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

OCT 20 2003

Report Number: A-03-03-00384

Dr. Lisa G. Kaplowitz, M.D., M.S.H.A.
Deputy Commissioner for Emergency Preparedness and Response
Virginia Department of Health
1500 E. Main Street, Suite 214
Richmond, Virginia 23219

Dear Dr. Kaplowitz:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) report entitled " Commonwealth of Virginia's Efforts to Account For and Monitor Sub-Recipients' Use of Bioterrorism Hospital Preparedness Program Funds."

A copy of this report will be forwarded to the action official noted below for her review and any action deemed 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 (5 U.S.C. 552, as amended by Public Law 104-231), OIG reports issued to the department's grantees and contractors are made available 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.)

If you have any questions or comments about this report, please do not hesitate to call me or Leon Skros, Audit Manager, at 215-861-4472 or through e-mail at lskros@oig.hhs.gov. To facilitate identification, please refer to report number A-03-03-00384 in all correspondence.

Sincerely yours,

Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosures - as stated

Direct Reply to HHS Action Official:

Nancy J. McGinness
Director, Office of Financial Policy and Oversight
Room 11A55, Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

COMMONWEALTH OF VIRGINIA

EFFORTS TO ACCOUNT FOR AND MONITOR SUB-RECIPIENTS' USE OF BIOTERRORISM HOSPITAL PREPAREDNESS PLANNING PROGRAM FUNDS

OCTOBER 2003
A-03-03-00384

Office of Inspector General

http://oig.hhs.gov/

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services, reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

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 awarding agency will make final determination on these matters.

EXECUTIVE SUMMARY

OBJECTIVE

Our objectives were to determine whether the Virginia Department of Health (State agency) properly recorded, summarized and reported bioterrorism preparedness transactions in accordance with the terms and conditions of the cooperative agreements and whether the State agency has established controls and procedures to monitor sub-recipient expenditures of Health Resources and Services Administration (HRSA) funds. In addition, we inquired as to whether Bioterrorism Hospital Preparedness Program (Program) funding supplanted programs previously provided by other organizational sources.

FINDINGS

Based on our validation of the questionnaire completed by the State agency and our site visit, we determined that the State agency generally accounted for program funds in accordance with the terms and conditions of the cooperative agreement and applicable departmental regulations and guidelines. However, the State agency did not segregate expenditures by phase, within phase, or by priority area. Although segregation was not required, budget restrictions were specified in the cooperative agreement. State agency officials stated that their intent is to establish a methodology that will not only track expenditures by object codes but will include the ability to track expenditures by grant phases.

The State agency had a system in place to track and monitor sub-recipient activities. The State agency contracted with the Virginia Hospital and Health Association (Association) to assess and upgrade the preparedness of the Commonwealth's hospitals and collaboration entities to respond to bioterrorism. The State agency and the Association collaborated on and created a memorandum of understanding for use by the Association that specifically defines expectations for the dissemination of funds. The Association provides minutes of its periodic planning meetings to the State agency; however, we noted that there was no site visit component as part of the memorandum of understanding developed by the State agency. We believe that development of a site visit component, combined with the tracking and monitoring system already in place, will provide adequate monitoring and oversight of State agency sub-recipients.

In response to our inquiry as to whether the State agency reduced funding to existing public health programs, State officials replied that Program funding had not been used to supplant existing State or local programs.

The Association, as of the date of this report, has not provided requested expenditure documents, including actual cost incurred and start and completion dates for expenditures claimed by a hospital sub-recipient for the upgrade of two negative pressure rooms. Without the documentation we cannot determine whether the project expenditures meet the criteria outlined in the HRSA cooperative agreement guidance.

RECOMMENDATIONS

We recommend that the State agency:

1) segregate Program expenditures by phase, within phase, and by priority area.

2) implement a site visit component as part of its sub-recipient activities tracking and monitoring system and address problem areas, as they are identified.

3) require the Association to provide expenditure documentation, including actual cost incurred and start and completion dates, for the upgraded negative pressure rooms and determine whether the project expenditures meet the criteria outlined in the HRSA cooperative agreement guidance.

STATE AGENCY'S COMMENTS

In a written response to our draft report, the State agency generally concurred with our findings and our recommendations. In response to our recommendation that Program expenditures be segregated by phase, within phase, and by priority area, the State agency replied that the cooperative agreements do not require tracking of program expenditures by phase or priority area. The State agency's response is included in its entirety as an appendix to this report.

OIG COMMENT

The OIG agrees that the cooperative agreements do not require tracking of Program expenditures by phase or priority area. This is acknowledged in our report. However, budget restrictions were specified in the cooperative agreements. Segregation by phase or priority area would help facilitate meeting these budget restrictions. Also, the new 2003 cooperative agreement guidance specifically states that grantees must "develop and maintain a financial accounting system capable of tracking expenditures by priority area, by critical benchmark, and by funds allocated to hospitals and other health care entities."

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INTRODUCTION

BACKGROUND

Program

Since September 2001, the U.S. Department of Health and Human Services has significantly increased its spending for public health preparedness and response to bioterrorism. For FYs 2002 and 2003, the Department awarded amounts totaling $2.98 billion and $4.32 billion, respectively, for bioterrorism preparedness. Some of the attention has been focused on the ability of hospitals and emergency medical services systems to respond to bioterrorist events.

Congress authorized funding to support activities related to countering potential biological threats to civilian populations under the Department of Defense and Emergency Supplemental Appropriations for Recovery from and Response to Terrorist Attacks on the United States Act, 2002, Public Law 107-117. As part of this initiative, the HRSA made available approximately $125 million in FY 2002 for cooperative agreements with State, territorial, and selected municipal offices of public health. The Program is referred to as the Bioterrorism Hospital Preparedness Program. The purpose of this cooperative agreement program is to upgrade the preparedness of the Nation's hospitals and collaborating entities to respond to bioterrorism.

HRSA made awards to States and major local public health departments under Program Cooperative Agreement Guidance issued February 15, 2002. These awards provided funds for the development and implementation of regional plans to improve the capacity of hospitals, their emergency departments, outpatient centers, emergency management systems and other collaborating health care entities for responding to incidents requiring mass immunization, treatment, isolation and quarantine in the aftermath of bioterrorism or other outbreaks of infectious disease.

Annual Program Funding

The Program year covered the period April 1, 2002 through March 31, 2003 and the funding totaled $125 million. It has since been extended to cover the period through March 31, 2004.

Budget Restrictions

During the Program year, the cooperative agreements covered two phases. Phase I, *Needs Assessment, Planning and Initial Implementation*, provided 20 percent of the total award ($25 million) for immediate use. Up to one-half of Phase I funds could be used for development of implementation plans, with the remainder to be used for implementation of immediate needs. The remaining 80 percent of the total award ($100 million) was not made available until required implementation plans were approved by HRSA, at which point Phase II, *Implementation*, could begin. Grantees were allowed to roll over unobligated Phase I funds to Phase II. Grantees were required to allocate at least 80 percent of Phase II funds to hospitals and their collaborating entities through contractual awards to upgrade their abilities to respond to bioterrorist events.

Funds expended for health department infrastructure and planning was not to exceed the remaining 20 percent of Phase II funds.

Eligible Recipients

Grant recipients included all 50 States, the District of Columbia, the Commonwealths of Puerto Rico and the Northern Marianas Islands, American Samoa, Guam, the U.S. Virgin Islands, and the nation's three largest municipalities (New York, Chicago, and Los Angeles County). Those eligible to apply included the health departments of States or their bona fide agents. Individual hospitals, EMS systems, health centers and poison control centers work with the applicable health department for funding through the Program.

State Agency Funding

The following table details Program funding for budget year one:

Program Year 1 Amounts			
	Awarded	**Expended**	**Unobligated**
Year 1	$ 2,992,259	$ 1,169,060 (1)	$ 0

(1) As of February 28, 2003

OBJECTIVE, SCOPE AND METHODOLOGY

Objectives

Our objectives were to determine whether the State agency properly recorded, summarized and reported Program transactions in accordance with the terms and conditions of the cooperative agreements and whether the State agency has established controls and procedures to monitor sub-recipient expenditures of HRSA funds. In addition, we inquired as to whether Program funding supplanted programs previously provided by other organizational sources.

Scope

Our review was limited in scope and conducted for the purpose described above and would not necessarily disclose all material weaknesses. Accordingly, we do not express an opinion on the system of internal accounting controls. In addition, we did not determine whether costs charged to the Program were allowable.

Our audit included a review of State agency policies and procedures, financial reports, and accounting transactions during the period of April 1, 2002 through March 31, 2003.

Methodology

We developed a questionnaire to address the objectives of the review. The questionnaire covered the areas: (i) the grantee organization, (ii) funding, (iii) accounting for expenditures, (iv) supplanting, and (v) sub-recipient monitoring. Prior to our fieldwork, we provided the questionnaire for the State agency to complete. During our on-site visit, we interviewed State agency staff and obtained supporting documentation to validate the responses on the questionnaire.

Fieldwork was conducted at the State agency, and the Association offices in Richmond, Virginia and the HHS Office of Inspector General Regional Office in Philadelphia, Pennsylvania during June 2003. The State agency's comments on the draft report are included in their entirety as an appendix to this report. A summary of the State agency's comments follows the *Findings and Recommendations* section.

Our review was performed in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Based on our validation of the questionnaire completed by the State agency and our site visit, we determined that the State agency generally accounted for program funds in accordance with the terms and conditions of the cooperative agreement and applicable departmental regulations and guidelines. However, the State agency did not segregate expenditures by phase, within phase, or by priority area. Although segregation was not required, budget restrictions were specified in the cooperative agreement. State agency officials stated that their intent is to establish a methodology that will not only track expenditures by object codes but will include the ability to track expenditures by grant phases.

The State agency had a system in place to track and monitor sub-recipient activities. The State agency contracted with the Association to assess and upgrade the preparedness of the Commonwealth's hospitals and collaboration entities to respond to Bioterrorism. Also, the State agency and the Association collaborated on and created a memorandum of understanding for use by the Association that specifically defines expectations for the dissemination of funds. The Association provides minutes to the State agency of their periodic planning meetings. We noted that there was no site visit component as part of the memorandum of understanding developed by the State agency. We believe that development of a site visit component, combined with the tracking and monitoring system already in place will provide adequate monitoring and oversight of State agency sub-recipients.

In response to our inquiry as to whether the State agency reduced funding to existing public health programs, State agency officials replied that Program funding had not been used to supplant existing state or local programs.

The Association, as of the date of this report, has not provided requested expenditure documents, including actual cost incurred and the date of the completion, for expenditures claimed by a hospital sub-recipient for the upgrade of two negative pressure rooms. Without the documentation we cannot determine whether the project expenditures meet the criteria outlined in the HRSA cooperative agreement guidance.

Accounting for Expenditures

An essential aspect of the Program is the need for the grantee to accurately and fully account for bioterrorism funds. Accurate and complete accounting of Program funds provides HRSA a means to measure the extent the program is being implemented and that the objectives are being met. Although the State agency was not required to segregate expenditures in the accounting system by phase, within phase, or by priority area, there are budgeting restrictions set forth in the HRSA Program Cooperative Agreement Guidance and Summary Application Guidance for Award and First Allocation. Twenty percent of a grantee's total award will be made available in Phase I. Page 7 of the Cooperative Agreement Guidance states that indirect costs will be "limited to 10 percent of the Phase I and Phase II total."

Regarding Phase I funds:

> …Up to half of the Phase I funding may be allocated to planning and health department infrastructure to administer the cooperative agreement. At least half (50%) of the Phase I award must be allocated to hospitals and other health care entities to begin implementation of their plans….

Regarding Phase II funds, page 2 of the Summary Application Guidance for Award and First Allocation states:

> …Grantees will be required to allocate at least 80% of the Phase II funds to hospitals through written contractual agreements. To the extent justified, a portion of these funds could be made available to collaborating entities that improve hospital preparedness….

The State agency assigns each grant a unique project code. Within that project code, the State agency records financial transactions by major object codes such as salaries, contractual expenditures, supplies and materials, continuous charges and equipment. This process segregates all grants and enables the State agency to track expenditures by object. Expenditures at the State agency were not segregated in the central accounting system by phase, within phase, or by priority area. Although segregation was not required, budget restrictions were specified in the cooperative agreement. Specifically, expenditures for health department infrastructure and planning were not to exceed 50 percent of Phase I and 20 percent of Phase II funds. Without segregation of funds, the State agency has no assurance that funds expended do not exceed the budgeting restrictions set forth in the cooperative agreement. State agency officials stated that their intent is to establish a methodology that will not only track expenditures by object codes but will include the ability to track expenditures by grant phases.

Sub-recipient Monitoring

Recipients of Program grant funds are required to monitor their sub-recipients. The PHS Grants Policy Statement requires that "grantees employ sound management practices to ensure that program objectives are met and that project funds are properly spent." It reiterates recipients must:

> …establish sound and effective business management systems to assure proper stewardship of funds and activities….

In addition, the Policy Statement states that grant requirements apply to subgrantees and contractors under the grants.

> …Where subgrants are authorized by the awarding office through regulations, program announcements, or through the approval of the grant application, the information contained in this publication also applies to subgrantees. The information would also apply to cost-type contractors under grants….

The State agency had a system in place to track and monitor sub-recipient activities. The State agency contracted with the Association to assess and upgrade the preparedness of the Commonwealth's hospitals and collaboration entities to respond to bioterrorism. The Association assisted in the disbursement of funds awarded to Virginia by HRSA to hospital sub-recipients. The State agency and the Association collaborated on and created a memorandum of understanding for use by the Association that specifically defines expectations for the dissemination of funds. The checklist of items required prior to distribution of funds to regional planning groups includes, developing a needs assessment and reporting its findings, reviewing and analyzing information already available and plans already in place, developing an implementation work plan and logical timeline with measurable objectives prioritizing needs, integrating comments and providing feedback to State agency on any plans, data and or reports. The Association provides minutes to the State agency of its periodic planning meetings.

We noted that there was no site visit component as part of the memorandum of understanding developed by the State agency. We believe that development of a site visit component, combined with the tracking and monitoring system already in place will provide adequate monitoring and oversight of State agency sub-recipients.

Supplanting

Program funds were to be used to augment current funding and focus on bioterrorism hospital preparedness activities under the HRSA Cooperative Agreement Guidance. Specifically, funds were not to be used to supplant existing Federal, State, or local funds for bioterrorism, infectious disease outbreaks, other public health threats and emergencies, and public health infrastructure within the jurisdiction. Page 4 of the Cooperative Agreement Guidance states:

> …Given the responsibilities of Federal, State, and local governments to protect the public in the event of bioterrorism, funds from this grant must be used to

> supplement and not supplant the non-Federal funds that would otherwise be made available for this activity….

OMB Circular A-87 also states:

> …funds are not to be used for general expenses required to carry out other responsibilities of a State or its sub-recipients….

In response to our inquiry as to whether the State agency reduced funding to existing public health programs, State officials replied that Program funding had not been used to supplant existing State or local programs.

However, during our review of sub-recipient expenditures reported to the State agency, we noted that one sub-recipient hospital used HRSA grant funds to reimburse itself for $24,000 expended for a completed upgrade involving the installation of two negative pressure rooms. The documentation provided by the Association to the OIG for the upgrade was a budget estimate from the contractor for the work that had already been completed at some point in calendar year 2002. The documentation did not give a work start or completion date. Actual expenditure invoices were requested by the OIG from the Association, but as of the date of this report, the requested documents have not been provided. Without the documentation we cannot determine whether the project expenditures meet the criteria outlined in the HRSA cooperative agreement guidance.

Due to the limited scope of our review we did not ascertain whether the expenditures claimed by the sub-recipient were for expenses the sub-recipient intended to incur prior to receiving Program funds. We do believe, however, that the Association should provide documentation for the actual expenditures incurred, including a date of the upgrade's start and completion, to the State agency for approval. In our opinion, this example underscores the need for a site visit component to be added to State agency's sub-recipient activities tracking and monitoring system.

RECOMMENDATIONS

We recommend that the State agency:

1) segregate Program expenditures by phase, within phase, and by priority area.

2) implement a site visit component as part of its sub-recipient activities tracking and monitoring system and address problem areas, as they are identified.

3) require the Association to provide expenditure documentation, including actual cost incurred and start and completion dates, for the upgraded negative pressure rooms and determine whether the project expenditures meet the criteria outlined in the HRSA cooperative agreement guidance.

STATE AGENCY'S COMMENTS

In a written response to our draft report, the State agency generally concurred with our findings and our recommendations. In response to our recommendation that Program expenditures be segregated by phase, within phase, and by priority area, the State agency replied that the cooperative agreements do not require tracking of program expenditures by phase or priority area. The State agency's response is included in its entirety as an appendix to this report.

OIG COMMENT

The OIG agrees that the cooperative agreements do not require tracking of Program expenditures by phase or priority area. This is acknowledged in our report. However, budget restrictions were specified in the cooperative agreements. Segregation by phase or priority area would help facilitate meeting these budget restrictions. Also, the new 2003 cooperative agreement guidance specifically states that grantees must "develop and maintain a financial accounting system capable of tracking expenditures by priority area, by critical benchmark, and by funds allocated to hospitals and other health care entities."

APPENDIX

COMMONWEALTH of VIRGINIA

Department of Health

ROBERT B. STROUBE, M.D., M.P.H.
STATE HEALTH COMMISSIONER

P O BOX 2448
RICHMOND, VA 23218

TTY 7-1-1 OR
1-800-828-1120

August 26, 2003

Leon Skros
Audit Manager
Department of Health & Human Services
Office of Inspector General
Office of Audit Services
150 S. Independence Mall West
Suite 316
Philadelphia, PA 19106-3499

RE: Report Number: A-03-03-00384

Dear Mr. Skros:

This is in response to the Office of Inspector General's draft report providing the results of your self-initiated review of the "Commonwealth of Virginia's Efforts to Account For and Monitor Sub-Recipients' use of Bioterrorism Hospital Preparedness Program Funds."

The cooperative agreements do not require tracking of program expenditures by phase or priority area. Budget restrictions specified in the agreement require tracking of administrative costs versus other program expenditures. The Commonwealth's current budget and accounting systems already provide for tracking of administrative costs separate from other activities. We will continue to track expenditures in this method and are working on processes that will allow tracking by priority area.

The Virginia Department of Health (VDH) Office of Internal Audit will initiate periodic site audits of sub-recipients as allowed under current agreements.

The Virginia Hospital and Healthcare Association will provide documentation of the costs, and start and completion dates for the upgraded negative pressure rooms claimed by a hospital sub-recipient so VDH can determine whether these project expenditures meet the criteria outlined in the HRSA cooperative agreement guidance. VDH expects to receive this documentation by September 10, 2003.

Thank you giving us the opportunity to review and respond to your findings.

Sincerely,

Lisa G. Kaplowitz MD, MSHA

Lisa G. Kaplowitz, MD, MSHA
Deputy Commissioner
Emergency Preparedness and Response Programs

c: Robert B. Stroube, MD, MPH