

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**COMMONWEALTH OF VIRGINIA
DEPARTMENT OF HEALTH**

**SECTION 1864 - 1902 SURVEY AND
CERTIFICATION COSTS FOR HEALTH
CARE PROVIDERS AND SUPPLIERS**

OCTOBER 1, 1997 - SEPTEMBER 30, 1999



**AUGUST 2001
A-03-00-00209**



DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
OFFICE OF AUDIT SERVICES
150 S. INDEPENDENCE MALL WEST
SUITE 316
PHILADELPHIA, PENNSYLVANIA 19106-3499

August 3, 2001

The Honorable E. Anne Peterson, M.D., M.P.H.
Commissioner, Virginia Department of Health
1500 East Main Street
P.O. Box 2448
Richmond, Virginia 23218-2448

Dear Dr. Peterson:

This audit report presents the results of an Office of Inspector General (OIG), Office of Audit Services (OAS) review of survey and certification (S&C) costs allocated to the Medicare and Medicaid certification, and State licensing programs by the Virginia Department of Health (VDH), Center for Quality Healthcare Services and Consumer Protection (the Center). The objectives of the review were to determine whether S&C costs were allocated correctly among the Medicare and Medicaid certification, and State licensing programs; and whether the Federally approved indirect cost rates were properly applied. Our audit covered S&C costs reported to the Centers for Medicare and Medicaid Services (CMS) formerly known as the Health Care Financing Administration (HCFA) for Federal Fiscal Years (FYs) 1997 through 1999 (October 1, 1996 – September 30, 1999).

Our review disclosed that the Center utilized a reasonable methodology to allocate S&C costs to the Medicare and Medicaid certification, and State licensing programs and correctly applied the Federally approved indirect costs rates for FYs 1997-1999. However, based on our examination and analysis of financial information, supporting documentation and other available evidence, we found that the Center:

- Claimed unallowable costs totaling \$29,298 for the Medicare program in the first quarter of FY 1997 for the nurse aide program;
- Did not maintain adequate documentation to determine whether certain costs billed to VDH by the Virginia Department of Health Professions (DHP) for the nurse aide program were supportable, allowable, and accurate;
- Did not obtain approval from CMS or the HHS Division of Cost Allocation (DCA) to implement a new cost allocation methodology for joint licensing and certification surveys conducted at long term care (LTC) facilities beginning in FY 2000.

We recommend that the Center:

- Refund \$29,298 to the Medicare program for unallowable costs charged in FY 1997;
- Establish a process for assuring that the quarterly charges to the Federal programs for the nurse aide program are supportable, allowable, and accurate;
- Obtain final CMS/DCA approval for the new cost sharing methodology for joint licensing and certification surveys conducted at LTC facilities implemented in FY 2000.

By letter dated July 6, 2001, VDH responded to a draft of this report. We have attached the VDH letter as an appendix to this report. We have also summarized the VDH response and our comments after each individual finding area in the report. The VDH included additional documentation in the response that was too voluminous to be included in this report. However, we will provide CMS with a complete copy of the response.

BACKGROUND

Sections 1864(a) and 1902 of the Social Security Act (the Act) require that State health agencies or other appropriate State agencies be used to determine whether health care entities meet the requirements to participate in the Medicare (Title XVIII) and Medicaid (Title XIX) programs. Agreements between CMS and the various State Agencies (SA's) stipulate that CMS will provide funds to the SA for the reasonable and necessary costs of performing the functions authorized by the agreements. The functions the SA performs under these agreements are collectively referred to as the S&C process. These functions include activities such as: conducting investigations and fact-finding surveys; certifying and re-certifying health care providers; operating a toll-free home health hotline; providing nurse aid training and maintaining a nurse aide registry; and directly entering data into a national database known as the Online Survey Certification and Reporting System.

The SA surveys many institutions simultaneously for Medicare, Medicaid, and State licensure programs; therefore the costs must be equitably allocated between sharing programs. Surveys of health care facilities include: hospitals, nursing homes, home health agencies, rural health clinics, ambulatory surgical centers, hospices, and other health care facilities. The surveys determine whether these facilities are effectively doing all they must do to protect patient health and safety.

STATE PROGRAM

In the Commonwealth of Virginia S&C responsibility has been delegated to the Center which is responsible for assuring that health care providers and suppliers are in compliance with established Federal and state standards through the enforcement of applicable regulations and conditions of participation for each category of facility, provider, or supplier. The Center also obtains services for the S&C program from other state organizations such as DHP and the State Fire Marshal's office through interagency agreements that must be approved by CMS.

STATE SYSTEM FOR COST ALLOCATION AND REPORTING

The Center maintained a system to account for the costs of the S&C program and to allocate them to the Medicare and Medicaid certification, and State licensing programs. The S&C costs were reported to CMS on a quarterly basis using the Form 435 (State Survey Agency Quarterly Expenditure Report) for reimbursement of S&C effort for the Medicare and Medicaid programs. The Center's cost allocation methodology used in FYs 1997-1999 allocated total survey costs between Federal and state programs, according to the relative benefit accruing to each program from the S&C activity. The cost of a survey for a joint Medicare/Medicaid facility was shared equally between the Medicare and Medicaid programs, regardless of the number of beds assigned to each program.

OBJECTIVE, SCOPE AND METHODOLOGY

The objectives of our review were to determine whether S&C costs have been allocated correctly among the Medicare and Medicaid certification, and the State licensing programs; and whether the Federally approved indirect cost rates were properly applied. We conducted our review in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. Our audit covered S&C costs totaling approximately \$10 million that the Commonwealth of Virginia allocated to the Medicare and Medicaid programs and claimed during FYs 1997 through 1999.

To accomplish our audit objectives, we reviewed Form 435s and other supporting documentation submitted to CMS officials for the audit period and verified their support and accuracy. We also evaluated the accounting system used to account for costs incurred under the S&C program and reviewed the computations of the indirect costs charged to the Medicare and Medicaid programs for the audit period.

We performed our fieldwork primarily at the Virginia Department of Health, Center for Health Care Services and Consumer Protection in Richmond, Virginia from August to December 2000.

RESULTS OF REVIEW

We found that the Center generally utilized a reasonable methodology to allocate S&C costs to the Medicare and Medicaid certification, and State licensing programs and correctly applied the Federally approved indirect costs rates during FYs 1997-1999. However, we noted the following:

Unallowable Costs Charged To The Medicare Program

The Center erroneously billed unallowable costs totaling \$29,298 to Medicare in the second quarter of FY 1997 for the nurse aide program operated by DHP. This amount represented \$9,950 that should have been paid by the State licensing program and \$19,348 that exceeded the budget amount approved by CMS for the FY. Section 4500 of the CMS State Operations Manual (SOM) states that the S&C costs must be allocated to each benefiting program or activity to determine the payable costs for that program or activity. In addition, Section 4714 of the SOM states that the Title XVIII S&C total expenditures for a fiscal year may not exceed the amount approved for that period. The Center reported unallowable costs to Medicare because it did not have sufficient internal controls to ensure that the Form 435s were accurately prepared. As a result, the Medicare program was overcharged \$29,298 in FY 1997 for services provided by DHP which were over the approved budget and which, at least partially, should have been charged to SA activity.

VDH Response

The VDH proposes paying the \$9,950 State share of unallowable costs through a subsequent reduction to either the June 30, 2001 or September 30, 2001 Federal Quarterly Expenditure Report.

The \$19,346 that exceeded the approved budgeted amount would be partially repaid by VDH requesting CMS to increase the nurse aide budget cap by \$7,500 which would enable VDH to apply an unexpended balance of \$7,500 from the overall FY 1997 Medicare approved budget for Virginia. The VDH proposes to pay the remainder by using FY 1995 funds that were approved by CMS in FY 1999.

OIG Comment

The VDH proposal to repay the State's share of unallowable cost by reducing the charge to the Medicare program on a subsequent Federal Quarterly Expenditure Report will properly correct and establish the State's obligation.

The VDH should consult with CMS to establish the proper method to repay the refund to the Medicare program resulting from the budget overrun.

Inadequate Documentation for Interagency Billings

During FYs 1997-1999, the Center received billings totaling \$1.9 million for the nurse aide program through an interagency agreement with DHP. Sixty-nine percent of these charges represented allocated costs¹ and 31 percent represented direct costs. The Center did not have adequate documentation to determine whether the allocated costs were supported, allowable, and accurate. During the period, the Center charged 36 to 40 percent of the costs (allocated and direct) to the Medicare program and 6 to 7 percent to the State licensing program. The Department of Medical Assistance Services, Virginia's Single State Agency, using the Form 64, charged 53 to 58 percent of the costs to the Medicaid program.²

Section 4701 of the SOM requires the SA to provide support in its accounting and statistical records for all expenditures incurred in connection with the S&C program. No particular type of accounting records, methods or procedures are required, but the SA's accounting records and supporting documents must permit verification of all expenditures by Federal fiscal audit and CMS administrative review.

The Center lacked adequate documentation because it had not established a process for assuring that DHP costs were supportable, allowable, and accurate. As a result, the Center had no reasonable assurance that the allocated costs billed quarterly by DHP and charged to the Federal programs were supportable, allowable, and accurate.

VDH Response

The VDH as well as the Department of Medical Assistance Services expressed concern that the establishment of additional control measures will be duplicative, unnecessarily time consuming, costly and unproductive. They believe that there are sufficient mechanisms and acceptable control measures in place to provide reasonable assurance that quarterly charges by DHP are supportable, allowable and accurate. The VDH cites several reasons why the allocation system is sufficient. For example, DHP is the recognized repository for all nurse aide program records; existing State budgetary and accounting control measures are sufficient; and special studies of DHP were conducted with no adverse findings. Nevertheless, VDH has requested that the Virginia Auditor of Public Accounts (APA) include in its annual audit an examination of the DHP cost allocation methodology and the nurse aide program costs.

OIG Comment

We believe that VDH has no way to know whether the billed costs truly reflect the level of effort in the program. We do not propose additional controls. However, we believe that a periodic review of the costing methodology (perhaps on a limited sampling basis)

¹ The allocated costs represent the expenditures charged quarterly to the nurse aide program for eight separate cost allocation centers within DHP.

² Our audit did not cover the costs for the nurse aide program reported by the Department of Medical Assistance Services on the Form 64.

will provide a greater level of assurance that the billed costs are accurate. At present, VDH does not have the level of support for the billed costs from DHP to attest that the costs billed by VDH to Medicare are reasonable and accurate. We believe that the APA review, if performed, would confirm the accuracy of the allocation and subsequent charges.

New Cost Allocation Methodology For FY 2000 Not Approved By CMS/DCA

The Center did not obtain approval from CMS as required by the SOM to implement a new cost allocation methodology that redistributed the allocation rate between Federal and State programs from the approved 50/50 percentage split to an allocation more favorable to the Commonwealth. Likewise, the Center did not submit a Cost Allocation Plan (CAP) to DCA as required by 45 CFR 95.507 to implement the new cost allocation methodology. The Center was required to have an approved CAP to allocate costs based on a non-prescribed method.

The Center conducted an internal study and established a new methodology to allocate costs for joint licensing and certification surveys at LTC facilities to the Medicare and Medicaid certification, and State licensing programs. The objective of the study was to determine the current size of the Federal program compared to the existing State licensing program. Based on the study, the Center determined that the Federal certification percentage should be 78 percent and the State licensing percentage should be 22 percent instead of the CMS approved 50/50 split between the Federal and State programs. The Center implemented the new cost allocation methodology effective January 1, 2000.

While Section 4514(E) of the SOM allows the SA some flexibility in allocating costs for multi-program staff by comparing requirements under the Federal certification programs to requirements under the State licensure program, the cost allocation methodology must be approved by CMS before charges can be made using the methodology. The Center officials emphasized that the study was conducted to find a way to legitimately shift more costs to Federal programs, in order to fully support the additional staff it was hiring to implement National Nursing Home Initiative (NHI) Federal mandates. In addition, the officials stated that they assumed that CMS would be reasonable in sharing the added costs to implement the Federally mandated NHI, even though it did not obtain prior approval to shift more costs to the Federal programs.

Our review of correspondence between the Center and CMS showed that CMS requested additional information from the Center. The CMS officials were not satisfied with the methodology used by the Center in conducting the study and were not prepared to approve the new allocation methodology. The CMS specifically cited bias in the study and the lack of a statistically valid sample. At the time our fieldwork was completed, the study and resulting methodology remained under CMS review.

We did not review form 435s for FY 2000 since the period was outside the scope of our review. However, the Center determined that implementation of the new cost allocation

methodology would result in an increase in Medicare and Medicaid program cost in FY 2000. Based on the state/federal LTC survey costs for FY 1999, the Center estimated that Medicare program expenditures would increase annually by approximately \$158,200 and Medicaid program expenditures would increase by approximately \$251,938.

VDH Response

The VDH stated that they received approval from CMS on December 22, 2000 (after the OIG completed fieldwork) to use the new cost sharing methodology for joint licensing and certification surveys in FY 2000. The CMS did not fault the rationale for seeking a modification to the existing funding formula although CMS continues to have questions about the methodology and will defer approval of the fund split pending the development of additional documentation.

The VDH believes that this issue is now a moot point since approval was received from CMS and the issue should be removed from the report.

OIG Comment

We do not believe the issue of approval for a new cost methodology is moot, even with CMS' (provisional) approval. The VDH needs to work with CMS and the HHS DCA to address CMS' concerns. Although the CMS approval was required beginning in FY 2000 we are nearly in FY 2002 and all costs charged under the provisional method are subject to major revision. It is in VDH's best interest to provide the necessary information to CMS or DCA to ensure that costs are properly charged.

CONCLUSIONS AND RECOMMENDATIONS

During FYs 1997 through 1999, the Center used a reasonable methodology to allocate S&C costs to the Medicare and Medicaid certification, and State licensing programs. In addition, the Center correctly applied the federally approved indirect cost rates during the audit period. However, we noted that the Center erroneously charged the Medicare program unallowable costs associated with the nurse aide program; could not assure that costs were properly accumulated and billed to the Center by DHP; and changed the methodology for charging costs without CMS or DCA approval beginning in FY 2000.

We recommend that the Center:

- Refund \$29,298 to the Medicare program for unallowable costs charged in FY 1997;
- Establish a process for assuring that the quarterly charges to the Federal programs for the nurse aide program are supportable, allowable, and accurate;

- Obtain final CMS/DCA approval for the new cost sharing methodology for joint licensing and certification surveys conducted at LTC facilities implemented in FY 2000

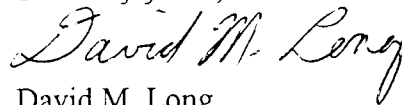
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Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any 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), HHS/OIG Office of Audit Services 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 exemptions in the Act, which the Department chooses to exercise. (See Section 5.71 of the Department's Public Information Regulation, dated August 1994, as revised.)

To facilitate identification, please refer to Common Identification Number A-03-00-00209 in all correspondence relating to this report.

Sincerely yours,



David M. Long
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:

Patricia Harris, Acting Regional Administrator
Centers for Medicare and Medicaid Services, Region III
Public Ledger Building Suite 216
150 S. Independence Mall West
Philadelphia, PA 19106-3499



COMMONWEALTH of VIRGINIA

Department of Health

P O BOX 2448
RICHMOND, VA 23218

E. ANNE PETERSON, M.D., M.P.H.
STATE HEALTH COMMISSIONER

TDD 1-800-828-1120

July 6, 2001

David M. Long
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General (OIG)
Office of Audit Services
Suite 316, 150 S. Independence Mall West
Philadelphia, Pennsylvania 19106-3499

RE: OIG Draft Audit Common Identification Number A-03-00-00209

Dear Mr. Long:

Thank you for sharing the draft version of the proposed Office of Inspector General (OIG) audit of survey and certification costs for Medicare and Medicaid-funded programs regulated by the Virginia Department of Health (VDH). We welcome the opportunity to comment on the OIG's draft findings prior to publication of the final version of the audit.

Overall, we are satisfied with our conduct of these programs as documented in your draft report. The only specific questioned expenditure (\$29,298) represents less than a third of one percent of the three years of expenditures your team reviewed. This is not pointed out to minimize your findings, but, rather, to put them in perspective. The audit narrative and findings underscore the fact that program administration is basically sound and strong.

After reviewing our comments and suggestions, we ask that you consider modifying your findings as recommended below. The remainder of this correspondence addresses the OIG draft findings followed by a discussion of each and a closing summary.

Finding 1: "Refund \$29,298 to the Medicare program for unallowable costs charged in FY 1997."

In FY 1997, the Virginia nurse aide program expenditure total was capped by the Center for Medicare and Medicaid Services (CMS; formerly HCFA) at \$150,055. VDH submitted charges of \$179,353 on the Federal Quarterly Expenditure Report forms (HCFA 435 form) in FY 1997, which exceeded the cap by \$29,298. Out of this total, \$9,949.56 are state costs and \$19,348.44 are Medicare funds. The \$19,348.44 in Medicare funds is owed CMS by VDH, and in turn to VDH by the Department of Health Professions (DHP), which received the funds. We also submitted, as required by CMS, a cumulative HCFA 435 form corresponding to the FY 1997 cap of \$150,055. This discrepancy in year end totals between the two federal reporting forms for FY 1997 was not recognized by CMS at the time.

THE STATE OBLIGATION OF \$9,949.56

We propose repaying the state's share of the unallowable costs to CMS by reducing the charge to the Medicare program, on either the 6/30/01 or the 9/30/01 Federal Quarterly Expenditure Report, by \$9,949.56 and charging this amount to state funds.

REFUND OF \$19,348.44 TO THE MEDICARE PROGRAM

An unexpended balance of \$7,500 remains in the overall Medicare budget approved for Virginia in FY 1997. We will request that CMS increase the nurse aide program cap by this \$7,500 amount, thereby reducing the required refund from DHP/VDH from \$19,348.44 to \$11,848.44.

On May 11, 1999, VDH was notified, via a Department of Health and Human Services Additional Financial Information On Award form (HHS-640T), that CMS was increasing the Medicare approval for FY 1995 by \$66,622. This has resulted in an unexpended Medicare balance of \$66,622 for FY 1995. Since this notice came four years after the close of the state fiscal year in FY 1995, this \$66,622 cannot be reasonably applied to FY 1995. Accordingly, we will request that CMS raise the Medicare nurse aide program cap to the level needed to repay the overcharge and allow this agency to use the portion needed from the \$66,622 to reduce the federal amount owed by DHP/VDH to \$0.

Finding 2: "Establish a process for assuring that the quarterly charges to the Federal programs for the nurse aide program are supportable, allowable and accurate."

VDH and the Department of Medical Assistance Services (DMAS) contend that there are sufficient mechanisms and acceptable control measures in place to provide reasonable assurance that quarterly charges by DHP are supportable, allowable, and accurate. Both agencies are concerned that the establishment of additional control measures will be duplicative, unnecessarily time consuming, costly, and unproductive. The reasons are as follows:

DHP IS THE RECOGNIZED REPOSITORY FOR ALL NURSE AIDE PROGRAM RECORDS

DHP is the official repository for all public records and documentation supporting the costs that are reported for the nurse aide program. The interagency agreement between VDH, DMAS, and DHP, which has been approved by CMS, states in Sections 5.01f and 5.01g that the DHP is responsible for the following:

"maintaining fiscal and activity records to provide accountability and submit reports, as required by federal and state regulations on activities,"

"to make all records on nurse aide certification and registry accessible upon request for inspection by the government (HCFA) or its designated agents."

The parties to the current interagency agreement (DHP, VDH and DMAS) agree that maintaining duplicative sets of fiscal and accounting records at all three state agency locations would not serve any useful purpose. It would, in fact, impose an additional administrative burden and be paid for predominately from federal funds.

EXISTING STATE BUDGETARY AND ACCOUNTING CONTROL MEASURES

As a Virginia state agency, DHP is subject to all established state accounting and budgeting policies, procedures, and reporting requirements. DHP is also audited annually by three independent state entities:

1. Virginia Department of Accounts (DOA) - the executive agency that serves as the state's Comptroller
2. Virginia Auditor of Public Accounts (APA) - legislative agency responsible to the General Assembly

Please note: In an effort to further allay OIG concerns, VDH has requested that the APA include in its annual audit an examination of the DHP cost allocation methodology and the nurse aide program costs.

3. Virginia Department of General Services (DGS) - executive agency responsible for state procurement

There do not appear to be any findings resulting from these three annual audits that suggest the need for added oversight of DHP by VDH and DMAS.

The Virginia Board of Nursing of DHP administers the nurse aide program in Virginia. An established Cost Allocation Methodology is used by DHP to allocate costs to the Board of Nursing and to the other boards of health professions under DHP's supervision. A copy of this document is attached. This methodology was provided to CMS in 1990 to obtain the initial approval of the interagency agreement between VDH, DMAS, and DHP.

This allocation methodology was also furnished to Emilio Camarado, C.P.A., HCFA Medicaid Bureau Auditor, in May, 1995. Mr. Camarado visited VDH and DHP in 1995 and reviewed both agencies' cost allocation methodologies. In addition, DHP provided Mr. Camarado a report published in 1993 by David Griffith & Associates, Inc., a private, independent accounting firm, that examined and made recommendations that were incorporated into the existing cost allocation methodology used by DHP.

SPECIAL STUDIES OF DHP

As previously noted, DHP has been examined by a private, independent auditing firm during the period that the interagency agreement between the three state agencies has been in effect. The federal Medicaid auditor, Mr. Camarado, also conducted a review of the nurse aide program at DMAS, VDH, and DHP in May of 1995. There were no findings cited by Mr. Camarado during his visit. Moreover, there have been studies of DHP initiated by the Virginia legislature and conducted by the Joint Legislative and Audit Review Commission (JLARC). There have been no known findings related to any of these special studies, suggesting there is a need for more oversight of DHP by VDH and DMAS.

ADDITIONAL CONTROL MEASURES USED BY VDH AND DMAS

In addition to the established control measures that apply to all state agencies, VDH and DMAS routinely receive the following Commonwealth Accounting and Reporting System (CARS) forms and other data:

a. DHP Expenditure and Revenue Summaries

These reports show expenditures by quarter, fiscal year, and biennium, as well as the corresponding budgets for all cost centers in DHP (data processing, human resources, administration, finance, enforcement, administrative proceedings, practitioner intervention program, the attorney general, Board of Health Professions, transfers, the Nurse Executive Board, and the federal portion of the nurse aide program's expenditures). Copies of these documents were furnished to the OIG audit team during its visit to VDH.

b. CARS Expenditure Reports

These quarterly state accounting and budgeting forms are furnished to VDH and DMAS and provide detail on DHP's expenditures for the nurse aide program and the Nurse Executive Board by expenditure category. Copies of these documents were furnished to the OIG audit team during its visit to VDH.

c. Annual Nurse Aide Program Data

DHP provides an annual nurse aide program budget to DMAS and VDH, as well as annual data with respect to the numbers of nurse aides on the registry, the numbers of approved nurse aide training programs, the numbers of complaints against nurse aides that have been adjudicated by DHP and the number of DHP staff dedicated to administering the nurse aide program. Copies of these documents were provided as part of the records furnished to the OIG audit team during its visit to VDH.

The above data provide VDH and DMAS with information in reviewing and analyzing quarterly bills and significant changes in expenditures. Historically, we have called special meetings and raised questions whenever significant increases in the costs have been reported by DHP. DHP has furnished what appear to be reasonable explanations for the increased costs in each case. During their visit to VDH, the OIG audit team was provided with the records showing the results of such special meetings.

CMS EXPENDITURE CAP

DHP's annual expenditures for the nurse aide program were capped by CMS beginning in FY 1994. This cap is found each year in the budget approval letter issued by CMS to VDH. We assume that this cap, which is imposed independently by CMS, is established at an expenditure level that is comparable to state agencies with nurse aide programs similar in size and scope to the nurse aide program in Virginia.

OVERSIGHT BY DHP'S LICENSING BOARDS

DHP regulates the health professions in Virginia, such as doctors, nurses, pharmacists, etc., and is governed by professional licensing boards. These boards are made up of private citizens and provide an important measure of outside, independent control and oversight over DHP's activities.

CONCLUSIONS

Unless there are previously unstated and compelling reasons for concluding otherwise, our view is that these established control mechanisms should be accepted as providing a reasonable level of oversight and control with respect to DHP activities. Attempts to exercise more control would be unnecessarily duplicative and costly to the three state agencies involved. Adding new control measures would also be costly to the Medicare/Medicaid programs, responsible for paying two thirds of the costs.

The draft report does not acknowledge the existence of any of these control measures, nor does it provide any explanation concerning why these control measures are not sufficient. Moreover, the draft report does not identify any specific control measures that should be added nor suggest any measures that would be a more appropriate substitute for those already in place. In short, because no specific reasons for this finding are stated in the draft report, VDH is unable to determine what an acceptable remedy would be. Therefore, VDH respectfully requests that the OIG acknowledge and accept the established control measures as sufficient and delete this finding from the final report.

Finding 3: "Obtain HCFA/DCA approval for the new cost sharing methodology for joint licensing and certification surveys conducted at LTC facilities implemented in FY 2000."

VDH received approval from CMS on December 22, 2000 to use the new cost sharing methodology for joint licensing and certification surveys in FY2000. The approved methodology directs a 22/78% split between the state/federal long term care programs. Ms. Claudette V. Campbell, Associate Regional Administrator, Division of Medicaid and State Operations, CMS, approved the use of the methodology in a letter dated December 22 and addressed to Nancy Hoiheimer, Director, Center for Quality Health Care Services and Consumer Protection (see attached).

On page 5 of the draft audit, you acknowledge that implementation of the new cost methodology in FY 2000 is outside the scope of this review. The concern expressed relative to this issue states "the cost allocation methodology must be approved by HCFA before charges can be made using the methodology." The finding does not fault our rationale for seeking a modification to the extant funding formula. It does point out though, that, at the time of the review, "HCFA officials were not satisfied with the methodology used by the Center."

CMS continues to have questions about our methodology, and will defer final approval of the fund split pending the development of additional documentation. Nonetheless, they accepted expenditures charged by the Center using the 22/78% split beginning in January 2000. We understand and appreciate the concerns you raise about operating under an altered allocation methodology absent formal approval, and will, in the future, ensure that approval is sought in a more formal manner. However, because this issue is, chronologically, not part of the subject review (the audit encompassed FY 1997–FY 1999) and the identified problem—lack of HCFA approval for the allocation methodology—is now a moot point, VDH respectfully requests that this finding be excluded from OIG's final report.

COMMENTS SUMMARY

We are negotiating with CMS the best approach for refunding the \$29,298 owed to the Medicare program and expect to resolve this matter before the end of federal FY 2001. With regard to the second and third findings, VDH respectfully requests that these draft findings be eliminated from the final report. We have provided additional information herein explaining in detail the established control measures over DHP activities that are already in place. VDH and DMAS are convinced that these controls are sufficient to assure allowable and accurate charges. We are also concerned that imposing more controls will generate little or no benefit and be costly to all three agencies. As for the third finding, provisional approval for the 22/78% LTC split was obtained from CMS, which satisfies OIG's draft recommendation.

I understand that our respective staffs have discussed scheduling an exit conference and they have concluded that the formal written response will suffice to satisfactorily serve the interests of both the OIG and the Department of Health. I leave the decision on this to your discretion.

In closing, I would like to commend the OIG staff for the highly professional and considerate manner in which they conducted the audit at VDH last year. Staff at our Center for Quality Health Care Services and Consumer Protection were very complimentary concerning the courtesies shown to them by the OIG audit team. I would like to thank Mr.

Lee Skros, OIG Audit Manager, as well. In recent contacts with VDH staff, Mr. Skros appears to be making every effort to find solutions to OIG concerns that have the least burdensome impact upon the three state agencies involved.

If there are any remaining questions, please do not hesitate to contact me or Mrs. Hofheimer.

Sincerely,

A handwritten signature in cursive script that reads "E. Anne Peterson, M.D., M.P.H.".

E. Anne Peterson, M.D., M.P.H.
State Health Commissioner

Enclosures

cc: Regional Administrator, CMS, Region III