DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
Region 1
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SEP 2 7 1996

CIN: A-01-96-01501

Mr. Stephen A. Harriman
Commissioner. Department of Public Health
4 10 Capital Avenue, MS#13COM
P.O. Box 340308
Hartford. Connecticut 06 134-0308

Dear Commissioner Harriman:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General. Office of Audit Services' report entitled *Audit of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Title II. administered by the State of Connecticut.* A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

Final determination as to the actions taken on all matters reported will be made by HHS action official named below. We request that you respond to the HHS action 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.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG, OAS reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to the exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5 .)

To facilitate identification, please refer to Common Identification Number A-O 1-96-O 150 1 in all correspondence relating to this report.

Sincerely yours,

Richard J. Ogden
Regional Inspector General
for Audit Services

Enclosures - as stated

Direct Reply to HHS Action Official:
Chief. Cost Advisory and Audit Resolution Branch
Division of Grants and Acquisition Management
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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF THE RYAN WHITE COMPREHENSIVE AIDS RESOURCES EMERGENCY ACT OF 1990, TITLE II ADMINISTERED BY THE STATE OF CONNECTICUT

JUNE GIBBS BROWN
Inspector General

SEPTEMBER 1996
A-01-96-01501

EXECUTIVE SUMMARY

BACKGROUND

The Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (CARE Act), Title II, is intended to supplement amounts states were spending on the Human Immunodeficiency Virus (HIV[1]) epidemic and to improve services for HIV positive clients and their families who would otherwise have no access to health care (i.e, the CARE Act was intended to be the payor of last resort). In order to ensure that Care Act funds supplement state funding the Care Act requires an assurance that states maintain previous levels of effort.

The Department of Health and Human Services (HHS), under Title II of the CARE Act, has awarded the State of Connecticut Department of Public Health (DPH) $10,175,424 during the past six years to provide services to individuals with HIV disease and their families. The DPH provides HIV-related services and enters into agreements and contracts with other State departments and HIV CARE Consortia operating in various geographic areas throughout the State. An HIV CARE Consortium is an association of public and nonprofit private health care and support service providers, and community based organizations operating within a designated area. Services provided by Consortia include: case management, medical, nursing and dental care; diagnostic testing monitoring and medical follow-up *services,* mental health *services,* rehabilitative services, home health care, alternative/complementary services and support services, such as transportation, health insurance benefit assistance and emergency assistance.

OBJECTIVES

The objectives of this audit were to determine whether the State of Connecticut has a management system that assures:

- The State maintains its required level-of-effort for HIV-related activities, and
- CARE Act funds are used as the payor of last resort.

SUMMARY OF FINDINGS

The State of Connecticut should improve its management system to ensure that (1) reliable information is used in reporting that the State maintains its required level-of-effort for HIV-related activities, and (2) CARE Act funds are used as the payor of last resort.

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[1] - For purposes of this report, the term "HIV" also refers to "AIDS", unless the term "AIDS" is specifically stated.

Reporting State HIV-Related Activities: Level-of-Effort

Annually, the Governor provided the required assurances that the State will maintain its required level-of-effort for HIV-related activities. The DPH, however, could not support the Governor's assurances that the State would maintain its required level-of-effort for HIV-related activities. In this respect, DPH's reports of State funded HIV-related expenditures were not based on reliable information. This occurred because DPH did not provide State departments with guidance nor did DPH review and verify submitted data. As such, DPH has no assurance that the State has or will maintain HIV-related activities at the required level.

Care Act Funds as Payor of Last Resort

Contrary to Federal requirements, DPH utilized CARE Act funds to pay for items or services when other funds were available. For the five years ended June 30, 1995, DPH used CARE Act funds to pay $995,000 for drug assistance (Connecticut AIDS Drug Assistance Program) when State funds were available. Further, data provided by the Connecticut Department of Correction (DoC) indicates a significant portion of another $635,000 (FYs 1995 and 1996 only) was used for case management services provided to inmates who were the responsibility of DoC or the parole board. This occurred because the DPH did not: (1) provide specific guidance to State departments specifying that the departments are required to use available State funds before using CARE Act funds, (2) monitor the implementation of the payor of last resort requirement, and (3) establish a mechanism whereby the State pays for the services provided to inmates who remain under the custody of the DoC or the parole board.

By utilizing CARE Act funds when other funding is available, the DPH is not maximizing the possible services available to individuals with HIV. The DPH could have possibly provided additional HIV-related services to meet gaps in services identified by local or statewide HIV CARE Consortium.

RECOMMENDATIONS

Relative to reporting the State HIV related activities, we are recommending that DPH (1) provide written guidance to State departments regarding what data to report as HIV-related expenditures, (2) review and verify data submitted by State departments, and (3) submit a revised report for the latest year of HIV services funded by the State to establish the correct baseline for future years.

Relative to utilizing CARE Act funds as payor of last resort, we are recommending that DPH (1) provide State agencies guidance for utilizing existing State funds prior to CARE Act funds, (2) monitor State agencies to assure State agencies adhere to payor of last resort requirements, and (3) establish a mechanism whereby the State pays for the services provided to inmates who remain under the custody of the DoC or the parole board.

In response to our draft report, DPH officials concur with our recommendations relative to reporting the State HIV related activities. Regarding the utilization of CARE Act funds as payor of last resort, DPH officials have revised the Memorandum of Agreement (MOA) with the DSS to contain specific language requiring that CARE Act funds be used only after state-allocated funding is entirely expended. In addition, DPH officials indicated they will monitor the implementation of the MOA with DSS.

Regarding case management services provided to inmates who are the responsibility of DoC, DPH officials responded with DoC concerns that inmates released to parole are no longer under the jurisdiction of DoC and that it is not feasible for DoC to provide services to inmates because the DoC personnel providing case management services do not have access to inmates' HIV status due to the requirements of state confidentiality. We mention in our report that while parolees are not under the custody of DoC, Connecticut General Statutes establish that the parole board is responsible for parolees. Regardless of whether or not parolees are the responsibility of DoC, the DPH needs to establish that the appropriate party pay for the services provided. Further, regarding the confidentiality to inmates' HIV status due to state confidentiality laws, it should be noted that confidentiality laws apply to any provider. Currently, inmates voluntarily disclose HIV status to the DoC medical staff and the medical staff make the referral based on inmate authorization. The referral can be made to any appropriate service provider. We did not recommend that DoC provide the service, only that the DoC or the parole board pay for the service regardless of the provider. Accordingly, the concerns raised by DoC do not necessitate a change in our recommendation.

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INTRODUCTION

BACKGROUND

On August 18, 1990, Congress passed Public Law 10 1-3 8 1 entitled The Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (CARE Act). The CARE Act provides emergency assistance to localities that are disproportionately affected by Human Immunodeficiency Virus (HIV[2]). The CARE Act is multifaceted, with four titles directing resources to cities, states and demonstration grants. The CARE Act Title II is intended to supplement amounts states were spending on the HIV epidemic and to improve services for HIV positive clients and their families who would otherwise have no access to health care (i.e, the CARE Act was intended to be the payor of last resort).

Under Title II of the CARE Act, the Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA) awards funds to states. States use CARE Act funds to establish and operate HIV care consortia that provide services to HIV-infected individuals and their families. A consortium is an association of one or more public and nonprofit private health care and support service providers operating in areas determined by the state to be most affected by HIV disease. The consortium uses the funds to plan, develop, and deliver medical and support services based on a comprehensive state plan.

In addition to funding consortia, states use CARE Act funds to provide HIV-infected people with home and community-based services, continuity of health insurance coverage, and prescription drugs. Awards to the State of Connecticut Department of Public Health (DPH) AIDS Division under Title II of the CARE Act increased in 5 years, from $764 thousand in 1991 to $2.8 million in 1996. Over $10 million has been awarded to the DPH in the past six years.

DPH - Funding in Thousands							
Title	1991	1992	1993	1994	1995	1996	Cumulative
II	$764	$915	$1,068	$2,246	$2,405	$2,777	$10,175

In year four of the CARE Act (April 1994 through March 1995), the DPH entered into Memorandums of Agreement (MOAs) with five State departments to plan and develop services for persons with HIV. These State departments included the Department of Social Services (DSS) and the Department of Correction (DoC). In addition, the DPH funded the statewide HIV CARE Consortium and nine regional consortia representing over 70 agencies. The statewide HIV CARE Consortium is a statewide organization comprised of State departments, statewide organizations, community based agencies, regional consortia, and persons living with HIV and their families. Services provided by the statewide Consortia include: housing assistance, case management for inmates being released, pediatric case management, substance abuse treatments,

[2] - For purposes of this report, "HIV" also refers to "AIDS", unless the term "AIDS" is specifically stated.

and drug therapies. The Regional Consortiums cover all areas of the State including 169 towns in eight counties. Services provided by the regional consortia include: medical assistance; case management; and emergency assistance, which includes utilities assistance, transportation services, housing and meals.

SCOPE OF AUDIT

The objectives of this performance audit were to determine whether the State of Connecticut has an adequate management system that assures the State has maintained its required level-of-effort for HIV-related activities, and CARE Act funds are used as the payor of last resort. Our audit covered the period of DPH's CARE Act applications for 199 1 through 1995 (April 1, 199 1 through March 3 1, 1996) and the related State HIV-related expenditures for the period July 1, 1989 through June 30, 1994.

In planning and performing our audit, we limited our consideration of management controls to DPH's (1) accumulating and reporting of State funded HIV-related services, and (2) utilization of State and other available sources prior to the use of CARE Act funds. Specifically, we:

- Reviewed Connecticut's 1991 through 1995 Title II grant applications and Annual Reports of the State Comptroller,
- Interviewed officials from the State and the Greater Hartford Primary Care Consortium,
- Obtained an understanding of Department of Children and Families (DCF), DoC, DPH and DSS procedures for tracking HIV-related expenditures, and traced State HIV-related expenditures for 1989 through 1994, as reported in the State's 199 1 through 1995 CARE Act grant applications on schedule *HIV Services Funded by the State* to available supporting documentation at DCF, DoC, DPH and DSS,
- Reviewed DCF, DoC and DSS' relevant policies and procedures as well as guidance provided by DPH, and
- Reviewed the DPH's (1) MOAs with DSS and DoC, and (2) contracts with Connecticut Prison Association (CPA) and GHPCC. For MOAs between DPH and DoC, we reviewed the annual contracts with CPA for the two years ended June 30, 1996.

We conducted our audit in accordance with generally accepted government auditing standards during the period October 1995 through July 1996 at the Connecticut Departments of Correction, Children and Families, Public Health, and Social Services and the Greater Hartford Primary Care Consortium. We issued a draft report on August 9, 1996 and have appended DPH comments in their entirety (see Appendix).

FINDINGS AND RECOMMENDATIONS

The State of Connecticut should improve its management system to ensure that (1) reliable information is used in reporting that the State maintains its required level-of-effort for HIV-related activities, and (2) CARE Act funds are used as the payor of last resort.

REPORTING STATE HIV-RELATED ACTIVITIES: LEVEL-OF-EFFORT

Annually, the Governor provided the required assurances that the State will maintain its required level-of-effort for HIV-related activities. The DPH could not support the Governor's assurances that the State would maintain its required level-of-effort for HIV-related activities. In this respect, DPH's reports of State funded HIV-related expenditures were not based on reliable information. This occurred because DPH did not provide State departments with guidance nor did DPH review and verify submitted data. As such, DPH has no assurance that the State has or will maintain HIV-related activities at the required level.

The CARE Act, section 2617 (b) states in part:

> The application submitted . . . shall contain
>
> (1) a detailed description of the HIV-related services . . . that shall include . . . an accounting of the amount of funds that the State has expended . . . during the year preceding the year for which the grant is requested.
>
> (3) an assurance by the State that . . . the State will maintain HIV-related activities at a level that is equal to not less than the level of such expenditure for the 1-year preceding the fiscal year for which the State is applying to receive a grant under this part . . . .

Through its grant application instructions each year, HRSA requests the accounting and assurance referred to above. The DPH in its 199 1 - 1995 grant applications provided the accounting on the schedule *HIV Services Funded by the State.* The Governor of Connecticut signed the required assurance each year. For the live CARE Act application years, April 1991 through March 1996, Connecticut reported State funded HIV-related expenditures of $76.8 million (five years ending June 30, 1994).

The data as reported to HRSA on the schedules of *HIV Services Funded by the State* indicates that Connecticut did not maintain the required level-of-effort in at least 1994 (see Table 1). In this respect, State expenditures reported in application years 1994 and 1995, were less than the level-of-effort reported in grant year 1993 by $5 million and $2 million, respectively. We however, cannot confirm this because the reports are not reliable. In this respect, because of the issues identified below relative to (1) our review of reported costs, and (2) DPH's practices for data collection, we found the reports were not accurate or complete.

Application Year	Amount	(CT Fiscal Year)
1991 (4/1/91 - 3/31/92)	$8,693,918	7/1/89 - 6/30/90
1992 (4/1/92 - 3/31/93)	$11,439,061	7/1/90 - 6/30/91
1993 (4/1/93 - 3/31/94)	$21,218,552	7/1/91 - 6/30/92
1994 (4/1/94 - 3/31/95)	$16,192,863	7/1/92 - 6/30/93
1995 (4/1/95 - 3/31/96)	$19,218,564	7/1/93 - 6/30/94
Total	$76,762,958	

* DPH submitted its 1996 application on January 31, 1996. In the 1996 application, DPH reported $21,458,127 as State HIV-related expenditures. We did not review support for this amount. The DPH officials informed us that they utilized the same procedures for preparing the 1996 schedule as for earlier years.

Table I -State Reported Expenditures for HIV-Related Activities

Review of reported costs - We reviewed selected line items at several departments (approximately $54.5 million of the $76.8 million reported) from the schedules, *HIV Services Funded by the State.* We found that $24.5 million or 45 percent of the reported State HIV-related expenditures which we reviewed were unsupported or reported in error. Specifically, we found that:

- $15.9 million of the reported amounts was the Federal share of Medicaid HIV related expenditures for application years 1993 through 1995 (an average of $5.3 million per year). These were not State expenditures and State officials were unable to explain how they were included in the State funded expenditures.

- The DPH and the departments reporting to DPH could not locate support for S6.9 million of the expenditures reviewed ($0.9 million for 1991, $2.2 million for 1992, $2.2 million for 1993, $1 million for 1994 and $0.6 million for 1995).

- The DPH reported $1.7 million in error ($0.6 million addition error for FY 1993 and $1.1 million counted twice for FY 1992).

DPH 'spracticesfor data collection - The DPH officials apprised us that their data collection practices include utilizing both expenditures and appropriations/budgeted amounts. In this respect, DPH officials pointed out that approximately $32 million ($4.9 to $8.1 million per year) of the $76.8 million reported to HRSA was based on appropriations or budgeted amounts ($16.1 of the $32 million appropriations/budgets were reviewed above and included in some

unsupported and erroneous expenditures) and $44.7 million were based on expended amounts. These practices do not provide accurate data as appropriations and budgets are not expenditures. For example, we found DPH reported appropriated amounts for the Connecticut AIDS Drug Assistance Program (CADAP) when actual expenditures were only 32 percent to 71 percent of CADAP appropriations (46.3 percent for 1993, 71 percent for 1994 and 32.5 percent for 1995). Further, the DPH did not include in State HIV-related expenditures depreciation relating to capital expenditures of $2.1 million for FY 1995.

We believe the above examples show that the reported amounts are not reliable. In this respect, the above illustrates inaccurate and incomplete disclosure of financial results.

Title 45 Code of Federal Regulations Part 92, Subpart C, Post Award Requirements - Financial Administration, provides at 92.20 (a)(1):

> . . . Fiscal control and accounting procedures of the State . . . must be sufficient to - permit preparation of reports required by this part and the statutes authorizing the grant . . . .

In this respect, there should be an adequate management system which permits the preparation of reports based on accurate, current, and complete disclosure of financial results.

The DPH officials apprised us they have not provided written guidance to applicable State departments regarding what data to report as HIV-related expenditures. Further, DPH officials neither verify the accuracy and completeness of submitted data nor compare the data year to year to determine whether Connecticut has complied with the level-of-effort requirements.

Based on our review of DPH's reports of State funded HIV-related activities, we believe that the DPH does not know whether the State has or will maintain HIV-related activities at the required level. Title II funds of the CARE Act are intended to supplement State HIV funding. Without support that the State is maintaining its required level of effort HIV related services may not be maximized within the intent of the law.

Recommendations

We are recommending that the DPH:

1. Provide written guidance to State departments regarding what data to report as HIV related expenditures. For example, the guidance should (I) state that expenditures, not budgeted or appropriated amounts, should be reported, (2) define what services do and do not constitute HIV-related services for reporting purposes, and (3) require expenditure data from State departments to be reported to DPH in writing.

2. Review and verify the data reported by State agencies.

3. Submit a revised report for the latest year of HIV-related services funded by the State to establish the correct baseline for future years.

Auditee Comments

In response to our draft report, DPH officials concur with our recommendations,

CARE ACT FUNDS AS PAYOR OF LAST RESORT

Contrary to Federal requirements, CARE Act funds are being used to pay for items and services when other funds were available. For the five years ended June 30, 1995, DPH used CARE Act funds to pay $995,000 for drug assistance (CADAP) when State funds were available and a significant portion of another $635,000 (FYs 1995 and 1996) for case management services provided to inmates who were the responsibility of the Connecticut Department of Correction and/or the State. This occurred because the DPH did not: (1) provide specific guidance to State departments specifying that the departments are responsible for using available State funds before using CARE Act funds, (2) monitor the implementation of the payor of last resort requirement, and (3) establish a mechanism whereby the State pays for the services provided to inmates who remain under the custody of the DoC and/or the State. Accordingly, the DPH is not maximizing the possible services available to HIV individuals.

The Notice of Grant Award incorporates P.L. 101-381 (the CARE Act) as one of the terms and conditions of the award.

> The CARE Act, section 2617 (a) & (b) states:
>
> > The Secretary shall not make a grant to a State . . . unless the State prepares and submits, to the Secretary, an application . . . containing such agreements, assurances, and information as the Secretary determines to be necessary . . . .
> >
> > The application submitted...shall contain an assurance by the State that-...the State will ensure that grant funds are not utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made with respect to that item or service...under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or by an entity that provides health services on a prepaid basis.

In effect, the CARE Act requires that CARE Act funds be used as the payor of last resort

Department of Social Services

In 1989, DSS established the CADAP with funds appropriated by the Connecticut legislature. The CADAP provides drug therapies for individuals (1) who have a certified medical diagnosis of HIV disease and are not Medicaid eligible, (2) who are determined to have a net income equal to or below a percentage (currently 300 percent) of the Federal poverty level, and (3) whose medical insurance may pay only a portion of the drugs covered by the CADAP. Since Connecticut first received funding under the CARE Act (April 199 1), the DPH has entered into Memorandums of Agreement (MOA) with the DSS to supplement the State-funded CADAP.

The DSS administers the CADAP and pays for all CADAP expenditures from the State CADAP account, then quarterly reimburses the State account with funds from the CARE Act account. The state appropriated $2,354,800 in State funds for the CADAP during State-fiscal years 1991 through 1995. During this same period, DSS charged the CARE Act $1,174,398 while the DSS did not use $1,147,721 of the $2,354,800 originally appropriated for CADAP. Subsequently, the DSS made the $1,147,721 of State funds available for purposes other than the CADAP.

The DSS charged the CARE Act a total of $1,174,398 when $995,403 in State funds were specifically appropriated and still available for the same purpose. Accordingly, $995,403 in CARE Act funds were not used as the payor of last resort (see Table 2).

State Fiscal Year	STATE FUNDS			CARE Act Expenditures	CARE Act Funds Not Used as Payor of Last Resort
	Appropriations	Expenditures	State Approp. Unspent		
1	2	3	4 (2 - 3)	5	6 (lessor of 4 or 5)
1991	$109,789	$1,108	$108,681	$98,961	$98,961
1992	388,253	272,744	115,509	226,862	115,509
1993	745,758	368,375	377,383	315,904	315,904
1994	519,000	192,222	326,778	245,659	245,659
1995	592,000	372,630	219,370	287,012	219,370
	$2,354,800	$1,207,079	$1,147,721	$1,174,398	$995,403

Note: Ryan White program started April 1, 1991 (amounts in 1991 adjusted for last quarter of fiscal year)

Table 2 - Connecticut AIDS Drug Assistance Program Since CARE Act Funding

While the DPH's MOA with DSS references the CARE Act, the MOA does not cite the payor of last resort requirement of the CARE Act under the DSS responsibilities section of the MOA. Further, DPH officials apprised us that they had not monitored DSS' compliance with this requirement and were not aware that the DSS was using CARE Act funds prior to expending State appropriations for the CADAP.

Accordingly, the DPH is not maximizing the possible services available to HIV individuals. The DPH, over a five year period, could possibly have provided $995,403 of additional CADAP services or other HIV-related services to meet gaps in services identified by local or statewide HIV Care Consortiums had DSS used available State funds.

Recommendations

The DPH should ensure that CARE Act funds provided to DSS are not used to make payments for any item in which payment has been made or can reasonably be expected to be made under any State health benefits program. Specifically, we are recommending that the DPH:

1. Provide specific guidance to DSS, for example by adding a clause in its MOAs with DSS, specifying that DSS is responsible for complying with the CARE Act provision regarding payor of last resort.

2. Monitor DSS' implementation of the MOA

Auditee Comments

The DPH officials have revised the MOA with the DSS to contain specific language requiring that CARE Act funds be used only after state-allocated funding is entirely expended. In addition. DPH officials indicated they will monitor the implementation of the MOA.

Department of Correction

In September 1994, the DPH entered into a MOA with the DoC to contract with the nonprofit Connecticut Prison Association (CPA) to establish a program to facilitate the transition of inmates with HIV into the community. The program, Transitional Linkage to the Community (TLC), which was funded with CARE Act funds, provides for case management services to be provided to HIV infected inmates within 90 days of the inmate's earliest release date and to continue for 30 days after release, or until the client can be successfully transferred to a community-based case manager. The DPH utilized $635,209 of CARE Act funds ($285,448 for State FY 1995 and $349,761 for State FY 1996) for the TLC program.

In accordance with Connecticut General Statute Title 18, Chapter 325, Section 18-100d, the DoC or the board of parole is responsible for the supervision of persons convicted of a crime until the expiration of the maximum term or terms for which he was sentenced. Per CORPUS *JURIS SECUNDUM, A CONTEMPORARY STATEMENT OF AMERICAN LAW AS DERIVED FROMREPORTED CASES AND LEGISLATION,* § 80, inmates have a right to medical care and prison officials have a corresponding duty to provide such care. Further, per § 82, the medical care must be reasonably designed to meet both an inmate's routine and emergency medical needs.

Connecticut General Statute Title 18, Chapter 325, Section 18- 84 defines an inmate and prisoner to include any person in the custody of the Commissioner of Correction or confined in a facility of the DoC until released from such custody or control, including any person on parole. The DoC officials apprised us that inmates released to various community service programs are under custody of DoC until the inmate reaches the expiration of his sentence. Per DoC's Community Services Manual, effective, July 1, 1994, parolees are the responsibility of the Board of Parole.

The DoC has established programs to provide for both the medical and community reintegration needs of its prisoners. In this respect, the Health Services Unit provides direct medical services and the Community Services Unit provides community service programs (approximately 60 programs contracted with independent contractors). These community-based service programs are residential or non-residential programs provided by private, non-profit organizations, and State departments which offer housing, transportation, employment and counseling services to incarcerated, paroled or discharged offenders. For FY 1995 the State appropriated $29.4 million for the Health Services Unit and $16.6 million for the Community Services Unit. The DoC returned $1.1 million and $1.2 million, for these units respectively, to the State's General Fund.

The Community Services Unit has Community Services Officers (CSO) who are responsible for the day-to-day supervision of inmates in the community, ensuring that inmates are in compliance with the conditions of their release. The CSO, prior to inmates' release to a community service program, initiates a preliminary work-up of inmates' needs and assessments (case management plan). The case management approach to supervision focuses on the goal of effective and coordinated reintegration of an inmate into the community. The case management plan shall assess inmates' needs in the following areas: (1) medical and health care, (2) mental health care, (3) education, (4) vocational training and work skills, (5) substance abuse treatment, (6) sex offender treatment, and (7) family/residence or community resources. After the inmate's release, the CSO meets face-to-face with the inmate for at least ten hours per week for the first thirty days. Thereafter, the CSO is responsible for following up with the inmate and the community based program until the inmates' end of sentence.

In addition to the services provided by the CSO, the individual community service programs are responsible for certain case management services, such as: assistance with applications for entitlement programs, post release housing assistance, employment skills, substance abuse education, medical referrals, and discharge planning. The services provided by the CSOs and the DoC's Community Services programs are very similar in nature to the case management services provided by TLC. For example, TLC's responsibilities include initiating contact with clients while incarcerated, assessing clients needs to develop a community based treatment plan, initiating and coordinating applications for entitlement, and linking clients to permanent case management programs through various community based programs. Regardless of the similarities between TLC, CSOs and community service programs, it remains DoC's and the parole board's responsibility to provide for and meet the needs of inmates while they remain under the custody of DoC and the parole board.

A significant portion of TLC's efforts are provided to clients while the inmates are under the custody of DoC or the parole board. In this respect, DoC-provided data shows that at least 33 percent of clients serviced by TLC had a release status (e.g., community release, half-way house, transitional supervision and parole) which placed them under the custody of the DoC or the parole board at the time services were provided. Further, DPH, DoC and TLC officials informed us that TLC services clients for 90 days (approximately 75 percent of time under TLC care for any single client) prior to release from DoC. In this regard, three of the four objectives of the TLC contract relate to client care (establish contact while incarcerated, assess each client's needs and begin development of treatment plan while incarcerated, and provide a bridge between correctional facility and community at time of release). The first two objectives can only be satisfied while the client is incarcerated and under the custody of DoC. The third objective requires contact while the inmate is incarcerated and after release. Officials from DPH, DoC and TLC have informed us that all services provided by TLC start while the inmates are incarcerated. In support of these services being provided prior to release, an independent evaluation conducted under the fourth TLC contract objective by a contracted third party reported "*The TCMs* [transitional case managers] *begin acquisition of needed services for inmates during incarceration.* ."

We believe that for those TLC clients who are still under custody of DoC or the parole board (all inmates prior to release and inmates released to community release programs), it is the responsibility of DoC or the parole board to provide and pay for such care. The TLC, however, does not maintain records of the inmates' sentence status. Records of the inmates' status are not maintained because the DPH did not design the TLC program for DoC or the parole board to pay for services provided to inmates under the custody of the DoC or the parole board. In this regard, the DPH contract with CPA does not distinguish between inmates who are under the custody and the responsibility of DoC versus inmates who served their full sentence and are no longer under the custody of DoC. Further, the MOA between DPH and DoC does not stipulate that DoC will pay for services rendered under the TLC program to inmates who are under the custody of DoC or the parole board.

We commend DPH for initially identifying the needs of HIV positive prisoners and developing the expertise to meet those needs. Now that the expertise has been developed, the DPH should develop a mechanism whereby DoC or the parole board pays for the services provided to inmates who remain under the custody of DoC or the parole board. This would enable the DPH to maximize its use of CARE Act funds and possibly provide additional HIV-related services to meet gaps in services identified by local or statewide Consortiums.

Recommendation

We are recommending that the DPH establish a mechanism whereby DoC or the parole board pays for the services provided to inmates who remain under the custody of DoC and the parole board.

Auditee Comments

In comments to our draft report, DPH officials did not dispute that the DoC or the parole board has responsibility for the services provided to inmates who remain under the custody of DoC or the parole board. However, they requested that the final report reflect DoC comments that (1) inmates released to parole are no longer under the jurisdiction of DoC, as the Board of Parole is a separate agency, (2) it is not feasible for CSO to provide services to inmates because the CSOs do not have access to inmates' HIV status due to the requirements of state confidentiality, and (3) the information in the report be changed to show the release status of the 33 percent TLC clients as follows: 15.5 percent paroled to the supervision of the Board of Parole; 10.5 percent released to transitional supervision; and 7.0 percent transferred to halfway house programs.

Additional OIG Comments

We mention in our report (page 9) that the parole board rather than DoC has been responsible for parolees since July 1, 1994. Further, we mention that Connecticut General Statute Title 18, Chapter 325, Section 18-100d, establishes that the board of parole is responsible for the supervision of persons convicted of a crime until the expiration of the maximum term or terms for which he was sentenced. Regardless of whether or not parolees are the responsibility of DoC, the DPH still needs to establish a mechanism for the appropriate party to pay for the services provided to inmates.

Regarding the auditees second comment, it should be noted that the confidentiality laws apply to any provider of services, including TLC. Currently, inmates voluntarily disclose HIV status to the DoC medical staff and the medical staff make the referral based on inmate authorization. The referral can be made to any appropriate service provider. Further, we did not recommend that CSOs provide the service, only that the DoC or the parole board pay for the service regardless of the provider. Nevertheless, the DoC does not dispute that the CSO and the

community service programs provide services similar to the TLC. The DoC does not relieve itself of the responsibility to pay just because the service is provided by the TLC and not the CSO. As such, comments provided by DoC do not change our conclusion that DoC and the parole board have responsibility for these services provided to inmates.

Lastly, while the DOC wanted the report to disclose the release status of the 33 percent TLC clients, which we disclose in the Auditee Comments above, this further refinement still shows that the 33 percent are all under the custody of the DoC or the parole board. Accordingly, our conclusions and recommendations remain the same.

APPENDIX

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF COMMISSIONER

September 6, 1996

Richard J. Ogden
Regional Inspector General for
Audit Services
Office of Audit Services
Department of Health and Human Services
John F. Kennedy Federal Building
Boston. MA 02203

Dear Mr. Ogden:

Thank you for the opportunity to review the draft report entiried "Audit of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990. Title II. administered by the State of Connecticut." This Department's comments are as follows.

The first issue addressed *in* the draft audit is entitled "Reporting State HIV-Related Activities." We concur with the recommendations. We also wish to point out that in the five years since rhis Department has administered this funding, we have never received guidance from rhe DHHS Heaith Resources Services Administration on compliance with this program requirement. In fact, draft guidance for 1997 contains a table similar to those found in guidance documents from previous years. entitled "HIV Services Funded by the State." As in rhe past. this *year's* draft document asks for funding and *not* specifically for expenditure data and does not defme HIV related expenditures. Though we agree that inadvertent errors may have been made in the past. we and other states need guidance from WRSA to meet this requirement. Nevertheless, we have taken **steps** to improve accounting for HIV-reiared expenditures of all state agencies in Connecticut in the 1997 application.

The second issue addressed in the draft audit is use of CARE Act funds as payor of last resort for the Department of Social Services. The current Department of Public Health (DPH) memorandum of agreement with the Cepartment of Social Services (DSS) does contain specific language requiring that CARE Act funds be used only after state-allocated funding is entirely expended. Until the audit occurred. we had been unaware that DSS was expending federal funds before exhausting state funds. We have shared the drafi audit findings with DSS. and we will be monitoring their implementation of the memorandum of agreement. DSS has requesred that the audit report reflect on page 7 that 300 percent of the federal poverty level is determined based on net income.

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The third issue addressed in the draft audit is use of CARE Act funds as payor of last resort for the Department of Correction (DOC). DOC previously gave extensive comments to the auditors. In these comments. they pointed out that inmates released to parole are no longer under the jurisdiction of DOC, as the Board of Parole is a separate agency. The audit report should be amended to reflect that. DOC has also explained that it is not feasible for Community Service Officers to provide these services to inmates because the CSOs do not have access to information on inmates' HIV status due to the requirements of state confidentiality laws. They also request that the information *on* page 10 be changed to show the release status of the 33 percent of the Transitional Linkage into the Community (TLC) clients as follows: 15.5 percent paroled to the supervision of the Board of Parole: 10.5 percent released to transitional supervision; and 7.0 percent transferred to halfway house programs.

I appreciate the opportunity to provide comments on the draft audit and hope that the final audit will reflect our views. If you have any questions, please call Beth Weinstein. Director of AIDS Programs. at (860) 509-7832.

Sincerely,

Stephen A. Harriman
Commissioner of Public Health

SAH/sm

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