DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

December 12, 1996

CIN: A-02-95-02517

Dr. Margaret Hamburg
Commissioner of Health
New York City Department of Health
125 Worth Street
New York, New York 10013

Dear Dr. Hamburg:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' (OAS) report entitled "Audit of Eligibility Under Title I of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, New York Eligible Metropolitan Area". Our period of review covered the 05 program year, April 4, 1995 to April 3, 1996. A copy of this report will be forwarded to the action official noted below for review and any action determined necessary.

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

To facilitate identification, please refer to Common Identification Number A-02-95-02517 in all correspondence relating to this report.

Sincerely yours,

John Tournour
Regional Inspector General
for Audit Services

Enclosures - as stated

Direct Reply to HHS Action Official:

Chief, Grants and Audit Resolution Branch
Division of Grants and Procurement Management
Health Resources and Services Administration
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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF ELIGIBILITY UNDER TITLE I OF THE RYAN WHITE COMPREHENSIVE AIDS RESOURCES EMERGENCY ACT OF 1990

NEW YORK ELIGIBLE METROPOLITAN AREA

JUNE GIBBS BROWN
Inspector General

DECEMBER 1996
A-02-95-02517

EXECUTIVE SUMMARY

Background

The Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (CARE Act) was created as a comprehensive response to the Human Immunodeficiency Virus (HIV) epidemic and its impact on individuals, families, communities, cities and states. The CARE Act was intended to establish services for HIV clients who would otherwise have no access to health care and to provide emergency relief funding to communities with the highest number of reported AIDS cases, as confirmed by Department of Health and Human Services (HHS), Centers for Disease Control and Prevention.

Under Title I of the CARE Act, the HHS, Public Health Service (PHS), Health Resources and Services Administration (HRSA), awards grants to cities designated as Eligible Metropolitan Areas (EMAs). The EMAs are responsible for awarding funds and monitoring local service providers. One of the largest EMAs is New York City. The New York EMA (NYEMA) consists of the five boroughs of New York City, and Westchester, Rockland, and Putnam Counties. The New York City Department of Health was designated as the local entity responsible for the administration of Ryan White funds for its geographic area of responsibility. The NYEMA provides funding, through prime contracts, to service providers who provide Title I services to eligible HIV infected individuals and their families. For the period April 4, 1995 - April 3, 1996 the 05 year, HRSA awarded the NYEMA $93.6 million.

Objective

The objective of our audit was to determine whether the NYEMA, its contractors and service providers have adequate procedures in place to assure that all CARE Act clients receiving services are individuals with HIV disease and their families.

Summary of Findings

Our review of 17 service providers, with 41 contracts totaling $12.6 million and covering a range of Title I services, disclosed varying degrees of compliance with CARE Act eligibility criteria. At eight providers, with twenty-five contracts, we found acceptable documentation in the case record to support positive HIV serostatus of clients receiving Title I services. We considered acceptable documentation to include medical records, laboratory test results, and physician certifications. At nine service providers with sixteen contracts totaling $2.9 million, documentation was considered unacceptable as no form of acceptable evidence was found in the case records or made available for our review.

For these service providers, often the only evidence of HIV infection was the client's self disclosed notation in the case record. To a large degree, services were often provided to individuals classified by the service provider as "at risk" of being affected by HIV. Furthermore, we noted that documentation of HIV status was not always present where services were provided to a family member of the individual with HIV disease.

Since documentation to support CARE Act eligibility was inadequate or lacking, neither the NYEMA, its contractors or service providers could provide assurance that Title I services were provided only to eligible individuals and their families as required by the CARE Act.

We attribute this condition to the fact that the NYEMA did not provide detailed guidance to its contractors specifying the primary case record documentation required to be maintained for HIV infected individuals and their families. Rather, the NYEMA provided only basic program criteria which stated that eligibility for CARE Act services are for HIV infected individuals and their families. However, standards were not established which would have guided the contractors and service providers with the required minimum level of documentation (e.g. laboratory report or other medical certification) necessary to support the client's HIV status. Basically, it was left to the service providers' discretion to develop its own procedures and documentation standards to support client eligibility.

Furthermore, while we noted that periodic monitoring of its service providers was conducted by NYEMA's contractors, it appeared that their reviews of case record files to determine the adequacy of documentation to support the individual's HIV status were not sufficient to disclose instances of non compliance with Title I eligibility requirements.

Subsequent to the start of our audit, HRSA issued guidelines to the EMAs relating to the establishment of procedures to ensure client eligibility. The guidelines emphasized that Title I grantees should have procedures in place to document client eligibility and that these procedures should be communicated to all service providers. The NYEMA disseminated the guidelines to its contractors and, in addition, requested them for the 1996 program year contract application, to furnish their program eligibility criteria and provide information on how the service providers plan to document eligibility. In our opinion, these steps when fully implemented, should provide greater assurance that Title I services will be provided only to eligible individuals and their families.

In addition, at the service provider level, we noted inaccuracies and inconsistencies in the number of clients reported to the NYEMA as receiving services under the CARE Act in about 59 percent of the service providers reviewed. Several of the service providers duplicated case counts or otherwise overstated the number of HIV clients actually receiving services. Since program effectiveness and future funding decisions are, in part, measured by the number of HIV clients receiving services, it is important that the numbers reported to the NYEMA are correct.

RECOMMENDATIONS

We are recommending that the NYEMA:

1. Continue to provide its contractors and service providers with guidance which will enable them to develop and maintain adequate documentation to ensure that Care Act services are offered to eligible individuals and their families,

2. Provide guidance which will enable its contractors to strengthen on-site monitoring reviews to evaluate and ensure the sufficiency of documentation maintained by the service providers to support eligibility determinations,

3. Require its contractors to periodically reconcile the number of HIV positive individuals reported as receiving Title I services to the service providers records to ensure the accuracy of the statistical data reported.

In a separate report to HRSA, we discussed our observations of client eligibility at certain service providers administering outreach and recovery/readiness risk reduction programs funded under Title I. Since guidelines on eligibility and related documentation need to be clarified for these programs, we are not including in this report the results of our review at these providers.

AUDITEE COMMENTS

The NYEMA generally concurred with the recommendations and indicated that corrective action has been taken. In this regard the EMA (1) has issued guidelines to its contractors concerning client eligibility for Title I services and documentation of HIV serostatus which was passed on to service providers, and (2) during site visits will review documentation of HIV serostatus.

The NYEMA did not comment on our recommendation to periodically reconcile the number of HIV positive individuals reported as receiving Title I services to the service providers records. Instead it claimed that our understanding of the intent of its reporting system was misrepresented. Our intent was to emphasize that statistical data reported by the service providers need to accurately show the extent of client activity in terms of the actual number of HIV positive clients served and the number of services provided to eligible clients seen during the reporting period. These statistics are important factors in measuring the overall effectiveness of the service providers' Title I program. Accordingly, these statistics should be periodically reconciled to the service provider records to ensure accurate reporting.

In addition, the NYEMA's response contained certain technical changes for inclusion in the final report. To the extent we considered it feasible and practical, the technical comments offered were incorporated into our final report. The NYEMA's written comments are appended in their entirety as Appendix C to the report.

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INTRODUCTION

Background

On August 18, 1990, Congress passed Public Law 101-381 entitled The Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (CARE Act). The CARE Act provides emergency assistance to localities that are disproportionately affected by HIV. The CARE Act is multifaceted, with four titles directing resources to cities, states and demonstration grants. The purpose of Title I of the CARE Act is to provide resources to cities facing high HIV caseloads to develop and sustain systems of care that emphasize a continuum of services and reduce inpatient burdens.

The Department of Health and Human Services (HHS), Public Health Service (PHS), Health Resources and Services Administration (HRSA) awards Title I funds to eligible Metropolitan Areas (EMAs). Specifically, HRSA awards grants to the chief elected official that administers the public agency providing outpatient and ambulatory services to the greatest number of individuals with AIDS. One of the EMAs is New York City. The New York EMA consists of the five boroughs of New York City, and Westchester, Rockland, and Putnam Counties. For the period April 4, 1995 - April 3, 1996 the 05 year, HRSA awarded the NYEMA $93.6 million.

The chief elected official, the Mayor of the City of New York, designated the New York City Department of Health (NYCDOH) as the local entity responsible for administering Ryan White funds. An HIV Planning Council, as required under the Act, was created and was charged with establishing priorities for the allocation of Title I funds, developing a comprehensive plan for delivering of Title I services, and assessing the efficiency of the administration of Title I funds.

As the grantee, NYCDOH entered into a master contract with Medical Health Research Association of New York City, (MHRA), a private not-for-profit organization to administer the Title I program in the five boroughs of New York City. In this capacity MHRA is responsible for the following:

- awarding Title I funds to direct service providers in the five boroughs of New York City through a competitive Request For Proposal (RFP) process,

- monitoring and assessing the performance of service providers, and reporting to the NYCDOH and the Planning Council the information (both programmatic and fiscal analyses) needed to assess the performance of the Title I program as a whole.

Under this contract with the NYCDOH for the 05 year, MHRA has administrative responsibility for approximately 157 contractors, or service providers, with over 304 contracts. Public or nonprofit private organizations are eligible for funding to provide services on a contract basis. These providers include hospitals, universities, and community-based organizations, among others. The total amount awarded under these contracts totaled $79.7 million. These contracts provided a wide range of services including Medical Care, Substance Abuse, Case Management, Mental Health, Food, Housing and Outreach. Of this amount:

-- $48.6 million in contracts were awarded to Community Based Organizations, Hospitals, and Universities.

-- $21.6 million in contracts were awarded to a New York State Agency, Health Research Institute (HRI). HRI used these Title I funds, in part, to help support various services for the uninsured.

-- $9.5 million in contracts were awarded to various New York City Departments: Human Resources Administration, Department of Health, Department of Corrections, Department of Mental Health, and the Commission on Human Rights.

The NYDOH also contracted with the Westchester County Department of Health (WCDOH), to manage the disbursement of Title I funds for the delivery of services in the New York counties of Westchester, Rockland, and Putnam. For the 05 year, Westchester County Department of Health was awarded $3.9 million. Under this contract WCDOH had administrative responsibility for eighteen contractors with 33 contracts.

OBJECTIVES, SCOPE and METHODOLOGY

We conducted our audit in accordance with generally accepted government auditing standards. The objective of the audit was to determine whether the NYEMA, its contractors, MHRA and WCDOH, and the service providers have adequate procedures in place to assure that all CARE Act clients receiving services are individuals with HIV disease and their families. Our audit covered the grantees 05 program year, or April 4, 1995 to April 3, 1996.

In planning and performing our audit, we identified those control procedures that we considered to be an important part of the grantee's management controls in determining eligibility under the CARE Act. Because of its importance to our audit objective, we requested from the NYEMA at the start of our audit, their written procedures and management controls established to ensure that only eligible individuals receive CARE Act services. In its reply, the grantee acknowledged that it had not directly issued a specific policy regarding documentation of HIV status at the service provider level. The grantee indicated that the eligibility requirements for Ryan White funded services are communicated to all prospective service providers and that proposals submitted in response

to its RFP for Title I funding, must contain a service delivery plan which indicates that proposed beneficiaries are Ryan White eligible. The NYEMA noted that it was unaware of any specific guidance provided by HRSA in establishing policy and guidance for service providers regarding documentation for eligibility.

With this understanding, we designed the following steps to accomplish our audit objective. We:

-- determined the adequacy of guidance provided by the grantee in its contractual agreements with its contractors (MHRA and WCDOH) to ensure compliance with CARE Act eligibility requirements.

-- determined whether the contractors established adequate procedures to ensure that service providers were designing proposals for Ryan White eligible beneficiaries.

-- determined whether standards were established requiring the documentation to be maintained to ensure client eligibility for Title I services.

-- determined the effectiveness of the contractor's monitoring procedures to ensure that service providers were adequately documenting eligibility for Title I services as prescribed in their service plans.

-- determined whether statistical data reported by the service providers to the NYEMA on the number of HIV clients receiving services were accurately compiled and supported by case record documentation.

After obtaining an understanding on the types of services provided under the CARE Act, we judgementally selected service providers for on-site review. The criteria used to select service providers included those with significant contract awards, those with multiple contracts, and those providing a range of Title I services.

Using the aforementioned criteria, we selected for review 17 service providers with 41 contracts totaling $12.6 million. Thirty-four of the contracts were administered by MHRA ($11.8 million) and seven contracts were administered by WCDOH ($800,000). The contracts covered the majority of Title I funded services. A listing of service providers and service categories selected for review are shown in Appendices A and B.

At the service provider level we:

-- reviewed eligibility policies and procedures,

-- selected the latest statistical reports on clients served,

-- reconciled statistical reports on clients served to service provider records,

-- judgementally selected client case records and reviewed the documentation maintained to support the client's HIV status.

As noted above, we were advised at the start of our audit that the NYEMA did not promulgate specific guidance to its contractors on the documentation necessary to be maintained by the service providers to support positive HIV status of the clients receiving services. Accordingly, we established our own criteria which we considered as acceptable documentation when we performed our review of the case files selected for audit. In this regard, we accepted laboratory test results, physician certification statements, and medical case records which contained at least one form of the evidence previously cited supporting the client's HIV status.

Because the NYEMA and the OIG were mutually sensitive to the issue of protecting the anonymity and confidentiality of the HIV infected individuals selected for review during the audit, a formal audit protocol was developed. The purpose of the protocol was to design audit procedures which would ensure client confidentiality and also enable the OIG to achieve its audit objective.

Finally, included in our initial sample selection were several service providers administering outreach and at risk recovery/readiness risk reduction programs. We are not including in this report the results of our review at these service providers. We have included our observations of client eligibility for these programs in a separate report to HRSA.

We conducted field work at the administrative offices of NYDOH, MHRA, HRI, WCDOH, New York City Departments of Human Resources Administration, Department of Corrections, and at 17 judgementally selected service providers during the period September 1995 through June 1996.

FINDINGS AND RECOMMENDATIONS

Our review of 17 service providers, with 41 contracts totaling $12.6 million and covering a range of Title I services, disclosed varying degrees of compliance with CARE Act eligibility criteria. At eight providers, with twenty-five contracts, we found acceptable documentation in the case record to support positive HIV serostatus of clients receiving Title I services. We considered acceptable documentation to include medical records, laboratory test results, and physician certifications. At nine service providers with sixteen contracts totaling $2.9 million, documentation was considered unacceptable as no form of acceptable evidence was found in the case records or made available for our review.

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17 - service providers reviewed
 8 - acceptable documentation of client eligibility
 9 - unacceptable documentation of client eligibility
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For these service providers, often the only evidence of HIV infection was the client's self disclosed notation in the case record. To a large degree, services were often provided to individuals classified by the service provider as "at risk" of HIV infection. Furthermore, we noted that documentation of HIV status was not always present where services were provided to a family member of the individual with HIV disease.

Since documentation to support CARE Act eligibility was inadequate or lacking, neither the NYEMA, its contractors or service providers could provide assurance that Title I services were provided only to eligible individuals as required by the CARE Act.

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Cause - NYEMA did not issue detailed policy on minimum
        documentation requirements

                          and,

        Contractor's monitoring was insufficient to disclose
        instances of noncompliance with eligibility criteria
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We attribute this condition to the fact that the NYEMA did not provide detailed guidance to its contractors specifying the primary case record documentation required to be maintained for HIV infected individuals and their families. Rather, the NYEMA provided only basic program criteria which stated that eligibility for CARE Act services are for HIV infected individuals and their families. However, standards were not established which would have guided the contractors and service providers with the required minimum level of documentation (e.g. laboratory report or other medical certification) necessary to support the client's HIV status. Basically, it was left to the service providers' discretion to develop its own procedures and documentation standards to support client eligibility.

Furthermore, while we noted that periodic monitoring of its service providers was conducted by NYEMA's contractors, it appeared that their reviews of case record files to determine the adequacy of documentation to support the individual's HIV status were not sufficient to disclose instances of non compliance with Title I eligibility requirements.

Subsequent to the start of our audit, HRSA issued guidelines to the EMAs relating to the establishment of procedures to ensure client eligibility. The guidelines emphasized that Title I grantees should have procedures in place to document client eligibility and that these procedures should be communicated to all service providers. The NYEMA disseminated the guidelines to its contractors and, in addition, requested them for the 1996 program year contract application, to furnish their program eligibility criteria and provide information on how the service providers plan to document eligibility. In our opinion, these steps when fully implemented, should provide greater assurance that Title I services will be provided only to eligible individuals and their families.

In addition, at the service provider level, we noted inaccuracies and inconsistencies in the number of HIV clients reported to the NYEMA as receiving services under the CARE Act in about 59 percent of the service providers reviewed. Several of the service providers duplicated case counts or otherwise overstated the number of clients actually receiving services. Since program effectiveness and future funding decisions are in part measured by the number of HIV clients receiving services, it is important that the numbers reported to the NYEMA are correct.

Criteria

The purpose of Title I grants is contained in section 2604 (b)(1) of the Act which states in part that:

> " ...The chief elected official shall use amounts...to provide direct financial assistance...for the purpose of delivering or enhancing HIV-related--
>
> > (A)outpatient and ambulatory health and support services, including case management and comprehensive treatment services, for individuals and families with HIV disease and...
> >
> > (B)inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities."

As discussed in more detail below, we found that at nine of the seventeen providers reviewed, adequate procedures were not in place to assure that services were rendered only to individuals and families with HIV disease. At six of the nine service providers, the case records did not always contain adequate documentation to support the positive HIV status of the individual receiving services. At the three remaining service providers, documentation of HIV status was not always present where services were provided to a family member (significant other) of the individual with HIV disease.

6 service providers - client's HIV status not documented

3 service providers - services rendered to family member of individual whose positive HIV status was not documented.

Inadequate Documentation for HIV Individuals Receiving Services

For six service providers, we determined that acceptable evidence of positive HIV infection was not maintained in the case record. In this regard, program eligibility criteria, established by the service provider as part of its approved program design, was not consistently adhered to resulting in services provided to potentially ineligible individuals. Following are examples at three of the six service providers reviewed where we found that Title I services were provided without documentation of positive HIV infection contained in the client's case record.

Service Provider I

This service provider received two contracts; $210,728 for a Community Based Aftercare program for recovering substance abuse addicts, and $76,222 for a Support Groups program. Both contracts were funded as Substance Abuse services under Title I.

For both programs we found that client eligibility was not adequately documented. While the programs' eligibility criteria stated that services would be provided to HIV positive clients, we noted that for the majority of clients served there was no independent verification or documentation to support HIV infection. For both programs, the client's self disclosure of HIV infection was the primary basis for acceptance into the programs.

For each program, individual client case records were not established. Rather, only intake, demographic worksheets and referral forms were maintained to support the caseload of clients served. These forms provided basic information on the client's HIV status as disclosed by the client. Service Provider I's procedures did not require independent verification of the client's attestation.

For a representative month, we tested the reliability of caseload statistics furnished by Service Provider I to MHRA. For the Aftercare program, Service Provider I reported that 203 clients were provided services under Title I. By reviewing the intake and demographic worksheets, we determined that 209 individuals were actually seen. Of this number, only 20 clients classified themselves as HIV positive. Nineteen, reported that they were HIV negative, while 81 reported themselves as HIV "status unknown." The remaining 89 clients did not respond to the question of HIV status on the demographic worksheets.

A similar pattern was found for the Support Group program. While 58 clients were reported as receiving Title I services in one month tested, the supporting demographic worksheets showed that only 46 clients were actually in the program. Of this number eight clients self disclosed themselves as HIV positive. One client attested to being HIV negative, while seven were reported as HIV "status unknown." The remaining 30 clients did not respond to the question asking for their HIV status.

Since the preponderance of clients served by both programs, for the period tested, were not classified as HIV positive, Title I funds were being used for purposes not intended by the CARE Act. For the most part services were being provided to individuals "at risk" of HIV instead of individuals and their families with HIV disease. Moreover, Service Provider I was reporting to MHRA their entire caseload for both programs as HIV positive individuals eligible for services under Title I.

Service Provider J

This service provider operated a food program under Title I and received a $390,000 contract in the 05 year to operate a food bank and to provide congregate meals and home delivered meals to eligible HIV infected clients.

The program eligibility criteria, as defined in the scope of service section of Service Provider J's contract, provides that "HIV status must be documented, via M11Q Medical Request for Home Care." This form is a local New York City Office of Home Care Services form used by NYC agencies to document an individual's primary and secondary diagnosis, drugs regimen, and a patient's physical capabilities as certified by a physician. In our review of provider case records, we considered this form, when properly completed and certified by a physician, as acceptable evidence of a client's HIV disease status.

For the month tested, Service Provider J reported that 119 clients received Title I services. Using the service provider's sign in sheets for congregate, food bank, and homebound meals we were able to determine that only 87 individuals received services. The program director could not reconcile or explain the differences of 32 in the case count.

We tested for client eligibility by examining 56 of the 87 files, consisting of 33 congregate and food bank clients and 23 clients who received home delivered meals. For the congregate and food bank clients we found that 12 case files contained the Form M11Q, and therefore, were eligible for Ryan White services. Of the balance of 21 clients, four files could not be located, and 17 contained no documentation to support eligibility for Title I services. The files did not contain a form M11Q, medical record or any other acceptable evidence to support the HIV status of the client served. The files only contained the service provider's nutrition intake form. The program director stated that these individuals were probably walk-in clients who were not able to provide documentation of HIV disease. Nevertheless, Title I services were provided to these clients.

For the 23 individuals receiving home delivered meals only seven case files contained acceptable supporting documentation for Title I services. The remaining 16 case files did not contain any eligibility documentation or evidence to support the HIV status of the clients served.

Without adequate evidence to document the client's HIV disease, Service Provider J cannot provide assurance that it is providing services only to HIV infected individuals and their families as required by its contract with MHRA and the Care Act.

Service Provider N

MHRA awarded a contract for $204,026 to this service provider to provide Adult Day Treatment Services (ADT) to HIV individuals with a history of substance abuse.

For the test month reviewed, the service provider reported that 80 clients received ADT services under Title I. However, at the entrance conference we were informed that 80 was not the correct number of clients because they were reporting a cumulative number of clients who received services throughout the year. We were informed that the correct number of individuals who received services in our test month was 39.

Our review of the 39 case files showed that 22 cases contained acceptable documentation of the client's positive HIV status. The files contained a completed M11Q, laboratory report or medical record to support client eligibility. For the remaining 17 cases, however, the files contained no evidence to support the positive HIV status of the client receiving ADT services. The Program Director advised us that these individuals only received intake services, and never returned to the program. Nevertheless, these clients were reported to MHRA as eligible HIV positive clients who received ADT services under the contract.

Inadequate Documentation for Family Members Receiving Title I Services

Under the CARE Act, family members of an individual with positive HIV, are eligible to receive Title I services. For three providers included in our sample, we found that acceptable documentation of HIV status was not always present where services were provided to a family member of the individual with HIV disease. We were advised by program managers that in those instances where the individual with HIV disease was not being served by the facility where the family member received services that it was often difficult to obtain documentation supporting HIV infection of the individual. According to New York State law, in order to obtain such documentation including the medical records, it was necessary for the HIV infected individual to sign a formal release form authorizing disclosure of his HIV status. We noted in our review that often attempts were made by the

service providers to obtain a formal release. However, services were not denied to the family member if the HIV information was not obtained. Following is an illustrative example of this condition at one provider reviewed.

Service Provider K

This service provider, a mental health facility was awarded two contracts under Title I, a Case Management contract for $175,000, and a Family Mental Health contract for $150,000. Under the scope of service section of these contracts services were limited to HIV infected individuals and their families.

We reviewed 30 client files for one month. We noted that the same clients serviced under the Family Mental Health contract were also serviced under the Case Management contract. Accordingly, we were able to assess eligibility for both programs by reviewing documentation for the same 30 clients.

For 15 cases we were able to confirm the HIV status of the individual receiving services. Since the individual was a client of the provider, medical records were obtained via the consent and release form and was maintained to support client eligibility. For the remaining 15 cases, however, the services were rendered to a family member of the individual with HIV.

In these cases, the HIV individual was not a client of Service Provider K, and, therefore, did not have to authorize disclosure of HIV status. Services were nevertheless provided to the family member even though there was no independent verification of the HIV status of the individual.

From reviewing the case notes and other data in the files, e.g. family psychosocial assessments, we were able to find a nexus or relationship between the HIV individual and the family member receiving services. Several of the cases reviewed involved bereavement cases where mental health services were provided to a significant other who lost a family member to AIDS. In other cases, mental health services were provided to child (ren) of a parent who died or was suffering from AIDS and who were exhibiting anti-social behavior and experiencing educational problems in school. While, we recognize that a release form could not be obtained in these cases involving a death of an HIV infected individual, it, nevertheless raises a program vulnerability in that Title I funds could be used for non program purposes where a family member incorrectly asserts that he was related to an individual with HIV infection.

We attribute the weaknesses found at service providers in documenting Title I eligibility to a lack of detailed guidance issued by the NYEMA to its contractors on the primary documentation required to be maintained to ensure that services are only provided to Ryan White eligible individuals and their families. We noted that the NYEMA and its contractors provided only basic program eligibility criteria to the service providers. It

required the service providers to stipulate that they would design programs and services to individuals with HIV disease and their families. However, standards were not established which would have guided the service providers with the minimum level of documentation (e.g. laboratory report or other medical clarification) necessary to support the client's HIV condition. Basically, it was left up to the service provider to develop its own procedures and documentation standards to support client eligibility under the Title I program.

Program Monitoring

The NYEMA delegated primary responsibility for program monitoring to its contractors, MHRA and WCDOH. As part of their responsibility, the contractors were required to make periodic site visits to the service providers and review various aspects of the contracts, including program administration and management, fiscal management and the adequacy of program service levels. We noted, however, that the monitoring guidelines established by the contractors did not provide for specific review of client eligibility. Specifically, the program coordinators responsible for the monitoring reviews, did not always review client charts to determine the adequacy of documentation to support the HIV positive status of the clients served. For the most part, the focus of their visits were on program compliance issues as noted previously, and not on the adequacy of evidence to document client eligibility for CARE Act services.

For the providers we visited during our audit, we requested the monitoring reports for the period covered by our review. In those instances where we found problems in the client records supporting eligibility, we noted that the program coordinators did not disclose or report similar findings in their monitoring reports. To validate the accuracy of our observations, the contractors during their subsequent site visits to these providers, made chart reviews to assess client eligibility. The results of their follow-up reviews confirmed our observations that adequate evidence to support client eligibility was lacking in the client case folders.

Since the monitoring guidelines did not contain specific steps to validate client eligibility, monitoring reviews made by program coordinators were inconsistent and often lacked coverage of program eligibility. Accordingly, neither the NYEMA nor its contractors could provide adequate assurance that service providers were serving only HIV clients and their families as required by the CARE Act.

In summary, our review of eligibility procedures established by the NYEMA, its contractors and at a representative number of service providers, showed that controls were not always in place to ensure that Title I services were being provided only to eligible clients and their families. For the period covered by our review, the 05 year, April 4, 1995 to April 3, 1996, the guidance provided by the NYEMA to its contractors specifying the primary documentation to be maintained to support HIV positive serostatus was not in

sufficient detail to ensure compliance with CARE Act eligibility requirements. At those providers where we found acceptable documentation to support client eligibility, adequate procedures were in place despite the lack of specific guidance from the NYEMA and its contractors. These providers put in place their own controls to document client eligibility. For those providers that did not have adequate procedures, we believe that they could have benefitted from more specific guidance from the NYEMA. At these providers, we concluded that about $2.9 million, involving 16 contracts, could have been expended on programs that provided Title I services to potentially ineligible individuals and their families.

SUBSEQUENT EVENTS

On August 21, 1995, subsequent to the start of our audit, HRSA issued guidelines to the EMA's relating to the establishment of procedures to ensure and document that clients receiving services supported by Title I and/or Title II of the CARE Act are eligible beneficiaries, i.e.. individuals living with HIV/AIDS and their families.

These guidelines were issued based on a previous OIG audit that recommended that HRSA require the EMA's to strengthen their systems and controls to ensure that only individuals with HIV disease and their families receive services provided through CARE Act funds.

In these guidelines HRSA stated that "Each Title I and II grantee should have in place written procedures to ensure client eligibility. The written procedure should be communicated to and required of all service providers supported by Title I and II funds. Procedures for providers supported with CARE Act funds should include the following:

- Require that primary documentation of positive HIV serostatus be kept in the client's file on-site in at least one location among the CARE-funded network. Examples of acceptable proof of HIV serostatus include lab test results and physician statements.

- Client files at every location should include primary documentation or reference to the primary documentation in the form of a certified referral form or a notation that eligibility has been confirmed (including the name of person/organization verifying eligibility, date, and nature and location of primary documentation).

- Program monitoring and activities undertaken by Title I and II grantees should include review of documentation of client eligibility by programs/providers."

On December 13, 1995, NYEMA disseminated these guidelines to MHRA and WCDOH for distribution to their service providers in order to have these guidelines incorporated in

their 06 year CARE Act applications. In addition to alerting contractors to documentation requirements, the NYEMA also made revisions to their contracts under the Scope of Service section of the 06 year contracts.

For the 06 year, the service providers were asked not only for their eligibility criteria, but also to provide information on how they plan to document eligibility. In our opinion, these steps when fully implemented, should provide greater assurance that Title I services will be provided only to eligible individuals and their families.

Statistical Reporting

During our site visits, we noted inaccurate and inconsistent reporting by service providers on the number of HIV positive clients receiving services. Monthly, the providers submit to their contractor, MHRA or WCDOH, program fiscal, service delivery and program activity data, on form "Ryan White Comprehensive AIDS Resource Emergency Act, Title I Monthly Fiscal and Program Monitoring Report." On this form the provider certifies to the accuracy of program activity including the number of HIV clients seen and provided services during the month. Since program effectiveness and future funding levels are, in part, measured by the number of HIV clients served, it is important that the number of clients reported are accurate.

We found reporting problems in 24 of 41 contracts reviewed or 59 percent. Specifically:

-- 15 contracts counted the same clients under more than one contract

-- 5 contracts understated the number of clients receiving services

-- 4 contracts overstated the number of clients receiving services

We noted that the statistical data on clients served were not independently verified by program coordinators at the time of their monitoring visits to the service providers. Accordingly, the information was relied upon by the NYEMA and its contractors when program evaluation and effectiveness studies were made of the provider's programs. It is apparent that future program decisions, including funding levels and program effectiveness, could be impaired if inaccurate program statistics on the actual number of HIV clients served are reported to management.

Recommendations:

We are recommending that the NYEMA:

-- Continue to provide its contractors and service providers with guidance which will enable them to develop and maintain adequate documentation to ensure that Care Act services are offered to eligible individuals and their families,

-- Provide guidance which will enable its contractors to strengthen on-site monitoring reviews to evaluate and ensure the sufficiency of documentation maintained by the service providers to support eligibility determinations,

-- Require its contractors to periodically reconcile the number of HIV positive individuals reported as receiving Title I services to the service providers records to ensure the accuracy of the statistical data reported.

Auditee Comments

The NYEMA generally concurred with the recommendations and stated that corrective action has been taken. In this regard NYEMA issued guidelines to its contractors concerning client eligibility for Title I services and documentation of HIV serostatus which was passed on to service providers. These policies were incorporated into the contract renewal process and will be evaluated through the contract monitoring process which includes two site visits to each provider annually. The EMA also stated that chart reviews are conducted as part of the site visit, and documentation of HIV serostatus will be included in the review. In addition, the EMA responded that the eligibility guidelines issued by HRSA will be used to guide future development of new service priorities for the EMA.

The NYEMA did not comment on our recommendation to periodically reconcile the number of HIV positive individuals reported as receiving Title I services to the service providers records to ensure the accuracy of the statistical data. The EMA responded that the recommendation appears to be linked to a finding associated with the reporting system that does not accurately represent the system that is currently in place. In their response the NYEMA stated that contract compliance and program effectiveness are measured by the delivery of units of service delivered to clients, not the number of clients served. A client may receive two or more services at the same agency, and the agency will report each unit of service provided. It would be appropriate to have the clients counted more than once for a single contract.

In addition, the NYEMA's response contained certain technical changes for inclusion in the final report. To the extent we considered it feasible and practical, the technical comments offered were incorporated into our final report.

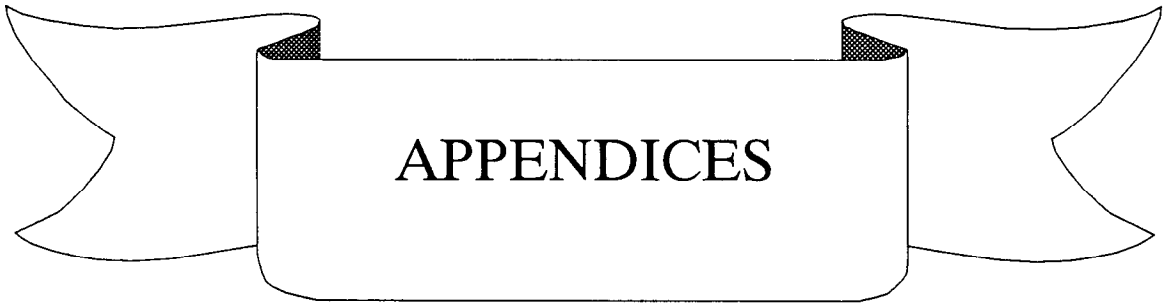
Additional OIG Comments

We believe that contractors should periodically reconcile the number of HIV infected individuals reported to service provider records. As discussed in the report during our site visits, we noted inaccurate and inconsistent reporting by service providers on the number of HIV positive clients receiving services. Further, we stated that since program effectiveness and future funding levels are, in part, measured by the number of HIV clients served it is important that the number of clients reported are accurate.

In their response, the NYEMA stated that compliance and program effectiveness are measured by the delivery of units of service delivered to clients, not the number of clients served. In our opinion, if the number of clients reported as being served is inaccurate, the corresponding number of services reported as provided to the clients could also be inaccurate.

To illustrate: In one month tested, service provider N reported that 80 clients received ADT services under Title I. At the entrance conference we were informed that 80 was not the correct number of clients because they were reporting a cumulative number of clients who received services throughout the year. We were informed that the correct number of individuals who received services in our test month was 39. The service provider nevertheless reported that 80 units of services were provided which corresponded exactly to the overstated number of clients reported.

Since program effectiveness and future funding levels are, in part, measured by the number of HIV clients served, and the corresponding number of services provided to HIV clients it is important that the number of clients reported are accurate. Therefore, we still believe that the NYEMA should require its contractors to periodically reconcile the number of HIV positive individuals reported as receiving Title I services to the service providers records to ensure the accuracy of the statistical data reported.


APPENDICES

SCHEDULE OF SERVICE PROVIDER RECORDS REVIEWED

SERVICE PROVIDER	DOCUMENTED CASES	CASES REVIEWED	HIV DOCUMENTED	UNDOCUMENTED
ADEQUATE				
Service Provider A	42	42	42	0
Service Provider B	509	82	82	0
Service Provider C	46	20	20	0
Service Provider D	45	25	25	0
Service Provider E	97	20	20	0
Service Provider F	1758	132	132	0
Service Provider G	245	73	71	2
Service Provider H	98	30	28	2
SERVICE PROVIDERS 8				
INADEQUATE				
Service Provider I (1)	255	255	0	255
Service Provider J (1)	87	56	19	37
Service Provider K (2)	30	30	15	15
Service Provider L (1)	30	11	7	4
Service Provider M (2)	114	47	32	15
Service Provider N (1)	39	39	22	17
Service Provider O (1)	264	51	41	10
Service Provider P (1)	98	34	30	4
Service Provider Q (2)	104	39	32	7
SERVICE PROVIDERS 9				
TOTAL 17	3861	986	618	368

(1) Inadequate documentation for HIV individual receiving services.

(2) Inadequate documentation for family member receiving services.

APPENDIX B

SCHEDULE OF CONTRACTS AWARDED AND REVIEWED
BY SERVICE CATEGORY

SERVICE CATEGORY	TOTAL CONTRACTS	TOTAL DOLLARS	AUDITED CONTRACTS	AUDITED DOLLARS	PERCENTAGE AUDITED	
					CONTRACTS	DOLLARS
MEDICAL CARE	53	$31,238,240	5	$2,449,850	9%	8%
SUBSTANCE ABUSE	50	11,299,772	4	1,118,996	8%	10%
FOOD/NUTRITION	19	3,735,823	4	661,518	21%	18%
HOUSING	21	5,187,015	4	3,148,092	19%	61%
HOME HEALTH CARE	9	1,996,678	1	206,785	11%	10%
CASE MANAGEMENT	31	5,558,490	9	3,201,157	29%	58%
MENTAL HEALTH	58	8,297,379	5	716,368	9%	9%
TRANSPORTATION	1	70,000	1	70,000	100%	100%
INFORMATION DISS.	4	610,600	0	0	0%	0%
DENTAL CARE	8	1,185,533	0	0	0%	0%
CLIENT ADVOCACY	19	2,901,987	2	482,558	11%	17%
BUDDY/COMPANION	4	307,057	1	40,474	25%	13%
ADOPTION/FOSTER CARE	8	1,301,866	1	150,000	13%	12%
OTHER COUNSELING	14	1,434,263	3	212,016	21%	15%
PROGRAM SUPPORT	11	2,838,942	1	131,250	9%	5%
TOTAL	310	$77,963,645	41	$12,589,064	13%	16%

Does not include Education/Risk Reduction/Outreach programs.

THE CITY OF NEW YORK
DEPARTMENT OF HEALTH
OFFICE OF THE COMMISSIONER

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October 11, 1996

John Tournour
Regional Inspector General for Audit Services
Department of Health and Human Services
Jacob K. Javits Federal Building
26 Federal Plaza, RM 3900A
New York, NY 10278-0062

Re: ID# A-02-95-02517

Dear Mr. Tournour:

I appreciate having the opportunity to review and comment on the draft report entitled "Audit of Eligibility Under Title I of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, New York City Eligibility Metropolitan Area received September 3, 1996 and am pleased that these comments will be considered in the preparation of the final report. The draft report has been shared with the staff of the Bureau of Ryan White CARE Services, the Westchester County Department of Health (WCDOH), and Medical and Health Research Association of New York City, Inc. (MHRA). Their views on the findings have been incorporated in the following discussion.

The EMA developed a policy addressing the documentation of client eligibility before the audit was completed. In December 1995 the NYCDOH issued guidelines to MHRA and WCDOH concerning client eligibility for Title I services and documentation of HIV serostatus which was passed on to service providers. These policies were incorporated into the contract renewal process and will be evaluated through the contract monitoring process which includes two site visits to each provider annually. Chart reviews are conducted as part of the site visit, and documentation of HIV serostatus will be included in the review. The eligibility guidelines issued by HRSA will be used to guide future development of new service priorities for the EMA.

Comments on specific sections of the report are identified below.

1. The report refers to the New York City Eligibility Metropolitan Area. This should be changed to the New York Eligible Metropolitan Area.

2. The report should note in its introduction (background) that the New York EMA includes the Tri-County region and is not confined to New York City.

3. The New York City Department of Health is mistakenly referred to as NYCEMA in the background section (page i).

4. As a point of clarification, the first reference to Year 5 in the background section should note that the grant period was from April 4, 1995 - April 3, 1996.

5. The grant award identified in the report is rounded up to $93.6 but does not reference the carryover funds ($7,849,675) approved by HRSA for use during this period. These funds were allocated to service contracts in the EMA. The funding level used for the report should either include the carryover, or specifically state that the carryover is not included.

6. In the first paragraph under the Summary of Findings it should be noted that the source documents (confirming HIV serostatus) used to perform the review were selected by the auditors in the absence of a policy from HRSA at the start of the audit (page i).

7. The first paragraph on page ii should be qualified by stating that in some instances the NYEMA could not provide assurance that Title I services were provide only to eligible individuals and their families as required by the CARE Act. As currently written, it suggests that this was a universal problem.

8. While the report does make an attempt to recount the events related to the issuance of policy statements on eligibility, the current tone of the report places the main burden for the failure of such action on the New York EMA. There should be a reference earlier in the report to the Subsequent Events section of the report which outlines the chronology of events related to the issuance of policies concerning documentation of eligibility. The HRSA guidelines were issued August 21, 1995, at which time NYCDOH was advised these guidelines were in draft form. During discussions with HRSA in December we were advised that these guidelines were effective. On December 13, 1995 the NYCDOH instructed WCDOH and MHRA to implement the eligibility guidelines and develop procedures to monitor their implementation (as noted in the report).

9. The last paragraph on page iii states that the results of the review of outreach and harm reduction services have not been included in the report, but will be sent as a separate report to HRSA. To more accurately represent the scope of the audit, we recommend identifying the number of programs that were excluded from the report by reporting the total number of contracts reviewed, the total number of contracts with acceptable documentation, the number of contracts with acceptable documentation

Auditor's Note:
To the extent we considered it feasible and practical, the technical comments offered were incorporated into our final report.

that are excluded from this report, the total number of contracts without acceptable documentation, and the total number of contracts without acceptable documentation that have been excluded from the report.

10. The section under Summary of Findings that refers to nine service providers with unacceptable documentation should be more specific and include the service categories reviewed. The second paragraph should be clarified to more carefully describe what is meant by *To a large degree services were often...* These are rather non-specific statements and could be misleading.

11. On page two, the report notes "the NYCEMA also entered into an intergovernmental agreement with the Westchester County Department of Health..." this should be corrected to note that the NYCDOH has a contract with WCDOH to manage Title I funds for the Tri-County region.

12. On page three, it is noted that 41 contracts were reviewed, while on page four the report states that the results of the review of outreach and risk recovery/recovery readiness/low threshold services are not included in the report. It would be easier to understand the scope of the audit if the actual number of contracts reviewed was noted, followed by the number of contracts that fell in to the two service categories that have been excluded from this report. (See #9)

13. The tables on page five should be revised to include the number of providers reviewed, the number of contracts reviewed, the number of contracts with acceptable documentation, and the number of contracts with unacceptable documentation.

14. A statement concerning the fact that HRSA did not have a policy concerning documentation of eligibility should be repeated on page five.

15. The final report, which will be public information, should not contain the names of providers.

16. In situations where it is noted that client eligibility was not adequately documented, if the client self disclosed his/her HIV status, it should be so noted.

17. In the Statistical Reporting Section on page 13, the capability and intent of the reporting system is misrepresented. Contract compliance and program effectiveness are measured by the delivery of units of service delivered to clients, not the number of clients served. A client may receive two or more services at the same agency; and the agency will report each unit of service provided. It would be appropriate to have the clients counted more that once for a single contract in the example provided. At this time I cannot comment on the recommendation concerning the reconciliation of HIV positive individuals receiving services to ensure the accuracy of the statistical data because the recommendation appears to be linked to a finding associated with the reporting system that does not accurately represent the system that is currently in place.

Auditor's Note:
To the extent we considered it feasible and practical, the technical comments offered were incorporated into our final report.

I trust these comments will be considered in the preparation of the final report. Please feel free to contact JoAnn Hilger at 693-1440 if you have any questions or comments concerning our views.

Sincerely,

Benjamin A. Mojica, MD, MPH
Deputy Commissioner of Health
Division of Disease Intervention

cc: Mr. Mahoney
Mr. Troob
Mr. Netburn
Ms. Hilger

Enclosures - as stated

Direct Reply to HHS Action Official:

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