also the payment error rate of 10 percent and I urge the chamber to support the amendment before us.

THE CHAIR:

Will you remark further? Will you remark further on Senate A?

If not, the Chair will try your minds.

All those in favor of Senate Amendment Schedule A, please indicate by saying Aye.

SENATORS:

Aye.

THE CHAIR:

All those opposed say Nay.

The Ayes have it. Senate A is
adopted.

Senator Doyle.

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SENATOR DOYLE:

Thank you, Mr. President.

With the adoption of Senate A, what this bill does now is it does two main things. Under the current audit process it provides two points: number one, it provides the non-profit providers the opportunity to go to court as the opportunity to appeal a final decision of DSS of the audit. So in the -- in the remote situation that -- that they feel like it's -- it's -- they're concerned enough about the final decision, they have a right to appeal to the Superior Court which is -- is a proper due process offer and also requires the Department of DSS to draft regulations for the audit process and present them to the Regulations Review Committee.

These are the remaining two provisions of the bill and I ask the chamber to support the bill.

Thank you, Mr. President.

THE CHAIR:

Thank you, sir.

Will you remark further on the bill as amended?

Senator Kane.

SENATOR KANE:

Thank you, Mr. President. Good evening.

THE CHAIR:

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Good evening.

SENATOR KANE:

Or is it morning? I too rise in favor of this bill. We did have this in the Human Services Committee as Senator Doyle spoke. A number of the providers came to us in regards to this issue and had some very deep concerns. I'm happy to say that I think we worked well on this bill together and I urge my colleagues for their support.

THE CHAIR:

Thank you, Senator.

Do you care to remark further? Do you care to remark further on the bill as amended?

If not, Senator Doyle.

SENATOR DOYLE:

Yes, Mr. President, I move the bill to the Consent Calendar.

THE CHAIR:

Without objection, so ordered.

Mr. Clerk.

Senator Looney.

SENATOR LOONEY:

Yes thank you, Mr. President.

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calendar page 32, Calendar 218, Substitute for Senate Bill 302; Calendar 223, Substitute for Senate Bill 380; Calendar 230, Senate Bill 283; calendar page 33, Calendar 235, Substitute for Senate Bill 216; calendar page 34, Calendar 258, Substitute for Senate Bill 274; calendar page 35, Calendar 316, Substitute for Senate Bill 278; calendar page 36, Calendar 318, Substitute for Senate Bill 418 and calendar page 40, Calendar 546, Senate Resolution Number 17.

Mr. President, I believe that completes the items placed on the Consent Calendar.

THE CHAIR:

The machine is open on the Consent Calendar.

THE CLERK:

The Senate is voting by roll call on the Consent Calendar. Will all senators please return to the chamber? The Senate is voting by roll on the Consent Calendar. Will all senators please return to the chamber?

THE CHAIR:

Senators please check the board to make certain that your vote is properly recorded. If all Senators have voted and all Senators votes are properly recorded, the machine will be locked

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and the Clerk may take a tally.

THE CLERK:

Motion is on passage of Consent Calendar

Number 1.

Total Number Voting	35
Those Voting Yea	35
Those Voting Nay	0
Those Absent, Not Voting	1

THE CHAIR:

Consent Calendar 1 is adopted.

Senator Looney.

SENATOR LOONEY:

Yes thank you, Mr. President.

Mr. President, I would yield the floor to any members for announcements or points of personal privilege.

THE CHAIR:

Are there announcements or points of personal privilege? Are there announcements or points of personal privilege?

Seeing none, Senator Looney.

SENATOR LOONEY:

Thank you, Mr. President.

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are not?

COMM. M. STARKOWSKI: You know, it's difficult, Representative Gibbons. Those are some of the discussions we've been having with the independent on -- entity that's going to have to do the evaluation because they brought to our attention that the sample size is going to be so small but we're going to try to work with the number of people that we have. Again, you know it's -- it's a freedom of choice.

REP. GIBBONS: Right

COMM. M. STARKOWSKI: And I think if you were at the meeting a couple of weeks ago just on PCCM, you would have also seen that were a number of people that joined PCCM and then stayed on PCCM for a month or two and then moved back to MCO. So I think you're going to see that churning back and forth until the clients actually understand. And whether they make a personal decision, are they getting better service now that they're working in a, quote, PCCM environment, instead of when they working in an MCO environment.

REP. GIBBONS: Well, we've testimony that they're certain hospitals and physicians who would like to join it. So I hope that the evaluators discuss -- talk to those groups who are prohibited from participating in a PCCM because they're not within the pilot regions and see what they have to say?

COMM. M. STARKOWSKI: Okay.

REP. GIBBONS: So that's one question.

Going on to extrapolation, because I work -- helped you work --

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COMM. M. STARKOWSKI: Yes.

REP. GIBBONS: -- with that in 2005. What is the dollar amount under which we exempted people

from being subject to the extrapolation? Was it \$150,000?

COMM. M. STARKOWSKI: Yes, it was. Yes, it was.

REP. GIBBONS: Would it make sense to raise that amount at all?

COMM. M. STARKOWSKI: No. I think it's work out pretty good. We actually have exempted a number of individuals from -- or entities from the extrapolation. I think it was in the 30- or 40-number range. We -- we actually don't get a lot of criticism from our providers in the audit process. Once the audit is completed, the audit works back to John McCormick -- is our new head of a quality assurance, it goes back to him. He reviews it. The providers have an opportunity to appeal back to John.

REP. GIBBONS: Uh-huh.

COMM. M. STARKOWSKI: John will then review audit findings again and work with the entity. One of the misconceptions is that we extrapolate all the clerical errors.

REP. GIBBONS: Uh-huh.

COMM. M. STARKOWSKI: We just make a differentiation with providers because a number of providers will try to claim that most of the errors are considered clerical errors.

REP. GIBBONS: -- clerical errors. Right

COMM. M. STARKOWSKI: They don't have the documentation of -- of an assigned physician for an order, and they say it's a clerical error. And we say, no, because it literally has to be a doctor's order to get paid -- reimbursed for the service.

So we think that the process has worked fairly well. Even the provider associations we've

worked with have worked with us through this process and, you know, as commissioner of DSS, we do receive quite of few concerns from provider groups on a number of issues and this has not been an issue --

REP. GIBBONS: -- It's not one of them.

COMM. M. STARKOWSKI: -- where we've received any major concerns. One or two provider's here and there with their particular. But when that happens, they can appeal to me. We work with our legal counsel. We look and see if all of the criteria was appropriate, whether the audit was done appropriately, whether the exceptions are done appropriately, and then we work with the provider. And a number of the providers, too, in the event that they do owe us significant dollars, we'll work through a repayment plan.

REP. GIBBONS: And what is the look-back period right now for an audit?

COMM. M. STARKOWSKI: You know, the audits will go back to anywhere from two to three to four years, depending on the service and the provider. We hope to increase the number of audits, which may not make providers happy, but the audits will be done more timely because we did get an authorization for 10 new staff in the audit division in DSS, and actually, two staff in the Attorney General's Office to work with us on some of those audits where we do find fraud or abuse.

REP. GIBBONS: Okay. Thank you.

One last question, on SB 281 on the public participation. We've certainly heard from DSS that there is ample time and room for public participation, but I believe the bill also adds two psychiatrists to the preferred drug bill or am I thinking of the wrong bill?

COMM. M. STARKOWSKI: I think that was another bill I testified on last week --

COMM. M. STARKOWSKI: Good afternoon

REP. AMBERCROMBIE: It's nice to see you

COMM. M. STARKOWSKI: Same here

A VOICE: (Inaudible.)

REP. AMBERCROMBIE: Well, that's true, but let's say it like it is.

Thank you for being here, Commissioner, and for waiting while we had to fix the microphones.

I'd like to ask some questions about the auditing process at this point, and I'd like to piggyback a little bit on what Representative Gibbons had talked about. What's extrapolate?

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COMM. M. STARKOWSKI: Extrapolate is where we take -- we'll take a sample --

REP. AMBERCROMBIE: Uh-huh.

COMM. M. STARKOWSKI: -- and then depending on that sample -- it's a representative sample of, let's say it's 10,000 claims, and we'll take a sample of 100 claims and if your dollar value in a 10,000 claims was \$100,000, then we'll look through the cost of every error or every abuse or every unidentified document, whatever it is that we're auditing, and let's say it comes out to that the 100 claims that we've looked had a value of \$1,000, which meant that each claim was worth \$10 for \$1,000. Right?

We'll then -- if the error was worth \$1 that meant it was worth 10 percent of every one of the claims. Okay? And then we'll take that number and we'll assign it to the overall population of claims that they submitted to us.

So, in other words, if you assigned 10 percent

of a dollar amount here then it would be 10 percent of a dollar amount here, but in those situations even with extrapolation the example I gave before, there's a provider in Connecticut that provides home-care services they did 175,000 claims they submitted on an annual basis. They had a \$11 million in claims that they were paid for. And even with extrapolation, we took a \$29,000 audit adjustment, out of \$11 million in claims.

REP. AMBERCROMBIE: Okay. Thank you for that part of it. Now I understand it a little bit more.

Our look back is seven years, is my understanding. Is that -- where did we come up with that number? Is that in compliance with federal -- what's the federal look-back on the Medicaid fraud?

COMM. M. STARKOWSKI: You know, I couldn't actually tell you right now. I'm not sure. I mean, I think -- I think the staff person I'm looking for -- I'm looking at him right now.

A VOICE: (Inaudible.)

COMM. M. STARKOWSKI: It's the record retention requirement in the State for the seven years.

REP. AMBERCROMBIE: Okay. And you talked a little bit about the appeals process, can you go through that again?

COMM. M. STARKOWSKI: Yes.

REP. AMBERCROMBIE: -- as far as -- my understanding is the appeals process goes through you? We don't have anybody from the outside taking a look at that to kind of -- not that you're objective -- not objective but you know, another set of eyes. Can you explain that appeals process?

COMM. M. STARKOWSKI: That -- that's a standard way that's a standard way an appeals process works but understand our auditors will go in and

they will take the sample -- they'll -- first of all, they'll let them know they're coming in unless they have some reason to not let them know because they think there's fraud or abuse. So they'll come in, they'll audit the entity; they'll tell them what records they need to have in advance so that way the accountant or the comptroller can get all the records together. They'll take a reasonable sample of the records. They'll come in, and they'll take information off of our data warehouse. So if they're looking at a universe of 175,000 claims and they're going to sample 1,000 claims, let's say. They've already done a random sample through our system to say these are the 1,000 claims we need. This is the information we need.

So they'll go in. They'll do the audit. They'll work with the comptroller or they'll work with whoever's been assigned to -- from entity to work with them. They'll do a draft audit. They release the draft to the entity so the entity knows what the audit exceptions are. Then they will, as a quality assurance, they'll finalize the audit. They will send that audit to out to the entity. The entity, then gets a period, a window period, to comment on the final comments on the audit and what the audit recommendations are.

They, then, have that opportunity again to go back to quality assurance, to work with assurance and say, You know, you said we didn't have a doctor's signature, well, you know what, between the draft and the final, we've found a box that was hidden under a desk from an employee that left; here's three of those forms that have the doctor's signatures on them; we didn't realize that they had left them on their desk and they didn't, you know, put them -- file them appropriately.

We'll review that. We'll see if that impacts the audit.

If that impacts it, then they'll change the

findings of the audit. After the audit findings are considered final, from that point, the entity still has the right to come back to the Department, appeal to me and say, Here's the justification; here's why I think that they're -- the audit findings are an error; here's the information I supplied.

So they'll try to provide substantiation to me. I'll work with our legal counsel to look at it, to say, okay, you tell me, as another pair of objective eyes, can you look at -- this is the requirement; it says that there has to have a doctor's signature on the form and a date -- the date comply -- let's say that the audit exception -- here's the forms that they sent, did they comply?

And then I'll be the final arbiter. That doesn't stop, literally, an entity from trying to move into court to say that they still don't like my decision. The court still has to make a decision whether they want to hear the case or not, and it has been common for the court to say we don't want to hear the case.

In situations where we've actually -- the audit has determined fraud and abuse. Those cases have been brought as high as the State Supreme Court. And, in fact, in a case that was brought before the State Supreme Court, they not only reiterated our -- the appropriateness of our audit process -- of our extrapolation, but they were the ones that pretty much said that if we didn't have the process that we have, we could be in jeopardy of losing the federal reimbursement.

So I think -- I think our audit process has -- has worked successfully. About 2004 2005, Representative Gibbons and a number of other legislators worked on similar legislation. That's why some of those pieces are in there now that provide a little bit more flexibility, provide more opportunities for the entity to work with the agency. And, at

that time, again, the allegation was that the extrapolation was costing providers millions and millions of dollars, but we don't see that as a case at all.

REP. ABERCROMBIE: Okay. When -- when a provider contracts with DSS, are they given written notification about what the audit process is and what -- what they will be responsible for to submit to you?

COMM. M. STARKOWSKI: In the provider agreement and depending on the service they provide, they'll be told what they have to substantiate, what is considered a valid claim, what information is needed to substantiate that claim, how long to keep the information. So they're given a template on -- on what they have to do as a participating provider.

REP. ABERCROMBIE: And you haven't yet heard any concerns from them that it's not clear enough that the procedures in place are not clearly defined?

COMM. M. STARKOWSKI: I -- I can't say that on a whole. I mean on the whole, I haven't. Have there been individual providers? There's a provider right now that has an appeal into me over a number of issues on an audit that my legal counsel's reviewing right now.

But, individually, there may be providers that come on specific situations in an audit and -- and want me to make a decision on whether I thought it was a clerical error or was it more than, you know, something substitutive that we said it was substitutive in the audit. But I can't say I get more than -- and I'm not looking to solicit all these appeals, but I can't say that I get more than probably ten or 12 appeals in a year out of hundreds and hundreds of providers and probably thousands of providers that we have out there now that get audited.

REP. ABERCROMBIE: How many auditors do we have, and

about how many audits do they do per year?

COMM. M. STARKOWSKI: Again, I'll look at -- 30 auditors and about 150 a year.

Now, understand that there's some audits that aren't referenced in this bill. But nursing home audits, we actually have an outside entity because there's so many nursing homes, and, again, the dollar amount is so high that they actually help us and provide a number of audits for nursing homes.

REP. ABERCROMBIE: And in your testimony you had said that you weren't in favor of this bill because of it being costly. Can you explain that a little bit as far as -- you know, we're hearing from the providers that the look-back is what's really hurting them. That -- that if we had a -- a better policy in place where we knew that we would be doing an audit even three to four years versus most of them are saying that the look-back, the seven years, is what's hurting them. Is that what's driving up your cost that you're saying in this bill --

COMM. M. STARKOWSKI: No, no.

REP. ABERCROMBIE: -- and is there any room -- do you have any idea where we can get a better handle on this whole audit process. Because I have to tell you, I've been sitting on this committee since 2005, and this is an issue when I meet with the providers that comes up year after year. So there's got to be a disconnect somewhere's along the line whether it's a seven year look-back, which is hurting them, or perhaps -- you know, we don't have clear policies in place that they're understanding. You know, some of these providers are very small business, you know. And this could be very cumbersome for them. So do you have any ideas on this bill where we could maybe meet in the middle?

COMM. M. STARKOWSKI: You know, Representative

Abercrombie, I think we did that about three or four years ago, and I think that the process has moved fairly smooth. I think what you're going to see is the same providers that wanted the original bill that had some of the same language in that we negotiated with legislators to provide some additional cover for the providers and to provide -- address some of the concerns of the Department. The same providers are bringing up the same bill that didn't pass four or five years ago and it was negotiated into a different bill. They're bringing up the exact same issues.

The 10-percent issue that unless there's 10 percent -- that a provider can have up to 10 percent before we do any extrapolation and before we start to recoup dollars. I wouldn't -- and first of all, I don't it's federally allowable to say to our providers that we would not recoup if you had 10 percent of -- of your payments that we paid to you had a problem that was identified in the audit.

Second of all, why would we, especially in these economic times, set a benchmark to say to an entity, that's okay, you can have shoddy work up to 10 percent and there won't be any financial penalty on you. I mean, I think what we -- you know, we only recoup 15 to 20 million dollars a year on these audits. I mean it's not like we're out there with, approximately, \$4 billion in healthcare expenditures bringing in \$2 billion in audit exceptions. Based on the providers that we audit, it's not a significant amount of money.

So I think that the bill that stands that we've been working with has worked fairly well. The providers haven't approached me along the way to say, Mike, we need to talk to you because let's try to do something different; we'd like to work with you, but let's try to do something different.

And I think there's misconceptions, and I think it's some individual providers that are

starting to continue to push this language and not the providers in general.

REP. ABERCROMBIE: Okay. Well, I guess that would be an area that you and I would probably disagree upon.

COMM. M. STARKOWSKI: Okay

REP. ABERCROMBIE: So I guess we have to agree to disagree, but I do appreciate your honesty in this, but I do think that, you know, we have a process in place and from what I'm hearing, the process isn't working as well as it could be.

So I think that there is some adjustments that we could make. Now, you know, we would love for you to give us some input on this as to where you think we could make them. You know, I know, at this point, you probably don't think there are any adjustments that needed to be looked at, but I would appreciate it if maybe your staff could take another look --

COMM. M. STARKOWSKI: Okay

REP. ABERCROMBIE: -- and maybe send us an email as to where you think we could make some adjustments because, you know, I have to tell you, you've said all the right things being up here as far as what you feel that your department is doing. But that's not what we're hearing from the providers out there. And, you know, you say, you know, perhaps, we want to make sure that the people are doing everything that they are supposed to be doing according to the rules. I think they are, and I think that, you know, I think it's a little unfair to think that they're not. So I think the audits are important, you know. I believe in them, but I think that we really need to look at the process we have in place right now.

So thank you, Mr. Commissioner, I appreciate it

COMM. M. STARKOWSKI: We'll work with you.

SENATOR DOYLE: Thank you.

Representative Walker.

A VOICE: (Inaudible.)

SENATOR DOYLE: Representative Lyddy.

REP. LYDDY: Thank you, Mr. Chair.

I apologize for being late, Commissioner. I just have a quick question, just one.

The Senate --

A VOICE: (Inaudible.)

REP. LYDDY: The Senate Bill 220, the reporting bill. I was wondering if you could -- I heard that you had some redraft language?

COMM. M. STARKOWSKI: Yes.

REP. LYDDY: Can you summarize that redraft language for me?

COMM. M. STARKOWSKI: Sure.

REP. LYDDY: Thank you.

COMM. M. STARKOWSKI: What we -- we're not -- in the changes we made, we're not eliminating the Manage Care Advisory Council, the SNAP E&T, the home -- the reporting for the Home Care Program, the reporting for the community based-services, and we would replace the five days with 30 days, where there was a reporting requirement of five days for the -- any federal sanctions, et cetera, and it removes only parting of the reporting requirement.

We -- I thought that there was a new bill redrafted, but I can get you a version if you want it?

up together because we have a lot of people speaking on the same bills. So I'd just like people to start thinking about -- for everyone's benefit, for everyone in the audience to kind of have an opportunity to speak, maybe people can come together and at some point after the message is given on a certain bill. Others just think about -- if you're going to come up provide something new because we want people to be able to get home at a reasonable hour.

That being said, at this point, the first member of the public is Martin Acevedo.

Is Martin here?

MARTIN ACEVEDO: I'm here, sir.

SENATOR DOYLE: Thank you.

MARTIN ACEVEDO: Good morning, Senator Doyle, Representative Walker, members of the Committee.

My name is Martin Acevedo, and I'm the general counsel of Companions and Homemakers, Inc. Next to me is Linda Johnson, president of Companions and Homemakers, Inc. We provide homemaker companion services for private -- private pay clients as well as clients of the Connecticut Homecare Program for Elders, which is administered by DSS.

We are here to testify in support of RB 283. This bill seeks to amend the statute that enables DSS to perform audits of its providers and assess extrapolated penalties following an audit. Extrapolation is a process by which the average error rate found in a random sample of audited claims is extrapolated to the entire universe of claims paid to the provider.

A small billing discrepancy, Scribner's error, or overpayment can and will translate to thousands of dollars in extrapolated charges.

We want to make clear that this proposed Bill does not eliminate extrapolation, rather it's purpose is to bring the audit process in line with Medicaid and Medicare law, upon which, the bill is supposed to be modeled. Federal law sets forth minimum standards which must be met before extrapolation can be applied and also provides a right of judicial review of the results of an audit. That is not present in the current statute.

Audits are consuming, uncertain and unduly stressful events. It is not unusual for an audit to take or last several months. By the time the process is concluded, only a few months will go by before the next audit looms in the horizon.

In our case, we have undergone these audits for years. Despite our relentless efforts to cross every T and dot every I, DSS will inevitably find cause to extrapolate because there are no written regulations or standards governing the process. DSS is free to craft new grounds for extrapolation every -- with every new audit without prior notice to the provider. Because there is no right of appeal, the auditors discretion to extrapolate cannot be challenged as arbitrary or capricious.

DSS's uncheck power to exact extrapolated payments from providers without accountability in a built-in system of checks and balances is reminiscent of totalitarian-like societies.

In my research I have yet to find a similar statute where a state actor can, in essence, effect the taking without due process of law and this unchecked authority has led to abuses.

During an exit conference to discuss the results of an audit back in 2003, my client was asked by the auditors why -- my clients asked of the auditors why she was being

extrapolated on a regular basis, despite meticulous recordkeeping and a low error rate. The DSS auditor looked at my client -- that gentleman was here present in court -- in court -- excuse me -- before this body today. And looked at my client and drawing a bull's-eye circle in the air, told my client in the presence of her attorney, back then, that she was considered a big target. My client, understandably, was shocked.

It is no secret that we have actively advocated for statutory audit reform, most recently during the 2008 and 2009 legislative sessions. Efforts, which DSS has obviously vehemently opposed. Significantly, on June 4, of last year just one day after the 2009 session adjourned, DSS's office of quality assurance served my client with three notices of audit. Unlike, prior audit's in which only claims pertaining to one access agency would be audited. This audit encompassed all three access agencies with which we have contracts. DSS also refused to give us the specific sample information before the commencement of the audit. As a result, we were forced to file a Freedom of Information request. Shortly thereafter, the auditors finally agreed to give us the sample information for one out of the three access agencies in questions.

The sample information consisted of the names of 100 clients and certain dates of -- of service. Upon closer examination, we were dismayed to find out that out of the 100 clients, 16 of them were repeats from the 2007 audit. That was our prior audit. These were difficult cases. Cases that DSS knew could result in significant disallowances if errors were found.

Given that we have approximately 1,000 clients with this access agency, it reasonably follows that DSS could not have chosen the audited sample at random. This, again, raises additional questions about the fairness of the

audit process and the internal methodologies employed by DSS to audit its providers.

Keep in mind, ladies and gentlemen, that for extrapolation to be reliable the sample must be random and statistically valid; otherwise, the results of the audit are biased and unreliable.

To this date, our Freedom of Information request for information pertaining to the matter in which DSS randomly selects providers for audits and claims to be audited remain largely unanswered. These actions and countless others not told by others for fear of retribution, pale in comparison to what was done to Dr. Richard Weber, a DSS provider who is testifying here today.

Dr. Weber was referred to criminal prosecution by the Office of Quality Assurance after he dared to complain to former Representative Crystel Truglia about the fairness of the audit process and the practices of the Office of Quality Assurance. Doctor Weber filed suit
--

SENATOR DOYLE: Okay. Could you please summarize?

MARTIN ACEVEDO: Yes.

SENATOR DOYLE: I'm trying to -- three minutes was up (inaudible).

MARTIN ACEVEDO: Dr. Weber is here. He filed suit, and DSS felt compelled to pay a \$725,000 settlement for what was done to him.

LINDA JOHNSON: And I sense, the Commissioner named my agency, Companions and Homemakers and also anonymously mentioned the dollar amount that we supposedly have to pay. And the way he said it he made me feel like he was claiming we had fraud. I'd like to show you because I brought it here. This is -- this supposed fraud, we're missing a check mark. This one time sheet, we process 5,000 a week. This one

time sheet cost \$29,000. And it's because somebody didn't check down here. Now, at the last audit they didn't charge us for that, but they decided at this audit since we figured out how to get every else right. They were going to find something new to charge us with.

And it's not the dollar amount, and I'm really sick of people saying, well, you bill 11 million and you only had to pay 26,000. At first, they told us we owed 300,000, that held up me deciding to give anybody a raise in my company because every single time we get an audit, I can't make a decision. I have no idea if I'm going to owe a million dollars or \$5. And the thing goes on for six months. Your companies -- you can't do anything. And then they come again and again, and they basically have told me, literally, he said, because we bill so much, which is because we do a good job by the way. We don't have a contract for 11 million, it's because case managers choose to use us because of that, he said I'm a big target. So my 3 percent error rate -- and that's all I've ever had is 3 percent -- cost this much money every year. So they say if we're to come in for three days and we're going to give up \$30,000, let's do it.

MARTIN ACEVEDO: Exactly.

LINDA JOHNSON: Not fair and it's causing me to decide whether or not I want to do business with the State of Connecticut, which is why those dentist aren't doing business for the State of Connecticut either. Why do think everybody stops doing it? Is because you make it so darn difficult to do it. So people --

SENATOR DOYLE: Well, the Committee's are looking into this -- I mean, we're not done. So I would just -- rest assured we're hearing both sides. We're going to explore it over the next few weeks to try to get some compromise.

MARTIN ACEVEDO: If -- if -- if I could just, you

know; reply to what --

SENATOR DOYLE: Well, I mean, sir, let's ask some question because others -- people -- there's a long list, and I don't want to --

MARTIN ACEVEDO: I'm sorry.

SENATOR DOYLE: I can't show bias towards anyone.

MARTIN ACEVEDO: Yes, of course, yes.

SENATOR DOYLE: Representative Abercrombie.

REP. ABERCROMBIE: So you're saying that you were audited in June of '07 and then you were audited again in June of '09, so two years?

LINDA JOHNSON: Correct.

REP. ABERCROMBIE: Before 2007, when was your audit before that?

LINDA JOHNSON: I want to say, 2005, but I --

REP. ABERCROMBIE: So they've been consistent with every two years for you?

LINDA JOHNSON: At least and they take at least six months and that's from the time they tell you they're going to audit you and the time that you -- and it's not because it takes them that long to audit. We hand them everything. They just decide to stretch it on for six months so you can't -- the auditor's only in our office for three days.

REP. ABERCROMBIE: So what do you think is a reasonable amount of time that they should -- that it should take them to audit you?

LINDA JOHNSON: I think they should have -- they -- it's a pretty simple -- time-sheets signed, not signed. I mean I don't think it should go on for more than a month.

REP. ABERCROMBIE: All right. Thank you and thank you for your testimony.

Thank you, Mr. Chair.

SENATOR DOYLE: Thank you.

Any other questions?

Representative.

REP. BUTLER: Thank you, Mr. Chairman.

I just have a question about the targeting. You mention in your testimony that one client was point blank told that they're a target.

MARTIN ACEVEDO: Uh-huh. We are a target.

REP. BUTLER: Yes, and -- and were you given any rationale as to why you're such a target?

LINDA JOHNSON: Because of the amount of money we bill. So a 3 percent error rate will recoup the State \$25,000 or whatever amount it might be.

My, you know, nightmare that I go through every of couple of years and it's always July so it ruins my summer. But my nightmare is what if I had a bad day (inaudible) person. I have a full-time 40-hour-a-week person. All they do is look at these time sheets. That's all they do. But what if she's having a bad day? And what if that bad day happens to be the day that they pick to do -- to pick that sample from?

But I honestly don't believe those samples are true. This lady that we got charged for. She's been a difficult client, per se, meaning billing client, because we do a lot of one-time onlys for her. She goes to the doctor a lot. That means a new service order every single time she gets a ride to the doctor. And so the minute I saw her name on the list -- that she was on the list before, I knew there's no way this can be random. How -- how do I -- and, you know, I don't even do

the billing anymore, but why do I know these names? And it's because certain clients are more difficult than other clients. They have a lot more paperwork so you're liable to make more mistakes.

My other argument is they only extrapolate paid claims. They don't take into account all the ones that on their error they didn't pay me. So that makes the extrapolation unfair, right there.

REP. BUTLER: Right. Well, thank you, and we understand your issues.

LINDA JOHNSON: Sorry.

MARTIN ACEVEDO: All we're asking --

SENATOR DOYLE: Thank you.

MARTIN ACEVEDO: -- is a simple ability to be able to appeal to Superior Court.

SENATOR DOYLE: Yes, that's in the bill.

Okay.

Any other questions?

Representative Gibbons.

REP. GIBBONS: Thank you, Mr. Chairman.

Thank you for coming to testify. I was on the original committee with the Commissioner where we worked out the first release of extrapolations for companies doing business of less than 150,000 and (inaudible). And we knew that it wasn't perfect what we had done, but it was a start at that point. I've suggested to the Chairman that we're going to have to sit down before this bill goes any further and have the Commissioner and one of his representatives in the room with some of the people and decide what is really happening.

I think there's a valid reason to have audits and to have extrapolations.

MARTIN ACEVEDO: Absolutely, absolutely.

REP. GIBBONS: But what you're saying certainly differs from what he said as to what is following federal law. It's a nightmare, I have to say, dealing with any government agency in this state. I don't care which one it is. And I'm sorry to feel that way when I'm representing the State in so many ways. But I think that the paperwork and the amount of red tape has just become insurmountable in all instances.

So I do think that before we move this along, we need to convene some meetings and hash out what needs to be done.

LINDA JOHNSON: Can I just make one small comment real quick. We also bill DSS directly for the same services and they're Medicaid funded. Okay? DSS has not chosen to audit themselves in the 20 years that I've done business with them. If they actually notified me and told me they were going to audit me, I'd tell them, Sorry, I don't have a contract with you so you have no right to look at my time sheets; you have no right to look at anything, yet I've been providing Medicaid dollars for 20 years to the Department of Social Services. They don't have their act together. They're expecting everybody else to have their act together and it's not fair.

SENATOR DOYLE: Okay.

MARTIN ACEVEDO: This bill if --

SENATOR DOYLE: All right. Thank you.

MARTIN ACEVEDO: Thank you. Thank you.

SENATOR DOYLE: Any other question from

legislators?

Seeing none, the next speaker is Nancy Shaffer.

After Nancy, we're going back to Public. It's Kathleen Wyatt.

Ms. Shaffer.

NANCY SHAFFER: Good afternoon, Senator Doyle and Representative and members of the Committee.

My name is Nancy Shaffer, and I am the state long-term care ombudsman. I'm here today on behalf of the long-term care consumers of Connecticut and, in particular today, the residential care home consumers.

My colleague, Mr. McGaughey spoke very succinctly this morning to Raise Bill Number 5232. And so I just wanted to very briefly affirm some of things that he mentioned that the -- Ombudsman Program has had a long-standing belief that the enhancements that are put into this bill, before you, are reasonable and appropriate and assist to meets the needs of this population of individuals.

As Mr. McGaughey mentioned, these are folks who, generally speaking, have minimal resources, limited family and social supports, and may suffer from a variety of both physical, mental health and other kinds of limitations. So to enhance this involuntary discharge notice so that the contact information for advocacy organizations is presented to the resident when they're given their involuntary discharge notice, is very important because these folks, generally speaking, don't have the wherewithal and the resources in order to find advocates.

The time frame goes from 10 days to 15 business days in which they can appeal, and that, again, is also reasonable and appropriate, and I appreciate your

KEVIN HAUSCHULZ: Okay.

REP. WALKER: The Oxford House has a structure.

KEVIN HAUSCHULZ: Uh-huh.

REP. WALKER: CCAR has a structure.

KEVIN HAUSCHULZ: Uh-huh.

REP. WALKER: DMHAS houses have a structure, but they're still other houses out there that don't have any structure, and they use sober houses as their umbrella to protect them to not provide a structure. And that's what I think we're looking at is not to -- to erode anything that's already working. Trust us, I mean we look very happily at things that work, but when we find situations where nobody is making sure that everything is in place, that's where we're concerned.

So I want everybody to understand that this is not to disrupt what has happened that has been good in your life. We are just making sure that everybody has the opportunity to get all those things.

So thank you for your testimony.

KEVIN HAUSCHULZ: Thank you, Representative Walker.

REP. WALKER: Okay. Martin Sbriglio and Jane McNichol, Michael Theriault, then Lisa Reynolds.

Good afternoon.

MARTIN SBRIGLIO: Good afternoon.

Representative Walker, Committee members, my name is Martin Sbriglio. I'm chief executive officer of Riders Health Management. We provide skilled nursing facilities services in Connecticut. And I'm here to support Senate Bill 283, AN ACT CONCERNING AUDITS BY THE

DEPARTMENT OF SOCIAL SERVICES.

I agree with what Representative Abercrombie said earlier. I think there is a disconnect. Certainly, we have major concerns about the audit process. Seven years of record retention is -- is impossible. I can tell you every year we have to rent more space and more rooms and I've had -- it's just impossible to maintain the recordkeeping. Beyond that, I've had staff work until two in the morning after putting in a normal eight-hour day and have them there the next day to do the job of fulfilling information requests from the DSS.

If we don't provide the data, of course, we get fined and there's recoupments, and it's almost impossible to run the company. Our focus should be patient care. I fear that these audits -- originally, we've been doing this 60 years, my family and I, these audits originally were intended -- intended to be fraud audits. I fear they've become a source of revenue and a way to generate money for the State. It's not -- it's -- it's lost its way. These are supposed to be fraud audits.

We are here to provide care. You're here to make sure we provide that care. We agree with that but if you're using these audits to generate revenues for the State of Connecticut, that's hurting the patients. That's hurting everyone. It doesn't do a service to the society, which is really what we're here for. In fact, I'd go even further to say that these audits should include -- if the findings are in favor of the provider, those should be disclosed.

But, anyway, I'm going to make it short. I've already provided written testimony. Any questions?

REP. WALKER: That's my question.

Yes. Any questions from the Committee?

SENATOR DOYLE: Thank you.

The next speaker is Sandi Carbonari. Is Sandi here?

Okay.

Is Richard Weber here?

RICHARD WEBER: Good afternoon, Committee members.

I'm Richard Weber. I'm a practicing physician in Stamford, Connecticut since 1987. I am a board certified internist and ophthalmologist and assistant clinical professor at Albert Einstein College of Medicine.

I was contacted a few weeks ago by the proponents of Raised Senate Bill 283 concerning the manner in which audits are conducted by the Department of Social Services.

Evidently, through a Freedom of Information request, the bill's proponents discovered that the State of Connecticut settled claims that I'd brought in federal court against the Department of Social Services, Office of the Chief State's Attorneys and multiple employees of these departments, including DSS's Office of Quality Assurance and former DSS Commissioner, Patricia Wilson-Coker.

My experience with DSS spans a period of more than 10 years. In the interest of brevity, I will inform you that I was the subject of an audit in 1999, at which time 8000 -- 8,000 extrapolated -- dollars extrapolated from a \$1400 were recouped by DSS for my use of a specific billing code. My office had consistently used that code based upon specific instructions from DSS.

As a result of the audit and my disappointment with the process and how I was treated, I contacted, in 2001, my State Representative,

Christel Truglia. Representative Truglia asked me to prepare a letter outlining my experience which she then forwarded to DSS Commissioner Wilson-Coker -- and I'll refer back to that letter in a moment.

Of great interest to this Committee should be the fact that on the very day that Commissioner Wilson-Coker responded to Representative Truglia, the manager of the Office of Quality Assurance, the very same gentleman referred to earlier by Attorney Acevedo as drawing the target in the air, in retaliation for my letter to my representative and in violation of my right of free speech, had his staff initiate a criminal referral to the Medicaid Fraud Control Unit for investigation, prosecution and my eventual arrest.

During this investigation a search warrant was executed at my office, with patients and staff present, by armed inspectors of the Medicaid Fraud Control Unit and the Stamford Police Department. This seized about 25 patient charts which could have been just as easily obtained by other noninvasive and nonconfrontational methods.

With the assistance of my attorney, Michael Kogut and the law firm of Murtha Cullina, we vigorously fought the charges, which I always believed were malicious and unfounded, specifically. During the hearing for suppression and dismissal of the search and arrest warrants based upon violation of my right of free speech by contacting Representative Truglia, heard by Judge Christine Keller in Hartford Superior Court, we prevailed as the State dismissed the charges after multiple days of testimony before Judge Keller.

Shortly thereafter, we sought permission to sue the State, Office of Chief State's Attorney and Department of Social Services along with multiple state employees. The

claim lingered and we were unable to receive any redress from the Claims Commission.

We, therefore, filed suit in federal court in December -- 2006, against the same actors charging violation of my civil rights, malicious prosecution, wrongful arrest and overall wanton and reckless behavior by DSS and its employees during my entire audit process.

After countless hours away from my practice and depositions and extensive discovery, the State finally settled in October 2008. I've believe you've been provided with the settlement agreement.

Through the extensive discovery and FOIA request process, we had a unique, though costly, look at the Department of Quality Assurance and its managers. I have reviewed an extensive number of audits, documents, computer printouts, provider complaints and correspondence.

My review of the DSS audit process revealed that oftentimes it's arbitrary, capricious and unfair to providers who serve a disadvantaged group of patients without the right to independent review or appeal from the draconian decisions of DSS.

I applaud the bill's proponents and respectfully ask the Committee to give providers only what they are entitled to, a fair and objective process with the right to independent review and appeal.

I have my letter, here, that I sent to Dr. -- to -- to Representative Truglia dated January 17, 2001, and I conclude it by saying, Per our conversation, I would request that item number 6 -- was it -- this is nine years ago -- was a change of audit process. The same person heads the committee, sets parameters for review, his review, makes up rules for review, decides the review. There's no appeal process

by a physician, no separation of powers and no physician supervising.

I also concluded by stating that I believe that the audit personnel need an adjustment in their attitude -- that didn't go over too well with them -- and the -- I would also second that the appeal process cannot be heard by a state employee.

At one point in December, 2005, we put in a FOIA request seeking all documents in which a -- an audit had been reversed by -- from -- by the audit director from the audit manager. And they were not able to provide a single document to show where that had ever occurred.

Thank you for your consideration and your time.

REP. WALKER: Thank you for your testimony.

Any questions?

You submitted all of that documentation to -- to us?

RICHARD WEBER: The documentation on the settlement agreement --

REP. WALKER: Yes.

RICHARD WEBER: -- was provided, I think, by Mr. Ace -- Attorney Acevedo.

REP. WALKER: I -- I totally -- I am extremely sorry for what you had to go through, sir.

RICHARD WEBER: Thanks very much.

REP. WALKER: And we'll keep working on this.

RICHARD WEBER: Okay.

REP. WALKER: Thank you.

RICHARD WEBER: Thank you.

things of that nature that people just don't have access to.

REP. ABERCROMBIE: Thank you, Mr. Chair.

Thank you, ma'am.

SENATOR DOYLE: Thank you.

Any other questions?

Seeing none, thank you.

Brian Ellsworth, then Curtiss Kolodney and Stan Soby.

BRIAN ELLSWORTH: Good afternoon, Senator Doyle, members of the Human Services Committee.

My name is Brian Ellsworth. I'm the president and CEO of the Connecticut Association for Home Care and Hospice whose members serve over 100,000 frail, elderly, and disabled citizens in Connecticut.

I come before you today to speak in support of SB 283 regarding imposition of due process protections in audits, as well as in a 10 percent error threshold in extrapolation of audit findings.

Let me just kind of summarize our testimony.

We were very involved in the original audit bill in 2005 as well as the companion piece of the legislation in 2005 that clarified particular audit practices relating to home healthcare. Since that time, the Department has made great strides -- and I want to give credit where credit is due. The tone and scope of audits has changed considerably and the communication with the Department has also improved significantly. So, in some respects, the legislation in 2005 is a success story.

Having said that, I think that there are concerns remaining particularly about the due

process aspects of the bill. Right now, today, it's not at all clear that a provider can -- can go to court, further, after the Department's final audit report. And in some cases, the audit findings can be a considerable amount of money.

We think that the bill's language with respect to issuing regulations and providing a right of private action in Superior Court makes sense and are -- are just reasonable check and balance as we, kind of, head -- sail into the headwinds of major budget deficits. And -- and the addition of 12 new auditors at DSS who will be, quite frankly, looking for something to do. And -- and we're very concerned that there needs to be a check and a balance there.

We also support the -- the error threshold. But I want to really stress to you that in the event that concerns are raised about the fiscal impact of the error threshold or jeopardization of federal participation, I would strongly urge you not to throw the baby out with the bath water. Do the other parts of this bill, and we can come back to the error threshold at a later date if that poses a problematic thing for you.

We think the due process protection is the protections for clerical errors. Those are very important, and I would strongly urge your adoption of those amendments.

Thank you.

SENATOR DOYLE: Thank you, Brian.

Any questions?

Okay. Representative.

REP. ABERCROMBIE: Good afternoon.

Thank you for being here.

Just a couple of quick questions.

In other audits that we do, is it the normal procedure that they are able to take it to the next level when it comes to the court system? Is this -- are we trying to align ourselves up with other procedures that we have in place?

BRIAN ELLSWORTH: Well, the statute makes reference to Chapter 54 and -- and accords it to, you know, due process protections along those lines.

I had some back and forth with my lawyer. I wouldn't portray myself as, you know, a complete expert in where you have the rights of court action and where not, but my understanding is that it is somewhat unclear in this particular case because the statute uses the phrase "review" instead of the word "appeal." If it was the word "appeal," then it would be considered a contested case which then would provide that ability to go to court, or at least that ability to go to court would be more clear. Because the statute used the word "review," the underlying statute, that's what creates the problem. So you could conceivably fix it by changing that word in the statute or providing this right of action.

As to what other statutes do, I suppose it depends on how they're phrased.

REP. ABERCROMBIE: Okay.

And secondly, you know, I'm sure you've been here all day so you've heard the conversations going round and round. You know, we'd really like to sit down with the Commissioner, and really try to work this out because we do feel that some changes need to be made. And as you can see, we've got a lot of testimony. Could you just send some bullets of your testimony? And -- and like you just described about changing the wording from "appeal" to "review" or "reveal" to "appeal." You know, things like that so that when we have the conversations with the Commissioner, maybe we

can negotiate some of these issues. And then the bottom line, what you think is the bare minimum that we should not negotiate on.

BRIAN ELLSWORTH: Okay. I'd -- I'd be happy to do that.

And -- and we've had a long go around on this issue. I would say five years ago, in 2005, this was the number one issue for my organization by a large margin.

And -- and DSS has improved. And so I would encourage those conversations and would be happy to participate in them as well.

REP. ABERCROMBIE: Thank you.

Thank you, Mr. Chair.

SENATOR DOYLE: Thank you.

I -- I just -- I'm not sure if we give you an appeal right. I think we should define it more that just changing that word because then it's ambiguous. But, anyway, we'll talk about that down the road.

Any other questions?

Seeing none, thank you.

Next speaker is Curtiss Kolodney.

CURTISS KOLODNEY: Good afternoon, Senator Doyle and the other distinguished members of the Human Services Committee.

HB 5243

My name's Curtiss Kolodney, and I've been in sustained recovery from alcohol and other drug addictions since July 20, 2004.

And I'm not going to go through and read my testimony. But, you know, for me to able to sit here and say that is really something because, I'll tell you, for 30 years I struggled to try to figure out to myself that

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Senator Coleman.

SENATOR COLEMAN: Dorian, just wanted to say,
Hello.

DORIAN PARKER: Hey.

SENATOR COLEMAN: I think that the last time I saw
you is when I was having car trouble and you
helped me get my car started. I was happy to
see you that day. I'm also happy to see you
on this day.

DORIAN PARKER: Thank you.

SENATOR COLEMAN: And glad that you're involved in
what you're doing. As long as I've known you,
you've been making the effort to help people
so keep that up.

DORIAN PARKER: I think we all are public servants
in our own right.

Thank you very much.

SENATOR DOYLE: Thank you again for you patience.

Next speaker is Terry Edelstein -- stein, Luis
Rivera, April Raczka -- I think.

Terry.

TERRY EDELSTEIN: Good afternoon, members of the
Committee.

My name is Terry Edelstein. I'm the president
and CEO of the Community Providers
Association.

I have two testimonies. I am going to speak,
today about Senate Bill 283 concerning the
Medicaid audits. I've also submitted written
testimony about the electronic health records.

And you've heard from other speakers who have
encouraged you to consider including community

providers and any kind of incentives relating to electronic health records.

You've also heard considerable testimony, today about Medicaid audits so I'm going to give a little bit of a summary of my testimony.

It is not unreasonable for a state agency that, as Commissioner Starkowski said, does \$4 billion in healthcare payments to establish regulations governing an audit process for that \$4 billion. And that's one of the important components of the proposed legislation. It was in previous versions of legislation.

The responses about the State losing its ability to recoup funds from fraudulent providers is not the issue. The issue is that those providers who are willing to comply with the State Medicaid program need written compliance manuals, guidelines, protocols and regulations to be able to have the information for compliance.

The organizations that I represent include behavioral health providers. The adult providers have been audited for many years, but the children's providers were mostly only recently audited within the past year or two years. Many of them have audits still open, a year after the audit process started. Most of them have contracted with attorneys to try to resolve any kind of issues relating to the audit process.

One organization reduced exposure from \$800,000 to \$100,000. If this is considered a recoupment of Medicaid fraud, the provider certainly needs the protocols and procedures to be able to document appropriately so that appropriately that provider can repay what it needs to provide. We're looking for guidance and assistance.

Page 3 of my testimony includes a memo that I

had sent to the Audit Division, prior to a meeting that was cancelled almost a year ago, that outlined a number of our questions. We wanted to sit with the Department to review those questions.

I talked to Commissioner Starkowski in August of last year to ask how I could manage to meet with the Audit Department.

In any case, I wish that we could resolve this without speaking in public hearing. We work very cooperatively with many other state agencies on issues of this level of importance, and we're please that the Committee is willing to sit with the trade association. You will have heard from four or five associations today speaking as the associations because most individual providers are not going to speak about these issues, publicly. And you've heard from a couple of providers who were here.

So we look forward to working with you on simplifying the bill as much as possible but coming up with some remedy so that we do have regulations in place.

SENATOR DOYLE: Thank you, Terry.

Any comments?

Representative Lyddy.

REP. LYDDY: Thank you, Terry, for being here.

You know, it's interesting to hear your testimony regarding the training and whatnot for the providers. You know, the Judicial, you're trained on almost everything, every little thing on how to collect the data and whatnot. And Judicial puts a lot of -- CSSD puts a lot of effort into doing that and that's not even for Medicaid reimbursement. That's for data collection so that they have that data.

Now what you're talking about is thousands of dollars of reimbursements, you would think the State would have a little bit more of a vested interest in that. And it's disheartening to hear that there is not that training provided to the providers in the sense that you're referring to.

So I wanted to lend my support to that and inquire as to why that's -- why that's not available.

TERRY EDELSTEIN: And we've had similar experiences, not only with CSSD but DCF, DMHAS, DDF, DCF, if I didn't just mention them. Most of the service provider agencies are very willing to work on regulations. We work on implementation policies for regulations. We work on the policies relating to the implementation policies. The goal is to be able to provide the services directly to the consumers in the best way we possibly can.

REP. LYDDY: So you're -- are you handed a manual and said, Here make sense of this and we're --

TERRY EDELSTEIN: There is no manual.

REP. LYDDY: -- going to come and audit you.

There's none.

TERRY EDELSTEIN: There is no manual. That's why our association has worked with law firms and the individual providers have had to seek their own legal representation to guide them through the process. There isn't something that you pull off the shelf. If you're a new provider in Connecticut, you can --

REP. LYDDY: Good luck.

TERRY EDELSTEIN: -- look in a dozen places, as well as federal guidance, but there's no one manual that says here are the rules.

REP. LYDDY: Great. Thank you.

Thank you, Mr. Chair.

SENATOR DOYLE: Thank you.

Representative Walker.

REP. WALKER: Terry, thank you for you testimony.

And I'm going to be honest. There were -- when we sat down this morning, we didn't realize the depths -- at least, I didn't realize the depths of the audit problems that -- that providers and people are receiving. And I think we've got something to really work hard on, if nothing else.

And it's going to be interesting to see what the dollar amount will be put on once we come up with these procedures so I look forward to working with you.

TERRY EDELSTEIN: Well, thank you very much. I appreciate it.

SENATOR DOYLE: Thank you.

Any other comments?

Seeing none, thank you, Terry.

Next speaker is Luis Rivera. Luis here?

LUIS RIVERA: Good afternoon, Senator Doyle, Representative Walker, and distinguished members of the Human Services Committee.

I am Luis Rivera, volunteer coordinator for Connecticut Community for Addiction Recovery, Bridgeport Community Recovery Center.

I am here today to voice my concerns about Housing Bill 5243, AN ACT CONCERNING SOBER HOMES.

Recovery housing has enabled individuals to pursue outpatient treatment, attend support

collectively with our relationship. There's clearly need in Northeast Connecticut as you are aware. There's a significant indigent population there, and we're there to serve it. And as its manifest in the numbers in our practice, 40 percent of that being Medicaid or self-pay.

SENATOR DOYLE: Thank you.

Any other comments?

Seeing none, thank you very much.

ROBERT SMANIK: Thank you.

SENATOR DOYLE: Next speaker is Marghie Giuliano, then Rhonda Boisvert and Nancy Trawick-Smith.

MARGHIE GIULIANO: Good afternoon, Representative Walker, Senator Doyle, members of the committee. My name is Marghie Giuliano. I'm executive vice president of the Connecticut Pharmacists Association. And I'm here to testify in strong support of Senate Bill 283, AN ACT CONCERNING AUDITS BY THE DEPARTMENT OF SOCIAL SERVICES.

Actually, the CPA was the lead organization several years ago on having this audit issue addressed because of the financial hits that our pharmacies were taking by the extrapolation method. And, actually, the legislation that was passed in 2005 helped other providers but failed to help pharmacies because there was a section in there that said if the aggregate amount of claims that you submitted each year was greater than \$150,000, then you were still subject to extrapolation. So, obviously, with the cost of drugs and the number of prescriptions and claims that are submitted on an annual basis, no pharmacy is, you know -- submits less than \$150,000 in claims. So it's still -- it's still a big issue for us.

So, to this point, we're certainly supportive

of the fact that, you know, the -- the bill does several things. It attempts to clarify what audits, you know, will allow -- what audits allow, as well as it strengthens the ability of providers to be protective from clerical versus fraudulent issues.

I'll just mention two of my pharmacies actually have been a subject of audits. And one of their -- one of the pharmacies told me that they're being looked at for \$324,000 to be recouped by the State because a couple of the prescriptions that they filled were high-price drugs and required diagnosis codes on them to be paid for. Well, their computer record had the diagnosis code on it, but because it wasn't written on the hard copy prescription then they were really not conforming with what had to be done, so now this drug gets to be extrapolated across their whole, you know, universe of prescription. And it comes out to a \$324,000 bill. You know, you have to fill a lot of prescriptions to make up that \$324,000.

So I'll just sum up, you know, we -- we appreciate the way the language has been written. It really does help to address this. I like the fact that we're talking about asking them to clarify their sampling methodology because it's interesting that there's always these high-price drugs that are selected that also might have another issue. So there's -- there's always ways to get money back from the pharmacies for clerical issues. So, you know, we appreciate this, and we know that the State is hiring new auditors, so I'm sure they're going to be vigilant. We just ask that they be fair.

SENATOR DOYLE: Thank you.

Any comments or questions?

Representative Johnston.

REP. JOHNSTON: Thank you, Mr. Chairman.

Marghie, what that -- what did that pharmacy do? They paid the 300-something-thousand dollars or what's the net result of that --

MARGHIE GIULIANO: So what -- what this pharmacist has done, he has spent the past two weeks writing up a 29-page report. He is working with a company who deals with audits like this that will help him, you know, strengthen his arguments. They will have a meeting. He may have to get an attorney. Sometimes the pharmacist will hire an attorney, and then they will go in for mediation with the Department. And I'm sure -- I mean I would hope that, you know, our argument is the Department of Consumer Protection regulates us, and they accept computer records as -- as part of practice. So if the Department of Consumer Protection recognizes those records then why shouldn't the Department of Social Services. So I do think some of these things will be rectified. I'm sure he won't get out with a zero balance. There's always going to be something that, you know, they will -- they will collect for, but, yes, that's what he'll do. He's already talking with a company that helps with audits.

REP. JOHNSTON: Does the Department, at some point in time, offer settlements between the two figures or between the pharmacy claiming that they have no obligation on this and the Department's initial finding to the point that both sides would save administrative costs? Does that happen and is that part of the process?

MARGHIE GIULIANO: I -- that's part of the process. I mean, they do eventually come out with an agreed upon figure. And, again, you know, it's really -- I don't know what those results are, but I do know that they do eventually come out with something.

REP. JOHNSTON: Thank you.

MARGHIE GIULIANO: You're welcome.

SENATOR DOYLE: Representative Abercrombie.

REP. ABERCROMBIE: Thank you.

Boy, you make your way around this building.

MARGHIE GIULIANO: I don't know, it's been a really tough year --

REP. ABERCROMBIE: I just saw you at Insurance, Public Health.

In your testimony, is it in your testimony about the fact about the Consumer Protection where they take the electronic one where DSS doesn't?

MARGHIE GIULIANO: No, no.

REP. ABERCROMBIE: Send us an email.

MARGHIE GIULIANO: Okay.

REP. ABERCROMBIE: Thank you.

SENATOR DOYLE: Thank you.

Any -- any other?

Representative Lyddy.

REP. LYDDY: Just a quick question. We heard from the provider community -- the community provider community that training is a large gap in this whole issue. Do you or is there training available to your pharmacists regarding the audit process?

MARGHIE GIULIANO: Yes. Actually, we just had a program. Obviously, pharmacists have to do continuing education, so we actually invited the Department of Social Services auditors to our program in February. And they did talk about some of the, you know, mishaps with an audit. Again, that -- that's -- it's very

helpful, but when -- when you're looking at these clerical issues, it's, you know, \$300,000 is a lot to fly.

REP. LYDDY: Absolutely, absolutely. I'm glad that you're actually reaching out to DSS and inviting them in. That's great.

Thank you, Mr. Chairman.

SENATOR DOYLE: Thank you.

Any other questions?

None, thank you very much.

MARGHIE GIULIANO: Thank you.

SENATOR DOYLE: Next speaker is Rhonda Boisvert.
Is Rhonda here?

RHONDA BOISVERT: Thank you for the sexy version of my last name.

SENATOR DOYLE: Okay.

RHONDA BOISVERT: It's actually Boisvert, but I'll take the Boisvert.

Okay. I'm testifying today in opposition to HB 5232, TRANSFER AND DISCHARGE OF RESIDENTIAL CARE HOME RESIDENTS.

And, actually, this really pertains to involuntary discharge. I just -- I want people to -- I'm sorry, I didn't even say, Senator Doyle, Representative and Human Services Committee, hello. My name is Rhonda Boisvert, and I am the past president of the Connecticut Association of Residential Care Homes. I also own and help to operate Pleasant View Manor, an 18-bed home in Watertown; and Shailerville Manor, a 15-bed home in Haddam.

I'm not going to read all of my testimony here, but I want to say that there are,

SENATOR DOYLE: Next speaker is Nancy
Trawick-Smith. Is Nancy here? Yes.

NANCY TRAWICK-SMITH: Senator Doyle, Representative
Walker, and members of the Human Services
Committee, my name is Nancy Trawick-Smith, and
I'm the director of Community Companion and
Homemaking Services.

I'm a not-for-profit -- we are not-for-profit
companion-homemaker service in Willimantic.
And I'm also a chairman of the board of
directors of the Connecticut Homemakers and
Companion Association. And I'm speaking to --
in support of Senate Bill 283, AN ACT
CONCERNING AUDITS BY THE DEPARTMENT OF SOCIAL
SERVICES.

I've submitted written testimony and I'm
totally changed it after hearing -- being here
since ten o'clock this morning and hearing six
hours of testimony. I'm not going to go into
a great deal of details since you heard
everything, and I have too.

The Connecticut Homemakers and Companion
Association was also very involved with the
original audit legislation in 2004, 2005,
whatever. And we saw a lot of really good
changes. And now I'm really, really sad and
very disturbed of all the things I'm hearing
that we -- seems like we are backsliding quite
a bit.

I'm just going to say that I -- I -- given
what I've heard today, I do believe we need
regulations. We need provider manuals so that
we know what to expect. We shouldn't expect
extrapolation on the basis of clerical errors
at all. It should not be based on that. It
should be based on, you know, if an -- someone
-- if we were billed -- if we received payment
for something we didn't do, yes, but not on
the basis of check marks, not on the basis of
clerical errors at all. We shouldn't do that
at all.

I am -- I believe that there should be the right of appeal. I mean, these are really, really heavy duty fines. It's like extrapolation but I call them fines. And we should have the right to appeal outside of the Department itself. We really should. We -- it should be able to go to Superior Court. These are, you know, big, big fines.

So, finally, we have a large budget deficit. And I'm going to repeat what people said earlier, but I do worry that these audits have become a way of recouping money as opposed to finding fraud. That's what they really should be about is finding fraud. So I do worry that that is, you know, causing this overzealousness to, you know, recoup money. So I won't go any further.

SENATOR DOYLE: Thank you.

Any other comments or questions?

REP. WALKER: I like your commercial.

NANCY TRAWICK-SMITH: Oh, you know, it's not me that's the other person that was speaking. I'm Community Companions -- that's not my mother.

REP. WALKER: You're not Companions and Homemakers?

NANCY TRAWICK-SMITH: I'm Community Companion -- it's a very similar name, Community Companion Homemaking Services.

REP. WALKER: Oh, okay.

NANCY TRAWICK-SMITH: The woman who was speaking here earlier --

REP. WALKER: She was Companions for Homemakers.

NANCY TRAWICK-SMITH: Yes.

REP. WALKER: I thought you were, too.

SUPPORT SB-283

Senator Doyle, Representative Walker, and members of the Human Services Committee,

This testimony is in support of Raised Bill No. 283, an act concerning audits by the Department of Social Services.

This bill's amendments address some of the concerns remaining with the fairness of DSS compliance audits of provider agencies in the Connecticut Home Care Program for Elders. Despite recent improvements made to the process, there are still areas of the audits that should be corrected and/or clarified. First and foremost, provider agencies should be given the guidelines by which the Department of Social Services conducts its audits and sampling methodologies, as stated in section 1.

In section 2, the audit would be limited to services performed during the two-year period up to notification of the audit or 200 claims, whichever is less. Currently, all companies, no matter their size, are audited with 100 claims as the random sample. A sampling of 100 claims is not statistically relevant across all agencies and therefore unfair to the larger companies when error rates are applied. To go a step further and still keep the math easy to apply, a suggestion would be to have a graduated sampling system, such as 100 samples for companies' under \$1 million in total population for a two-year period; 200 samples for \$2 million, and so on.

In section 3, this legislation seeks to limit extrapolation projections to only those claims that result in a financial finding, not a clerical error. A missing checkmark or a wrong day of the week on a time/activity sheet should not be considered a willful violation of program rules and providers should not be subjected to a financial consequence. Extrapolation should only be used if the findings resulted in an overpayment, i.e. paid for work not delivered, or underpayment to a provider.

Also, a provider aggrieved by the decision should have the right to appeal to a third party. In Section 9, the designee of the DSS will not just preside over the review, but can render a decision. This is important for the outcome to be determined by an impartial person.

While audits are necessary for the integrity of the program, these provisions ensure the state's vendors have the right to due process and you should approve these amendments.

Sincerely yours,

Eileen H. Adams

FAV Home Care LLC

16 Vincent Road

Bristol, CT 06010

Also a member of the Connecticut Homemaker & Companion Association

CT ASSOCIATION OF AGING AND SERVICE PROVIDERS
MARCH 2, 2010
HUMAN SERVICE COMMITTEE TESTIMONY

The Ct Association of Nutrition and Aging Service Providers support SB # 283. As this state's largest meal providers to homebound seniors we are well aware of the detrimental effect our current system of audit penalties has on our most vulnerable population. Although this association's meal providers have had impeccable audit results we fully understand that even small audit findings under current audit regulations result in fewer meals to this state's elderly residents.

Due to the nature of our service many meal programs provide a high volume of service that allows the smallest of errors to lead to large penalties. In addition, we are part of larger sponsoring agencies that sponsor smaller programs that also fall under DSS audit regulations. Current regulations calculate penalties on an agency's entire volume imposing penalties on small programs that exceed the amount of money that program received under their DSS contract.

It would be expected that any finding of fraud would result in strict and costly penalties however clerical errors should not have penalties that far exceed the value of the error and ultimately adversely affects the seniors our programs are contracted to serve. SB #00283 offers reasonable regulations for minor penalties that will not bankrupt programs that are committed to serving the state of CT's elderly residents. We fully support the passing of this legislation.

Respectfully Submitted,
Joel Sekorski, President
CT Association of Nutrition and
Aging Service Providers



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Norwich, Connecticut 06360-2326

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Senator Doyle, Representative Walker and Members of the Human Services
Committee

Re: SB 283 (Raised), AN ACT CONCERNING AUDITS BY THE DEPARTMENT OF
SOCIAL SERVICES

As President and CEO of United Community and Family Services, Inc. (UCFS), I
would like to express my support for SB 283.

We fully support the right of our funders to audit our agency however we also expect that audits will be conducted fairly and consistently. The language in SB 283 clearly outlines the amount of notice the agency to be audited will be given, fairness in how extrapolations are applied, expectations regarding how findings are reported and an appeal process. All this is good business. State agencies and private agencies are partners in service provision. In order to meet expectations, both parties need to agree to, and fully understand, what the expectations are. We need to know what the rules are in order to follow them. Clearly outlining expectations between partners ensures that solid relationships are maintained, which in the end benefits the clients we serve.

Charles Seeman
President/CEO

March 2, 2010



**Testimony Submitted 3/2/10 to the Human Services Committee
By Mary-Kate Gill, Director of Elder Services, New Opportunities, Inc.**

As a provider of a number of services for clients of the CT Home Care Program, New Opportunities, Inc. strongly supports House Bill No. 283: An Act Concerning Audits by DSS.

In 2002, DSS audited New Opportunities, Inc. and examined a sample of 96 claims for Meals on Wheels, homemaker and companion services and emergency response systems. 2 claims for companion services had errors. DSS did not dispute the fact that the companion services were delivered – the hours of service were properly verified by the clients' signatures. The only error was that the companion had failed to check the type of activities (reading, monitor client activities) she had engaged in with her client. Therefore these two claims totaling \$34.56 were disallowed. The penalty for these two errors was \$10,485.00.

The Department of Social Services policy is that penalties for any errors are calculated using an extrapolation formula based upon the total of all payments for the two-year period being audited, including payments made to New Opportunities, Inc. for Meals on Wheels, Chore and Emergency Response System services. These programs had no errors, yet all payments received by New Opportunities, Inc. from DSS for these services were included in the calculation of penalties for Companion Program errors. It should be noted that the total payment to New Opportunities, Inc. for companion services for the two-year audit period was approximately \$20,000.

Although we were assured by DSS that our agency had, in fact, a very good audit, this was little consolation to our organization as we were forced to pay this huge penalty. We urge your support to implement fair and reasonable audit practices. Current DSS audit policy seriously impacts our capacity to provide services to our community's frail elders.

Please contact me at 203-575-4209 if you wish additional information. We thank you for your consideration and hope to have your support for this important legislation.

Mary-Kate Gill
Director of Elder Services
New Opportunities, Inc.
232 North Elm St.
Waterbury, CT 06702
mgill@newopportunitiesinc.org

T19
16-16

Statement of Martin Sbriglio
on behalf of the
Connecticut Alliance for Subacute Care
before the
Human Services Committee
March 2, 2010
Senate Bill 283

Sen. Doyle, Rep. Walker and members of the committee:

My name is Martin Sbriglio. I am president and chief executive officer of Ryder's Health Systems, Inc., that owns and operates several long-term care facilities in Connecticut. We are not some out-of-state conglomerate—we are a family-owned company that has tried to do the best we can in serving the needs of our patients for 60 years. I am also representing the Connecticut Alliance for Subacute Care, a small state association that has affiliated members in this industry.

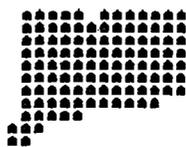
I would like to offer brief comments on Senate Bill 283, An Act Concerning Audits by the Department of Social Services.

This bill will bring some fairness back to the audit process. It makes a great deal of sense and I hope you will pass it. Specifically, SB 283 will:

- Give providers like myself an explanation of the audit process in writing before it starts.
- Limit the sampling of claims to prior two-year period.
- Allow us to have a final report of the matter, dispute it, or take the issue to Superior Court if we feel that step is justified.

I can go into each of these elements individually if you would like.

Overall, the playing field on these audits is not level. The provisions of SB 283 will rectify this and allow us to concentrate on our core mission of providing consistent, high-quality care to our patients. Thank you.



Connecticut Association for
**HOME CARE
 & HOSPICE**

Leadership | Education | Advocacy | Information | Collaboration

T29
 24-5

TESTIMONY CONCERNING

SB 283 – AN ACT CONCERNING AUDITS BY THE DEPARTMENT OF SOCIAL SERVICES

Before the Human Services Committee

March 2, 2010

Senator Doyle, Representative Walker, and members of the Human Services Committee, my name is Brian Ellsworth and I am President & CEO of the Connecticut Association for Home Care & Hospice (CAHCH), whose members serve over 100,000 elderly, disabled, and terminally ill Connecticut citizens. CAHCH is pleased to provide comments in support of S.B. 283, which proposes to add important due process protections to Department of Social Services' (DSS) audits of providers, as well as establish a 10% error threshold prior to extrapolation of audit findings.

It is important to note that CAHCH members' experience on DSS financial audits has significantly improved from the myriad of problems we had five years ago. This improvement is no doubt due to the enactment of several bills in 2005 (Public Acts 05-195 & 272), which clarified policy on physician signatures on the plan of care and electronic recordkeeping, as well as formalized an internal DSS review process on audit findings. The Department has significantly improved its communication with home care providers, giving us better insight on audit trends and issues to watch. The improved communication has included DSS making presentations to our membership and working with us to clarify policy issues as they have arisen. We appreciate the Department's willingness to engage in a dialogue to promote compliance.

However, given the budget deficit, the Department's hiring of 12 new auditors and possibility of turnover of key personnel, concerns still remain about the use of extrapolation in DSS audits. An important concern is the difficulty that a provider would have if they were to challenge the Department's final audit findings in Superior Court. The proposed bill would remedy this problem by clearly establishing a right to go to Superior Court to challenge an administrative determination. We see this as a critical check and balance on the Department's authority to extrapolate audit findings as we sail into the headwinds of major budget deficits.

Also of concern is the ability of DSS to extrapolate audit findings even when they represent a small portion of a provider's billings and/or are of a minor clerical nature. Medicaid rates for home health providers are already 30% below the actual costs of care, further cuts through the audit process, when not accompanied by fraud or willful misconduct, are particularly troublesome.

If the General Assembly, in its infinite wisdom, is concerned that the proposed bill's error threshold of 10% is too high, we would urge you to NOT throw the baby out with the bathwater and to adopt the other changes in the bill as proposed, including the aforementioned due process protections and the clarification regarding clerical errors, and modify the proposed error threshold as necessary.

Thank you for the opportunity to present our concerns to you.

(T48)
30-29

TESTIMONY IN SUPPORT OF SB 283: AN ACT CONCERNING AUDITS BY THE DEPARTMENT OF SOCIAL SERVICES

Senator Doyle, Representative Walker, and members of the Human Services Committee, my name is Nancy Trawick-Smith and I am the director of Community Companion and Homemaking Services, a non-profit companion-homemaker agency in Willimantic. I am also a member of the Board of Directors of the Connecticut Homemakers and Companions Association. I am testifying in support of ²⁸³SB ~~286~~: AN ACT CONCERNING HOMEMAKER AND COMPANION AGENCIES AND AUDITS FOR VENDOR FRAUD. Homemaker and companion agencies are currently audited by the Department of Social Services Department of Quality Assurance to ensure that providers are not being paid for service that has not been provided or service that is not authorized. Auditors basically review documentation, which in the case of homemaker-companion agencies are the timesheets of the employees providing the service. They check to make sure that the service performed does not exceed the service ordered by the program case managers, that the timesheets are properly signed by the client or caregiver, and the activities performed are the activities ordered. Rather than review all of the agency documentation, the auditor will review a sample of maybe 100 visits and look for errors. When an error, for example, a one-hour over service is found the dollar amount of that error is recouped. Because we are dealing with a sampling, DSS will not only recoup what they have paid for that hour. They will compute an error rate for your sample and multiply that by the entire universe of your claims for the two-year period that is being audited. Suddenly a \$16 error- a one-hour error- turns into a \$3200 error. The idea behind extrapolation is that if you had this error rate in the sampling you must have had the same error rate all the time. The problem is there is no margin for error. You can have a "near perfect" audit and still pay thousand and thousands of dollars back to the government. You have to understand the nature of these "errors". Perhaps it is over servicing a client by a couple of hours because there was a problem with a dryer and the homemaker forgot to call to get the extra time authorized. It might be because a daughter signed a timesheet for her mother and the agency forgot to let the access agency know that a signature is different. These are all hours that are provided but someone merely failed to get the proper authorization or make a phone call within the allowable time period. This bill would create a 10% margin of error.

Currently, any appeal of the audit process goes to just another entity within the Department of Social Services. This would allow the agency to appeal the decision of the Department of Social Services to the Superior Court. This seems only reasonable considering sometimes we are talking about the Department of Social Services recouping tens of thousands of dollars from an agency

because of an unauthorized signature on a timesheet or a homemaker who spends too long at a client's home.

Currently, Companion-Homemaker agencies are paid a maximum of \$16.32 per hour by the access agencies. They are only paid for the time that they are with the client. They are not paid for travel time and they are not reimbursed for mileage to transport an older person to the doctor or the store. When they have to pay back something like \$3200 for a \$16 error this really hurts. Once again in many cases the service has taken place, the employee paid but someone has failed to get the proper authorization for a needed service or the wrong person, maybe a son or daughter, has signed without proper authorization. Errors like these don't constitute fraud.

I would like to thank you for hearing my testimony and encourage you to contact me with any questions you might have.

Nancy Trawick-Smith
Chairman, Connecticut Homemakers and Companions Association
Director, Community Companion and Homemaking Services
90 South Park St.
Willimantic, CT 06226
Tel: (860) 456-3626
Email: (860) 456-0107



T9 10-7

Companions & Homemakers

We know what you're going through.

MARCH 2, 2010

HUMAN SERVICES COMMITTEE

TESTIMONY OF COMPANIONS & HOMEMAKERS, INC. IN SUPPORT OF RB 283 AN ACT CONCERNING AUDITS BY THE DEPARTMENT OF SOCIAL SERVICES

My name is J. Martin Acevedo and I am the General Counsel of Companions & Homemakers, Inc. (C&H), a homemaker-companion agency in business since 1990. C&H has 10 offices throughout the State of Connecticut. The company cares for over 3000 older adults and employs over 1600 caregivers. C&H provides services to private pay clients as well as clients of the Connecticut Home Care Program for Elders administered by DSS. We are here to testify in favor of RB 283.

This bill seeks to amend the statute that enables DSS to perform audits of its providers and assess extrapolated penalties following an audit. Extrapolation is the process by which the average error rate found in a random sample of audited claims is "extrapolated" to the entire universe of claims paid to the provider. A small billing discrepancy, scrivener's error, or overpayment, can and will translate to thousands of dollars in extrapolated charges.

Under current law, DSS can impose extrapolated penalties even in the absence of fraud and also based upon errors of clerical nature. To this date, DSS has neglected to enact regulations or standards to ensure the fairness of the audit process. To our knowledge, no policy transmittals have ever been issued putting providers on notice of the specific grounds upon which DSS relies to determine whether a specific offense can result in extrapolated charges. Shockingly, there is no right to a hearing before a hearing officer to contest the results of an audit, nor is there a right to appeal the results of an audit in court.

This proposed bill does not eliminate extrapolation. Rather, its purpose is to bring the audit process in line with Medicaid and Medicare law. Federal law sets forth minimum standards which must be met before extrapolation can be applied and also provides a right of judicial review of the results of an audit.

Tel: 860-677-4948 Fax: 860-409-2530 613 New Britain Avenue, Farmington, CT 06032

www.CompanionsandHomemakers.com

March 2, 2010
Human Services Committee
Testimony of Companions & Homemakers, Inc.
Raised Bill 283.
Page 2 of 4

Audits are time-consuming, uncertain, and unduly stressful events. It is not unusual for an audit process to last several months. By the time the process is concluded, only a few months will go by before the next audit looms in the horizon.

In our case, we have undergone these audits for years. Despite our relentless efforts to "cross every 't' and dot every 'i,'" DSS will inevitably find cause to extrapolate. Because there are no written regulations or standards governing the process, DSS is free to craft new grounds for extrapolation with every new audit, without prior notice to the provider. Because there is no right of appeal, the auditor's discretion to extrapolate cannot be challenged as arbitrary or capricious.

DSS' unchecked power to exact extrapolated payments from providers without accountability is reminiscent of totalitarian-like societies. In my research, I have yet to find a similar state statute wherein a state actor can, in essence, effect a "taking" without due process of law.

Not surprisingly, this unfettered authority can and has lead to instances of abuse and arbitrariness.

For example, during an exit conference to discuss the results of an audit in 2003, my client asked why it was being audited and extrapolated on a regular basis despite its meticulous recordkeeping and low error rate. The DSS auditor looked at my client and, drawing a "bullseye" circle in the air, told her—in the presence of her attorney—that she was considered a "big target." My client, understandably, was shocked.

It is no secret that we have actively advocated for statutory audit reform, most recently during the 2008 and 2009 legislative sessions, efforts which DSS has vehemently opposed.

Significantly, on June 4, 2009, just one day after the 2009 session adjourned, DSS' Office of Quality Assurance served my client with three notices of audit. Unlike prior audits, in which only claims pertaining to one access agency would be audited, this audit encompassed all three access agencies with which we have contracts. DSS also refused to give us the specific sample information before the commencement of the

March 2, 2010.
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Testimony of Companions & Homemakers, Inc.
Raised Bill 283.
Page 3 of 4

audit. As a result, we were forced to file a Freedom of Information request. Shortly thereafter, the auditors agreed to give us the sample information for one out of the three access agencies in question.

The sample information consisted of the names of 100 clients and certain dates in which our caregivers rendered services. Upon closer examination, we were dismayed to find out that, out of the 100 clients, 16 were repeats from our 2007 audit. These were difficult cases—cases DSS knew could result in a significant disallowance if errors were found.

Given we have approximately 1000 clients with this access agency, it reasonably follows DSS could not have chosen the audited sample at random. This, again, raises additional questions about the fairness of the audit process and the internal methodologies employed by DSS to audit its providers. Keep in mind that, for extrapolation to be reliable, the sample must be random and statistically valid. Otherwise, the results of audit are biased and unreliable.

To this date, our Freedom of Information requests for information pertaining to the manner in which DSS randomly selects providers for audits and claims to be audited remain largely unanswered.

These actions, and countless others not told by others for fear of retribution, pale in comparison to what was done to Dr. Richard Weber, a DSS provider who is testifying today. Dr. Weber was referred to criminal prosecution by the Office of Quality Assurance after he dared to complain to former Representative Christel Truglia about the fairness of the audit process and the practices of the Office of Quality Assurance. Dr. Weber filed suit in federal court to vindicate his rights. In the fall of 2008, the State settled the lawsuit and paid Dr. Weber \$725,000 in damages for what was done to him. (A copy of the settlement agreement, which we obtained through Freedom of Information, is attached.)

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Page 4 of 4

We understand and agree that audits are necessary to preserve the integrity of the system. We do not quarrel with that proposition. Audits, however, must be conducted fairly and in accordance with due process of law.

We believe the proposed amendment to the audit statute will help curb future abuse and arbitrariness against law-abiding service providers subject to the specter of an audit. The proposed amendment also will incorporate into the statute desperately needed procedural due process protections and other mechanisms for ensuring the integrity and fairness of the audit process and the sampling methodologies employed by the Office of Quality Assurance.

Passing this bill is a matter of basic due process and fundamental fairness—a matter of right and wrong. At a minimum, the statute should be amended to require DSS to issue regulations to ensure the fairness of the audit process and to include a right to formal administrative and judicial review.

We urge you to do everything within your power to ensure Raised Bill 283 becomes law.

Thank you for your consideration.

ATTACHMENTS

1. True Copy of \$725,000 settlement agreement between the State of Connecticut and Dr. Richard Weber.
2. Exhibits A and B consisting of copies of 2 timesheets from our 2009 audit, each reflecting the extrapolated amount charged (\$25,166 and \$12,583, respectively) based upon the absence of "checkmarks"—a scrivener's error.



T46 30-1

*Statement Before:
The Human Services Committee
Tuesday, March 2, 2010*

Re: RB 283: An Act Concerning Audits by the Department of Social Services

Good morning Rep. Walker, Sen. Doyle and members of the Human Services Committee. 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 approximately 1,000 pharmacists in the state. I am here to testify in strong support of RB 283: An Act Concerning Audits by the Department of Social Services.

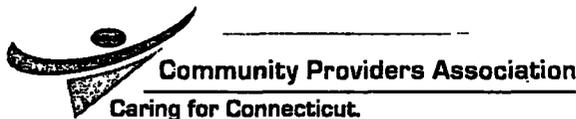
The Connecticut Pharmacists Association was the lead organization in spearheading audit reform within the Department of Social Services several years ago. Our intent was to provide relief to pharmacies that were taking unfair financial hits through the department's practice of extrapolation. New legislation was passed in 2005 helping improve this situation. However, the inclusion of section (d)3(C) in current law, which allows extrapolation when "the value of the claims in aggregate exceeds one hundred fifty thousand dollars on an annual basis" virtually excludes every pharmacy in this state. What this means specifically to pharmacies, is that they continue to be unfairly treated in terms of shouldering significant and unwarranted financial fines.

To this point, we endorse and strongly support RB 283 as it attempts to clarify what audits allow as well as it strengthens the ability of providers to be protected when clerical vs. fraudulent issues are found. In Section I(d)(2) the time period and number of claims allowed for review is defined. Additionally, Section I(d)3 clarifies that clerical errors cannot be the basis of extrapolation. Most audits reveal clerical errors from part-time clerks. These errors have come at great expense to pharmacies. For example, one pharmacy is currently opposing a fine because a prescription did not include a diagnosis code on the hard copy, but the computer records did. For this, the state is fining the pharmacy \$324,000. Another pharmacy reported a bill of \$200,000 for this same issue.

We also support Subsection (4) for several reasons. It states that extrapolation can only occur when the payment error rate involving the provider is greater than 10 percent and removes the language that allowed for extrapolation if the claims in aggregate exceeded \$150,000. This is critical to pharmacies as most do have claims in aggregate in excess of \$150,000 due to the cost of pharmaceuticals and the number of prescriptions processed. In other words, currently all pharmacies are still subject to extrapolation.

Additionally, we are supportive of Section 12. Section 12 states that the department must adopt regulations ensuring the fairness of the audit process, including sampling methodologies. It seems as though there is significant bias in the current process for claim selection in that selection tends to be only those claims that are extremely expensive thus ultimately benefiting the state and hurting the pharmacy.

We urge the committee to support this legislation. With the addition of new auditors, we know that the state will be vigilant to recoup funds. We just ask that it be for the appropriate reasons of fraud, waste or abuse, not clerical or technical errors.



T39

28-1

March 2, 2010

To: Human Services Committee

From: Terry Edelstein, President/CEO

Re: Testimony on S.B. 283 AAC Audits by the Department of Social Services

Please accept this testimony regarding S.B. 283. We support the proposed legislation for its goal of making the DSS audit process an open, transparent process. That is not the situation right now.

The Connecticut Community Providers Association represents organizations that provide services and supports for people with disabilities and significant challenges including children and adults with substance use disorders, mental illness, developmental, and physical disabilities.

We spoke to this issue a year ago in your Committee. Once again we ask you to approve legislation that will remedy a process that is greatly in need of repair. This past year most organizations providing psychiatric services to children have been audited by DSS. While our Association has been offering training in "corporate compliance" for many years, few providers were prepared for these DSS audits, for the most part because of the absence of clear, written policies and procedures governing the audits. It is important to note that these same providers are licensed and monitored by state agencies and subject to federal and state fiscal audits. They aren't strangers to a regulatory process.

Not only has the DSS audit process been a "work in progress" but the preliminary audit findings are threatening the financial viability of some of the community provider agencies.

As an association, we made numerous efforts to meet with DSS in order to clarify the process and better educate our members about what to expect in the audit process and how to prepare. Our efforts were rebuffed many times over. Nine months ago we framed an agenda for a

CCPA

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CCPA Testimony on S.B. 283 AAC Audits by the Department of Social Services
March 2, 2010 – page 2

meeting that was subsequently cancelled that highlights the myriad of issues that needed to be addressed. As you will see at the end of this written testimony, our all over goal was to assure compliance, but we needed verification of the rules governing the audit process. We sought concrete information about audit tools, written guidance, and resolution of specific documentation details. Finally we asked DSS to provide training for private providers to assure audit compliance.

Without guidance from DSS, our association relied on consultation from a number of law firms. We established our own corporate compliance forum for education and sharing of best practices. And we encouraged each private provider agency undergoing an audit to contract with its own legal counsel to represent the organization in the audit process. As one provider wrote to me, "I don't thing that the state wants us to waste taxpayer dollars on the time consuming and costly process of resolving audit issues, when dollars are better spent on care which is in short supply already," let alone make paybacks in the six figures.

To highlight a few of the critical issues that SB 283 would address:

1. There were no written policies and procedures governing the audits. There are no regulations governing the program. This makes it extremely difficult to comply with an audit when there are no explicit up front rules on the process. Other states utilize formal audit guidelines and regulations. Connecticut should do the same.
2. The audits were focused on paper compliance. Based on the preliminary audit findings, providers have been cited on technical documentation issues, most notably relating to physician signatures and appointment start and end times. With extrapolation, these technical errors have been magnified resulting in potentially devastating paybacks.
3. Most auditors were new to the field of auditing children's mental health programs. There was uncertainty about what information they were seeking and how that information was to be documented. Sampling methodologies were not clear. There seemed to be no standardization in the auditing process.

We appreciate the opportunity of testifying and welcome the opportunity of working with the Committee and DSS with regard to improving the audit process.

CCPA Testimony on S.B. 283 AAC Audits by the Department of Social Services
 March 2, 2010 – page 3

CCPA agenda proposed to DSS June 10, 2009:

1. Goals of the meeting
 - a. Assuring compliance
 - b. Verification of the “rules” governing the audit process
 - c. Assuring transparency of the process
 - d. Making improvements to the process
2. Issue areas
 - a. Audit tools
 - i. Audit checklist
 - ii. Audit manual
 - iii. Case selection process
 - iv. Extrapolation methodology
 - b. Official guidance
 - i. Statutory references
 - ii. Regulations
 - iii. Policies
 - iv. Official memoranda
 - v. Creation of a compliance manual
 - c. Process details
 - i. Assuring consistency between/among auditors
 1. Auditor training?
 2. Auditor guidance on detail they are seeking?
 - ii. Timing for resolution of audit findings
 - d. Implementation detail
 - i. Medical Direction
 1. Clarification of MD responsibility
 - a. Medical direction
 - b. Acceptable supporting documentation
 - i. In chart only?
 - ii. In Medicaid application?
 - iii. In table of organization?
 - iv. In job descriptions?
 2. MD/ Psychiatrist sign off
 - a. Timing for sign-off
 - b. Timing of updated of sign offs
 3. Progress notes
 - a. Sign off responsibility
 - b. Model notes
 4. Consistency between 2003 Parrella letter and federal policy
 5. APRN sign off status
 6. Verification of medical necessity
 - ii. Definition of start time, end time
 - iii. Billing codes
 1. Use of correct billing codes
 2. Addressing clarifications and updates to billing codes
 3. Consistency between DSS and Behavioral Health Partnership in providing guidance to providers
 - e. Industry status
 - i. Audit findings
 1. Standard issue areas and process for rectifying
 2. Agency-specific issue areas
 - ii. Resolving current audit exposures
3. Training for the field

T23

20-7

TESTIMONY OF RICHARD B. WEBER, M.D.
JOINT COMMITTEE ON HUMAN SERVICES
MARCH 2, 2010

Good morning Mr. Chairman and Committee members. My name is Richard Weber. I have been a practicing physician in Stamford, CT since 1987. I am a board certified internist and ophthalmologist and assistant clinical professor at Albert Einstein Medical School in New York. I was contacted a few weeks ago by the proponents of Raised Senate Bill No. 283 concerning the manner in which audits are conducted by the Department of Social Services ("DSS").

Evidently, through a Freedom of Information request, the bill's proponents discovered that the State of Connecticut settled claims that I had brought against the Department of Social Services and Office of the Chief States Attorney and multiple employees of these departments, including those in DSS's office of Quality Assurance and former DSS Commissioner Patricia Wilson-Coker. The bill's proponents asked me to share this experience with you. I do so with great interest and concern for other medical providers who encounter the DSS audit process.

My experience with DSS spans a period of more than ten (10) years. In the interest of brevity, I will inform you that I was the subject of an audit in 1999 at which time 8,000 extrapolated dollars were recouped by DSS for my use of a specific billing code. My office had consistently used that code based on instructions from DSS in 1995 and, as recently as September of 2006, my office manager again confirmed its use with provider relations by telephone.

As a result of the audit and my disappointment in the process and how I was treated, I contacted my State Representative Crystal Truglia. Representative Truglia, who asked me to prepare a letter outlining my experience which she forwarded to then DSS Commissioner Wilson-Coker.

Of great interest to this Committee should be the fact that on the very day that Commissioner Wilson-Coker responded to Rep. Truglia, the manager of the office of Quality Assurance, in retaliation for my letter to my representative and in violation of my right of free speech, had his staff initiate a criminal referral to the Medicaid Fraud Control Unit for investigation, prosecution and my eventual arrest.

During this investigation a Search Warrant was executed at my office with patients and staff present by armed Inspectors of the Medicaid Fraud Control Unit and Stamford Police Department, to seize about twenty five patient charts which could have just as easily have been obtained via other noninvasive and non-confrontational methods.

With the assistance of my attorney who is here with me today, Michael Kogut, and the law firm of Murtha Cullina, LLP, we vigorously fought the charges which I always believed were malicious and unfounded. Specifically, during a hearing for suppression and dismissal of the search and arrest warrants based upon violation of my right of free speech by contacting Rep. Truglia, heard by Judge Christine Keller in Hartford Superior Court, we prevailed as the state dismissed the charges after multiple days of testimony before Judge Keller.

Shortly thereafter, we sought permission to sue the State, Office of Chief States Attorney and Department of Social Services along with multiple state employees. The claim lingered and we were unable to receive any redress from the Claims Commission.

We therefore filed suit in federal court in December, 2006 against the same actors charging violation of my civil rights, malicious prosecution, wrongful arrest and overall wanton and reckless behavior by DSS and its employees during my entire audit process. After countless hours away from my practice and depositions and extensive discovery, the state finally settled in October, 2008.

Through the extensive discovery and FOIA request process we had a unique, though costly, look at the Department of Quality Assurance and its managers. I have reviewed an extensive number of audits, documents, computer printouts, provider complaints and correspondence.

My review of the DSS audit process revealed that often times it is arbitrary, capricious and very unfair to providers who generously serve a disadvantaged group of patients without the right to independent review or appeal from the draconian decisions of DSS. I should note that at the time I was audited, Medicaid represented less than two (2) percent of my overall reimbursement.

In light of my extensive experience with DSS and its Office of Quality Assurance, I think I have a somewhat unique viewpoint of Raised Bill No. 283. I applaud the bill's proponents and respectfully ask the Committee to give providers only what they are entitled to. A fair and objective process with the right to independent review and appeal.

I believe Section 2 of the original bill should limit review of claims to one (1) year.

In regard to Section 3, I would hope that the legislature would add to the list of items which cannot be extrapolated any billing dispute, legitimate grievance, or arbitrary ruling of the department, or any ruling which is not backed by an absolute rule, is capricious, not uniformly enforced, or the provider believed to be correct, etc.

As for Section 4, in light of the actions of the department and need to protect the providers, I would hope that the "or" just before "(B) documented....." would be changed to "and". This would protect the provider from at least the extrapolated damages resulting from DSS's arbitrary and inconsistent enforcement of certain rules for certain providers. I also believe the claims in the aggregate exceeding \$150,000 on an annual basis should remain in subsection (C).

In regard to Section 6, again, in light of the prior conduct of this department, 30 days after the provider gives the required documentation should be sufficient to provide a preliminary report. Providers may have to report to their HMO's, insurers, licensing boards, hospitals etc, that they are under some type of investigation and limiting the time of this procedure would be beneficial to the provider as well as the state. We are aware of one instance where at least four years after the provider gave documentation, the department still had not produced a signed preliminary report and the audit remained open.

In regard to Section 7, again there is no time limit set for DSS to arrange the exit conference. This is to the detriment of the provider who would like for the audit to be closed.

As for Section 8, the provider should also have to agree to this later date, or the audit should be closed in favor of the provider.

In regard to Section 9, the appeal to a designee of the Commissioner is not a fair and independent review. In the past the appeal of an audit decision was directly to the Quality Assurance manager's supervisor. In addition, all sign offs for referral to the MFCU had to be approved by the same supervisor. After a FOIA request, the Department was unable to provide a single document to us where the supervisor overruled the manager's decision either to change an audit or overrule a referral for criminal investigation.

As far as I am concerned, this appeal process is ineffective. I would hope that the person or persons undertaking the appeal would not be a state employee but rather perhaps a panel of providers, physicians, nursing home personnel, or other independent knowledgeable individuals.

Lastly, the appeal to Superior Court provision contained in Section 10 is essential to maintain integrity in the process.

DSS has a huge budget yet there is no medical director over seeing this expenditure of funds or to act as an intermediary to this state agency.

Thank you all for your time and interest.

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

RICHARD B. WEBER, M.D.	:	CIVIL NO. 3:06cv2009(PCD)
<i>Plaintiff</i>	:	
	:	
v.	:	
	:	
JOHN F. MCCORMICK, ET AL.	:	
<i>Defendants</i>	:	October 2, 2008.

SETTLEMENT AGREEMENT AND GENERAL RELEASE

WHEREAS, the plaintiff, Richard B. Weber, M.D. (hereinafter "Dr. Weber" or "plaintiff") brought the above-referenced civil action in Federal Court in Connecticut; and,

WHEREAS, all defendants deny any liability or wrongdoing and this Settlement Agreement and General Release (hereafter "Agreement") shall not be construed as an admission or finding of any guilt or wrongdoing by any of the defendants; and,

WHEREAS, the plaintiff and the defendants have determined that settlement of this action would best serve their interests;

NOW THEREFORE, in consideration of mutual covenants and promises set forth below, the plaintiff and the defendants agree as follows:

1. Within two business days of the effective date of this Agreement, plaintiff shall, pursuant to Rule 41(a)(1)(ii) of the Federal Rules of Civil Procedure file the Stipulation of Dismissal, signed by counsel for the parties hereto, an unsigned copy of which is attached.

2. Richard B. Weber, M.D., does on behalf of himself, his successors and assigns, for and in consideration of the sum of \$725,000.00 (Seven Hundred Twenty Five Thousand Dollars) paid by the STATE OF CONNECTICUT, herewith release and forever discharge, the STATE OF CONNECTICUT, the Office of the Chief State's Attorney, Christopher Morano, Kevin Kane, David Best, John DeMattia, Nancy Salerno, Concezio DiNino, Steven Oborski, Brian Leslie, Robert Maurer, Jr., Kenneth O'Brien, Paul Murray, Lawrence Skinner, the Connecticut Department of Social Services, John McCormick, Donna Frank, Mark Comerford, Patricia Wilson-Coker, James Wietrak, all in their individual and official capacities, and all other present or former officers, agents and employees of the State of Connecticut, from all actions, causes of actions, suits, claims, controversies, damages and demands of every nature and name, in law or in equity, including attorneys' fees and costs, which plaintiff ever had, now has or hereafter can, shall or may have, including but not limited to the claim filed with the Office of the Claims Commissioner, File No. 20099 and any claim of any sort related to the allegations of the plaintiff in either this action or Claim File No. 20999.

3. The payment of \$725,000.00 (Seven Hundred Twenty Five Thousand Dollars) to Dr. Weber shall be made within thirty days of the federal court's entry of the judgment of dismissal in this case.

4. Dr. Weber forever waives his right to request the Connecticut General Assembly to review the decision of the Claims Commissioner dated December 7, 2007, in File No. 20099, or any claim or action regarding the individuals and state agencies named above. Dr. Weber also waives his right to initiate any claim or

action in the Connecticut General Assembly related to the allegations in his complaint. Dr. Weber forever waives his right to the propriety of any and all rulings made in this matter including the dismissal of all claims in this matter.

5. Plaintiff and his attorneys understand and agree that the State of Connecticut will report its payments of the settlement proceeds to all appropriate taxing authorities, and the defendants make no representation regarding the tax consequences of these payments. The plaintiff's counsel agrees to provide the defendants' counsel with a completed form W-9 immediately upon the signing of this agreement as a condition precedent to the payment set forth in the above paragraph.

6. The plaintiff agrees that the payment referenced above are the only payments to be made by the defendants and/or by the State of Connecticut in connection with the claims asserted by the plaintiff, including but not limited to, claims for punitive damages, compensatory damages including emotional distress, and any claims for costs, interest, attorney's fees, or other litigation expenses.

7. The parties agree and understand that this Agreement hereto, does not constitute an admission of any kind by the defendants of any liability or wrongdoing whatsoever, and may not be used in any pending or future legal proceeding, except as may be necessary to enforce the provisions of this Agreement, or as otherwise required by law.

8. Plaintiff represents and agrees that he fully understands his right to discuss any and all aspects of this Agreement with his counsel, and that he has availed himself of this right to the full extent he desired to do so. Plaintiff further represents and agrees that he has carefully read and fully understands all of the provisions of this Agreement, that

he had a reasonable amount of time in which to review and consider this Agreement and that he has the capacity to enter into this Agreement.

9. The plaintiff and the defendants acknowledge that they consent to this Agreement as their free act and deed, and that they enter into this Agreement without any coercion or duress.

10. This Agreement shall bind the parties, their heirs, administrators, representatives, executors, successors and assigns.

11. This Agreement shall be construed as a whole according to its fair meaning, and not strictly for or against any of the parties. Unless the context indicates otherwise, the term "or" shall be deemed to include the term "and" and the singular or plural number shall be deemed to include the other.

12. This Agreement shall be governed by the substantive laws of the State of Connecticut.

13. The provisions of this Agreement are severable. If any part of it is found unenforceable, all other provisions shall remain fully valid and enforceable, unless the unenforceable provision is an essential element of the bargain.

14. The Agreement is effective on the date that it is signed by plaintiff and counsel as provided below.

PLAINTIFF

Richard B. Weber
Richard B. Weber, M.D.

STATE OF CONNECTICUT)
COUNTY OF Fairfield)

ss. 10/2/08, 2008

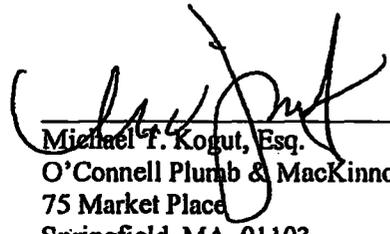
Personally appeared before me Richard B. Weber, M.D., signer and sealer of the foregoing Settlement Agreement and General Release, who acknowledged the same to be his free act and deed before me.

Mark Ross

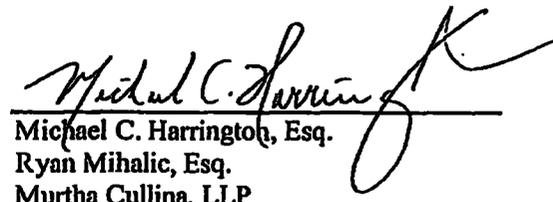
Notary Public/
Commissioner of the Superior Court

**My Commission Expires
Dec. 31, 2010**

THE PLAINTIFF
Richard B. Weber, M.D.



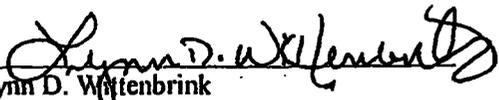
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Exh. A.

10-6

COMPANIONS & HOMEMAKERS, INC. TIME SHEET
 P.O. Box 568 Farmington, CT 06034-0568
 P (860) 677-4948 • F (860) 674-8978

CLIENT NAME Lois [redacted] Employee Name [redacted]
 (Please Print) (Please Print)
 Week Ending date 9/28/07 Office: Please Circle Urbicfield Hartford • New Haven
 (Always Sunday) Farmington • Fairfield • Glastonbury • Old Saybrook • Norwich • Middletown • Enfield • Southbury

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	TOTAL
DATE	9/24	9/25	9/26	9/27	9/28			
TIME IN	2:00	2:00	3:00	3:00	3:00			
TIME OUT	7:00	6:30 PM	7:00	7:00	7:00			
DAILY TOTAL								19.5

CLIENT FULL SIGNATURE DAILY

[Handwritten signatures for each day: Lois, Lois, Lois, Lois, Lois]

** Your signature authorizes the billing of the above hours and that the hours are accurate.
 *** Please do not authorize in advance of service.

Employee Signature: [redacted] Date: 9/28/07
 NOTE: CLIENT MUST SIGN FOR EACH VISIT!

If for any reason a client signature cannot be obtained at the time of visit, call the office immediately for instructions.

Please check off tasks completed.

Companion

- Supervise activities
- Reminder for medication
- Escort to activities / appt.
- Assist with communications
- Accompany on walk
- Other: _____

	MILEAGE						
	Mon	Tue	Wed	Thur	Fri	Sat	Sun
Supervise activities	✓	✓	✓	✓	✓		
Reminder for medication	✓	✓	✓	✓	✓		
Escort to activities / appt.				✓			
Assist with communications	✓	✓	✓	✓	✓		
Accompany on walk	✓	✓	✓	✓	✓		
Other: _____							

Mileage Approval Client Signature _____

Homemaker

- Vacuuming / Dust / Mop
- Bathroom / Kitchen
- Laundry / Change Linens
- Clean refrigerator
- Shopping / Errands
- Meal Preparation / Clean up
- Other: _____

2009 Audit
 \$25,166

Eth. B.

COMPANIONS & HOMEMAKERS, INC. TIME SHEET

P.O. Box 568 Farmington, CT 06034-0568
P (860) 677-4948 • F. (860) 674-8978

CLIENT NAME JOYCE KIRWAN Employee Name MELCIE LAUREL
(Please Print) (Please Print)

Week Ending date 4/1/02 Office: Please Circle
(Always Sunday) Farmington • Fairfield • Glastonbury • Litchfield • Old Saybrook • Norwich • Middletown • Enfield • So.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	TOT.
DATE		4/1/02	4/2/02					
TIME IN		3:30	3:30					
TIME OUT		7:30	7:30					
DAILY TOTAL		4	4					8

CLIENT FULL SIGNATURE DAILY
J. Kirwan *J. Kirwan*

** Your signature authorizes the billing of the above hours and that the hours are accurate.
*** Please do not authorize in advance of service.

Employee Signature: _____ Date: _____

NOTE: CLIENT MUST SIGN FOR EACH VISIT!

If for any reason a client signature cannot be obtained at the time of visit, call the office immediately for instructions.

Please check off tasks completed.

- Companion**
- Supervise activities
 - Reminder for medication
 - Escort to activities / appt.
 - Assist with communications
 - Accompany on walk
 - Other: _____

- Homemaker**
- Vacuuming / Dust / Mop
 - Bathroom / Kitchen
 - Laundry / Change Linens
 - Clean refrigerator
 - Shopping / Errands
 - Meal Preparation / Cleanup
 - Other: TAKE HER OUT

MILEAGE							Mileage Approval Client Signature	
Mon	Tue	Wed	Thur	Fri	Sat	Sun		
	✓	✓						

2009 Audit \$121.583

canpfa

Dedicated to Creating the Future of Aging Services

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

Presented to the Human Services Committee

By Mag Morelli

March 2, 2010

Regarding

- **Senate Bill 283, An Act Concerning Audits by the Department of Social Services**
- **House Bill 5354, An Act to Provide Incentives for Hospital to Adopt Electronic Health Records**
- **House Bill 5232, An Act Concerning Transfer or Discharge of Residential Care Home Patients**

Good morning Senator Doyle, Representative Walker, and members of the Human Services Committee. My name is Mag Morelli and I am the President the Connecticut Association of Not-for-profit Providers for the Aging (CANPFA), an organization of over 150 non-profit providers of aging services representing the full continuum of long term care. I am here today to present testimony in favor of Senate Bill 283, An Act Concerning Audits by the Department of Social Services and House Bill 5354, An Act to Provide Incentives for Hospital to Adopt Electronic Health Records, and against House Bill 5232, An Act Concerning Transfer or Discharge of Residential Care Home Patients

Senate Bill 283, An Act Concerning Audits by the Department of Social Services
CANPFA supports this bill and has long called for modifications to the audit process to make it more effective and efficient, as well as less costly for the providers. Therefore we support this bill which we believe would bring efficiency to the audit process and encourage the state to perform their audits in a timelier manner.

Currently the Department has up to seven years to perform an audit of a skilled nursing facility provider's cost report. The providers, and particularly the smaller providers, are at a disadvantage when their cost reports are audited after such a long period of time. The documentation requirements are very strict and a late audit may require hard copy financial documentation of invoices and cancelled checks from over ten years ago. The hours of staff time spent researching and retrieving documentation for an overdue audit can be very costly for a facility. As you can imagine, the changes in staffing, software and bookkeeping systems over the years can exacerbate this problem. And most upsetting, when a bookkeeping error is found after ten or so years, the extrapolation of that error can mean thousands of dollars in penalties – not because the error was intentional or egregious, but just because it happened so long ago. In fact, there have been cases where the auditor approved a nursing facility's bookkeeping method – but several years later the next auditor did not agree. The facility was then penalized for utilizing that previously approved method for the several years that ensued between audits.

The modifications to the audit process proposed in Senate Bill 283 would go a long way to resolve these issues. We would suggest a few minor changes to the proposed language:

- In the new section (2) we would request that the concept of cost reports audits be referenced and accommodated so that it would read "...shall be limited to a review of claims OR COST REPORTS filed during the two-year period prior to the date the provider receives written notice from the commissioner of the audit, pursuant to subdivision (1) of this subsection, or, IN THE CASE OF FEE FOR SERVICE REIMBURSEMENT, two hundred claims, whichever is less." This change is necessary to accommodate skilled nursing facility cost report audits that are included in this bill.
- In the new section (4) we would suggest maintaining the "sustained or high level of payment error" standard rather than the 10% error rate and would eliminate the \$150,000 cap. Limiting extrapolation in this manner brings the Medicaid audit process in line with Medicare standards under the Medicare Modernization Act.

House Bill 5354, An Act to Provide Incentives for Hospital to Adopt Electronic Health Records

CANPFA supports the state's efforts to secure private and federal funds for investment in health information technology and the development of a state-wide health information exchange. We would like to raise awareness with the Committee that long term care providers are very important electronic health record users and that the successful