



CONNECTICUT ASSOCIATION FOR
HEALTHCARE AT HOME™

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.



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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



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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.