

*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:



- \* 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@kennedyctr.org](mailto:vreyher@kennedyctr.org).

Sincerely,



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Vice President of Rehabilitation Services