

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**CONNECTICUT CLAIMED  
UNALLOWABLE MEDICAID  
PAYMENTS FOR TARGETED CASE  
MANAGEMENT SERVICES PROVIDED  
TO INDIVIDUALS WITH CHRONIC  
MENTAL ILLNESS**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



Gloria L. Jarmon  
Deputy Inspector General  
for Audit Services

August 2015  
A-01-14-00001

# *Office of Inspector General*

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## EXECUTIVE SUMMARY

*Connecticut claimed approximately \$958,000 of unallowable Medicaid payments during 2009 through 2011 for Targeted Case Management services provided to individuals with chronic mental illness.*

### WHY WE DID THIS REVIEW

Case management services assist Medicaid beneficiaries in gaining access to medical, social, educational, and other types of services. When these services are furnished to a specific population within a State, they are known as Targeted Case Management (TCM) services. Prior Office of Inspector General reviews found that some States did not always claim Federal Medicaid reimbursement for TCM services in accordance with Federal and State requirements. We conducted this audit to determine whether the Connecticut Department of Social Services' (State agency) claims for Federal Medicaid reimbursement of TCM services met Federal and State requirements. We selected the State agency because we had not previously reviewed its TCM services.

The State agency administers Connecticut's Medicaid program and has designated three target groups that receive TCM services. We reviewed TCM services provided by the Department of Mental Health and Addiction Services (DMHAS) to one of the three target groups, individuals with chronic mental illness. Therefore, in this report, "TCM services" refers only to Medicaid TCM services provided by DMHAS to individuals with chronic mental illness. We selected this target group for review because it had the highest monthly payment rates of the three groups for TCM services.

The objective of this review was to determine whether the State agency claimed Federal Medicaid reimbursement for TCM services in accordance with Federal and State requirements.

### BACKGROUND

TCM services are furnished to specific populations in a State. Allowable TCM services for Medicaid-eligible beneficiaries include the assessment to determine service needs, the development of a specific care plan, the referral to needed services, and the monitoring and followup of needed services. However, allowable Medicaid TCM services do not include direct medical, educational, or social services to which the Medicaid-eligible individual has been referred.

During our audit period, the State agency paid for TCM services on the basis of monthly payment rates that DMHAS calculated using salaries, fringe benefits, contract costs, and other indirect costs.

We reviewed the payment rates used to calculate the Medicaid payments for TCM services from January 1, 2009, through December 31, 2011. Specifically, we reviewed the salaries, fringe benefits, contract costs, and other indirect costs included in the rate calculations to determine

whether the Medicaid payments complied with Federal and State requirements. The State agency claimed \$68,903,789 (\$37,055,324 Federal share) for TCM services paid during this period.

## **WHAT WE FOUND**

The State agency did not always claim Federal Medicaid reimbursement for TCM services in accordance with Federal and State requirements. Specifically, the monthly payment rates that DMHAS calculated included costs that (1) had already been accounted for in a different service cost base and, therefore, should not have been included in the payment rate calculation or (2) were overstated. Consequently, the State agency overstated its claim for Federal reimbursement by \$1,874,257 (\$945,506 Federal share) because it made Medicaid payments for TCM services on the basis of these rates. In addition, the State agency claimed reimbursement for duplicate payments totaling \$24,873 (\$12,437 Federal share) that it made for some TCM services. As a result of using an overstated payment rate and making duplicate payments, the State agency claimed unallowable Medicaid payments of \$1,899,130 (\$957,943 Federal share) for 2009 through 2011. We attributed the overstatement to the State agency's lack of sufficient oversight of DMHAS and its lack of adequate internal controls to detect and prevent duplicate payments.

The State agency also included potentially unallowable costs in its payment rate calculations, which may have overstated its claims for Federal Medicaid reimbursement. DMHAS included the entire contract cost of programs administered by private nonprofit agencies in its TCM payment rate calculations. These programs included both TCM services and services unrelated to TCM. The State agency, however, was unable to provide adequate documentation to show how much of these costs were allowable TCM services and allocable to Medicaid. Accordingly, we were unable to determine the allowability of an additional \$42,581,884 (\$23,049,659 Federal share) in TCM reimbursement.

## **WHAT WE RECOMMEND**

We recommend that the State agency:

- refund \$957,943 to the Federal Government,
- provide additional documentation to the Centers for Medicare & Medicaid Services (CMS) that shows how much of the \$42,581,884 in potentially unallowable costs is allowable or refund \$23,049,659 (Federal share) to the Federal Government,
- adjust future payment rates for TCM services and work with CMS to determine the unallowable Medicaid payments that should be refunded to the Federal Government,
- establish controls to ensure that the payment rate methodology used to claim Medicaid reimbursement for TCM services is in accordance with Federal and State requirements, and
- improve controls used to detect and prevent duplicate payments.

## **STATE AGENCY COMMENTS AND OUR RESPONSE**

In written comments on our draft report, the State agency concurred with our first, third, fourth, and fifth recommendations but did not fully concur with our second recommendation. Regarding our second recommendation, State agency officials stated that they do not believe that the \$23,049,659 should be refunded to the Federal Government. In this regard, the officials stated that they are in the process of retroactively revising all expenditures to comply with the newly approved State plan amendment for expenditures claimed on the basis of payment rates for TCM services calculated after July 1, 2008. Furthermore, the officials also stated that they will work with CMS to confirm the validity of the amounts claimed for Federal Medicaid reimbursement for expenditures claimed on the basis of payment rates for TCM services calculated prior to July 1, 2008. However, the State agency maintains that these expenditures are allowable for Federal reimbursement, based on the information and procedures that existed at the time.

In response to the State agency's comments, we maintain that the State agency should provide additional documentation to CMS that shows how much of the \$42,581,884 in potentially unallowable costs is allowable or refund \$23,049,659 (Federal share) to the Federal Government. We commend the State agency for working with CMS to revise its expenditures claimed on the basis of payment rates calculated after July 1, 2008, and to confirm the validity of expenditures claimed on the basis of payment rates calculated prior to July 1, 2008.

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## INTRODUCTION

### WHY WE DID THIS REVIEW

Case management services assist Medicaid beneficiaries in gaining access to medical, social, educational, and other types of services. When these services are furnished to a specific population within a State, they are known as Targeted Case Management (TCM) services. Prior Office of Inspector General reviews found that some States did not always claim Federal Medicaid reimbursement for TCM services in accordance with Federal and State requirements.<sup>1</sup> We conducted this audit to determine whether the Connecticut Department of Social Services' (State agency) claims for Federal Medicaid reimbursement of TCM services met Federal and State requirements. We selected the State agency because we had not previously reviewed its TCM services.

The State agency administers Connecticut's Medicaid program and has designated three target groups that receive TCM services. We reviewed TCM services provided by the Department of Mental Health and Addiction Services (DMHAS) to one of the three target groups, individuals with chronic mental illness. Therefore, in this report, "TCM services" refers only to Medicaid TCM services provided by DMHAS to individuals with chronic mental illness. We selected this target group for review because it had the highest monthly payment rates of the three groups for TCM services.

### OBJECTIVE

Our objective was to determine whether the State agency claimed Federal Medicaid reimbursement for TCM services in accordance with Federal and State requirements.

### BACKGROUND

#### Medicaid Program

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.

States use the standard Form CMS-64, Quarterly Medicaid Assistance Expenditures for the Medical Assistance Program (CMS-64 report), to report actual Medicaid expenditures for each quarter, and CMS uses it to reimburse States for the Federal share of Medicaid expenditures. The amounts reported on the CMS-64 report and its attachments must represent actual

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<sup>1</sup> *Review of Targeted Case Management Services Rendered by the Massachusetts Department of Social Services During Federal Fiscal Years 2002 and 2003 (A-01-04-00006) and Review of Medicaid Targeted Case Management Services Provided by the Maine Bureau of Child and Family Services During Federal Fiscal Years 2002 and 2003 (A-01-05-00004).*



expenditures with supporting documentation. States claim TCM payments on lines 24 and 24A of the CMS-64 report. The amount that the Federal Government reimburses to State Medicaid agencies, known as Federal financial participation or Federal share, is determined by the Federal medical assistance percentage (FMAP), which varies based on a State's relative per capita income. Although FMAPs are adjusted annually for economic changes in the States, Congress may increase or decrease FMAPs at any time. During our audit period, Connecticut's FMAP ranged from 50.00 percent to 61.59 percent.<sup>2</sup>

## **Connecticut Medicaid Program**

In Connecticut, the State agency administers the provision and payment of Medicaid services. The State agency uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims.

## **Medicaid Coverage of Targeted Case Management Services**

The Social Security Act (the Act) authorizes State Medicaid agencies to provide case management services to Medicaid beneficiaries (§ 1905(a)(19)). Furthermore, the Act defines case management services as “services that will assist individuals eligible under the [State] plan in gaining access to needed medical, social, educational, and other services” (§ 1915(g)(2)). CMS's State Medicaid Director Letter 01-013, dated January 19, 2001 (the Letter), refers to case management services as TCM when the services are furnished to specific populations in a State. The Letter states that allowable TCM services include assessment of the individual to determine service needs, development of a specific care plan, referral and related activities to help the individual obtain needed services, and monitoring and followup. However, the Letter states that case management services do not include the direct delivery of the underlying medical, educational, or social services to which the Medicaid-eligible individual has been referred.

The CMS *State Medicaid Manual* states that Federal financial participation is not available for the specific services needed by an individual as identified through case management activities unless they are separately reimbursable under Medicaid. Also, Federal financial participation is not available for the cost of the administration of the services or programs to which recipients are referred (CMS *State Medicaid Manual* § 4302.2(G)(1)).

## **Payment Rate Calculation**

The State agency paid for TCM services based on a “blended” monthly payment rate that DMHAS calculated each year using (1) the salaries, fringe benefits, contract costs, and other indirect costs attributed to State employees providing TCM services and (2) the costs of the contracts with private/nonprofit (PNP) providers that rendered TCM services. The State agency reimbursed DMHAS one monthly payment for each Medicaid beneficiary, whether the beneficiary received TCM services from State employees providing TCM services, a PNP provider, or a combination of both during the month.

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<sup>2</sup> Under the provisions of the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5, as amended by P.L. No. 111-226, States' FMAPs were temporarily increased for the period October 1, 2008, through June 30, 2011.

## HOW WE CONDUCTED THIS REVIEW

We reviewed the payment rates used to calculate the Medicaid payments for TCM services from January 1, 2009, through December 31, 2011.<sup>3</sup> Specifically, we reviewed the salaries, fringe benefits, contract costs, and other indirect costs included in the rate calculations to determine whether the Medicaid payments complied with Federal and State requirements. The State agency claimed \$68,903,789 (\$37,055,324 Federal share) for TCM services paid during this period.

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 objectives.

Appendix A contains the details of our audit scope and methodology.

## FINDINGS

The State agency did not always claim Federal Medicaid reimbursement for TCM services in accordance with Federal and State requirements. Specifically, the monthly payment rates that DMHAS calculated included costs that (1) had already been accounted for in a different service cost base and, therefore, should not have been included in the payment rate calculation or (2) were overstated. Consequently, the State agency overstated its claim for Federal reimbursement by \$1,874,257 (\$945,506 Federal share) because it made Medicaid payments for TCM services on the basis of these rates. In addition, the State agency claimed reimbursement for duplicate payments totaling \$24,873 (\$12,437 Federal share) that it made for some TCM services. As a result of using an overstated payment rate and making duplicate payments, the State agency claimed unallowable Medicaid payments of \$1,899,130 (\$957,943 Federal share) for 2009 through 2011.

We attributed the overstatement to the State agency's lack of sufficient oversight of DMHAS and its lack of adequate internal controls to detect and prevent duplicate payments.

The State agency also included potentially unallowable costs in its payment rate calculations, which may have overstated its claims for Federal Medicaid reimbursement. DMHAS included the entire contract cost of programs administered by private nonprofit agencies in its TCM payment rate calculations. These programs included both TCM services and services unrelated to TCM. The State agency, however, was unable to provide adequate documentation to show how much of these costs were allowable TCM services and allocable to Medicaid. Accordingly, we were unable to determine the allowability of an additional \$42,581,884 (\$23,049,659 Federal share) in TCM reimbursement.

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<sup>3</sup> We reviewed the TCM monthly payment rate calculations for State fiscal years (SFYs) 2004 through 2011 because the audit period included adjustment claims that were initially paid before January 1, 2009.

## **FEDERAL AND STATE REQUIREMENTS**

### **Federal Requirements**

The Social Security Act requires that payment for services be consistent with efficiency, economy, and quality of care (§ 1902(a)(30)(A)).

Federal regulations require the State to maintain documentation for payment rates and make it available to the Department of Health and Human Services on request (42 CFR § 447.203).

Office of Management and Budget (OMB) Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, states that allowable costs must be necessary and reasonable for proper and efficient administration of the program, be allocable to Federal awards, and be adequately documented (2 CFR part 225, Appendix A, § C(1)).<sup>4</sup>

The CMS *State Medicaid Manual* and the Letter preclude reimbursement for the provision of direct services (medical, educational, or social) to which the Medicaid-eligible individual has been referred (CMS State Medicaid Manual, § 4302.2, the Letter (I)).

The CMS *State Medicaid Manual* further states that payment for case management services may not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. In addition, payment may not be made for services for which no payment liability is incurred (CMS State Medicaid Manual, § 4302.2(F)).

### **State Requirements**

State regulations prohibit payment for case management services that duplicate payments made for other services covered under the Medicaid program (The Connecticut State Plan, Supplement 1 to Attachment 3.1-A(2), page 3, TN No. 94-015 (effective July 1, 1994); and Connecticut Administrative Code § 17-134d-144(c)(2)).

State regulations require payment for case management services to be based on actual direct and indirect costs to provide the services. For each SFY, the State agency must establish a payment rate for case management services based upon the previous fiscal year's actual costs, as updated for inflation (Connecticut Administrative Code § 17-134d-148).

## **THE STATE AGENCY CLAIMED UNALLOWABLE FEDERAL REIMBURSEMENT**

The State agency did not always claim Federal Medicaid reimbursement for TCM services in accordance with Federal and State requirements because, in calculating the monthly payment rates, DMHAS included costs that (1) had already been accounted for in a different service cost base and therefore should not have been included in the payment rate calculation or (2) were overstated. Consequently, the State agency overstated its claim for Federal reimbursement by \$1,874,257 (\$945,506 Federal share). In addition, the State agency claimed Federal

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<sup>4</sup> After our audit period, OMB consolidated and streamlined its guidance, which is now located at 2 CFR part 200.

reimbursement totaling \$24,873 (\$12,437 Federal share) for some duplicate TCM service payments.

### **Payment Rates Were Developed Using Costs Accounted for in a Different Cost Base**

The State agency claimed Federal Medicaid reimbursement for TCM services based on monthly payment rates that were based, in part, on costs that had already been accounted for in a different service cost base. Specifically, DMHAS included \$1,783,093 of PNP costs in its TCM payment rate calculations that were also included in the State agency's Medicaid Community Based Medicaid Administrative Claims rate calculations. The State agency claimed unallowable Medicaid payments of \$941,540 (\$470,770 Federal share) as a result of this error.

### **Payment Rates Were Developed Using Overstated Costs**

The State agency claimed Medicaid payments for TCM services provided during SFYs 2004 through 2011 on the basis of monthly payment rates that included overstated costs. These costs were overstated because they exceeded actual amounts or were based on incorrect service hours, salaries, and wages.

State regulations require payment for case management services to be based on actual costs. However, DMHAS calculated monthly payment rates using cost figures that exceeded actual amounts. For example, DMHAS used a final monthly payment rate of \$327.21 for TCM services provided in 2008.<sup>5</sup> However, DMHAS's actual 2008 costs resulted in a monthly payment rate of only \$320.78. Accordingly, the monthly payments made for each Medicaid beneficiary were overstated by \$6.43 (\$327.21 minus \$320.78). The State agency claimed unallowable Medicaid payments of \$732,528 (\$366,004 Federal share) as a result of this error.

DMHAS also calculated monthly payment rates using incorrect service hours, salaries, and wages. Specifically, DMHAS made input errors for 57 of its employees that overstated their service hours by 4,714 hours and salaries and wages by \$145,848. The State agency claimed unallowable Medicaid payments of \$200,189 (\$108,732 Federal share) as a result of this error.

In total, the State agency claimed unallowable Medicaid payments totaling \$932,717 (\$474,736 Federal share) as a result of including overstated costs in its payment rate calculation.

### **The State Agency Claimed Federal Reimbursement for Duplicate Payments**

The State agency also claimed Federal reimbursement for duplicate Medicaid payments made to DMHAS for some TCM services. Specifically, the State agency claimed multiple TCM monthly payments for the same Medicaid beneficiaries for the same month. The State agency claimed unallowable Medicaid payments of \$24,873 (\$12,437 Federal share) as a result of this error.

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<sup>5</sup> The final monthly payment rate of \$327.21 was calculated by multiplying the 2007 final payment rate of \$319.23 by the 2008 GDP deflator of 2.50 percent. The 2008 GDP deflator was published in Connecticut's *Economic Report to the Governor, Economic Assumptions of the Governor's Budget, G.D.P. Deflator Projections*.

## **THE STATE AGENCY CLAIMED REIMBURSEMENT FOR POTENTIALLY UNALLOWABLE COSTS**

The State agency included potentially unallowable costs in its payment rate calculations, which may have overstated its claims for reimbursement. Specifically, DMHAS included the entire contract costs of programs administered by PNP providers in its payment rate calculations. These costs included expenditures for services that potentially did not meet the definition of Medicaid TCM.

The DMHAS contracts with the PNP providers describe the level of care provided by each program to the TCM recipients. We determined, on the basis of our review of these contracts, that there was a significant risk that some of the provided services were not allowable Medicaid TCM services. For example, the Young Adult Community Treatment Team contract states that direct psychiatric services may be provided to clients. Other examples include the Case Management contract and the Homeless Outreach and Engagement Case Management contract, which both state that the case manager may take a client to programs. Direct services, such as psychiatric evaluations or treatments and transportation, are not allowable Medicaid TCM services.

The State agency was unable to provide adequate documentation, such as timesheets or the results of a random moment timestudy,<sup>6</sup> to show how much of these costs were allowable TCM services and allocable to the Medicaid program. Accordingly, we were unable to determine the allowability of an additional \$42,581,884 (\$23,049,659 Federal share) for TCM services.

## **THE STATE AGENCY LACKED ADEQUATE CONTROLS**

The Medicaid overpayments occurred because the State agency did not have adequate controls in place to ensure that the amounts claimed for TCM services and submitted for Federal reimbursement were in compliance with Federal and State requirements. The State agency made its payments on the basis of the TCM payment rate calculation by DMHAS. However, the State agency did not adequately monitor the methodology DMHAS used to determine payment rates. Specifically, the State agency did not ensure that the payment rates were based on costs that:

- had not already been accounted for in a different service cost base;
- were necessary, reasonable, and based on actual expenditures; and
- were supported by adequate documentation.

The State agency also did not have adequate controls to detect and prevent some duplicate payments.

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<sup>6</sup> A random moment timestudy (RMTS) is a sampling method designed to determine the amount of effort that a group of employees spends on various activities. The results of a RMTS can be used to allocate costs to various programs.

## RECOMMENDATIONS

We recommend that the State agency:

- refund \$957,943 to the Federal Government,
- provide additional documentation to CMS that shows how much of the \$42,581,884 in potentially unallowable costs is allowable or refund \$23,049,659 (Federal share) to the Federal Government,
- adjust future payment rates for TCM services and work with CMS to determine the unallowable Medicaid payments that should be refunded to the Federal Government,
- establish controls to ensure that the payment rate methodology used to claim Medicaid reimbursement for TCM services is in accordance with Federal and State requirements, and
- improve controls used to detect and prevent duplicate payments.

## STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our first, third, fourth, and fifth recommendations but did not fully concur with our second recommendation. Regarding our second recommendation, State agency officials stated that they do not believe that the \$23,049,659 should be refunded to the Federal Government. The officials stated that they have worked with CMS to revise their TCM payment rate methodology and that the State agency and CMS have agreed on a new process to calculate the payment rates for TCM services as outlined in State plan amendment 08-009, which was approved on February 18, 2015, with an effective date of July 1, 2008. The State agency added that it is in the process of retroactively revising all expenditures claimed on the basis of payment rates for TCM services calculated after July 1, 2008, to comply with the newly approved State plan amendment.

For expenditures claimed on the basis of payment rates for TCM services calculated prior to July 1, 2008, State agency officials stated that they will, in good faith and to the best of their ability, work with CMS to confirm the validity of the amounts claimed for Federal Medicaid reimbursement. In addition, the officials stated that, to the extent possible, they would provide any available documentation and analysis in their possession to support the amounts claimed. Nevertheless, the State agency's position is that the expenditures claimed on the basis of the payment rates for TCM services calculated prior to July 1, 2008, are allowable for Federal reimbursement, based on the information and procedures that existed at the time.

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

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

We maintain that the State agency should provide additional documentation to CMS that shows how much of the \$42,581,884 in potentially unallowable costs is allowable or refund \$23,049,659 (Federal share) to the Federal Government. We commend the State agency for working with CMS to revise its expenditures claimed on the basis of payment rates calculated after July 1, 2008, and to confirm the validity of expenditures claimed on the basis of payment rates calculated prior to July 1, 2008.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

From January 1, 2009, through December 31, 2011, the State agency paid \$68,903,789 (\$37,055,324 Federal share) to DMHAS for Medicaid TCM services with service dates from March 2004 through November 2010.<sup>7</sup> We reviewed the claimed TCM services and the DMHAS TCM monthly payment rate calculations for SFYs 2004 through 2011.

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only those internal controls related to our objective.

We performed our fieldwork at the State agency's office in Hartford, Connecticut, from October 2013 through November 2014.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws and regulations and the State plan;<sup>8</sup>
- held discussions with CMS officials to gain an understanding of the Medicaid TCM services program;
- held discussions with State agency officials to gain an understanding of State policies and controls as they relate to the payment rate methodology for Medicaid TCM services;
- obtained a computer-generated file from the MMIS containing all claims for Medicaid TCM services with paid dates during the period January 1, 2009, through December 31, 2011;
- reviewed and reconciled the MMIS claim data to the State agency's reports for current expenditures reported on the CMS-64 reports;
- evaluated the MMIS claims data to identify 209,544 TCM services provided by DMHAS and PNP providers and claimed by DMHAS totaling \$68,903,789 (\$37,055,324 Federal share);

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<sup>7</sup> We limited our review to TCM services provided and claimed by DMHAS with HCPCS code "T2023." This HCPCS code is for TCM services provided to persons with chronic mental illness.

<sup>8</sup> State plan amendments for the audit period had been withdrawn. Therefore, the applicable State plan amendment as of October 1, 1996, was effective during our audit period.



- reviewed DMHAS’s payment rate calculation for TCM services and its supporting documentation;
- determined whether costs included in the payment rate calculation were allocable and allowable as TCM costs;
- determined the amount that the State agency was reimbursed in excess of the amounts allowed by Federal and State regulations by:
  - computing the allowable payment rate for each SFY by removing unallowable costs from the payment rate calculation;
  - calculating the payment rate difference between the Medicaid amount claimed (paid amount) and the allowable payment rate;
  - multiplying the payment rate difference by the number of units paid; and
  - totaling the differences to determine the amount that the State agency was reimbursed in excess of the amounts allowed by Federal and State regulations; and
- discussed the results of our review and provided our recalculations to State agency officials.

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 objectives.



RODERICK L. BREMBY  
Commissioner

APPENDIX B: STATE AGENCY COMMENTS

STATE OF CONNECTICUT  
DEPARTMENT OF SOCIAL SERVICES  
OFFICE OF THE COMMISSIONER

TELEPHONE  
(860) 424-5053

TDD/TTY  
1-855-470-3767

FAX  
(860) 424-5057

EMAIL  
[commis.dss@ct.gov](mailto:commis.dss@ct.gov)

June 19, 2015

David Lamir, Regional Inspector General for Audit Services  
U.S. Department of Health and Human Services  
Government Center-Room 2425  
John F. Kennedy Building  
Boston, MA 02203

Re: OIG Audit performed on the Connecticut Department of Social Services Report Number A-01-14-00001

Dear Mr. Lamir:

The State of Connecticut Department of Social Services, the Connecticut State agency for the Medicaid program, has reviewed the report issued by the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) Audit Number A-01-14-00001. The audit objective was to determine whether the State agency claimed Federal Medicaid reimbursement for targeted case management (TCM) services in accordance with Federal and State requirements. Provided below are our responses to each recommendation.

**OIG Recommendation:**

OIG recommends that the State agency refund \$957,943 (Federal share) to the Federal Government.

**State of Connecticut Department of Social Services Response:**

The State concurs with the recommendation. The State will refund the \$957,943 by adjusting a future CMS-64 Quarterly Expense Report.

**OIG Recommendation:**

OIG recommends that the State agency provide additional documentation to CMS that shows how much of the \$42,581,884 in potentially unallowable costs is allowable or refund \$23,049,659 (Federal share) to the Federal Government.

**State of Connecticut Department of Social Services Response:**

The State does not fully concur with the recommendation. The State does not believe that the \$23,049,659 should be refunded to the Federal government. The State has worked with CMS

Letter to Mr. Lamir  
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to revise the State's TCM rate methodology and we have agreed on a new process to calculate TCM rates as outlined in the Connecticut State Plan Amendment (SPA) 08-009 approved February 18, 2015 with an effective date of July 1, 2008.

The State is currently in the process of revising all expenditures claimed retroactively to July 1, 2008 to be in compliance with the new approved SPA 08-009.

For the State fiscal years ended June 30, 2004 to June 30, 2008, the State will, in good faith and to the best of its ability, work with CMS to confirm the validity of amounts claimed for Federal Medicaid reimbursement. The State shall, to the extent possible, provide any available documentation and analysis in its possession to support the amounts claimed, however, given the years these claims were originally billed we are uncertain of the availability of such documentation. It is the State's position, however, that expenditures claimed for fiscal years 2004 through 2008 are allowable for Federal Medicaid reimbursement, based upon the information and procedures that existed at that time.

**OIG Recommendation:**

OIG recommends that the State agency adjust future payment rates for TCM services and work with CMS to determine the unallowable Medicaid payments that should be refunded to the Federal Government.

**State of Connecticut Department of Social Services Response:**

The State concurs with the recommendation. The State is calculating the TCM rate for current claims in accordance with the approved rate methodology outlined in the SPA 08-009 that was approved on February 18, 2015. The State is also in the process of revising all expenditures claimed retroactively to July 1, 2008 to be in compliance with the new approved SPA 08-009.

**OIG Recommendation:**

OIG recommends that the State agency establish controls to ensure that the payment rate methodology used to claim Medicaid reimbursement for TCM services is in accordance with Federal and State requirements.

**State of Connecticut Department of Social Services Response:**

The State concurs with the recommendation. A significant amount of effort was put forth to finalize the SPA 08-009 that was approved on February 18, 2015. The SPA 08-009 outlines the calculation of TCM rates that will be used for rates effective July 1, 2008. The Connecticut Department of Social Services will coordinate with the Connecticut Department of Mental

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Health and Addiction Services to develop a scheduled review of rate calculations based on documented cost reports to ensure that the rates are calculated in accordance with the approved rate methodology and are based on actual allowable costs incurred for targeted case management services.

**OIG Recommendation:**

OIG recommends that the State agency improve controls used to detect and prevent duplicate payments.


**State of Connecticut Department of Social Services Response:**

The State concurs with the recommendation. The duplicate issuance of payments was determined an isolated occurrence. The new electronic health record system implemented in 2014 by the Connecticut Department of Mental Health and Addiction Services contains validation controls that will prevent future duplicate payments.

Thank you for the opportunity to respond to these recommendations. The State of Connecticut Department of Social Services remains committed to maintaining the integrity of all aspects of the Medicaid program from the health and well-being of our beneficiaries to the proper utilization of funds in support of this vital program.

If you have any questions or comments or require any additional information from the Department, do not hesitate to contact my office. In my absence you should feel free to contact Deputy Commissioner Kathleen Brennan at [Kathleen.brennan@ct.gov](mailto:Kathleen.brennan@ct.gov); (860) 424-5693; John McCormick, Director, Office of Quality Assurance at [John.McCormick@ct.gov](mailto:John.McCormick@ct.gov); (860) 424-5920 or Frank LaRosa, Manager, Office of Quality Assurance at [Frank.larosa@ct.gov](mailto:Frank.larosa@ct.gov); (860) 424-5855.

Sincerely,

  
Roderick L. Bremby  
Commissioner

C: Curtis Roy, Audit Manager  
Kathleen M. Brennan  
John McCormick  
Frank LaRosa