

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