

TESTIMONY BEFORE THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATION
COMMITTEE
REGARDING SCOPE OF STUDY FOR IMPROPER MEDICAID PAYMENTS

June 29, 2012

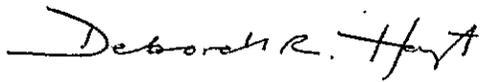
The Connecticut Association for Home Care and Hospice applauds the Legislative Program Review and Investigation Committee for their efforts to include those of us in the health care industry to be a part of the solution in dealing with Medicare and Medicaid fraud and abuse. Local home care and hospice agencies have a responsibility to the state of Connecticut to uphold the integrity of their Medicare programs through corporate compliance plans.

The areas of this analysis will evaluate the fiscal policies and annual budgets of community health care providers but at what cost? According to the federal government and the National Association for Home Care and Hospice (NAHC) private contractors received \$102 million to review Medicaid fraud data in 2008 but only found about \$20 million in overpayments resulting in the loss of \$80 million dollars. A cost effective means for evaluation is necessary to reduce the rising expense of Connecticut's Medicaid program so that state agencies can continue providing quality, affordable health care and hospice services in resident's homes.

While fraud and abuse is committed by a very small population of health care workers, it hurts the home care and hospice industry as a whole and affects the accessibility of care for their clients. The auditing process places a significant strain on both for-profit and non-profit health care agencies that use valued staff time and resources to comply with rigorous auditing demands. In many cases, fraud investigations result in a much smaller infraction due to human error than previously assumed by the Department of Social Services.

CAHCH supports Connecticut's Medicaid Fraud Control Unit in the important work that they do but we will continue to speak out for struggling home care and hospice providers who are crippled by unnecessary audits and accusations of Medicare fraud. I encourage you to thoroughly compare the effectiveness of Connecticut's Medicaid program integrity efforts to that of other states so that a cost savings model can be adapted to the needs of local health care providers who already struggle with Medicaid reimbursement rates.

If considerable federal and state resources are invested into statewide Medicaid program integrity then clear outcome measures should be identified so that established goals are met. A thorough process of program evaluation needs to be set in place prior to implementation to ensure that all the necessary actions are taken to serve the purpose of reducing Medicaid cost, fraud, and abuse. The same rigorous standards of accountability should be applied to the new Medicaid integrity program that established agencies experience during an audit. I would like to thank the committee for considering the community health perspective and current challenges across the continuum of care.



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