DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Region IX
Office of Audit Services
50 United Nations Plaza, Rm. 171
San Francisco, CA 94102-4912

Report Number: A-09-03-01013

FEB 28 2005

Donald Kwalick, M.D.
Chief Health Officer
Clark County Health District
P.O. Box 3902
Las Vegas, Nevada 89127-3902

Dear Dr. Kwalick:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Ryan White Title I Funds Claimed by a Primary Medical and Dental Contractor of the Las Vegas Eligible Metropolitan Area for the Fiscal Year Ended February 28, 2002." A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

The HHS action official will make final determination as to the actions taken on all matters reported. We request that you respond to the 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.

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Please refer to report number A-09-03-01013 in all correspondence.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

RYAN WHITE TITLE I FUNDS CLAIMED BY A PRIMARY MEDICAL AND DENTAL CONTRACTOR OF THE LAS VEGAS ELIGIBLE METROPOLITAN AREA FOR THE FISCAL YEAR ENDED FEBRUARY 28, 2002

FEBRUARY 2005
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Office of Inspector General

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OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

The U.S. Senate Finance Committee requested that we examine the implementation of Ryan White Comprehensive AIDS Resources Emergency (CARE) Act Title I at the local level. Under CARE Act Title I, the Health Resources and Services Administration (HRSA) makes grants to local eligible metropolitan areas (EMAs) that have been hit hardest by the HIV/AIDS epidemic. The CARE Act Title I program is the payer of last resort for people living with HIV/AIDS who have limited insurance coverage or no other source of health care.

The Las Vegas EMA received about $4.7 million during fiscal year (FY) 2001, the period of our review, to provide CARE Act Title I services.[1] On behalf of the chairman of the Clark County Commission, the Clark County Health District (Health District) acts as the CARE Act Title I grantee. In this role, the Health District issued a contract totaling $868,661 to Clark County's University Medical Center–Wellness Center (Wellness Center) to provide primary medical care and dental care to low-income people with HIV/AIDS. The FY 2001 CARE Act Title I grant application stated that the Wellness Center was providing primary medical care and dental care to almost 1,400 clients.

OBJECTIVES

In response to the U.S. Senate Finance Committee's request, we conducted audits nationwide, including an audit of the Health District to determine the following:

- Did the Health District ensure that the Wellness Center provided the expected **program services** to clients eligible for CARE Act Title I?

- Did the Health District ensure that the Wellness Center followed Federal requirements for claiming **program costs** under CARE Act Title I?

SUMMARY OF FINDINGS

The Health District did not specify and, therefore, could not ensure that the Wellness Center provided an expected level of **program services** with the $868,661 it was awarded. Further, the Health District did not ensure that the Wellness Center followed Federal requirements for claiming **program costs** under CARE Act Title I.

Program Services. Contrary to CARE Act Title I requirements, the Health District did not establish an expected level of **program services** in its contract with the Wellness Center to guide program performance. Without knowing the level of services that the Wellness Center should have provided to eligible clients, the Health District could not ensure that the Wellness Center met the service needs of people with HIV/AIDS in the Las Vegas EMA.

[1] For CARE Act Title I, HRSA defined FY 2001 as the period from March 1, 2001, through February 28, 2002.

Program Costs. The Health District did not ensure that the Wellness Center followed Federal requirements for claiming **program costs** under CARE Act Title I. Specifically, the Wellness Center:

- did not use actual costs as its basis to charge the program;
- assessed clients higher copayments than appropriate;
- did not separately account for copayments collected and did not use the funds to provide additional program services; and
- claimed $26,760 in unallowable costs, including $3,723 for program services provided to ineligible clients.

Both the Health District and Wellness Center contributed to these problems. At the grantee level, the Health District did not provide adequate fiscal and program monitoring to ensure that the Wellness Center claimed only actual and allowable costs to provide services to eligible clients and complied with Federal requirements for CARE Act Title I. At the contractor level, the Wellness Center did not establish a cost schedule for professional services based on actual costs, did not use the correct copayment schedule, did not have a system to track copayments for CARE Act Title I, and did not follow the contract requirements to use copayment revenue to provide additional program services. In addition, the Wellness Center did not have adequate controls to prevent or detect unallowable charges and did not always screen clients for eligibility.

As a result, the Health District did not know the actual costs of providing medical and dental services and, thus, could not measure program efficiency, and program funds provided to the Wellness Center may have subsidized the University Medical Center. Further, by not monitoring the Wellness Center's assessment of copayments, the Health District may have created a financial barrier that deterred clients from seeking needed services. Without proper accounting and use of copayments, the Wellness Center was unable to determine the amount of copayments collected or use the copayment revenue to provide additional program services. For the unallowable charges, the Health District reimbursed the Wellness Center at least $26,760, which could have been used to provide additional program services to eligible people in the Las Vegas EMA.

RECOMMENDATIONS

We recommend that the Health District:

1. refund $26,760 to the Federal Government, the total amount overpaid to the Wellness Center;[2]
2. include in its contract with the Wellness Center a specified level of program services it expects the Wellness Center to provide;

[2] The draft report recommended a refund of $27,760. Based on additional documents provided by the Wellness Center, we reduced the amount to $26,760.

3. ensure that the Wellness Center develops and implements a cost schedule based on actual costs;

4. ensure that copayments the Wellness Center charges clients agree with requirements of CARE Act Title I;

5. ensure that the Wellness Center develops and implements procedures to record the assessment and collection of copayments, and uses copayment revenue to provide additional CARE Act Title I services; and

6. require the Wellness Center to follow its client eligibility policies and procedures to ensure that CARE Act Title I costs are claimed for eligible clients.

HEALTH DISTRICT COMMENTS

In its written comments on the draft report, the Health District agreed with four of our six recommendations (numbers 2, 4, 5, and 6); however, it did not agree with recommendations 1 and 3 nor with all the conclusions presented in the findings.

The Health District disagreed with recommendation 1 to refund $26,760. The Health District believed that there was no substantive reason for a refund because $19,778 of the $26,760 of questioned costs was allowable. In addition, the Health District stated that the Wellness Center had a $630,000 financial loss and provided services well in excess of all available grant funds. The Health District also disagreed with recommendation 3 to require the Wellness Center to charge based on actual costs. The Health District stated that it is "extremely difficult" for the Wellness Center to develop a cost schedule based on actual costs. However, the Health District stated that it will ensure that costs charged to CARE Act Title I are always less than actual costs to maximize services available to the HIV community.

Where appropriate, we made changes in the report to reflect the Health District's written comments. We also included the full text of the Health District's comments as an appendix to this report.

OFFICE OF INSPECTOR GENERAL RESPONSE

The Health District should refund the $26,760. We do not know if the Health District incurred allowable costs that it did not claim, because we limited our audit to the costs that the Wellness Center claimed for reimbursement under CARE Act Title I and found that $26,760 was unallowable for Federal reimbursement. The Wellness Center did not provide documentation related to costs that may have been allowable but were not claimed; however, if such documentation is available, it should be provided to the HRSA action official for consideration.

The Wellness Center did not bill the Health District based on actual costs, as required by CARE Act Title I. In addition, the Health District provided no documentation to show that CARE Act Title I program funding was less than the actual costs of providing services.

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INTRODUCTION

BACKGROUND

Ryan White CARE Act Title I

The U.S. Senate Finance Committee requested that we examine the implementation of CARE Act Title I at the local level. Within the U.S. Department of Health and Human Services, HRSA administers the CARE Act, enacted in 1990 and reauthorized in 1996 and 2000. The objective of CARE Act Title I is to improve access to comprehensive, high-quality, community-based medical care and support services for the HIV/AIDS community. To deliver services, HRSA awards grants to EMAs, which are urban areas disproportionately affected by the incidence of HIV/AIDS. The CARE Act Title I program is the payer of last resort for people with HIV/AIDS who have limited insurance coverage or no other source of health care.

HRSA makes grants to the local government's mayor or county executive, who, while remaining the steward of the Federal funding, usually gives the day-to-day program administration to the local health department, referred to by HRSA as the CARE Act Title I grantee. Using service priorities established by the local CARE Act Title I planning council, the grantee contracts for health care and support services, including medical and dental care, prescription drugs, housing, transportation, counseling, home and hospice care, and case management.

The grantee is responsible for overseeing the service providers' performance and adherence to contractual obligations. The grantee is responsible for providing oversight through:

- **program monitoring**, to assess the quality and quantity of services provided; and

- **fiscal monitoring**, to ensure that contractors use the funds for approved purposes and pursuant to Federal, State, and local regulations and guidelines.

If monitoring reveals problems, HRSA advises the grantee to offer the contractor technical assistance, or in serious cases, a corrective action plan. The CARE Act Title I Manual states:

> In an era of managed care and shrinking resources, it is in the EMA's [grantee's] best interest to know how well agencies function in spending and managing service dollars.

For FY 2001, HRSA funded 51 EMAs for about $604 million. From the enactment of CARE Act Title I through FY 2003, total Federal funding was about $5 billion.

Las Vegas EMA

The Las Vegas EMA covers a 3-county area with close to 7,000 individuals living with HIV/AIDS. For FY 2001, HRSA awarded a CARE Act Title I grant totaling about $4.7 million to the Health District, which serves as the CARE Act Title I grantee for the EMA. The Health

District contracted with external agencies to provide services in the Las Vegas EMA. In FY 2001, the Health District worked with 24 agencies to provide program services.

Wellness Center

The University Medical Center is a county owned and operated hospital, governed by the Board of Hospital Trustees. The Wellness Center, which specializes in HIV/AIDS primary care, is the outpatient HIV/AIDS clinic for the University Medical Center and provides integrated medical, social, dental, educational, and preventative services to HIV/AIDS clients. The Wellness Center entered into a contract with the Health District to provide primary medical and dental care to low-income people with HIV/AIDS. The FY 2001 CARE Act Title I grant application stated that the Wellness Center was providing primary medical care and dental care to almost 1,400 clients. During FY 2001, the Wellness Center reported total CARE Act Title I expenditures of $868,661, which equaled the amount awarded by the Health District. The Wellness Center was reimbursed based on monthly invoices submitted to the Health District.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

In response to the U.S. Senate Finance Committee's request, we conducted audits nationwide, including an audit of the Health District to determine the following:

- Did the Health District ensure that the Wellness Center provided the expected **program services** to clients eligible for CARE Act Title I?

- Did the Health District ensure that the Wellness Center followed Federal requirements for claiming **program costs** under CARE Act Title I?

Scope

We audited the CARE Act Title I contract between the Wellness Center and the Health District for $868,661.

We selected the Wellness Center, the Health District's largest contractor, for audit based on our evaluation of program files and the type of services provided to CARE Act Title I clients. Specifically, a previous audit conducted by an independent auditor indicated that the Wellness Center used a different copayment schedule than was in the contract with the Health District.

We limited our reviews of internal controls at the Health District and the Wellness Center to the procedures needed to accomplish our audit objectives. Meeting the objectives did not require a complete understanding or assessment of the internal control structure of either the Health District or the Wellness Center. We performed our fieldwork at the Health District and the Wellness Center in Las Vegas, NV.

Methodology

To accomplish our objectives, we performed audit procedures at the Health District and the Wellness Center.

At the Health District, we:

- interviewed officials responsible for program and fiscal monitoring;
- obtained a list of all contractors and amounts of funding;
- reviewed independent auditor reports required by Office of Management and Budget Circular A-133;
- reviewed contracts for selected contractors; and
- researched general background material, such as local health commission minutes and newspaper articles, for selected contractors.

At the Wellness Center, we:

- interviewed contractor officials,
- traced costs from reimbursement vouchers and Financial Status Reports to the check registers and salary and benefit worksheets,
- reviewed the supporting documentation for all costs claimed on the check registers and salary and benefit worksheets,
- evaluated the revenue collected for providing CARE Act Title I services,
- reviewed the Wellness Center's monthly program reports for services provided to CARE Act Title I clients,
- evaluated the basis for the costs of services provided at the Wellness Center, and
- verified medical records for services provided at the Wellness Center for a sample of CARE Act Title I clients.

We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

The Health District did not specify and, therefore, could not ensure that the Wellness Center provided an expected level of **program services** with the $868,661 it was awarded. Further, the Health District did not ensure that the Wellness Center followed Federal requirements for claiming **program costs** under CARE Act Title I.

EXPECTED LEVEL OF PROGRAM SERVICES

Contrary to CARE Act Title I requirements, the Health District did not establish an expected level of program services in its contract with the Wellness Center to guide program performance. Without knowing the level of services that the Wellness Center should have provided to eligible clients, the Health District could not ensure that the Wellness Center met the service needs of people with HIV/AIDS in the Las Vegas EMA.

CARE Act Title I Manual Requirements

The 1996 CARE Act Title I Manual required grantees to document progress toward specific, measurable objectives or goals. Section III of the manual required all providers that received funds from CARE Act Title I grantees to submit a completed Annual Administrative Report. This report can be used to meet the requirements of the Government Performance Results Act of 1993 to document progress toward specific, measurable objectives or goals by providing aggregate client and service counts.

Expected Level of Program Services Not Established

The Health District did not establish a specific level of program services that the Wellness Center was expected to provide. Although the CARE Act Title I Manual required grantees to document progress toward specific, measurable program service objectives or goals that would guide program performance, the Health District did not include these requirements in the contract with the Wellness Center. The contract only required the Wellness Center to provide $653,033 of primary care services and $215,628 of dental care services. As a result, the Health District could not ensure that the Wellness Center met the local service needs of people with HIV/AIDS.

PROGRAM COSTS

The Health District did not ensure that the Wellness Center followed Federal requirements for claiming program costs under CARE Act Title I. Specifically, the Wellness Center:

- did not use actual costs as its basis to charge the program;
- assessed clients higher copayments than appropriate;
- did not separately account for copayments collected and did not use the funds to provide additional program services; and

- claimed $26,760 in unallowable costs, including $3,723 for program services provided to ineligible clients.

Both the Health District and Wellness Center contributed to these problems. At the grantee level, the Health District did not provide adequate fiscal and program monitoring to ensure that the Wellness Center claimed only actual and allowable costs to provide services to eligible clients and complied with Federal requirements for CARE Act Title I. At the contractor level, the Wellness Center did not establish a cost schedule for professional services based on actual costs, did not use the correct copayment schedule, did not have a system to track copayments for CARE Act Title I, and did not follow the contract requirements to use copayment revenue to provide additional program services. In addition, the Wellness Center did not have adequate controls to prevent or detect unallowable charges and did not always screen clients for eligibility.

As a result, the Health District did not know the actual costs of providing medical and dental services and, thus, could not measure program efficiency, and program funds provided to the Wellness Center may have subsidized the University Medical Center. Further, by not monitoring the Wellness Center's assessment of copayments, the Health District may have created a financial barrier that deterred clients from seeking needed services. Without proper accounting and use of copayments, the Wellness Center was unable to determine the amount of copayments collected or use the copayment revenue to provide additional program services. For the unallowable charges, the Health District reimbursed the Wellness Center at least $26,760, which could have been used to provide additional program services to eligible people in the Las Vegas EMA.

Actual Costs Not Used as a Basis To Charge the Program

The Notice of Grant Award specified that the award was subject to the terms of 45 CFR part 74, which required that grant funds be used only for actual and allowable costs. No provision for profit or other amount above cost was provided for in these principles.

The Wellness Center did not establish a cost schedule for its CARE Act Title I professional medical and dental services based on actual costs, violating principles of 45 CFR part 74. Rather, it used a cost schedule that the University Medical Center established many years before, which it adjusted each year to reflect market rates and to meet anticipated costs of the Wellness Center's budget. This condition went undetected because the Health District provided inadequate fiscal monitoring to ensure that the Wellness Center claimed only actual costs and to ensure that the cost schedule was based on actual costs.

As a result, the Health District did not know the actual costs of providing medical and dental services, could not measure program efficiency, and provided program funds to the Wellness Center that may have subsidized the University Medical Center. Wellness Center budget reports (responsibility reports) indicated that the Wellness Center operated at a profit for the period ended February 28, 2002, while the University Medical Center operated at a deficit. The University Medical Center did not demonstrate how much, if any, of the excess revenue reported

on the responsibility reports for the Wellness Center was created with CARE Act Title I funding and may have been used to subsidize the University Medical Center.

Clients Assessed Higher Copayments

The contract between the Health District and the Wellness Center included a copayment schedule that agreed with CARE Act Title I. CARE Act Title I prohibited grantees from charging clients a copayment if their income was less than or equal to 100 percent of the poverty line. For individuals with incomes from 101 to 400 percent of the poverty line, CARE Act Title I limited the copayment to a percentage of income or a percentage of the total cost of services.

The Wellness Center assessed higher copayments to clients who were eligible for lower copayments. Specifically, the Wellness Center used the CARE Act Title III copayment schedule, which listed copayment amounts higher than those in the CARE Act Title I schedule. For clients who were at or below 100 percent of the poverty line, the copayment schedule indicated a $50 copayment, when they should not have been charged a copayment. Similarly, the schedule indicated that clients who were from 101 to 400 percent of the poverty line should be charged a higher copayment than allowed by CARE Act Title I. Further, the Wellness Center incorrectly determined client income when calculating copayments. To determine a client's income and the copayment owed, the Wellness Center counted only people with HIV/AIDS as family members. This decreased the number of people in a household, increased the client's income on a per-person basis, and increased the copayment amount the client owed.

The Wellness Center considered it appropriate to use the Title III copayment schedule and to count only individuals with HIV/AIDS when calculating copayments. Further, the Health District failed to monitor the Wellness Center to ensure that it charged copayments based on the correct schedule and properly calculated copayments. As a result, the Health District may have created a financial barrier with the excessive copayments that deterred clients from seeking needed services. We were unable to determine the amount of unallowable copayments the Wellness Center charged because its accounting records were unreliable.

Copayments Collected Not Tracked and Not Used To Provide Additional Program Services

The contract required the Wellness Center to track copayments collected and use the revenue to provide additional program services. Contrary to these requirements, the Wellness Center did not account for the CARE Act Title I copayments it collected from clients and did not use the funds to provide additional program services. The Wellness Center manually adjusted claims for professional services provided at the Wellness Center for copayments received from clients. However, it did not have a reliable system to record copayments due and received. These problems were not detected because the Health District failed to monitor the Wellness Center to ensure that it had a system to track the copayments and provided additional services with the revenue. Wellness Center officials stated they did not establish an effective accounting system to track copayments, could not determine copayments collected, and could not demonstrate that the Wellness Center provided additional services with copayment revenue.

Unallowable Costs Claimed

The Wellness Center claimed $26,760 of costs that were not allowable based on the cost principles of 45 CFR part 74. Specifically, the Wellness Center claimed:

- $16,055 of CARE Act Title III and IV costs under Title I;
- $6,982 for duplicate payments, duplicate patient charges, and unsupported expenditures; and
- $3,723 for CARE Act Title I services provided to people who were not enrolled in the program on the date of service.

These unallowable costs went undetected because the Wellness Center did not have adequate controls to prevent or detect unallowable charges and did not always screen clients for eligibility. The Health District did not provide adequate monitoring to ensure that the Wellness Center claimed only allowable costs for eligible clients. As a result, the Wellness Center claimed $26,760 of unallowable costs that could have been used to provide additional program services to eligible people in the Las Vegas EMA.

CARE Act Title III and IV Expenditures Claimed as Title I

Federal regulations (45 CFR part 74) required that grant funds be used only for actual and allowable costs. Allowable costs were defined as the sum of the allowable direct and allocable indirect costs less any applicable credits. The cost principles did not allow the costs of another program, such as CARE Act Title III or IV, to be claimed as CARE Act Title I expenditures.

The Wellness Center claimed $16,055 in unallowable indirect costs for a consultant who did not properly allocate time spent on CARE Act Title I, III, and IV activities. For example, the consultant claimed $2,475 on the Title I expenditure report for time spent writing the Title III grant application. Wellness Center officials stated that the Title III expense was charged to Title I because it was not allowable under Title III. We did not review other Title III and IV costs claimed under Title I to determine if they would have been allowable under the other programs. Wellness Center officials were unable to determine what portion of the $16,055, if any, was for Title I activities.

Duplicate Payments and Patient Charges, and Unsupported Expenditures

The cost principles at 45 CFR part 74 did not allow duplicate payments or patient charges, or unsupported expenditures. The Wellness Center claimed $6,982 in unallowable expenditures for duplicate payments, duplicate patient charges, and unsupported expenditures. The duplicate payments of $929 included a claim for $662.50 paid twice to an outside physician. The duplicate patient charges of $5,510 included $4,983 for an intravenous solution provided at the Wellness Center that had been charged twice. The Wellness Center did not provide supporting documentation for $543 in claims.

Costs Claimed for Ineligible Clients

CARE Act Title I services were intended for properly enrolled clients, which Program Policy Guidance No. 1 required be verified. This guidance indicated that grantees were expected to establish and monitor procedures to ensure that all providers verified and documented client eligibility. In addition, the cost principles at 45 CFR part 74 did not allow expenditures for clients who were not enrolled in the program.

The Wellness Center claimed $3,723 for services provided to eight clients who were not enrolled in the program on the date of service, violating client eligibility guidelines in Program Policy Guidance No. 1 and cost principles at 45 CFR part 74. Wellness Center staff provided these clients with services or referrals for services before determining their eligibility. For clients who received services before an eligibility determination, the Wellness Center sent them a letter indicating that if they failed to enroll in the program, they would be financially responsible for the services. However, the Wellness Center did not require service providers to bill the clients and did not require potential CARE Act Title I clients to pay for the services; rather, the Wellness Center claimed the amounts billed by providers for these services on the monthly CARE Act Title I expenditure reports as if the services were provided to eligible clients.

RECOMMENDATIONS

We recommend that the Health District:

1. refund $26,760 to the Federal Government, the total amount overpaid to the Wellness Center;[3]

2. include in its contract with the Wellness Center a specified level of program services it expects the Wellness Center to provide;

3. ensure that the Wellness Center develops and implements a cost schedule based on actual costs;

4. ensure that copayments the Wellness Center charges clients agree with requirements of CARE Act Title I;

5. ensure that the Wellness Center develops and implements procedures to record the assessment and collection of copayments, and uses copayment revenue to provide additional CARE Act Title I services; and

6. require the Wellness Center to follow its client eligibility policies and procedures to ensure that CARE Act Title I costs are claimed for eligible clients.

[3] The draft report recommended a refund of $27,760. Based on additional documents provided by the Wellness Center, we reduced the amount to $26,760.

HEALTH DISTRICT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on the draft report, the Health District agreed with four of our six recommendations (numbers 2, 4, 5, and 6); however, it did not agree with recommendations 1 and 3 nor with all the conclusions presented in the findings.

In the following sections, we summarized the Health District's comments on each recommendation and the related finding and responded to the Health District's comments. Where appropriate, we made changes in the report to reflect those comments. We also included the full text of the Health District's comments as an appendix to this report.

Recommendation 1 – Refund $26,760 to the Federal Government

Health District Comments

The Health District disagreed with the recommendation to refund the $26,760 of unallowable costs.[4] It believed that $19,778 of the $26,760 of questioned costs was allowable. Further, the Health District believed that the Wellness Center incurred a financial loss of over $630,000 during the audit period and provided services well in excess of all available grant funds.

Although the Health District agreed that it inadvertently claimed $6,982 for duplicate and unsupported expenditures and stated that the Wellness Center changed its procedures to prevent duplicate billings, the Health District did not agree to make a refund.[5] Further, the Health District disagreed that the remaining $19,778 was unallowable:

- It stated that $16,055 was claimed for a consultant who worked only on CARE Act grants, and it should not matter to which CARE Act title the consultant's fees were charged as long as the work related to the CARE Act grants. To prevent this type of claim in the future, the Health District stated that the Wellness Center would require consultants to record time separately for each grant.

- It stated that $3,723 was claimed for clients not enrolled on the date of service but who were eventually determined to be eligible for the services received. To prevent this type of claim in the future, the Wellness Center hired a full-time eligibility specialist to ensure eligibility before services are rendered.

Office of Inspector General Response

The Wellness Center's proposed changes should ensure that it claims only allowable costs in the future. However, we disagree with the Health District that it should not refund the $26,760.

[4] The draft report recommended a refund of $27,760. Based on additional documents provided by the Wellness Center, we reduced the amount to $26,760.

[5] The draft report questioned $7,982. Based on additional documents provided by the Wellness Center, we reduced the amount to $6,982.

We do not know if the Health District incurred allowable costs that it did not claim, because we limited our audit to the costs that the Wellness Center claimed for reimbursement under CARE Act Title I and found that $26,760 was unallowable for Federal reimbursement. The Wellness Center did not provide documentation related to costs that may have been allowable but were not claimed; however, if such documentation is available, it should be provided to the HRSA action official for consideration.

Regarding the consultant, the Health District is incorrect that it does not matter to which CARE Act title the consultant's time was charged. HRSA requires grantees to report the use of grant funds accurately by title because each title provides funds for specific purposes. Without HRSA's approval, costs related to CARE Act Titles III and IV, such as the $2,475 cost for writing the Title III grant application, would not be allowable under Title I.

Regarding client eligibility, the Health District provided no documentation to show that the clients were enrolled on the date of service. Further, as of July 2003 three of the clients were never enrolled in the program. After receiving the Health District's comments on the draft report, we again requested documentation that showed the clients were eligible; contrary to the Health District's comments, the Wellness Center informed us that the clients were never screened for eligibility. Thus, the related costs are unallowable.

Recommendation 2 – Include in the Contract With the Wellness Center a Specified Level of Program Services

Health District Comments

The Health District agreed with the recommendation to specify a level of program services in its contract with the Wellness Center and stated that it already implemented a new contract template. However, the Health District disagreed with the finding that led to the recommendation. Specifically, the Health District disagreed that the CARE Act Title I Manual, in effect when the contract was negotiated, required grantees to specify measurable goals or objectives. The Health District also stated that required services are not foreseeable and can vary from patient to patient. Further, the Health District stated that it ensured that local service needs were met because every HIV client at the Wellness Center received services.

Office of Inspector General Response

The Health District's proposed changes regarding its new contract template should enable better measurement of contractor performance. However, we disagree that there was no requirement, when the contract was negotiated, to specify measurable goals or objectives, or treating all patients at the Wellness Center demonstrated that the Health District met local service needs.

The Health District is incorrect that there was no requirement in the 1996 CARE Act Title I Manual to document progress toward measurable goals or objectives. In the draft report, we inadvertently referred to section III, chapter 3 of the 2002 CARE Act Title I Manual; however, section III of the 1996 Manual in effect when the contract was negotiated also included the requirement to document progress toward measurable goals. We corrected the reference to the

manual in this report to reflect the reporting requirement in effect during the period of the contract.

Section III of the 1996 Manual states that all CARE Act Title I providers are required to complete an Annual Administrative Report. This report collects aggregate client and service counts and can be used to meet the requirements of the Government Performance Results Act of 1993 to document progress toward measurable goals or objectives. Although the Health District completed the Annual Administrative Report for the audit period, it could not evaluate performance against a standard because there were no specified goals in the contract with the Wellness Center.

The Health District's assertion that all patients at the Wellness Center received services does not demonstrate that the Health District ensured that all local service needs were met. The CARE Act required grantees to use Title I funds efficiently to provide services to people with HIV/AIDS. To use these funds efficiently, the Health District, with guidance from the local AIDS Planning Council, needed to identify the types and amounts of services required and allocate funds to contractors according to need.

Recommendation 3 – Ensure That the Wellness Center Develops and Implements a Cost Schedule Based on Actual Costs

Health District Comments

Although the Health District agreed that the Wellness Center did not charge the Title I program for actual costs, it disagreed with the recommendation to require the Wellness Center to charge based on actual costs. The Health District stated that it is "extremely difficult" for the Wellness Center to develop a cost schedule based on actual costs. However, the Health District stated that it will ensure that costs charged to CARE Act Title I are always less than actual costs to maximize services available to the HIV community.

The Health District also disagreed with our conclusion that the Wellness Center may have operated at a profit for the audit period. The Health District provided financial data and analysis to demonstrate that the Wellness Center incurred a financial loss of over $630,000 during the audit period.

Office of Inspector General Response

CARE Act Title I required grantees to use actual costs as the basis to charge the program. The Health District did not comply with this requirement and should ensure that the Wellness Center develops and implements a cost schedule based on actual costs or another method that allows the Wellness Center to charge CARE Act Title I for actual costs.

We reviewed the financial data and analysis provided by the Health District supporting its comment that the Wellness Center operated at a financial loss during our audit period. After discussions with University Medical Center officials, we concluded that the documentation did not include all departmental revenues and costs. In addition, the Health District did not evaluate

costs for allowability under CARE Act Title I. Consequently, the financial loss computed by the Wellness Center was overstated and not specifically related to the CARE Act Title I contract.

Recommendation 4 – Ensure That Copayments Agree With Requirements of CARE Act Title I

Health District Comments

The Health District agreed with the recommendation to charge the correct copayment amounts and verified that the Wellness Center was currently using the correct copayment schedule for CARE Act Title I. The Health District also agreed that clients were assessed higher copayments than allowed and stated that it inadvertently used a fee schedule from another title of the CARE Act.

Office of Inspector General Response

The Health District's action to require the Wellness Center to use the correct copayment schedule should prevent overcharging of clients.

Recommendation 5 – Ensure That the Wellness Center Implements Procedures To Record Copayments and Uses Copayment Revenue To Provide Additional Services

Health District Comments

The Health District agreed with the recommendation to track copayments and use the revenue for additional Title I services; however, it disagreed that copayments were not used to provide additional services during the audit period. The Health District stated that all patient payments were used as net revenue and enabled the Wellness Center to provide additional services.

Office of Inspector General Response

The Health District's actions to require the Wellness Center to track copayments and use the revenue for additional services should ensure that program income is used to expand the program. However, without discrete accounting for copayments, the Health District was unable to document that copayments were used to provide additional CARE Act Title I services.

Recommendation 6 – Require the Wellness Center To Follow Client Eligibility Policies and Procedures

Health District Comments

The Health District agreed with the recommendation to require the Wellness Center to follow client eligibility policies and procedures to ensure that CARE Act Title I costs are claimed only for eligible clients. Specifically, the Health District stated the Wellness Center hired a full-time eligibility specialist to verify client eligibility before services are rendered. However, the Health

District disagreed with the finding that services were provided to ineligible clients; it stated that all those clients were ultimately determined to be eligible.

Office of Inspector General Response

The Health District's action to require the Wellness Center to determine client eligibility before services are rendered should ensure that services are provided to eligible individuals. However, we disagree that services were provided only to eligible individuals during the audit period. The Health District provided no evidence that any clients we identified as ineligible for CARE Act Title I services were eligible on the date service was provided. In fact, a Wellness Center official confirmed that none of these clients was screened for eligibility. Also, as of July 2003, three of the eight clients were never enrolled in the program.

APPENDIX

CLARK COUNTY
HEALTH DISTRICT

Mission: To protect and promote the health, the environment and the well-being of Clark County residents and visitors.

November 17, 2004

Ms. Lori A. Ahlstrand
Regional Inspector General
For Audit Services
Region IX
Office of Audit Services
50 United Nations Plaza, Rm. 171
San Francisco, CA 94102-4912

Re: Report A-09-03-01013

Dear Ms. Ahlstrand:

In response to the OIG October 2004 Draft Report on the Las Vegas EMA Medical and Dental Contractor for the period March 2001 to February 2002 we are furnishing the following information for each of the OIG findings and recommendations.

The report was promised in 30 days at the August 2003 exit conference but did not arrive until October 2004 or 13 months later. This lengthy delay has made it difficult to retrieve pertinent information due to the additional staff turnover that has occurred in the interim.

Finding: The Health District did not establish a specific level of service required by the CARE Act Manual.

We do not concur with this finding. On page 4 of the report, reference is made to Section III, Chapter 3 of the CARE Act Title I Manual requiring specific measurable objectives or goals. The CARE Act Manual in effect in early 2001 when the contract between UMC Wellness and the Health District was negotiated and signed had no such chapter or requirement. (See Table of Contents of the manual in effect at that time – Attachment I.) Current manual requirements were not in effect at the time contracts were entered into over three years ago.

The contract required the subgrantee to provide comprehensive medical services and specialty referrals. Quantification of such service levels is difficult because the services are provided based on the needs of the patients that actually present. The services needed are not foreseeable and can vary considerably depending on each patient's particular medical status. UMC is the most comprehensive acute care facility in Nevada and is also the state's only Level I trauma center. As such, the facility is deemed competent to provide comprehensive medical services to all HIV patients presenting according to their needs.

The District did ensure that all three intake locations for HIV clients refer these clients to Wellness for all primary care needs. The District also ensured services were provided to HIV clients presenting at Wellness in accordance with posted hospital policy that services will not be denied to any HIV individuals. Thus the District did ensure that the local service needs of people with HIV were met.

Finding: The District did not ensure that Wellness followed requirements for claiming costs under the CARE Act and did not use actual costs as its basis to charge the program.

We concur with this finding. Charges to the program were less than actual costs as demonstrated below. Since prior year experience had shown that Wellness operated at a loss and was subsidized by local taxpayers after adjustments were applied to billed charges, it was known that charges to the grant were less than actual costs. 45 CFR part 74 does not prohibit grant funds being used for less than actual costs with the difference being made up by local subsidies.

Finding: Wellness responsibility reports indicated that Wellness operated at a profit for the audit period subsidizing UMC.

We do not concur with this finding.

- The term "Revenue" in the headings "Inpatient Revenue" and "Outpatient Revenue" on the responsibility reports means ***billed*** charges which are always significantly above amounts actually collected. One cannot interpret these revenues as income for Wellness.
- The summary sheet which reflects calculated Gain/(Loss) for Wellness for the audit period is attached (See Attachment II.) This sheet shows Wellness lost over $630,000 during the period.
- Responsibility reports for each of the twelve months of the period March 2001 to February 2002 are attached (See Attachment III.) A narrative explaining responsibility reports is also attached (See Attachment IV.)
- These reports show total expenditures of $2,405,017 against total revenue (**billed charges**) of $2,509,515. The revenue (billed charges) exceeds expenditures by $104,498.
- The $104,498 is offset by two factors, namely the amount of billed charges that was not collected ($213,000) and the amount of overhead costs allocable to Wellness ($523,190). The two offsets result in a $631,692 loss for Wellness for the period.
- The amount of billed charges not collected is at least $293,044.13 or 65.57% of the total billed charges of $446,943.64 shown on the totals page (last page) of the Ryan White report (See Attachment V.) The amount not collected is likely to be higher because the account balance of $15,469.11 shown as a receivable may never actually be collected. This report includes charges for the audit period for all Title I patients still in the UMC system including some care provided in non-Wellness clinics and still receiving care. This report can be summarized as follows:

Total billed charges	$446,943.64	
Less Title I payments	<128,791.71>	
Less patient payments	< 9,638.69>	
Less remaining as receivables	< 15,469.11>	
Amount not collected	$293,044.13	or 65.57%

The amount not collected consists of $282,845.78 in adjustments or discounts reflected on the report and another $10,198.35 in adjustments in another database and not shown on the report.

- The amount of overhead costs allocable to Wellness is $523,190 based on the FY 2002 Medicare cost report as audited by CMS (See Attachment VI.)

Finding: Clients were assessed higher copayments than appropriate.

We concur with this finding. A fee schedule applicable to another CARE Act Title was inadvertently used for a portion of the audit period. When this was discovered, the correct fee schedule was used and all family members not just HIV members were counted.

Finding: Wellness did not use copayments to provide additional services.

We do not concur with this finding. All patient payments were used as net revenue to provide additional services. Patient payments were tracked and are reflected on the Ryan White report (See Attachment V.)

Finding: The District failed to monitor Wellness to ensure correct copayments were assessed and recorded.

We concur with this finding. Anytime there is ever a finding, one can always say the respective grantor failed to monitor the recipient sufficiently. The CARE Act only allows the District 5% to administer this highly complex program consisting of over 13 providers. The Health District is already spending more than double this amount to administer the program relying on local subsidies. More comprehensive monitoring of the large number of disparate agencies with varying levels of internal controls will necessitate even greater subsidies from the District. It is unreasonable for the federal government to expect such intense monitoring and yet allow such little funding for that purpose.

Finding: Unallowable costs of $16,055 were claimed for a consultant.

We do not concur with this finding. Because the consultant did not segregate work on different CARE Act titles into discrete blocks of time on the time sheet and reported aggregate CARE Act work, the entire block of time was disallowed. Standard cost allocation practice allows for proration of aggregate amounts into individual components. All of the work related to CARE Act grants. All consultants now list each grant separately on the time sheet.

Finding: Duplicate and unsupported expenditures totaling $7,982 were charged to the grant.

We concur with this finding. This was inadvertent. One-thousand dollars ($1,000) in duplicate billings were identified and credited back to Title I in 2003. These billings are miniscule when contrasted with the $630,000 loss suffered by Wellness.

To prevent duplicate billings Wellness protocol for reimbursement from Title I has been changed. Prior to submitting any requests for reimbursement to the Health District, a Ryan White Program Specialist at Wellness, reviews all bills via patient name, provider name, date of service and amount of service to identify any potential duplicate billings. This four check system is done manually on a regular basis (3-4 times a week). In the future, Wellness will track financial information for Title I on the Title I web-based client tracking system (WebCIM).

Finding: Costs of $3,723 were claimed for ineligible clients.

We do not concur with this finding. All nine clients were ultimately determined to be eligible for services under Title I. At the time the clients presented for eligibility determination, they were not denied services. The District ensured that the primary care needs of the HIV community were met. However, since Title I is the payor of last resort, it was necessary to verify whether a certain potential payor was obligated to pay for services prior to final determination. After researching the payor's obligations it was determined that the services required by eight of the nine individuals were specialized services for which the payor was not obligated. The ninth individual was determined to be undocumented such that the payor had no responsibility. These nine individuals were then retroactively determined eligible as of the date they presented for eligibility determination. In addition to CARE Act requirements Wellness is required to abide by JACHO and EMTALA guidelines which require that no client is refused service based on ability to pay for such services. In addition, it is standard CMS practice to retroactively determine Medicare and Medicaid eligibility. It is unreasonable to expect immediate eligibility determinations at the moment services are necessary and at the same time meet the service needs of the HIV community.

Recommendations

1. That the District refund $27,760 to the federal government as the total amount overpaid to Wellness.

   We do not concur with this recommendation. Since Wellness lost over $630,000 and provided services well in excess of all available grant revenue, there is no substantive reason for a refund.

2. That the District specifies a level of program services in the contract.

   We concur with this recommendation.

The District has implemented a new contract template to ensure all program services, including Wellness services, include the following:

- A description of the type and level of services to be provided
- The estimated number of clients/patients to be served for each service category
- A minimum number of clients/patients to be served during the project period
- A client file must be maintained for each client
- Proper documentation of services rendered must be maintained in each file
- Proper documentation of eligibility status for every client must be maintained in each client file
- Appropriate signed release of information must be maintained in each client file
- Documentation of services rendered and eligibility must be tracked in the Ryan White Title I web-based client tracking system (WebCIM)

In addition, the contract template includes the following specific requirements for Wellness and any other medical provider:

- Incorporate and ensure compliance of ethical standards as established for all health care providers and legal standards as defined by federal and state governments regulating confidentiality including HIPAA requirements
- Incorporate and ensure, to the extent possible, adherence to the established HIV clinical practice standards and the most current Public Health Service (PHS) guidelines for treatment and care of persons living with HIV/AIDS
- Track and document CD4 counts, viral load counts and death incidence
- Track and document routine services including recommended vaccinations and recommended screening tests

3. That the District ensure that Wellness implements a cost schedule based on actual costs.

We do not concur with this recommendation. It is extremely difficult for Wellness to develop a cost schedule based on actual costs. The cost schedule used by Wellness is reflective of the market in this area. The procedure for developing the cost schedule is comparable to that used by other major acute care facilities. UMC has over 20,000 charges on the charge master. The cost schedule is revised annually and periodically reviewed based on actual expenditures incurred by Wellness. The District will ensure that costs charged to grant (charges less adjustments) are always less than actual costs to maximize services available to the HIV community.

4. That the District ensure copayments agree with CARE Act requirements.

We concur with this recommendation. We have verified Wellness is in fact using the correct schedule of copayments. The contract requires that Wellness utilize the current CARE Act copayment schedule. In the event a subsequent schedule is issued by the federal government during the contract period, Wellness is required to use the more recent schedule.

5. That the District ensure that Wellness assesses and records copayments appropriately and uses copayments for additional services.

We concur with this recommendation. Copayments are recorded as a payment to each client's account. Copayments are tracked in the UMC fiscal database and can be totaled and printed out for a given period in question. All copayments received are recorded as Wellness net revenue and used for additional services for eligible clients.

6. That the District require Wellness to follow eligibility policies to ensure CARE Act Title I costs are claimed for eligible clients.

We concur with this recommendation. Wellness has hired a full time eligibility specialist who verifies client eligibility prior to services being rendered. In addition, eligibility is renewed annually for Title I clients to coincide with the grant funding cycle. In December, all Title I clients are notified that they must renew eligibility. Beginning March 1, all patients are re-screened and eligibility is verified.

Sincerely,

Donald S, Kwalick, MD, MPH
Chief Health Officer

DSK/bjm

Attachments