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TARIQ ABDULAZIZ, *

CLAIMANT, *

V. * FILE NO. 24260

STATE OF CONNECTICUT *

DEPARTMENT OF SOCIAL SERVICES, *

RESPONDENT. *

* * * * * * * * * * * * * * * * * * *

DEPOSITION OF KATHY A. BRUNI

Taken before Frances Teti Prentice, Licensed Shorthand Reporter 076 and Notary Public within and for the State of Connecticut, at the Office of the Attorney General, 55 Elm Street, Hartford, Connecticut, on October 27, 2016, commencing at 10:03 a.m.

APPEARANCES:

FOR THE CLAIMANT:

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FOR THE RESPONDENT:

STATE OF CONNECTICUT
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ALSO PRESENT:

Tariq Abdulaziz

STIPULATIONS

IT IS STIPULATED by counsel for the parties that each party reserves the right to make specific objections in open Court to each and every question asked and the answers given thereto by the witness, reserving the right to move to strike out where applicable, except as to such objections as are directed to the form of the question.

IT IS STIPULATED by counsel for the parties that the proof of the authority of the Notary Public before whom this deposition is taken is waived.

IT IS STIPULATED AND AGREED by counsel for the parties that any defects in the Notice are waived.

IT IS FURTHER STIPULATED by counsel for the parties that the reading and signing of the deposition are waived.

KATHY A. BRUNI,
of the Department of Social Services,
55 Farmington Avenue, Hartford,
Connecticut 06105, date of birth 3/4/54,
having first been duly sworn, was examined
and testified as follows:

DIRECT EXAMINATION

BY MR. KOGUT:

Q. Miss Bruni, would you just identify yourself for the record, please?

A. Kathy Bruni.

Q. I know that you said you preferred your -- first of all, let me ask you this: Have you been deposed before?

A. Yes.

Q. Okay. So you, I'm sure, appreciate the fact that I get to ask the questions and --

A. I get to answer.

Q. -- you get to answer. And if you don't understand my question or you want it repeated or rephrased, please by all means just ask, as long as we speak one at a time to make it much easier for the Court Reporter. That would be much easier.

You're here by reason of a deposition subpoena?

A. Yes.

Q. Okay. That was served upon you at your office or you received it at your office?

A. Yes.

Q. Okay. I'm just going to show you a copy of it. (Handing.) Is that the subpoena that you received to be here this morning?

A. Yes.

(Bruni Exhibit No. 1, subpoena, marked for identification.)

BY MR. KOGUT:

Q. If anything I ask you is objected to you by your counsel, unless he instructs you not to answer, I would like you to answer the question. If there is something that you need to consult with him about, please do.

My first question is, based on your preference of address, would you, for the record, tell us your address?

A. I would prefer not to give my personal residence in the presence of a provider.

Q. Why is that?

A. It's my personal preference.

Q. Is there a particular reason?

A. It's my personal preference. I'm uncomfortable with it.

Q. Okay. Would you describe your duties and responsibilities and what your position is within the Department of Social Services?

A. I'm the director of the Community Options Unit at the Department of Social Services, the Operations Unit. And in that role, I oversee the Medicaid waiver programs, and I have been responsible for the ABI 2 waiver program since December of 2014, which was its inception, and I also assumed responsibility for the ABI 1 June 1st of 2016.

Q. Just generally, how long have you been employed with the Department of Social Services?

A. Twelve years.

Q. And when were you -- when did you become a member of the Community Options Unit?

A. I came to the Community Options Unit in 2006, but it's been renamed several times and the responsibilities have changed.

Q. Okay. What title did you have when you came to the Unit in 2006?

A. Program manager.

Q. And did your title change after that?

A. Yes, it changed.

Q. If you could, just -- as best you remember, just go through the years and what the titles have been.

A. Okay. I was a Social Services program manager from 2006 to 2014, and in 2014 I became a director, program director.

Q. What director? I'm sorry.

A. Program director.

Q. Program director. And what was the difference between being a Social Services manager for eight years roughly from '06 to '14 and then program manager in '14?

A. Additional responsibilities.

Q. Okay. Let's start with Social Services manager. What were your responsibilities then?

A. I oversaw the preadmission screening program, the Home Care Program For Elders.

Q. So this preadmission screening and program for elders was just all -- that was all one or were there --

A. That's -- they're separate functions.

Q. Okay. So what category of individuals were you servicing in the pread --

A. Preadmission screening program is a federally mandated program that requires applicants to nursing homes be screened for the potential presence of a developmental disability or serious mental illness.

Q. So would it be fair to say that, from 2006 to

2014, you were dealing strictly with geriatrics?

A. Primarily geriatrics, yes.

Q. There are nongeriatrics who are admitted to nursing homes, correct?

A. It's just a screening program. I don't -- we have a contractor that's actually doing that, and I oversee the contract.

Q. Who did you oversee?

A. The contractor for that is Ascend Management.

Q. I'm sorry?

A. Ascend Management Innovations.

Q. A-S-C-E-N-D?

A. A-S-C-E-N-D, correct.

Q. Overseeing that, what were your actual duties and responsibilities?

A. Contract compliance, reports to CMS, Centers for Medicaid and Medicare Services.

Q. Prior to becoming Social Services manager in 2006, where were you employed and what were you doing?

A. I was employed by the Department from 2004 to 2006 as a program manager in the Social Work Division, and in that position I oversaw the personal care assistant waiver, so I did have responsibility for persons with physical disabilities who were under the age of 65.

Q. Could you explain that in more detail for me?

A. A personal care assistance waiver is a Medicaid waiver program that provides personal care attendant services to people with physical disabilities to provide for their activities of daily living and instrumental activities of daily living.

Q. So did you -- were you responsible for approving or hiring the PCAs?

A. I was not. It's a self-directed program, so the individual client or consumer is responsible for hiring the PCAs. My responsibility was oversight of the waiver program.

Q. I'm sorry. But could you just describe what that oversight is in a little more detail?

A. It's drafting the waiver document to submit to the Centers for Medicare and Medicaid Services for approval, monitoring the Department's compliance with the requirements in the waiver and the assurances in the waiver.

Q. In the Community Options Unit where you were employed, how many different waiver programs were there?

A. There's 11.

Q. Eleven. You said that rather quickly. Could you describe them, each?

A. Sure. There's -- the Department of Social

Services directly administers the Home Care Program For Elders, the personal care assistance waiver, the ABI Waiver 1, the ABI Waiver 2 and the Katie Becket waiver. The Katie Becket waiver is for medically fragile children. I also have managed that since it 2006, so I have a range of experience and responsibilities there.

Then there are three waivers operated by the Department of Developmental Services that the Department oversees, and that is the comprehensive waiver, the individual family support waiver, the employment and day supports waiver. And then there are two waivers for persons with autism spectrum disorder, one for children and one that's a lifespan waiver, and those were administered but -- administered by DSS but operated by DDS until July of 2016 when they transferred directly to my responsibility.

There's one other Medicaid waiver program that's a mental health waiver that I was instrumental in developing with the Department of Mental Health and Addiction Services, and that waiver is directly operated by the Department of Mental Health and Addiction Services but the administrative responsibility is with the Department.

Q. Do you have a staff?

A. No, I do it all myself. Yes, I do.

Q. I wouldn't be surprised in this day and age.

A. Getting close. Yes, I do have a staff.

Q. How many individuals?

A. There may be about 35. That's a guess. I'd have to actually --

Q. That's statewide?

A. It's within the central office.

Q. It's all in the central office?

A. All in the central office.

Q. Are you the direct supervisor of each of them?

A. No.

Q. Do you have managers that manage them?

A. Yes, I do.

Q. And they report to you?

A. Yes, they do.

Q. How many different reports do you have?

A. I have a public assistance consultant that reports to me, policy consultant. I have two managers and one nursing supervisor as well as an administrative assistant that report directly to me.

Q. Where were you employed prior to 2004?

A. I was employed by a community provider, Connecticut Community Care.

Q. Could you give me a brief description of your educational training post secondary school?

A. Sure. I have an undergraduate degree from what was St. Joseph College in social work. I have a graduate degree in social work from Southern Connecticut State University. I have a master's in public administration from the University of New Haven, and I'm a Licensed Clinical Social Worker.

Q. When did you receive your master's?

A. 1988.

Q. When were you licensed as a clinical social worker?

A. I'm guessing around 2000.

Q. Okay.

A. I'm not --

Q. That's okay.

A. I would have to pull it out and look.

Q. No, I'm not -- if that's the best memory you have, around 2000 --

A. It's been a while.

Q. Sure.

A. But it wasn't -- it wasn't right after. There was a gap of about ten years, I think.

Q. Can you describe for me the difference between ABI 1 and ABI 2?

A. Yes. There are some differences in the service array, and there's a difference in the permissible cost

cap for the service plans.

Q. Could you be a little more descriptive? When you say difference in the service array --

A. I think there's agency-based PCAs available under Waiver 2. Recovery assistant is available under Waiver 2. And the cost cap for Waiver 2 is a hundred and fifty percent of the institutional cost cap; whereas, Waiver 1, it's 200 percent.

Q. Can you describe for me the difference between these particular waiver programs and the direct provider relationships that DSS has with providers and provider agreements?

A. Could you repeat that, please.

Q. Sure. The difference between the waiver program or programs which you oversee and providers who provide other medical care and services pursuant to a provider agreement with the Department.

A. The requirements under both waivers of providers are the same. It's the same provider agreement.

Q. So what's the difference?

A. Does that answer --

Q. If that's your answer, that's fine.

What's the difference between a waiver program and a traditional provider?

MR. BARBER: By "traditional provider," do you mean a provider of waiver services?

MR. KOGUT: No, no, nonwaiver services.

BY MR. KOGUT:

Q. I'm trying to understand the difference between a waiver program and a nonwaiver program.

A. Okay. The difference between a waiver program and a nonwaiver program is a waiver program is something that the State applies to CMS for to offer nontraditional Medicaid services, so to offer services that are not available under the Medicaid State plan, and to target those services to a specific population.

Q. And when did you first become involved in the ABI waiver program?

A. I became involved with the ABI waiver program when Waiver 2 was initiated December 1, 2014.

Q. And what was the extent of your involvement beginning on December 1, 2014?

A. I was directly responsible for the social work staff that did the assessments and care plan development for those provide -- for those clients.

Q. Okay. Could you maybe just take some time and explain to me how that program worked and the interaction between social workers, clients, to the extent you call them clients -- I'm not sure what you

call them -- and other contractors? How does it all work?

A. Okay. We receive a referral for the program, and that referral could come from anywhere. We do a screening to determine a preliminary determination of functional and financial eligibility, confirmation of the brain injury, and then we would have a social worker go out to the home and assess the client and develop a service plan and provide options for those services to the consumer or their representative and implement the plan.

Q. When you say we provide a service plan, who is the "we"?

A. "We" is the Department.

Q. Okay. Do you have a head social worker who signs off on those or how does that work?

A. For the ABI 2 Waiver?

Q. Yes.

A. I had several staff members who were assigned to review the plans and to approve them.

Q. Because you weren't there for the ABI 1; were you?

A. When?

Q. Well, in -- you said you became program manager in 2014?

A. No, I became a director in 2014. I was a program manager in 2004 and 2006.

Q. I'm sorry; I thought you told me you were Social Services manager from '06 to '14 and then, '14, program director?

A. Program director, program director in 2014.

Q. What is the difference between a program director and a Social Services manager?

A. I had already explained that but it was more responsibilities, more staff.

Q. You supervised more staff and more programs?

A. Yep, yep.

Q. And I'm sorry if you've already described this, but can you explain to me the difference again between ABI 1 and 2? It's the difference in the service array, as you called it?

A. Right. There's some additional services available under ABI 2 that are not available under ABI 1, and there is a difference in the cost cap, which in ABI 1, the service plan cost cap is 200 percent of the average institutional cost and in ABI 2, it's 150 percent.

Q. And who makes the determination if someone qualifies for ABI 1 or ABI 2?

A. ABI 1 is currently closed to intake, so all

applicants are applying for ABI 2.

Q. So is that the opportunity to have more services, in ABI 2?

A. Different services, not more services.

Q. Is it more costly than ABI 1?

A. No, it's less costly because the cost cap is 150 percent, not 200 percent.

Q. Do you happen to know roughly in fiscal year 2016 how much the Department spent on the ABI waiver program?

A. Not offhand.

Q. Do you have a range, an idea of how much?

A. The average per participant was approximately $100,000 a year.

Q. When you say "per participant," how do you describe participant, a client?

A. We refer to them as participants or consumers, but it is synonymous with client.

Q. So roughly in 2016, the average, just an average, expenditure for each participant was about $100,000?

A. Right.

Q. Okay. And could you describe for me what individuals or vendors were receiving those funds?

A. Service providers that were credentialed and

enrolled as waiver providers that were authorized on the individual service plan were the ones who were paid for those services.

Q. And did you have any direct dealing at all with the actual service plans?

A. On ABI 2?

Q. Yes.

A. No.

Q. You don't have to approve them or review them?

A. As I said, I had several staff assigned who did those approvals.

Q. Right. But it ultimately didn't end up on your desk to sign off on or approve?

A. Not unless they had questions or concerns.

Q. What types of questions would be asked?

A. They might have questions about if that was the appropriate service, if there was a concern about the hours of service that were authorized. I was a resource to my staff.

Q. Did your -- do you call it a unit or department?

A. I call it a unit.

Q. Okay. Did your unit conduct audits?

A. We conduct audits of our access agency, our contracted access agencies, which are the providers of

case management services.

Q. Who was that in 2014?

A. It would be Connecticut Community Care, the Area Agency on Aging of South Central Connecticut. It would be Southwest Connecticut Agency on Aging and Western Connecticut Agency on Aging, but those audits were for the Home Care Program For Elders.

Q. Did you in 2014 conduct any audits of the ABI waiver program?

A. I did not.

Q. Did anyone in your department?

A. In DSS?

Q. Well, I assume that's where you're working. Yes.

A. I don't know when they conducted an audit specifically.

Q. If the audit was conducted, would you be consulted or would a report have been given to you, an audit report?

A. I would have seen results, yes.

Q. Do you have any memory today of seeing any such audits in 2014?

A. I don't recall that it was an audit. I think there was a complaint and an investigation.

Q. And do you know, during 2014 -- we'll call it

calendar year 2014, not fiscal year 2014 -- how many complaint investigations were conducted?

A. I don't know.

Q. Do you know if it's fewer than ten or more than ten?

A. I don't know.

Q. Who would have conducted the investigation?

A. The Quality Assurance Unit of the Department.

Q. Okay. That's Mr. McCormick's unit?

A. Yes.

Q. Would that be at your request or would the complaint come directly to Quality Assurance?

A. It would not have come through me. I had no responsibility for the program at that time.

Q. But whoever the complaining party was, would you not be interested in knowing if there is inadequate services being provided or too many services or your social worker staff isn't really paying attention? Wouldn't that be important to you?

A. Yes, it would.

Q. Okay. But you never received any outcome of these complaint investigations?

A. I think I did see the results.

Q. Did you ever take any particular action against any of your employees as a result of such

investigations?

A. I did not because they were not my employees at the time. As I said, I did not become responsible for the staff until December 1, 2014, and at that time there were only three staff responsible at that time.

Q. Okay. Well, how about 2015, calendar year 2015; do you recall any particular complaint investigations in 2015?

A. I do not.

Q. Do you recall taking any particular action against any employees or vendors as a result of any investigations?

A. I did not.

Q. I'm going to show you what's been previously marked in Mr. McCormick's deposition as Exhibit 1.

MR. KOGUT: Can we just keep it this way?

MR. BARBER: That's fine. Why don't we put McCormick 1 just so it's clear.

MR. KOGUT: Do you want to remark this McCormick 1? It just -- you know, it just gets confusing with the various --

MR. BARBER: Are these the originals?

MR. KOGUT: That's the original, yes.

MR. BARBER: I don't think you want to mark the originals.

MR. KOGUT: No, but she can mark the copy if you'd like, if that's what you're asking.

MR. BARBER: Yes.

MR. KOGUT: If you can, just remark this as McCormick Exhibit 1.

MR. BARBER: Oh, you're -- okay.

MR. KOGUT: Well, they're all copies, but this is the original.

MR. BARBER: Yes, yes.

(Off-the-record discussion.)

(McCormick Exhibit No. 1, ABI Waiver Program Provider Registry Application, marked for identification.)

BY MR. KOGUT:

Q. Could you just take your time to look at that, Miss Bruni? It is Miss or Mrs.?

A. Ms.

Q. Have you ever seen this document before?

A. I have -- yes, I have.

Q. Okay. But this -- was this document -- this document was completed prior to -- well, let me ask you this: Based on your review of the document, when was this completed?

A. Looks like it was completed in 2007.

Q. Okay. Well before you became involved in the ABI waiver program, correct?

A. Correct.

Q. Okay. So when would you have seen this document?

A. I think within the last year.

Q. Any particular reason that you remember why you would have reviewed this document?

A. Yes, because we were updating our provider enrollment process, so it would be important for me to look and see what was in place as we move forward.

Q. Okay. When you say we were updating the Provider Enrollment Agreement, who is the "we"?

A. The Department.

Q. Any particular individuals?

A. I worked with our legal department and our Provider Enrollment Unit that works with our claims processing entity, HP Enterprises, on the standard Medicaid Provider Enrollment Agreement.

Q. And what was your direct role in updating the Provider Enrollment Agreement?

A. We have a standard Medicaid Provider Enrollment Agreement. I had no role in modifying that or changing that whatsoever. We do have an addendum, a program-specific addendum to the Provider Enrollment

Agreement that all providers were asked to sign, similar as they were asked to sign in the elder waiver several years ago when we made that change.

Q. Okay. Let me just ask again, what was your direct involvement in updating the Provider Enrollment Agreement? If your answer is none, that's fine.

A. The Medicaid Provider Enrollment Agreement, I had no role in updating that.

Q. For the ABI waiver?

A. Oh, the ABI waiver? I didn't have any role in updating that. I wrote the addendum to the provider agreement this year.

Q. Okay. And what prompted you in the updating of the Provider Enrollment Agreement?

A. We -- as we manage waivers, what we had done with the Home Care Program For Elders several years ago, we were actually paying double. We were paying our access agencies who were doing case management to credential and enroll our providers and then the providers would bill them, so we'd be paying the access agencies to process claims. Then they would turn around and bill the Medicaid management information system to process claims, so we were double-paying for claims processing. And we also had inconsistencies among five agencies who were credentialing providers.

So we changed and had all of the providers sign the Medicaid standard Provider Enrollment Agreement and a program-specific addendum so all the providers directly enrolled as Medicaid providers and now bill directly to Medicaid.

Q. When you say you were double-paying, for which services --

A. Claims processing.

Q. I know, but which services, which social services were you paying the double payment? Was it for your elder --

A. The elder program, yes.

Q. Okay. When did that first come to your attention that the Department was overpaying?

A. I did not say we were overpaying. Let me explain it again.

Q. Well, you said double-paying.

A. No. Okay. We were double-paying for our claims processing process. We were paying our contracted case management entities to process claims who turned around and submitted those claims to the MMIS, so we were paying the MMIS to process claims. From a programmatic and fiscally responsible position, that makes no sense.

So we modified the waiver program when we were

doing the renewal, and we changed the way that we were enrolling and credentialing providers.

Q. And this first came to your attention with regard to the elder program?

A. It's not anything that came to my attention. It's the way we had operated for a number of years.

Q. Did you seek any recoupment or repayment for this so-called double payment?

A. They were not overpayments, sir.

Q. I said -- no. We can have your answer reread but you --

A. They were not -- I said the Department was paying twice for the claims processing function by paying the contracted access agency and the MMIS contractor. We eliminated the middleman; that's what we did.

Q. Did you seek any overpayment from any entity for paying twice?

A. No, of course not.

Q. How did that paying twice impact, if at all, the ABI waiver program for brain injuries?

A. The model that we developed for the claims processing under the Home Care Program For Elders to have a fiscal intermediary credential the provider and set up a system where the providers enroll directly with

Medicaid and bill the Medicaid management information system directly is the same model we have in place for our largest waiver program in the state, the Home Care Program For Elders. It makes sense. That was the best way to do the process.

Q. And whose policy decision was that?

A. The Department's.

Q. Any one particular individual?

A. No. It was a joint decision of the Department.

Q. Was there some kind of group or some kind of working group that reviewed this and made that decision?

A. Not really, no. I mean, it certainly was something we did -- I did in consultation with my director.

Q. Who was your director?

A. Kate McEvoy.

Q. What is her title?

A. Medicaid director.

Q. Who began the process of updating the enrollment agreement?

A. We did not change the Medicaid Enrollment Agreement. Providers were asked to sign the standard Medicaid Provider Agreement. It was not updated.

Q. Okay. Ms. Bruni, it's not my style to bicker with you, but you said that at some point the Department

began updating the Provider Enrollment Agreement.

A. I said I wrote the addendum to the Provider Enrollment Agreement.

Q. I understand that part. We're going to get to the addendum. I have it here.

A. Okay.

Q. But the addendum followed some decision to update the Provider Enrollment Agreement.

A. To change the way we did the Provider Enrollment Agreement from the fiscal intermediary to have the provider directly enroll with Medicaid as a provider the way we did it in other waivers.

Q. If you know, why up until that point in time weren't the providers directly enrolled?

A. I can't answer that because I wasn't responsible for the programs at that time prior.

Q. And there's nobody that you can identify within the Department that was responsible for initiating changing these particular providers to a direct Provider Enrollment Agreement?

A. Since I'm the director of waiver services and we had done this successfully with the Home Care For Elders Program providers, I made the recommendation to the Department that we do that also for the ABI providers and PCO.

Q. To whom individually did you make that recommendation?

A. My director, Kate McEvoy.

Q. Was that in writing?

A. No, not that I recall.

Q. Why not?

A. I can't answer. I don't know why not. We'd meet regularly and I discussed it with her.

Q. Was there any particular written review that led you to the recommendation of the direct provider enrollment?

A. Not that I recall.

Q. Did you believe it would save the Department money?

A. Yes.

Q. And how did you come to that conclusion?

A. Same thing, we were not paying the fiscal intermediary to process claims and paying the MMIS to reprocess the same claim.

Q. Did you conduct any particular written analyses?

A. I don't recall.

Q. If you did or had somebody on your behalf or direction conduct a written analysis, would that be contained in your department files?

A. I don't recall a written analysis. It's written into the waiver document. That's where it's written.

Q. I'm asking about the initial decision, the basis for the decision to have the direct provider enrollment --

A. The basis --

Q. Let me just finish.

-- after years and years of not conducting that program, that waiver that way.

A. The basis for that was what we had done with the Home Care Program For Elders and how successful that transition was to having the providers bill directly to Medicaid after signing a Medicaid Provider Enrollment Agreement, and the savings -- the contractual savings for not paying the access agencies to do that function was several million dollars.

MR. KOGUT: If you could, just mark this. This will be McCormick Exhibit 2.

(McCormick Exhibit No. 2, Allied Community Resources document, five pages, marked for identification.)

BY MR. KOGUT:

Q. If you could, just take your time and take a

look at that for me, Ms. Bruni. (Handing.)

A. Okay.

Q. Have you seen that document before?

A. I think I have seen -- I don't -- I've seen the document. I'm not sure if I saw it with necessarily this name but I've seen the document. I'm familiar with what it is, yeah.

Q. Was it just generally blank or --

A. Yeah.

Q. -- with a different agency name?

A. Blank, I think I have seen it.

Q. Okay. Did this -- was this reviewed by you in making a determination to change the enrollment process?

A. I was not involved in 2014.

Q. That wasn't my question.

A. Okay.

Q. My question was did you review this in making a determination to change the provider agreement process?

A. I'm sure I must have at some point.

Q. But you have no memory today of reviewing that?

A. I'm familiar with it so I must have reviewed it at some point.

Q. In making a recommendation to change the enrollment to have the providers enroll directly, what, if any, documents did you review?

A. I reviewed the addendum that we had done for the Home Care Program For Elders, and I reviewed the standard Medicaid provider agreement.

Q. Did you review any documents preparing for this deposition?

A. Yes.

Q. Could you tell me what those are?

A. The complaint, the regulations and some e-mails.

Q. And who were the e-mails from or to?

A. I believe they were from the Social Work Unit. It involved Dorian Long and Lara Stauning, who was the attorney who represented -- who worked with the Social Work Unit.

Q. What was the general substance of those communications?

A. The ones that I saw had to do with the program regulations.

Q. Roughly what time frame would those have been?

A. 2013.

Q. Was there any discussion in those communications regarding updating the Provider Enrollment Agreement?

A. Not that I recall.

Q. Other than speaking to your counsel, did you

have any discussions with anyone in preparation for this deposition?

A. No, I did not.

MR. KOGUT: I'll have this marked as McCormick Number 3.

(McCormick Exhibit No. 3, Allied Community Resources document, three pages, marked for identification.)

BY MR. KOGUT:

Q. Take your time and just look through what is now marked McCormick Exhibit Number 3. (Handing.)

A. Okay.

Q. Does this document look familiar, whether you've reviewed it in blank or with another agency contract name?

A. I don't recall this one.

Q. Okay. Would you agree with me that the signature is dated October 30, 2015?

A. Yes.

Q. That's nearly a year after you became director?

A. After I began responsibility for ABI Waiver 2.

Q. Right, as director?

A. Yes, yes.

Q. I believe you said December 1, 2014?

A. Correct.

Q. So this is nearly a year afterwards?

A. Yep.

Q. And is it your testimony that you never reviewed this particular document --

A. What I'm saying is I don't recall.

Q. If I could just finish the question.

Is it your testimony that you have no memory of reviewing this document in updating the Provider Enrollment Agreement which began in 2016?

A. I do not recall reviewing this document.

Q. Do you recall reviewing any other documents in working on your addendum for the 2016 provider enrollment?

A. Not anything in addition to what I've already stated.

Q. I saw you looking at the last page there. It's called Documentation For Cognitive Behavioral Programs. Do you see that page?

A. I do.

Q. Have you seen this before?

A. I'm not sure.

Q. Do you know what it is?

A. I'm thinking -- it's not a provider report. I don't know what it is. I don't know what it is.

Q. You've never seen anything like this?

A. I haven't seen anything in a long time. I don't know what this is.

Q. Certainly it's not something you reviewed in making a determination to have an updated Provider Enrollment Agreement?

A. No.

Q. Did you review any claims for the ABI waiver program participants or any other documents which had to do with reimbursement for that program before you updated the Provider Enrollment Agreement?

A. I don't routinely review claims, no.

Q. But was it --

A. I do get reports from the fiscal intermediary about the claims.

Q. Correct me if I'm wrong. Was it your testimony that one of the reasons for having direct provider enrollment was for cost savings?

A. The cost savings related to direct provider enrollment has to do with not paying the fiscal intermediary and the Medicaid management information system to both process the claims.

Q. So the answer is yes?

A. Yes.

Q. Okay. Thank you. Were you involved in

drafting or reviewing any particular policies and procedures related to the ABI waiver program?

A. I participated in the development of the newest regulations.

Q. And when were those promulgated?

A. May of 2016, with an effective date of July 1, 2016.

Q. And what was your -- what was your involvement, the extent of your involvement?

A. I worked with our legal department in the drafting of those regulations.

Q. And anyone in particular?

A. Michael Slitt.

Q. And was there anything that motivated the Department to promulgate new policies and procedures?

A. The ones that we had in place were outdated. We needed to reflect the changes with the Provider Enrollment Agreement, but most importantly we needed to get information into the regs regarding the CMS final rules that were issued in March of 2012. That was important to get information into the regs about the settings requirements that CMS had changed.

Q. Was it as important to make those changes in 2013?

A. I wasn't responsible for the program in 2013.

Q. That wasn't my question.

A. I can't answer the question because I wasn't responsible in 2013.

Q. Based on your years of experience, do you believe it would have been prudent to make those changes in 2013 if CMS made changes in 2012?

A. What I can say about the changes that CMS made in 2012 is that it's taken a couple of years to fully understand the implications of those changes, and waiting a couple of years to update the regulations has been very prudent because the direction has become clearer.

Q. Wasn't it four years, 2012 to 2016?

A. It took a while to get the regs drafted and we got the language into the regulations, which was part of our CMS transition plan. And, actually, the State has been demonstrated to other states, about the quality of the language we put in the regs, about the settings requirements as an example for other states to follow in their program regs, so to me what was important was to get it right.

Q. Do you have any written analyses or reviews that led you to offer new or promulgating new policies and procedures within your department?

A. Can you say that again, please.

Q. Any memoranda, writings, communications between and among people that resulted in the promulgation of new regulations?

A. There's probably e-mails.

Q. Probably or you believe that there are e-mails?

A. I believe -- we had to schedule meetings, so I'm sure there were.

Q. Who were part of those meetings?

A. It was Michael and myself, and I had staff members come in and out so . . .

Q. What level staff members?

A. Supervisory. And I also involved -- I have one nurse and one social worker who are assigned to reviewing the ABI 2 plans, so I involved them as well.

Q. Do you know how many providers signed the new Provider Enrollment Agreement for the ABI waiver program?

A. I believe they all did.

Q. I'll ask the question again. Do you know how many?

A. Offhand, no.

Q. Do you have a range?

A. I'm not going to guess at that.

Q. So you have no -- as director, you have no idea how many providers newly enrolled in 2016 for the ABI

waiver program?

A. I think there was somewhere between 80 and a hundred.

MR. KOGUT: Do you want to take some time?

MR. BARBER: Yes.

MR. KOGUT: Yes, why don't we break for a few minutes.

(Recess taken from 10:49 a.m. to 10:55 a.m.)

MR. KOGUT: Would you please read back the last question and answer.

(Whereupon, the record was read back by the Court Reporter.)

BY MR. KOGUT:

Q. At any time during your tenure here with regard to the ABI Medicaid waiver program, did you have any direct contact, either by e-mail or other communication, with the direct providers?

A. Yes.

Q. And how often would that occur and for what reasons?

A. It would occur if they reached out to me. It's happened quite a bit in the last few months around a couple of issues. They have questions about the -- they had questions about the enrollment and they have

questions about the electronic visit verification system that the State is beginning.

Q. Okay. Did you have or do you have any role in the actual creation or reviewing of the service plans?

A. I do not.

Q. Who would be responsible for that?

A. Depending on the time frame you're talking about, it was the DSS social workers in the past. Currently it is access agency care managers who are developing the service plans.

Q. And are you familiar with the codes, the billing codes, that the ABI Waiver -- Medicaid waiver program providers were requested or asked to use?

A. I don't know the procedure codes off the top of my head.

Q. I'm not asking for the numbers, the CPT codes. I'm just asking if you're familiar with them.

A. There are procedure codes associated with each service, yes.

Q. At some point during your tenure, did they change?

A. Yes.

Q. And when was that and what was the reason?

A. We added a second procedure code to the cognitive behavioral service provider to accommodate the

distinction between the service being provided in person, face-to-face, and the sometimes follow-up or phone calls that occurred.

Q. Did you, during the course of your tenure regarding the ABI Medicaid waiver program, send out I'll refer to it as a blast e-mail to all providers with certain announcements or transmittal notices or anything like that?

A. Yes. And there also are important messages and provider bulletins that are on the HPE web site, so that's the standard means of communication.

Q. Okay. Are you familiar with the process in 2015 -- I understand your dates that you gave to us but -- the recredentialing process in 2015?

A. Yes.

Q. Is it fair to say it was the spring of 2015?

A. I don't recall exactly. But as part of the waiver, CMS was looking for us to recredential providers at a minimum of every two years.

Q. And did you initiate that process?

A. I changed it in the waiver. I believe the process initiated in Quality Assurance.

Q. Okay. And that was shortly after you became program director?

A. Yes.

Q. Because you became program director December 1st of 2014?

A. I was a program director I think sooner than that, but I assumed the responsibility for the ABI Waiver 2 December 1, 2014.

Q. Okay. And was part of your responsibility in accepting that or taking that role in December of 2014 to implement the recredentialing process?

A. Yes.

Q. And what did that consist of?

A. When we talk about credentialing, we talk about the service definition and credentials specified in the waiver document itself. And every two years, we ask our fiscal intermediary to verify that the provider meets those credentials. That's at the point of enrollment and every two years thereafter.

Q. Would it be fair to say, with the new provider agreement, you no longer have an intermediary?

A. That's not correct. We still have a fiscal intermediary. The fiscal intermediary continues to do the credentialing, and then they issue a credentialing letter that the provider uses to re-enroll with the MMIS system.

Q. Are you familiar, during your tenure with any -- I may have asked this, excuse me, but any

requests for recoupment for overpayments for either the misuse of coding or overcoding of the ABI waiver program providers?

A. I have heard that there have been some requests for repayment, but I wasn't -- that was not since I've been a director. They predated me.

Q. Who would you hear that from? Was that just --

A. I actually had heard it from a client about one of their providers.

Q. Were they complaining?

A. No. They were complaining about the provider. They weren't complaining about the process.

Q. Oh, okay. So if I understand you correctly, your intermediary would still be responsible for recredentialing your providers?

A. Yes.

MR. KOGUT: This is McCormick Exhibit Number 4.

(McCormick Exhibit No. 4, Connecticut Department of Social Services Medical Assistance Program Provider Enrollment Application, marked for identification.)

BY MR. KOGUT:

Q. Do you want to take the time to go through that

and see if you're familiar with it?

A. I know what it is.

Q. I know you know what it is. But do you want to take some time to go through it?

A. Okay.

Q. So what is it?

A. It's the standard Medicaid Provider Enrollment Agreement.

Q. Is this something that was used and adapted to the ABI waiver program?

A. The Medicare Provider Enrollment Application that the ABI providers do is an online application, and I haven't gotten into the online application. But I believe this is, you know, everything that's included in it.

Q. And is this the document that's a result of the impetus to update the enrollment agreement and have providers directly enroll?

A. This is the document that the providers would utilize to directly enroll, yes.

Q. Is this the first time that they were ever required to directly enroll?

A. The ABI providers?

Q. Correct.

A. Yes, unless they were providing other services

already as a Medicaid provider, which some of them are.

Q. When's the first time you saw this document?

A. Probably when we were going to make the changeover.

Q. Which would have been roughly when, late 2015?

A. Probably.

Q. Okay. And were you asked to participate in any way in this new application?

A. In this?

Q. Yes. I know you call it --

A. No. I had no -- I have no -- this is a standard Medicaid Provider Enrollment Agreement. I have nothing to say about this.

Q. You participated in the addendum?

A. The addendum, yes.

Q. Okay. And would you explain to me what the addendum consisted of?

A. The addendum is program-specific information as it pertains to the waiver program. I mean, this -- this covers a physician. It covers a hospital.

Q. Right.

A. It covers a range of providers. But there certainly is nothing specific in here about programmatic requirements of a waiver, so that's why we did an addendum.

Q. Do you know if there are any significant differences between the 2015 provider agreement through the intermediary that you've looked at and this new provider enrollment application?

MR. BARBER: Which exhibit number are you referring to?

MR. KOGUT: It would be the 2015 --

A. This one?

BY MR. KOGUT:

Q. Number 3.

A. 10/30/15?

Q. Yes.

A. Okay. Certainly the Medicaid provider agreement is a more comprehensive document.

Q. As far as program requirements go for the ABI waiver providers, was there any significant change, whether in billing or use of units, between 2015 and 2016?

A. In terms of the billing, the billing changed in 2016, July 1, 2016, where they're billing the MMIS directly. In the year before is when we changed and added the second procedure code for the cognitive behavioral service to differentiate between the in-person and the non in-person service.

Q. And what was the difference between the

in-person and non in-person?

A. In terms of the rate difference or in terms of what's the difference?

Q. Both the rate and -- the rate, the difference and the reason for the change.

A. The reason for the change is there was -- we really felt that there needed to be a distinction as the service was being provided both in person, face-to-face in the presence of the client directly, and then ancillary type of calls, other consultations with providers that might take place on the phone or via e-mail or a contact with a client that was not in person. So we increased the rate for the in-person service and decreased the rate for the non face-to-face.

Q. Was there any --

A. And made quarter-hour units for the non face-to-face.

Q. So there was a change in units?

A. Yes. No, a change in the billing units.

Q. The reimbursement for units?

A. It was a change in the ability to bill a -- the unit became defined as a quarter-hour as opposed to a unit.

Q. Would it be fair to say that prior to that, a unit was one hour?

A. A unit was a unit. You would presume it to be an hour, so that if somebody were billing -- if somebody were providing five minutes of service, they could potentially bill a unit.

Q. And that was accepted by the Department; was it not?

A. Up until we made the change --

Q. Correct.

A. -- yes.

Q. But for years it had been a single unit, whether it was 15 minutes or whether it was one hour?

A. Correct.

Q. And was there any -- ever any audits conducted in reviewing clinical notes or charts or billing to determine actually how much time was being spent for one unit?

A. I would not -- I didn't conduct any audit, so I don't know the answer to that.

Q. Did any audits ever come across your desk which indicated that providers were billing for that one-hour unit and providing services for 15 minutes or less?

A. I don't know how we would know that in an audit if somebody wasn't recording time.

Q. Well, I asked about reviewing documentation, clinical charts and otherwise, to make that

determination.

A. I did not do those audits.

Q. The question was do you recall seeing any come across your desk?

A. I did see some information come across my desk.

Q. What was that information?

A. It was a result of an investigation following a complaint.

Q. A complaint from a consumer?

A. I don't believe it was a consumer.

Q. A competitor?

A. I don't believe it was a competitor.

Q. Internally?

A. No.

Q. What's the difference in reimbursement now on the one-hour unit versus the 15-minute unit? Or is it divided by four?

A. The one-hour unit is 105, $105. That's for the in-person, face-to-face. The non face-to-face is $78 an hour, which I think breaks down to 19.50 per quarter-hour.

Q. And do the social workers review the providers having a face-to-face or non face-to-face?

A. Generally, the face-to-face is in a team meeting, so the social worker would be there; a case or

care manager would be there. The way the services are authorized, it's authorized under the procedure code at the 105, that procedure code, and then the billing will accept either that procedure code or the other procedure code. So it's like a pick group, if that makes sense.

Q. Has the Department set a policy now preventing the providers from directly participating in team meetings?

A. Would you repeat that?

MR. KOGUT: Would you read it back?

(Whereupon, the record was read back by the Court Reporter.)

A. Absolutely not. Providers are expected to be present for team meetings. That's the purpose of a team meeting.

BY MR. KOGUT:

Q. And if I understand you correctly, there's no program in place to review, for clinical reasons, whether the face-to-face or non face-to-face was clinically appropriate?

A. I'm not sure I understand your question. I'm sorry.

Q. Sure. If a provider believed that it was important for clinical reasons to spend time face-to-face with the consumer, does the Department at

any time make a determination that that was clinically inappropriate and will pay for the non face-to-face instead of the face-to-face?

A. No, actually just the opposite. We put a requirement in the waiver that the cognitive behavioral provider should see the client face-to-face at least quarterly.

Q. Right. But you said that was only in team meetings.

A. It's face-to-face.

Q. Right. But only team meetings, not --

A. Not only team meetings. But, I mean, the --

Q. What would be the other face-to-face meetings?

A. If they met independently with the client.

Q. And did the Department review those clinical decisions made by the provider to meet face-to-face outside a team meeting?

A. No.

Q. Never has?

A. Not that I'm aware of.

Q. Never questioned a provider's --

A. I mean -- well, absolutely.

Q. Never questioned a provider's use of the face-to-face, one-hour unit?

A. It's the responsibility of the care manager to

develop a service plan and authorize the hours of service. So they would, in fact, ask questions about the service, what's being delivered, what's the rationale for the hours. That's what they're being paid to do.

Q. Is the unit -- billing of units in the actual service plan?

A. No. As I -- the number of units for the service for the month is authorized in the service plan, yes.

Q. That's determined by a social worker?

A. At a team meeting, yes.

Q. In consultation with the consumer --

A. Yep.

Q. -- and/or his representative or her representative and the provider?

A. Yes.

Q. Okay. If you just give me two minutes, I might wrap up.

A. Okay.

(Whereupon, a recess was taken from 11:16 a.m. to 11:17 a.m.)

BY MR. KOGUT:

Q. Ms. Bruni, is it your testimony that the non face-to-face unit policy is in the service plan?

A. No. The service plan doesn't have a policy. The non face-to -- the differentiation between the face-to-face and the non face-to-face distinction as to the service is spelled out in the Medicaid waiver application itself. The service plan gives a number of units of cognitive behavioral service, and then it's up to the provider how those units get utilized over the course of the month, whether it be, you know, how many hours of face-to-face and how many of non face-to-face.

Q. And I believe it was your testimony that there hasn't really been a problem within the Department about I'll call it overutilization of the non face-to-face -- or the face-to-face?

A. I didn't say that.

Q. Has there been?

A. It's certainly something that's a concern.

Q. To whom?

A. To me.

Q. Okay. What is the concern?

A. Concern that there may be overutilization.

Q. Have you conducted any audits to satisfy that concern?

A. I have not.

Q. Have you referred anything to QA to satisfy that concern?

A. I have not.

Q. Is there a requirement to have an actual written service plan?

A. Yes.

Q. Is it a requirement to have the service plan distributed to the provider?

A. Yes.

Q. And is there a requirement to have a provider sign the service plan?

A. No.

Q. Why not?

A. The client signs the service plan.

Q. And why not the provider?

A. The requirement is that the client sign the service plan.

Q. Does the client do it in consultation with the provider?

A. The client chooses their provider and the provider is listed on the service plan.

Q. Right. But in terms of what the service plan is going to be, does the client consult the provider to determine whether he or she is receiving adequate services in the service plan?

A. That would be something that would be discussed at a team meeting, and it would be discussed between the

care manager and the client and their representative at reassessment.

Q. Fair to say that you're dealing with a population with diminished mental capacity?

A. Yes.

Q. Is it your testimony that the Department can rely on what the client or the consumer wants?

A. This is a person-centered planning model. It involves the input of the consumer to the maximum extent possible. If they have a representative, we involve the representative, whether that be a conservator or family member.

Q. It's your testimony that of the 80 to 100 providers, each of them receive a copy of the service plan for every one of their consumers?

A. They need to know what services they're authorized to provide.

Q. That wasn't the question. The question was is it your testimony that all the providers are provided with a copy of the service plan for each of their clients?

A. They should be.

Q. Are they?

A. As far as I know.

Q. Have you had any complaints from any providers

that they weren't adequately or timely receiving such service plans?

A. Not since I've taken over.

Q. Okay. Thank you.

MR. KOGUT: I have no other questions.

MR. BARBER: No questions.

(Whereupon the deposition was concluded and the witness excused at 11:21 a.m.)

CERTIFICATE OF REPORTER

I, Frances Teti Prentice, Licensed Shorthand Reporter 076 and Notary Public duly commissioned and qualified in and for the State of Connecticut, do hereby certify that there came before me on October 27, 2106 the following named person, to wit: KATHY A. BRUNI, who was by me duly sworn to testify to the truth and nothing but the truth; that she was thereupon carefully examined upon her oath and her examination reduced to writing under my supervision; that this deposition is a true record of the testimony given by the witness.

I further certify that I am neither attorney nor counsel for nor related to nor employed by any of the parties to the action in which this deposition is taken and, further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto, nor financially interested in the action.

IN WITNESS THEREOF, I have hereunto set my hand and affixed my seal this 3rd day of November, 2016.

s/s _____

Frances Teti Prentice, Notary Public

My Commission expires: 3/31/2019

License expires: 12/2016

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Allied Community Resources document, three pages

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Connecticut Department of Social Services Medical Assistance Program Provider Enrollment Application

- END OF EXHIBIT INDEX -

- ORIGINAL EXHIBITS HELD BY MR. KOGUT -

STATE OF CONNECTICUT
OFFICE OF THE CLAIMS COMMISSIONER

****
TARIQ ABDULAZIZ, *
CLAIMANT, *
V * FILE NO 24260
STATE OF CONNECTICUT *
DEPARTMENT OF SOCIAL SERVICES, *
RESPONDENT *
****

DEPOSITION OF KATHY A. BRUNI

Taken before Frances Teti Prentice, Licensed Shorthand Reporter 076 and Notary Public within and for the State of Connecticut, at the Office of the Attorney General, 55 Elm Street, Hartford, Connecticut, on October 27, 2016, commencing at 10 03 a.m.

APPEARANCES

FOR THE CLAIMANT·
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ALSO PRESENT
Tariq Abdulaziz

STIPULATIONS

IT IS STIPULATED by counsel for the parties that each party reserves the right to make specific objections in open Court to each and every question asked and the answers given thereto by the witness, reserving the right to move to strike out where applicable, except as to such objections as are directed to the form of the question.

IT IS STIPULATED by counsel for the parties that the proof of the authority of the Notary Public before whom this deposition is taken is waived.

IT IS STIPULATED AND AGREED by counsel for the parties that any defects in the Notice are waived.

IT IS FURTHER STIPULATED by counsel for the parties that the reading and signing of the deposition are waived.

KATHY A. BRUNI,
of the Department of Social Services,
55 Farmington Avenue, Hartford,
Connecticut 06105, date of birth 3/4/54,
having first been duly sworn, was examined
and testified as follows

DIRECT EXAMINATION

BY MR. KOGUT·

Q. Miss Bruni, would you just identify yourself for the record, please?

A. Kathy Bruni

Q. I know that you said you preferred your -- first of all, let me ask you this: Have you been deposed before?

A. Yes.

Q. Okay. So you, I'm sure, appreciate the fact that I get to ask the questions and --

A. I get to answer

Q. -- you get to answer. And if you don't understand my question or you want it repeated or rephrased, please by all means just ask, as long as we speak one at a time to make it much easier for the Court Reporter. That would be much easier.

You're here by reason of a deposition subpoena?

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A. Yes.
Q. Okay. That was served upon you at your office or you received it at your office?
A. Yes
Q. Okay. I'm just going to show you a copy of it. (Handing.) Is that the subpoena that you received to be here this morning?
A. Yes
(Bruni Exhibit No 1, subpoena, marked for identification)
BY MR. KOGUT·
Q. If anything I ask you is objected to you by your counsel, unless he instructs you not to answer, I would like you to answer the question. If there is something that you need to consult with him about, please do.
My first question is, based on your preference of address, would you, for the record, tell us your address?
A I would prefer not to give my personal residence in the presence of a provider
Q. Why is that?
A. It's my personal preference.
Q. Is there a particular reason?

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A. It's my personal preference. I'm uncomfortable with it.
Q. Okay. Would you describe your duties and responsibilities and what your position is within the Department of Social Services?
A. I'm the director of the Community Options Unit at the Department of Social Services, the Operations Unit. And in that role, I oversee the Medicaid waiver programs, and I have been responsible for the ABI 2 waiver program since December of 2014, which was its inception, and I also assumed responsibility for the ABI 1 June 1st of 2016
Q. Just generally, how long have you been employed with the Department of Social Services?
A. Twelve years
Q. And when were you -- when did you become a member of the Community Options Unit?
A. I came to the Community Options Unit in 2006, but it's been renamed several times and the responsibilities have changed.
Q. Okay. What title did you have when you came to the Unit in 2006?
A. Program manager
Q. And did your title change after that?
A. Yes, it changed.

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Q. If you could, just -- as best you remember, just go through the years and what the titles have been.
A. Okay I was a Social Services program manager from 2006 to 2014, and in 2014 I became a director, program director
Q. What director? I'm sorry.
A. Program director
Q. Program director. And what was the difference between being a Social Services manager for eight years roughly from '06 to '14 and then program manager in '14?
A. Additional responsibilities
Q. Okay. Let's start with Social Services manager. What were your responsibilities then?
A. I oversaw the preadmission screening program, the Home Care Program For Elders.
Q. So this preadmission screening and program for elders was just all -- that was all one or were there --
A. That's -- they're separate functions
Q. Okay. So what category of individuals were you servicing in the pread --
A Preadmission screening program is a federally mandated program that requires applicants to nursing homes be screened for the potential presence of a developmental disability or serious mental illness.
Q. So would it be fair to say that, from 2006 to

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2014, you were dealing strictly with geriatrics?
A. Primarily geriatrics, yes.
Q. There are nongeriatrics who are admitted to nursing homes, correct?
A. It's just a screening program. I don't -- we have a contractor that's actually doing that, and I oversee the contract.
Q. Who did you oversee?
A The contractor for that is Ascend Management.
Q. I'm sorry?
A Ascend Management Innovations.
Q. A-S-C-E-N-D?
A. A-S-C-E-N-D, correct
Q. Overseeing that, what were your actual duties and responsibilities?
A Contract compliance, reports to CMS, Centers for Medicaid and Medicare Services.
Q. Prior to becoming Social Services manager in 2006, where were you employed and what were you doing?
A. I was employed by the Department from 2004 to 2006 as a program manager in the Social Work Division, and in that position I oversaw the personal care assistant waiver, so I did have responsibility for persons with physical disabilities who were under the age of 65

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Q. Could you explain that in more detail for me?
A. A personal care assistance waiver is a Medicaid waiver program that provides personal care attendant services to people with physical disabilities to provide for their activities of daily living and instrumental activities of daily living.
Q. So did you -- were you responsible for approving or hiring the PCAs?
A. I was not. It's a self-directed program, so the individual client or consumer is responsible for hiring the PCAs. My responsibility was oversight of the waiver program.
Q. I'm sorry. But could you just describe what that oversight is in a little more detail?
A. It's drafting the waiver document to submit to the Centers for Medicare and Medicaid Services for approval, monitoring the Department's compliance with the requirements in the waiver and the assurances in the waiver
Q. In the Community Options Unit where you were employed, how many different waiver programs were there?
A. There's 11
Q. Eleven. You said that rather quickly. Could you describe them, each?
A. Sure. There's -- the Department of Social

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Services directly administers the Home Care Program For Elders, the personal care assistance waiver, the ABI Waiver 1, the ABI Waiver 2 and the Katie Becket waiver The Katie Becket waiver is for medically fragile children. I also have managed that since it 2006, so I have a range of experience and responsibilities there
Then there are three waivers operated by the Department of Developmental Services that the Department oversees, and that is the comprehensive waiver, the individual family support waiver, the employment and day supports waiver And then there are two waivers for persons with autism spectrum disorder, one for children and one that's a lifespan waiver, and those were administered but -- administered by DSS but operated by DDS until July of 2016 when they transferred directly to my responsibility
There's one other Medicaid waiver program that's a mental health waiver that I was instrumental in developing with the Department of Mental Health and Addiction Services, and that waiver is directly operated by the Department of Mental Health and Addiction Services but the administrative responsibility is with the Department.
Q. Do you have a staff?
A. No, I do it all myself Yes, I do.

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Q. I wouldn't be surprised in this day and age.
A. Getting close. Yes, I do have a staff.
Q. How many individuals?
A. There may be about 35 That's a guess I'd have to actually --
Q. That's statewide?
A. It's within the central office
Q. It's all in the central office?
A. All in the central office.
Q. Are you the direct supervisor of each of them?
A. No
Q. Do you have managers that manage them?
A Yes, I do.
Q. And they report to you?
A. Yes, they do
Q. How many different reports do you have?
A. I have a public assistance consultant that reports to me, policy consultant. I have two managers and one nursing supervisor as well as an administrative assistant that report directly to me
Q. Where were you employed prior to 2004?
A. I was employed by a community provider, Connecticut Community Care.
Q. Could you give me a brief description of your educational training post secondary school?

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A. Sure. I have an undergraduate degree from what was St. Joseph College in social work. I have a graduate degree in social work from Southern Connecticut State University I have a master's in public administration from the University of New Haven, and I'm a Licensed Clinical Social Worker
Q. When did you receive your master's?
A. 1988
Q. When were you licensed as a clinical social worker?
A. I'm guessing around 2000
Q. Okay.
A I'm not --
Q. That's okay.
A. I would have to pull it out and look.
Q. No, I'm not -- if that's the best memory you have, around 2000 --
A. It's been a while.
Q. Sure.
A. But it wasn't -- it wasn't right after There was a gap of about ten years, I think.
Q. Can you describe for me the difference between ABI 1 and ABI 2?
A. Yes There are some differences in the service array, and there's a difference in the permissible cost

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cap for the service plans
Q. Could you be a little more descriptive? When you say difference in the service array --
A. I think there's agency-based PCAs available under Waiver 2 Recovery assistant is available under Waiver 2 And the cost cap for Waiver 2 is a hundred and fifty percent of the institutional cost cap, whereas, Waiver 1, it's 200 percent.
Q. Can you describe for me the difference between these particular waiver programs and the direct provider relationships that DSS has with providers and provider agreements?
A. Could you repeat that, please.
Q. Sure. The difference between the waiver program or programs which you oversee and providers who provide other medical care and services pursuant to a provider agreement with the Department.
A. The requirements under both waivers of providers are the same. It's the same provider agreement.
Q. So what's the difference?
A. Does that answer --
Q. If that's your answer, that's fine.
What's the difference between a waiver program and a traditional provider?

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MR. BARBER. By "traditional provider," do you mean a provider of waiver services?
MR. KOGUT: No, no, nonwaiver services
BY MR. KOGUT:
Q. I'm trying to understand the difference between a waiver program and a nonwaiver program.
A. Okay The difference between a waiver program and a nonwaiver program is a waiver program is something that the State applies to CMS for to offer nontraditional Medicaid services, so to offer services that are not available under the Medicaid State plan, and to target those services to a specific population.
Q. And when did you first become involved in the ABI waiver program?
A I became involved with the ABI waiver program when Waiver 2 was initiated December 1, 2014
Q. And what was the extent of your involvement beginning on December 1, 2014?
A. I was directly responsible for the social work staff that did the assessments and care plan development for those provide -- for those clients
Q. Okay. Could you maybe just take some time and explain to me how that program worked and the interaction between social workers, clients, to the extent you call them clients -- I'm not sure what you

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call them -- and other contractors? How does it all work?
A. Okay We receive a referral for the program, and that referral could come from anywhere. We do a screening to determine a preliminary determination of functional and financial eligibility, confirmation of the brain injury, and then we would have a social worker go out to the home and assess the client and develop a service plan and provide options for those services to the consumer or their representative and implement the plan.
Q. When you say we provide a service plan, who is the "we"?
A. "We" is the Department.
Q. Okay. Do you have a head social worker who signs off on those or how does that work?
A. For the ABI 2 Waiver?
Q. Yes.
A. I had several staff members who were assigned to review the plans and to approve them.
Q. Because you weren't there for the ABI 1; were you?
A When?
Q. Well, in -- you said you became program manager in 2014?

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A. No, I became a director in 2014. I was a program manager in 2004 and 2006
Q. I'm sorry; I thought you told me you were Social Services manager from '06 to '14 and then, '14, program director?
A. Program director, program director in 2014
Q. What is the difference between a program director and a Social Services manager?
A I had already explained that but it was more responsibilities, more staff
Q. You supervised more staff and more programs?
A. Yep, yep
Q. And I'm sorry if you've already described this, but can you explain to me the difference again between ABI 1 and 2? It's the difference in the service array, as you called it?
A. Right. There's some additional services available under ABI 2 that are not available under ABI 1, and there is a difference in the cost cap, which in ABI 1, the service plan cost cap is 200 percent of the average institutional cost and in ABI 2, it's 150 percent.
Q. And who makes the determination if someone qualifies for ABI 1 or ABI 2?
A. ABI 1 is currently closed to intake, so all

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applicants are applying for ABI 2.
Q. So is that the opportunity to have more services, in ABI 2?
A. Different services, not more services
Q. Is it more costly than ABI 1?
A. No, it's less costly because the cost cap is 150 percent, not 200 percent.
Q. Do you happen to know roughly in fiscal year 2016 how much the Department spent on the ABI waiver program?
A. Not offhand.
Q. Do you have a range, an idea of how much?
A. The average per participant was approximately $100,000 a year
Q. When you say "per participant," how do you describe participant, a client?
A. We refer to them as participants or consumers, but it is synonymous with client.
Q. So roughly in 2016, the average, just an average, expenditure for each participant was about $100,000?
A. Right.
Q. Okay. And could you describe for me what individuals or vendors were receiving those funds?
A. Service providers that were credentialed and

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enrolled as waiver providers that were authorized on the individual service plan were the ones who were paid for those services
Q. And did you have any direct dealing at all with the actual service plans?
A. On ABI 2?
Q. Yes.
A. No
Q. You don't have to approve them or review them?
A. As I said, I had several staff assigned who did those approvals
Q. Right. But it ultimately didn't end up on your desk to sign off on or approve?
A. Not unless they had questions or concerns.
Q. What types of questions would be asked?
A. They might have questions about if that was the appropriate service, if there was a concern about the hours of service that were authorized. I was a resource to my staff.
Q. Did your -- do you call it a unit or department?
A. I call it a unit.
Q. Okay. Did your unit conduct audits?
A We conduct audits of our access agency, our contracted access agencies, which are the providers of

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case management services.
Q. Who was that in 2014?
A. It would be Connecticut Community Care, the Area Agency on Aging of South Central Connecticut. It would be Southwest Connecticut Agency on Aging and Western Connecticut Agency on Aging, but those audits were for the Home Care Program For Elders.
Q. Did you in 2014 conduct any audits of the ABI waiver program?
A. I did not.
Q. Did anyone in your department?
A. In DSS?
Q. Well, I assume that's where you're working. Yes.
A. I don't know when they conducted an audit specifically
Q. If the audit was conducted, would you be consulted or would a report have been given to you, an audit report?
A. I would have seen results, yes.
Q. Do you have any memory today of seeing any such audits in 2014?
A. I don't recall that it was an audit. I think there was a complaint and an investigation.
Q. And do you know, during 2014 -- we'll call it

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calendar year 2014, not fiscal year 2014 -- how many complaint investigations were conducted?
A. I don't know
Q. Do you know if it's fewer than ten or more than ten?
A I don't know
Q. Who would have conducted the investigation?
A. The Quality Assurance Unit of the Department.
Q. Okay. That's Mr. McCormick's unit?
A. Yes.
Q. Would that be at your request or would the complaint come directly to Quality Assurance?
A. It would not have come through me. I had no responsibility for the program at that time
Q. But whoever the complaining party was, would you not be interested in knowing if there is inadequate services being provided or too many services or your social worker staff isn't really paying attention? Wouldn't that be important to you?
A Yes, it would.
Q. Okay. But you never received any outcome of these complaint investigations?
A. I think I did see the results.
Q. Did you ever take any particular action against any of your employees as a result of such

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investigations?
A. I did not because they were not my employees at the time. As I said, I did not become responsible for the staff until December 1, 2014, and at that time there were only three staff responsible at that time.
Q. Okay. Well, how about 2015, calendar year 2015; do you recall any particular complaint investigations in 2015?
A. I do not.
Q. Do you recall taking any particular action against any employees or vendors as a result of any investigations?
A. I did not.
Q. I'm going to show you what's been previously marked in Mr. McCormick's deposition as Exhibit 1.
MR. KOGUT: Can we just keep it this way?
MR. BARBER. That's fine Why don't we put McCormick 1 just so it's clear
MR. KOGUT Do you want to remark this McCormick 1? It just -- you know, it just gets confusing with the various --
MR. BARBER. Are these the originals?
MR. KOGUT: That's the original, yes.
MR. BARBER. I don't think you want to mark the originals.

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MR. KOGUT: No, but she can mark the copy if you'd like, if that's what you're asking.
MR. BARBER. Yes
MR. KOGUT: If you can, just remark this as McCormick Exhibit 1
MR. BARBER. Oh, you're -- okay
MR. KOGUT: Well, they're all copies, but this is the original
MR. BARBER. Yes, yes.
(Off-the-record discussion.)
(McCormick Exhibit No 1, ABI Waiver Program Provider Registry Application, marked for identification.)
BY MR. KOGUT:
Q. Could you just take your time to look at that, Miss Bruni? It is Miss or Mrs.?
A. Ms.
Q. Have you ever seen this document before?
A I have -- yes, I have
Q. Okay. But this -- was this document -- this document was completed prior to -- well, let me ask you this: Based on your review of the document, when was this completed?
A. Looks like it was completed in 2007

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Q. Okay. Well before you became involved in the ABI waiver program, correct?
A. Correct.
Q. Okay. So when would you have seen this document?
A. I think within the last year
Q. Any particular reason that you remember why you would have reviewed this document?
A. Yes, because we were updating our provider enrollment process, so it would be important for me to look and see what was in place as we move forward.
Q. Okay. When you say we were updating the Provider Enrollment Agreement, who is the "we"?
A. The Department.
Q. Any particular individuals?
A. I worked with our legal department and our Provider Enrollment Unit that works with our claims processing entity, HP Enterprises, on the standard Medicaid Provider Enrollment Agreement.
Q. And what was your direct role in updating the Provider Enrollment Agreement?
A We have a standard Medicaid Provider Enrollment Agreement. I had no role in modifying that or changing that whatsoever We do have an addendum, a program-specific addendum to the Provider Enrollment

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Agreement that all providers were asked to sign, similar as they were asked to sign in the elder waiver several years ago when we made that change
Q. Okay. Let me just ask again, what was your direct involvement in updating the Provider Enrollment Agreement? If your answer is none, that's fine.
A The Medicaid Provider Enrollment Agreement, I had no role in updating that.
Q. For the ABI waiver?
A. Oh, the ABI waiver? I didn't have any role in updating that. I wrote the addendum to the provider agreement this year
Q. Okay. And what prompted you in the updating of the Provider Enrollment Agreement?
A. We -- as we manage waivers, what we had done with the Home Care Program For Elders several years ago, we were actually paying double. We were paying our access agencies who were doing case management to credential and enroll our providers and then the providers would bill them, so we'd be paying the access agencies to process claims. Then they would turn around and bill the Medicaid management information system to process claims, so we were double-paying for claims processing. And we also had inconsistencies among five agencies who were credentialing providers.

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So we changed and had all of the providers sign the Medicaid standard Provider Enrollment Agreement and a program-specific addendum so all the providers directly enrolled as Medicaid providers and now bill directly to Medicaid.

Q. When you say you were double-paying, for which services --

A. Claims processing.

Q. I know, but which services, which social services were you paying the double payment? Was it for your elder --

A. The elder program, yes

Q. Okay. When did that first come to your attention that the Department was overpaying?

A. I did not say we were overpaying. Let me explain it again.

Q. Well, you said double-paying.

A No Okay We were double-paying for our claims processing process We were paying our contracted case management entities to process claims who turned around and submitted those claims to the MMIS, so we were paying the MMIS to process claims From a programmatic and fiscally responsible position, that makes no sense.

So we modified the waiver program when we were

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doing the renewal, and we changed the way that we were enrolling and credentialing providers

Q. And this first came to your attention with regard to the elder program?

A. It's not anything that came to my attention. It's the way we had operated for a number of years.

Q. Did you seek any recoupment or repayment for this so-called double payment?

A. They were not overpayments, sir

Q. I said -- no. We can have your answer reread but you --

A. They were not -- I said the Department was paying twice for the claims processing function by paying the contracted access agency and the MMIS contractor We eliminated the middleman, that's what we did.

Q. Did you seek any overpayment from any entity for paying twice?

A. No, of course not.

Q. How did that paying twice impact, if at all, the ABI waiver program for brain injuries?

A. The model that we developed for the claims processing under the Home Care Program For Elders to have a fiscal intermediary credential the provider and set up a system where the providers enroll directly with

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Medicaid and bill the Medicaid management information system directly is the same model we have in place for our largest waiver program in the state, the Home Care Program For Elders It makes sense. That was the best way to do the process

Q. And whose policy decision was that?

A. The Department's

Q. Any one particular individual?

A. No It was a joint decision of the Department.

Q. Was there some kind of group or some kind of working group that reviewed this and made that decision?

A. Not really, no. I mean, it certainly was something we did -- I did in consultation with my director

Q. Who was your director?

A. Kate McEvoy

Q. What is her title?

A Medicaid director

Q. Who began the process of updating the enrollment agreement?

A. We did not change the Medicaid Enrollment Agreement Providers were asked to sign the standard Medicaid Provider Agreement. It was not updated.

Q. Okay. Ms. Bruni, it's not my style to bicker with you, but you said that at some point the Department

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began updating the Provider Enrollment Agreement.

A. I said I wrote the addendum to the Provider Enrollment Agreement.

Q. I understand that part. We're going to get to the addendum. I have it here.

A. Okay

Q. But the addendum followed some decision to update the Provider Enrollment Agreement.

A To change the way we did the Provider Enrollment Agreement from the fiscal intermediary to have the provider directly enroll with Medicaid as a provider the way we did it in other waivers

Q. If you know, why up until that point in time weren't the providers directly enrolled?

A. I can't answer that because I wasn't responsible for the programs at that time prior

Q. And there's nobody that you can identify within the Department that was responsible for initiating changing these particular providers to a direct Provider Enrollment Agreement?

A. Since I'm the director of waiver services and we had done this successfully with the Home Care For Elders Program providers, I made the recommendation to the Department that we do that also for the ABI providers and PCO

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Q. To whom individually did you make that recommendation?
A. My director, Kate McEvoy
Q. Was that in writing?
A. No, not that I recall
Q. Why not?
A. I can't answer I don't know why not. We'd meet regularly and I discussed it with her
Q. Was there any particular written review that led you to the recommendation of the direct provider enrollment?
A Not that I recall.
Q. Did you believe it would save the Department money?
A Yes.
Q. And how did you come to that conclusion?
A Same thing, we were not paying the fiscal intermediary to process claims and paying the MMIS to reprocess the same claim.
Q. Did you conduct any particular written analyses?
A. I don't recall
Q. If you did or had somebody on your behalf or direction conduct a written analysis, would that be contained in your department files?

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A. I don't recall a written analysis. It's written into the waiver document. That's where it's written
Q. I'm asking about the initial decision, the basis for the decision to have the direct provider enrollment –
A The basis --
Q. Let me just finish.
-- after years and years of not conducting that program, that waiver that way.
A. The basis for that was what we had done with the Home Care Program For Elders and how successful that transition was to having the providers bill directly to Medicaid after signing a Medicaid Provider Enrollment Agreement, and the savings -- the contractual savings for not paying the access agencies to do that function was several million dollars
MR. KOGUT: If you could, just mark this
This will be McCormick Exhibit 2
(McCormick Exhibit No 2, Allied Community Resources document, five pages, marked for identification.)
BY MR. KOGUT:
Q. If you could, just take your time and take a look at that for me, Ms. Bruni. (Handing.)

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A. Okay
Q. Have you seen that document before?
A. I think I have seen -- I don't -- I've seen the document. I'm not sure if I saw it with necessarily this name but I've seen the document. I'm familiar with what it is, yeah.
Q. Was it just generally blank or –
A. Yeah.
Q. -- with a different agency name?
A. Blank, I think I have seen it.
Q. Okay. Did this – was this reviewed by you in making a determination to change the enrollment process?
A. I was not involved in 2014
Q. That wasn't my question.
A. Okay
Q. My question was did you review this in making a determination to change the provider agreement process?
A. I'm sure I must have at some point.
Q. But you have no memory today of reviewing that?
A. I'm familiar with it so I must have reviewed it at some point.
Q. In making a recommendation to change the enrollment to have the providers enroll directly, what, if any, documents did you review?

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A I reviewed the addendum that we had done for the Home Care Program For Elders, and I reviewed the standard Medicaid provider agreement.
Q. Did you review any documents preparing for this deposition?
A. Yes.
Q. Could you tell me what those are?
A The complaint, the regulations and some e-mails.
Q. And who were the e-mails from or to?
A. I believe they were from the Social Work Unit. It involved Dorian Long and Lara Stauning, who was the attorney who represented -- who worked with the Social Work Unit.
Q. What was the general substance of those communications?
A. The ones that I saw had to do with the program regulations.
Q. Roughly what time frame would those have been?
A. 2013
Q. Was there any discussion in those communications regarding updating the Provider Enrollment Agreement?
A. Not that I recall.
Q. Other than speaking to your counsel, did you

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have any discussions with anyone in preparation for this deposition?
A. No, I did not.
MR. KOGUT: I'll have this marked as McCormick Number 3
(McCormick Exhibit No 3, Allied Community Resources document, three pages, marked for identification.)
BY MR. KOGUT:
Q. Take your time and just look through what is now marked McCormick Exhibit Number 3. (Handing.)
A. Okay
Q. Does this document look familiar, whether you've reviewed it in blank or with another agency contract name?
A I don't recall this one.
Q. Okay. Would you agree with me that the signature is dated October 30, 2015?
A. Yes.
Q. That's nearly a year after you became director?
A After I began responsibility for ABI Waiver 2.
Q. Right, as director?
A. Yes, yes
Q. I believe you said December 1, 2014?

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A Correct.
Q. So this is nearly a year afterwards?
A. Yep.
Q. And is it your testimony that you never reviewed this particular document --
A. What I'm saying is I don't recall.
Q. If I could just finish the question. Is it your testimony that you have no memory of reviewing this document in updating the Provider Enrollment Agreement which began in 2016?
A I do not recall reviewing this document.
Q. Do you recall reviewing any other documents in working on your addendum for the 2016 provider enrollment?
A. Not anything in addition to what I've already stated.
Q. I saw you looking at the last page there. It's called Documentation For Cognitive Behavioral Programs. Do you see that page?
A. I do.
Q. Have you seen this before?
A. I'm not sure.
Q. Do you know what it is?
A. I'm thinking -- it's not a provider report. I don't know what it is. I don't know what it is.

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Q. You've never seen anything like this?
A. I haven't seen anything in a long time. I don't know what this is.
Q. Certainly it's not something you reviewed in making a determination to have an updated Provider Enrollment Agreement?
A. No
Q. Did you review any claims for the ABI waiver program participants or any other documents which had to do with reimbursement for that program before you updated the Provider Enrollment Agreement?
A. I don't routinely review claims, no.
Q. But was it --
A I do get reports from the fiscal intermediary about the claims.
Q. Correct me if I'm wrong. Was it your testimony that one of the reasons for having direct provider enrollment was for cost savings?
A. The cost savings related to direct provider enrollment has to do with not paying the fiscal intermediary and the Medicaid management information system to both process the claims.
Q. So the answer is yes?
A. Yes.
Q. Okay. Thank you. Were you involved in

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drafting or reviewing any particular policies and procedures related to the ABI waiver program?
A. I participated in the development of the newest regulations
Q. And when were those promulgated?
A. May of 2016, with an effective date of July 1, 2016
Q. And what was your -- what was your involvement, the extent of your involvement?
A I worked with our legal department in the drafting of those regulations
Q. And anyone in particular?
A. Michael Slitt.
Q. And was there anything that motivated the Department to promulgate new policies and procedures?
A. The ones that we had in place were outdated. We needed to reflect the changes with the Provider Enrollment Agreement, but most importantly we needed to get information into the regs regarding the CMS final rules that were issued in March of 2012 That was important to get information into the regs about the settings requirements that CMS had changed.
Q. Was it as important to make those changes in 2013?
A. I wasn't responsible for the program in 2013

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Q. That wasn't my question.
A. I can't answer the question because I wasn't responsible in 2013
Q. Based on your years of experience, do you believe it would have been prudent to make those changes in 2013 if CMS made changes in 2012?
A. What I can say about the changes that CMS made in 2012 is that it's taken a couple of years to fully understand the implications of those changes, and waiting a couple of years to update the regulations has been very prudent because the direction has become clearer
Q. Wasn't it four years, 2012 to 2016?
A. It took a while to get the regs drafted and we got the language into the regulations, which was part of our CMS transition plan. And, actually, the State has been demonstrated to other states, about the quality of the language we put in the regs, about the settings requirements as an example for other states to follow in their program regs, so to me what was important was to get it right.
Q. Do you have any written analyses or reviews that led you to offer new or promulgating new policies and procedures within your department?
A Can you say that again, please.

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Q. Any memoranda, writings, communications between and among people that resulted in the promulgation of new regulations?
A. There's probably e-mails
Q. Probably or you believe that there are e-mails?
A. I believe -- we had to schedule meetings, so I'm sure there were
Q. Who were part of those meetings?
A. It was Michael and myself, and I had staff members come in and out so
Q. What level staff members?
A. Supervisory And I also involved -- I have one nurse and one social worker who are assigned to reviewing the ABI 2 plans, so I involved them as well.
Q. Do you know how many providers signed the new Provider Enrollment Agreement for the ABI waiver program?
A. I believe they all did.
Q. I'll ask the question again. Do you know how many?
A. Offhand, no
Q. Do you have a range?
A. I'm not going to guess at that.
Q. So you have no -- as director, you have no idea how many providers newly enrolled in 2016 for the ABI waiver program?

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A. I think there was somewhere between 80 and a hundred.
MR. KOGUT Do you want to take some time?
MR. BARBER. Yes
MR. KOGUT Yes, why don't we break for a few minutes
(Recess taken from 10.49 a.m. to 10 55 a.m.)
MR. KOGUT· Would you please read back the last question and answer
(Whereupon, the record was read back by the Court Reporter)
BY MR. KOGUT·
Q. At any time during your tenure here with regard to the ABI Medicaid waiver program, did you have any direct contact, either by e-mail or other communication, with the direct providers?
A. Yes.
Q. And how often would that occur and for what reasons?
A. It would occur if they reached out to me. It's happened quite a bit in the last few months around a couple of issues. They have questions about the -- they had questions about the enrollment and they have

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questions about the electronic visit verification system that the State is beginning.
Q. Okay. Did you have or do you have any role in the actual creation or reviewing of the service plans?
A I do not.
Q. Who would be responsible for that?
A. Depending on the time frame you're talking about, it was the DSS social workers in the past. Currently it is access agency care managers who are developing the service plans.
Q. And are you familiar with the codes, the billing codes, that the ABI Waiver -- Medicaid waiver program providers were requested or asked to use?
A. I don't know the procedure codes off the top of my head.
Q. I'm not asking for the numbers, the CPT codes. I'm just asking if you're familiar with them.
A. There are procedure codes associated with each service, yes.
Q. At some point during your tenure, did they change?
A Yes
Q. And when was that and what was the reason?
A We added a second procedure code to the cognitive behavioral service provider to accommodate the

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distinction between the service being provided in person, face-to-face, and the sometimes follow-up or phone calls that occurred.

Q. Did you, during the course of your tenure regarding the ABI Medicaid waiver program, send out I'll refer to it as a blast e-mail to all providers with certain announcements or transmittal notices or anything like that?

A. Yes. And there also are important messages and provider bulletins that are on the HPE web site, so that's the standard means of communication.

Q. Okay. Are you familiar with the process in 2015 -- I understand your dates that you gave to us but -- the recredentialing process in 2015?

A. Yes

Q. Is it fair to say it was the spring of 2015?

A. I don't recall exactly But as part of the waiver, CMS was looking for us to recredential providers at a minimum of every two years.

Q. And did you initiate that process?

A. I changed it in the waiver I believe the process initiated in Quality Assurance

Q. Okay. And that was shortly after you became program director?

A. Yes

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Q. Because you became program director December 1st of 2014?

A I was a program director I think sooner than that, but I assumed the responsibility for the ABI Waiver 2 December 1, 2014.

Q. Okay. And was part of your responsibility in accepting that or taking that role in December of 2014 to implement the recredentialing process?

A. Yes

Q. And what did that consist of?

A. When we talk about credentialing, we talk about the service definition and credentials specified in the waiver document itself And every two years, we ask our fiscal intermediary to verify that the provider meets those credentials That's at the point of enrollment and every two years thereafter

Q. Would it be fair to say, with the new provider agreement, you no longer have an intermediary?

A That's not correct. We still have a fiscal intermediary The fiscal intermediary continues to do the credentialing, and then they issue a credentialing letter that the provider uses to re-enroll with the MMIS system.

Q. Are you familiar, during your tenure with any -- I may have asked this, excuse me, but any

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requests for recoupment for overpayments for either the misuse of coding or overcoding of the ABI waiver program providers?

A. I have heard that there have been some requests for repayment, but I wasn't -- that was not since I've been a director They predated me.

Q. Who would you hear that from? Was that just --

A. I actually had heard it from a client about one of their providers.

Q. Were they complaining?

A. No They were complaining about the provider They weren't complaining about the process

Q. Oh, okay. So if I understand you correctly, your intermediary would still be responsible for recredentialing your providers?

A. Yes.

MR. KOGUT: This is McCormick Exhibit Number 4

(McCormick Exhibit No 4, Connecticut Department of Social Services Medical Assistance Program Provider Enrollment Application, marked for identification.)

BY MR. KOGUT:

Q. Do you want to take the time to go through that

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and see if you're familiar with it?

A. I know what it is.

Q. I know you know what it is. But do you want to take some time to go through it?

A. Okay

Q. So what is it?

A. It's the standard Medicaid Provider Enrollment Agreement

Q. Is this something that was used and adapted to the ABI waiver program?

A. The Medicare Provider Enrollment Application that the ABI providers do is an online application, and I haven't gotten into the online application. But I believe this is, you know, everything that's included in it.

Q. And is this the document that's a result of the impetus to update the enrollment agreement and have providers directly enroll?

A. This is the document that the providers would utilize to directly enroll, yes

Q. Is this the first time that they were ever required to directly enroll?

A. The ABI providers?

Q. Correct.

A. Yes, unless they were providing other services

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already as a Medicaid provider, which some of them are.
Q. When's the first time you saw this document?
A. Probably when we were going to make the changeover
Q. Which would have been roughly when, late 2015?
A. Probably
Q. Okay. And were you asked to participate in any way in this new application?
A. In this?
Q. Yes. I know you call it --
A. No I had no -- I have no -- this is a standard Medicaid Provider Enrollment Agreement. I have nothing to say about this.
Q. You participated in the addendum?
A. The addendum, yes
Q. Okay. And would you explain to me what the addendum consisted of?
A. The addendum is program-specific information as it pertains to the waiver program. I mean, this -- this covers a physician. It covers a hospital
Q. Right.
A. It covers a range of providers But there certainly is nothing specific in here about programmatic requirements of a waiver, so that's why we did an addendum.

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Q. Do you know if there are any significant differences between the 2015 provider agreement through the intermediary that you've looked at and this new provider enrollment application?
MR. BARBER. Which exhibit number are you referring to?
MR. KOGUT: It would be the 2015 --
A. This one?
BY MR. KOGUT:
Q. Number 3.
A. 10/30/15?
Q. Yes.
A. Okay Certainly the Medicaid provider agreement is a more comprehensive document.
Q. As far as program requirements go for the ABI waiver providers, was there any significant change, whether in billing or use of units, between 2015 and 2016?
A In terms of the billing, the billing changed in 2016, July 1, 2016, where they're billing the MMIS directly In the year before is when we changed and added the second procedure code for the cognitive behavioral service to differentiate between the in-person and the non in-person service
Q. And what was the difference between the

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in-person and non in-person?
A. In terms of the rate difference or in terms of what's the difference?
Q. Both the rate and -- the rate, the difference and the reason for the change.
A. The reason for the change is there was -- we really felt that there needed to be a distinction as the service was being provided both in person, face-to-face in the presence of the client directly, and then ancillary type of calls, other consultations with providers that might take place on the phone or via e-mail or a contact with a client that was not in person. So we increased the rate for the in-person service and decreased the rate for the non face-to-face.
Q. Was there any --
A. And made quarter-hour units for the non face-to-face.
Q. So there was a change in units?
A. Yes No, a change in the billing units.
Q. The reimbursement for units?
A. It was a change in the ability to bill a -- the unit became defined as a quarter-hour as opposed to a unit.
Q. Would it be fair to say that prior to that, a unit was one hour?

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A. A unit was a unit. You would presume it to be an hour, so that if somebody were billing -- if somebody were providing five minutes of service, they could potentially bill a unit.
Q. And that was accepted by the Department; was it not?
A. Up until we made the change --
Q. Correct.
A -- yes.
Q. But for years it had been a single unit, whether it was 15 minutes or whether it was one hour?
A. Correct.
Q. And was there any -- ever any audits conducted in reviewing clinical notes or charts or billing to determine actually how much time was being spent for one unit?
A. I would not -- I didn't conduct any audit, so I don't know the answer to that.
Q. Did any audits ever come across your desk which indicated that providers were billing for that one-hour unit and providing services for 15 minutes or less?
A. I don't know how we would know that in an audit if somebody wasn't recording time.
Q. Well, I asked about reviewing documentation, clinical charts and otherwise, to make that

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determination.
A. I did not do those audits.
Q. The question was do you recall seeing any come across your desk?
A. I did see some information come across my desk.
Q. What was that information?
A. It was a result of an investigation following a complaint.
Q. A complaint from a consumer?
A. I don't believe it was a consumer
Q. A competitor?
A. I don't believe it was a competitor
Q. Internally?
A No
Q. What's the difference in reimbursement now on the one-hour unit versus the 15-minute unit? Or is it divided by four?
A. The one-hour unit is 105, $105 That's for the in-person, face-to-face. The non face-to-face is $78 an hour, which I think breaks down to 19 50 per quarter-hour
Q. And do the social workers review the providers having a face-to-face or non face-to-face?
A. Generally, the face-to-face is in a team meeting, so the social worker would be there, a case or

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care manager would be there. The way the services are authorized, it's authorized under the procedure code at the 105, that procedure code, and then the billing will accept either that procedure code or the other procedure code. So it's like a pick group, if that makes sense
Q. Has the Department set a policy now preventing the providers from directly participating in team meetings?
A. Would you repeat that?
MR. KOGUT Would you read it back?
(Whereupon, the record was read back by the Court Reporter)
A. Absolutely not. Providers are expected to be present for team meetings. That's the purpose of a team meeting
BY MR. KOGUT·
Q. And if I understand you correctly, there's no program in place to review, for clinical reasons, whether the face-to-face or non face-to-face was clinically appropriate?
A. I'm not sure I understand your question. I'm sorry
Q. Sure. If a provider believed that it was important for clinical reasons to spend time face-to-face with the consumer, does the Department at

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any time make a determination that that was clinically inappropriate and will pay for the non face-to-face instead of the face-to-face?
A. No, actually just the opposite. We put a requirement in the waiver that the cognitive behavioral provider should see the client face-to-face at least quarterly
Q. Right. But you said that was only in team meetings.
A. It's face-to-face.
Q. Right. But only team meetings, not --
A Not only team meetings But, I mean, the --
Q. What would be the other face-to-face meetings?
A. If they met independently with the client.
Q. And did the Department review those clinical decisions made by the provider to meet face-to-face outside a team meeting?
A. No
Q. Never has?
A. Not that I'm aware of.
Q. Never questioned a provider's --
A. I mean -- well, absolutely
Q. Never questioned a provider's use of the face-to-face, one-hour unit?
A. It's the responsibility of the care manager to

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develop a service plan and authorize the hours of service. So they would, in fact, ask questions about the service, what's being delivered, what's the rationale for the hours That's what they're being paid to do.
Q. Is the unit -- billing of units in the actual service plan?
A. No As I -- the number of units for the service for the month is authorized in the service plan, yes
Q. That's determined by a social worker?
A. At a team meeting, yes.
Q. In consultation with the consumer --
A Yep
Q. -- and/or his representative or her representative and the provider?
A. Yes
Q. Okay. If you just give me two minutes, I might wrap up.
A Okay
(Whereupon, a recess was taken from 11 16 a.m. to 11 17 a.m.)
BY MR. KOGUT·
Q. Ms. Bruni, is it your testimony that the non face-to-face unit policy is in the service plan?

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A. No The service plan doesn't have a policy The non face-to -- the differentiation between the face-to-face and the non face-to-face distinction as to the service is spelled out in the Medicaid waiver application itself The service plan gives a number of units of cognitive behavioral service, and then it's up to the provider how those units get utilized over the course of the month, whether it be, you know, how many hours of face-to-face and how many of non face-to-face

Q. And I believe it was your testimony that there hasn't really been a problem within the Department about I'll call it overutilization of the non face-to-face -- or the face-to-face?

A I didn't say that.

Q. Has there been?

A. It's certainly something that's a concern.

Q. To whom?

A. To me.

Q. Okay. What is the concern?

A. Concern that there may be overutilization.

Q. Have you conducted any audits to satisfy that concern?

A. I have not.

Q. Have you referred anything to QA to satisfy that concern?

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A I have not.

Q. Is there a requirement to have an actual written service plan?

A. Yes

Q. Is it a requirement to have the service plan distributed to the provider?

A. Yes.

Q. And is there a requirement to have a provider sign the service plan?

A No

Q. Why not?

A The client signs the service plan.

Q. And why not the provider?

A. The requirement is that the client sign the service plan.

Q. Does the client do it in consultation with the provider?

A The client chooses their provider and the provider is listed on the service plan.

Q. Right. But in terms of what the service plan is going to be, does the client consult the provider to determine whether he or she is receiving adequate services in the service plan?

A. That would be something that would be discussed at a team meeting, and it would be discussed between the

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care manager and the client and their representative at reassessment.

Q. Fair to say that you're dealing with a population with diminished mental capacity?

A. Yes.

Q. Is it your testimony that the Department can rely on what the client or the consumer wants?

A. This is a person-centered planning model It involves the input of the consumer to the maximum extent possible. If they have a representative, we involve the representative, whether that be a conservator or family member

Q. It's your testimony that of the 80 to 100 providers, each of them receive a copy of the service plan for every one of their consumers?

A. They need to know what services they're authorized to provide.

Q. That wasn't the question. The question was is it your testimony that all the providers are provided with a copy of the service plan for each of their clients?

A. They should be.

Q. Are they?

A. As far as I know

Q. Have you had any complaints from any providers

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that they weren't adequately or timely receiving such service plans?

A. Not since I've taken over

Q. Okay. Thank you.

MR. KOGUT· I have no other questions

MR. BARBER. No questions.

(Whereupon the deposition was concluded and the witness excused at 11 21 a.m.)

CERTIFICATE OF REPORTER

I, Frances Teti Prentice, Licensed Shorthand Reporter 076 and Notary Public duly commissioned and qualified in and for the State of Connecticut, do hereby certify that there came before me on October 27, 2106 the following named person, to wit: KATHY A. BRUNI, who was by me duly sworn to testify to the truth and nothing but the truth, that she was thereupon carefully examined upon her oath and her examination reduced to writing under my supervision, that this deposition is a true record of the testimony given by the witness.

I further certify that I am neither attorney nor counsel for nor related to nor employed by any of the parties to the action in which this deposition is taken and, further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto, nor financially interested in the action.

IN WITNESS THEREOF, I have hereunto set my hand and affixed my seal this 3rd day of November, 2016

s/s _____

Frances Teti Prentice, Notary Public
My Commission expires 3/31/2019
License expires. 12/2016

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