



Empowering those with Intellectual and developmental disabilities to realize their dreams.

*Testimony Submitted to the Human Services Committee:*

Submitted By: Karen Rettenmeier, Director of Finance, MARC Community Resources, LTD  
Public Hearing Date: February 11, 2015

Support and Recommendations Regarding:

Proposed H.B. No. 6550: AN ACT CONCERNING MEDICAID PROVIDER AUDITS.

Senator Moore, Representative Abercrombie, Senator Slossberg, Representative McGee and distinguished members of the Human Services Committee: I appreciate the opportunity to provide testimony regarding these important issues. I am Karen Rettenmeier, Director of Finance for MARC Community Resources, LTD. We provide Adult Day, Supported Employment, Residential, and Independent Living services to people with Intellectual and Developmental Disabilities. We are among the 500+ member agencies of the Connecticut Association of Nonprofits (CT Nonprofits.)

We support the concepts presented in the proposed legislation and applaud the Committee for your efforts to develop the proposed process to ensure that audits of providers who receive payments under the state Medicaid program are conducted 'in a fair and reasonable manner. We urge passage of HB. No. 6500 with additional recommendations as outlined below.

In particular, we support the following aspects of the proposed legislation:

That subsection (d) of section 17b-99 of the general statutes be amended to establish:

1. Clear parameters governing the use of extrapolation in Medicaid provider audits
2. Specific minimum standards for statistical sampling, including a minimum error rate and types of statistical sampling that may be used.
3. Acceptable methods by which providers may challenge extrapolated findings of overpayment
4. Requirements concerning transparency, outreach and education by the Department of Social Services to reduce provider errors.

In addition, we respectfully submits the following recommendations:

- \* Develop a 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.

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- \* Establish consequences that are appropriate to any identified discrepancies/concerns: We recommend that there is a clear distinction established 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.'
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- \* Evaluate the overarching 'tone' of the Medicaid Audit Process: As this is the first round of audits on a relatively new system of payment, it is recommended that the audits should be implemented in a manner which is corrective in nature as opposed to punitive. The nonprofit organizations involved, are primarily funded by the State of Connecticut. Therefore, funds necessary to repay audit findings will likely result in cuts to program service /client care needs.

Due to current regulations, we are required to return any excess funds received during each fiscal year that were not expended. Because our primary support comes from state funds, there is little opportunity for us to build up reserves to have the funds available if we are faced with extrapolation. In addition, the amount of actual earnings received during the period audited would be reduced, resulting in an overpayment to the state based on our actual profit.

There is a big difference between clerical errors and fraudulent billing. Without clearly defined standards and guidelines, there is too much room for confusion and individual interpretation. In the end, the people that will be most hurt are the people that we support.

Thank you again for your time and consideration. Please do not hesitate to contact me with any questions, or for additional information.

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