

Testimony Submitted by – Lisa Martin, Executive Director, Independent Living Solutions, LLC

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

Senator Moore, Representative Abercrombie, Senator Slossberg, Representative McGee and members of the Human Services Committee: My name is Lisa Martin and I am the Executive Director of Independent Living Solutions

My agency has been providing services to brain injury survivors for 12 years under the Acquired Brain Injury Waiver.

I very much appreciate your efforts to ensure that audits of providers are done “in a fair and reasonable manner”. I urge passage of HB. No. 6500 for these reasons:

My agency was notified of the impending audit in June 2012. The following August, 2012 HMS requested a sampling of 100 invoices including employee timesheets and staffing schedules.

Once the requested documentation was submitted I received a “**draft of improper payment report**” in Jan. 2013 which stated that I owed **\$87,454.00** (the sample of 100 showed that there were overpayments in the amount of 6,346.47 which they divide by 100 than apply that number to the “claim universe” which was 1,378 invoices that had been paid during the sample time period. The total came to 87,454.36)

I was given the opportunity to disagree with the findings, which I did. I found invoices that had not been submitted in the original sample request and other documentation that I thought would reduce the overpayment amount. In May 2013 I received a “**revised draft of improper payment report**” which stated that I now owed **\$354,206.22!!!**

As you can imagine I panicked! All I could think about was the fact that there was no way my agency could afford to repay that amount and continue to provide services to our consumers. This meant that not only would the consumers have a major disruption to the services they had been receiving but that I would have to lay off approximately 100 caregivers!

At this point I ran to the aid of CAN as recommended by some of my colleagues. They recommended that I hire a law firm that helped them with their audits (TCORS)

TCORS assisted me with refuting many of the reasons that HMS claimed that I was overpaid based on the fact that I was never given the regulations that HMS was

citing in their determinations. (i.e. I was told that if someone provided 7.75 hrs of services that I could bill for 8.0, that's against regulations)

On April 8, 2014 I received a **“revised final improper payment report”** with the final amount owed of **\$8,708.96**. The end cost to the agency was actually close to \$41,000 after all legal fees were paid not to mention the amount of time, effort and stress it caused.

During the course of this audit another source of frustration was the fact that Allied Community Recourses, the fiduciary agency hired by DSS to oversee proper payments, had no accountability for these overpayments. Many of the errors were clerical on the part of our agency however I was under the impression that Allied was responsible for catching any errors and bringing those errors to our attention as they have many times in the past. In certain cases these errors are correctable and would enable us to “re-bill” without losing funds for services provided.

Another issue with the audit that should be addressed is the timeliness of the “re-payment”. HMS notified me that they would “offset the payment due from future payments” within 30 days of the notice. That can cause quite a hardship to the agency. I feel that a payment schedule should be set up that is mutually agreed upon.

Our primary goal is to provide the best services to the population that we serve and I give you my sincerest thanks for your time and attention to this bill.

Please feel free to contact me if you should have any further questions.

Lisa Martin

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**I 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, I support 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.

- * 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.