DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

FEB 18 2009

TO: Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of Connecticut's Community Based Medicaid Administrative Claim for State Fiscal Year 2004 (A-01-06-00008)

Attached is an advance copy of our final report on the Community Based Medicaid Administrative Claim submitted by the Connecticut Department of Social Services (the State agency) for State fiscal year (FY) 2004. We will issue this report to the State agency within 5 business days.

The State agency, through contracts awarded by the Connecticut Department of Mental Health and Addiction Services (DMHAS), purchases administrative case management activities from organizations that provide mental health and related services. For State FY 2004, the State agency began claiming Federal reimbursement for the costs of these activities through a Community Based Medicaid Administrative Claim. To compute the costs claimed, the State agency used a random moment timestudy (RMS) of employee activities at the 81 contracted organizations that provided these activities.

The State agency claimed $9.3 million for State FY 2004 as a prior-period adjustment to the quarter that ended June 30, 2005. On February 3, 2006, the Centers for Medicare & Medicaid Services (CMS) issued a letter of deferral to the State agency for the $9.3 million claimed. CMS subsequently requested that we conduct this review.

Our objective was to determine whether the State agency's Community Based Medicaid Administrative Claim for State FY 2004 complied with Federal requirements.

The State agency's Community Based Medicaid Administrative Claim may not have fully complied with Federal requirements. Specifically:

- The State agency's calculation was based on the Medicaid-allocable costs incurred by the 81 contracted organizations ($149,387,577), which exceeded by $19.7 million the total

amount that DMHAS actually paid to these contracted organizations ($129,663,145) for both Medicaid and non-Medicaid services and activities. We were unable to determine the impact of overstating the cost base on the Community Based Medicaid Administrative Claim because of other errors in the calculation.

- The documentation from the RMS was inadequate for us to determine whether the administrative case management activities were allowable and whether they were provided to Medicaid applicants or eligibles.

- The allocation method that the State agency used to identify and determine the amount of administrative case management activities contained deviations from acceptable statistical sampling practices.

We were unable to quantify the effect of these omissions and deviations from acceptable practices. Specifically, these omissions and deviations affected both the accuracy of the calculations of the costs allocated to the Community Based Medicaid Administrative Claim and the validity of the RMS used to allocate these costs. We are therefore unable to express an opinion on the allowability of the State agency's $9.3 million Community Based Medicaid Administrative Claim for State FY 2004.

These omissions and deviations occurred because the State agency did not establish adequate procedures to ensure that its Community Based Medicaid Administrative Claim complied with Federal requirements.

We recommend that the State agency:

- draft its future contracts with the 81 contracted organizations to identify and properly value the amount of administrative case management activities purchased through the contracts and subsequently claimed on the Community Based Medicaid Administrative Claim and

- work with CMS to determine what portion of the Community Based Medicaid Administrative Claim of $9,270,413 for the year that ended June 30, 2004, was allowable under Federal requirements by, at a minimum:

    - limiting the cost base used to calculate the Community Based Medicaid Administrative Claim to the amount that DMHAS actually paid the 81 contracted organizations,

    - obtaining sufficient documentation from the RMS to determine the allowability of the activities used to allocate the costs, and

    - following acceptable statistical sampling practices.

In written comments on our draft report, the State agency generally agreed with our recommendations.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov or Michael J. Armstrong, Regional Inspector General for Audit Services, Region I, at (617) 565-2689 or through e-mail at Michael.Armstrong@oig.hhs.gov. Please refer to report number A-01-06-00008.

Attachment

Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

FEB 20 2009

Report Number: A-01-06-00008

Mr. Michael P. Starkowski
Commissioner
Department of Social Services
25 Sigourney Street
Hartford, Connecticut 06106

Dear Mr. Starkowski:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Connecticut's Community Based Medicaid Administrative Claim for State Fiscal Year 2004." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, OIG reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. Accordingly, this report will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Curtis Roy, Audit Manager, at (617) 565-9281 or through e-mail at Curtis.Roy@oig.hhs.gov. Please refer to report number A-01-06-00008 in all correspondence.

Sincerely,

Michael J. Armstrong

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF CONNECTICUT'S COMMUNITY BASED MEDICAID ADMINISTRATIVE CLAIM FOR STATE FISCAL YEAR 2004

Daniel R. Levinson
Inspector General

February 2009
A-01-06-00008

Office of Inspector General

http://oig.hhs.gov

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Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The Federal and State Governments jointly fund and administer the Medicaid program. Section 1903(a)(7) of the Social Security Act permits States to claim Federal reimbursement for 50 percent of the costs of Medicaid administrative activities that are necessary for the proper and efficient administration of the State plan.

In Connecticut, the Department of Social Services (the State agency) administers the Medicaid program. The State agency, through grant-in-aid contracts awarded by the Connecticut Department of Mental Health and Addiction Services (DMHAS), purchases administrative case management activities from organizations that provide mental health and related services. For State fiscal year (FY) 2004, the State agency began claiming Federal reimbursement for the costs of these purchased administrative activities on the Centers for Medicare & Medicaid Services (CMS) Form CMS-64 through a process referred to as the Community Based Medicaid Administrative Claim. To compute the Community Based Medicaid Administrative Claim, the State agency used a random moment timestudy (RMS) of employee activities at the 81 contracted organizations that provided these activities.

The State agency claimed $9.3 million for Federal reimbursement of Community Based Medicaid Administrative Claim-related costs during the State FY that ended June 30, 2004, as a prior-period adjustment to the quarter that ended June 30, 2005. On February 3, 2006, CMS issued a letter of deferral to the State agency for the $9.3 million claimed. CMS subsequently requested that we conduct this review.

OBJECTIVE

Our objective was to determine whether the State agency's Community Based Medicaid Administrative Claim for State FY 2004 complied with Federal requirements.

SUMMARY OF FINDINGS

The State agency's Community Based Medicaid Administrative Claim may not have fully complied with Federal requirements. Specifically:

- The State agency's calculation was based on the Medicaid-allocable costs incurred by the 81 contracted organizations ($149,387,577), which exceeded by $19.7 million the total amount that DMHAS actually paid to these contracted organizations ($129,663,145) for both Medicaid and non-Medicaid services and activities. We were unable to determine the impact of overstating the cost base on the Community Based Medicaid Administrative Claim because of other errors in the calculation.

- The documentation from the RMS was inadequate for us to determine whether the administrative case management activities were allowable and whether they were provided to Medicaid applicants or eligibles.

- The allocation method that the State agency used to identify and determine the amount of administrative case management activities contained deviations from acceptable statistical sampling practices.

We were unable to quantify the effect of these omissions and deviations from acceptable practices. Specifically, these omissions and deviations affected both the accuracy of the calculations of the costs allocated to the Community Based Medicaid Administrative Claim and the validity of the RMS used to allocate these costs. We are therefore unable to express an opinion on the allowability of the State agency's $9.3 million Community Based Medicaid Administrative Claim for State FY 2004.

These omissions and deviations occurred because the State agency did not establish adequate procedures to ensure that its Community Based Medicaid Administrative Claim complied with Federal requirements.

RECOMMENDATIONS

We recommend that the State agency:

- draft its future contracts with the 81 contracted organizations to identify and properly value the amount of administrative case management activities purchased through the contracts and subsequently claimed on the Community Based Medicaid Administrative Claim and

- work with CMS to determine what portion of the Community Based Medicaid Administrative Claim of $9,270,413 for the year that ended June 30, 2004, was allowable under Federal requirements by, at a minimum:

    - limiting the cost base used to calculate the Community Based Medicaid Administrative Claim to the amount that DMHAS actually paid the 81 contracted organizations,

    - obtaining sufficient documentation from the RMS to determine the allowability of the activities used to allocate the costs, and

    - following acceptable statistical sampling practices.

DEPARTMENT OF SOCIAL SERVICES COMMENTS

In written comments on our draft report, the State agency generally agreed with our recommendations. The State agency's comments are included in their entirety as Appendix D.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Section 1903(a)(7) of the Act permits States to claim Federal reimbursement for 50 percent of the costs of Medicaid administrative activities that are necessary for the proper and efficient administration of the State plan. States submit expenditures for administrative activities for reimbursement on the Form CMS-64, "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program" (CMS-64).

Connecticut's Community Based Medicaid Administrative Claim

In Connecticut, the Department of Social Services (the State agency) administers the Medicaid program. The State agency, through grants-in-aid awarded by the Connecticut Department of Mental Health and Addiction Services (DMHAS), purchases Medicaid administrative case management activities from organizations that provide mental health and related services. The contracted organizations that provide these purchased services include clinics and shelters, components of universities and hospital systems, religious and service organizations, and a local government (Appendix A).

For State fiscal year (FY) 2004, the State agency began claiming Federal reimbursement for the costs of these purchased administrative activities on the CMS-64 through a process referred to as the Community Based Medicaid Administrative Claim.[1] To compute the Community Based Medicaid Administrative Claim, the State agency conducted a random moment timestudy (RMS) of the activities of the employees of each contracted organization to determine the portion of these activities that were allocable to the Medicaid program (Appendix B). This RMS included a multistage sample consisting of (1) a random selection of 750 contracted organization employees and (2) a random selection of a moment of time from each of these employees' work schedules. The State agency applied the results of the RMS to the contracted organizations' reported Medicaid-allocable costs for the State FY that ended June 30, 2004 (Appendixes A and C).

The State agency's initial Community Based Medicaid Administrative Claim totaled $9.3 million for the State FY that ended June 30, 2004. The State agency claimed this amount at 50-percent

[1]In 2004, the State agency contracted with a third-party contractor to develop the Community Based Medicaid Administrative Claim. This contingency fee contract was valued at 8 percent of new Federal funds generated by the contractor's efforts. The State agency did not claim the contingency fee for Federal reimbursement.

Federal financial participation (FFP) as a prior-period adjustment on its CMS-64 for the quarter that ended June 30, 2005. The State agency's claim for FFP was based on the assumption that DMHAS purchased administrative case management activities from the 81 contracted organizations. The State's share of the Community Based Medicaid Administrative Claim was the portion of the $129,663,145 grant-in-aid contract payments that DMHAS paid for administrative case management activities.

On February 3, 2006, CMS issued a letter of deferral to the State agency for the $9.3 million in costs claimed for Federal reimbursement. CMS subsequently requested that we review the Community Based Medicaid Administrative Claim because it was the State agency's first claim to include these types of administrative costs.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency's Community Based Medicaid Administrative Claim for State FY 2004 complied with Federal requirements.

Scope

We reviewed the $9.3 million in Community Based Medicaid Administrative Claim costs that the State agency claimed as a prior-period adjustment for the State FY that ended June 30, 2004, on its CMS-64 report for the quarter that ended June 30, 2005. We will report the results of our review of the Community Based Medicaid Administrative Claims totaling $19.9 million for the quarters that ended December 31, 2005, March 31, 2006, and June 30, 2006, in a separate report.

Our objective did not require an understanding or assessment of the State agency's internal control structure. We limited our review to the State agency's preparation of the Community Based Medicaid Administrative Claim.

We performed our fieldwork from June 2006 through October 2007 at the State agency and DMHAS in Hartford, Connecticut, and at several contracted organizations throughout the State whose costs were used to develop the Community Based Medicaid Administrative Claim.

Methodology

To accomplish our audit objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

- interviewed officials and reviewed policies with the State agency, DMHAS, and seven contracted organizations whose costs were used to develop the Community Based Medicaid Administrative Claim;

- reviewed the State agency's oversight of the activities of the contractor that prepared the claim;

- reviewed the grant-in-aid contracts between DMHAS and the 81 contracted organizations whose costs were included in the Community Based Medicaid Administrative Claim;

- reviewed the cost allocation plan approved by the Division of Cost Allocation of the U.S. Department of Health and Human Services and the State agency's methodology for allocating administrative costs;

- traced the 81 contracted organizations' reported costs used to calculate the Community Based Medicaid Administrative Claim to supporting financial reports;

- traced the 81 DMHAS grant-in-aid payments to the annual financial reports of the 81 contracted organizations;

- reviewed the documentation supporting the activities sampled in the RMS;

- reviewed the RMS for statistical validity; and

- reviewed the Community Based Medicaid Administrative Claim calculations for mathematical accuracy.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

The State agency's Community Based Medicaid Administrative Claim may not have fully complied with Federal requirements. Specifically:

- The State agency's calculation was based on the Medicaid-allocable costs incurred by the 81 contracted organizations ($149,387,577), which exceeded by $19.7 million the total amount that DMHAS actually paid to these contracted organizations ($129,663,145) for both Medicaid and non-Medicaid services and activities. We were unable to determine the impact of overstating the cost base on the Community Based Medicaid Administrative Claim because of other errors in the calculation.

- The documentation from the RMS was inadequate for us to determine whether the administrative case management activities were allowable and whether they were provided to Medicaid applicants or eligibles.

- The allocation method that the State agency used to identify and determine the amount of administrative case management activities contained deviations from acceptable statistical sampling practices.

We were unable to quantify the effect of these omissions and deviations from acceptable practices. Specifically, these omissions and deviations affected both the accuracy of the calculations of the costs allocated to the Community Based Medicaid Administrative Claim and the validity of the RMS used to allocate these costs. We are therefore unable to express an opinion on the allowability of the State agency's $9.3 million Community Based Medicaid Administrative Claim for State FY 2004.

These omissions and deviations occurred because the State agency did not establish adequate procedures to ensure that its Community Based Medicaid Administrative Claim complied with Federal requirements.

FEDERAL REQUIREMENTS

The CMS "State Medicaid Manual," section 4302.2(G)(2), states:

> When FFP is claimed for any functions performed as case management administrative activities under § 1903(a) of the Act, documentation must clearly demonstrate that the activities were provided to Medicaid applicants or eligibles, and were in some way connected with determining eligibility or administering services covered under the State plan.

Office of Management and Budget Circular A-87, Attachment B, section h.6.a, states that sampling methods used to allocate salaries to Federal awards must meet acceptable statistical sampling methods and the results must be statistically valid.

California Department of Health Services, Departmental Appeals Board Decision No. 1606 (1996), noted that " . . . backcasting would be appropriate only if it can be established that circumstances in the sampled period are not substantially different than those in the retroactive claim period."

NONCOMPLIANCE WITH FEDERAL REQUIREMENTS

Overstated Cost Base

The State agency used an overstated cost base when estimating the DMHAS expenditures on which the Community Based Medicaid Administrative Claim was based. The maximum cost base that the State agency could have used was $129,663,145, the total payments that DMHAS made for the 81 contracts. The contracts included the provision of both Medicaid and non-Medicaid services and activities. Accordingly, the cost base should have been further limited to Medicaid allocable services and activities and thus should have been less than DMHAS's total payments ($129,663,145). However, the cost base that the State agency used, $149,387,577, exceeded DMHAS's total payments by $19.7 million. We were unable to determine the impact

of this overstatement on the estimate of DMHAS expenditures for administrative case management activities because of the other errors in the Community Based Medicaid Administrative Claim calculation.

Inadequate Documentation

We cannot express an opinion on the allowability of the State agency's Community Based Medicaid Administrative Claim because the State agency provided us with inadequate support for the RMS that it used to calculate its claim. Specifically:

- The RMS that the State agency used to calculate its Community Based Medicaid Administrative Claim was not supported by adequate documentation. Specifically, the only documentation that the State agency, the State agency's contractor, and the contracted organizations maintained to support the RMS was the telephone pollster's notes, their related classifications, and definitions of the classifications (Appendix B). However, some of the notes or activity code descriptions contained insufficient detail to demonstrate whether the activities were provided solely to Medicaid applicants or eligibles.

- Because the documentation did not clearly demonstrate to whom the activities were provided and whether the individual was a Medicaid applicant or eligible, we could not determine whether an administrative case management activity was part of a direct service that had already been billed to Medicaid or another Federal program. The lack of documentation raised the possibility that the State agency might have received duplicate reimbursement for certain administrative activities by separating or "unbundling" them from the related direct services.

- The State agency used a Medicaid eligibility rate based on payer statistics for DMHAS clients served by approximately 180 contracted organizations throughout the State (Appendix C). Because the RMS documentation that the State agency provided did not indicate the payer status (e.g., Medicare, Medicaid, private insurance, or self-pay) of the clients involved with the sampled activities, we have no assurance that the DMHAS-wide rate based on data from 180 contracted organizations was reflective of the clients of the 81 contracted organizations.

- Four of the eighty-one contracted organizations whose costs were included in the cost base of the Community Based Medicaid Administrative Claim had State-funded grant-in-aid contracts that did not include the provision of administrative case management activities. The State agency could not provide other documentation that these four contracted organizations were paid to provide Medicaid administrative case management activities. As a result, we have no assurance that the costs associated with these four contracted organizations relate to Medicaid administrative case management activities provided to Medicaid applicants or eligibles through the grant-in-aid contracts.

Deviations From Acceptable Statistical Sampling Practices

The State agency used an allocation method that contained deviations from acceptable statistical sampling practices, as the following examples illustrate:

- Acceptable statistical sampling practices involve using a random number generator to produce (1) a set of random numbers used to select the sample and (2) the "seed number" needed to recreate the random number selection so that the sample can be independently validated. The State agency did not retain either the random numbers used or a seed number.

- Acceptable statistical sampling practices call for using the appropriate estimation formula for the type of sample selected. The State agency used a single-stage estimation formula, which is intended for use with a simple random sample, to appraise a sample selected as a multistage sample, thus potentially biasing the sample results.

- Acceptable statistical sampling practices reduce the potential for bias by ensuring that only eligible employees are selected for participation in an RMS, study participants do not have access to potentially biasing information, and employees are not notified in advance. The State agency's methodology contained the following departures from these acceptable practices to reduce bias:

    - Some of the 81 contracted organizations included ineligible employees such as security guards, cafeteria workers, and group home workers on the employee work schedules that they provided to the State agency. Because these employees spent 100 percent of their time on indirect activities, their inclusion created a bias that contributed to the high general administration response rate of 40 percent.

    - Instructional materials that the State agency provided to the contracted organizations stated that compliance with the RMS would help generate additional funds to the State and the contracted organizations.

    - Before the RMS was conducted, the State agency provided each of the 81 contracted organizations with the names and contact times of employees who would be surveyed by the RMS pollster, thus potentially influencing the employees' assigned duties at the time they were polled. Employees with contact times outside of normal business hours were instructed in advance to telephone in their activities at the appointed contact time.

- Acceptable statistical sampling practices ensure that "backcasting" methods are used only when the two time periods are not significantly different. The State agency's RMS sampled employee activities during June through August 2005 and applied the results to costs incurred for the State FY that ended June 30, 2004. The State agency could not demonstrate that the Medicaid eligibility rates in 2005 were the same as those in 2004 and therefore could not provide assurance that the two time periods were not significantly different.

- Acceptable statistical sampling practices include providing appraisal results (i.e., precision of the estimates) to provide some assurance that the sampled items represent the population as a whole. The State agency was unable to provide appraisal results to show that the 750 sampled items properly reflected the approximately 107 million moments in the population.

- Acceptable statistical sampling practices call for proper treatment of invalid responses. Of the 750 RMS responses, 117 were deemed to be invalid and therefore were removed from the sample. Of the 117 invalid responses, 70 were related to employee nonresponses. Although the State agency removed these nonresponses from the sample results, it did not remove the associated employee costs. As a result, the State agency overstated the amount of general and administrative costs allocated to the Community Based Medicaid Administrative Claim.

Because of these deviations from acceptable statistical sampling practices, the State agency was unable to provide reasonable assurance that its statistical methodology was valid.

EFFECT OF STATE AGENCY'S OMISSIONS AND DEVIATIONS

We were unable to quantify the effect of the omissions and deviations from acceptable practices that the State agency made when calculating the Community Based Medicaid Administrative Claim. Specifically, the omissions and deviations affected both the accuracy of the calculations of the costs allocated to the Community Based Medicaid Administrative Claim and the validity of the RMS used to allocate these costs. We are therefore unable to express an opinion on the allowability of the State agency's $9.3 million Community Based Medicaid Administrative Claim for State FY 2004.

LACK OF ADEQUATE PROCEDURES

These omissions and deviations occurred because the State agency did not establish adequate procedures to ensure that its Community Based Medicaid Administrative Claim complied with Federal requirements.

RECOMMENDATIONS

We recommend that the State agency:

- draft its future contracts with the 81 contracted organizations to identify and properly value the amount of administrative case management activities purchased through the contracts and subsequently claimed on the Community Based Medicaid Administrative Claim and

- work with CMS to determine what portion of the Community Based Medicaid Administrative Claim of $9,270,413 for the year that ended June 30, 2004, was allowable under Federal requirements by, at a minimum:

- limiting the cost base used to calculate the Community Based Medicaid Administrative Claim to the amount that DMHAS actually paid the 81 contracted organizations,

- obtaining sufficient documentation from the RMS to determine the allowability of the activities used to allocate the costs, and

- following acceptable statistical sampling practices.

DEPARTMENT OF SOCIAL SERVICES COMMENTS

In written comments on our draft report, the State agency generally agreed with our recommendations. Specifically, the State agency said that it would work with CMS to determine what portion of the Community Based Medicaid Administrative Claim for the year that ended June 30, 2004, was allowable under Federal requirements. The State agency also said that, after it reaches agreement with CMS on procedures for claiming these administrative costs, the State agency would use those procedures to recalculate any additional claims already submitted and to calculate any future claims. In addition, the State agency said that, once agreement is reached, it would modify its contracts with the 81 organizations, if required, to better identify the dollars associated with administrative case management activities.

The State agency's comments are included in their entirety as Appendix D.

APPENDIXES

DETAILS OF ORGANIZATIONS PARTICIPATING IN CONNECTICUT'S COMMUNITY BASED MEDICAID ADMINISTRATIVE CLAIM PROGRAM FOR FISCAL YEAR 2004

	Provider Name	Federal Share	State Grant-in-Aid	Medicaid Allocable Costs[1]	Provider Type
1	Ability Beyond Disability	$22,743	$1,864,150	$366,484	Clinic/Shelter
2	Advanced Behavioral Health	$282,871	$4,763,025	$4,558,305	Clinic/Shelter
3	Alcohol and Drug Recovery Center	$455,810	$2,690,090	$7,345,127	Clinic/Shelter
4	ALSO Cornerstone, Inc.	$99,283	$2,361,067	$1,599,893	Clinic/Shelter
5	Applied Behavioral Rehab and Research Institute	$6,504	$144,316	$104,814	Clinic/Shelter
6	APT Foundation	$286,588	$2,219,694	$4,618,199	Clinic/Shelter
7	Asian Family Services	$3,002	$93,776	$48,367	Clinic/Shelter
8	Bridge House	$45,649	$1,183,410	$735,612	Clinic/Shelter
9	Bridgeport - Central CT Coast YMCA, Inc.	$4,648	$219,515	$74,902	Service Organization
10	Bridges Community Support System	$230,601	$5,157,341	$3,716,008	Clinic/Shelter
11	Catholic Charities of Fairfield County	$33,246	$456,022	$535,748	Religious Organization
12	Catholic Charities Family Services - Waterbury	$35,487	$1,099,757	$571,856	Religious Organization
13	Center for Human Development, Inc.	$211,779	$3,782,836	$3,412,709	Clinic/Shelter
14	Centers for City Churches	$7,179	$116,777	$115,681	Religious Organization
15	Central Naugatuck Valley Help	$105,955	$1,449,535	$1,707,410	Clinic/Shelter
16	Chemical Abuse Service Agency, Inc.	$91,874	$789,165	$1,480,500	Clinic/Shelter
17	Chrysalis Center, Inc.	$141,836	$2,869,129	$2,285,614	Clinic/Shelter
18	Columbus House	$45,299	$1,053,081	$729,973	Clinic/Shelter
19	Community Health Center	$3,374	$46,616	$54,366	Clinic/Shelter
20	Community Health Resources, Inc.	$199,088	$10,632,992	$3,208,187	Clinic/Shelter
21	Community Mental Health Affiliates	$335,222	$8,315,958	$5,401,915	Clinic/Shelter
22	Community Prevention & Addiction Services	$89,318	$483,627	$1,439,317	Clinic/Shelter
23	Community Renewal Team (no 2004 contract)				Clinic/Shelter
24	Connecticut Counseling Centers	$248,422	$515,765	$4,003,181	Clinic/Shelter
25	Connecticut Renaissance	$164,289	$948,057	$2,647,425	Clinic/Shelter
26	Connection, Inc.	$99,716	$1,459,248	$1,606,862	Clinic/Shelter

[1]The State agency computed Medicaid allocable costs to be a contracted organization's annual expenditures less unallowable expenditures (per Office of Management and Budget Circular A-87), indirect costs, and supporting Federal funds.

DETAILS OF ORGANIZATIONS PARTICIPATING IN CONNECTICUT'S COMMUNITY BASED MEDICAID ADMINISTRATIVE CLAIM PROGRAM FOR FISCAL YEAR 2004

	Provider Name	Federal Share	State Grant-in-Aid	Medicaid Allocable Costs[1]	Provider Type
27	Continuum of Care, Inc.	$150,539	$2,777,815	$2,425,851	University
28	Coordinating Council for Children in Crisis	$3,808	$18,763	$61,363	Clinic/Shelter
29	Crossroads	$153,192	$674,710	$2,468,598	Clinic/Shelter
30	CTE	$10,140	$0	$163,405	Clinic/Shelter
31	Dixwell Newhallville Community Mental Health	$28,004	$305,789	$451,268	Clinic/Shelter
32	Fairfield Community Services	$2,770	$28,401	$44,643	Clinic/Shelter
33	Family & Children Agency, Inc.	$23,945	$291,488	$385,845	Clinic/Shelter
34	Farrell Treatment Center	$34,272	$94,534	$552,278	Clinic/Shelter
35	First Step	$120,897	$3,588,156	$1,948,194	Clinic/Shelter
36	Friendship Service Center	$6,225	$48,164	$100,315	Religious Organization
37	Gilead	$217,763	$4,664,465	$3,509,131	Clinic/Shelter
38	Goodwill	$64,141	$1,298,438	$1,033,603	Clinic/Shelter
39	Hall-Brooke Behavioral Health Services	$10,110	$531,574	$162,923	Hospital
40	Harbor Health	$253,641	$3,954,406	$4,087,280	Clinic/Shelter
41	Hartford Behavioral Health	$59,648	$910,356	$961,187	Clinic/Shelter
42	Hartford Dispensary	$455,059	$1,272,252	$7,333,016	Clinic/Shelter
43	Helping Hand Center	$15,692	$87,498	$252,869	Clinic/Shelter
44	Integrated Behavioral Health	$89,299	$1,622,785	$1,438,998	Clinic/Shelter
45	Inter-Community MH Group	$291,882	$4,095,566	$4,703,524	Clinic/Shelter
46	Interlude, Inc.	$69,797	$807,350	$1,124,737	Clinic/Shelter
47	Keystone House	$100,489	$2,096,368	$1,619,330	Clinic/Shelter
48	Laurel House	$54,162	$1,118,672	$872,795	Clinic/Shelter
49	Leeway Inc. (no 2004 contract)				Clinic/Shelter
50	Liberty Community Services	$52,472	$218,621	$845,562	Clinic/Shelter
51	LMG Programs	$449,930	$1,235,326	$7,250,372	Clinic/Shelter
52	Marrakech	$33,074	$532,970	$532,970	Clinic/Shelter
53	McCall Foundation	$114,034	$353,688	$1,837,595	Clinic/Shelter
54	Mental Health Association of Connecticut	$349,162	$6,587,502	$5,626,546	Clinic/Shelter
55	Mercy Housing Shelter Corp	$67,985	$1,331,762	$1,095,542	Religious Organization
56	Midwestern Connecticut Council on Alcoholism	$183,083	$778,011	$2,950,281	Clinic/Shelter
57	Morris Foundation	$76,656	$1,138,811	$1,235,276	Clinic/Shelter

DETAILS OF ORGANIZATIONS PARTICIPATING IN CONNECTICUT'S COMMUNITY BASED MEDICAID ADMINISTRATIVE CLAIM PROGRAM FOR FISCAL YEAR 2004

	Provider Name	Federal Share	State Grant-in-Aid	Medicaid Allocable Costs[1]	Provider Type
58	My Sister's Place, Inc.	$77,642	$958,687	$1,251,151	Clinic/Shelter
59	New Directions	$27,039	$58,957	$435,722	Clinic/Shelter
60	New Haven Home Recovery	$31,133	$267,150	$501,696	Clinic/Shelter
61	NW Center for Families	$12,132	$92,134	$195,497	Clinic/Shelter
62	Operation Hope	$5,488	$314,802	$88,427	Clinic/Shelter
63	Pathways	$55,889	$940,581	$900,625	Clinic/Shelter
64	Perception Programs	$64,665	$404,970	$1,042,044	Clinic/Shelter
65	Positive Directions	$8,564	$56,702	$137,997	Clinic/Shelter
66	Regional Network of Programs	$366,932	$2,474,868	$5,912,901	Clinic/Shelter
67	Reliance House	$327,451	$5,079,165	$5,276,692	Clinic/Shelter
68	Rushford	$509,153	$6,233,664	$8,204,721	Hospital
69	St. Luke's Lifeworks	$76,360	$897,468	$1,230,504	Religious Organization
70	St. Vincent DePaul Society MDT	$6,383	$128,806	$102,862	Religious Organization
71	St. Vincent DePaul Society of Waterbury	$62,532	$1,323,080	$1,007,660	Religious Organization
72	Stafford (Town of) Family Services	$8,222	$66,005	$132,489	Local Government
73	Supportive Environmental Living Facility	$66,382	$1,217,278	$1,069,712	Clinic/Shelter
74	Torrington Chapter of FISH	$1,668	$28,928	$26,880	Clinic/Shelter
75	United Community & Family Services	$10,128	$173,700	$163,213	Clinic/Shelter
76	United Services	$380,835	$5,594,025	$6,136,952	Clinic/Shelter
77	Valley Mental Health Center	$263,729	$5,174,871	$4,249,850	Clinic/Shelter
78	Wheeler Clinic	$78,787	$556,472	$1,269,612	Clinic/Shelter
79	Yale University Child Study Center	$6,983	$112,533	$112,533	University
80	Yale University Hamden Behavioral Health	$28,740	$276,329	$463,122	University
81	YWCA	$1,922	$52,780	$30,963	Service Organization
	Total	**$9,270,413**	**$129,663,145**	**$149,387,577**	

RANDOM MOMENT TIMESTUDY ACTIVITY CODES FOR CONNECTICUT'S COMMUNITY BASED MEDICAID ADMINISTRATIVE CLAIM PROGRAM

Activity Code Description	Included in Community Based Medicaid Administrative Claim?	Number of RMS[1] Responses
(1) Direct Medical Services is used for direct medical care, treatment, and/or counseling services, including medical and mental health assessments and evaluations to correct or ameliorate a specific condition. Includes all related paperwork, clerical activities, or staff travel required to perform these activities.	No	58
(2) Direct Nonmedical Services is used for activities that are not medical in nature, such as education, employment, job training, or social services provided to clients. Includes all related paperwork, clerical activities, or staff travel required to perform these activities.	No	38
(3) Targeted Case Management (TCM) is used for services that assist and enable clients to gain access to needed medical, social, educational, or other services, including assessment, service planning, service linkage, ongoing monitoring, ongoing clinical support, and advocacy services provided to clients.	No	74
(4) Referral, Coordination, and Monitoring of Medical Services covers the linking of individuals and families with Medicaid service providers to plan, carry out, and maintain a health service plan (not billable TCM).	Yes	57
(5) Referral, Coordination, and Monitoring of Nonmedical Services covers the linking of individuals and families with providers to plan, carry out, and maintain a non-health related service plan (not billable TCM).	No	24
(6) Client Assistance To Access Medicaid Services includes arranging for specific provisions, such as transportation or translation assistance, that are necessary for an individual or family to access Medicaid services.	Yes	5
(7) Client Assistance To Access Non-Medicaid Services includes arranging for specific provisions, such as transportation or translation assistance, that are necessary for an individual or family to access non-Medicaid educational and social services.	No	4
(8) Outreach for Medicaid Services is for activities that inform individuals about Medicaid and how to access Medicaid and related services and about the importance of accessing medical, mental health, and alcohol and drug services and maintaining a routine place for health care. Activities include bringing persons into the Medicaid system for the purpose of determining eligibility and arranging for the provision of medical and other health-related services.	Yes	4

RANDOM MOMENT TIMESTUDY ACTIVITY CODES FOR CONNECTICUT'S COMMUNITY BASED MEDICAID ADMINISTRATIVE CLAIM PROGRAM

Activity Code Description	Included in Community Based Medicaid Administrative Claim?	Number of RMS Responses
(9) Outreach for Non-Medicaid Services is used for activities that inform individuals about non-Medicaid social, vocational, and educational programs and how to access them.	No	1
(10) Facilitating Access to the Medicaid Program includes assisting an individual or family to make application for Medicaid or referring them to the appropriate agency to make application, as well as assisting an individual to maintain Medicaid eligibility.	Yes	4
(11) Facilitating Access to Non-Medicaid Programs includes assisting an individual or family in applying for non-Medicaid assistance (e.g., food stamps, day care, and legal aid) and referring them to the appropriate agency to submit the application.	No	3
(12) Program Planning, Policy Development, and Interagency Coordination Related to Medical Services is used for activities associated with developing strategies to improve the coordination and delivery of medical and mental health services to individuals and families and for collaborative activities with other agencies to provide effective medical services.	Yes	28
(13) Program Planning, Policy Development, and Interagency Coordination Related to Non-Medical Services is used for activities associated with developing strategies to improve the coordination and delivery of non-Medicaid human services to individuals and families and for collaborative activities with other agencies to provide non-Medicaid services.	No	17
(14) General Administration is used for activities that cannot be directly assigned to program activities.	Yes	208
(15) Not Scheduled at Work is used when the staff person being sampled is not scheduled to be at work.	No	108
(16) Invalid Response is used when the position is vacant, the sampled worker does not respond to the pollster, or the worker responds more than 48 hours after the observation moment.	No	117
Total RMS responses		750

[1]RMS = random moment timestudy.

CALCULATION OF CONNECTICUT'S COMMUNITY BASED MEDICAID ADMINISTRATIVE CLAIM FOR FISCAL YEAR 2004

The Connecticut Community Based Medicaid Administrative Claim was calculated by:
(1) subtracting the general administration, not scheduled to work, and invalid RMS responses from the RMS response total to determine the net RMS response total;
(2) dividing the number of RMS responses by the net RMS response total to determine the net RMS response percentage;
(3) multiplying the net RMS response percentage by the Medicaid eligibility rate to determine the allocable RMS response percentage;
(4) multiplying the net RMS response percentage by the total Medicaid allocable cost base to determine the total claim by activity code; and
(5) multiplying the total Community Based Medicaid Administrative Claim by activity code by the Medicaid administrative cost Federal financial participation (FFP) rate of 50 percent.

Community Based Medicaid Administrative Claim Calculation[1]

RMS Activity Code	Number of RMS Responses	RMS Response %	Net Number of RMS Responses 1	Net RMS Response % 2	Medicaid Eligibility Rate % 3	Allocable RMS Response % 4 = 2 x 3	Total Medicaid Allocable Cost Base 5	Total Claim by Activity Code 6 = 4 x 5	Medicaid Administrative Cost FFP Rate % 7	FFP by Activity Code 8 = 6 x 7
1	58	7.73%	58	18.30%						
2	38	5.07	38	11.99						
3	74	9.87	74	23.34						
4	57	7.60	57	17.98	34.83%	6.26%	$149,387,577	$9,354,836	50%	$4,677,418
5	24	3.20	24	7.57						
6	5	0.67	5	1.58	34.83	0.55	$149,387,577	$820,600	50	$410,300
7	4	0.53	4	1.26						
8	4	0.53	4	1.26	100.00	1.26	$149,387,577	$1,885,017	50	$942,508
9	1	0.13	1	0.32						
10	4	0.53	4	1.26	100.00	1.26	$149,387,577	$1,885,017	50	$942,508
11	3	0.40	3	0.95						
12	28	3.73	28	8.83	34.83	3.08	$149,387,577	$4,595,358	50	$2,297,679
13	17	2.27	17	5.36						
14	208	27.73	0	N/A						
15	108	14.40	0	N/A						
16	117	15.60	0	N/A						
Total	**750**	**100%**	**317**	**100%**	**N/A**	**12.41%**	**N/A**	**$18,540,828**	**N/A**	**$9,270,413**

[1]Some values are rounded.

In its response to the letter of deferral from the Centers for Medicare & Medicaid Services, the State agency said that it used State fiscal year (FY) 2005 Medicaid eligibility rates because this rate information was not consistently collected from the 81 contracted organizations before 2005. This Medicaid eligibility rate was not limited to the clients serviced by the specific 81 contracted organizations whose costs were used to calculate the Community Based Medicaid Administrative Claim. Instead, it was based on the type of health insurance coverage used by all 59,550 active clients served by 180 contracted organizations of the Department of Mental Health and Addiction Services as of December 31, 2004, the midpoint of State FY 2005. The 34.83-percent Medicaid eligibility rate comprised two groups of clients: 15,797 with dual Medicare and Medicaid coverage (26.53 percent) and 4,942 with Medicaid-only coverage (8.3 percent). The State agency did not demonstrate that the December 31, 2004, rates were equivalent to FY 2004 rates.

Connecticut Department of Mental Health and Addiction Services Clients by Type of Health Insurance Coverage

Type of Health Insurance	Number of Clients	Percent
Medicare and Medicaid	15,797	26.53%
Medicaid	4,942	8.30
Subtotal	**20,739**	**34.83**
Medicare	7,992	13.42
State general assistance	10,292	17.28
Department of Mental Health and Addiction Services	16,580	27.84
Health maintenance organizations	332	0.56
Other	3,615	6.07
Total	**59,550**	**100.00%**

MICHAEL P. STARKOWSKI
Commissioner

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

TELEPHONE
(860) 424-5053
TDD/TTY
1-800-842-4524
FAX
(860) 424-5057
EMAIL
commis.dss@ct.gov

November 20, 2008

Mr. Michael J. Armstrong
Regional Inspector General for Audit Services
Office of Audit Services, Region I
JFK Federal Building
Boston, MA 02203

Dear Mr. Armstrong:

I am writing in response to the recent draft audit report, "Review of Connecticut's Community Based Medicaid Administrative Claim for State fiscal Year 2004 (A-01-06-00008)" provided to the Connecticut Department of Social Services (DSS) on October 21, 2008. In it, the Connecticut claim for these services was cited for omissions and deviations from acceptable practices that affected the accuracy and calculations of costs for the Community Based Medicaid Administrative claim. In total, federal financial participation of $9.3 million was questioned and the review states that the OIG is unable to express an opinion on the allowability of these costs given the issues cited.

Specifically, the draft review makes the following recommendations:

- The State should draft future contracts with the contracted organizations that deliver community based Medicaid administrative claims (CB MAC) to identify and properly value the amount of administrative case management activities purchased through the contracts and subsequently claimed as CB MAC.

- The State should work with CMS to determine what portion of the Community Based Medicaid Administrative claim for SFY 2004, was allowable under federal requirements. At a minimum this review should limit the cost base used to calculate the claim to actual payments to the DMHAS contractors, obtain sufficient documentation from RMS to support the claimed activities, and follow acceptable statistical sampling practices.

The Department agrees to work with CMS to determine what portion of the community based Medicaid administrative claim of $9,270,413 for the year that ended on June 30, 2004 was allowable under federal requirements. Once we understand the procedure that CMS would like us to utilize, we will use that procedure for any additional prior claims that have already been submitted, as well as any claims that may be submitted in the future.

In regard to the recommendation regarding DMHAS contracts, once a procedure has been agreed to, the Department will review the methods by which we can document costs for these activities under the agreed upon procedures. If required under the procedures established, the State will modify the contracts with DMHAS contracted organizations to better identify dollars associated with administrative case management activities.

Thank you again for the opportunity to comment on your draft review. If you have any specific questions in regard to this matter, please contact James Wietrak, our Acting Deputy Commissioner for Administration at (860) 424-5903.

Sincerely,

Michael P. Starkowski (gps)

Michael P. Starkowski, Commissioner
Connecticut Department of Social Services

Cc: Claudette Beaulieu, Deputy Commissioner
Pat Rehmer, Deputy Commissioner, DMHAS
James Wietrak, Acting Deputy Commissioner
Steve Netkin, OPM
David Parrella
Lee Voghel
John McCormick
Mike Gilbert