

PA 14-162

HB5500

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**CONNECTICUT
GENERAL ASSEMBLY
HOUSE**

**PROCEEDINGS
2014**

**VOL.57
PART 9
2693 - 3043**

Have all members voted? Have all members voted?
Will the members please check the board to determine
if your vote is properly cast?

If all members have voted, the machine will be
locked and the Clerk will take a tally.

Will the Clerk please announce the tally.

THE CLERK:

House Bill 5592 as amended by House "A."

Total number voting	144
Necessary for passage	73
Those voting Yea	144
Those voting Nay	0
Those absent and not voting	7

(Deputy Speaker Sayers in the chair.)

DEPUTY SPEAKER SAYERS:

The bill as amended is passed.

Will the Clerk please call Calendar Number 217.

THE CLERK:

On page 42, Calendar Number 217, favorable report
of the joint standing committee on Appropriations,
Substitute House Bill Number 5500, AN ACT CONCERNING
PROVIDER AUDITS UNDER THE MEDICAID PROGRAM.

DEPUTY SPEAKER SAYERS:

Representative Abercrombie.

REP. ABERCROMBIE (83rd):

Good evening, Madam Speaker. It's a pleasure to see you up there.

DEPUTY SPEAKER SAYERS:

It's a pleasure to see you, ma'am. And Happy Birthday.

REP. ABERCROMBIE (83rd):

Thank you.

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

DEPUTY SPEAKER SAYERS:

The question before the chamber is acceptance of the joint committee's favorable report and passage of the bill.

Representative Abercrombie, you have the floor, ma'am.

REP. ABERCROMBIE (83rd):

Thank you, Madam Speaker.

Madam Speaker, the Clerk has an amendment, LCO 4464. I ask that the Clerk please call the amendment and I be granted leave of the chamber.

DEPUTY SPEAKER SAYERS:

Will the Clerk please call LCO Number 4464, which will be designated House Amendment Schedule "A."

THE CLERK:

LCO Number 4464, designated House "A" and offered by Representative Abercrombie and Senator Slossberg.

DEPUTY SPEAKER SAYERS:

The Representative seeks leave of the chamber to summarize the amendment. Is there any objection to summarization? Is there any objection?

Hearing none, Representative Abercrombie, you may proceed with summarization.

REP. ABERCROMBIE (83rd):

Thank you, Madam Speaker.

Madam Speaker, this is a strike-all amendment, which now becomes the bill. What this bill does is it makes a number of changes to auditing process concerning Medicaid providers. You know, our providers are only looking for fairness and they want some legislative oversight. I have to tell you this is a bill that we've been working on for a couple of years. I would like to take this opportunity to thank my ranking member, Representative Terrie Wood, who has been instrumental in this process and I move adoption.

DEPUTY SPEAKER SAYERS:

The question before the chamber is adoption of House Amendment Schedule "A." Will you remark on the amendment?

Representative Wood of the 141st.

REP. WOOD (141st):

Thank you, Madam Speaker.

I would also like to thank the chairman of the committee because this is a very important bill that we've been working on and certainly you've done tremendous due diligence and this is something we hopefully everyone will support. One question to the proponent of the bill, through you, Madam Speaker.

DEPUTY SPEAKER SAYERS:

Please prepare your question.

REP. WOOD (141st):

Were the -- I know the dental community had significant concerns about the audit process as it was. Have they signed on to this current language, through you, Madam Speaker.

DEPUTY SPEAKER SAYERS:

Representative Abercrombie.

REP. ABERCROMBIE (83rd):

Yes, through you, Madam Speaker, yes, they have. And we've also included in it that DSS not only has to

have a medical provider, but also a dental specialist on staff, through you, Madam Speaker.

DEPUTY SPEAKER SAYERS:

Representative Wood.

REP. WOOD (141st):

Great. Thank you. No further questions and I stand in very strong support of the amendment.

DEPUTY SPEAKER SAYERS:

Representative Miner of the 66th.

REP. MINER (66th):

Thank you, Madam Speaker.

If I might just a few questions to the proponent of the amendment, please, through you.

DEPUTY SPEAKER SAYERS:

Please prepare your question, sir.

REP. MINER (66th):

Thank you, Madam Speaker.

Madam Speaker, there was a time, I think earlier this spring that a number of us met with a private audit company that had been contracting on behalf I think of a number of different agencies in the state and their sole purpose was to look at records and find fraud. And through you to the gentle lady, is this different than fraud?

DEPUTY SPEAKER SAYERS:

Representative Abercrombie.

REP. ABERCROMBIE (83rd):

Through you, Madam Speaker, yes, it is.

DEPUTY SPEAKER SAYERS:

Representative Miner.

REP. MINER (66th):

Thank you, Madam Speaker.

And so the circumstances that are embedded in this amendment really are what might otherwise be some kind of an error so some kind of a coding adjustment that might be embedded in policy then rather than an outright act to try to defraud the state of Connecticut out of money. Is that correct, through you?

DEPUTY SPEAKER SAYERS:

Representative Abercrombie.

REP. ABERCROMBIE (83rd):

Thank you, Madam Speaker.

Through you, Madam Speaker, yes, you're absolutely correct. What this gets to is more the process, the protocols, which according to the providers is lacking, and goes to the clerical errors

that we are seeing through the process. Through you, Madam Speaker.

DEPUTY SPEAKER SAYERS:

Representative Miner.

REP. MINER (66th):

Thank you, Madam Speaker.

You know, I referred to a meeting that I had and I know others did with one of the providers, one of the people who actually looked at the books, looked at the files and was required, I guess, to make some presumptions on this extrapolation and one of the things that they mentioned to me was that it seemed pretty clear to them that this was in most cases a difference of opinion and so that without clear guidance from the Legislature, the agency wouldn't know how to direct them. They were coming back with findings and no one was taking any action on it. I was the other day having some dental work done as a matter of fact and my dentist mentioned to me that they were concerned that the state had asked many of them to take on large pools of our Connecticut citizens through the HUSKY program or some other and now we're feeling like we're playing this game of gotcha. And so, Madam Speaker, I am happy to support

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the amendment. I'm happy to support the bill and I do know that both chairs and the ranking members have worked hard to get this resolved and so thank you very much.

DEPUTY SPEAKER SAYERS:

Thank you, sir.

Representative Srinivasan.

REP. SRINIVASAN (31st):

Good evening, Madam Speaker.

DEPUTY SPEAKER SAYERS:

Good evening, sir.

REP. SRINIVASAN (31st):

It's good to see you there, Madam Speaker.

DEPUTY SPEAKER SAYERS:

Thank you.

REP. SRINIVASAN (31st):

I, too, rise in strong support of this amendment because several dentists have approached me not just this year, but in the last term as well, very concerned about these audits and that they do not have a clear-cut protocol as to what are the criteria that is used when the dentist have been audited so I'm glad that through the chair and the ranking member over the

years we now have a system in place moving forward when these audits are conducted.

Through you, Madam Speaker, just two questions for the proponent of the amendment.

DEPUTY SPEAKER SAYERS:

Please prepare your questions, sir.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker.

Through you, Madam Speaker, the audits that are in the books right now, would these rules also apply to them moving forward or will it only be for audits that are -- that come to the books after we pass the bill. Through you, Madam Speaker.

DEPUTY SPEAKER SAYERS:

Representative Abercrombie.

REP. ABERCROMBIE (83rd):

Through you, Madam Speaker, this will pertain to anyone that is getting an audit, through you, Madam Speaker.

DEPUTY SPEAKER SAYERS:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker.

So if an audit has not been resolved and it is in process than these rules would apply to them, as well, Madam Speaker. Through you, Madam Speaker.

DEPUTY SPEAKER SAYERS:

Representative Abercrombie.

REP. ABERCROMBIE (83rd):

Through you, Madam Speaker, I think the challenge is going to be that the dates that are -- this goes into effect, it's going to take some time for DSS to put the protocols on the website to get staff in place so depending on the time line I'm not sure if current audits will get the same luxury. Through you, Madam Speaker.

DEPUTY SPEAKER SAYERS:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker.

And through you, my final question is this process of extrapolation that exists, will that continue and that was not clear while reading the bill about the dollar amount and how the extrapolation will happen going forward? Through you, Madam Speaker.

DEPUTY SPEAKER SAYERS:

Representative Abercrombie.

REP. ABERCROMBIE (83rd):

Thank you, Madam Speaker.

Through you, the extrapolation is not being changed in this bill because it goes to the budget, which was not in the budget, but from what we heard from the providers, the biggest issue is not having the protocols in place, not being able to get the proper training to know what is considered a clerical error so our hope is by having these standards put in place and for the providers to be able to see them that there will be a better understanding so that the extrapolation will not be as severe as we've seen in the past, through you, Madam Speaker.

DEPUTY SPEAKER SAYERS:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker.

And I want to thank the good chairwoman for her answers. Thank you.

DEPUTY SPEAKER SAYERS:

Thank you, sir.

Representative Carter of the 2nd.

REP. CARTER (2nd):

Thank you very much, Madam Speaker.

You know, we have a lot of different kind of bills that come through this place and when I started learning about some of the policies that were going on in the state, I was taken back to my days in the military and we would get these huge inspections where somebody would come and there would be a huge IG team to check everything out, but afterwards, one of the best parts was they would actually go through piece by piece by piece and talk about what the findings were so we only knew -- we knew the rules coming in and we were prepared and we knew what they were looking for and on the other side, we knew the rules and we knew the findings so we could improve ourselves. You know, that's not -- that's not what has been happening in Connecticut and I really think that this is a great bill and I think it goes a long way to helping a lot of people in our state so I will support it and I hope everyone else does, too.

Thank you.

DEPUTY SPEAKER SAYERS:

Thank you, sir.

Will you remark? Will you remark further on the amendment that is before us?

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

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER SAYERS:

Those opposed, nay.

The ayes have it. The amendment is adopted.

Will you remark further on the bill as amended?

Representative Wood.

REP. WOOD (141st):

Thank you, Madam Speaker.

I just have a few further comments in support of this bill. We had heard from the dentists in particular that the audit process was highly penalizing to them if they made a very simple mistake on their -- in their filing form and they had made a great deal of effort to gain more dentists participating in the Medicaid program. They went from 140 to 1600 in last three or four years and they're very proud of that effort to serve that -- that community and a lot of dentists were -- didn't want to stay on because of the punitive aspect of these audits. So part of the bills that I think -- plus with the dentists, 80 percent of the challenged -- 80

percent of the challenged dentists won their appeal so clearly there was something highly punitive and not effective in the way they were coordinating the audit.

What this does is DSS provides and publishes a website to provide free provider training to help avoid errors in filling out the forms and it helps with the compliance aspect of it and also DSS has to report to the Human Service Committee February of next year. So they will report to us. We do have oversight over this and I think it makes a great deal of sense. It's commonsense and we're respecting the process, but still honoring what needs to be done. So thank you, Madam Speaker. I stand in support of this.

DEPUTY SPEAKER SAYERS:

Thank you.

Will you remark further on the bill as amended?

Will you remark further on the bill as amended?

If not, will staff and guests please come to the well of the House. Will the members please take your seats. The machine will be opened.

THE CLERK:

The House of Representatives is voting by roll.

The House of Representatives is voting by roll. Will members please return to the chamber immediately.

DEPUTY SPEAKER SAYERS:

Have all members voted? Have all members voted?
Will the members please check the board to determine
if your vote is properly cast?

If all members have voted, the machine will be
locked and the Clerk will take a tally.

Will the Clerk please announce the tally.

THE CLERK:

House Bill 5500 as amended by House "A."

Total number voting	143
Necessary for passage	72
Those voting Yea	143
Those voting Nay	0
Those absent and not voting	8

DEPUTY SPEAKER SAYERS:

The bill as amended is passed.

Will the Clerk please call Calendar Number 420.

THE CLERK:

On page 26, Calendar Number 420, favorable report
of the joint standing committee on Insurance and Real
Estate, Substitute Senate Bill Number 199, AN ACT
CONCERNING LONG-TERM CARE INSURANCE PREMIUM RATE
INCREASES.

DEPUTY SPEAKER SAYERS:

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GENERAL ASSEMBLY
SENATE**

**PROCEEDINGS
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**VETO
SESSION**

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SENATE

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May 7, 2014

House Bill 5115, move to place on the Consent
Calendar.

THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

And also, Madam President, Calendar 500 on Page 17,
Calendar 5547, move to place on the Consent Calendar.

THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

Thank you, Madam President. Moving to Calendar Page
18, where there is one item, Calendar 507, House Bill
5530, move to place on the Consent Calendar.

THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

Thank you, Madam President. Moving to Calendar Page
19, where we have four items. The First, Calendar
514, House Bill 5521, move to place on the Consent
Calendar.

THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

And the second, Calendar 516, House Bill 5500, move to
place on the Consent Calendar.

THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

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Calendar 500, House Bill 5547.

On Page 18, Calendar 507, House Bill 5530.

On Page 19, Calendar 512, House Bill 5386.

Calendar 514, House Bill 5521.

Calendar 516, House Bill 5500.

Calendar 517, House Bill 5305.

On Page 20, Calendar 527, House Bill 5592.

Calendar 528, House Bill 5453.

On Page 21, Calendar 531, House Bill 5299.

Calendar 533, House Bill 5290.

On Page 22, Calendar 541, House Bill 5456.

Calendar 539, House Bill 5294.

On Page 24, Calendar 551, House Bill 5588.

Calendar 552, House Bill 5269.

On Page 25, Calendar 564, House Bill 5489.

Calendar 562, House Bill 5446.

(HB5466)

On Page 26 --

THE CHAIR:

Hold on. Okay. Sorry. Please proceed.

THE CLERK:

On Page 26, Calendar 568, House Bill 5434.

Calendar 569, House Bill 5040.

Calendar 566, House Bill 5535.

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SENATOR LOONEY:

If we might pause for just a moment to verify a couple of additional items.

Madam President, to verify an additional item, I believe it was placed on the Consent Calendar and Calendar Page 30, on Calendar Page 30, Calendar 592, Substitute for House Bill 5476.

THE CHAIR:

It is, sir.

SENATOR LOONEY:

It is on? Okay. Thank you. Thank you, Madam President. If the Clerk would now, finally, Agenda Number 4, Madam President, Agenda Number 4 one additional item ask for suspension to place up on Agenda Number 4 and that is, ask for suspension to place on the Consent Calendar an item from Agenda Number 4.

THE CHAIR:

Seeing no objection, so ordered, sir.

SENATOR LOONEY:

Thank you, Madam President, and that item is Substitute House Bill Number 5566 from Senate Agenda Number 4.

Thank you, Madam President. If the Clerk would now, if we might call for a vote on the Consent Calendar.

THE CHAIR:

Mr. Clerk. Will you please call for a Roll Call Vote on the Consent Calendar. The machine will be opened.

THE CLERK:

An immediate Roll Call has been ordered in the Senate.

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An immediate Roll Call on Consent Calendar Number 2 has been ordered in the Senate.

THE CHAIR:

If all members have voted, all members have voted, the machine will be closed. Mr. Clerk will you please call the tally.

THE CLERK:

Consent Calendar Number 2.

Total number voting	36
Necessary for adoption	19
Those voting Yea	36
Those voting Nay	0
Those absent and not voting	0

THE CHAIR:

The Consent Calendar passes. Senator Looney.

SENATOR LOONEY:

Thank you, Madam President. Two additional items to take up before the, our final vote on the implementer. If we might stand for just, for just a moment.

The first item to mark Go is, Calendar, to remove from the Consent Calendar, Calendar Page 22, Calendar 536, House Bill 5546. If that item might be marked Go.

And one additional item, Madam President, and that was from Calendar, or rather from Agenda Number 4, ask for suspension to take it up for purposes of marking it Go, that is House Bill, Substitute for House Bill 5417. Thank you, Madam President.

THE CHAIR:

Seeing no objection, so ordered, sir.

SENATOR LOONEY:

**JOINT
STANDING
COMMITTEE
HEARINGS**

**HUMAN
SERVICES
PART 3
934 – 1259**

2014

She is out of the building with a family commitment. Having said that, our first speaker this morning is from the public official's list. We welcome Commissioner Bremby from the Department of Social Services.

Good morning, Commissioner.

COMMISSIONER RODERICK BREMBY: Good morning, Senator Slossberg, distinguished members of the Human Services Committee. My name is Rod Bremby. I'm the commissioner of the Department of Social Services and I'm here to testify before you this morning on two bills that impact the Department, Senate Bill 409, AN ACT CONCERNING THE DEPARTMENT OF SOCIAL SERVICES. This bill requires the department to conduct a study of DSS programs to include, one, the responsiveness of department programs to recipients of services; two, identification of problems, if any, that exist within such programs; and three, whether staff is allocated in a manner to meet the need for services within such programs.

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SENATOR SLOSSBERG: Commissioner, I'm just going to stop you just for second. I'm going to remind you and everyone else. Because we have somebody who is, you know, keeping up with typing wise and signing, I'm going to ask everybody to slow down.

Okay. Pam, I think we need you to shift just a smidge. How is that? Okay. We're working this out. We're working this out. We're working this out.

Thank you, Commissioner. Please continue.

COMMISSIONER RODERICK BREMBY: Sure. The Department of Social Services supports the basic needs of children, families, elders and older persons

application processing as an area in need of improvement. In response, we launched four long-term care hubs solely dedicated to processing these applications. In addition, we recently an auto-initiate a redetermination so that people whose documents have been received in Connect CT do not lose benefits. Through these efforts, we've seen an improvement in the timeliness of processing applications, paperwork is no longer being lost and consumers are able to reach us in person, by phone and online.

Speaking specifically to this bill, we have a number of concerns. First, the scope of the study is not defined. It is unclear if the intent of the bill is for the department to study all programs administered by the agency, which would be extensive or if there are specific programs in particular that the report should focus on. This bill also requires the department to report on responsiveness of department programs to recipients; however, this may be difficult to ascertain. First, the definition of "responsiveness" is going to differ depending on who is interpreting the language. Second, a follow-up study of this magnitude would mostly have to be contracting out as we do not have the resources to dedicate to this.

The Governor's recommended mid-term budget, however, does not include any additional funding for such a study. Also, the RFP for consulting services would take a considerable amount of time allotted to complete which may not fit within the time frame that the bill allows.

Moving on quickly to House Bill 5500, AN ACT CONCERNING PROVIDER AUDITS UNDER THE MEDICAID PROGRAM, this bill proposes several new

provisions to be added the department's statutes, which govern the provider audit process. The department has a long history of understanding the need for compliance audits and the value that audits bring to the Medicaid assistance programs. The department also understands that without the ability to recoup overpayments for noncompliance, the audits would be rendered worthless. The investment in this compliance function has paid dividends. The Connecticut Medicaid program has one of the lowest payment error rates in the United States. The Centers for Medicaid and Medicare services audits the payment accuracy of all state Medicaid programs on a three-year cycle. The fiscal year 2012 published estimated error rate for Connecticut is 2.2 percent. This error rate is less than half of the national average and puts Connecticut in the top tier of Medicaid programs.

The primary purpose of our audit division is to ensure compliance. For the fiscal year ending June 30, 2013, the audit division issued 130 audit reports identifying approximately \$20 million in overpayments. The need for compliance in the multibillion dollar Medicaid program cannot be understated. Connecticut's medical assistance programs are governed by an extensive and comprehensive array of federal and state policies, regulations and statutes. Enrolled providers are entrusted to understand all applicable guidelines and accurately bill for all covered services. Most are granted the right to bill directly for goods and services rendered with relatively few upfront edits. It is then our responsibility to ensure that both the fiscal and programmatic integrity of these claims. In addition, we believe there may well be a direct correlation between poor billing compliance and the quality of the related medical services.

For example, a provider cited for inaccurate or out-of-date documentation of care plans may be relying inadequate or outdated clinical information in making decisions affecting patient care. It is important to note that the proposed provider audit requirements regulations were drafted in collaboration with the Office of the Attorney General and we anticipate that they will be taken up by the Regulations Review Committee at their April meeting. These regulations are a response to Public Act 10-116, which required the department to adopt regulations that would ensure the fairness of the audit process including but not limited to the sampling methodologies associated with the process. The department believes that any changes to the statute should be postponed to allow implementation of audit regulations developed pursuant to that directive. As background, our QA provider audit process uses a sample of audit claims in an extrapolation method to determine the number of payment errors and the amount of overpayments the state needs to collect from providers. Extrapolation takes the results of a sample, applies it to the large claims universe, providers must make repayments to the state based on these error amounts.

The Connecticut Supreme Court upheld the use of this method in the 2008 Supreme Court ruling Gold Star Medical Services, Inc, et al., versus the Department of Social Services. Providers aggrieved by this decision in a final audit report may request a review of the audit findings which is performed by a designee of the commissioner outside the Office of Quality Assurance. And if a provider is not satisfied with the audit review, the provider may appeal to the superior court. In addition to this

formal review process, providers may request the director of the Office of Quality Assurance to perform an informal review of a final audit report. The department has the discretion to suspend the recoupment of payments while an appeal is pending.

We have specific comments regarding the provisions of the bill that I will not go through at this time so as to expedite the -- the hearing. So I'll stop and wait for any questions that you might have.

SENATOR SLOSSBERG: Thank you, Commissioner.

And thank you for your testimony today. As you know, we're going to be hearing more from various people with regard in particular to the audit bill and, you know, I wonder if you have any comments in regards to the number of concerns that people have raised the audit process is -- can be overly cumbersome and fraught with, you know, initial findings that seem incredibly -- the words are harsh. I know there was in one instance where an initial -- initial letter goes out and says someone is -- you know, has committing an error in the amount of \$10 million and it turns to be something more than a couple of thousand, but in the meantime, it is -- causes -- you know, reeks havoc on an agency. You know, I wonder if you have thoughts of how we can address some of that. You know, on the one hand, recognizing that the department needs to be rigorous in the audit process, but there is -- you know, it's got to be balanced as well and I think most of our providers do a good job and are honest in trying to comply with the requirements, but you know, it seems like -- I think there is this sense of, you know, people, on the one hand you're looking for fraud, but really almost making like a hostile work environment. I'm

wondering if you could share some thoughts on, you know, where you go with that.

COMMISSIONER RODERICK BREMBY: I have heard a number of concerns about the way in which our audit process operates. What I can say is that is that we have a set of regulations that's currently being formed and promulgated. And in that process, we've had a number of comments received. We've amended those regulations to reflect some of the concerns and we think that the committee will take up that set of regulations next month and I think that is probably the best process to go through. With specific issues, sometimes people conflict or conflate the payment audit function with fraud audit or fraud investigation. They are to wholly different processes. The provider audits are those processes where we come in to take a look to ensure that providers are actually billing correctly, using the correct code or some other provision that -- that is outlined in the provider agreements.

Some of the difficulty comes when you have a sample and in that sample there is a violation or perhaps an overpayment and that overpayment ratio is extrapolated to the full universe of claims. That methodology is used by a number of states around the country and that methodology was challenged here in the state of Connecticut all the way to the Supreme Court level so it was upheld. We continually look for better ways. In fact, we think that that best possible way to reduce some of the concerns is by getting out more -- getting out in front of audits to help train provider groups on what we're looking for, what the audit process entails, how we are pulling our samples. It's that sort of upfront preventive work, I think, that can eliminate the findings, if you will, that we sometimes uncover.

We have a process for recoupment that is fairly flexible. We don't attempt to recover all of the overpayment all at once, but we go through a process to try to work out something that's reasonable and doesn't create harm for the business. The providers that we work with here we need in our program. They preserve -- the perform a very vital and valuable service, but at the same time, the funding that we use to pay the providers is wholly the states. It also belongs to CMS and so we're obligated to CMS for the funding that provide for us to pay our providers for the services they over to the people we serve that the payment is accurate and so we are an agent, if you will, of ensuring that these payments are as accurate as they can be. So yes, I have heard of concerns. We continue to find ways to try to alleviate or avoid the concerns, but I think the best methodology for reducing those concerns is getting out in front and doing more education training and sharing of the process.

SENATOR SLOSSBERG: Okay. One other question in regards to that, though, we've heard a lot, you know, in the last -- as a matter of fact for as long as I've been in this building, we've had a -- there has been this discussion about having dentists participate in the Medicaid program and I can remember the arguments about, you know, rates and access and it -- it's been a ongoing and longstanding problem that has, you know, in the last number of years gotten better in terms of the number of providers, but now we're hearing from dentists quite significantly that the audit process in particular is not fair to them and that they're being audited by medical providers who are not familiar with ADA standards and that as such they're -- it's not an appropriate review and couple that with the

extrapolation methodology, there is some real concern. Could you address that?

COMMISSIONER RODERICK BREMBY: Yes. Late last fall, my leadership team and I met with the Connecticut Dentist Association about these very concerns. We followed up by having the QA office attend a meeting to talk with providers about what we're looking for and how audits are conducted and performed. We've also entered into an agreement with an external entity to provider independent review of findings so that we can have a more well-versed current assessment of the actual work that's being performed by dentists. So we did hear that concern. In talking about the dental program very briefly, you're absolutely correct. Connecticut had a poor dental program years ago due to improper payments mostly and also difficultly in enrolling a number of dentists.

Today, Connecticut has the best Medicaid dental program in the nation because of the commitment of our providers and the enhanced payments that are offered. We do not want to see a reduction in the number and the quality of our providers and so we're very attentive and we will continue to make the necessary adjustments so that we can get a healthy balance between payment audit efficiency and correctness and finding a way to increase the enrollment of providers in our programs. They perform a very valuable service for us.

SENATOR SLOSSBERG: Okay. Thank you very much and thank you for your commitment to working with them. I know that this is a serious concern for many of us. With that, I'm just going to see if there are questions. I think Senator Markley may have had some, but --

Representative Ritter.

REP. RITTER: Thank you, Madam Chair.

Thank you, Commissioner. I hope everybody on the committee knows that this particular topic has also been one that has come before the medical assistance program oversight committee. It's been the subject of the report just issued on network adequacy that came from legislation last year and will be undoubtedly further discussed there briefly this coming Friday and then I'm hopeful that a week from -- a month from this coming Friday, the report discussion may be able to continue and I just wanted to make sure everybody knew that because there is information also in that report pertinent to this particular topic of this audits. And sorry if I wasn't specific on that.

In addition, and I'm quite sure the committee knows about the program review and investigation report on the audits also that you can find easily access on their website. It was pretty thorough and has a lot of information if this is -- and it's good information for us to keep before us when we look at this because it does provide explanations of all these processes. I'm glad -- thank you, Madam Chair, for mentioning the dentists. It's only recently that I've had some conversations with -- with the dentists and also I was able to discuss that with representatives from the audit division of DSS, too, to try to understand what it is exactly that has changed and at least a very important component of the conversation is a better understanding on the part of the providers, the quote, targets, or whatever, of the audits of exactly what it is that is being audited, the procedures and what they -- and what the exact expectations are and it's my opinion that a lot of this arises because that just had not been

perhaps happening or heard. I don't know which, but in ways that I think could enhance the process greatly and undoubtedly enhance its ability to act on what needs to be acted on and not act on what does not need to be acted on.

So it's certainly an interest of my that this continues to look at that. And, Commissioner, if you want to respond that, that will be fine, but we will indeed be continuing to talk about this. Thank you.

COMMISSIONER RODERICK BREMBY: We look forward to additional conversation about this topic. I think you're absolutely correct. I think that many providers who have not been audited previously, may not know the level of detail or exactly what we're looking for and how we come to our conclusions. The agency has stepped up the audit functioning in ways that some providers may have never been audited before and so moving into this new space it's a new experience. I think coupled with that there is the backdrop of conversation around fraud investigation that then conflates with this and so they know people in the public space know that the agency is attempting to increase our ability to identify and root out fraud and they believe that they audits are somehow that functionality and they're not.

The team that goes out to review fraud is pretty sure that they know what they are looking for and it's a wholly different experience. The audit investigation is pulling samples and going through just to make sure that the payment methodology comports so there is a lot more to learn. There is a lot more to share and so we look forward continued conversation around these issues.

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REP. RITTER: And I think I would encourage the committee also to take that as a commitment when we look at what we're intending to do here and it's -- absolutely this is how it should be happening and if it's not, shame on all of us in order to change that or turn it around I think we quite possibly want to continue discussions along that way and do what we can to help the agency be able to keep up that end of the commitment. Thank you.

SENATOR SLOSSBERG: Okay. Thank you.

Senator Markley.

SEANTOR MARKLEY: Thank you, Madam Chair.

And thank you, Commissioner. You know, I often -- we have these discussions on a regular basis. I think I'll see you tomorrow again at the other meeting, in fact, and your answers are always responsive and express concerns with exactly the things that are concerning me, they're reassuring in that respect and nonetheless sometimes I feel the frustration, which I think is natural as a legislator, which is you feel responsible for making sure that things are done correctly, but you're standing an arm's length from it and you're dependent on the executive branch to make these things happen.

Let me just ask you something on that score concerning your testimony on Senate Bill 409 concerning a study of the Department of Social Services. You know, I've had a communication from social service advocates who are not necessarily the people who are first turning to me when they have concerns about their frustrations with the -- with the progress of the roll out and I almost -- I almost feel about mentioning to you because I know how much

horrible and so I think we can argue that in many respects we're both right, but let me conclude by saying that this agency is committed to exceptional service. We're also mindful that that service begins with not only technology, but high human touch and we'll never walk away from that, but we need to start with the very basics of data and metrics and that's something, as an agency, we have not had before. We're developing and so those future annual reports we will begin to report out on not just what we're doing and how many people we're touching, but how we're doing it. Timeliness, I could go on and on. Timeliness is better than it's ever been before. I can say that a number of pending cases is 30 percent below January 2012. I can go on and on about the data, but it doesn't help if we're not communicating that data on a real time basis.

We have committed to MAPOC to begin to put up dashboards, public dashboards so people can take a look and see how things are going.

SEANTOR MARKLEY: Thank you very much for that answer, Commissioner. And I do think that the figures that presumably you're looking at on a regular basis that indicate the progress generally available would go a long ways towards assuaging people's concerns about the implementation of this system, which is obviously an enormous and overdue undertaking. And as I said, the first time we spoke that something that if you can accomplish will be -- you will have done a favor for the state of Connecticut.

Let me ask you on the -- on the question of the audits, I, too, have heard especially from the dentists with their concerns and I was very sympathetic to their position, which is we have

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made a real effort to step up on the Medicaid side of things and now we feel that we're to some extent suffering for it. Is it the intention of the department that every dentist, in fact, undergo this kind of error audit that -- that is the one that they seem to be the most concerned about?

COMMISSIONER RODERICK BREMBY: It is the intention that the agency audit all of our medical providers, Medicaid program providers at some point. We are I think in the regulations that are being promulgated talks about a process -- it calls out a process. We may not audit every one every three years. Some we may audit consecutive years and then skip several years so there is some randomness about that, as we think there should be, but it is our intent that all providers be audited at some point in time to ensure that they are billing in compliance with the program rules.

SEANTOR MARKLEY: And when you make the distinction between error and fraud, which certainly is an important distinction, is it -- is it a completely separate audit function which is going after those two things. In other words, if the fraud side is identified by -- by aspects of the billing that would raise suspicions, whereas, the error audit is just a regular kind of rolling audit. Is that correct?

COMMISSIONER RODERICK BREMBY: That is correct. And also, we had a conversation I think my first year here where we were talking about the audit function and we were talking about the use of predictive analytics. That skill set, that technology is now in place so based upon really good sense of targets or behavior that then drives the fraud investigation. Provider audits are more random and routine, just

checking to make sure that the billing is done appropriately. So when I say the fraud investigation function is wholly different, it's a wholly different group of people as well.

SEANTOR MARKLEY: The folks who are doing the error investigations are an outside firm that's contracted or is paid on a percentage of their recovery. Is that correct?

COMMISSIONER RODERICK BREMBY: We have contracted with a company, HMS, to perform some rack audits for us. They are a contingency-based company so if they find overpayment and underpayment they are compensated. So if a provider has under billed the agency, this auditor is agency, this provider is also compensated and we also suffice to say notify the entity that you've under billed us and so you need to accurately reflect that.

SEANTOR MARKLEY: And what is the expertise of the people that are assigned to do these audits in terms of -- let's say the dental profession. Is this a function that can handled by anybody with a proper kind of bookkeeping background or is it something that you need to understand the specialty in order to do it properly?

COMMISSIONER RODERICK BREMBY: There have been occasions where audit findings have been challenged. What the auditors are attempting to do is match up a billing against a service and also to assess whether that service is even necessary. In those cases, what we do repetitious services so maybe there is an extractions, several extractions on the same side of the mouth or something. In those situations now and going forward with a contract, we bring them in to analyze that to review that because some providers are saying

no this is medically -- no, this was medically necessary, but our auditor is sitting there looking at the frequency and so when there's a conflict, we're now using providers who can say they are correct even though that does not appear to be appropriate. As a medical provider, we can tell you that it is or it was in this instance. So the background of our folks, most of them have financial backgrounds, audit services backgrounds, accountants. They're more the financial investigative types. They're not typically medical types who go in to perform these audits, but the supports to review -- to look over their shoulder to help guide are practicing professionals.

SEANTOR MARKLEY: Thank you very much, Commissioner.

And thank you, Madam Chair.

SENATOR SLOSSBERG: Thank you, Senator, for your questions.

And just to clarify, on to the last question that Senator Markley asked, I understand that you get guidance from medical providers, but I think the operative question with regard to the dentist is are those dentists?

COMMISSIONER RODERICK BREMBY: We have contracted with an organization for dentists to provide dental guidance to our investigators as they have completed an audit and where there is a difference of opinion. That has not been the case. I mean, because of we're hearing, we knew that we need to change.

SENATOR SLOSSBERG: And so when did that change?

COMMISSIONER RODERICK BREMBY: I don't have the date of the contract, but I can -- I can get you the information.

SENATOR SLOSSBERG: But that's recent?

COMMISSIONER RODERICK BREMBY: The information of who we contract with.

SENATOR SLOSSBERG: That's a recent change?

COMMISSIONER RODERICK BREMBY: Yes.

SENATOR SLOSSBERG: Okay. Thank you for that. And thank you for your clarification.

Are there any other questions from the members?

Seeing none, thank you again, Commissioner, as always. We appreciate you being here and your good work.

COMMISSIONER RODERICK BREMBY: Thank you very much.

As an agency, I think I can speak on behalf of the men and women who come to work every day seeking to serve Connecticut residents, we appreciate the opportunity.

SENATOR SLOSSBERG: Thank you.

Our next speaker is Commissioner Porter. Good afternoon.

COMMISSIONER AMY PORTER: Good afternoon, Senator Slossberg, and distinguished members of the Human Services Committee. My name is Amy Porter and I am the Commissioner for the Department of Rehabilitation Services. I appreciate the opportunity to be able to share today our department's perspective on Raised Bill 5321, AN ACT CONCERNING INTERPRETER QUALIFICATIONS. Overall, our department supports the intent of this bill. It takes a lot of strides in aligning the state's

MATTHEW KATZ: And remaining members -- remaining members of the Human Service Committee. My name is Matthew Katz. I'm the EVP CEO of the Connecticut State Medical Society. On behalf of our more than 6,000 members, thank you for the opportunity to submit written testimony and provide oral testimony today on House Bill 5500, AN ACT CONCERNING PROVIDER AUDITS UNDER MEDICAID PROGRAM. We believe that there is a significant need today to reform the current audit process under the Medicaid program here in the state and support strongly this committee's efforts. Connecticut physicians and their office staff face significant challenges in preparing for and responding to the audits and financial reviews tied to Medicaid. CSMS believes that there are audit methodologies which can support the state's need to identify deficiencies and over payments as well as underpayments while also ensuring fair and just treatment of physicians during the audit process. We do not have that today.

We support the intent of this bill and offer that further statutory and regulatory changes are, in fact, necessary to protect not only the public, but also the physicians. We strongly believe that there should be no financial ties or incentives during the audit process or recoupment for those that are doing the audits. We believe that in Section E of the bill it should specifically state that there should be a flat fee as opposed to any formula basis or percentage given to the auditors inside or outside of the organization as an incentive. We believe it's a perverse incentive that leads to problems. We feel a greater level of detail needs to be done and provider through the audit process and that they need to be public to ensure that there is no misuse or abuse. Extrapolation methodologies are complex and are statistical. They need to be presented,

identified and explained to anyone going through the audit process. They are not today.

It must be a statistician or someone familiar with statistics. It must be done in a valid, random methodology or stratified when appropriate and necessary. Outliers need to be identified and removed in order for it to be appropriate. We feel strongly that the analysis must be provided within the regulation itself to allow for understanding consistency and adherence. Further, in looking to develop these, we need to make sure that in the context of a visit, we're comparing apples to apples, not apples to grapefruit, which often happens leading to excessive requests initially as was pointed out earlier often later being identified as not being excessive and rather reasonable. In addition, extrapolation needs to actually identify with the physicians undergoing the audit how they need to comply, what information they need to provide. We are dealing with electronic medical records today, someone needs to be familiar with that. We need to ensure that the people reviewing also have a medical understanding background within that same specialty to understand that, in fact, those services may or may not have been reported appropriately in the first place. They have to understand ICD-9, classification of disease as well as current procedural terminology.

The written information provides additional information, but in closing, I just want to say that there needs to be an appeal mechanism and process that does not cause every physician to have to go to court to address if there is a deficiency. It shouldn't be the same agency that initially initiates the appeal that you go to on a secondary appeal and you shouldn't have to go court to find -- to rectify the

situation. So with that, we appreciate the opportunity to provide comment. We're here to answer any questions and work with this committee throughout the process and we really appreciate looking closely at this here today to ensure that physicians who want to be part of the Medicaid program remain part of the Medicaid program and do not leave because of what we see as an abuse of the system.

SENATOR SLOSSBERG: Thank you for your testimony and for being here today. I think we share that common goal and I know that we're working hard to make sure that we do have providers for the Medicaid program and that we continue to have them and that we are good partners in that effort. So we appreciate your expertise and we look forward to working with you on an ongoing basis. Are there any questions?

No questions. Thank you.

MATTHEW KATZ: Thank you very much.

SENATOR SLOSSBERG: Our next speaker is Edward Schreiner followed by Martin Acevedo.

Good afternoon.

EDWARD SCHREINER: Good afternoon.

SENATOR SLOSSBERG: Can you please press the button and make sure your microphone is one? Thank you.

EDWARD SCHREINER: My name is Ed Schreiner. I'm the chairman of the board for Northeast Pharmacy Service Corporation, which is a group purchasing organization representing 105 participating Connecticut pharmacies and a number of others throughout New England. More importantly today, I'm the owner of Stoll's

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Pharmacy in Waterbury, Connecticut, since 1988. So for the past 25 years, I've had a few experiences with Medicaid audits and it's -- it's my perception that audits were originally corrective in nature and educational. They were focused on helping us to submit those clean claims that are required by CMS and over the years that focus has changed and they're much more punitive now. My written testimony has a number of examples in there, but we're seeing routinely to sum it up is we're routinely experiencing recoupments due to the clerical key punch errors and administrative record keeping errors that have nothing to do with fraud and there simple honest errors.

And the examples in my testimony indicate that the audit process regularly seeks to recover hundreds of thousands of dollars from small business owned pharmacies, family-owned pharmacies even when the right patients getting the right drug at the correct price in the program and there is no fraud. I think that speaks powerfully to the punitive nature that audits have become under the Connecticut Medicaid program. I'm just going to highlight one instance in my testimony. The issue of the tamper proof pad. A pad for a Medicaid patient has to have three different criteria to make it tamper proof so we know it's not tampered with. All of the pharmacies I mentioned in there with these 100,000 dollar fines all of them issues where they had accepted -- they may have two of the three criteria but not all three and its incomprehensible to me that a pharmacy can face 100,000 dollar fine for one prescription because the prescription was written on the wrong kind of paper. It's even worse when the pharmacy after the fact, we find these out, we go back to the prescribers, we get authorization, we get documentation that this was the therapy that was intended. The

prescription was filled right, but the audit process doesn't allow any further documentation to verify that that was, in fact, a legitimate prescription and it was filled correctly. The findings stand. The penalties occur.

I have other examples that weren't in my testimony. I could go on and on and on about what's been happening recently. Kind of summary, you know, I would say that you know, the pharmacy community and I'm sure other providers would love to see DSS mandated to go back to the way it used to be where these audits -- and we understand that audits serve a purpose. They certainly help educate the providers. They should be corrective in nature. They should be there to search for those providers that are committing fraud and financially gaining at the expense of the state. We don't have an issue with that, but we think that the audits should go back to being corrective in nature. Federal programs - other federal programs do that. CMS with this Medicare Part D regulations specifically say correct those problems that come up with audits that are clerical in nature. Don't punish the provider. Correct them. I mean, that's what they do under Medicare Part D. I don't know why that doesn't happen in Medicaid.

So in summary, I thank you for your support. I'm so happy to see 5500 coming to light. I would ask and it would be my hope that somehow we could work it so that these clerical errors aren't part of the extrapolation process which comes up with these huge fines, but certainly and my colleagues would certainly appreciate any effort you could give us and any help you could give us to make DSS return to those -- you know, remove those punitive types of penalties and return to the way it was intended to be.

SENATOR SLOSSBERG: Thank you very much.

You know, when the agency comes up and talks about being very consistent about looking at their programs and quality assurance. We hear that and we encourage that, but I'll tell you I don't think anybody wants to be working in a that environment so we appreciate you coming and sharing that and in particular some of the very -- the good specifics that are in your written testimony.

Representative Cook, do you have a question?

REP. COOK: Yes, thank you, Madam Chair.

How are you? Thank you for your testimony.

EDWARD SCHREINER: thank you.

REP. COOK: I just have a quick question. I see the financial burden when it comes to penalties and fines. What does it take out of your manpower in a pharmacy to try to go through and try to prove the fact that this was either a clerical error or something else? Could you elaborate on what that could do to your pharmacy and your staff?

EDWARD SCHREINER: Oh, yeah. Well, I can speak to my personal practice and I'm sure most of the small business owners run it the same way. I mean, I'm the owner of the pharmacy so the buck stops here. So pretty much what happens is when we get these findings and you're sitting and looking at a piece of paper that says you owe 139,000 dollars to the state. The first thing you think is how am I going to pay that. I'm going to have layoff my full-time professional pharmacist. I'm going to have to work 90 hours a week all by myself or I'm going

to have to take out a huge loan and hope they don't come back and do it again because the next time they come and audit me. So what to do we do?

We go back and we look at each single item and we say well what's the finding and what can we do to prove that that was a valid, legitimate prescription so we'll routinely contact doctors. We'll have to contact clinics. We'll get statements from the providers that say yes I did write that prescription. It was a legitimate prescription. That's my signature. I know of owners who have gotten actually medical records from nursing homes and hospital records that show that that patient was seen on that day and was treated and this was what was ordered and this is why it's medically necessary and it seems to be very frustrating that in certain instances as with the tamper-proof pad, none of that is allowable. So that's very time consuming to do. They give us 30 days to respond to the initial audit. I'm aware of pharmacists that go through audits that it ends up dragging out for a year or two and they still end up paying hundreds of thousands of dollars in fines. Eventually what most seems to be more frequently happening is after that first finding comes through now we hire lawyers and there is another added burden.

When we go for that final exit interview, I haven't gone through one myself in a number of years, but I'm told that the DSS representative will have a number of lawyers in the room so it behooves us to have our own representation, which adds another expense, which takes away from our ability to run our businesses.

REP. COOK: Thank you. And I'm sorry for the trouble that you seem to be -- not you specifically, but the pharmacists that have

been having them. I know that we've been fighting to get some money back your way since it's kind of gone back and forth for the last few years, but this is something that we need to fix, Madam Chair.

EDWARD SCHREINER: We do appreciate that. And it's all about fairness and reality. I mean, there is no fraud going on here in most of these cases. I'm not saying that I never happens. I'm saying the penalties are so punitive for what they're finding for infractions, it's just not right.

REP. COOK: Thank you. Thank you.

SENATOR SLOSSBERG: Thank you.

Yes, Representative Case.

REP. CASE: Thank you, Madam Chair.

I appreciate you coming out today. Interestingly enough in one of the towns that I represent, there is a group that is under audit. They've been under audit for a year and a half. Their fines were close to the six figure amount. It's been proven to date so far that 90 percent of them are clerical errors though doctors writing prescriptions and you know, the way the payments come in and it has gone to lawyers and now they've defrayed it down they're around the 20 to 30,000 dollar range and a fine, but the agency is still going forward with -- because they feel they haven't done anything and I hope it comes out to show that they haven't because of what they do and it's just -- like you said, it costs you guys money and it takes away from our -- from what you actually do for the people in the state of Connecticut and what this organization does for the people of the state of Connecticut so I

hope we can resolve it, as was stated before and we can move forward because as you said, once attorneys get involved, state attorneys get involved too, and that costs us a lot of money out of our budget.

EDWARD SCHREINER: Yeah. I'm not surprised to hear to that people are going through that. You know, pharmacy owners, you know, we're all small businessmen in the state just like a lot of other small businesses. We have a lot of pride in our business and when we're accused of the -- you know, we see these fines and we take it personal and there is nothing -- we're health care providers. We're there to help the community and we take it personal when an outside agency comes in and says that this isn't right and you're doing this wrong and we see these huge numbers. It's not surprising to me that pharmacy probably even if you could get it from 150,000 to 20,000 dollars where a pharmacy would keep going if they felt that they were right and there was no intent or error that was really fraudulent.

REP. CASE: It just keeping people honest. That's all.

EDWARD SCHREINER: Yeah.

SENATOR SLOSSBERG: Senator Coleman.

SENATOR COLEMAN: I listened to your testimony. I wanted to ask you whether or not you were at all exaggerating when you said that the infractions, clerical errors, technical errors, fines and penalties amounted to hundreds of thousands of dollars.

EDWARD SCHREINER: I'm not.

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SENATOR COLEMAN: I just think to Representative Case's question and I'm assuming it wasn't an exaggeration.

EDWARD SCHREINER: No. It is not. I can you give a specific -- I've talked to some of my colleagues. As a chairman of the board for Northeast, we're a group purchasing organization, but we do a lot of other representation including me being here today. So we have a lot of owners, you know, when we hear we're getting a Medicaid audit, we'll say, you know, what can we do to prepare so we'll call our colleagues. I can tell you as a pharmacy owner, we had one prescription on a non-tamper proof pad. It had two of the three elements to make it accurate. It was a \$52 prescription. Okay. That's what the state paid for that prescription. The claim was disallowed because it didn't have all the elements. They had all that documentation I was telling you about that wasn't allowed. The recouped amount after extrapolation was \$95,000 -- over \$95,000, which was 1,835 times the original value that the state paid. That is a face.

SENATOR COLEMAN: Is there a formula that's used in order to arrive at that?

EDWARD SCHREINER: Yes. The way the formula works is they take 100 claims -- well, they'll look at a whole bunch of claims, but they -- and this is the last time I did it and how it was explained to me when my last audit was. They looked at 100 claims where the total cost was under \$1,000 and those are randomly generated I'm told. I don't know how they're generated. So they look at those 100 claims and they take their -- their findings, their exceptions. They say this doesn't meet the rules, this doesn't meet the rules, and this doesn't meet

the rules and they add that total number up. So they take that number, you know, whatever the amount of the payments were and they take that and they divide it by 100. Okay. So in this case, it was 52 -- if there was only -- I don't know how many penalties there were, but they did extrapolate it out for this one for me. So that \$52 prescription divided by 100 claims, 100 extrapolations (inaudible) every claim they filled in two years had a \$5.20 error. So they multiply that \$5.20 error by the whole -- every single claim for the -- for the width the audit, you know, the sample of audit, maybe two years, and they find a penalty of \$52 for that one claim to all of those claims. That's how they came up with \$95,000.

SENATOR COLEMAN: It doesn't sound quite fair. Thank you for your testimony and your answers to my questions.

SENATOR SLOSSBERG: Are there any other questions?

Thank you very much.

EDWARD SCHREINER: You're welcome. Thank you for your time today.

SENATOR SLOSSBERG: Okay. Our next speaker is Martin Acevedo followed by Deb Hoyt.

MARTIN ACEVEDO: Good afternoon.

SENATOR SLOSSBERG: Good afternoon.

MARTIN ACEVEDO: Madam Chair, members of the committee, my name is Martin Acevedo and I'm the general counsel of Companions and Homemakers, Inc, a homemaker companion agency founded 23 years ago. The company cares for over 3,000 older adults and employs over 3,000 caregivers. CNH provides services to clients

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in the Medicaid program and we are pleased to provide testimony in support of bill 5500. In 2010, this body passed Public Act 10-116, a law that amended Section 17b-99d of the General Statutes to include certain protections for providers of Medicaid services during the course of audits. The statute, as amended, requires DSS to enact regulations to carry out the provisions of the statute as amended and chiefly to ensure the fairness of the audit process including, but not limited to the sampling methodologies associated with the process.

Well, four years later, we have no regulations in place. While DSS filed proposed regulations with the regulations review committee last year, they withdrew the regulations as the result of strong opposition from -- on the part of the provider community. They have since refilled the regulations, draft regulations with almost no changes whatsoever. They made technical changes to the regulations and left everything else exactly the same. And the issue is that the regulations include no tangible substantive protections or specific guidance for service providers undergoing audits. In other words, the regulations do nothing to comply with the statutory mandate for fairness. And this is precisely why bills like this one need to be brought forward. The bill would amend Section 17b-99d to include protections for providers undergoing audits and these are the protections that should have been included in the regulations but were not.

The bill for instance requires DSS to provide free training to providers on how to enter claims to avoid clerical errors. I have a comment about that. We recommended the bill be amended to require DSS to promulgate an audit provider manual and specific written guidance.

This guidance can be done by way of a bulletin and posted online. Since DSS has taken the position that clerical errors do not bar extrapolated disallowances, DSS should provide education on how to minimize exposure to extrapolated findings and the rationale is fairly simple. Providers are entitled to know what the specific rules of the game are before they are found at fault for breaking them.

And this is particularly true in light of the potentially devastating consequences of extrapolation. The bill also requires that DSS when deciding what provider to audit would (inaudible) it's supposed to be on a random basis, quote/unquote, it requires that DSS first direct its efforts to providers with a higher compliant risk based on past audits or errors. What we suggest is that the section be amended to provide for a more definite set of parameters to be applied by DSS when determining which agency to audit. For example, Medicare law limits extrapolation to situations where there is sustained or high-level of payment error on the part of the provider or document that educational prevention given that the provider has failed to correct the payment error.

So we would like to see a standard of that nature be integrated into the law. We have a final -- respectfully, we submit a final recommendation or amendment. While the audit statute, the present one, provides for a right to appeal the audit results in superior court. Those appeals are highly technical and hinge upon the development of a proper record before the administrative agency, in this case DSS, (inaudible) will in turn inform a judge's decision-making process when adjudicating the appeal. Currently, if the providers seeks internal review of the agency's findings, the

review is conducted by an employee of DSS appointed by the commissioner. Providers have no rights to submit evidence to contest the findings -- excuse me -- no right to submit witness testimony, no right of cross-examination and no right of procedural -- procedural due process in the form of internal review by an administrative -- an impartial administrative law judge. In other words, providers are severely limited in their ability to develop a proper record for judicial review.

SENATOR SLOSSBERG: Martin --

MARTIN ACEVEDO: Yes.

SENATOR SLOSSBERG: You're well past the bell. But I've got your testimony here and I have a number of questions.

MARTIN ACEVEDO: Okay.

SENATOR SLOSSBERG: So I'm just going to move into the questions.

MARTIN ACEVEDO: Yes.

SENATOR SLOSSBERG: So the first thing I wanted to ask you -- first of all, thank you. And I would just -- I've had experience with Companions and Homemakers with your agency and I would just on a personal note commend you, the agency for wonderful work. But a couple of questions in regard to the testimony that you've offered today. The first thing is given that you are general counsel so you're a lawyer, could you define for me what the Medicare law -- in terms of what does -- what is the definition of a "high-level" -- a "sustained" or "high-level" of payment error. How do you define that?

MARTIN ACEVEDO: Well, what happens is that agency conducting the -- the audit has to look at the provider and say is this provider the type of provider that in the past has exhibited a high level of payment error. In other words, this is a provider that we've gone back again and again and said, look, you need to fix this area of billing. You need to fix this compliance issue. And that provider notwithstanding that educational intervention has failed to fix those problems and those problems continue to come up during the course of audits. So what we're saying is let's adopt a similar standard that is set forth in Medicare. In the current bill, we have something similar to that, but the problem is that the standard doesn't apply if the agency makes over \$150,000, which essentially renders that provision useless. Most agencies -- most providers do well over \$150,000 of business a year. So current provision in the statute does serve no purpose because it essentially nullifies the standard.

SENATOR SLOSSBERG: I understand what you're saying. In terms of the Medicare -- the Medicare limit on extrapolation, though, if it's only for those people where is a sustained or a high-level of payment error, does that mean -- how does Medicare law then -- do they not extrapolate to first time offenses at all?

MARTIN ACEVEDO: No, they do. Yeah, they do.

SENATOR SLOSSBERG: Okay. So how does that work, though, if sustained or high-level of payment error refers to only those where you've gone back and say, this is a problem. This is a problem. This is a problem.

MARTIN ACEVEDO: Certainly, there is extrapolation. There is no question about that. But I think what the agency does is that it takes -- it

takes into consideration a series of factors in making a determination as to whether the -- the error or the disallowance is the kind of disallowance that can lead to extrapolation. In other words, they have a very systematic, programmatic framework within which they operate. They have guidelines. They have written -- they have written guidance. They have manuals. They have all sorts of tools that they provide to the service providers so that service providers are aware of -- of what's coming in the course of an audit. And my understanding in this case is that DSS has an audit provider manual, but they don't want to share with the provider community for some reason.

So I think that's something to take into account. We're asking for specific -- this bill really is about the utter lack of specific guidance for the providers. There is none.

SENATOR SLOSSBERG: No. I understand that. I'm just asking some specific questions just to flesh this out a little bit. In terms of the internal review, you know, I would just let you know that that's something that's been expressed in this committee a number of times and we do have a bill seeking to try to deal with what -- we'd like to see an impartial DSS hearing -- internal hearing, as well, but I think that we're working through that process so I would encourage anyone who is here today and interested in that particular aspect to be taking a look at our Senate bill that's doing that. I think it's -- I want to say it's Senate Bill 214.

Marie, do you know if it's 214? On fair hearings?

SB250

We can get you that number, though. So it is something that we're working on in terms of trying to make sure that when anyone has to have something reviewed by the agency that they have a fair hearing.

MARTIN ACEVEDO: We think that's a critical component of the fairness mandate of the statute. Without that component, I mean, think about it, you have an employee of DSS that's directly appointed by the commissioner, essentially reviewing audit findings that were generated by other employees of the agency. So I have a hard time believing that's there is full impartiality in that regard. So I think that's an important -- a critical component to advance the statutory mandate for fairness in the process.

SENATOR SLOSSBERG: Thank you very much for your testimony and for your answers today.

MARTIN ACEVEDO: Thank you.

SENATOR SLOSSBERG: I don't think there are any other questions for you at this time.

Our next speaker is Deb Hoyt followed by Deb Pulon.

Oh, and that bill is Senate Bill 250 that we were talking about.

Good afternoon.

HB5500
DEBORAH HOYT: Good afternoon, Senator and good afternoon, members of the Human Services Committee. My name is Deborah Hoyt and I'm president and CEO of the Connecticut Association for Health Care at Home. I represent 60 of Connecticut's licensed and certified home health care and hospice agencies

in the state that provider services to Medicaid clients and we foster cost-effective health care in the setting that people prefer most, which is their homes. I'm here to support S.B. 5500 and the fair and accurate auditing of home health care providers.

First and foremost, our association and our agency providers strongly believe in the ethical provision of home health care services and hospice services to Connecticut residents under the Medicaid program. We support the elimination of health care fraud in any form. To that end, we believe that a fair and reasonable system of auditing home care and hospice providers is not only appropriate, but it's necessary to ensure the viability and soundness of Connecticut's Medicaid programs. Currently, all home care and hospice agencies are scheduled by the State Department of Social Services, DSS, to be audited every three years for the full three-year bid. As an association, we're proud of the high standards that our provider agencies exhibit in their business practices, documentation, coding and billing processes despite a very challenging environment of constantly changing state and federal regulations.

One of our core services as an association is to provide extension education and information regarding proper documentation and adherence to DSS and DPH regulations. Obviously, we desire an environment where the audit department provides ongoing education and guidance so that we can get better at paperwork in order to put our focus back on delivering the cost-efficient care that helps patients and saves the state money. I do have serious concerns about the perception of fraud or intentional fraudulent billing when in most cases obviously these errors are found in the audit process to be

clerical in nature. I just want to give an example. One of our home health care agencies received an initial DSS audit findings letter after a routine audit of nearly \$10 million in Medicaid overbilling. While that's shocking enough obviously for a home health care agency administrator to receive, they're also obligated to share that letter with their board of directors, banks, other business partners despite the fact that these initial findings may be very explainable and just might be cursory.

In fact, after a year of meeting with the Department of Social Services and spending hundreds of hours of home care agency staff time, also \$10,000 in legal fees. This agency's initial nearly \$10 million audit finding was reduced to a more realistic \$4,500 in clerical errors. So I guess our challenge is -- and this story is no isolated.

I know that Senator Coleman brought this up before. The association has evidence of many stories like this one. Obviously, some with smaller initial audit findings, but similar in scale of representing the disparity from initial finding to the final outcome. I guess our concerns here are that, you know, while in the end the home health care agency may come out relatively okay from a financial perspective, the human resource impact from senior management and then the need to -- you know, to hire, you know, outside counsel on this is just such a strain on these home care agencies and these are the home care agencies that are being paid 58 cents on the dollar under Medicaid. I mean, they're doing this work for free and on top it, the audit take backs are just ridiculous and the stress that these agencies are put under.

We've seen some of the home health care agencies just say we're not going to supply services to Medicaid customers anymore because we can't do it from a reimbursement perspective and on top of it, the audits are just too onerous. I just want to stress to you that this process is just not working. We have had the DSS department staff come in and help do some education. I think you've heard from previous testifiers that making sure that the expectation is there upfront. Our providers will fully comply. They want to comply. They want this system to work, but we just can't -- this punitive position is just something that is just not working for us.

SENATOR SLOSSBERG: Okay.

DEBORAH HOYT: Okay. Thank you.

SENATOR SLOSSBERG: Thank you, Deb. We appreciate your testimony. Hold on. I think there are questions so don't run away. Can I just ask you one question, though, was there a time when this process changed that it went from being not so horrible to really horrible or has it always been really horrible?

DEBORAH HOYT: You know, I've only been leading this association for nearly four years and since I've been there obviously, it's been very challenging. It just seems to be getting more and more stressful because this is such a time of change. Obviously, with the affordable care act and some of the things that are happening on the federal side and also a lot of changes on the state level, there is just so much change and the ability for them to comply from a coding and billing perspective is just getting more challenging so when there isn't clear expectations from DSS on how the audit is going to run, it's just been compounding it.

So I can't speak long-term, but that's how it works now.

SENATOR SLOSSBERG: Thank you very much.

Representative Case following by Representative Zupkus.

REP. CASE: Thank you, Madam Chair.

It's more of a comment, but it's also a question because I want to know how it is out there in the field. I was on the phone with an agency out in my area just now and it was the one I spoke on earlier who -- they got \$80,000 in fines because DSS didn't like their electronic records and they've settled on \$16,000 to date. And you just -- I was shocked because I was just talking to him on the phone and he said that last week they had a doctor that used a rubber stamp on a prescription. That's a \$7,000 fine. They made phone calls after phone calls and they said okay, we'll accept 2500. And -- so that is happening out there. It's crazy stuff like that. And that's going to hurt -- and it's a small nursing agency and he says every time I go on a call for a Medicaid visit I know I'm losing money.

DEBORAH HOYT: It's an interesting point and I think that you made the point that agencies have to settle and sometimes they just get so exhausted and they just don't have the manpower to just see it through to the end, but some of them just say, I know these are just clerical errors, but I'm going to pay 20,000 because I've just got to get back to business and you know, it's the implication that they're guilty when, in fact, they just don't have the manpower to be able to see it through.

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REP. CASE Exactly and exactly what you and what he said to me is I just don't have the ability to hire anymore lawyers and that's why he had to settle. So I thank you for your testimony and thank you, Madam Chair.

SENATOR SLOSSBERG: Representative Zupkus.

REP. ZIOBRON: Thank you, Madam Chair.

I was just curious to your same question of when this -- if it changed, when it changed and what the difference is. So now I have a comment is I hear a lot from the whole medical industry that I'm afraid if we don't help you what's going to happen is the people that you're taking care of will not be taken care of because of all of these things so thank you for coming and sharing and I hope that -- we have to do something to help you out so we can continue to take care of these people.

DEBORAH HOYT: Thank you. I appreciate that comment and just to get you a point about the longevity of this problem. One of the testifiers that's following me who is -- has been with a home care agency for a long time from a CFO position, he could probably answer that question for you.

REP. ZIOBRON: Okay. Great.

DEBORAH HOYT: Okay.

SENATOR SLOSSBERG: Thank you very much.

DEBORAH HOYT: Thank you.

SENATOR SLOSSBERG: Next speaker is Deb Polun followed by Jeff Berkeley.

DEBORAH POLUN: Good afternoon. For the record, my name is Deb Polun. I'm the director of government affairs and media relations for the Community Health Center Association of Connecticut. And I want to thank Senator Slossberg and the members of the committee for having this hearing today and giving me the opportunity to provide support for House Bill 5500, AN ACT CONCERNING PROVIDER AUDITS UNDER THE MEDICAID PROGRAM. I'm going to join the growing chorus of voices in support of this bill.

Just to give you a bit of background, federally-qualified health centers in Connecticut serve about 340,000 residents all across the state in urban areas, rural areas and suburban areas in every part of the state. Sixty percent of their patients are on Medicaid. So Medicaid audits are a really significant component of what happens with the interactions between health care centers and DSS. These patients are really in need of health care. They get comprehensive medical, dental and behavioral health care at health centers as well as wraparound services like translation, enrollment in HUSKY or Access Health, sometimes enrollment in SNAP and so forth. And they do a really good job. On behalf of the health centers, I want to also add our support the concept of audits, but done in a way that makes a lot more sense than how they're done today:

The audits -- the requests that are included in some of the audits are overbroad. They go beyond the scope of time period sometimes of the audit. They ask sometimes irrelevant questions about employee compensation, grants that the health centers received which should not be relevant to how they're spending Medicaid dollars and so forth. So we would

really like to see some clarification and tightening of the audit process. Specifically, I wanted to thank you for including the requirement for training. This is something that the health centers have asked for from DSS. We'd like to see training going on all the time because all providers are hiring new bills and coders and other staff through the year. We'd like to support the limitation of scope to the information that's required and also the elimination of payment incentives for the audit contractors who are therefore incented to try to find errors.

We support the reexamination of the extrapolation process, but would like to see this tightened even further. I will just call your attention to the OLR report on audits that came out in August and in the OLR report, it cites the NCSL, the National Conference of State Legislature, surveyed some states about whether they use extrapolation. They got 18 states to respond and 10 of them extrapolation. So does that mean that 55 percent of all of the states in the country use extrapolation? We don't know, but if we were to use that method that DSS uses when they do their audits, we would just assume that 55 percent of every state in the country uses extrapolation.

So that's the kind of danger you can run into using that method. We like the idea of limiting to like claims, but would also like to limit it even further than that. And then also just to add my voice to the need to clarify between an error that was clearly intentional and an error that unintentional and we know that there are clerical errors made sometimes and they should try to be reduced, but providers should wait to fix those errors before they are unfairly penalized. So I want

to thank you for your support of this bill and of health centers. Thank you.

SENATOR SLOSSBERG: Thank you very much. Thank you for your testimony. I think you make a good point about your extrapolation. I think we're going to try that in another setting at some point.

DEBORAH POLUN: All right. I'm happy to help.

SENATOR SLOSSBERG: That's a very interesting experience.

Representative Zupkus.

REP. ZIOBRON: Thank you, Madam Chair.

I have just one quick question actually for clarification because I'm sorry I've been in and out, but the gentleman before you also, just touched on it briefly about training. Is there training that happens now through DSS?

DEBORAH POLUN: I'm guessing that that varies by provider because I know that our health centers have been asking for training and they have been unable to get training from DSS. I think that somebody might have mentioned that they have gotten training so I'm guessing it goes with whether DSS has the resources at the time to do so.

REP. ZIOBRON: Okay. Because I was just reading prior testimony and they were stating that they do do training and just for clarification.

DEBORAH POLUN: No. We haven't been able to get that training done.

REP. ZIOBRON: Thank you.

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DEBORAH POLUN: You're welcome.

SENATOR SLOSSBERG: Any other questions?

All right. Thank you.

DEBORAH POLUN: Thank you.

SENATOR SLOSSBERG: We now have Jeff Berkley followed Carolyn Malon.

Good afternoon.

JEFFREY BERKLEY: Good afternoon, Senator Slossberg and Representative -- members of the Human Services Committee. My name is Jeff Berkley. I'm a facial surgeon who participates with Medicaid and Medicare programs. My group practice consists of eight surgeons that practice in five offices throughout Connecticut. I teach in a residency program at Yale and I'm head of the Department of Dentistry at Midstate Medical Center and I'm also president elect of the Connecticut State Dental Association. I'm testifying in support of House Bill 5500.

I underwent one of the earlier dental audits. The auditor was pleasant, but not a dentist. He had minimal definitions, standards of care or protocols involved in my specialty. I did make efforts to educate them in this regard, which hopefully helped them in later audits, but I find it highly inappropriate that we should need to educate those auditing us. Having received many calls from members, it appears that many findings involve disputes over coding, appropriate but uncovered clinical treatment and standards being enforced by DSS that do not correspond to ADA standards. The law does not require extrapolation for audit findings. It was intended to fight fraud. The

instances that I cited about certainly do not qualify as fraud, yet the auditors are extrapolating all negative findings to the entire universe of patients within the audit people triggering repayment demands that extreme even for minor issues.

The extrapolation extends even to different providers within the same group practice. It is this inappropriate extrapolation that creates the most concern. Through the efforts of the CSDA, our state has risen from the very bottom to be a model for providing access to care for the citizens of Connecticut. The CSDA has offered to help in educating the auditors who we feel should be dentists. We have met with Commissioner Bremby and suggested formulating a reasonable set of standards together, educating dentists to those standards and suggested the dental commission be more actively empowered to discipline flagrant violators. To date, these have not been implemented. With the amount of negative feedback being created by the audit process in extrapolation, I fear that we will potentially be faced with the loss of many of our very best providers.

House Bill 5500, as written, solves most of the issues that are causing providers to consider leaving the program while still allowing the auditors to identify outliers committing fraud; however, there are some areas of improvement I would like to suggest. A licensed dentist and where appropriate a licensed dental specialist should be used in all phases of the dental audit. They should enforce standards that follow the American Dental Associations' Standards and coding. Any variations from the above that are required by DSS -- and I'm not sure why that would occur -- should be specifically noted and published to all

providers before holding them liable. The appeals process and the audit should involve dentists who are not the paid auditors and perhaps the dental commission. I would also suggest that audit penalties already closed be modified to reflect the provisions of this law that restricts the inappropriate extrapolation.

Thank you for your time and I urge you to support this valuable and urgently needed bill and I welcome any questions you may have.

SENATOR SLOSSBERG: Thank you so much for being here, Jeffrey. We appreciate your testimony and congratulations on your upcoming presidency.

JEFFREY BERKLEY: Thanks.

SENATOR SLOSSBERG: Are there questions?

Yes, Representative Ackert.

REP. ACKERT: Thank you, Madam Chair.

And thank you for your testimony. As the way this legislation written now, do you believe it accomplishes exactly what you're looking for it to do?

JEFFREY BERKLEY: Exactly, no. You know, the problem with this legislation specifically to different professions is that they're different professions, but I think that most of the problems that we're hearing are addressed in the bill, and obviously some of the suggestions for amendment by me and by previous people seem to be ways that could improve on the bill.

REP. ACKERT: Thank you. And I appreciate that input.

SENATOR SLOSSBERG: Thank you. Are there any other questions?

Seeing none, thank you very much.

Our next speaker is Carolyn Malon. Is that what you told me?

CAROLYN MALON: Yes.

SENATOR SLOSSBERG: Okay. I'm sorry.

CAROLYN MALON: No one gets it right.

SENATOR SLOSSBERG: Followed by Dr. Douglas Keck.

Good afternoon.

CAROLYN MALON: Good afternoon, Senator Slossberg and Representatives of the Human -- members of the Human Services Committee. My name is Carolyn Malon. I practice dentistry in Farmington, Connecticut. I'm a general dentist. I am a Medicaid provider. I am the immediate past president of the Connecticut State Dental Association and I'm here to testify in support of House Bill 5500, but also for the amendments to that bill such as -- such has been suggested by previous speakers.

Over the last -- course of the last several years, as I'm sure you're aware, the leadership of the state dental association as well as closely with the leadership of our state to develop of a network of dental Medicaid providers that is the envy of other states in our country. We currently have over 1800 dental providers enrolled in the Medicaid program. Unfortunately, there have been a small number of providers who have been found to have committed fraudulent activity in the course of their Medicaid billings, but the vast

majority of our dentists are honestly trying to provide care for people at a much reduced rate from our usual fees. H.B. 5500 would be a good start towards making the audit process more fair while at the same time ensuring that those who are perpetuating fraud are appropriately reprimanded or penalized.

Our concerns are similar to what other speakers have said. There is currently no standards -- written standards for what's in the dental documentation. For instance, our providers are asked now in audits to document -- to have documentation for the rationale for the taking of routine x-rays. I understand that that's something that's necessary and required in the standard of care in the medical -- in the medical field, but documenting the taking of routine x-rays is not required in the dental realm. I had the honor of serving on the State Dental Commission for six years. When a dentist has a complaint against them, the Department of Public Health does an investigation. If the dentist disagrees with the DPH decision, a hearing is held and members of the dental commission comprised of a hearing panel, most of the commissioners are dentists, although there are some public members and it is primarily dentists and a public member normally who make up that hearing panel. Most of those commissioners then are those who can best decide whether the dentist provided an appropriate standard of care.

It would seem logical to me that Medicaid audits ought to follow a similar process such that if someone is audited and disagrees with the findings that the appeals process afterwards would be an independent body and some group that is not part of DSS and that included dentists who understand what is standard of care in our profession. I would

respectfully -- one other final thing, Senator Slossberg, you asked about is the process very different now and I think the process of more audits has come from that floor of 150,000, which allows for extrapolation and when that -- when that bill was put into effect a number of years ago, there were many fewer providers in the system. \$150,000 at the time was a very high amount of money. It no longer is. So for instance, in the dental community, we had very few providers in the first place, very few of them reached that \$150,000 floor.

So you might have had two or three -- I was a Medicaid provider 20 years ago for 10 years. I was never audited. I never hit that floor. Now, it's very common and very easy to hit that \$150,000 floor and I think that may be the start of all of this ballooning of the audit process.

SENATOR SLOSSBERG: Thank you for that clarification and I really appreciate that. And for your comments in regard to how this handled -- you know, how questions are handled when it comes to public health so I think you've given at least me some things to think about of possible ways to address there. Are there questions?

Seeing none --

CAROLYN MALON: Just in closing, you know, we have the leadership of the State Dental Association. We wish to assist our members in complying with DSS guidelines. We try to -- we try to educate our own members so that everyone is on the same page and doing the same thing and at the same time, we're protecting the public. Our charge as an association is for our membership and for the public who we serve. We've very adamant that those who are really committing fraud should be penalized, but at the same time,

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those who are merely making honest errors in charting or billing should be treated fairly and shouldn't have this -- you know, this cloud hanging over them that they have to fight.

SENATOR SLOSSBERG: Thank you very much.

Representative Wood.

REP. WOOD: Thank you, Madam Chair.

Very good points. Thank you for being here. This is a question not so much related to the bill, but just general informational question. 1800 dentists are taking the Medicaid program.

CAROLYN MALON: Correct.

REP. WOOD: That represents what percentage of the dentists in the state?

CAROLYN MALON: Sixty percent approximately.

REP. WOOD: Okay.

CAROLYN MALON: Sixty.

REP. WOOD: Six zero. All right. Thank you very much. And again, thank you for your testimony.

CAROLYN MALON: You're very welcome. Thank you.

SENATOR SLOSSBERG: Our next speaker is Dr. Douglas Keck followed by Dr. Mark Desrosiers.

DOUGLAS KECK: Good afternoon, Senator Slossberg and members of the Human Services Committee. My name is Douglas Keck. I'm a pediatric dentist and a Medicaid provider in New Haven and Madison Connecticut, as well as a clinical professor in the pediatric dental residency program at Yale New Haven Hospital. I'm also a

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provider who has been audited by the Department of Social Services on a postpayment review of claims between May 1, 2010 and December 31, 2012. I'm testifying in support of House Bill 5500, AN ACT CONCERNING PROVIDER AUDITS IN THE MEDICAID PROGRAM. My testimony is also endorsed by the American Academy of Pediatric Dentistry and the Connecticut Society of Pediatric Dentists. I'm testifying today because I am concerned that Medicaid dental provider audits in Connecticut will damage children's access to oral health care.

With the implementation of the Affordable Care Act and the expansion of Medicaid in Connecticut, it would deleterious to lose the large provider base that has been gained over the last several years by adding yet another barrier to obtain oral health care. State auditors are subjecting dentists to review by non-dentists and making determinations contrary to accepted clinical practice. Such audits could dramatically reduce the number of dentists willing participate in Medicaid thus impacting access to the citizens of Connecticut who are most in need of a dental home. I'm greatly concerned that several long-time dental Medicaid providers in Connecticut have received audits with recommendations contrary to accepted clinical practice guidelines. Furthermore, the audit trigger point of \$150,000 billed per year subjects nearly all providers of Medicaid dental services in Connecticut with the possibility of an audit.

The methodology for extrapolation is unreasonable as it utilized this low threshold trigger which was instituted in 1995 when the fees were lower. While we are cognizant of fraud and its effects on the services that we provide, we believe that audits should be triggered by providers who bill for

inappropriate services rather than how much money they bill for the care that they deliver. In addition, the audit should be conducted by a peer who is familiar with the way dentistry is delivered, what a proper course of treatment might be and the unique dental disease pattern that is common to the Medicaid population. In the case of services provider by a pediatric dentist, the peer reviewed should be a pediatric dentist. The Medicaid population has a completely different disease pattern, dietary habits, restorative needs and health literacy level than the populations with private dental insurance. I am further concerned that a lack of communication from the auditors to the dental practitioners suggests that the auditor's intent is not to end fraudulent activity, but rather to find a hidden source of revenue.

My hope is that there will be immediate development of guidelines and documentation requirements that practitioners must follow and that will be the basis of the record review during the audit process. I would also appreciate an overview of the audit process and how practitioners and/or groups are selected as I was in the dark from the beginning of the process to my exit conference with the auditors. In conclusion, I would like to sincerely thank you for your time today and respectfully request that there be a moratorium on new audits and a stay on the audits currently in process until appropriate audit guidelines are developed in consultation with the American Dental Association and the American Academy of Pediatric Dentistry and such efforts I think can be coordinated with the Connecticut State Dental Association, the Connecticut Society of Pediatric Dentists, the Dental Commission and Medicaid program officials in an efficient and effective manner.

I would ask that you support this bill so that we can use this system appropriately without threatening the utilization of dental services in the state of Connecticut.

SENATOR SLOSSBERG: Thank you very much for your testimony. We appreciate it.

As you know, we've had a lot of discussion about this already. I share your concern about the effect of this in particular on our -- the dentist's -- our dental providers in the Medicaid program. I did notice that you were talking about the threshold and other people have mentioned that as well. You said was instituted in 1995. I'm not sure that a threshold is a good idea in the first place, but let's say we were stay with a threshold at all. It was \$150,000. Do you have a suggestion as to what a reasonable number would be?

DOUGLAS KECK: I would suggest that there isn't a reasonable number because there are different fees and charges for different services. In pediatric dentistry, for example, is more a volume-based example of dentistry while say prosthetic dentistry, which is crowns and bridges and dentures, so there is a wide variability. My highest procedure amount might be \$285 for a pediatric crown; whereas, an adult crown might be \$2,000. So that's why the \$150,000 -- so I guess what I'm saying is should be instituted to go towards fraudulent activities. There are algorithms to find outliers that don't include a minimum or a threshold to go through. I think you don't need to reinvent the wheel to find out what private insurance use to find outliers. I guess the answer to that I don't think there should be a minimal threshold number just

because there is such a wide variety of services that we provide.

SENATOR SLOSSBERG: Yeah. Well, your point is well taken in that if you have a threshold and yet we're trying to get kids to actually go to the dentist on a regular basis that the more you are successful in getting kids to go see you, the more likely you are to get hit with an audit. I think your point is well made.

So having said that, are there other questions from the committee members?

Thank you very much and I just want to tell you that I'm very sorry that I'm sitting up here eating chocolate while you're talking. My dentist would kill me, but it's keeping me going. Oh, well, by all means, there is always chocolate to go around up here.

So our next speaker is Dr. Mark Desrosiers followed by Rich Corcoran.

MARK DESROSIERS: Thank you.

SENATOR SLOSSBERG: Did I get your last name right?

MARK DESROSIERS: Desrosiers. It's slaughtered, but I'm comfortable with it. You did well.

SENATOR SLOSSBERG: I did okay. I said that. That's pretty good.

MARK DESROSIERS: Senator Slossberg, Representative Abercrombie and members of the Human Services Committee. My name is Mark Desrosiers. I'm currently the president of the Connecticut State Dental Association and a participating provider in the Connecticut dental Medicaid Program. I'm here today to speak in support of House Bill 5500, which seeks to ensure that

audits of providers who receive payments under the state Medicaid program are performed fairly and accurately. The Connecticut State Dental Association is proud of the fact that Connecticut has a dental Medicaid delivery system which not only works, but is now considered a national model. Currently, as you have heard, there are more than 1800 dentists who participate in this program:

Not only is their access to the highest quality of dental care available, but Connecticut children are utilizing that care as well at rates that are the second highest in our nation. Unfortunately, some providers have been responsible for perpetuating fraud and abuse within this program and we understand the need for the Connecticut Department of Social Services Quality Assurance Unit to audit practitioners who have been identified as outliers. However, we have serious concerns about the manner in which these audits are currently being performed. While we agree that audits are important in order to identify fraud and abuse, the current system is place undue hardships on all providers who provide these services. If left unresolved, we fear that this may result in the unintended consequence of dismantling Connecticut's very successful program and that will have an impact on the citizens who are most in need.

As president of the Connecticut State Dental Association, I have heard from numerous dentists who have been audited by the department. I and others from our organization have met with Commissioner Bremby to discuss the audits and our concerns. To date, our concerns are unresolved. One of the main concerns that we have is the use of extrapolation. I think you're getting used to hearing that. Hopefully -- and it seems like

this bill is attempting to address that -- the current methodology we feel is unreasonable and given the low threshold of \$150,000, it should be indexed properly. Overpayments due to clinical errors, appropriate but uncovered clinical treatments, justified coding disputes and clinical situations should not be extrapolated. Also, extrapolation has been applied in the same way to both groups of practitioners as well as solo practitioners. We feel this is not appropriate.

Another bill -- another issue that this bill attempts to improve and we strongly support is the increased transparency. It would require the providing of training for new providers of claims in order to avoid clerical errors. While this would certainly be helpful, developing and utilizing valid guidelines in support of current dental practice in coordination with dentists and making those known to all providers would be most helpful. Currently, the Medicaid standards that the auditors are holding dentists to are higher than those that we are held to with private insurance.

I just have a few more points.

SENATOR SLOSSBERG: Please see if you can wrap up.

MARK DESROSIERS: The auditors are not dentists, yet they've been determining the standard of care in dentistry which is not appropriate. We encourage amending this bill to stipulate that dentists are involved from the beginning in determining if the standard of care rendered meets the proper standards. Dentists should not be making auditing decisions and auditors should not be making dental decisions. Moving forward, as you heard earlier, we feel that a moratorium should be placed on random audits

not thought to be associated with fraud and a stay be granted for audits currently in progress at least until the dental community can collaborate with the department on how to make these audits effective, transparent and as fair as possible.

I applaud and support the intent of House Bill 5500 and what it attempts to do and look forward to working with you to make it better. Thank you for your time and I'm happy to answer any questions.

SENATOR SLOSSBERG: Thank you very much.

Okay. Representative Ackert.

REP. ACKERT: Thank you, Madam Chairman.

Thank you, Doctor, for all the good work that CSDA does not just in the -- more in your voluntary basis for those that need services. I was just touching base on one of the programs you were talking about. This was brought for the home care providers about the training for the process and you're saying primarily near providers. Has there been training for existing providers to the level that would help with this auditing process?

MARK DESROSIERS: No. We met with Commissioner Bremby. We tried to established a relationship whereby we were happy to even help give the auditors some dental knowledge to at least make them more knowledgeable about what we do and also we were hoping that they would give us some kind of training so that we understood the standards that we are being held to because you heard from others, too. We're not sure what that is and you don't want to find out during an audit. It's too late then.

REP. ACKERT: No. That's a very good point. I think that in our profession we do our profession well, but some of the things that we're not trained on, you're trained in providing dental services -- you know, making sure that if we're going to meet an audit process that we are given proper training on that and not learn through penalties so thank you for your testimony.

MARK DESROSIERS: You got it. Thank you.

SENATOR SLOSSBERG: Okay. Representative Case.

REP. CASE Madam Chair, it's really a comment if I could make it while we have the good man in front of us. I appreciate you coming. Just a concern that I've had with this process not only the auditing, but in the state of Connecticut, we require medical insurance until you're 26. I just wanted to see what you feel the effects are because we cut down to 18. Do you see -- more or less patients between 18 and 26 because -- because their insurance is cutoff for dental?

MARK DESROSIERS: I don't know if I really have the background to answer that question with any authority. We are science based. We have data. Some other members of my group might have --

SENATOR SLOSSBERG: Representative, I would suggest, you know, rather than putting the doctor on the spot here on your question, which I think is an interesting one, although relatively irrelevant to the actual audit process.

REP. CASE Well, because he could audited to see if he has any patients over 18 that have slipped through.

SENATOR SLOSSBERG: My suggestion though I guess since he's not really comfortable answering the question that you --

REP. CASE I will --

SENATOR SLOSSBERG: There may be some other -- other folks that would be happy to discuss this with you. I think we have a couple more speakers and maybe people would be willing to hang around and they could have that conversation with you and you can speak with them.

REP. CASE Thank you, Madam Chair.

SENATOR SLOSSBERG: Thank you. Are there any other questions?

No, seeing none, thank you very much for your testimony.

MARK DESROSIERS: Thank you.

SENATOR SLOSSBERG: And for your service.

Our next speaker is Rich Corcoran followed by -
- I'm not sure if I can read this. It looks like Burnilda. Is that right?

A VOICE: Yes, that's right.

SENATOR SLOSSBERG: Burnilda Ferray. Okay. That's good. It's smaller. I need better glasses so I don't think -- I know we have a lot of dentists here, but I don't we have the ophthalmologist. Wrong committee.

Okay. Mr. Corcoran, thank you.

HB5500 RICHARD CORCORAN: Good afternoon, Senator Slossberg and the Human Services committee members. My name is Rich Corcoran and I am the chief

business officer and CFO for VNA Community Health Care. Our agency covers 7,000 patients annually -- approximately annually residing in Old Saybrook to Derby, Middletown, out to West Haven and Orange and up to Cheshire and so on and we pride ourselves in being a very, very capable and ethical organization. We totally support Bill 5500 and fair and accurate auditing. We need to do better. After you hear this testimony that we get 60 cents on a dollar, you have to wonder why we even take Medicaid patients because there is just too much risk and too much loss. At some point in time, we have do something better here.

We are committed to working with DSS on collaborating on auditing and collaborating on all the new initiatives and models and everything else. We really want to work in the state of Connecticut to help make the system better. The auditing thing though is like the fear of God and it's a punitive environment. Yes, it is. I want to tell you one quick story about our agency. We had an audit about two years ago and it started out as a 3.6 million dollar fine. They selected 100 claims. The universe was 31,000 claims. So these hundred claims are supposed to represent the 31,000 claims. After working with the Department, we were able to reduce it -- actually, there were some errors by the auditors that had to be removed the audit and therefore everything started to come back into line, but at the end of the day, we had 118 dollars in errors out of these 100 claims sample. \$118 extrapolated to \$58,000.

So we paid the \$58,000. I have to tell you that I feel that extrapolation and the sampling is -- is just doesn't make any sense. It doesn't pass the smell test, you know. How can 100 claims represent your accuracy on the other

30,900. It just doesn't seem to make sense. I would be happy to go into more detail on that, but in any event, I think the sampling is best used to detect as a screening tool whether there is very sloppy work going on or whether there is fraud and abuse going on. But I don't believe the extrapolation -- the sampling method is good for extrapolation purposes.

When I also -- I also would like to support other testimony with regard to 17b-99 and the ABC of Section (d)(3) which states that it should not be based on projections -- extrapolated projections unless there is a sustained or high-level payment, documented educational intervention has failed or the value of claims exceed \$150,000. In other words, it's okay that if you do \$150,000, you can make -- less than \$150,00 you can make lots of errors. It doesn't matter -- the \$150,000 should go away. I believe -- I agree with some of the other testimony. This is about detecting errors. I mean, this is supposed to be about detecting fraudulent abuse and working with providers to help reduce errors. Thank you for your consideration and I would be happy to answer any questions.

SENATOR SLOSSBERG: Thank you very much for your testimony and be here.

Yes, Representative Ackert.

REP. ACKERT: Thank you, Madam Chair.

Just for clarification, Mr. Corcoran, was it -- I know somebody in the field and she has been working on me on this situation in my area so is it -- is it actual -- you write a check sort of thing or is you get reduce reimbursements. Correct?

RICHARD CORCORAN: They take it out of the next check or two.

REP. ACKERT: Yeah. So they just reduce your --

RICHARD CORCORAN: Yeah, they recoup it. And that budget has increased a lot. That's one of the reasons why I think there is -- there is some intensive auditing going on because it's kind of budget driven now. They want the dollars.

REP. ACKERT: Yes. Thank you.

SENATOR SLOSSBERG: Okay. Are there any further questions?

Yes, Representative Bowles.

REP. BOWLES: Thank you, Madam Chair. I appreciate that.

I have been long aware of some of the challenges for the audit system that's conducted by DSS and the characterization I believe you just used was punitive in nature and is budget driven. What I would ask is -- is what are the qualifications of the people who typically do the audits on behalf of the agency in terms of -- of knowing, you know -- in terms of your practice itself, too. I'm just curious in terms of any kind of -- is it purely an audit based on books or is it also an audit based on practice?

RICHARD CORCORAN: Well, it is based on practice as well. Bremby testified earlier today that it was -- they were determining medical necessity on some of these visits that we do. They are accountants. I'm an accountant. I'm not a clinician. In fact, in home care, nurses practice only with an order from a physician so I don't know how they're qualified to be

determining medical necessity. And as far as having a collaborative relationship with DSS whereby we have a group of home care people that are helping to advise DSS on how to determine some of these things, that doesn't exist. And as far as the education to providers, by the way, that doesn't exist either.

REP. BOWLES: And could you characterize the appeal process, your experience with that please?

RICHARD CORCORAN: Well, yes, I can. I mean, when it came to this \$3.6 million letter that we got, which is more than our net worth by the way, we were -- we were -- we did have a meeting. We had to have a meeting because this is where you have to advise your board of directors, your bank, you know, everybody and we were going through a fiscal year end audit so now that's becoming a problem, right. So anyway, to characterize it, we then had to have a meeting as quickly as we could get. After doing lots and lots of follow-ups by the way for two to three times to the Department -- to the audit department, so we did have our meeting. We were able to throw out a bunch of things because they weren't even enforceable during the period of our audit. So that was one major step. Now, we were advised that we didn't even need lawyers.

Now, I don't know about you, but if you get a \$3.6 million fine and you've got to talk to your board of directors about it, you better have some counsel. Yeah, it's probably a good idea. It's job security, too. So anyway, we did have -- we did have meetings with DSS about the audit and it took several months to get it to -- to get it to closure, but again, that was \$118 in errors out of about 100 claims. It just doesn't pass the smell test to me.

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mb/gbr HUMAN SERVICES COMMITTEE

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REP. BOWLES: Thank you very much.

Thank you, Madam Chair.

SENATOR SLOSSBERG: Thank you.

Are there any other questions?

I would just let anybody who is here testifying or interested in House Bill 5500 just suggest to all of you that, you know, when the commissioner testified earlier he did speak as to regulations that are being promulgated and I would suggest that people get a look at them and see what you think about them in terms of concerns and what not that perhaps there are areas of agreement, perhaps there are areas of disagreement, but it's certainly something useful for us all to be aware of. So I didn't mean to do that on your time, Mr. Corcoran.

Thank you.

Our next speaker is Burnilda Ferray followed by Jenn Fornier.

And I would also just tell you anybody who wants -- you know, if you've got written testimony and other people have said what you are saying, you can certainly feel free to go off script if need be within your three-minute time period.

BURNILDA FERRAY: Thank you. Good afternoon, Senator Slossberg and members of the Human Services Committee. My name is Burnilda Ferray, public policy specialist for the Connecticut Community Providers Association and I'm actually here today to provide testimony in place of CCPAC president. She's home sick

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today. So she sends her apologies for not being here in person.

CCPA represents community-based organizations that provide health and services for children, adults and families in multiple areas including mental health, substance abuse disorders and developmental disabilities. Our members serve more than 500,000 people each here. I'm here today to strongly support House Bill 5500, a bill that addresses the critical concerns raised by community providers and others with respect to the transparency and conduct of audits under the Medicaid program. CCPA is firmly in favor of audits under the Medicaid program. We believe that they are necessary and we are opposed to any form of fraud or abuse in the system. We simply want audits to be fair, consistent and equitable as they are meant to be.

House Bill 5500 makes many improvements to the auditing process. First, the bill ensures that audits of providers who receive payments under the state Medicaid program are performed fairly and accurately. Second, the bill ensures that a contractor acting on behalf of DSS shall have access only to information relevant to the audit. No access is authorized to information that is confidential or prohibited from disclosure by law. Third, House Bill 5500 eliminates the potential for any possible conflict of interest in that it does not allow payment to the auditor to be based upon findings as determined by that auditor that is due to Medicaid. And fourth, this bill limits the process of extrapolation to a sample to like claims as opposed to the entire number of claims billed a provider within the three-year period.

We are thankful for these proposed improvements to the auditing process. As you've heard today, there exists challenges within the current methodologies of the audits which can create unintended and sometimes catastrophic consequences for community providers who have -
- who may have a clerical error on Medicaid claims. Simple clerical errors can result in the penalty -- a penalty hundreds of times the original amount when extrapolated to all claims. In addition to paying thousands of dollars for clerical errors, a provider must then hire legal counsel to appeal this finding and must pay for that representation as well. In some cases, the total amount due from providers as a result of clerical errors can literally threaten the financial viability of a provider.

As a final point and while it is somewhat secondary to this bill, it is still extremely pertinent, I would like to say that the amount set aside in the state budget as revenue for Medicaid fraud and abuse, \$64 million for fiscal year '14 and 103 million for fiscal year '15 is ambitious at best. We believe it is unrealistic given that research shows that actual fraud and abuse in the system seems to be fairly low and that was -- we heard a little bit about that earlier this morning.

Can I just wrap up if that's okay with you?

Thank you.

So we have two requests regarding House Bill 5500 that we submit respectfully. First, in regard to paragraph (b), we would like to ask that all providers not just new providers be provided free training in avoiding clerical errors. And second, we request that the term like claims in paragraph (d) be defined in the

definition section of this bill to avoid any confusion. Thank you.

SENATOR SLOSSBERG: Okay. Thank you very much for your testimony. Any questions?

Please tell Maura that we hope she feels better soon.

BURNILDA FERRAY: I will. Thank you.

SENATOR SLOSSBERG: Okay. Our next speaker is Jenn Fornier followed by Julia Wilcox.

JENNIFER FORNIER: Good afternoon.

SENATOR SLOSSBERG: Good afternoon.

JENNIFER FORNIER: My name is Jenn Fornier and I'm the vice president and in-house counsel for HARC, a Connecticut non-profit agency serving people with intellectual and related disabilities and their families. HARC has been at the forefront of the movement to improve the lives of people with intellectual disabilities since it was founded in 1951 by families who stood up for fundamental human rights that were denied to their children. At a time when institutionalization was the only option available, HARC's founding families rejected the notion of sending their loved ones to a place where they would exist in substandard conditions instead of living full lives.

Today, I am testifying in support of House Bill 5500 in an effort to ensure that the audits of providers receiving payment under the state Medicaid program are performed fairly and accurately. Medicaid fraud waste and abuse are not acceptable in any manner and we, at HARC, fully support compliant billing practices without exception. That said, the current

method for conducting audits is unworkable and the set aside as revenue in the state budget to the tune of \$64 million in fiscal '14 and 103 million in fiscal '15 established revenue capture not regulatory compliance as the driver for the process. My concerns with the audit are numerous but the two issues that cause the most angst are how the independent contractors performing the audits are paid for their work and how damaging the extrapolation of claims can be to an agency like ours.

As it pertains to the contractors performing the DSS Medicaid audits, they are paid on a contingency fee and as such, receive a portion of their payments they recover from providers. Right off the bat, the process is skewed toward finding errors and is inherently conflicted. This practice is akin to allowing insurance companies to pay auditors incentives to deny a certain percentage of claims, a practice that is not permitted because the quality of care is compromised. It is no different in our case. Since the auditors are being paid based on errors found across a full universe of claims. The amount of financial damage that can be done to safety net providers ultimately compromises care and services and harms the very people DDS and DSS are charged with serving.

House Bill 5500 Section (e) proposes a change in the payment structure to the audit contractor in order to stop current practices and resolve the conflicts of interest. A flat fee would bring integrity back to the audit process and support regulatory compliance instead of revenue generation on the backs of the safety net. This brings me to my concerns regarding extrapolation of which we have heard many today. The practice of extrapolating and error over a three-year period as a fair representation of a clerical error in a sample

of 100 claims is both unreasonable and crippling to providers such as HARC. As Commissioner Bremby mentioned in his testimony earlier today, Connecticut has a 2.2 percent error rate. Fraudulent billing is minimal because the integrity of the work done by the providers in Connecticut is great; however, the current extrapolation practice is literally banking on fines to meet revenue goals.

This is not a process founded in ensuring fiscal and programmatic integrity as he said it was. Senator Slossberg, as you mentioned earlier, providers are fined excessive amounts and then have to fight to get those fines reduced to reasonable levels and other providers in the field have testified to that very fact today. Providers like ours are forced to spend money they don't have to hire legal counsel to assist with appeals, staff members turn their attention away from providing care and on to audit defense and ultimately both financial and human resources exhausted, literally exhausted. The end result if you win the fight may be a reduction in fines, but the cost to the provider is great. Resources that should be devoted to programs and services are depleted and not easily if ever recovered; however, if the end result is a hefty fine, that can mean the end of a provider's ability to serve the most vulnerable among us which puts additional stress on the state and its citizens, your constituents, who now will have limited resources for support.

Safety net providers of care and service to the intellectually disabled of Connecticut have suffered through and barely survived steep budget cuts and cannot be further subjected to take backs from an audit process designed to fill a budget revenue line. House Bill 5500

Section (d) stipulates auditors online perform extrapolation of claims based on a sample like claims rather than the entire universe. We applaud that. This is a reasonable exercise of the extrapolation process unlike the current methodology.

Thank you for your time today for listening to all of us and for paying attention to such an important issue.

SENATOR SLOSSBERG: Okay. Thank you for your testimony, Jenn.

I wanted to ask you a question. You know said you're in-house counsel and so -- some of the information -- the Commissioner testified -- and a lot of your testimony was about the contingency fee that, you know, that they're on a contingency basis.

JENNIFER FORNIER: Right.

SENATOR SLOSSBERG: And so the Commissioner testified that the Affordable Care Act mandates that all states contract with a recovery audit contractor or RAC to perform audits of Medicaid providers and that they are to be paid on a contingency basis.

JENNIFER FORNIER: And we challenge that.

SENATOR SLOSSBERG: Okay. And you would challenge that?

JENNIFER FORNIER: Absolutely challenge that. There is no integrity in a recovery process that is supposed to be looking out ferreting out legitimate abuse if I get paid for every error I find.

SENATOR SLOSSBERG: Now, I understand you're saying you challenge sort of the legitimacy of the -- of the thought of this being a performance-based contract or a contingency basis. Can you speak at all to whether the Affordable Care Act requires that these contractors be paid on a contingency basis? Do you have any knowledge of that? It's okay if you don't. I don't want to put you on the spot.

JENNIFER FORNIER: It's pretty limited the knowledge that I do have around that. Most of my colleagues in other states that I communicate with on this issue are all viciously challenging that notion because there are many ways for the act to have the -- the intended outcome without needing to have payment based on each error. So it's largely in the field of what we're looking at.

SENATOR SLOSSBERG: Okay. But you're hearing from - - your similarly situated people in other states who are hearing the same thing and interpreting it the same way and also pushing back in the same way. So I think that's something that I know I would like to get a little bit more information on because obviously if this is part of federal law then we're going to have to work with what we can work with, but on the other hand, sometimes it's more of a question of interpretation. So I'm sure that's something else that we're going to continue to look at.

JENNIFER FORNIER: There is an interesting correlation back as well. If you look at the amount of dollars that come out in an audit report as a fine and then what's actually fought and limited down to. So we've got 10 million coming down to a couple of thousand in the legitimate error, it does, to me, raise a question of whether or not the integrity of the

audit at its outset made sense because if you can -- if you can bring it down that drastically, then the concept of getting paid against what I find and extrapolate out versus what's a legitimate error.

SENATOR SLOSSBERG: Yeah, but do you know do they get paid on what they actually find versus what is actually recovered? So if it starts out at 10 million, is it a 10 million -- does 10 million go in their -- in their line -- in their bucket to say okay so we found 60 million, you guys only recovered, you know, five of that, but (inaudible.)

JENNIFER FORNIER: Sure. It goes against what the recovery is, the ultimate recovery, but it's not different than I'm going to aim high and see where I end up versus starting with that's completely legitimate and fair.

SENATOR SLOSSBERG: And understanding that it's still -- you guys end up having to fight it and spend your resources doing that, which is not exactly what we want to be doing, but -- thank you for trying to help with that.

Are there further questions?

All right. Thank you again.

Our next speaker is Julia Wilcox. Good afternoon.

JULIA WILCOX: Good afternoon. Clearly alphabetical order was in play here. Good afternoon, Senator Slossberg and distinguished members of the committee. I appreciate the opportunity to provide testimony regarding House Bill 5500. My name is Julia Wilcox, senior public policy specialist for the Connecticut Association of Nonprofits. CT Nonprofits is a member

organization that represents more than 525 mission-based nonprofit agencies. Approximately 300 of our member organizations contract with the state government for a variety human and social services. CT Nonprofit supports the concepts in the proposed legislation. We applaud the committee for exploring the proposed process to ensure that audits of providers are performed fairly and accurately.

The nonprofit provider community remains committed to producing high quality outcomes that meet the rising demand for services and ensure the highest quality of care. Our member organizations welcome the opportunity to utilization quality assurance systems which accurately portray the value and quality of services and protect the citizens of Connecticut from fraud or abuse of any kind. We urge passage of House Bill 5500 with additional recommendations as outlined in my testimony. And you do have my written testimony before you. The first page summarizes the areas of the bill that we strongly support the reasons for that support. And I would like to, if I may, just simply highlight the recommendations as outlined on page 2.. Our first recommendation is to develop a streamlined process to increase efficiencies since the process is set up as an audit as opposed to an investigation, it would behoove all parties to provide at least a portion of the targeting information to be audited in advance of the actual audit. A great deal of time and resources are lost on both sides due to the need for providers to gather requested information while DSS auditors are actually present. The amount of time and resources spent in the process cannot be overstated.

First, for the provider to interrupt operations and dedicate increased staff to process at one time and second for DSS auditors to literally wait while agency staff gather the required information which may be a period of several hours, if not days or weeks. The inefficiency in the process as it currently stands invariably has a great impact on the anticipated cost savings or the outcome. The second recommendation is to establish consequences that are appropriate to any identified discrepancies or concerns. We recommend that there is a clear distinction made between the clerical errors and fraudulent documentation. It would stand to reason that there would be necessary penalties for fraudulent documentation; however, as you've heard today, in situations where there are clearly errors that are clerical in nature, we propose that there would be a penalty with an established ceiling.

The third recommendation is to evaluate the tone of the Medicaid audit process as this is the first round of audits in a relatively new system of payment, it is recommended that the audit should be implemented in a manner which is corrective in nature as opposed to punitive. The nonprofits organizations involved are primarily are funded by the state of Connecticut and therefore funds necessary to repay any findings will likely result in cuts to programs and client care needs. And our final recommendation is to develop a Medicaid audit implementation task force as the state moves forward with this process. And I'll simply say that Connecticut Nonprofits looks forward to working with DSS and with the committee certainly to bring together providers who represent each of the stakeholder groups because, as you've heard today, we feel that's an essential part of the piece, everything from

the dentist who have provided testimony to other groups. I think that it's really critical that all aspects are concerned when -- when these processes are developed.

And with that, I'll close. Again, you have my written testimony in full.

SENATOR SLOSSBERG: Thank you very much and we appreciate you being here and -- and the additional recommendations and suggestions that you've made which we'll definitely take a look at it.

Are there questions from committee members?

No, I don't see any questions. So thank you again.

That is our last signed up speaker. If anyone in the room hasn't had a chance to say anything and would like to speak at this time, we invite you to the microphone. Okay. First call. Going second. Okay. Last chance. The door is closed. This public hearing is now adjourned. Thank you.



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page 1, line 4



*Testimony before the Human Services Committee
Roderick L. Bremby, Commissioner
March 13, 2014*

Good morning, Senator Slossberg, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Roderick Bremby and I am the Commissioner of the Department of Social Services. I am here before you today to testify on bills that impact on the Department.

HB5500

S.B. No. 409 AN ACT CONCERNING THE DEPARTMENT OF SOCIAL SERVICES

The bill requires the department to conduct a study of DSS programs to include: (1) The responsiveness of department programs to recipients of services, (2) identification of problems, if any, that exist within such programs, and (3) whether staff is allocated in a manner to meet the need for services within such programs.

The Department of Social Services supports the basic needs of children, families, elders and older adults, including persons with disabilities, through economic aid, health services, social work services, child support, energy aid, elderly protective services and many others. We currently service more than 750,000 state residents through the several dozen programs administered by the agency.

On July 1, 2013, we launched our statewide ConneCT initiative that seeks to make necessary technological investments as well as transform our antiquated business practices. While we are still rolling out pieces of the project, to date several key components have been implemented and are fully operational, including: one statewide toll-free number, an integrated voice response (IVR) system, three Benefit Centers, "My Account" online feature and the "Am I Eligible" screening tool.

On a typical day, we experience approximately 11,160 people calling the toll-free number and 4,360 use the IVR system. Furthermore, due to a revolutionary business redesign in the way our field offices operate, approximately 85% of people coming into our regional offices are leaving the same day with resolution.

Another key component is the development of a centralized document management center. At the launch of ConneCT, DSS had on hand some 200,000 pieces of unprocessed pieces of paperwork. Today, there are fewer than 3,000.

We are constantly striving to improve our processes. We frequently review our practices and make changes to better serve our consumers. For example, we identified long-term care application processing as an area in need of improvement. In response, we launched four long-term care hubs solely dedicated to processing these applications. In addition, we recently launched an auto-initiation of redetermination so that people do not lose benefits. Through these efforts, we have seen an improvement in the timeliness of processing applications, paperwork is no longer being lost and consumers are able to reach us in person, by phone, and online.

Speaking specifically to this bill, the Department has a number of concerns. First, the scope of the study is not defined. It is unclear if the intent of the bill is for the Department to study all programs administered by the agency, which would be extensive, or if there are specific programs in particular that the report should focus on. This bill also requires the Department to report on “responsiveness of department programs to recipients . . .”, however this may be difficult to ascertain. First, the definition of responsiveness is going to differ depending on who is interpreting the language. Second, a follow-up study of this magnitude would most likely have to be contracted out as we do not have the resources to dedicate to this. The Governor’s recommended midterm budget, however, does not include any additional funding for such a study. Also, the RFP for consulting services would take a considerable amount of the time allotted to complete a study.

H.B. No. 5500 AN ACT CONCERNING PROVIDER AUDITS UNDER THE MEDICAID PROGRAM.

This bill proposes several new provisions to be added to the department’s statutes, which govern the provider audit process.

The Department has a long history of understanding the need for compliance audits and the value that audits bring to the Medical Assistance programs. The Department also understands that without a financial penalty for non-compliance, the audits would be rendered worthless. The investment in this compliance function has paid dividends. The Connecticut Medicaid program has one of the lowest payment error rates in the United States. The Centers for Medicaid and Medicare Services performs audits the payment accuracy all state Medicaid programs on a three year cycle. The FY 2012 published estimated error rate for Connecticut is 2.2%. This error rate is less than half of the national average and puts Connecticut in the top tier of Medicaid programs.

The primary purpose of our audit division is to assure compliance. For the fiscal year ending June 30, 2103, the Audit Division issued 130 audit reports identifying approximately \$20 million in overpayments. The need for compliance in the multi-billion dollar Medicaid program cannot be understated. Connecticut’s Medical Assistance Programs are governed by an extensive and comprehensive array of federal and state policies, regulations and statutes. Enrolled providers are entrusted to understand all applicable guidelines and accurately bill for all covered services. Most providers are granted the right to directly bill for goods and services rendered with relatively few upfront edits. It is then our responsibility to ensure both the fiscal and programmatic integrity of these claims. In addition, we believe that there may well be a direct correlation between poor billing compliance and the quality of the related medical services. For

example, a provider cited for inadequate or out of date documentation of care plans may be relying on inadequate or outdated clinical information in making decisions affecting patient care.

It is important to note that proposed Provider Audit Requirements Regulations were developed in collaboration with the Office of the Attorney General and we anticipate that they will be taken up by the Regulations Review Committee at their April meeting. These regulations are a response to Public Act 10-116, which required the department to adopt regulations that would ensure the fairness of the audit process, including, but not limited to, the sampling methodologies associated with the process. The Department believes that any changes to the statute should be postponed to allow implementation of the audit regulations developed pursuant to that directive.

As background, our Quality Assurance provider audit process uses a sample of audit claims and an extrapolation method to determine the number of payment errors and the amount of overpayments to collect from providers. Extrapolation takes the results of a sample and applies it to the larger claims universe. Providers must make repayments to DSS based on these extrapolated error amounts. The Connecticut Supreme Court upheld the use of the extrapolation process in the 2008 Supreme Court ruling *Goldstar Medical Services, Inc. et al. v Department of Social Services*.

Providers aggrieved by a decision in a final audit report may request a review of the audit findings, which is performed by a designee of the Commissioner outside the Office of Quality Assurance. If a provider is not satisfied with the audit review, the provider may appeal to Superior Court. In addition to this formal review process, providers may request the Director of the Office of Quality Assurance perform an informal review of a final audit report. The Department has the discretion to suspend the recoupment of payments while an appeal is pending.

Specific comments regarding provisions of the bill:

DSS has concerns with the definition of “extrapolation” proposed in this bill. We believe our proposed Provider Audit Requirements regulation defines all necessary terms. Our proposed definitions have been fully vetted through the public hearing process and reflect terminology commonly used in the statistical sciences. In our proposed regulation “Extrapolation” is defined as “...determining an unknown value by projecting the results of the review of a sample to the universe from which the sample was drawn.” The definition of “extrapolation” proposed in this bill contains ambiguous and undefined terms that would be impossible to administer, such as “nonvalid claim” and “other errors”. The Department respectfully requests that if a definition of “extrapolation” is to be established in statute, the definition proposed in our regulation be substituted for the language proposed by the Committee.

Section 1(3) (b) requires the Department to provide Medicaid providers information concerning the audit process, including, but not limited to providing free training for new providers on how to enter claims to avoid clerical errors. Our auditors have conducted numerous training sessions with various provider associations and are committed to continue the outreach to our provider community. Regarding provider billing, the Department’s contract with HP requires HP to

provide education about the Medicaid billing process. Education is provided through published "billing manuals" and face-to-face meetings. HP also operates a customer service department to address provider billing questions. If enhancements to the current resources are needed, they can be addressed by DSS without establishing a statutory requirement.

Section 1(3)(c) contains the term "relevant to the audit". Relevance is difficult to define and can be interpreted subjectively. Also, the proposed limitation on what records can be audited is in direct conflict with established regulations. For example, RCSA 17b-262-337, Requirements for Payment of Physicians' Services, includes the requirement:

"The department retains the right to audit any and all relevant records and documentation and to take any other appropriate quality assurance measures it deems necessary to assure compliance with these and other regulatory and statutory requirements."

Additionally, the Provider Enrollment Regulation and the multiple regulations governing provider specialties all contain specific documentation requirements. Most importantly, as the single state agency responsible for administering the Medicaid program, we must assure CMS that our Medicaid claiming is appropriate and consistent with all federal requirements. In order to give this assurance, we must have the ability to review all documents.

The proposed language in Section 1(3) (d) requiring auditors to perform extrapolation of claims based on a sample of like-claims is ambiguous and open to interpretation. The proposed Provider Audit Requirements regulation contains specific language that will avoid inconsistent interpretation. Performing audits on only "like claims" would seem to require the Department to perform multiple audits of each provider in order to establish a statistically valid sample from which to extrapolate. The administrative burden and fiscal impact on the Department would be tremendous and our ability to ensure compliance through the audit process would be compromised as a result. We respectfully request that the proposed Provider Audit Requirements regulations be promulgated and tested over the next few years.

The provision starting on line 33 specifying that DSS should first audit providers with a higher compliance risk could have the unintended consequence of increasing noncompliance across the program because previously compliant providers would know that they would not be audited.

Section 1(3)(e) proposes that DSS not pay on a contingency basis for audit recoveries. This conflicts with requirements under the Affordable Care Act (ACA) that mandate that all states contract with a Recovery Audit Contractor "RAC" to perform audits of Medicaid providers and that they are to be paid on a contingency basis. To meet these ACA requirements, DSS contracts with HMS to perform the RAC audits and pays them a percentage of identified overpayments and underpayments. And let me make clear that only RAC audits are contingency-based. Other audit contracts are not and there are no plans to make them such.

Lastly, the notice requirement contained within this bill is duplicative of current language in CGS section 17b-99 and the proposed audit regulation.

For the reasons stated above the Department is opposed to this bill.

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Testimony of the Connecticut State Medical Society
House Bill 5500 An Act Concerning Provider Audits Under the Medicaid Program
Human Services Committee
March 13, 2014

Senator Slossberg, Representative Abercrombie and members of the Human Services Committee, on behalf of the physicians and physicians-in-training of the Connecticut State Medical Society (CSMS), we thank you for the opportunity to submit testimony on House Bill 5500, An Act Concerning Provider Audits Under the Medicaid Program. CSMS believes there is a significant need to reform the current audit process under the Medicaid Program and supports the Committee's efforts through HB 5500 to do so.

Connecticut physicians and their office staff face a significant challenge in preparing for and responding to audits and financial reviews conducted by various private payers, as well as Medicare and Medicaid audits. CSMS understands that increased pressure to control healthcare costs and to identify fraud and abuse have led to increasingly frequent audits. CSMS believes that there are audit methodologies which can achieve these aims and support the state's need to identify deficiencies and overpayments, while also enduring fair and just treatment for physicians during the audit process. That said, certain methodologies can be implemented to ensure fair and just treatment of physicians when conducting audits while balancing the understandable needs of the state to identify deficiencies or overpayments. For that reason, we support the intent of HB 5500 and offer that further statutory or regulatory changes are necessary with regard to the audit process identified in HB 5500 to ensure that fairness and transparency are maintained throughout the process.

At the outset, CSMS would like to thank this Committee for the language contained in section (e) of HB 5500 prohibiting payment to contractors on the basis of the amount of overpayment. CSMS strongly believes that auditors should have no financial incentive throughout the course of an audit based on recoupment levels. Such financial incentives impede the audit process and raise questions about integrity of the process as a whole. To that end we would recommend that the language contained in section (e) of HB 5500 be expanded to specifically state that auditors shall be compensated on a "flat fee" basis or other formula that does not include a percentage of any financial recovery, so as not to incentivize these excessive findings without statistical merit.

The majority of the language HB 5500 specifically addresses the use of extrapolation in provider audits. We appreciate that the Committee understands the need for regulation of its use in audit procedures. However, we feel that a greater level of detail is needed because there can be misuse and abuse of extrapolation procedures that misrepresent the care provided and payments received.

Extrapolation methodologies employ a complex statistical formula. In order for results to be accurate, such formulas must be developed by a statistician with detailed knowledge of Medicaid claims analysis. Furthermore, the extrapolation formula must be provided in the audit report when the formula is used to calculate an alleged under or overpayment amount. The extrapolation itself must be done by an experienced statistician, and the name and credentials of the statistician performing the analysis must be supplied as part of the audit findings. This information is needed in order to validate the employment of a statistically reliable method applied by a trained and reliable statistician. Such validation is critical, given extrapolation has been known to be used to adversely impact physician payment for medically necessary services.

Extrapolation must be based on a statistically valid random sample using stratification when appropriate. A statistically valid random sample for a medical audit is a sample where every single claim has an equal opportunity to be included within that sample. A biased sample can result in a vast over-calculation of overpayment amounts when extrapolated to a larger universe. In other words, if a sample represents a higher average paid amount than the universe of claims, it may translate into a higher average overpayment amount than would be calculated from a true random sample. For example, without a statistically valid random sample, in a universe of 10,000 claims, a difference of \$10.00 could result in an overestimate in excess of \$100,000 in the overpayment demand. This is a key reason why a statistician with experience in statistically valid random sampling is essential to the audit process when extrapolation is used.

Additionally, all zero paid claims and claims with outliers must be removed from the sample prior to extrapolating any payment due. If the auditor believes any claims with outliers have been overpaid, those claims must be dealt with individually because they could lead to overestimation of any overpayment or underpayment. Unless the data are normally distributed, approximately normally distributed and/or symmetrical, the median (rather than the average) amount must be used to determine the central data point per unit audited as the basis for calculating the alleged overpayment. The lower bound of the two-sided 90% confidence interval should be used to calculate the alleged overpayment. Care must be taken to determine if those sampled truly represent a normalized sampling. CSMS feels strongly that such statistical analysis and statistical guidelines must be contained in statutory or regulatory language if the extrapolation methodology is going to be used. Without these statistical protections, the extrapolation process has significant potential to be fraught with errors and inaccuracies and there would be no way for such findings to be appealed.

Further, when looking at the development of a random sample or stratified random sample, care should be taken to make sure that when multiple services or procedures are provided within the context of a care visit, only claims of the same construction should be gathered. For example, if a preventive medicine visit and a sick office visit with the associated and appropriate modifier are reported using CPT® (Current Procedural Terminology) codes, guidelines, and conventions, the sampling should reflect only claims for these same services, associated codes, and modifiers. Any claims with additional services or procedures reported, or claims with only one of these two services documented, would suggest different care was provided during the patient encounter and therefore should not be used as part of the sample. Further, any claim that has previously been downcoded or bundled by the payer or state

agency should not be included in an extrapolated sampling, as the physicians coding for the service(s) tied to the particular encounter have been changed or manipulated.

In addition to the necessary constraints on the extrapolation process, additional statutory and/or regulatory protections are necessary for physicians undergoing Medicaid audits. Despite recent increases in primary care rates through the Accountable Care Act (ACA), many Connecticut physicians are electing to no longer participate in the Medicaid program, citing the uncertainty and unfairness of the Medicaid audit program as a significant reason. The costs associated with audits, both financially and in staff resources outweigh the benefits of participation. Ensuring a fair and just audit process will help to retain quality physicians in the Medicaid program, which serves an increasing number of Connecticut residents.

Statutory or regulatory guidance is also needed regarding to audit notices provided to physicians. Audit notice should be provided to physician practices with advance written notice sent by certified mail at least 30 business days prior to an audit. Additional information regarding the records required, the manner in which they are to be submitted, and any codes and modifiers in question must be provided.

With regard to auditor qualifications, statutory and/or regulatory guidance must state that all individuals performing medical audits have appropriate knowledge and experience in coding, including applicable ICD (International Classification of Diseases), CPT[®] (Current Procedural Terminology), and HCPCS (Healthcare Common Procedure Coding System) codes. Additionally, auditors must be familiar with the format and contents of medical records and claims forms used today in both private community practice as well as hospital based settings. Individuals auditing medical records for issues of coding and documentation should be certified in coding, with at least one year's auditing and/or coding experience. Further, individuals auditing medical records related to decisions of medical necessity must be licensed in the clinical discipline which provides appropriate knowledge and expertise to determine the medical necessity of clinical tests and procedures without the benefit of examining the patient.

Statutes and/or regulations should specify the information to be contained within the audit finding reports. The audit report should clearly identify any errors discovered in the audit, specifying all medical and reimbursement policies and procedures used in determining the outcome of the audit, and providing a copy of these policies and procedures to the physician as part of the audit report. If the auditor is unable to provide the specific medical reimbursement policies and procedures being relied upon, then the overpayment request specific to those policies and procedures should not be allowed. It is only fair that physicians be given copies of the medical policies and procedures documentation being relied upon by the auditor. If those policies and procedures are not available for any reason, the findings should be disallowed.

Additionally, the audit report should identify underpayments to the physician practice. The audit report should be provided within 30 days of the completion of the audit. Where repayment is sought, the audit report should clearly describe how the overpayment amount was calculated. The audit report should clearly detail the appeals process, and physicians should be afforded at least 30 days to challenge or appeal any audit report. CSMS strongly believes that a detailed appeals process and certain protections for physicians should be contained in statutory or regulatory language. Audit appeals should have at least two levels: an initial request for reconsideration and a second level appeal to an external qualified third party.

Furthermore, any decision to deny reconsideration should be made by a qualified physician. With regard to the second level of appeal, an external qualified third party should be utilized and such third party should be independent from the DSS staff. Finally, It should be specified that that physicians are not subject to alleged overpayment re-payments or recouplements while any appeal is pending.

CSMS also believes that the "look back" period for audits should be codified. State law currently limits the period to 18 months for commercial payers. For fairness and consistency, the proposed regulations should apply the same timeframe to the Medicaid program. Connecticut has seen multiple changes to the Medicaid contractors with vastly different physician payment rules and guidelines in a relatively short period of time. Limiting the "look back" period ensures fairness and consistency for physicians given the ever-changing Medicaid contractors used by the state.

CSMS appreciates the opportunity to provide these comments on HB 5500. We also appreciate the opportunity to provide suggestions for additional statutory and/or regulatory provisions that are necessary to ensure a fair and transparent audit process that will help retain physician participation in the Medicaid program and provide quality medical care to the patients of Connecticut.

Human Services Committee

Raised Bill No. 5500

An Act Concerning Provider Audits Under The Medicaid Program

Senator Slossberg, Representative Abercrombie and the Members of the Human Services Committee

My name is Edward Schreiner. I am a resident of 36 Pineridge Drive, Oakville, Ct. As a registered pharmacist, I have owned and operated Stoll's Pharmacy in Waterbury, Ct since 1988. I am also the Chairman of the Board of Directors for Northeast Pharmacy Service Corporation, a group purchasing organization (GPO) with approximately 275 participating community pharmacies throughout New England including 105 independent pharmacies in Connecticut

I would like to thank the Human Services Committee for raising Bill No. 5500: An Act Concerning Provider Audits Under the Medicaid Program and for conducting this public hearing today.

Provider audits conducted by the State of Connecticut Department of Social Services were originally intended to detect and deter fraud, waste and abuse involved with the Medicaid drug program. I fully agree with the DSS Medicaid Program's mandate to root out fraud, waste and abuse; however I think that it is important that auditing activities serve to deter and eliminate fraud, waste and abuse rather than severely penalize providers that have acted in good faith when providing services to Medicaid recipients. The manner in which Medicaid audits are currently being conducted and the business-crippling recoupments being taken by DSS audit activities appears to be more of an administrative mechanism to help fund the Medicaid budget rather than any effort to ensure appropriate payments to providers for medically necessary services.

When fraud, waste and abuse can be ruled out as motivating factors, fairness dictates that minor clerical errors should be adjusted on a claim specific basis without penalty. In fact CMS requires that claims be corrected, not recouped or used to extrapolate further monetary recoveries from pharmacy providers under Medicare Part D program rules. Considering that federal funding is a large part of the Medicaid program I cannot understand why this rule does not apply to DSS Medicaid audits as well.

I believe that the extrapolation process currently being used during Medicaid audits is extremely unfair and causes huge financial burdens for providers. By applying extrapolation over the entire universe of claims encompassed by the audit sample time frame, the Department of Social Service is pursuing excessive punitive recoupment for minor technical discrepancies where no intent of provider fraud is evident. Sec. 17b-99 (2) of the Connecticut General Statutes states that "any clerical error, including, but not limited to, recordkeeping, typographical, scrivener's or computer error, discovered in a record or document produced for any such audit, shall not of itself constitute a wilful violation of program rules unless proof of intent to commit fraud or otherwise violate program rules is established". Despite this regulation auditors frequently cite the Provider Agreement requirement to "adhere to all applicable state statutes and regulations promulgated by the Department" when issuing their findings. Using this justification pharmacies are frequently subject to recoupment of claim payments due to clerical, computer, or recordkeeping errors that have nothing to do with fraud and did not result in significant financial harm to the Medicaid program.

As the owner of Stoll's Pharmacy, I have experienced Medicaid audits on more than one occasion and found it to be a very stressful and intimidating process. At the exit interview from my most recent Medicaid pharmacy audit, I was told that no drug errors were found and that all changes we made to prescriptions were well documented and appropriate. One of the auditors requested that I pass along her compliments to my staff on the very clear documentation she found in our audited prescriptions. Approximately 3 weeks later I received a draft audit report detailing an extrapolated error amount of \$137,993.63 based upon two (2) errors identified

in the report. After back and forth discussions with the audit department and resubmission of documentation the auditor was given during the audit but seemed to have overlooked, the final report indicated an overpayment of \$6.59 based upon a keypunch error we had made on one prescription. The extrapolated fine for this claim was \$2802 which is more than 425 times the actual price Medicaid paid for the prescription!

I have been more fortunate than many other pharmacy providers when navigating a Medicaid audit. I am aware of three Connecticut pharmacies that are facing fines greater than \$100,000. These fines are due in part to findings indicating that some of the audited prescriptions were written on paper that only complied with *two of the three* elements required for the prescription blank to be considered tamper-proof!

The pharmacies have signed statements and/or medical records from the prescribers verifying that the prescriptions were in fact legitimate and were filled in accordance to their order but DSS refuses to accept this further documentation and insists that the pharmacist should have known they were written on improper paper. It is incomprehensible that a pharmacy can be fined \$100,000 solely because it billed for legitimate prescriptions that were written on the wrong paper. This certainly does not constitute provider fraud yet but it certainly implies a consistent pattern of auditor disregard for Sec 17b-99 (2) of the state statutes!

One of these pharmacy owner tells me his pharmacy is facing almost \$145,000 in penalties based on clerical mistakes involving 3 prescriptions with a total value of \$268 in payments received from the Medicaid program. This family owned pharmacy is struggling to find a way to pay this fine and remain in business.

As these examples demonstrate, the current Medicaid audit process routinely seeks to recover hundreds of thousands of dollars of legitimate payments made to pharmacies even when the correct drug is given to the correct patient for the correct price when no fraud has occurred. It is also disturbing that DSS maintains a no-negotiation policy that does not allow providers to provide any additional documentation after the fact to validate a prescription

How can this unfair audit practice be rectified? The ability to extrapolate findings for claims under \$1000 in value, over *all* of the paid claims encompassed by the audit sample time frame, provides DSS with the unintentional monetary incentive to recoup claims due to clerical, administrative or recordkeeping error. Extrapolation should only be allowed when clear-cut evidence is found and documented that a pattern of intentional fraud, waste and abuse has occurred. As with CMS rules for the Medicare Part D program, Medicaid should be required to correct the claim rather than recoup it when clerical, administrative or keypunch errors are found.

Raised Bill No. 5500 seeks to ensure that audits of providers who receive payments under the state Medicaid program are performed fairly and accurately. This legislation is necessary to ensure that provider audits return their focus to ferreting out fraud, waste and abuse while protecting all of Connecticut's Medicaid providers from excessive financial penalties based upon minor technicalities within the current audit guidelines operated by the Department of Social Services. In conclusion, I strongly urge you to support passage of Raised Bill No 5500 after including provisions to specify that extrapolation can only applied during Medicaid provider audits for cases of proven fraud, waste and abuse.

Thank you for your consideration of my views.

**Human Services Committee, Raised Bill 5500.
Testimony of Companions & Homemakers, Inc.
March 13, 2014 - Page 2 of 2**

Comment. We recommend the bill be amended to require DSS to promulgate an audit provider manual and issue periodic bulletins online to update the manual. Since DSS has taken the position that "clerical errors" do not bar extrapolated disallowances, DSS should provide education on how to minimize exposure to extrapolated findings. The rationale is simple: Providers are entitled to know what the specific rules of the game are before being found at fault for breaking them. This is particularly true in light of the potentially devastating consequences of extrapolation.

☒ requires that DSS, when deciding what provider to audit, first direct its efforts to providers with a higher compliance risk based on past audits or errors. **Comment.** We recommend that this section be amended to provide for a more definite set of parameters to be applied by DSS when determining which agency to audit. For example, Medicare law limits extrapolation to situations where there is "sustained or high level of payment error [on the part of the provider], or documented educational intervention [given to the provider] has failed to correct the payment error."

C&H respectfully suggests another amendment. While the audit statute provides for a right to appeal audit results in superior court, those appeals are highly technical and hinge upon the development of a proper *record* before the administrative agency (DSS). This record will, in turn, inform the judge's decision-making process when adjudicating an appeal. Currently, if the provider seeks *internal review* of the agency's findings, the review is conducted by an employee of DSS *appointed by the Commissioner*. Providers have no right to submit evidence to contest the findings, no right to submit witness testimony, no right of cross-examination, and no right to procedural due process in the form of internal review by an impartial administrative law judge. In other words, providers are severely limited in their ability to develop a proper record for review of DSS' audit findings by a superior court judge.

C&H, therefore, respectfully requests this bill be amended to provide for internal review of audit findings *by an impartial DSS hearing officer*. Internal review by a DSS hearing officer will enable providers to assemble a proper, meaningful record for appeal.

Thank you for considering our comments. I will be pleased to answer any questions.



CONNECTICUT ASSOCIATION FOR
HEALTHCARE AT HOME

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TESTIMONY

Delivered by Deborah R. Hoyt, President and CEO
The Connecticut Association for Healthcare at Home

Before the Human Services Committee
March 13, 2014

SUPPORT: H.B. 5500

AN ACT CONCERNING PROVIDER AUDITS UNDER THE MEDICAID PROGRAM

Good afternoon Senator Slossberg, Representative Abercrombie and honorable members of the Human Services Committee.

My name is Deborah Hoyt, and I am the President and CEO of the Connecticut Association for Healthcare at Home and I am here representing 60 Connecticut DPH licensed/Medicare certified home health and hospice agencies that foster cost-effective, person-centered healthcare in the setting people prefer most – their own home.

As a major employer with a growing workforce, our on-the-ground army of 17,000 home health care workers is providing high-tech and telehealth interventions for children, adults and seniors. We are working collaboratively every day with DPH and DSS to manage community-based patient populations and avoid their unnecessary rehospitalizations.

The Association Supports H.B. 5500 and the fair and accurate auditing of home care providers.

First and foremost, the Association and our agency providers strongly believe in the ethical provision of home care and hospice services to Connecticut residents under the Medicaid program. We support the elimination of healthcare fraud in any form.

To that end, we believe that a fair and reasonable system of auditing home care and hospice providers is not only appropriate, but necessary to ensure the viability and soundness of Connecticut's Medicaid programs. Currently, all home care and hospice agencies are audited by the State Department of Social Services (DSS) every three years for the full 3 year period.

As an Association, we are proud of the high standards that our provider agencies exhibit in their business practices, documentation, and coding and billing process despite a very challenging environment of constantly changing state and federal regulations. One of our core services as an Association is to provide extensive education and information regarding proper documentation and adherence to DSS and DPH regulation.



CONNECTICUT ASSOCIATION FOR
HEALTHCARE AT HOME

We also appreciate the DSS Audit Division's more recent openness to transitioning the audit process from a punitive position to one where home care providers can get better at coding and billing Medicaid claims.

The Association and our home care providers desire an environment where the Audit Division provides ongoing education and guidance so that we get better at the paperwork in order to put our focus back on delivering the cost-efficient care that helps patients, and saves the state money.

With hundreds of thousands of documents prepared each year by our agencies on its Medicaid clients, clerical errors will happen. We have shared our concerns about extrapolation, sampling and other specifics regarding clerical errors in a previous hearing on December 10, 2012, so I won't cover them in this forum.

I do want to express, however, our serious concern about the perception of fraud or intentional fraudulent billing when in most every case; errors found in the audit process are simply clerical in nature.

For example, one of our member home care agencies received an initial DSS audit finding letter identifying nearly \$10-million dollars in Medicaid overbilling. While that is shocking enough for a home care agency administrator to receive, they are obligated to share that information with their board of directors, banks and other business partners, despite the fact that that these initial finding may be explainable.

In fact, after nearly a year of meetings with DSS, hundreds of hours of home care agency staff time, and nearly \$10,000 in legal fees, the initial \$10-million audit finding was reduced to a more realistic \$4,500 in clerical errors.

The Association has evidence of many stories like this one – perhaps with smaller initial audit findings, but similar in scale representing the disparity from initial finding to final outcome.

We can make the audit process better and improve our home care agency efficiency at the same time – a win-win for both providers and the Audit Division with the Medicaid client receiving better care as a result.

Finally, I am concerned that the state budget and DSS expectation for audit take-backs combined with the new initiative for "fraud recovery" implies rampant fraudulent provider behavior – which is not the case in home care and hospice. Remember, these are the providers that are significantly under-reimbursed – at .58 cents on the dollar to serve the Medicaid population.

I urge the Human Services Committee to be mindful of these large dollar recovery targets and the additional and perhaps unnecessary scrutiny that Medicaid



CONNECTICUT ASSOCIATION FOR
HEALTHCARE AT HOME

providers will experience. This additional scrutiny will drive providers out of this market, leaving the state without home care and hospice agencies to care for the growing number of residents now qualified for Medicare services.

Thank you for your attention and I am pleased to answer any questions you may have.



Community Health Center Association of Connecticut

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Testimony of

Deb Polun

Director, Government Affairs/Media Relations
Community Health Center Association of Connecticut

House Bill 5500: An Act Concerning Provider Audits under the Medicaid Program
Human Services Committee

March 13, 2014

Thank you for this opportunity to **provide support** for House Bill 5500, An Act Concerning Provider Audits under the Medicaid Program.

The Community Health Center Association of Connecticut (CHCACT) is a nonprofit organization that exists to advance the common interests of Connecticut's federally qualified health centers (FQHCs) in providing quality health care. Through training, technical assistance, public policy work and other initiatives, CHCACT supports the 14 FQHCs in their provision of comprehensive medical, oral and behavioral health care to over 340,000 residents across the state every year.

A profile of FQHC patients in Connecticut (2012):

- 95% low income (under 200% of federal poverty level)
- 60% Medicaid/HUSKY
- 23% uninsured
- 14,787 homeless
- 73% racial/ethnic minorities

CHCACT supports the auditing of providers of Medicaid services, which are essential to identifying fraud and abuse of the Medicaid system. However, the current audit methodology places undue hardships on FQHCs and other providers by asking for excessive, overbroad information, including that related to non-state grants, employee compensation and funding in years not included in the audit.

Therefore, CHCACT thanks the Committee for proposing this legislation, which would go a long way toward improving the audit process.

Specifically, CHCACT supports:

- The requirement for DSS to provide training to new providers to help them avoid clerical error. CHCACT requests that this training be ongoing, as FQHCs and other health care providers hire new billers/coders on a continual basis.
- The limitation of scope to information necessary to support claims only.

- The proposed elimination of payment incentives for contractors performing provider audits based on the amount of overpayment by the Medicaid program to the provider.

CHCACT also offers the following suggestions:

- CHCACT supports the reexamination of the extrapolation process – but would recommend further tightening of the process than that proposed in the bill. Specifically, we strongly urge that extrapolation of audit findings occur only in cases where the error or defect occurs in more than 5% of the sampled claims. Errors that occur in less than 5% of the sampled claims should be considered immaterial and should not trigger extrapolation to all claims. Clarity regarding the methodology the State uses for the statistical sampling and the calculations used for extrapolation must be clear in order to prevent provider reimbursement from being unfairly and, in some cases, drastically reduced.
- There is a need for clear distinction between clerical errors and fraudulent documentation. Where the audit findings involve claims where the error or defect is procedural, and there is no intent to falsify or defraud, and the services provided to a Medicaid enrollee meet the definition of medical necessity, providers must be allowed to correct the defect and resubmit the claim within sixty (60) days before payment is denied for those claims and before extrapolation to other claims is calculated.

During this era of implementation of health reform, the FQHCs continue to be a critical part of the state's public health care system, providing care to some of the neediest residents of our state. In fact, FQHCS like hospitals are some of the only health care providers that turn no one away, including immigrants – both legal immigrants who have been here fewer than five years (and are therefore ineligible for Medicaid), and undocumented immigrants. Based on the experiences of Massachusetts, the role of health centers will likely increase with the increase in health insurance enrollment. The State's support in not making the audit process unduly cumbersome or punitive is critical to keeping administrative costs in check for all Medicaid providers, but most especially those who bear the heaviest burden of providing care to patients unable to pay for services.

I ask this Committee to report favorably on this bill and continue your historical support of health centers. Thank you.

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Legislative Testimony
Human Services Committee
HB 5500 AAC Provider Audits Under The Medicaid Program
Thursday, March 13, 2014
Jeffrey Berkley, DDS

Senator Slossberg, Representative Abercrombie and members of the Human Services Committee, my name is Jeffrey Berkley. I am an Oral and Maxillofacial surgeon who participates with the Medicaid Program. My group practice consists of eight surgeons that practice in five offices throughout Connecticut. I am an attending in the Department of dentistry at Yale, teaching in their residency program. I am head of the Dental Department at Midstate Medical Center. I am also President-Elect of the Connecticut State Dental Association and have received many calls from members regarding the audits. I am writing to testify in support of House Bill 5500 An Act Concerning Provider Audits Under The Medicaid Program.

I happened to be involved in one of the earliest audits and can not say definitively that the process has not improved since then. What I can do is relate my personal experiences and infer not that much has improved as many of the complaints I currently hear are similar to my experience. The auditor was pleasant, but was not a dentist and had minimal knowledge of the definitions, standards of care, or protocols involved in my specialty. I did make efforts to educate them in this regard, which hopefully helped in later audits, but find it highly inappropriate that we should need to educate those auditing us. It appears that the majority of findings involve disputes over coding intricacies, appropriate but uncovered clinical treatments, and standards being enforced by the DSS that do not correspond to ADA or current dental standards. Standards that are more common in medicine (an example of which would be requiring written documentation for the reason a radiograph was taken), are not the standard in dentistry. The law which allows extrapolation to audit violations does not require extrapolation for all findings. It was intended to fight fraud. The instances I cited above certainly do not qualify as fraud. Yet the auditors are extrapolating all negative findings to the entire universe of patients within the audit period, triggering repayment demands that are extreme for even minor issues. This extrapolation extends to different providers within the same group practice. From my experience and those of many who called, it is highly unlikely that current audits are random, as is required for the concept of extrapolation. It is this inappropriate extrapolation that creates the most concern.

At the urging of leadership of the CSDA, our state has risen from the bottom to be a model for providing access to care for the citizens of Connecticut. There are certainly instances of fraud and these should be pursued and punished. The CSDA has offered to help in educating the auditors, who we feel should be dentists. We have met with Commissioner Bremby and suggested formulating a reasonable set of standards together, assisting in educating dentists to those standards, and suggested the Dental Commission be more actively empowered to discipline flagrant violators. To date these have not been

implemented. With the amount of negative feedback being created by the audit process and extrapolation I fear that we will potentially be faced with the loss of many of our very best providers. These highly proficient and honest dentists who have now welcomed Husky patients into their practices are being dissuaded from continuing to do so.

HB5500 as written solves most of the issues that are causing providers to consider leaving the program while still allowing auditors to identify outliers committing fraud. To those, we should not only recoup payments but refer them for disciplinary action to the Dental Commission. There are areas of improvement that I would like to suggest. I feel that a licensed dentist, and where appropriate a licensed dental specialist, should be used in all phases of the audit. They should enforce standards that follow the American Dental Association guidelines for coding and protocols. Any variations from the above that are required (and I am not sure why that would occur), should be specifically noted and published to all providers before holding them liable. The appeals process in the audit should involve dentists who are not the paid auditors, perhaps the Dental Commission. I would also suggest that audit penalties already closed be modified to reflect the provisions of this law that restricts the inappropriate extrapolation. I thank you for your time and urge you to support this valuable and urgently needed bill.

Respectfully Submitted,

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Legislative Testimony
Human Services Committee
HB 5500 AAC Provider Audits Under The Medicaid Program
Thursday, March 13th, 2014
Carolyn J. Malon, DDS

Senator Slossberg, Representative Abercrombie and members of the Human Services Committee, my name is Carolyn Malon. I practice dentistry in Farmington, Connecticut and I am a Medicaid provider. I currently serve as the Immediate Past-President of the Connecticut State Dental Association. I am writing to testify in support of House Bill 5500 An Act Concerning Provider Audits Under The Medicaid Program.

Over the course of the last several years, the leadership of the Connecticut State Dental Association has worked closely with the leadership of our state to develop a network of dental Medicaid providers that is the envy of other states in our country. We currently have over 1800 dental providers enrolled in the Medicaid program.

It is an unfortunate fact that there have been a small number of providers who have been found to have committed fraudulent activity in the course of their billings. The vast majority of dentists enrolled however, are honestly trying to follow the rules and provide quality dental care to their patients. The audit process which looks for fraud is now adversely affecting many of our CSDA member dentists, and those of us in leadership roles in our association have been hearing from them. We feel that the provisions in HB 5500 would be good start towards making the audit process more fair, while at the same time ensuring that those who are perpetuating fraud are appropriately reprimanded or penalized. There are however additional concerns.

There are currently no written standards for required documentation in patient charts. The CSDA leadership has offered to work with DSS to develop a list of standards, so that our members who are providers understand what they need to do to avoid penalties. We have not yet received any communication from the Department of Social Services in this regard. Many of the violations which have been found during audits do not comply with what is currently considered standard of care in dentistry. Among other problems, these violations include the requirement for dentists to sign their notes in patient charts and to document the rationale for the taking of routine x-rays. These procedures are not standard of care in dentistry, although they may be considered so in the medical field. Nonetheless, dental providers are being penalized for these violations.

There is currently no process wherein a dentist can appeal a decision by the auditors. The same auditors are the only body which will review a decision. There are no dentists involved in the auditing process, and in my opinion, there should be. I would strongly urge an independent appeals body, which would include dentists. The CT State dental Commission could be used as a resource in the process of deciding what care and charting is appropriate.

I had the honor of serving on the Dental Commission for six years. When a dentist has had a complaint against them, the Department of Public Health does an investigation. If the dentist disagrees with the DPH decision, a hearing is held, and members of the dental commission comprise the hearing panel. Most of the commissioners are dentists, and can best decide whether the dentist provided an appropriate standard of care. It would seem logical to me that Medicaid audits should follow a similar process.

I would respectfully suggest that the Department of Social Services work with the Connecticut State Dental Association to develop a list of guidelines for dental Medicaid providers to ensure that they are in compliance with requirements for documentation and billing. I would further recommend that consultant dentists or members of the dental commission be included in the audit process, to guide the auditors in their decisions regarding the appropriateness of care.

The leadership of the CSDA wishes to assist our members in complying with DSS guidelines and in protecting the public. We are most adamant that those committing fraud be penalized, while we desire that those who are merely making honest errors in charting or billing be treated fairly.

I urge your support of HB 5500, and suggest that there be further efforts to modify the Medicaid audit process to ensure fair treatment of all providers.

Thank you.

Respectfully submitted,

Carolyn J. Malon, DDS
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860-677-8687
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Respectfully Submitted,

Name
Address
Office Phone
Email Address

Legislative Testimony
Human Services Committee
HB 5500 AAC Provider Audits Under the Medicaid Program
Thursday, March 13, 2014
Douglas B. Keck, DMD, MS

Senator Slossberg, Representative Abercrombie and members of the Human Services Committee, my name is Dr. Douglas Keck. I am a pediatric dentist and Medicaid provider in New Haven and Madison, Connecticut, as well as a Clinical Assistant Professor in the Pediatric Dental Residency Program at Yale-New Haven Hospital. I am also a provider who has been audited by the Connecticut Department of Social Services on a post-payment review of claims between May 1, 2010 and December 31, 2012. I am writing to testify in support of House Bill 5500: An Act Concerning Provider Audits under the Medicaid Program. My testimony is also endorsed by the American Academy of Pediatric Dentistry¹ and the Connecticut Society of Pediatric Dentists.²

I am testifying today because I am concerned that Medicaid Dental provider audits in Connecticut will damage children's access to oral health care. With the implementation of the Affordable Care Act and the expansion of Medicaid in Connecticut, it would be deleterious to lose the large provider base that has been gained over the last several years by adding yet another barrier to obtaining oral health care. State Auditors are subjecting dentists to review by non-dentists and making determinations contrary to accepted clinical practice. Such audits could dramatically reduce the number of dentists willing to participate in Medicaid, thus impacting access to the citizens of Connecticut who are most in need of a dental home.

I am greatly concerned that several long-time dental Medicaid providers in Connecticut have received audits with recommendations contrary to accepted clinical practice guidelines. Furthermore, the audit trigger point of \$150,000 billed per year subjects nearly all providers of Medicaid dental services in Connecticut with the possibility of an audit. The methodology for extrapolation is unreasonable as it utilized this low threshold trigger which was instituted in 1995 when fees were much lower. While we are cognizant of fraud and its effects on the services we provide, we believe audits should be triggered by providers who bill for inappropriate services,

¹ The American Academy of Pediatric Dentistry (AAPD) is the recognized authority on children's oral health. As advocates for children's oral health, the AAPD promotes evidence-based policies and clinical guidelines; educates and informs policymakers, parents and guardians, and other health care professionals; fosters research; and provides continuing professional education for pediatric dentists and general dentists who treat children. Founded in 1947, the AAPD is a not-for-profit professional membership association representing the specialty of pediatric dentistry. Its 9,000 members provide primary care and comprehensive dental specialty treatments for infants, children, adolescents and individuals with special health care needs. For further information, please visit the AAPD website at <http://www.aapd.org> or the AAPD's consumer website at <http://www.mychildrensteeth.org>.

² The Connecticut Society of Pediatric Dentists represents the specialty of Pediatric Dentistry in Connecticut and is dedicated to education, practice and research in the specialty of pediatric dentistry. CSPD is comprised of over 100 Connecticut pediatric dentists. The society provides liaison with other health care organizations, government entities, and private agencies concerned with the dental health of children, adolescents, and individuals with special health care needs.

rather than by how much money they bill for care they deliver. In addition, the audit should be conducted by a peer who is familiar with the way dentistry is delivered, what a proper course of treatment might be, and the unique dental disease pattern common to the Medicaid population. In the case of services provided by a pediatric dentist, the peer reviewer should be a pediatric dentist. The Medicaid population has a completely different disease pattern, dietary habits, restorative needs and health literacy level than populations with private dental insurance.

I am further concerned that a lack of communication from auditors' to the dental practitioners' suggests that the auditors' intent is not to end fraudulent activity, but rather to find a hidden source of revenue. My hope is that there will be immediate development of guidelines and documentation requirements that practitioners must follow and that will be the basis of the record review during the audit process. I would also appreciate an overview of the audit process and how practitioners and/ or groups are selected, as I was in the dark from the beginning of the process to my exit conference with the auditors.

According to CMS, it is their goal to increase the number of patients that receive at least one oral health visit while they are on the Medicaid roster by ten percentage points by 2015. In Connecticut, that number would need to go from 57% to 67% by 2015. Fortunately, Connecticut is a state that is being touted by the American Dental Association and the American Academy of Pediatric Dentistry as a model for the country of how well dental Medicaid programs can work if properly funded. It would be a travesty if all the care the dental community has brought to the underserved would be dismantled by the loss of providers due to extensive unfair and unreasonable audits. In addition, the dental utilization rate by our state's Medicaid population is now at the level of private insurance utilization. While fully cognizant of the need for program integrity and appropriate use of taxpayer funds, we should not forget about the people in this state most in need of oral health care.

In conclusion, I would like to sincerely thank-you for your time today and would respectfully request that there be a moratorium on new audits and a stay on audits currently in progress until appropriate auditing guidelines are developed in consultation with the American Dental Association and the American Academy of Pediatric Dentistry. Such efforts can be coordinated with the Connecticut State Dental Association, the Connecticut Society of Pediatric Dentists, the Dental Commission, and Medicaid dental program officials in an efficient and effective manner. I ask that you support this bill so that we can detect abuse in the system appropriately without threatening access and utilization of dental services in Medicaid.

Thank you for your considering our concerns and reviewing this request.

Respectfully Submitted,

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CSDA.com

Legislative Testimony
Human Services Committee
HB 5500 AAC Provider Audits Under The Medicaid Program
Thursday, March 13, 2014
Mark Desrosiers, DMD

Senator Slossberg, Representative Abercrombie, Senator Markley, Representative Wood and members of the Human Services Committee, my name is Dr. Mark Desrosiers and I am currently the President of the CT State Dental Association (CSDA). I am also an Endodontist in Glastonbury and West Hartford as well as a participating provider in the CT Dental Health Partnership, the CT dental Medicaid program. I am here today to speak on and to **support** House Bill 5500 An Act Concerning Provider Audits Under The Medicaid Program which seeks to ensure that audits of providers who receive payments under the state Medicaid program are performed fairly and accurately.

The CSDA is proud of the fact that Connecticut has a dental Medicaid delivery system which not only works, but is now considered a national model. Currently there are more than 1,800 dentists who participate in the Connecticut Dental Health Partnership (CTDHP), formerly known as HUSKY. These dentists have ensured that any child in Connecticut can receive a routine dental appointment within 11 days, and an emergency appointment within 24 hours, virtually unheard of in other states. Not only is there access to the highest quality dental care available, but Connecticut children are utilizing that care as well at rates that are the second highest in the nation. Unfortunately, some providers have been responsible for perpetrating fraud and abuse within this program, and we understand the need for the Connecticut Department of Social Services Quality Assurance Unit to audit practitioners who have been identified as outliers. However, we have serious concerns about the manner in which these audits are currently being performed. While we agree that audits are important in order to identify fraud and abuse, the current system is placing undo hardships on all providers who provide Medicaid services. If left unresolved, this may result in the unintended consequence of dismantling Connecticut's very successful program, which will have a great impact on the citizens in most need of dental care.

As President of the CSDA I have heard from numerous dentists who have been audited by the Department. I and others from our organization have met with Commissioner Bremby to discuss the audits and our concerns which to date have been unresolved. One of the main concerns that we have is the use of extrapolation which this bill attempts to address. The current methodology for extrapolation we feel is unreasonable given the low threshold trigger (\$150,000) that was instituted in 1995 when Medicaid fees were much lower. The threshold should be indexed properly. Overpayments due to clerical errors, appropriate but uncovered clinical treatments, justified coding disputes and unique clinical situations should not be extrapolated. Also, extrapolation has been applied in the same way to both groups of practitioners and individual practitioners which is not appropriate.

Another issue that this bills attempts to improve and which we strongly support is increased transparency. The bill would require the providing of training for new providers on how to enter claims in order to avoid clerical errors. While this would certainly be helpful, developing and utilizing valid guidelines in support of current dental practice in coordination with dentists and making those known to all providers would be most helpful.

The auditors are not dentists yet have been determining the standard of care in dentistry, which is not appropriate. We encourage amending this bill to stipulate that dentists are involved from the beginning in determining if the care rendered meets the proper standards. Dentists should not be making auditing decisions and auditors should not be making dental decisions!

Moving forward we feel that a moratorium should be placed on random audits not thought to be associated with fraud, and a stay be granted for audits currently in progress, at least until the dental community can collaborate with the Department on how to make these audits effective, transparent, and as fair as possible. I applaud and support the intent of the HB 5500 and what it attempts to do and look forward to working with you to make it even better.

Respectfully Submitted,

Mark Desrosiers
President
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TESTIMONY

Delivered by Richard J. CORCORAN
Chief Business Officer & CFO
VNA Community Healthcare, Inc.

Before the Human Services Committee
March 13, 2014

SUPPORT: H.B. 5500

**AN ACT CONCERNING PROVIDER AUDITS UNDER
THE MEDICAID PROGRAM**

Good morning Senator Slossberg, Representative Abercrombie and honorable members of the Human Services Committee.

Our home health care agency serves almost 7,000 patients annually residing in Old Saybrook to Derby to Middletown and we employ nearly 600 people. We make more than 1,000 home visits per day. Our main office is in Guilford, and we have a branch office in Hamden, and several caregiver and community resource centers in Old Saybrook, East Haven and North Haven.

We Support H.B. 5500 and the fair and accurate auditing of home care providers.

Our Agency's last experience

Our agency experienced a routine audit by DSS approximately two years ago. The end result of the audit was that our agency had a .38% error rate or \$118.00 of errors in the audit sample of 100 claims. Our penalty after extrapolation was \$58,000. Our accuracy rate was 99.6%. Our agency had 31,000 claims in the period covered by the audit.

The DSS Audits consist of the selection of 100 claims regardless of the size of the agency or the many variations in the amount and types of services provided.

Our agency works very hard to make sure we are as accurate as possible, we have many internal controls, and we have personnel that conduct internal audits of claims throughout the year. We reimburse the State anytime we find an error in our internal audits.

Sampling

We appreciate the attention to “extrapolation” in the proposed bill. The current sampling method is at best a screening tool for the detection of fraud and abuse.

If the DSS audit findings indicate that the error rate in the routine sample are acceptable, then case closed, pay the actual errors found and there should be no extrapolation such as I described above with our own agency.

If the DSS audit findings indicate unacceptable rates of error within a sample, then they should logically expand the sample and continue to look for fraud and abuse.

- (1) In the Raised Bill - “Extrapolation” is defined as the practice of inferring a frequency of dollar amount of overpayments It makes no common sense that we can infer a frequency of error based on 100 claims without considering the universe and the many variations of services provided within the universe of claims

It IS important to be **fair** to the providers that consistently have low error rates. We are proposing that when a provider has a consistently low error rate, that the provider NOT be unnecessarily penalized with extrapolation on what is known to be an error rate subject to error.

Let’s look for real fraud and abuse and be fair to providers that work hard to be accurate as possible.

Subsection (d) of section 17b-99 of the general statutes

We appreciate that this bill references this section of the statutes. We would like to be sure that the Department of Social Services enforces the timeline of the audit process. Serious audit issues and huge extrapolations, even if not final, require financial disclosure to our Board of Directors, Banks, and Outside Auditors. Obviously such appropriate disclosure can have serious repercussions.

Lastly, we would like to ask for consideration in a modification in Subsection (d) 3(C). This may help to accomplish the goals of this bill by applying more focus on organizations that do not take appropriate corrective action.

Perhaps the "or" can be changed to "and", or deleted

As currently written:

(d)(3) A finding of overpayment or underpayment to a provider in a program operated or administered by the department pursuant to this chapter or chapter 319t, 319v, 319y or 319ff, except a provider for which rates are established pursuant to section 17b-340, *shall not be based on extrapolated projections unless (A) there is a sustained or high level of payment error involving the provider, (B) documented educational intervention has failed to correct the level of payment error, **OR** (C) the value of the claims in aggregate exceeds one hundred fifty thousand dollars on an annual basis.*

Thank you for your consideration.

Respectfully submitted,

Richard J. Corcoran



CT Community Providers Association
Caring for Connecticut

spoken by
Brunilda Ferraj

To: Members of the Human Services Committee

From: Morna Murray, President and CEO

Re: HB 5500, AN ACT CONCERNING PROVIDER AUDITS UNDER THE MEDICAID PROGRAM

Date: March 13, 2014

Good afternoon Senator Slossberg, Representative Abercrombie, and distinguished members of the Human Services Committee. My name is Morna Murray and I am the President and CEO of the Connecticut Community Providers Association (CCPA). CCPA represents community-based organizations that provide health and human services for children, adults, and families in multiple areas, including mental health, substance use disorders, and developmental disabilities. Our members serve more than 500,000 people each year.

I am here today to strongly support HB 5500, a bill that responds to critical concerns raised by community providers and others with respect to the transparency and conduct of audits under the Medicaid program.

Let me note at the outset that CCPA is firmly in favor of audits under the Medicaid program, believes they are necessary, and is vehemently opposed to any form of fraud or abuse in the program. We simply want audits to be fair, consistent, and equitable, as they are meant to be.

There are, however, challenges with the current methodology of the audits which can create unintended and sometimes catastrophic results for community providers who may have a clerical error on Medicaid claims that then can result in a penalty hundreds of times that amount. In some cases, a penalty that literally threatens the financial viability of a provider.

First, I would like to list the many improvements that HB 5500 makes:

- HB-5500 ensures that audits of providers who receive payments under the state Medicaid program are performed fairly and accurately.
- HB 5500 ensures that a contractor acting on behalf of the Department of Social Services shall have access only to information relevant to the audit, no access is authorized to information that is confidential or prohibited from disclosure by law.
- HB 5500 eliminates the potential for any possible conflict of interest, in that it does not allow payment to the auditor to be based upon the finding as determined by that auditor that is due to Medicaid.
- The process of "extrapolation" is limited to claims based on a sample of "like claims," not based on the entire number of claims billed by a provider.

As I know you all have heard, there are many instances in which providers have had findings that "extrapolate" or "multiple out" (which is done over a period of 3 years) what might be a very small

CCPA

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amount, and more often than not a clerical error, which then turns into a very large penalty the provider is expected to pay. The provider must then hire legal counsel to clarify this finding, and obviously must pay for that representation as well.

One final mention – while somewhat ancillary to this bill, it is still extremely pertinent. The amount set aside in the state budget as revenue from Medicaid fraud and abuse (\$64 million for FY 14 and \$103 million for FY 15) is ambitious at best. We believe it is unrealistic, given that research shows actual fraud and abuse in the system to be fairly low. A 2013 survey by Pew Research found the overall Medicaid fraud rate to be 7%, and this figure includes mistakes such as clerical errors.

Dedicating such a large revenue figure for the state derived from excessive extrapolation of what are often simply clerical errors by community providers who are underfunded and have been for decades, seems to us to be a case of misplaced priorities.

Respectfully, we have two requests regarding HB 5500. First, we would like to ask that all providers, not just new providers, be provided free training in avoiding clerical errors on claims [Paragraph (b)].

Secondly, we respectfully request that the term “like claims” [Paragraph (d)] be defined in the definitions section of this bill so that there any lack of clarity is avoided

Again, we thank the Committee for paying attention to this important issue and providing the transparency it demands.

Thank you very much for your time and consideration. I would be happy to answer any questions you may have or provide any additional information. Please feel to contact me at (860) 257-7909 or mmurray@ccpa-inc.org.

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page 10, line 14

Testimony
In support of

HB 5500: 'AN ACT CONCERNING PROVIDER AUDITS UNDER THE MEDICAID PROGRAM'

Submitted to: Human Services Committee

Submitted by: Jennifer E. Fournier, Esq. on behalf of Harc, Inc.

Dated: March 13, 2014

Good morning. My name is Jennifer Fournier and I am the Vice President of Administration and In-House Counsel for Harc; a Connecticut non-profit agency serving people with intellectual and related disabilities, and their families. Harc has been at the forefront of the movement to improve lives of people with intellectual disability since it was founded in 1951 by families who stood up for fundamental human rights that were denied to their children. At a time when institutionalization was the only option available, Harc's founding families rejected the notion of sending their loved ones to a place where they would exist in substandard conditions, instead of living full lives. These families wanted their children to have enriched lives as meaningful members of the community; by going to school, working to the best of their ability and living in traditional homes.

Today I am testifying in support of HB 5500, in an effort to ensure that the audits of providers receiving payments under the state Medicaid program are performed fairly and accurately. Medicaid fraud, waste and abuse are not acceptable in any manner and we at Harc fully support compliant billing practices, without exception. That said, the current method for conducting audits is unworkable and the set aside in the state budget, to the tune of \$64m in 2014 and \$103m in 2015, establishes revenue capture, not regulatory compliance, as the driver for the process.

My concerns with the audit process are numerous but the two issues that cause the most angst are how the independent contractor performing the audit is paid for their work and how damaging the extrapolation of claims can be to our agency and those like it.

As it pertains to the contractors performing the DSS Medicaid audits, they are paid on a contingency fee and as such receive a percentage of the payments they recover from providers. Right off the bat the process is skewed toward finding errors and is inherently conflicted. This is akin to allowing insurance companies to pay reviewers incentives to deny a certain percentage of claims; a practice that is not permitted because the quality of care is compromised. It is no different in our case, since the auditors are being paid based on the errors found, and extrapolated. The amount of financial damage that can be done to safety net providers ultimately compromises care and services and harms the very people DDS and DSS are charged with serving. HB 5500 section (e) proposes a change in the payment structure to the audit contractor in order to stop the current practice and resolve the conflict of interest. The

change will bring integrity back to the audit process and support regulatory compliance instead of revenue generation on the backs of Connecticut's providers.

This brings me to my concerns regarding extrapolation. The practice of extrapolating an error over a 3 year period, as a fair representation of a clerical error found in a sample of 100 claims is both unreasonable and crippling to private providers such as Hara. Under the current extrapolation practice, providers need to spend money they don't have to hire legal counsel to assist with the appeals process, staff members turn their attention away from providing care and focus on audit defense and ultimately both financial and human resources are exhausted. The end result may be a reduction in fines but the cost to the provider is still great. The resources that should be devoted to programs and services are depleted and not easily, if ever, recovered. However, if the end result is a hefty fine, that can mean the end of a provider's ability to serve the most vulnerable among us, which will put additional stress on the state as its citizens, your constituents, have limited resources for support

Safety net providers of care and services to the intellectually disabled citizens of Connecticut have suffered through, and barely survived, steep budget cuts, and cannot be further subject to take backs from an audit process that is designed to fulfill a budget revenue line. HB 5500, section (d) stipulates that auditors only perform an extrapolation of claims based on a sample of like claims rather than the entire universe of claims billed by a provider. This is a reasonable exercise of the extrapolation process, unlike the current methodology. I would further suggest that extrapolation is capped at a particular dollar amount, so as to be both reasonable and predictable to struggling providers who need to set aside reserves in preparation for fines that may be incurred.

My thanks to the committee for your time today, for paying attention to such an important issue and for drafting a bill that tightens up the audit process so it is fair and reasonable in its execution while ultimately supporting regulatory requirements regarding fraud and abuse.



CT
NONPROFITS

...to serve, strengthen
and support Connecticut's
nonprofit community.

Tab
page 11, line 5

Testimony Submitted to the Human Services Committee:

Submitted By: Julia Wilcox, Senior Public Policy Specialist, CT Nonprofits

Public Hearing Date: March 13, 2014

Support and Recommendations Regarding:

Raised H.B. No. 5500: 'An Act Concerning Provider Audits Under the Medicaid Program'

Good Afternoon, Senator Slossberg, Representative Abercrombie, and distinguished members of the Human Services Committee: I appreciate the opportunity to provide testimony regarding these important issues. My name is Julia Wilcox, Senior Public Policy Specialist for the Connecticut Association of Nonprofits (CT Nonprofits.) CT Nonprofits is a membership organization that represents more than 525 mission-based, nonprofit agencies. Approximately 300 of our member organizations contract with state government for a variety of human and social services.

CT Nonprofits supports the concepts presented in the proposed legislation. We applaud the Committee for developing the proposed process to ensure that audits of providers who receive payments under the state Medicaid program are performed 'fairly and accurately.' The nonprofit provider community remains committed to producing high quality outcomes that meet the rising demand for services, and ensure the highest quality of care. Our member organizations welcome the opportunity to utilize quality assurance systems which accurately portray the value and quality of services and protect the citizens of Connecticut from fraud or abuse of any kind.

We urge passage of HB. No. 5500 with additional recommendations as outlined below.

In particular, CT Nonprofits support the following aspects of the proposed legislation:

1. The proposed requirement for the DSS to provide 'free training for new providers on how to enter claims to avoid clerical errors.' (Section 1b)
2. The limitation of scope to information necessary to support claims only. (Section 1c).
3. The proposed requirement for the DSS to reexamine the extrapolation process and the process to establish which providers would be subject to an audit as follows '... only perform an extrapolation of claims based on a sample of like claims and shall not perform such extrapolation based on the entire number of claims billed by any one provider. In determining which providers shall be subject to an audit, the department shall direct its efforts first to providers with a higher compliance risk based on past audits or errors.(section 1d)
4. The proposed shift in policy that would prevent the DSS from issuing payment to a contractor performing a provider audit '...on the basis of the amount of overpayment by the Medicaid program to the provider as determined by the provider audit.' (section 1e)

In addition, CT Nonprofits respectfully submits the following recommendations:

1. Develop a streamlined process to increase efficiencies: Since the process described is that of an 'audit' as opposed to an 'investigation,' it would behoove all parties to provide at least a portion of the targeted information to be audited, in advance of the actual audit. A great deal of time and resources are lost (on both sides) due to the need for provider agencies to gather requested information while DSS auditors are present. The amount of time and resources spent both a) for a provider to interrupt operations and dedicate an increased number of staff to the process at one time, and b) for DSS auditors to literally wait while agency staff gather the required information (which may be a period of several hours – if not days) cannot be overstated. The inefficiency in this process as it currently stands invariably has a great impact on the anticipated 'Cost Savings' of the outcome.
2. Establish consequences that are appropriate to any identified discrepancies/concerns: We recommend that there is a clear distinction established between clerical errors and fraudulent documentation. It would stand to reason that there would be necessary 'penalties' for fraudulent documentation. However, in situations where there has clearly been an error that is clerical in nature, we propose that there would be a 'penalty' with an established 'ceiling.'
3. Evaluate the overarching 'tone' of the Medicaid Audit Process: As this is the first round of audits on a relatively new system of payment, it is recommended that the audits should be implemented in a manner which is corrective in nature as opposed to punitive. The nonprofit organizations involved, are primarily funded by the State of Connecticut. Therefore, funds necessary to repay audit findings will likely result in cuts to program service /client care needs.
4. Develop a Medicaid Audit Implementation Taskforce: As the State moves forward to implement the proposed legislation, there would be a great deal of value in bringing together an appointed group of stakeholders to explore the process. It would be critical to include Provider representatives who are funded by various state agencies and have experienced the Medicaid Audit process firsthand. Their perspective and input would be invaluable in making informed decisions/recommendations.

In the past, CT Nonprofits has provided testimony regarding the process of utilizing anticipated Medicaid Audit findings as a mechanism for targeted cost-savings measures. These estimated savings have not been realized in the past, while the process (as implemented at this time) continues to utilize and redirect valuable resources from the very programs which operate in partnership with the state to provide services.

In closing, CT Nonprofits supports the Committee and the Department of Social Services, in their efforts to continually improve upon the delivery of services and assuring the highest standards in terms of accountability. We welcome the opportunity to serve as a resource as the State moves forward to implement the proposed legislation.

I thank you for your time and consideration of these critically important issues. As always, please do not hesitate to contact me at any time, with questions, or for additional information:

Julia Wilcox, Senior Public Policy Specialist
Connecticut Association of Nonprofits (CT Nonprofits)

JWilcox@ctnonprofits.org 860.525.5080 ext. 25

To: Members of the Human Services Committee

From: Roberta J. Cook, President and CEO

Re: Human Services Committee Public Hearings on HB-5000, An Act Concerning Provider Audits Under the Medicaid Program

Date: March 13, 2014

Senator Slossberg, Representative Abercrombie, Senator Coleman, Representative Stallworth, and distinguished members of the Human Services Committee, I thank you for your consideration of my testimony. My name is Roberta Cook and I am the President and CEO of BHcare, a regional nonprofit dedicated to improving the lives and health of the communities we serve by providing comprehensive behavioral health, prevention and domestic violence services. BHcare is designated as the Local Mental Health Authority for the towns of Ansonia, Branford, Derby, East Haven, Guilford, Madison, North Branford, North Haven, Oxford, Seymour and Shelton. Each year BHcare provides wraparound mental health and addiction services for more than 2700 Connecticut residents.

I am writing today in support of HB-5500, An Act Concerning Provider Audits Under the Medicaid Program. HB-5500 will strengthen the validity of Medicaid audits conducted by the Department of Social Services and the contractors acting on its behalf by limiting the extrapolation of claims to like claims rather than all claims billed by the provider; as well as eliminating payment based on the amount of overpayment deduced from the audit.

The current method for conducting audits, and the amount set aside in the state budget as revenue from Medicaid fraud and abuse (\$64 million for FY 14 and \$103 million for FY 15) is overly ambitious. I believe it is unrealistic, given that national data samples show actual fraud and abuse in the system to be fairly low. A 2013 survey by Pew Research found that the overall Medicaid fraud rate is 7%, and this figure includes mistakes such as clerical errors.

One of my main concerns is the practice of extrapolation, meaning using the results of a sample of claims that may have a clerical error (one not due to fraudulent actions of the provider, but reported to Medicaid nonetheless) and applying it to a larger population of claims. Currently the DSS and RAC audits use extrapolation as an automatic method by which to determine the number of payment errors and the amount of overpayments to collect from audited providers.

Here is an example from our 2010 audit:

TOTAL PAID CLAIMS	5,482
SAMPLE SIZE	100
SAMPLES WITH ERRORS	21
SAMPLE ERROR DOLLARS	\$1,240.62
AVG \$ ERROR/SELECTED CLAIM	\$12.41
EXTRAPOLATED ERROR AMOUNT (\$12.41 x 5,482)	\$68,101.79

17 of the 21 errors mentioned above were clerical errors.

I greatly support section (d) of HB-5500 which stipulates that auditors only perform an extrapolation of claims based on a sample of like claims rather than the entire number of claims billed by a provider; this is a fair exercise of the practice of extrapolation.

My other major concern is the practice of paying contractors who perform DSS Medicaid audits on a contingency fee basis based on a percentage of payments they collect from providers. There is an inherent conflict of interest in this practice, as it allows auditors to benefit from the total amount of payments they collect from providers. One can conclude that there is an incentive to auditors to find evidence of wrongdoings or errors. I strongly support section (e) of HB-5500 as it resolves this conflict of interest by requiring that DSS not issue payment to a contractor based on the amount of overpayment determined by the audit.

I thank the Human Services Committee for paying attention to this important issue and for drafting a bill that addresses the issues with Medicaid audits in a fair and reasonable way, while still holding those guilty of fraud and abuse accountable for their actions.



Testimony Submitted to the Human Services Committee:

Submitted By: Chet Doheny, Executive Director
ICES, Inc.
35 Elm Street
Naugatuck, CT. 06770

Public Hearing Date: March 13, 2014

Support and Recommendations Regarding:

Raised H.B. No. 5500: 'An Act Concerning Provider Audits Under the Medicaid Program'

Senator Slossberg, Representative Abercrombie, and distinguished members of the Human Services Committee: I appreciate the opportunity to provide testimony regarding these important issues. I am Chet Doheny, Executive Director of ICES Inc. Our agency is a multidimensional and innovative human services company serving the needs of children and adults since 1998. ICES, Inc. offers a broad range of residential, vocational, clinical and support services in diverse settings. We serve individuals in private residences, public schools, respite cares, emergency placements, community work sites, training centers, individualized home supports, continuous residential supports, and our own state-licensed group homes. ICES, Inc. specializes in serving individuals with cognitive disorders, mental illness, and who are in the autistic spectrum. During our years of service we have been extremely successful in decreasing challenging behaviors, while providing support to promote independence. We are among the 500+ member agencies of the Connecticut Association of Nonprofits (CT Nonprofits.)

We support the concepts presented in the proposed legislation and applaud the Committee for developing the proposed process to ensure that audits of providers who receive payments under the state Medicaid program are performed 'fairly and accurately.' We urge passage of HB. No. 5500 with additional recommendations as outlined below.

In particular, we support the following aspects of the proposed legislation:

- * The proposed requirement for the DSS to provide 'free training for new providers on how to enter claims to avoid clerical errors.' (Section 1b)
- * The limitation of scope to information necessary to support claims only. (Section 1c).
- * The proposed requirement for the DSS to reexamine the extrapolation process and the process to establish which provider would be subject to an audit as follows '... only perform an extrapolation of claims based on a sample of like claims and shall not perform such extrapolation based on the entire number of claims billed by any one provider. In determining which providers shall be subject to an audit, the department shall direct its efforts first to providers with a higher compliance risk based on past audits or errors.(section 1d)

- * The proposed shift in policy that would prevent the DSS from issuing payment to a contractor performing a provider audit '...on the basis of the amount of overpayment by the Medicaid program to the provider as determined by the provider audit.' (section 1e)

In addition, we respectfully submit the following recommendations related to the proposed legislation:

- * Streamlined process to increase efficiencies: Since the process described is that of an 'audit' as opposed to an 'investigation,' it would behoove all parties to provide at least a portion of the targeted information to be audited, in advance of the actual audit. A great deal of time and resources are lost (on both sides) due to the need for provider agencies to gather requested information while DSS auditors are present. The amount of time and resources spent both a) for a provider to interrupt operations and dedicate an increased number of staff to the process at one time, and b) for DSS auditors to literally wait while agency staff gather the required information (which may be a period of several hours – if not days) cannot be overstated. The inefficiency in this process as it currently stands invariably has a great impact on the anticipated 'Cost Savings' of the outcome.

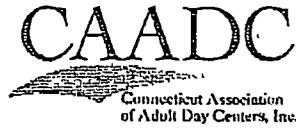
Consequences that are appropriate to any identified discrepancies/concerns: We recommend that there is a need for clear distinction between clerical errors and fraudulent documentation. It would stand to reason that there would be necessary 'penalties' for fraudulent documentation. However, in situations where there has clearly been an error that is clerical in nature, we propose that there would be a 'penalty' with an established 'ceiling.' As this is the first round of audits on a relatively new system of payment, it is recommended that the audits should be corrective in nature and not punitive. Paying for exuberant penalties would be difficult and detrimental to the overall goal of the agencies and the human service community as a whole. Agencies are limited in the capital that can be accumulated, due to restriction within the contracts with State agencies, as well as a continuing reduction of rates for services. Due to these restrictions agencies are aggressively reviewing costs just to maintain a proper level of client care service. If burdened by an unfair and disproportionate penalty, due to an honest clerical error, may cause the closure of agencies.

Thank you again for your time and consideration. Please do not hesitate to contact me with any questions, or for additional information.

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Because Everyone Should Reach Their Full Potential



Testimony to the Human Services Committee

Submitted in support of

House Bill 5500, An Act Concerning Provider Audits under the Medicaid Program

March 13, 2014

The Connecticut Association of Adult Day Centers (CAADC), an organization of 49 adult day centers from across the state of Connecticut, respectfully submits the following testimony in strong support of An Act Concerning Provider Audits under the Medicaid Program and offers the Committee our assistance as you consider this bill.

As Connecticut Home Care Program and Medicaid providers, adult day centers provide a wonderful community based service to older adults. Adult day centers provide a full day of medical and social services to clients on the Connecticut Home Care Program, including door to door transportation, for just \$70.22 a day.

CAADC members understand, accept and support the need to protect the integrity of the state funded and waiver home care programs through state audits, but we urge the Legislature to implement this bill which will bring a level of fairness and balance to that audit process.

The recent reliance on third party contractors to perform audits based on contingency causes a conflict in the auditing process. The incentive in such a system is to maximize the size of the audit findings, not to ensure the accuracy of the review. An audit review should be focused on ensuring the integrity of the billing process and we strongly support the proposal contained in this bill to prohibit the use of contingency arrangements with third party audit contractors.

While we agree that there is a place for the use of various audit methods, it has been our members' experience that the practice of extrapolation has been exploited and has left providers with no alternative but to seek settlements on their own or to hire costly legal assistance to fight the unjustified extrapolated results. This can be an extremely time consuming and expensive exercise for adult day center providers and the result is almost always a reduction in the extrapolated amount because it was unjustly inflated to begin with.

We therefore support the implementation of protections from unjust extrapolation and would like to respectfully suggest that the Committee consider adding a "de minimis" clause to the legislation whereby findings under a certain amount are not be held subject to the extrapolation provisions. One of our members experienced a situation where a finding of less than \$100 resulted in an extrapolation and remittance of close to \$10,000. Another member

had two findings totaling less than \$100 which resulted in an extrapolation and remittance of over \$36,000. These findings seem overly punitive for the situations and these members are not alone.

To clarify our interpretation of the proposal, we respectfully pose the question of whether the proposed protections in the bill regarding "like claims" would pertain to adult day centers. Due to the nature of our service, adult day centers basically utilize just one or two types of claims or billing codes for home care program clients.

In conclusion, CAADC would like to thank the Committee for raising this bill which would bring a level of fairness to the audit and oversight process and again offer the Committee our assistance as you consider this bill.

Thank you for your consideration of this testimony.

CAADC, 1340 Worthington Ridge, Berlin, CT 06037, (860) 828-8653, adc@leadingagect.org

View our video about how wonderful a day can be at a certified adult day center.
Go to www.leadingagect.org and click on *Adult Day Centers*

Oral Health for All



March 13, 2014

HUMAN SERVICES COMMITTEE TESTIMONY

RAISED BILL 5500: AN ACT CONCERNING PROVIDER AUDITS UNDER THE MEDICAID PROGRAM.

Dear Senator Slossberg, Representative Abercrombie and members of the Human Services Committee,

I want to thank you for this opportunity to address H.B. 5500. I am Mary Moran Boudreau, writing on behalf of the Connecticut Oral Health Initiative, the only oral health advocacy organization in Connecticut with the vision of "Oral Health for All."

Connecticut Oral Health Initiative urges you to pass this bill as we have a strong concern about the impact on access to oral care for our low-income residents in Connecticut. The current environment of random audits by the Department of Social Services (DSS) are causing undo stress upon the dental community and we fear it will result in a number of dentists withdrawing from the program, and fewer Medicaid-enrolled children and families having access to quality care.

With the changes to Dental Medicaid made in 2006, the number of dentists participating in the Medicaid program increased from under 300 in 2006 to over 1800 today. The results are seen in the increase in utilization of Medicaid-enrolled children from 46% in 2006 to almost 70% in 2013. Most importantly, the data collected by the Department of Public Health reports that:

1. There are significant oral health disparities in CT with minority and low-income children having the highest level of dental disease.
2. Compared to 2006-2007, fewer children have untreated decay and more minority children have dental sealants.
3. Connecticut met the Healthy People 2010 objectives for reducing the prevalence of decay experience and untreated tooth decay among elementary school children, but did not meet the Healthy People 2010 objective for increasing the prevalence of dental sealants.¹

We still need to make strides in the utilization of the services by people of color in the areas of preventive and therapeutic care in Connecticut.

It is unfortunate when some providers perpetrate fraud and abuse within the Medicaid program, and we agree with the need for the DSS to audit practitioners. However, the current random audit system is placing hardships on all providers who provide Medicaid services, including those who do not demonstrate any unusual billing practices, and who might strongly consider withdrawing from the Medicaid program as result of undue scrutiny. It is the issue of dental practices not knowing what is expected that may cause dentists to withdraw from providing care to our neediest citizens.

We believe that, in the interest of this program's continued success in providing services to Connecticut's citizens, a moratorium should be placed on random audits until the DSS makes these audits effective, transparent, and as fair as possible.

Thank you for your attention to this important issue and your commitment to the health and oral health of Connecticut residents.

Sincerely,

Mary Moran Boudreau, Executive Director

¹ Connecticut Department of Public Health, Office of Oral Health. Every Smile Counts, The Oral Health of Connecticut's Children, Hartford, Connecticut, October 2012. http://www.ct.gov/dph/lib/dph/oral_health/pdf/oral_health_ct_2012_rev.pdf



Testimony Submitted to the Human Services Committee:

Submitted By: Terry Ford, Assistant Executive Director, Horizons

Public Hearing Date: March 13, 2014

Support and Recommendations Regarding:

Raised H.B. No. 5500: 'An Act Concerning Provider Audits Under the Medicaid Program'

Senator Slossberg, Representative Abercrombie, and distinguished members of the Human Services Committee: I appreciate the opportunity to provide testimony regarding these important issues. I am Terry Ford, Assistant Executive Director for Horizons based in South Windham. We provide services for individuals with developmental disabilities where they live, work, learn and play. We are among the 500+ member agencies of the Connecticut Association of Nonprofits (CT Nonprofits.)

We support the concepts presented in the proposed legislation and applaud the Committee for developing the proposed process to ensure that audits of providers who receive payments under the state Medicaid program are performed 'fairly and accurately.' We urge passage of HB. No. 5500 with additional recommendations as outlined below.

In particular, we support the following aspects of the proposed legislation:

- * The proposed requirement for the DSS to provide 'free training for new providers on how to enter claims to avoid clerical errors.' (Section 1b)
- * The limitation of scope to information necessary to support claims only. (Section 1c).
- * The proposed requirement for the DSS to reexamine the extrapolation process and the process to establish which provider would be subject to an audit as follows '... only perform an extrapolation of claims based on a sample of like claims and shall not perform such extrapolation based on the entire number of claims billed by any one provider. In determining which providers shall be subject to an audit, the department shall direct its efforts first to providers with a higher compliance risk based on past audits or errors.(section 1d)
- * The proposed shift in policy that would prevent the DSS from issuing payment to a contractor performing a provider audit '...on the basis of the amount of overpayment by the Medicaid program to the provider as determined by the provider audit.' (section 1e)

HORIZONS

In addition, we respectfully submit the following recommendations related to the proposed legislation:

- * Streamlined process to increase efficiencies: Since the process described is that of an 'audit' as opposed to an 'investigation,' it would behoove all parties to provide at least a portion of the targeted information to be audited, in advance of the actual audit. A great deal of time and resources are lost (on both sides) due to the need for provider agencies to gather requested information while DSS auditors are present. The amount of time and resources spent both a) for a provider to interrupt operations and dedicate an increased number of staff to the process at one time, and b) for DSS auditors to literally wait while agency staff gather the required information (which may be a period of several hours – if not days) cannot be overstated. The inefficiency in this process as it currently stands invariably has a great impact on the anticipated 'Cost Savings' of the outcome.

- * Consequences that are appropriate to any identified discrepancies/concerns: We recommend that there is a need for clear distinction between clerical errors and fraudulent documentation. It would stand to reason that there would be necessary 'penalties' for fraudulent documentation. However, in situations where there has clearly been an error that is clerical in nature, we propose that there would be a 'penalty' with an established 'ceiling.' As this is the first round of audits on a relatively new system of payment, it is recommended that the audits should be corrective in nature and not punitive. These agencies are almost fully funded by the State and funds necessary to repay audit findings will likely result in cuts to client care needs.

Thank you again for your time and consideration. Please do not hesitate to contact me with any questions, or for additional information.

Terry R. Ford
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Testimony Submitted to the Human Services Committee:

Submitted By: Ronald C. Fleming, Ph.D., LCSW

Public Hearing Date: March 13, 2014

Raised H.B. No. 5500:

'An Act Concerning Provider Audits Under the Medicaid Program'

Senator Slossberg, Representative Abercrombie, and distinguished members of the Human Services Committee: I appreciate the opportunity to provide testimony regarding these important issues. My name is Ronald C. Fleming, Ph.D., LCSW, President & CEO of Alcohol & Drug Recovery Centers, Inc. [ADRC]. ADRC has been continuously serving persons with substance use disorders in the Greater Hartford region since 1973. ADRC provides services to several thousand citizens of the state each year.

We urge passage of HB. No. 5500 and have a few additional recommendations as outlined below.

We believe all of the following elements of the raised bill are important to providers and represent a fair approach to the need for accountability:

- * The proposed requirement for the DSS to provide 'free training for new providers on how to enter claims to avoid clerical errors.' (Section 1b). The lack of offered training on these, at times, complex systems needs to be addressed.
- * The limitation of scope to information necessary to support claims only. (Section 1c).
- * The proposed requirement for the DSS to reexamine the extrapolation process and the process to establish which provider would be subject to an audit as follows '... only perform an extrapolation of claims based on a sample of like claims and shall not perform such extrapolation based on the entire number of claims billed by any one provider (section 1d). Over extending findings can generate significant hardship for providers.
- * In determining which providers shall be subject to an audit, the department shall direct its efforts first to providers with a higher compliance risk based on past audits or errors.(section 1d)
- * The proposed shift in policy that would prevent the DSS from issuing payment to a contractor performing a provider audit '...on the basis of the amount of overpayment by the Medicaid program to the provider as determined by the provider audit.' (section 1e)

In addition, we respectfully submit the following recommendations related to the proposed legislation:

- * Streamlined process to increase efficiencies: Since the process described is that of an 'audit' as opposed to an 'investigation,' it would behoove all parties to provide at least a portion of the targeted information to be audited, in advance of the actual audit. A great deal of time and resources are lost (on both sides) due to the need for provider

agencies to gather requested information while DSS auditors are present. The amount of time and resources spent both a) for a provider to interrupt operations and dedicate an increased number of staff to the process at one time, and b) for DSS auditors to literally wait while agency staff gather the required information (which may be a period of several hours – if not days) cannot be overstated. The inefficiency in this process as it currently stands invariably has a great impact on the anticipated 'Cost Savings' of the outcome.

- * Consequences that are appropriate to any identified discrepancies/concerns: We recommend that there is a need for clear distinction between clerical errors and fraudulent documentation. It would stand to reason that there would be necessary 'penalties' for fraudulent documentation. However, in situations where there has clearly been an error that is clerical in nature, we propose that there would be a 'penalty' with an established 'ceiling.' As this is the first round of audits on a relatively new system of payment, it is recommended that the audits should be corrective in nature and not punitive. These agencies are almost fully funded by the State and funds necessary to repay audit findings will likely result in cuts to client care needs.

Operating as we do, with scarce resources and rates that often fail to fully cover the true cost of care, it is vital to establish a system which offers a more appropriate balance while managing accountability. We also feel it is important to recognize that the vast majority of providers are working very hard to be in compliance with applicable regulations, thus an approach less based on a punitive and more on a partnership approach is indicated [consider the model of the Behavioral Health Partnership – which has improved care and saved money].

Thank you again for your time and consideration. Please do not hesitate to contact me with any questions, or for additional information.

Contact information: 860-714-3701; rfleming@stfranciscare.org



New England Home Care

Taking Advanced Care Home

Written Testimony William Sullivan, Vice President

New England Home Care

Public Hearing Regarding Bill No. 5500

March 13, 2014

Dear Senator Slossberg and Representative Abercrombie, Senator Markley and Representative Wood and members of the Human Services Committee, we support the testimony of Deborah Hoyt, President and CEO of the Connecticut Association for Healthcare at Home. We are also in favor of Bill No. 5500 and recommend that DSS consider positive audit histories, corporate compliance planning and robust process improvement methods prior to initiating extrapolation methods.

I am William Sullivan, Vice President of New England Home Care and have been working at New England Home Care for the past 23 years. During that time I have worked with DSS on approximately 15 audits. You will never find anyone who will say that going through an audit is a pleasant experience. There is a tremendous amount of work involved as well as fear and anxiety related to the outcome. This fear is primarily due to the DSS ability to use extrapolation to come up with their final audit figures, which in many cases far exceed the findings.

Whenever fear is involved true process improvement cannot take place. In the current system agencies are encouraged to spend more time fighting the identified issue than building in controls to ensure that the problem doesn't continue. In many instances monies and efforts spent by the agency far exceed the final audit exposure.

We support an auditing process at the state, this is not about DSS and their authority to identify and address fraudulent activity. This is about working with compliant agencies and helping them improve without exposing them to the threat of extrapolation.

My recommendation is for agencies to implement an authentic corporate compliance plan. This plan would include such items as appointing a Corporate Compliance Officer, training staff on specific audit issues identified by the state and updating policies and procedures to reflect controls within the agency.

During audits agencies should be given the opportunity to address issues in a corrective action plan and build these items into their ongoing corporate compliance process. The corrective action plan would be submitted to DSS for approval. The plan would identify corrective action, as well as those individuals responsible for oversight and an acceptable date of compliance.

Only items found on the initial audit would be recouped from the agency and not extrapolated. Extrapolation would only be used if an agency refused to create a corrective action plan or if an agency's findings rose to a level of fraudulent activity.

Creating a community of providers where compliance is a proactive effort as opposed to a reactive penalty is a better system for everyone.

Thank you for your time and consideration.

Respectfully Submitted,
William Sullivan
Vice President, New England Home Care

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Connecticut Licensed
Medicare/Medicaid Certified

Legislative Testimony
Human Services Committee
HB 5500 AAC Provider Audits Under The Medicaid Program
Thursday March 13th 2014
John J Mooney, DMD

Senator Slossberg, Representative Abercrombie, and members of the Human Services Committee, my name is Dr. John Mooney I practice general dentistry in Putnam, Connecticut and my practice provides care to over 700 Medicaid adults and children. I currently serve as the Connecticut State Dental Association Chair of the Access to Care Committee and have been fully engaged in the recruitment and retention of Medicaid providers throughout the state. I also serve on the Medicaid Dental Provider Relations Board and have participated in a Private practice Partnership with Generations an FQHC located in Putnam.

As you are all probably aware, over the course of the past several years the CSDA has worked very hard recruiting providers into the Medicaid program. Prior to 2008 we had less than 200 participating providers, today we have over 1,800. With very simple fixes to a broken Medicaid dental delivery system we have been able to insure that no child on Medicaid has to wait more than 24 hours for a dental emergency to be addressed and any child can get a routine appointment within 11 days. We've seen utilization rates that are equal or greater than children with private insurance. While we saw an initial surge in the amount of decay control(restorative) treatment delivered to the Medicaid population we are now seeing a dramatic decrease in restorative treatment and a concomitant rise in maintenance cleaning visits indicating that this population oral health is improving. No other program in the world (including countries with mid-level providers!!) has experience this dramatic improvement in oral health in so quick a timeframe. As legislators you should be proud that Connecticut has become a model state for CMS.

All that said it's unfortunate that there are "outliers", a small number of providers who have been found to commit fraudulent activity in their treatment and billing practices. I believe there is universal agreement that these individuals should be dealt with vigorously because they are taking advantage of one of the most vulnerable groups of our society. However I also believe, and have seen that the vast majority of the dentists who provide Medicaid services do so honestly as a public service to those individuals who have economically been left behind. In an effort to control fraud, DSS has instituted an audit policy. While this makes sense, the audit process is fraught with issues that if not dealt with, could cause a massive drop in provider numbers and negatively affect the dental access that they now have..

I commend the Committee for having the foresight to address the issue of extrapolation. Extrapolation done without guidelines represents the most onerous piece of the entire audit process. It assumes guilt on the part of the provider without evidence. Extrapolation is inappropriately being applied to providers who have made minor clerical/charting errors even though the present law excludes this

practice. Auditors are also inappropriately applying charting standards that are inconsistent with industry wide charting standards. When an "error" is found the implication is the dentist has done something wrong, even though the patient was delivered the appropriate level of care. We also have cases of non-dentist auditors interpreting radiographs and questioning clinical judgment. Clearly this lies outside their area of expertise.

My greatest concern is, as news of these audits and their abuse spreads throughout the provider community that many providers will decide it's just not worth the trouble to continue being a Medicaid provider anymore. Each time we lose a provider that means anywhere between 5-100 patients will be inconvenienced forcing them to search for a new provider. The best circumstance is to prevent this scenario from happening. I strongly support the adoption of HB5500 as a step in that direction.

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Legislative Testimony
Human Services Committee
HB 5500 AAC Provider Audits Under The Medicaid Program
Thursday, March 13, 2014
Bill Nash, DMD

Good afternoon Senator Slossberg, Representative Abercrombie, and members of the Human Services Committee. My name is Dr. William C. Nash. I am a general dentist practicing in Fairfield for the past 36 years. I am the Vice-President of the Connecticut State Dental Association and a participant in all 6 CT Mission Of Mercy clinics, which have provided several million dollars of free dental care to the citizens of Connecticut. I am writing to you today in support of HB 5500. It is imperative that DSS's auditing process be fair to all concerned while accomplishing their stated purpose, i.e. to root out fraud and abuse within the program. I fully support this effort. Not only is it wrong but abusive practices drain money otherwise used to treat deserving children. Connecticut's Husky program has become a national model for meeting the needs of disadvantaged children. CT's utilization rates for Husky children equal that of children with commercial insurance, something no other state has done. I urge you not to destroy what has taken so much effort to build up.

The problem is that the present system of audits is so onerous that, if nothing is done, many of the dentists who are honestly trying to help Husky patients will drop out of the program. I have personally spoken to several dentists who have heard the horror stories about the audits and are ready to remove their names as Husky providers immediately. I have spent a lot of time trying to dissuade them, telling them that once our story is told and understood, we can get fair treatment from Connecticut's state agencies.

To be more specific, there is a threshold for extrapolating errors found in a small number of charts (100) to all Husky patients seen by that dentist. Right now, if a dental practice bills over \$150,000/year, extrapolation applies to all patients seen by that practice. In other words, errors found in 100 charts can be applied to as many as 1500 charts. In today's world, \$150,000 is not a large number for a single dentist to bill out. I understand that level was established in 1995, well before the reimbursement rates were increased in 2008. Please increase the level to \$250,000 and make it apply to individual dentists, not the entire practice.

Of greater concern is the charting standards applied by the auditors. No one seems to know where these standards came from; they certainly do not reflect the standard practice of dentistry today. The CSDA has asked for the specifics of these standards with no result. When the auditors apply a standard without telling anyone what that standard is, well, of course they will find "mistakes". This is totally unfair and frustrating to participating dentists.

Please let the CSDA have a voice in developing standards for charting, including criteria for treatment, radiographic and preventative protocols. There are several instances of auditors claiming inappropriate treatment and disallowing payment for radiographs. This is most certainly not an auditor's area of expertise. They have no justification for rejecting claims for treatment that should be based on clinical judgment.

We ask that audits be suspended until these problems are resolved. Also we ask that earlier audits be reviewed and amended to conform to these newly developed criteria.

Thank you for your consideration. And thank you all for all the work you do for the betterment of the citizens of Connecticut.

William C. Nash, D.M.D.
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Legislative Testimony
Human Services Committee
HB 5500 AAC Provider Audits Under the Medicaid Program
March 14, 2014
Ira M. Greene, DDS

Senator Slossberg, Representative Abercrombie and members of the Human Services Committee, my name is Dr. Ira Greene. I currently serve as the President of the Connecticut Society of Pediatric Dentistry. I have been in the private practice of pediatric dentistry in Avon, Connecticut since 1984. I have been a long time faculty member in pediatric dentistry at the University of Connecticut (1982) and have provided expertise for many years to the Connecticut Department of Public Health regarding standards of care for the treatment of children and older patients with special needs. I currently sit on the Department of Social Services Dental Policy Advisory Council I am also a Medicaid provider I am writing to advocate for passage of House Bill 5500 An Act Concerning Provider Audits Under The Medicaid Program.

As president of the Connecticut Society of Pediatric Dentistry many colleagues have approached the Executive Board of the Society with their concerns regarding the current auditing policies of the Department of Social Services. It has been reported by the auditors themselves that their intent is to audit every participating dentist in the Medicaid program. It is our concern that this reflects harmful and misguided public policy. It also may be not the best utilization of valuable tax payer dollars. The major thrust of any auditing process should be to discover and combat fraud. Pediatric dentists in general treat their patients based on their post- doctoral training and in compliance with the guidelines of the American Academy of Pediatric Dentistry. In contrast the auditing process as employed by DSS in Connecticut is by report largely based on their 1984 manual which was recognized by DSS itself as being problematic. It was revised in 2013 but this revision has not yet been released. Standards for audit must be based on current clinical practices. These standards must be published ahead of time and not subject to interpretation. Auditing all providers punishes those professionals who are trying to provide a high standard of care while navigating in an often difficult and cumbersome program that by itself is not free from errors. Undergoing an audit is a time consuming stressful and financially expensive process for the participating dentist. Many of my colleagues will hire attorneys to protect their rights and their reputations. The end result will be diminished participation by highly skilled professionals and therefore decreased access by patients enrolled in Medicaid to the expert care they may require.

I would like to sincerely thank-you for your time today and ask that you support this valuable bill and consider impact of the bill on the citizens of the State of Connecticut

Respectfully Submitted on Behalf of the Membership
of the Connecticut Society of Pediatric Dentistry

Ira M. Greene, DDS
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Testimony Submitted to the Human Services Committee

Submitted By: Lois Nesci, CEO
Catholic Charities – Archdiocese of Hartford

Public Hearing Date: March 13, 2014

Support and Recommendations Regarding

Raised H.B. No. 5500: 'An Act Concerning Provider Audits Under the Medicaid Program'

Senator Slossberg, Representative Abercrombie, and distinguished members of the Human Services Committee: I appreciate the opportunity to provide this testimony regarding this important issue. Catholic Charities of the Archdiocese of Hartford supports the intent of House Bill No. 5500. Catholic Charities is a multi-service nonprofit agency operating 36 locations in the counties of Hartford, New Haven, and Litchfield.

This bill attempts to ensure that audits of providers who receive payments under the State Medicaid program are performed fairly and accurately. Audits are necessary and important for the Medicaid program and we absolutely condemn deliberate Medicaid fraud and abuse.

The current method of extrapolation may place significant hardship for providers in monies required to be returned and legal fees. In some cases providers have had to make decisions to "close their doors." There are times when errors are inadvertent or simply clerical.

In particular, we support the following aspects of the proposed legislation:

- * The proposed requirement for the DSS to provide 'free training for new providers on how to enter claims to avoid clerical errors.' (Section 1b)
- * The limitation of scope to information necessary to support claims only. (Section 1c).
- * The proposed requirement for the DSS to reexamine the extrapolation process and as follows '... only perform an extrapolation of claims based on a sample of like claims and shall not perform such extrapolation based on the entire number of claims billed by any one provider.
- * The proposed shift in policy that would prevent the DSS from issuing payment to a contractor performing a provider audit '...on the basis of the amount of overpayment by the Medicaid program to the provider as determined by the provider audit.' (section 1e)

In addition, we respectfully submit the following recommendations related to the proposed legislation:

We recommend that there is a need for clear distinction between clerical errors and fraudulent documentation. It would stand to reason that there would be necessary 'penalties' for intentional fraudulent documentation. However, in situations where there has clearly been an error that is clerical in nature, we propose that there would be a 'penalty' with an established 'ceiling.' As this is the first round of audits on a relatively new system of payment, it is recommended that the audits

should be corrective in nature and not punitive. Our agency is significantly funded by State departments and funds necessary to repay audit findings will likely result in cuts to client care needs.

We also recommend a clarification in the definition of "like claims," whether the reference is to levels of care or individual compliance standards.

We appreciate this first step in the process and thank you for your time and consideration

Respectfully submitted,



Lois Nesci, Chief Executive Officer
Catholic Charities – Archdiocese of Hartford



a community support system

941-949 Bridgeport Avenue | Milford, CT 06460 | 203-878-6365 | www.BridgesCT.org

Testimony for hearing scheduled on Thursday, March 13, 2014 11:00am – unable to present in person

HB-5500: AN ACT CONCERNING PROVIDER AUDITS UNDER THE MEDICAID PROGRAM

As Chief QA/Compliance Officer at Bridges.. A Community Support System, Inc., we have experienced three (3) DSS audits since 2002. Audits are an expectation of our business of providing health care to an area that covers nearly 225,000 individuals and families and includes to residents of Milford, Orange West Haven and extends for some services into the towns of, Ansonia, Bethany, Derby, Seymour, Shelton and Woodbridge. Despite the anxiety that these events cause, we often have gotten helpful feedback regarding our processes to assure we are in compliance with the all applicable DSS regulations.

However, there are components of the auditing process that appear unfair and inaccurate. We have been vocal about these at the time of our exit interviews with DSS auditing staff.

This includes the practice of extrapolation -- that is, taking the results of a sample of claims that may have a clerical error and applying it to a larger population of claims. For us that meant, treatment plans that had missed a date on one page(found on following pages) was extrapolated to a much larger number of claims. If the purpose is to unearth fraud and abuse, and not take what could simply be a paperwork error and multiple it exponentially so as to fill a revenue line in the state budget, then this practice seems unfair. This further endangers the backbone of vital services and supports that we as a community provider perform day in a day out for the most vulnerable people in our state.

We very much support section (d) of HB-5500, which stipulates that auditors only perform an extrapolation of claims based on a sample of like claims rather than the entire number of claims billed by a provider. This is a reasonable exercise of the practice of extrapolation, very unlike what is currently in place.

At the time of our 2008 audit a new intensive home based program had procedures in place that were not adequately addressed in the audit regulations. Some of the documents were missed by the auditor on site. Responding to these items cost us additional time and money, including legal consult.

Of particular concern to us is the fact that contractors performing DSS Medicaid audits are paid on a contingency fee basis, receiving a percentage of the payments they collect from providers. There seems to be an inherent conflict of interest in this method, as it allows auditors to benefit from the total amount of payments they collect from providers. One might conclude there is an incentive to auditors to find evidence of errors or wrongdoings.

We strongly support section (e) of HB-5500, as it resolves this conflict of interest by requiring that DSS not issue payment to a contractor on the basis of the amount of overpayment by the Medicaid program to the provider as determined by the provider audit

Submitted by,

Terri Eblen, MA, LPC

Chief Quality Assurance/Compliance Officer

Bridges .A Community Support System, Inc

Phone: 203-878-6365 x 311 Fax: 203-877-3088

Email: teblen@bridgesmilford.org



Martin D. Schwartz
PRESIDENT & CEO

Valerie S. G. Reyher, CRC, NCC
VICE PRESIDENT OF REHABILITATION SERVICES

Testimony Submitted to the Human Services Committee

Submitted By: Valerie Reyher, Vice President of Rehabilitation Services, The Kennedy Center, Inc.

Public Hearing Date: March 13, 2014

Support and Recommendations Regarding

Raised H.B. No. 5500: 'An Act Concerning Provider Audits Under the Medicaid Program'

Senator Slossberg, Representative Abercrombie, and distinguished members of the Human Services Committee: I appreciate the opportunity to provide testimony regarding these important issues. My name is Valerie Reyher and I am the Vice President of Rehabilitation Services at The Kennedy Center, Inc. We provide services to individuals with disabilities throughout the state of Connecticut, but most heavily in Fairfield and New Haven counties. We have been a non-profit service provider for nearly 65 years, assisting the most vulnerable population to live in their communities, to pursue employment, and to be active members of society. We provide services funded by the Department of Developmental Services serving over 700 individuals per year; Department of Mental Health and Addiction Services, serving over 400 individuals per year; Bureau of Rehabilitation Services serving over 500 individuals per year; and the Department of Social Services Acquired Brain Injury Waiver, serving 20 individuals per year. We are among the 500+ member agencies of the Connecticut Association of Nonprofits (CT Nonprofits.) and CCPA.

We support the concepts presented in the proposed legislation and applaud the Committee for developing the proposed process to ensure that audits of providers who receive payments under the state Medicaid program are performed 'fairly and accurately' We urge passage of HB. No. 5500 with additional recommendations as outlined below.

In particular, we support the following aspects of the proposed legislation.

- * The proposed requirement for the DSS to provide 'free training for new providers on how to enter claims to avoid clerical errors.' (Section 1b)
- * The limitation of scope to information necessary to support claims only. (Section 1c).
- * The proposed requirement for the DSS to reexamine the extrapolation process and the process to establish which provider would be subject to an audit as follows '... only perform an extrapolation of claims based on a sample of like claims and shall not perform such extrapolation based on the entire number of claims billed by any one provider. In determining which providers shall be subject to an audit, the department shall direct its efforts first to providers with a higher compliance risk based on past audits or errors.(section 1d)
- * The proposed shift in policy that would prevent the DSS from issuing payment to a contractor performing a provider audit '...on the basis of the amount of overpayment by the Medicaid program to the provider as determined by the provider audit.' (section 1e)

In addition, we respectfully submit the following recommendations related to the proposed legislation:



THE KENNEDY CENTER

Celebrating the Potential of All People

- * Streamlined process to increase efficiencies: Since the process described is that of an 'audit' as opposed to an 'investigation,' it would behoove all parties to provide at least a portion of the targeted information to be audited, in advance of the actual audit. A great deal of time and resources are lost (on both sides) due to the need for provider agencies to gather requested information while DSS auditors are present. The amount of time and resources spent both a) for a provider to interrupt operations and dedicate an increased number of staff to the process at one time, and b) for DSS auditors to literally wait while agency staff gather the required information (which may be a period of several hours – if not days) cannot be overstated. The inefficiency in this process as it currently stands invariably has a great impact on the anticipated 'Cost Savings' of the outcome.

- * Consequences that are appropriate to any identified discrepancies/concerns: We recommend that there is a need for clear distinction between clerical errors and fraudulent documentation. It would stand to reason that there would be necessary 'penalties' for fraudulent documentation. However, in situations where there has clearly been an error that is clerical in nature, we propose that there would be a 'penalty' with an established 'ceiling.' As this is the first round of audits on a relatively new system of payment, it is recommended that the audits should be corrective in nature and not punitive. These agencies are almost fully funded by the State and funds necessary to repay audit findings will likely result in cuts to client care needs.

- * Mechanisms to dispute contradictory claims: We recommend that in instances where a claim is reported to have been submitted by the Fiscal Intermediary (FI) to Medicaid for reimbursement that is found to be in conflict with the claim submitted by the agency to the FI or there is no record of the agency submitting such claim to the FI, that the FI be held for the burden of proving the claim was in fact submitted by the agency. Agencies should not have to incur the 'penalty' for a claim submitted by the FI in which the agency is clear demonstrating no record of submission.

- * Clear and concise guidelines, documentation, and procedures for demonstrating compliance: We recommend that clear and concise procedures are established of what providers must document to demonstrate services rendered. Provider documentation should not be contingent upon documentation provided by the state (i.e. DDS IP.5 Plan of Action Page), nor should the documentation require a daily signature from the person receiving services and/or their guardian/conservator for each services rendered throughout the day. If there is a signature requirement, we recommend the signature be required no less than monthly and should be submitted with the claim submission to demonstrate confirmation from the person who has received services.

- * Ongoing Communication and Training: Given the nature and sensitivity around possible fraud, we recommend that DSS provide ongoing information and training to providers pertaining to documentation and demonstration of services. Trainings should also focus on realistic encounters that providers face and how to submit a claim that clearly depicts the services and supports that are required. Additionally, DSS needs to ensure that service authorizations are provided to providers in a timely and efficient manner (i.e. within 48 hours of a planning meeting) to allow providers to know exactly what changes have been officially approved and modified from Central Office, and to ensure that services are provided, no more or less, than what is approved. The authorization provided needs to have consistent details as to that which has been submitted to the FI.

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Thank you again for your time and consideration. Please do not hesitate to contact me with any questions, or for additional information. I may be reached at 203-365-8522 x 267 or via email at vreyher@kennedvctr.org.

Sincerely,

Valerie S. G. Reyher

Valerie S. G. Reyher, CRC, NCC
Vice President of Rehabilitation Services

Human Services Committee**Raised Bill No. 5500****An Act Concerning Provider Audits under the Medicaid Program**

March 13, 2014

Senator Slossberg, Representative Abercrombie and Distinguished Members of the Human Services Committee

My name is Patricia Monaco. I am the President and CEO of Northeast Pharmacy Service Corporation representing 105 independent community pharmacies in Connecticut. I am a Connecticut resident. I am submitting this testimony in support of Raised Bill 5500, An Act Concerning Provider Audits under the Medicaid Program. I thank the Committee for raising this bill.

Northeast Pharmacy Service Corporation is a pharmacy service administrative organization (PSAO) whose services include group purchasing, third party contracting, education and training in all areas surrounding the *business of pharmacy*.

Independent community pharmacies are many times located in inner cities with large state Medicaid populations. Deep family heritages have kept many of the pharmacies in these locations through years of reimbursement cuts from the state. These businesses are part of the fabric of many of these communities; sometimes the only provider of pharmaceutical services to some of the poorest and sickest of our state's residents

Both our pharmacy network and NPSC understand that audits help to ensure the prudent management of taxpayer dollars and help to detect and prevent fraud, waste, and abuse. What we don't understand is why the state's findings in many of the audits we are aware of have been exceedingly punitive for clerical/administrative errors. In the Medicare D prescription plans, CMS does not recover on these claims, they correct them. Even when CMS recovers on a prescription claim, they do not extrapolate; they recover on that claim. In Connecticut by sharp contrast, the state recovers and extrapolates in amounts that may be thousands of times more than the original claim(s)!

Many Connecticut pharmacies serving the CT Medicaid population are not being treated fairly or reasonably in the state's audit process. A clerical error is not fraud; it may be an error made by the prescribing physician. It is not waste; the patient received the medicine that was prescribed. It is not abuse; it is a legitimate prescription written by a licensed physician approved by the state.

A clerical error of an incorrect NPI number should be corrected not extrapolated. A controlled substances drug prescription not written on the proper tamper resistant paper by the physician has led to recovery in amounts over 1000 times the prescriptions value. This shouldn't happen. One might say that pharmacies doing a large amount of Connecticut Medicaid business are

being targeted with the intent to recover as much as possible with blatant disregard of what the intent is of an audit.

Twenty nine states in the union have passed legislation on audit standards in the commercial world of pharmacy claims. The state of Massachusetts is reviewing their state Medicaid audit processes and recoveries. They are in their fourth round of audits in an effort to understand and make adjustments to arrive at a more equitable process. Clearly, it is important that the state of Connecticut processes for Medicaid audits be made fair and equitable, as well.

On behalf of all independent community pharmacies in the State of Connecticut, NPSC sincerely hopes that the Human Services Committee can change the current state audit processes to be made more fair and equitable.

I ask for your support of Raised Bill 5500.

Sincerely,

Patricia Monaco, MBA

President/CEO

Northeast Pharmacy Service Corporation



Testimony Submitted to the Human Services Committee:

Submitted By: Anne L. Ruwet CEO – CCARC, Inc.

Public Hearing Date: March 13, 2014

Support: Raised H.B. No. 5500: 'An Act Concerning Provider Audits Under the Medicaid Program' Senator Slossberg, Representative Abercrombie, and distinguished members of the Human Services Committee: I appreciate the opportunity to provide testimony regarding this important issue. My name is Anne Ruwet and I am fortunate to serve as the CEO of CCARC, Inc. for over the past 19 years. CCARC, Inc. has been provider of services for people with disabilities since 1952 providing Day and Residential Services in. The State of Connecticut should be proud that we have a strong network of human service providers that provide essential and critical services to the most vulnerable citizens of our state.

I am here today to support the concepts presented in the proposed legislation and appreciate the foresight of the Committee for developing processes to ensure that audits of providers who receive payments under the state Medicaid program are performed 'fairly and accurately.' We urge passage of HB. No. 5500 although with a few additional recommendations as outlined below.

I support the following aspects of the proposed legislation:

- * The proposed requirement for the DSS to provide 'free training for new providers on how to enter claims to avoid clerical errors.' (Section 1b)
- * The limitation of scope to information necessary to support claims only. (Section 1c).
- * The proposed requirement for the DSS to reexamine the extrapolation process and the process to establish which provider would be subject to an audit as follows '... only perform an extrapolation of claims based on a sample of like claims and shall not perform such extrapolation based on the entire number of claims billed by any one provider. In determining which providers shall be subject to an audit, the department shall direct its efforts first to providers with a higher compliance risk based on past audits or errors.(section 1d)
- * The proposed shift in policy that would prevent the DSS from issuing payment to a contractor performing a provider audit '...on the basis of the amount of overpayment by the Medicaid program to the provider as determined by the provider audit.' (section 1e)

In addition, these are proposed recommendations to modify this bill:

- * Streamline process to increase efficiencies: Since the process described is that of an 'audit' as opposed to an 'investigation,' it would behoove all parties to provide at least a portion of the targeted information to be audited, in advance of the actual audit similar to the independent financial audits that are performed each year. The amount of time and resources spent both a) for a provider to interrupt operations and dedicate an increased number of staff to the process at one time, and b) for DSS auditors to literally wait while agency staff gather the required information (which may be a period of several hours – if not days) cannot be overstated. The inefficiency in this process as it currently stands invariably has a great impact on the anticipated 'Cost Savings' of the outcome.
- * Consequences that are appropriate to any identified discrepancies/concerns: We recommend that there is a need for clear distinction between clerical errors and fraudulent documentation. It would stand to reason that there would be necessary 'penalties' for fraudulent documentation. However, in situations where there has clearly been an error that is clerical in nature, we propose that there would be a 'penalty' with an established 'ceiling.' As this is the first round of audits on a relatively new system of payment, it is recommended that the audits should be

corrective in nature and not punitive. These agencies are almost fully funded by the State and funds necessary to repay audit findings will likely result in cuts to client care.

Our private provider system of care operates efficiently and effectively without having any cost of living increases in many years. We are all working toward the same mission to provide quality services to our most vulnerable citizens but we must work collaboratively to reach this end

Thank you again for your time and consideration. Please do not hesitate to contact me with any questions, or for additional information.

Anne L. Ruwet
CEO
950 Slater Rd.
New Britain, CT 06052
860-229-6665

CONNECTICUT ASSOCIATION FOR
HEALTHCARE AT HOME

CONNECTICUT ASSOCIATION OF HEALTH CARE FACILITIES

CONNECTICUT
HOSPITAL
ASSOCIATION

State Medical Society



Connecticut

Statement to the Human Services Committee**March 13, 2014****Supporting****HB 5500, An Act Concerning Provider Audits Under The Medicaid Program**

As statewide associations representing providers of Medicaid services throughout the continuum, we join together in support of HB 5500, An Act Concerning Provider Audits Under The Medicaid Program.

Fraud and abuse have no place within the healthcare system and should never be tolerated within the Medicaid program. As Medicaid providers, the members of our respective associations understand, accept, and support the need to protect the integrity of the program through state oversight and audits, but we encourage efforts to ensure that the oversight and audit processes used by state government are fair and balanced, and are designed so as not to add unnecessary expense to the healthcare field.

We have all previously called for audit practices that are fair, balanced, efficient, and cost effective, and that do not place unnecessary burdens on law-abiding providers. We therefore have all provided testimony today in support of HB 5500, An Act Concerning Provider Audits Under The Medicaid Program, which would bring a level of fairness into the audit and oversight process.

Thank you for your consideration of our joint statement of support.

Deborah Hoyt, Connecticut Association for HealthCare at Home, (203) 774-4939

Matthew Barrett, CAHCF, (860) 290-9424

Jim Iacobellis, CHA, (203) 294-7310

Ken Ferrucci, CSMS, (203) 865-0587

Mag Morelli, LeadingAge, (860) 828-2903

CONNECTICUT ASSOCIATION OF COMMUNITY PHARMACIES, INC.
NOME ASSOCIATES
151 TWO ROD HIGHWAY
WETHERSFIELD, CT 06109
860-841-1490

Human Services Committee
Testimony in Support of HB 5500 AAC Provider Audits Under the
Medicaid Program
March 13, 2014

Senator Slossberg, Representative Abercrombie and Members of the Human Services Committee, my name is Carrie Rand-Anastasiades. I am the Executive Director of the CT Association of Community Pharmacies. We are an Association representing large pharmacies such as Walgreens, Rite-Aid, Genoa Healthcare and Price Chopper to name a few. I would like to testify in support of HB 5500 AAC Provider Audits Under the Medicaid Program.

Numerous States across the country have passed legislation setting parameters on provider/pharmacy audits to ensure that abusive practices are not used. Audits were originally used as mechanisms to prevent fraud and abuse, which is reasonable and just. Unfortunately, pharmacy audits have become a way for States to collect huge fines from local providers. They are no longer focussed on fraud, waste and abuse but technical miscues. In terms of the pharmacy community, that just underwent audit, tens of million of dollars were racked up for mistakes, like physicians not using tamper resistant pads for controlled prescriptions, that pharmacies did not even make. These administrative mistakes were extrapolated across the entire book, of Medicaid business, of just those prescriptions under review, resulting in millions of dollars in fines paid to the State. For one such company doing business with the State, the liability was \$12 million dollars.

Pharmacy reimbursement has been cut so low that we have seen numerous pharmacies go out of business or opt out of participating in the State Employee Plan. Using tactics like this further reduces the pharmacy's profitability and whether they can continue to service the Medicaid population.

Although we would like to work with the Committee on the fine details, we feel this is a good bill that curtails abusive extrapolation practices. We urge you to support this legislation.

BIG Y FOODS, INC. • GENOA HEALTHCARE • PRICE CHOPPER • RITE AID
THE STOP & SHOP SUPERMARKET COMPANY •
WAL-MART • WALGREEN COMPANY •
NATIONAL ASSOCIATION OF CHAIN DRUG STORES

March 13, 2014

Raised H.B. No. 5500: 'An Act Concerning Provider Audits Under the Medicaid Program.

Senator Slossberg, Representative Abercrombie, and distinguished members of the Human Services Committee,

I appreciate the opportunity to provide testimony regarding **Raised H.B. No. 5500: 'An Act Concerning Provider Audits Under the Medicaid Program.** For over 30 years, the Brain Injury Alliance of Connecticut has served individuals with brain injuries, their families and the professionals who work with them. We are also among the 500+ member agencies of the Connecticut Association of Nonprofits (CT Nonprofits.)

We support the concepts presented in the proposed legislation and applaud the Committee for developing the proposed process to ensure that audits of providers who receive payments under the state Medicaid program are performed 'fairly and accurately.' We urge passage of HB. No. 5500 with additional recommendations as outlined below.

In particular, we support the following aspects of the proposed legislation:

- * The proposed requirement for the DSS to provide 'free training for new providers on how to enter claims to avoid clerical errors.' (Section 1b)
- * The limitation of scope to information necessary to support claims only. (Section 1c).
- * The proposed requirement for the DSS to reexamine the extrapolation process and the process to establish which provider would be subject to an audit as follows '... only perform an extrapolation of claims based on a sample of like claims and shall not perform such extrapolation based on the entire number of claims billed by any one provider. In determining which providers shall be subject to an audit, the department shall direct its efforts first to providers with a higher compliance risk based on past audits or errors. (section 1d)
- * The proposed shift in policy that would prevent the DSS from issuing payment to a contractor performing a provider audit '...on the basis of the amount of overpayment by the Medicaid program to the provider as determined by the provider audit.' (section 1e)

In addition, we respectfully submit the following recommendations related to the proposed legislation:

- * Streamlined process to increase efficiencies: Since the process described is that of an 'audit' as opposed to an 'investigation,' it would behoove all parties to provide at least a portion of the targeted information to be audited, in advance of the actual audit. A great deal of time and resources are lost (on both sides) due to the need for provider agencies to gather requested information while DSS auditors are present. The amount of time and resources spent both a) for a provider to interrupt operations and dedicate an increased number of staff to the process at one time, and b) for DSS auditors to literally wait while agency staff gather the required information (which may be a period of several hours - if not days) cannot be overstated. The inefficiency in this process as it currently stands invariably has a great impact on the anticipated 'Cost Savings' of the outcome.

- * Consequences that are appropriate to any identified discrepancies/concerns: We recommend that there is a need for clear distinction between clerical errors and fraudulent documentation. It would stand to reason that there would be necessary 'penalties' for fraudulent documentation. However, in situations where there has clearly been an error that is clerical in nature, we propose that there would be a 'penalty' with an established 'ceiling.' As this is the first round of audits on a relatively new system of payment, it is recommended that the audits should be corrective in nature and not punitive. These agencies are almost fully funded by the State and funds necessary to repay audit findings will likely result in cuts to client care needs.

Thank you again for your time and consideration. Please do not hesitate to contact me with any questions, or for additional information.

Submitted by,

Julie Peters, CBIS
Executive Director

Brain Injury Alliance of CT
200 Day Hill Road, Ste. 250, Windsor, CT 06095
(860) 219-0291 x301

Raised H.B. No. 5500: 'An Act Concerning Provider Audits Under the Medicaid Program'

Senator Slossberg, Representative Abercrombie, and distinguished members of the Human Services Committee: I appreciate the opportunity to provide written testimony regarding this important issue. My Name is Paul Rosin and I am the Executive Director of Community Residences Inc. a not-for-profit multi-service provider of day, residential, and family support to children and adults with special needs. I am providing testimony as a member of the Connecticut Association for Not Profits.

We support the concepts presented in the proposed legislation and applaud the Committee for developing the proposed process to ensure that audits of providers who receive payments under the state Medicaid program are performed 'fairly and accurately.' We urge passage of HB. No. 5500 with additional recommendations as outlined below.

In particular, we support the following aspects of the proposed legislation:

- * The proposed requirement for the DSS to provide 'free training for new providers on how to enter claims to avoid clerical errors.' (Section 1b)
- * The limitation of scope to information necessary to support claims only. (Section 1c).
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- * The proposed shift in policy that would prevent the DSS from issuing payment to a contractor performing a provider audit '...on the basis of the amount of overpayment by the Medicaid program to the provider as determined by the provider audit.' (section 1e)

In addition, we respectfully submit the following recommendations related to the proposed legislation:

- * Streamlined process to increase efficiencies: Since the process described is that of an 'audit' as opposed to an 'investigation,' it would behoove all parties to provide at least a portion of the targeted information to be audited, in advance of the actual audit. A great deal of time and resources are lost (on both sides) due to the need for provider agencies to gather requested information while DSS auditors are present. The amount of time and resources spent both a) for a provider to interrupt operations and dedicate an increased number of staff to the process at one time, and b) for DSS auditors to literally wait while agency staff gather the required information (which may be a period of several hours – if not days) cannot be overstated. The inefficiency in this process as it currently stands invariably has a great impact on the anticipated 'Cost Savings' of the outcome.
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punitive. These agencies are almost fully funded by the State and funds necessary to repay audit findings will likely result in cuts to client care needs.

Thank you again for your time and consideration. Please do not hesitate to contact me with any questions, or for additional information.

Paul M. Rosin
Executive Director
Community Residences Inc.
732 West Street, Southington, Ct
(860) 621-7600 ext. 111





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Human Services Committee Public Hearing
Thursday, March 13, 2014
11:00 AM

Testimony for Connecticut General Assembly HB-5500

Thank you for the opportunity to comment on HB-5500, AN ACT CONCERNING PROVIDER AUDITS UNDER THE MEDICAID PROGRAM. As the Executive Director for Kuhn Employment Opportunities, Inc., a nonprofit agency that focuses on assisting approximately 450 individuals with disabilities gain employment, I urge you to pass HB 5500.

We at Kuhn recognize that audits are necessary and important for the Medicaid program, and we absolutely condemn Medicaid fraud and abuse to the fullest. However, using this same audit process to generate revenue (\$64 million for FY 14 and \$103 million for FY 15) to close the State budget gap is highly unrealistic and overly ambitious. In addition, it has the potential to create an aggressive environment to find revenue at the detriment of private non-profit agencies like Kuhn even for unintentional clerical errors.

A point to support my above assertion is the fact that contractors performing DSS Medicaid audits are paid on a contingency fee basis, receiving a percentage of the payments they collect from providers. This type of audit practice is currently avoided by the business community because of an inherent conflict of interest which allows auditors to benefit from the total amount of payments they collect.

We strongly support section (e) of HB-5500, as it resolves this conflict of interest by requiring that DSS not issue payment to a contractor on the basis of overpayment by the Medicaid program to the provider as determined by the provider audit.

Again, we thank the Committee for paying attention to this important issue for community providers and for drafting a bill that addresses the problems with audits in a fair and reasonable way, while still holding any fraud or abuse in the system completely accountable.

Thank you for your time and attention.

Robert Stephens
Executive Director

Board of Directors

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Executive Director: Robert L. Stephens





Testimony to the Human Services Committee

Submitted by Mag Morelli, President of LeadingAge Connecticut

March 13, 2014

Supporting

HB 5500, An Act Concerning Provider Audits under the Medicaid Program

Good afternoon Senator Slossberg, Representative Abercrombie, and members of the Human Services Committee. My name is Mag Morelli and I am the President of LeadingAge Connecticut, a statewide membership organization representing over 130 mission-driven and not-for-profit provider organizations serving older adults across the continuum of long term care, services and supports and including senior housing. On behalf of LeadingAge Connecticut, I would like to submit the following testimony in support of HB 5500, An Act Concerning Provider Audits under the Medicaid Program, and offer the Committee our assistance as you consider this bill.

Fraud and abuse have no place within the health care system and should never be tolerated within the Medicaid program. As Medicaid providers, the members of LeadingAge Connecticut understand, accept and support the need to protect the integrity of the program through state oversight and audits, but we encourage efforts to ensure that the oversight and audit processes used by state government are both fair and balanced and are designed so as not to add unnecessary expense to the health care field.

LeadingAge Connecticut has previously called for audit practices that are fair, balanced, efficient and cost effective and which do not place unnecessary burdens on law abiding providers. We therefore support this proposal which would bring a level of fairness into the audit and extrapolation processes and which would prohibit the use of a contingency payment method to reimburse outside audit contractors.

We also urge the state to make sure that the audit standards, which consist of state Medicaid payment regulations and policy provisions, are updated and clarified. While oversight is imperative to maintaining the integrity of the Medicaid program, it should not add unnecessary costs and burdens to the system.

Thank you for this opportunity to submit this testimony.

Mag Morelli, President



(860) 828-2903, mmorelli@leadingagect.org, 1340 Worthington Rldge, Berlin, CT 06037 www.leadingagect.org

LeadingAge Connecticut is a membership organization representing over 130 mission-driven and not-for-profit provider organizations serving older adults across the continuum of care including nursing homes, residential care homes, housing for the elderly, continuing care retirement communities, adult day centers, home care and assisted living agencies. By continuing a tradition of mission-driven, consumer-centered management and competent, hands-on care, not-for-profits set the standard in the continuum of housing, care and services for the most vulnerable aging adults.