



Senate

General Assembly

File No. 429

January Session, 2009

Senate Bill No. 1085

Senate, April 2, 2009

The Committee on Human Services reported through SEN. DOYLE of the 9th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

***AN ACT CONCERNING HOMEMAKER AND COMPANION AGENCIES
AND AUDITS FOR VENDOR FRAUD.***

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Subsection (d) of section 17b-99 of the general statutes is
2 repealed and the following is substituted in lieu thereof (*Effective July*
3 *1, 2009*):

4 (d) The Commissioner of Social Services, or any entity with whom
5 the commissioner contracts, for the purpose of conducting an audit of
6 a service provider that participates as provider of services in a
7 program operated or administered by the department pursuant to this
8 chapter or chapter 319t, 319v, 319y or 319ff, shall conduct any such
9 audit in accordance with the provisions of this subsection. For
10 purposes of this subsection "provider" means a person, public agency,
11 private agency or proprietary agency that is licensed, certified or
12 otherwise approved by the commissioner to supply services
13 authorized by the programs set forth in said chapters.

14 (1) Not less than thirty days prior to the commencement of any such
15 audit, the commissioner, or any entity with whom the commissioner
16 contracts to conduct an audit of a participating provider, shall provide
17 written notification of the audit to such provider, unless the
18 commissioner, or any entity with whom the commissioner contracts to
19 conduct an audit of a participating provider makes a good faith
20 determination that (A) the health or safety of a recipient of services is
21 at risk; or (B) the provider is engaging in vendor fraud. A copy of the
22 regulations established pursuant to subdivision (12) of this subsection
23 shall be appended to such notification.

24 (2) Any audit conducted pursuant to this subsection shall be limited
25 to a review of claims filed during the two-year period prior to the date
26 that the provider receives written notice from the commissioner of the
27 audit, pursuant to subdivision (1) of this subsection, or two hundred
28 claims, whichever is less.

29 [(2)] (3) Any clerical error, including, but not limited to,
30 recordkeeping, typographical, scrivener's or computer error,
31 discovered in a record or document produced for any such audit, shall
32 not of itself constitute a wilful violation of program rules and shall not
33 be used as the basis for extrapolated projections unless proof of intent
34 to commit fraud or otherwise violate program rules is established.

35 [(3)] (4) A finding of overpayment or underpayment to a provider in
36 a program operated or administered by the department pursuant to
37 this chapter or chapter 319t, 319v, 319y or 319ff, shall not be based on
38 extrapolated projections unless the error rate exceeds ten per cent and
39 (A) there is a sustained or high level of payment error involving the
40 provider, or (B) documented educational intervention has failed to
41 correct the level of payment error,], or (C) the value of the claims in
42 aggregate exceeds one hundred fifty thousand dollars on an annual
43 basis.]

44 [(4)] (5) A provider, in complying with the requirements of any such
45 audit, shall be allowed not less than thirty days to provide
46 documentation in connection with any discrepancy discovered and

47 brought to the attention of such provider in the course of any such
48 audit.

49 [(5)] (6) The commissioner, or any entity with whom the
50 commissioner contracts, for the purpose of conducting an audit of a
51 provider of any of the programs operated or administered by the
52 department pursuant to this chapter or chapter 319t, 319v, 319y or
53 319ff, shall produce a preliminary written report concerning any audit
54 conducted pursuant to this subsection, and such preliminary report
55 shall be provided to the provider that was the subject of the audit, not
56 more than sixty days after the conclusion of such audit.

57 [(6)] (7) The commissioner, or any entity with whom the
58 commissioner contracts, for the purpose of conducting an audit of a
59 provider of any of the programs operated or administered by the
60 department pursuant to this chapter or chapter 319t, 319v, 319y or
61 319ff, shall, following the issuance of the preliminary report pursuant
62 to subdivision [(5)] (6) of this subsection, hold an exit conference with
63 any provider that was the subject of any audit pursuant to this
64 subsection for the purpose of discussing the preliminary report.

65 [(7)] (8) The commissioner, or any entity with which the
66 commissioner contracts, for the purpose of conducting an audit of a
67 service provider, shall produce a final written report concerning any
68 audit conducted pursuant to this subsection. Such final written report
69 shall be provided to the provider that was the subject of the audit not
70 more than sixty days after the date of the exit conference conducted
71 pursuant to subdivision [(6)] (7) of this subsection, unless the
72 commissioner, or any entity with which the commissioner contracts,
73 for the purpose of conducting an audit of a service provider, agrees to
74 a later date or there are other referrals or investigations pending
75 concerning the provider.

76 [(8)] (9) Any provider aggrieved by a decision contained in a final
77 written report issued pursuant to subdivision [(7)] (8) of this
78 subsection, may, not later than thirty days after the receipt of the final
79 report, request, in writing, a review on all items of aggrievement. Such

80 request shall contain a detailed written description of each specific
81 item of aggrievement. The designee of the commissioner who presides
82 over the review shall be impartial and shall not be an employee of the
83 Department of Social Services Office of Quality Assurance or an
84 employee of an entity with whom the commissioner contracts for the
85 purpose of conducting an audit of a service provider. Following
86 review on all items of aggrievement, the designee of the commissioner
87 who presides over the review shall issue a final decision.

88 (10) The provider shall have the right to appeal a final decision to
89 the Superior Court in accordance with the provisions of chapter 54.

90 [(9)] (11) The provisions of this subsection shall not apply to any
91 audit conducted by the Medicaid Fraud Control Unit established
92 within the Office of the Chief State's Attorney.

93 (12) The commissioner shall adopt regulations, in accordance with
94 the provisions of chapter 54, to carry out the provisions of this
95 subsection and to ensure the fairness of the audit process, including,
96 but not limited to, the sampling methodologies associated with the
97 process.

98 Sec. 2. Subsection (c) of section 17b-342 of the general statutes is
99 repealed and the following is substituted in lieu thereof (*Effective July*
100 *1, 2009*):

101 (c) The community-based services covered under the program shall
102 include, but not be limited to, the following services to the extent that
103 they are not available under the state Medicaid plan, occupational
104 therapy, homemaker services, companion services, meals on wheels,
105 adult day care, transportation, mental health counseling, care
106 management, elderly foster care, personal care assistance, minor home
107 modifications and assisted living services provided in state-funded
108 congregate housing and in other assisted living pilot or demonstration
109 projects established under state law. For purposes of this subsection,
110 "personal care assistance" means assistance with activities of daily
111 living, including, but not limited to, bathing, dressing, grooming,

112 toileting and mobility. Recipients of state-funded services and persons
113 who are determined to be functionally eligible for community-based
114 services who have an application for medical assistance pending shall
115 have the cost of home health and community-based services covered
116 by the program, provided they comply with all medical assistance
117 application requirements. Access agencies shall not use department
118 funds to purchase community-based services or home health services
119 from themselves or any related parties.

120 Sec. 3. Section 17b-343 of the general statutes is repealed and the
121 following is substituted in lieu thereof (*Effective July 1, 2009*):

122 The Commissioner of Social Services shall establish annually the
123 maximum allowable rate to be paid by said agencies for homemaker
124 services, chore person services, companion services, respite care, meals
125 on wheels, adult day care services, case management and assessment
126 services, transportation, mental health counseling and elderly foster
127 care, except that the maximum allowable rates in effect July 1, 1990,
128 shall remain in effect during the fiscal years ending June 30, 1992, and
129 June 30, 1993. The Commissioner of Social Services shall prescribe
130 uniform forms on which agencies providing such services shall report
131 their costs for such services. Such rates shall be determined on the
132 basis of a reasonable payment for necessary services rendered. The
133 maximum allowable rates established by the Commissioner of Social
134 Services for the Connecticut home-care program for the elderly
135 established under section 17b-342, as amended by this act, shall
136 constitute the rates required under this section until revised in
137 accordance with this section. The Commissioner of Social Services shall
138 establish a fee schedule, to be effective on and after July 1, 1994, for
139 homemaker services, chore person services, companion services,
140 respite care, meals on wheels, adult day care services, case
141 management and assessment services, transportation, mental health
142 counseling and elderly foster care. The commissioner shall establish a
143 fee for transportation services of not less than eight dollars for each
144 trip away from the elderly person's home. Such transportation fee shall
145 be in addition to the applicable hourly rate for the agency's services.

146 The commissioner may annually increase any fee in the fee schedule
147 based on an increase in the cost of services. The commissioner shall
148 increase the fee schedule effective July 1, 2000, by not less than five per
149 cent, for adult day care services. Nothing contained in this section shall
150 authorize a payment by the state to any agency for such services in
151 excess of the amount charged by such agency for such services to the
152 general public.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2009</i>	17b-99(d)
Sec. 2	<i>July 1, 2009</i>	17b-342(c)
Sec. 3	<i>July 1, 2009</i>	17b-343

HS *Joint Favorable*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 10 \$	FY 11 \$
Department of Social Services	GF - Cost	Significant	Significant

Municipal Impact: None

Explanation

Section 1 of the bill changes the audit methods of the Department of Social Services (DSS) by limiting both the scope of the reviews and the use of extrapolated projections. These changes are expected to reduce the amount of funds that DSS recoups annually from audits. The total reduction in any one year cannot be known in advance. However, given that DSS recoups approximately \$12 million annually from this process, the cost is expected to be significant.

Additionally, the bill’s provision concerning extrapolation may be in conflict with federal Medicaid requirements. If this is determined to be true, it could jeopardize Connecticut’s receipt of federal matching funds.

The bill also gives providers the right to appeal an audit decision to the Superior Court. This change will result in an administrative cost to DSS and the Superior Court. This cost is expected to be minimal, as DSS has received only 13 requests for audit reviews since 2005.

The bill also adds personal care assistance (PCA) as a covered service under the Connecticut Home Care program. The impact of this change is uncertain. Should PCA services be added to the overall service package that an individual receives, there would be an increased cost to the state. However, should PCA services be substituted for more costly services now provided by certified nurses

assistants, a savings may result.

Finally, the bill establishes a transportation fee of no less than \$8 each way for homemaker and companion agencies. This is expected to result in an annual cost to DSS of approximately \$1 million.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

Sources: Public testimony, DSS cost and caseload data

OLR Bill Analysis**SB 1085*****AN ACT CONCERNING HOMEMAKER AND COMPANION AGENCIES AND AUDITS FOR VENDOR FRAUD.*****SUMMARY:**

This bill (1) makes changes in the statutory procedures for Department of Social Services (DSS) audits of service providers, (2) requires DSS to provide personal care assistance (PCA) services under the Connecticut Homecare Program for Elders (CHCPE) and (3) requires DSS to establish a separate transportation fee for CHCPE provider agencies of at least \$8 per trip away from a participating senior's home.

EFFECTIVE DATE: July 1, 2009

§ 1 — AUDIT PROCEDURES, LIMITS, AND NOTICES

By law, the DSS commissioner or contracted audit agency must audit service providers of the department's welfare programs, such as Temporary Family Assistance; the State Supplement Program; Food Stamps (now called the Supplemental Nutrition Assistance Program); State-Administered General Assistance (SAGA); Medicaid; HUSKY B; the Connecticut Pharmaceutical Contract to the Elderly and Disabled (ConnPACE); and payment for nursing homes, residential care homes, and home- and community-based care.

Regulations and Audit Notices

The bill requires the DSS commissioner to adopt regulations, in accordance with the Uniform Administrative Procedure Act (UAPA), to ensure the fairness of the audit process, including associated sampling methodologies.

It requires the DSS commissioner, or any agencies he uses to audit

service providers, to attach a copy of the department's audit regulations to the written notice he is required to send a provider. (The law defines a provider as a person or a public, private, or proprietary agency licensed, certified, or otherwise approved by the commissioner to provide authorized services.)

By law, the DSS commissioner, or audit agency must give written notice to the provider at least 30 days before beginning the audit, unless, in good faith, it determines that (1) the service recipient's health or safety is at risk or (2) the provider is engaging in vendor fraud.

Audit Scope

The bill limits the scope of an audit to a review of the lesser of either (1) claims filed during the two years before the date the provider receives written notice of the audit from DSS or (2) 200 claims. Current law does not limit the number or age of claims that may be reviewed.

Clerical Errors

The bill prohibits a clerical error discovered in a record or document produced for the audit from being used as the basis for extrapolated projections unless proof of an intent to commit fraud or otherwise violate program rules is established. The law defines a "clerical error" as including recordkeeping, typographical, writer's, and computer errors.

Extrapolation

The bill prohibits DSS from finding that an overpayment or underpayment was made to a provider based on extrapolated projections, unless the error rate exceeds 10% and one of two other conditions of existing law are met: (1) the provider has sustained a high level of payment error or (2) the documented educational intervention has failed to correct the error levels.

The bill removes DSS's ability to use the extrapolated projections to find under- or overpayment if aggregate claims exceed \$150,000 annually.

Extrapolation is the practice of (1) dividing the total number of payment errors found in a sample of documents by the sample size to arrive at average errors per sample and (2) multiplying this by the total number of claims to arrive at a presumed, extrapolated number of payment errors for all payments to the provider during the audit time period.

Provider Requests For Review of Decisions

By law, a provider aggrieved by a decision in a final audit report can, within 30 days after receiving the report, request in writing a review of all items in question by an impartial person the commissioner designates. The bill requires this person to issue a final decision. The bill also gives a provider the right to appeal a final decision to Superior Court under UAPA.

§ 2 — PERSONAL CARE ASSISTANCE (PCA) SERVICES UNDER CHCPE

The bill requires DSS to provide PCA services under CHCPE. It defines “personal care assistance” as assistance with activities of daily living, including bathing, dressing, grooming, toileting, and mobility.

Currently, DSS provides PCA services only through (1) a state-funded PCA pilot program for certain qualifying seniors, (2) the PCA Medicaid waiver program for disabled adults, and (3) the acquired brain injury (ABI) Medicaid waiver program. Under these programs, participants hire their own assistants to help with personal care and activities of daily living, instead of going through a home health care agency. The participant hires and manages the assistant, but a financial intermediary handles the paperwork.

§ 3 — TRANSPORTATION FEE FOR CHCPE PROVIDERS

The bill requires DSS to establish a separate transportation fee for CHCPE provider agencies of at least \$8 per trip away from a senior’s home. This fee is added to the hourly rate these agencies are currently paid for services provided under the program. The law, unchanged by the bill, continues to allow DSS to annually increase these fee

schedules, based on increases in service costs. The state's rate for these services cannot exceed that charged to the public.

BACKGROUND

CHCPE

CHCPE is a Medicaid waiver and state-funded program that provides home and community-based services for qualifying individuals age 65 and older who are institutionalized or at risk of institutionalization. Services include care management, adult day care, adult foster care, homemaker services, transportation, meals-on-wheels, minor home modifications, and certain assisted living services. An "access" agency determines the most appropriate service package for each participant.

Related Bills

SB 814, reported favorably by the Human Services and Aging Committees, requires DSS to provide PCA services under CHCPE.

COMMITTEE ACTION

Human Services Committee

Joint Favorable

Yea 13 Nay 6 (03/19/2009)