Testimony of Joe Russell
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Opposition to Senate Bill 218
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Senate Health, Human Services and Medicaid Committee

Chair Burke, Vice Chair Beagle, Ranking Member Tavares, and Members of the Senate Health, Human Services and Medicaid Committee, thank you for allowing me to testify today in opposition to Senate Bill 218. My name is Joe Russell, and I am the executive director at the Ohio Council for Home Care and Hospice (OCHCH).

Since 1965, OCHCH has served as the voice of the home care and hospice industry in Ohio advocating for policies that improve home and community-based services. Today, our over 650 member agencies serve Ohio's most vulnerable children and aging populations where it matters most – in their homes.

OCHCH opposes SB 218 in its current form because it's unnecessarily broad and will not achieve what it intends to achieve—reduce fraud, waste and abuse. Furthermore, SB 218 could have serious negative effects for home health businesses, especially hurting small home health agencies, and is unfair to those longstanding providers who present little risk to Medicaid.

Fighting Fraud, Waste and Abuse

OCHCH strongly opposes fraud, waste and abuse in the Medicaid program. In fact, OCHCH has been working closely with the Ohio Department of Medicaid (ODM) to implement the Electronic Visit Verification (EVV) program that will require all in-home providers to use a smart device to verify that a service was delivered. Fraud will be all but impossible with this new system, yet audits will still be an issue because the audit system itself is broken.

It's critical that we fight fraud, waste and abuse—together. Those agencies that seek to ignore the law should be held accountable, but agencies that make mistakes should have the opportunity to address those issues and not be put into the same basket as those bad actors. Surety bonds won't help address these issues if they're not part of a more targeted approach that includes a better auditing system as well as ODM strengthen its systems to address waste and abuse, which this bill doesn't address.

SB 218 doesn't actually do anything to prevent fraud. In fact, without also addressing the broken Medicaid audit system the same issues will persist. The bill simply creates a mechanism for the state to recoup dollars from closing agencies that were put out of business by fines which were pulled out of thin air through AoS's "extrapolation" process. OCHCH and our members would very much like to have stronger mechanisms to reduce fraud and increase quality, but this bill doesn't create policy that gets us there.

Concerns with SB 218

Our members have two primary concerns with the current version of SB 218. First, it casts an unnecessarily wide net over all providers regardless of audit history or experience. While home health has become a target by state and federal policymakers to weed-out bad actors, we rarely hear about the good players and the good audits. There's simply an assumption that everyone is bad. In fact, in testimony given to this committee on May 15 by a representative from the AoS Office, it was said that "… we don't need to data mine, we are likely to find fraud by just random sampling providers." This is patently false, not to mention, offensive to agencies that have been in business for decades without any auditing issues.

Second, the bill requires training but it's not clear what the training would be for or how much would be required, other than to cover general Medicaid payment principles and provider agreement terms. Does ODM have the budget to train every provider that comes through the door? Beyond that, payment principles and provider agreement terms are fairly cut and dry and spelled out in statute and rule, so what would this training achieve? Audits look at billing documentation to verify payments, not at payments alone. Beyond that, if we want to ensure agency competency in specific areas, then we really should be looking at licensing home health agencies—which we're more than happy to discuss—not surety bonds and training.

Broken Audit Process

Recently, the Auditor of State's Office (AoS) has publicized numerous audit findings that levy huge fines against providers for noncompliance issues and improper payments making it seem as though these people are stealing from taxpayers. While there are certainly people that are committing fraud, the vast majority of these findings are related to issues with paperwork, not fraud. Despite knowing and being able to verify that these services are being provided, home health agencies are being publically humiliated as fraudulent characters. This is fundamentally wrong, yet the broken audit system allows this to happen.

The Auditor of State's Office regularly audits home health agencies throughout Ohio to ensure that agencies are following Medicaid rules and prevent fraud and abuse. After conducting an audit, the AoS refers any findings to ODM, where the Director of Medicaid determines if the state will move to collect the fines associated with violations.

Sometimes fines are well in excess of $1 million, and agencies are often forced to pay-back money that has nothing to do with the audit findings taking away resources that would have normally gone toward patient care. In the worst cases, patients are left without care when an agency closes due to huge fines that are not related to fraud. This process actually hurts quality rather than helps it.

There are several problems with this process including:

- *AoS is interpreting rules differently than ODM*—ODM is the regulator, not AoS, yet they are using their own interpretations (often inaccurately) to determine audit violations. Moreover, they do not explain to ODM how they are interpreting regulations so home health agencies are left to defend themselves.
- *AoS has broad authority to levy fines*—it's not clear exactly how AoS determines a fine. They use a method known as "extrapolation" that allows them to determine whatever

fine they want, even requiring repayment of legitimate payments for services that were already rendered.

- *AoS levies fines for issues that are clearly not fraud*—most of the violations and fines being levied on home health agencies are because of mistakes in paperwork, not fraud or abuse. Sadly, AoS often publicizes audits prior to their resolution claiming they committed fraud when that clearly wasn't the case, and thereby humiliating the agency.

- *Agencies hit with a fine have almost no options*— an agency is notified of a fine in writing, but has few options to contest the violations/fines. They can pay the fine in full, hire an attorney to fight the fine, or simply close their doors.

Overall, there is very little transparency in the auditing process. Not only is it unclear how and why violations and fines occur, but the full scope of the picture is withheld. For example, the testimony given on May 15th by the representative from AoS stated that "less than 10% of this money is successfully returned to the state" but failed to mention that these massive fines are putting people out of business and are being settled for a smaller amount.

Conclusion

Our members oppose SB 218 in its current form because it's unnecessarily broad and will not achieve what it intends to achieve—reduce fraud, waste and abuse. Our members are not entirely opposed to the idea of surety bonds, but without changes to the bill that will address the broken Medicaid audit system this becomes just another unfunded mandate that hurts businesses and those that rely on home health care. OCHCH looks forward to the opportunity to work with this committee and the bill sponsor to craft a bill that would take a targeted approach that goes after the bad guys and fixes the broken Medicaid audit systems.

Thank you again for allowing me to testify. I'm happy to answer any questions you may have at this time.