SEP - 2 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 Claims for State Fiscal Years 2005 and 2006 (A-01-08-00003)

Attached is an advance copy of our final report on community based Medicaid administrative costs claimed by the Connecticut Department of Social Services (the State agency) for State fiscal years (FY) 2005 and 2006. 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 contracted organizations that provide mental health and related services. In State FY 2004, the State agency began claiming Federal reimbursement for the costs of these activities on the Centers for Medicare & Medicaid Services (CMS) Form CMS-64 through a process referred to as the Community Based Medicaid Administrative Claim (CBMAC). To compute its CBMACs, the State agency used a random moment timestudy (RMS) of the employee activities at the 80 contracted organizations that provided these activities. The State agency claimed $19.8 million for Federal reimbursement of CBMAC-related costs during State FYs 2005 and 2006 based on the results of this RMS.

Our objective was to determine whether the State agency's CBMACs for State FYs 2005 and 2006 complied with Federal requirements.

The State agency's CBMACs may not have fully complied with Federal requirements. Specifically:

- The State agency's calculation of the CBMACs was based on the Medicaid-allocable costs incurred by the 80 contracted organizations ($161,480,735), which exceeded by $19 million the total amount that DMHAS actually paid to these contracted organizations ($142,440,646) for both Medicaid and non-Medicaid services and activities. We were unable to determine the impact of overstating the cost base on the CBMACs because of other errors in the calculation.

- The documentation from the RMS was inadequate for us to determine whether the sampled 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 the omissions and deviations from acceptable practices that the State agency made when calculating its CBMACs. Specifically, these omissions and deviations affected both the accuracy of the calculations of the costs allocated to the CBMACs and the validity of the RMS used to allocate these costs. We are thus unable to express an opinion on the allowability of the State agency's $19.8 million in CBMACs for State FYs 2005 and 2006.

These omissions and deviations occurred because the State agency did not establish adequate procedures to ensure that its CBMACs complied with Federal requirements.

We recommend that the State agency:

- work with CMS to determine what portion of the CBMACs totaling $19,813,373 for State FYs 2005 and 2006 was allowable under Federal requirements by, at a minimum:

    - limiting the cost base used to calculate the CBMACs to the amount that DMHAS actually paid the 80 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 and

- consider the results of this review in its evaluation of our prior recommendations.

In written comments on our draft report, the State agency 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 email at George.Reeb@oig.hhs.gov, or Michael J. Armstrong, Regional Inspector General for Audit Services, Region I, at (617) 565-2689 or through email at Michael.Armstrong@oig.hhs.gov. Please refer to report number A-01-08-00003 in all correspondence.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

Office of Audit Services
Region I
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203
(617) 565-2684

SEP - 8 2009

Report Number: A-01-08-00003

Mr. Michael P. Starkowski
Commissioner
Department of Social Services
25 Sigourney Street
Hartford, Connecticut 06106-5033

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 Claims for State Fiscal Years 2005 and 2006." 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 email at Curtis.Roy@oig.hhs.gov. Please refer to report number A-01-08-00003 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 CLAIMS FOR STATE FISCAL YEARS 2005 AND 2006

Daniel R. Levinson
Inspector General

September 2009
A-01-08-00003

Office of Inspector General

http://oig.hhs.gov

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THIS REPORT IS AVAILABLE TO THE PUBLIC
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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 contracted organizations that provide mental health and related services. The State agency began claiming Federal reimbursement for the costs of these purchased administrative activities in State fiscal year (FY) 2004 on the Centers for Medicare & Medicaid Services (CMS) Form CMS-64 through a process referred to as the Community Based Medicaid Administrative Claim (CBMAC). To compute the CBMAC, the State agency used a random moment timestudy (RMS) of employee activities at the 80 contracted organizations that provided these activities.

The State agency claimed $19.8 million for Federal reimbursement of CBMAC-related costs during State FYs 2005 and 2006.

OBJECTIVE

Our objective was to determine whether the State agency's CBMACs for State FYs 2005 and 2006 complied with Federal requirements.

SUMMARY OF FINDINGS

The State agency's CBMACs may not have fully complied with Federal requirements. Specifically:

- The State agency's calculation of the CBMACs was based on the Medicaid-allocable costs incurred by the 80 contracted organizations ($161,480,735), which exceeded by $19 million the total amount that DMHAS actually paid to these contracted organizations ($142,440,646) for both Medicaid and non-Medicaid services and activities. We were unable to determine the impact of overstating the cost base on the CBMACs because of other errors in the calculations.

- The documentation from the RMS was inadequate for us to determine whether the sampled 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 CBMACs 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 CBMACs totaling $19.8 million for State FYs 2005 and 2006.

These omissions and deviations occurred because the State agency did not establish adequate procedures to ensure that its CBMACs complied with Federal requirements.

RECOMMENDATIONS

We recommend that the State agency:

- work with CMS to determine what portion of the CBMACs totaling $19,813,373 for State FYs 2005 and 2006 was allowable under Federal requirements by, at a minimum:
    - limiting the cost base used to calculate the CBMACs to the amount that DMHAS actually paid the 80 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 and
- consider the results of this review in its evaluation of our prior recommendations.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency 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 State), the Department of Social Services (the State agency) administers the Medicaid program. The State agency, through grants-in-aid awarded by the State's 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 years (FY) 2005 and 2006, the State agency claimed 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 (CBMAC).[1] To compute the CBMAC, 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 751 contracted organization employees and (2) a random selection of moments 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 FYs that ended June 30, 2005, and June 30, 2006 (Appendixes A and C).

The State agency's CBMACs totaled $19.8 million for State FYs 2005 and 2006. The State agency claimed this amount at 50-percent Federal financial participation (FFP) based on the

[1]For these years, the State agency contracted with a third-party contractor to develop the CBMAC. 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.

assumption that DMHAS purchased administrative case management activities from the 80 contracted organizations. The State's share of the CBMACs was the portion of the $142,440,646 grant-in-aid contract payments that DMHAS paid for administrative case management activities.

Prior Office of Inspector General Report

In a prior report,[2] we reviewed the State agency's CBMAC for State FY 2004. We found that the State agency's CBMAC may not have fully complied with Federal requirements. We recommended that the State agency draft future contracts with the organizations whose activities were claimed on the CBMAC to identify and properly value the amount of administrative case management activities and work with CMS to determine what portion of the CBMAC for State FY 2004 was allowable under Federal requirements. The State agency generally agreed with our recommendations. CMS and the State agency had not completed corrective action as of June 16, 2009.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency's CBMACs for State FYs 2005 and 2006 complied with Federal requirements.

Scope

We reviewed the $19.8 million in CBMAC costs that the State agency claimed on its CMS-64 reports for the quarters that ended December 31, 2005, March 31, 2006, and June 30, 2006. State FY 2005 was claimed entirely on the December 31, 2005, CMS-64 report and State FY 2006 was claimed on the CMS-64 reports over the quarters ending December 31, 2005, March 31, 2006, and June 30, 2006.

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 CBMACs.

We performed our fieldwork from February through December 2008 at the State agency and DHMAS in Hartford, Connecticut, and at several contracted organizations throughout the State whose costs were used to develop the CBMACs.

[2] "Review of Connecticut's Community Based Medicaid Administrative Claim for State Fiscal Year 2004" (A-01-06-00008), issued February 20, 2009.

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 CBMACs;
- 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 80 contracted organizations whose costs were included in the CBMACs;
- 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 80 contracted organizations' reported costs used to calculate the CBMACs to supporting financial reports;
- traced the 80 DMHAS grant-in-aid payments to the annual financial reports of the 80 contracted organizations;
- reviewed the documentation supporting the activities sampled in the RMS;
- reviewed the RMS for statistical validity; and
- reviewed the CBMAC 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 CBMACs may not have fully complied with Federal requirements. Specifically:

- The State agency's calculation of the CBMACs was based on the Medicaid-allocable costs incurred by the 80 contracted organizations ($161,480,735), which exceeded by $19 million the total amount that DMHAS actually paid to these contracted organizations ($142,440,646) for both Medicaid and non-Medicaid services and activities. We were

unable to determine the impact of overstating the cost base on the CBMACs because of other errors in the calculations.

- The documentation from the RMS was inadequate for us to determine whether the sampled 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 CBMACs 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 CBMACs totaling $19.8 million for State FYs 2005 and 2006.

These omissions and deviations occurred because the State agency did not establish adequate procedures to ensure that its CBMACs 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 that the results must be statistically valid.

NONCOMPLIANCE WITH FEDERAL REQUIREMENTS

Overstated Cost Base

The State agency used an overstated cost base when estimating the DMHAS expenditures on which the CBMACs were based. The maximum cost base that the State agency could have used was $142,440,646, the total payments that DMHAS made for the 80 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 ($142,440,646). However, the cost base that the State agency used ($161,480,735) exceeded DMHAS's total payments by $19 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 CBMAC calculations.

Inadequate Documentation

We cannot express an opinion on the allowability of the State agency's CBMACs because the State agency provided us with inadequate support for the RMS that it used to calculate them. Specifically:

- The RMS that the State agency used to calculate its CBMACs was not supported by adequate documentation. The only documentation that the State agency, the State agency's contractor, and the contracted organizations maintained to support the RMS was the telephone pollsters' notes, the 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 80 contracted organizations.

- Four of the eighty contracted organizations whose costs were included in the cost base of the CBMACs 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 related 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 (1) only eligible employees are selected for participation in an RMS, (2) study participants do not have access to potentially biasing information, and (3) 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 80 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 44 percent.

    - Instructional materials that the State agency provided to the contracted organizations contained the potentially biasing statement that compliance with the RMS would help generate additional funds for the State and the contracted organizations.

    - Before the RMS was conducted, the State agency provided each of the 80 contracted organizations with the names and contact times of employees who would be surveyed by an 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 call for using rates in calculations that are representative of the entire time period of the calculation. The State agency used a Medicaid eligibility rate based on beneficiaries' health insurance coverage data on December 31, 2004, to calculate the CBMACs for both State FYs 2005 and 2006. However, the State agency could not demonstrate that this rate was representative of the entire time period of the two claims.

- Acceptable statistical sampling practices include providing appraisal results (i.e., precision of the estimates) to give 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 751 sampled items properly reflected the approximately 110 million moments in the population.

- Acceptable statistical sampling practices call for proper treatment of invalid responses. Of the 751 RMS responses, 115 were deemed to be invalid and therefore were removed from the sample. Of the 115 invalid responses, 57 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 CBMACs.

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 CBMACs. Specifically, the omissions and deviations affected both the accuracy of the calculations of the costs allocated to the CBMACs 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 CBMACs totaling $19.8 million for State FYs 2005 and 2006.

LACK OF ADEQUATE PROCEDURES

These omissions and deviations occurred because the State agency did not establish adequate procedures to ensure that its CBMACs complied with Federal requirements.

RECOMMENDATIONS

We recommend that the State agency:

- work with CMS to determine what portion of the CBMACs totaling $19,813,373 for State FYs 2005 and 2006 was allowable under Federal requirements by, at a minimum:

    - limiting the cost base used to calculate the CBMACs to the amount that DMHAS actually paid the 80 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 and

- consider the results of this review in its evaluation of our prior recommendations.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our recommendations. Specifically, the State agency said that it would work with CMS to determine what portion of the CBMACs for the years that ended June 30, 2005, and June 30, 2006, 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 80 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 STATE FISCAL YEARS 2005 AND 2006

	Provider Name	Federal Share[1]	State Grant-in-Aid	Medicaid Allocable Costs[2]	Provider Type
1	Ability Beyond Disability	$22,240	$3,300,318	$362,522	Clinic/Shelter
2	Advanced Behavioral Health	$320,189	$6,157,095	$5,219,135	Clinic/Shelter
3	Alcohol and Drug Recovery Center	$462,999	$2,820,829	$7,546,971	Clinic/Shelter
4	ALSO Cornerstone, Inc.	$83,453	$2,957,890	$1,360,296	Clinic/Shelter
5	Applied Behavioral Rehab and Research Institute	$9,140	$144,316	$148,983	Clinic/Shelter
6	APT Foundation	$317,949	$2,246,329	$5,182,629	Clinic/Shelter
7	Asian Family Services	$2,971	$144,406	$48,430	Clinic/Shelter
8	Bridge House	$50,472	$1,197,611	$822,698	Clinic/Shelter
9	Bridgeport - Central CT Coast YMCA, Inc.	$5,659	$222,149	$92,242	Service Organization
10	Bridges Community Support System	$242,629	$5,207,655	$3,954,889	Clinic/Shelter
11	Catholic Charities of Fairfield County	$33,021	$1,109,919	$538,252	Religious Organization
12	Center for Human Development, Inc.	$221,345	$3,963,576	$3,607,970	Clinic/Shelter
13	Center for City Churches	$3,548	$118,178	$57,840	Religious Organization
14	Central Naugatuck Valley HELP	$59,912	$1,707,597	$976,570	Clinic/Shelter
15	Chrysalis Center, Inc.	$189,370	$3,101,417	$3,086,771	Clinic/Shelter
16	Columbus House	$51,737	$1,159,467	$843,323	Clinic/Shelter
17	Community Health Center	$3,613	$48,393	$58,891	Clinic/Shelter
18	Community Health Resources Inc.	$593,148	$10,773,812	$9,668,418	Clinic/Shelter
19	Community Mental Health Affiliates	$514,118	$8,899,080	$8,380,220	Clinic/Shelter
20	Community Prevention & Addiction Services	$103,294	$776,940	$1,683,715	Clinic/Shelter
21	Community Renewal Team	$3,553	$90,150	$57,910	Clinic/Shelter
22	Connecticut Counseling Centers	$239,770	$484,193	$3,908,285	Clinic/Shelter
23	Connecticut Renaissance	$142,525	$1,287,118	$2,323,189	Clinic/Shelter
24	Connection, Inc.	$106,971	$1,675,708	$1,743,651	Clinic/Shelter
25	Continuum of Care, Inc.	$162,461	$2,957,859	$2,648,144	University
26	Coordinating Council for Children in Crisis	$3,921	$18,988	$63,905	Clinic/Shelter
27	Crossroads	$165,391	$2,121,946	$2,695,906	Clinic/Shelter
28	CTE	$9,053	$19,134	$147,570	Clinic/Shelter
29	Dixwell Newhallville Community Mental Health	$21,072	$309,458	$343,475	Clinic/Shelter

DETAILS OF ORGANIZATIONS PARTICIPATING IN CONNECTICUT'S COMMUNITY BASED MEDICAID ADMINISTRATIVE CLAIM PROGRAM FOR STATE FISCAL YEARS 2005 AND 2006

	Provider Name	Federal Share[1]	State Grant-in-Aid	Medicaid Allocable Costs[2]	Provider Type
30	Fairfield Community Services	$3,423	$28,742	$55,789	Clinic/Shelter
31	Family & Children Agency, Inc.	$36,234	$294,986	$590,621	Clinic/Shelter
32	Family Services Woodfield	$13,585	$356,015	$221,446	Clinic/Shelter
33	Farrell Treatment Center	$44,842	$296,038	$730,937	Clinic/Shelter
34	First Step	$121,038	$4,153,210	$1,972,941	Clinic/Shelter
35	Friendship Service Center	$4,117	$48,742	$67,100	Religious Organization
36	Gilead	$191,671	$5,164,726	$3,124,267	Clinic/Shelter
37	Goodwill	$78,676	$1,551,185	$1,282,428	Clinic/Shelter
38	Hall-Brooke Behavioral Health Services	$8,379	$537,953	$136,572	Hospital
39	Harbor Health	$271,497	$4,008,279	$4,425,441	Clinic/Shelter
40	Hartford Behavioral Health	$81,835	$991,989	$1,333,918	Clinic/Shelter
41	Hartford Dispensary	$468,065	$2,077,084	$7,629,538	Clinic/Shelter
42	Helping Hand Center	$14,917	$102,548	$243,153	Clinic/Shelter
43	Integrated Behavioral Health	$88,648	$1,641,661	$1,444,986	Clinic/Shelter
44	Inter-Community MH Group	$266,946	$3,948,512	$4,351,259	Clinic/Shelter
45	Interlude, Inc.	$73,570	$817,038	$1,199,207	Clinic/Shelter
46	Keystone House	$88,794	$2,152,023	$1,447,363	Clinic/Shelter
47	Laurel House	$59,030	$1,132,096	$962,197	Clinic/Shelter
48	Leeway Inc.	$2,761	$45,000	$45,000	Clinic/Shelter
49	Liberty Community Services	$49,320	$221,244	$803,920	Clinic/Shelter
50	LMG Programs	$479,403	$2,084,853	$7,814,354	Clinic/Shelter
51	Marrakech	$34,031	$702,638	$554,719	Clinic/Shelter
52	McCall Foundation	$127,086	$599,679	$2,071,523	Clinic/Shelter
53	Mental Health Association of CT	$374,463	$6,963,437	$6,103,819	Clinic/Shelter
54	Mercy Housing Shelter Corp	$144,301	$1,324,261	$2,352,138	Religious Organization
55	Midwestern CT Council on Alcoholism	$191,271	$1,083,394	$3,117,744	Clinic/Shelter
56	Morris Foundation	$145,140	$1,429,970	$2,365,812	Clinic/Shelter
57	My Sister's Place, Inc.	$68,052	$824,867	$1,109,267	Clinic/Shelter
58	New Directions	$30,812	$59,664	$502,236	Clinic/Shelter
59	New Haven Home Recovery	$16,307	$270,356	$265,805	Clinic/Shelter

DETAILS OF ORGANIZATIONS PARTICIPATING IN CONNECTICUT'S COMMUNITY BASED MEDICAID ADMINISTRATIVE CLAIM PROGRAM FOR STATE FISCAL YEARS 2005 AND 2006

	Provider Name	Federal Share[1]	State Grant-in-Aid	Medicaid Allocable Costs[2]	Provider Type
60	NW CENTER for Families	$11,974	$93,240	$195,171	Clinic/Shelter
61	Operation Hope	$4,776	$314,804	$77,847	Clinic/Shelter
62	Pathways	$36,397	$957,468	$593,277	Clinic/Shelter
63	Perception Programs	$72,434	$698,512	$1,180,684	Clinic/Shelter
64	Positive Directions	$9,176	$57,382	$149,567	Clinic/Shelter
65	Regional Network of Programs	$411,773	$2,515,768	$6,711,966	Clinic/Shelter
66	Reliance House	$332,132	$5,212,824	$5,413,808	Clinic/Shelter
67	Rushford	$389,025	$6,351,519	$6,341,172	Hospital
68	St. Luke's Lifeworks	$47,039	$895,588	$766,749	Religious Organization
69	St. Vincent DePaul Society MDT	$6,958	$130,352	$113,415	Religious Organization
70	St. Vincent DePaul Society of Waterbury	$15,026	$1,369,694	$244,933	Religious Organization
71	Stafford (Town of) Family Services	$10,339	$66,797	$168,522	Local Government
72	Supportive Environmental Living Facility	$65,806	$1,231,886	$1,072,647	Clinic/Shelter
73	Torrington Chapter of FISH	$1,796	$29,275	$29,275	Clinic/Shelter
74	United Community & Family Services	$9,214	$173,700	$150,188	Clinic/Shelter
75	United Services	$334,487	$5,770,080	$5,452,189	Clinic/Shelter
76	Valley Mental Health Center	$277,227	$5,298,088	$4,518,842	Clinic/Shelter
77	Wheeler Clinic	$99,198	$850,508	$1,616,951	Clinic/Shelter
78	Yale University Child Study Center	$6,987	$113,883	$113,883	University
79	Yale University Hamden Behavioral Health	$29,851	$322,145	$486,574	University
80	YWCA	$11,336	$53,413	$184,776	Service Organization
	Totals	**$9,906,687[3]**	**$142,440,646[3]**	**$161,480,735[3]**	

[1]Federal share, State grant-in-aid, and Medicaid allocable costs are for State fiscal year (FY) 2005.

[2]The Department of Mental Health and Addiction Services (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.

[3]Some values are rounded.

RANDOM MOMENT TIMESTUDY ACTIVITY CODES FOR CONNECTICUT'S COMMUNITY BASED MEDICAID ADMINISTRATIVE CLAIM PROGRAM FOR STATE FISCAL YEARS 2005 AND 2006

Activity Code Description	Included in CBMACs?[1]	Number of RMS[2] 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	47
(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	84
(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	54
(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	9
(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	3
(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	3

RANDOM MOMENT TIMESTUDY ACTIVITY CODES FOR CONNECTICUT'S COMMUNITY BASED MEDICAID ADMINISTRATIVE CLAIM PROGRAM FOR STATE FISCAL YEARS 2005 AND 2006

Activity Code Description	Included in CBMACs?[1]	Number of RMS[2] 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	0
(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	3
(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	4
(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	29
(13) Program Planning, Policy Development, and Interagency Coordination Related to Nonmedical 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	15
(14) General Administration is used for activities that cannot be directly assigned to program activities.	Yes	234
(15) Not Scheduled at Work is used when the staff person being sampled is not scheduled to be at work.	No	109
(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	115
Total RMS Responses		**751**

[1]CBMACs = Community Based Medicaid Administrative Claims
[2]RMS = Random moment timestudy

CALCULATION OF CONNECTICUT'S COMMUNITY BASED MEDICAID ADMINISTRATIVE CLAIMS FOR STATE FISCAL YEARS 2005 AND 2006

Connecticut's CBMACs were 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 CBMAC by activity code by the Medicaid administrative cost Federal financial participation (FFP) rate of 50 percent.

Connecticut's 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	47	6.26%	47	16.04%						
2	38	5.06	38	12.97						
3	84	11.19	84	28.67						
4	54	7.19	54	18.43	34.83%	6.42%	$161,480,735	$10,364,610	50%	$5,182,305
5	9	1.20	9	3.07						
6	3	0.40	3	1.02	34.83	0.36	$161,480,735	$575,812	50	$287,906
7	4	0.53	4	1.37						
8	3	0.40	3	1.02	100.00	1.02	$161,480,735	$1,653,386	50	$826,693
9	0	0.00	0	0.00						
10	3	0.40	3	1.02	100.00	1.02	$161,480,735	$1,653,386	50	$826,693
11	4	0.53	4	1.37						
12	29	3.86	29	9.90	34.83	3.45	$161,480,735	$5,566,179	50	$2,783,090
13	15	2.00	15	5.12						
14	234	31.16	0	N/A						
15	109	14.51	0	N/A						
16	115	15.31	0	N/A						
Totals	**751**	**100%**	**293**	**100%**	**N/A**	**12.41%**	**N/A**	**$19,813,373**	**N/A**	**$9,906,687**

[1]Some values are rounded.

In correspondence with the Centers for Medicare & Medicaid Services, the State agency said that it had used a Medicaid eligibility rate based on beneficiaries' health insurance coverage data on December 31, 2004, the midpoint of State FY 2005, to calculate the CBMACs for both State FYs 2005 and 2006. However, the State agency did not demonstrate that the December 31, 2004, rates were equivalent to the State FYs 2005 and 2006 rates. In addition, this Medicaid eligibility rate was not limited to the clients serviced by the specific 80 contracted organizations whose costs were used to calculate the CBMACs. 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 State agency as of December 31, 2004. 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 (8.30 percent).

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

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July 14, 2009

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 Years 2005 and 2006 (A-01-08-00003)" received by the Connecticut Department of Social Services (DSS) on July 7, 2009. 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 $19.8 million was questioned for these fiscal years. 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 delivery 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 State Fiscal Years 2005 and 2006, 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.

Similar to our earlier response on the OIG CBMAC review of SFY 2004, the Department agrees to work with CMS to determine what portion of the community based Medicaid administrative claim of $19.8 m for the years that ended on June 30, 2005 and June 30, 2006 was allowable under federal requirements. Once we agree with CMS on a procedure that we can 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 Lee Voghel, our Director of Financial Management & Analysis at (860) 424-5842.

Sincerely,

Michael P. Starkowski, Commissioner
Connecticut Department of Social Services

Cc: Joseph Barkus, CMS Region I, Boston
Mary Moriarty, CT CMS Liaison
Pat Rehmer, Deputy Commissioner, DMHAS
Steve Netkin, OPM
Mark Schaefer
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