DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

# Memorandum

NOV 5 1992

Date

Bryan B. Mitchell Bryan Mitchell
From Principal Deputy Inspector General

Subject Report on Selected Community Health Center Grantee Audit Findings (A-07-92-00518)

To James O. Mason, M.D., Dr. P.H.
Assistant Secretary for Health

The attached final management advisory report on the community health centers (CHC) program is provided to you for the purpose of alerting you to the magnitude of noncompliance issues and internal control weaknesses identified in audit reports on the program.

We reviewed 212 nonfederal audit reports pertaining to 171 or 33 percent of the 520 CHC grantees. These reports were prepared by certified public accountants and other nonfederal auditors. Findings and recommendations in these reports were previously submitted to the Public Health Service (PHS) for resolution during the period May 1, 1990 through September 30, 1991.

Our review of the nonfederal audit reports revealed that about: 46 percent of the CHC grantees had inadequate internal control systems (for example transactions were not properly authorized, assets were not safeguarded and the duty of recordkeeping was not properly segregated from other functions); 50 percent had inadequate accounting records and procedures; 36 percent had inadequate patient revenue systems; 20 percent had cash management practices that did not protect Federal funds and preclude excessive interest cost to the Federal Government; and 27 percent prepared inaccurate or untimely Financial Status Reports and Federal Cash Transaction Reports.

The major problems identified related to the accountability of funds. Accountability findings include internal controls, accounting procedures, billing and collection procedures, cash management and financial reporting. Strengthening internal controls of CHCs provide opportunities for better use of Federal funds and enhances the fiscal integrity of the CHCs' health program system. Therefore, we are recommending that the Health Resources and Services Administration (HRSA), PHS strengthen its monitoring procedures to improve CHCs' accountability. Additionally, HRSA should revise the program monitoring guide, "Primary Care Effectiveness Review" to include internal control systems, accounting records and procedures, patient revenue systems, cash management practices and other deficiencies noted in nonfederal audit reports. The

HRSA should provide greater emphasis on the guide through training workshops for regional staff, emphasizing areas identified as problems by the nonfederal audit reports. The HRSA should also consider using model systems and techniques in the workshops to improve CHC accountability. The PHS concurred with the report recommendations and have indicated that corrective action will be taken.

We would appreciate being advised within 60 days on the status of corrective action taken or planned on each recommendation. Please refer to Common Identification Number A-07-92-00518 in all correspondence relating to this report. If you wish to discuss our findings further, please call me or have your staff contact Daniel W. Blades, Assistant Inspector General for Audit Services at (301) 443-3582.

Department of Health and Human Services

# OFFICE OF INSPECTOR GENERAL

# REPORT ON SELECTED COMMUNITY HEALTH CENTER GRANTEE AUDIT FINDINGS


NOVEMBER 1992 A-07-92-00518

# EXECUTIVE SUMMARY

Recently, the community health center (CHC) program has been of particular interest within the Department of Health and Human Services (Department) and in the Congress. Concerns have been raised about the CHC program. In response to these concerns, the Office of Inspector General (OIG) is conducting a nationwide review of CHCs. The Department's regional offices are responsible for monitoring CHC compliance with statutory and administrative requirements.

This management advisory report is part of OIG's nationwide review efforts. The report summarizes the noncompliance issues and internal control weaknesses disclosed in selected CHC audit reports prepared by certified public accountants and other nonfederal auditors. We reviewed reports pertaining to 171 or 33 percent of the 520 CHCs. Approximately 68 percent or 117 of the 171 CHCs had less than $1 million in section 330 grant expenditures as shown in Appendix A. The objectives of our review were to categorize and summarize instances of noncompliance and internal control weakness contained in the audit reports and to identify areas of potential risk for the program. We identified 1 or more instances of noncompliance and/or internal control weakness in 71 percent of the 171 CHCs reviewed.

Officials in the Public Health Service (PHS) should already be aware of most of the issues in this report, because the findings have been reported to them in the independent auditors' reports. The findings in each of the reports are subject to PHS audit resolution.

To ensure proper stewardship of Federal funds, we believe PHS should direct more oversight attention to the following areas which may place the CHC program at risk. We found that the program monitoring guide, "Primary Care Effectiveness Review," places limited emphasis on these issues.

- **INTERNAL CONTROLS:** About 46 percent of the CHCs were maintaining systems of internal control that were inadequate for protecting resources against waste, loss and misuse, or for assuring that resource use was consistent with laws, regulations and award terms.
- **ACCOUNTING RECORDS AND PROCEDURES:** About 50 percent of the CHCs had inadequate accounting records for properly and accurately recording and accounting for the assets, liabilities, revenues and expenses of the CHCs. The effective and efficient operation of the CHCs was often hindered by the lack of properly implemented accounting system policies and procedures.
- **PATIENT REVENUE:** About 36 percent of the CHCs lacked adequate billing and collection procedures to maximize patient revenues and reduce reliance on Federal funding.

- **CASH MANAGEMENT:** About 20 percent of the CHCs had poor cash management practices which jeopardized Federal funds and resulted in excessive interest costs for the Federal Government.

- **PAYROLL TAXES:** About 6 percent of the CHCs were delinquent in payroll tax payments. In some cases, the late payments were symptomatic of more serious financial problems at the CHCs.

- **FINANCIAL REPORTING:** About 27 percent of the CHCs were preparing Financial Status Reports and Federal Cash Transaction Reports which were inaccurate or untimely. Also, a number of the CHCs' financial statements were unacceptable because they were not prepared in accordance with generally accepted accounting principles (GAAP).

- **STATUTORY REQUIREMENTS:** About 6 percent of the CHCs were in noncompliance with 1 or more of the general statutory requirements, such as the Civil Rights Act and the Drug Free Workplace Act. Potential legal liabilities from noncompliance could impact the CHCs' operations.

We recommend that PHS review the adequacy of the guide and that the regional staffs be directed to place greater emphasis on these areas. In their written response PHS concurred with the recommendation and indicated that corrective action will be taken. The entire text of the comments is included as Appendix D to the report.

# TABLE OF CONTENTS

# INTRODUCTION

## BACKGROUND

The CHC program, authorized under section 330 of the Public Health Service Act, was established in 1975 by Public Law 94-63. The objectives of the program are to support the development and operation of CHCs which provide primary health care services, supplemental health services and environmental health services to medically underserved populations. These populations include urban and rural areas designated by the Secretary of the Department as having a shortage of personal health services. The CHC program is administered by the Health Resources and Services Administration (HRSA), PHS. The Fiscal Year 1992 appropriation of $537 million is expected to provide funding to about 520 CHCs affecting about 5.4 million patients.

The Department's regional offices are responsible for monitoring CHC compliance with statutory and administrative requirements. The HRSA provides the regional offices with written guidance on how these requirements are to be met.

The CHCs are required to maintain a schedule of fees for services which covers the reasonable costs of operation. Systems must be established to bill and collect these fees and determine patient eligibility for discounts based on the ability to pay. Prior to the use of grant funds, the CHCs must utilize, to the maximum extent feasible, other Federal, State, local and private funding resources. The CHCs' costs which remain uncompensated due to patient discounts may be reimbursed by section 330 grant funds, provided charges are made to individual patients and a reasonable collection effort is made (42 CFR 51c.303).

Each CHC is required to have an annual financial audit conducted by an independent auditor. The audit is to determine whether:

- The CHC's financial statements present fairly the financial position and the results of its operations in accordance with GAAP.

- The CHC has an internal control structure to provide a reasonable assurance that Federal awards are managed in compliance with applicable laws and regulations that could have a material impact on the financial statements.

- The CHC has complied with laws and regulations that may have a direct and material effect on its financial statements.

The independent auditors' reports are submitted to the Department. The Department's OIG reviews the reports to: (1) determine whether they comply with Government reporting requirements; (2) summarize reported findings; and (3) identify any findings

improperly addressed. The OIG informs the CHC of the audit findings requiring corrective action. After the review is completed, OIG issues the independent auditors' reports to departmental PHS officials for resolution of the audit findings. The CHC has 30 days to respond to the PHS audit resolution official regarding action taken to correct the findings. The PHS resolution official has 6 months to satisfactorily resolve the findings with the CHC.

## SCOPE OF REVIEW

The objectives of our review were to summarize instances of noncompliance and internal control weaknesses contained in the independent auditors' reports of CHCs and to identify areas of potential risk to the CHC program. To accomplish this, we reviewed 212 CHC nonfederal audit reports submitted to and issued by OIG Region VII for the period May 1, 1990 through September 30, 1991. Prior to May 1, 1990, CHC audit reports were submitted to and issued by eight regional offices. Starting May 1, 1990, OIG Region VII gradually assumed responsibility for the issuance of these audit reports. Our review included only the nonfederal audit reports issued by OIG Region VII during the 17-month review period. See Appendix B.

Findings in the 212 nonfederal audit reports pertaining to section 330 were compiled, categorized, and summarized into deficiency categories. The summary data contained in this report was based on findings developed and reported by the independent auditors.

The 212 nonfederal audit reports pertained to 171 or 33 percent of the 520 CHCs. The audit reports addressed section 330 grant expenditures of $209.6 million and total expenses of $1.8 billion.

Overall, there were 143 nonfederal audit reports with findings. These audit reports contained 688 findings and 711 recommendations requiring audit resolution. The number of recommendations was greater than the number of findings because some systemic findings resulted in more than one recommendation related to the finding. Our report addresses the 688 audit findings, not the related recommendations.

The number of nonfederal audit reports and CHCs with section 330 findings was:

| | | CHCs | |
|---|---|---|---|
| Report Contents | Reports Issued | Number | Percentage |
| Findings | 143 | 121 | 71 |
| No Findings | 69 | 50 | 29 |
| **Total Reviewed** | **212** | **171** | **100** |

Because some CHCs had more than 1 fiscal year-end within our 17-month review period, there were a greater number of reports than applicable CHCs. Also, some CHCs were required to submit a revised report for the same fiscal year because the initial report was found to be unacceptable. In the latter instance, findings were not duplicated in our review because the initial reports were issued with one OIG finding indicating that the report was unacceptable, and revised reports were issued with findings as reported by the independent auditors.

We did not evaluate PHS' audit resolution activities. In addition to section 330 grant funds, CHCs receive other Federal funds. Our review did not include the other funds. Our review was performed in Kansas City, Missouri during the period September 1991 through December 1991. The entire text of PHS' comments to our recommendations is attached as Appendix D.

# FINDINGS AND RECOMMENDATIONS

Independent auditors reported findings at 71 percent of the selected CHCs (121 of 171). Findings ranged from relatively minor deficiencies such as the lack of a formal, written file retention policy, to more serious issues such as the failure of a CHC to pay payroll taxes in a timely manner. The latter could have been indicative of a poor financial condition which could ultimately result in the failure of the CHC. For five CHCs, findings were so serious that the auditors expressed substantial doubt about the entity's ability to continue to operate.

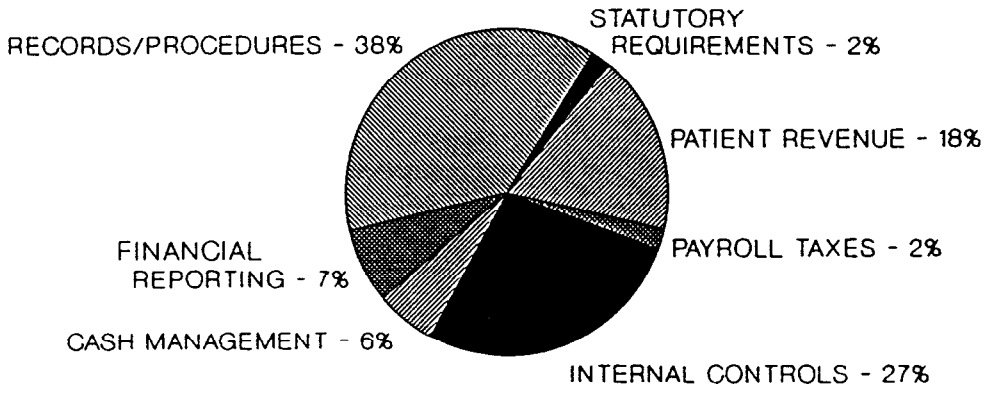
Many CHCs had findings related to systems for internal control and accounting records and procedures. Other findings pertained to billing and collecting revenue for patient services, management of cash, delinquent payroll taxes, financial reporting and general compliance requirements. The following table presents a summary by deficiency category of the findings contained in the 212 nonfederal audit reports reviewed.

| | | CHCs | |
|---|---|---|---|
| **Deficiency Category** | **Findings** | **Number** | **Percentage** |
| Internal Controls | 189 | 78 | 46 |
| Accounting Records and Procedures | 259 | 85 | 50 |
| Patient Revenue | 121 | 62 | 36 |
| Cash Management | 41 | 34 | 20 |
| Payroll Taxes | 13 | 10 | 6 |
| Financial Reporting | 51 | 46 | 27 |
| Statutory Requirements | 14 | 11 | 6 |
| **Total Findings Identified** | **688** | | |

*Throughout this report, the CHCs column represents the number of CHCs with one or more findings in the specified deficiency category or subcategory. Because a CHC often has more than one finding in a specified deficiency category or subcategory, or may have findings in multiple deficiency categories and subcategories, this column is not subject to summation. The percentage shown in the tables represents the percentage of CHCs, in relation to the 171 having reported findings, which had the deficiency category and subcategory.*

As shown in the preceding table, internal controls, accounting records and patient revenue were the predominant deficiencies at the CHCs. The graph below shows the distribution of the findings expressed as a percentage of the total deficiencies reported by the independent auditors. A distribution of CHCs with one or more findings per deficiency category is shown in Appendix C.

DISTRIBUTION OF FINDINGS
BY DEFICIENCY CATEGORY




## INTERNAL CONTROLS

The purpose of internal control is to provide reasonable assurance that objectives of the entity will be achieved and promote the efficient operation of an organization. Inadequate internal control procedures were reported at 46 percent of the CHCs (78 of 171). We categorized the findings into the following deficiency subcategories:

| Deficiency Subcategory | Findings | CHCs | Percentage |
|---|---|---|---|
| Authorizations | 61 | 34 | 20 |
| Safeguards | 41 | 27 | 16 |
| Segregation of Duties | 35 | 27 | 16 |
| Reconciliation | 52 | 38 | 22 |
| **Total Internal Control Findings** | **189** | | |

In order to have an adequate internal control system, there must be procedures which provide for:

- Proper authorization of transactions.

**Authorizations** assure that transactions are approved by personnel acting within the scope of their authority, thereby limiting access to assets. Procedural authorization findings were identified at 20 percent of the CHCs (34 of 171). Some CHCs were paying invoices and travel vouchers without the review and approval of an authorized official. Other instances were noted where time cards, pay rates, physician contracts, purchase orders and operating budgets were not properly authorized.

- Safeguards over assets.

The CHCs are required to **safeguard** all assets and assure that they are used solely for authorized purposes. Safeguards were not adequate at 16 percent of the CHCs (27 of 171). Some weaknesses included checks and cash not being stored in locked cabinets; failure to limit access to signature stamps; and failure to use pre-numbered patient encounter sheets. Inadquate safeguarding of cash and other assets could result in theft and mismanagement of funds.

- Segregation of duties to detect errors and irregularities.

The **segregation of duties** (or the division of recordkeeping and other functions and responsibilities among employees) is a basic tenet of internal control systems. It is one of the most effective means of preventing or detecting errors and misappropriation. Segregation of duties was not adequate at 16 percent of the CHCs (27 of 171). Of the 27 CHCs that failed to adequately segregate employee duties, 21 (78 percent) had total expenditures greater than $1 million. Therefore, these CHCs should have had a sufficient number of employees to facilitate an adequate segregation of duties.

At one CHC with total expenses of $1.1 million, one person performed all of the accounting functions except for signing the checks. This individual was responsible for making deposits; receiving and reconciling bank statements; preparing bills for payment and mailing checks to vendors; issuing purchase orders and verifying receipt of ordered materials; preparing monthly financial statements, including payroll reporting and preparation; and depositing payroll taxes.

- Independent checks of performance and evaluation such as reconciliations and management reviews.

Periodic **reconciliation** of bank statements, cash, inventory, financial reports and subsidiary ledgers to the control accounts, general ledger and other accounting records is an important internal control. This control is used by management to promote accuracy in accounting records and detect errors and irregularities. Auditors reported reconciliations were untimely, inaccurate or not performed at 22 percent of the CHCs (38 of 171).

Without adequate internal control procedures, management and PHS do not have reasonable assurance that Federal funds are protected from loss, waste, and misappropriation, and are properly used to further program objectives.

## ACCOUNTING RECORDS AND PROCEDURES

Federal regulations prescribe general financial management standards for CHCs. Included are requirements that financial management systems provide: (1) accounting records that are supported by source documentation and (2) procedures for determining the reasonableness, allowability and allocability of costs. Inadequate accounting records and procedures were identified at 50 percent of the CHCs (85 of 171).

We categorized the findings in the following deficiency subcategories:

| Deficiency Subcategory | Findings | CHCs | Percentage |
|---|---|---|---|
| *Records and Documentation* | | | |
| General Ledger | 32 | 27 | 16 |
| Source Documentation | 128 | 56 | 33 |
| *Policies and Procedures* | | | |
| General | 69 | 44 | 26 |
| Equipment Inventory | 30 | 25 | 15 |
| **Total Accounting Records/Procedures Findings** | **259** | | |

The **general ledger** is the permanent record of all financial transactions and the primary source of information for effective management and preparation of financial statements and reports. At 16 percent of the CHCs (27 of 171), the auditors reported that the general ledger system was inadequate or nonexistent. At 21 or 78 percent of the 27 CHCs with a reported inadequate or nonexistent general ledger, expenses totaled in excess of $1 million.

Costs are allowable if supported by adequate **source documentation** in the form of accounting records and other documents, such as canceled checks, paid bills, payrolls and award documents (45 CFR 74.61 (g)). For 33 percent of the CHCs (56 of 171), the auditors reported inadequate source documentation and records to support the costs claimed. Some examples include inadequate support for: consultant fees, lease and subcontract payments, payments to physicians, cash disbursements, cash receipts, travel expenses, and allocation of costs to programs.

Written **policies and procedures** are necessary for effective and efficient operations. The CHCs are expected to have certain systems, policies and procedures in place for managing funds, equipment and personnel before receiving funding from PHS. At 26 percent of the CHCs (44 of 171), policies and procedures were either nonexistent or inadequate in such areas as donated space, unallowable costs, the basic accounting system, procurement, competitive bidding, travel, and cashier duties.

The CHCs must keep adequate **equipment inventory** records to identify property purchased with Federal and nonfederal funds. In addition, a physical inventory of equipment must be taken at least once every 2 years to verify the existence, current utilization and need for the equipment (45 CFR 74.140). For 15 percent of the CHCs (25 of 171), equipment records or inventory procedures were inadequate. When CHCs fail to maintain adequate equipment management systems, equipment may be under-utilized, acquired unnecessarily, or poorly maintained.

Federal financial management standards may not be met when CHCs do not maintain adequate accounting records and procedures. With such weaknesses, it is difficult to provide assurance that Federal funds are properly spent in compliance with the laws and regulations applicable to the program.

## PATIENT REVENUE

Revenue from patient services is critical to CHC operations. Patient revenue reduces the amount of Federal funds required to operate the CHC and ultimately could assist the CHC in becoming self-sufficient. If charges are made to individual patients and a reasonable collection effort is made, those CHC costs which remain uncompensated due to patient discounts may be covered by section 330 funds (42 CFR 51c.107). For 36 percent of the CHCs (62 of 171), the systems used to charge for patient services, collect accounts receivable and recognize revenue were not adequate.

We categorized patient revenue findings in the following deficiency subcategories:

| Deficiency Subcategory | Findings | CHCs | Percentage |
|---|---|---|---|
| Fee Schedules | 8 | 8 | 5 |
| Billing and Collection | 48 | 31 | 18 |
| Management of Accounts Receivable | 65 | 43 | 25 |
| **Total Patient Revenue Findings** | **121** | | |

The CHCs are required to maximize all sources of income prior to the use of the Federal section 330 funds (42 CFR 51c.303) and to collect or make a reasonable effort to collect all accounts receivable (42 CFR 51c.107). A schedule of fees for patient services and adequate systems for billing, collecting and managing accounts receivable must also be established and maintained.

Fee schedules are necessary to establish the proper amounts to charge for patient services. Schedules must be designed to cover the reasonable costs of operation and include patient discounts adjusted on the basis of the patient's ability to pay. At 5 percent of the CHCs (8 of 171), auditors reported the use of outdated fee schedules and inadequate documentation regarding patient eligibility for sliding-fee-schedule discounts. These problems could result in incorrect charges to patients and increased costs to the Federal Government.

At 18 percent of the CHCs (31 of 171), **billing and collection** systems were not adequate to ensure that all services were billed, the correct rate was used or that due diligence was used in collection of accounts. For example, at one CHC, the minimum payment was not collected from almost half of the self-pay patients, and a collection agency was not used to pursue delinquent accounts. Another CHC did not bill third parties at the center's fee schedule rates and did not bill in a timely manner.

Auditors reported findings involving **management of accounts receivable** at 25 percent of the CHCs (43 of 171). The CHCs were not: (1) preparing or reviewing aged accounts receivable listings in a timely manner to refer the more delinquent accounts to collection agencies; (2) comparing the accounts receivable subsidiary ledgers to the general ledger control account to ensure accuracy and timely collection; or (3) following established approval and documentation procedures when writing off uncollectible accounts.

## CASH MANAGEMENT

At 20 percent of the CHCs (34 of 171), cash management practices did not adequately protect Federal funds or preclude excessive interest costs to the Federal Government.

We categorized cash management findings into the following deficiency subcategories:

| Deficiency Subcategory | Findings | CHCs | Percentages |
|---|---|---|---|
| Deposits | 11 | 9 | 5 |
| Draw Downs | 12 | 12 | 7 |
| Interest | 15 | 15 | 9 |
| FDIC Limits | 3 | 3 | 2 |
| **Total Cash Management Findings** | **41** | | |

Cash and check deposits were not timely at 5 percent of the CHCs (9 of 171). In the course of a CHC's daily operations, a significant amount of cash and checks may be received from patients and other sources. To protect these receipts from loss through theft or accidents, cash and checks should be deposited daily.

When funds are received through a letter of credit, the CHCs are required to "make draw downs as close as possible to the time of making disbursements" to minimize the time elapsing between the transfer of funds from the Federal Government and the actual disbursement by the CHC. At 7 percent of the CHCs (12 of 171), auditors reported that draw downs of Federal funds were not made in a timely manner. When CHCs draw down Federal funds in advance of the actual need, excessive interest costs are incurred by the Federal Government.

At 9 percent of the CHCs (15 of 171), Federal funds were not deposited in interest bearing accounts or interest earned on Federal funds was not returned. Interest income lost on idle funds equates to interest expense to the Federal Government, because funds are routinely borrowed to finance current Federal operations. The CHCs are required to maintain advances of Federal funds in interest bearing accounts, and remit any interest earned promptly (at least quarterly) to the funding agency. A maximum of $100 per year of interest earned on Federal funds may be retained by the CHC for administrative expenses.

At 2 percent of the CHCs (3 of 171), bank balances exceeded Federal Deposit Insurance Corporation (FDIC) limits, and the CHCs did not take measures to secure the excess funds on deposit. The FDIC insures accounts in member banks up to $100,000. The CHCs are required to deposit section 330 funds in banks with FDIC coverage and to collaterally secure the balance exceeding the FDIC coverage. We believe the increasing trend in bank failures makes strict adherence to these regulations imperative. If banks become insolvent, excess Federal and CHC balances may be lost, jeopardizing the CHC's continued operations.

## PAYROLL TAXES

Ten of the 171 CHCs (6 percent), were delinquent in paying their payroll taxes. For the years under review, section 330 expenditures at these 10 CHCs totaled $12.7 million.

Nonprofit organizations, such as CHCs, are required to withhold, report and remit employee payroll taxes for Social Security and income tax. In addition, the employer's share of Social Security and unemployment taxes must be reported and remitted quarterly. Penalties and interest are assessed for the late payment of these taxes. Generally, payroll taxes are allowable costs for the CHC program. However, costs of interest and penalties related to the late payment of these taxes are unallowable.

Nonremittance of payroll taxes is an indicator that a CHC is having serious financial difficulties. The audit reports for 4 of the 10 CHCs indicated that the entities were experiencing financial difficulties to such an extent that their continued ability to operate was uncertain. One of these CHCs had not paid payroll taxes for 6 quarters from 1987 through 1989. The delinquent taxes totalled $1.1 million, excluding interest and penalties. To generate funds to pay the delinquent taxes, one CHC sold a building.

Federal cash draw downs for the CHC program are provided on an as needed basis through the Department's payment management system. Funds can be requested and received daily, if necessary, to cover the Federal share of program expenditures. Although not discernable from the reports for these 10 CHCs, it seems likely that the Federal share of the cash necessary to pay payroll taxes was drawn down, but used for other purposes.

## FINANCIAL REPORTING

At 27 percent of the CHCs (46 of 171), financial reporting was inaccurate, untimely, or did not comply with Federal regulations.

The financial management system at each CHC must provide accurate, current and complete disclosure of the financial results of the program in accordance with Federal laws and regulations. Failure to prepare reports and other financial information in a proper, timely manner can result in incorrect decisions by management, inadequate use of available resources, poor planning of future services, undetected errors and unauthorized use of funds. At 16 percent of the CHCs (28 of 171), reports such as the Financial Status Report and the Federal Cash Transaction Report were not accurate or timely.

Section 330 requires the use of GAAP, as well as an annual audit of the CHCs' financial statements, systems of internal control and compliance with laws and regulations. At 12 percent of the CHCs (20 of 171), requirements of the PHS Act were not followed because financial statements were not prepared in accordance with GAAP or audits submitted by the CHCs did not adequately cover internal control or compliance.

## STATUTORY REQUIREMENTS

A number of statutory and regulatory requirements apply to the CHC program. Failure to comply with these requirements could have a material impact on a CHC's financial condition since violation may result in litigation against the CHC. Our review identified 11 CHCs, or 6 percent, that were not in compliance or lacked the necessary administrative controls to ensure compliance with laws and regulations such as the Civil Rights Act and the Drug Free Workplace Act.

## DEPARTMENT REGIONAL OVERSIGHT

The HRSA, as part of its reliance on the Department's regional staff to routinely review grantee operations, has developed a guide for evaluating grantee performance. This guide, "Primary Care Effectiveness Review" is designed to assist regional staff in their on-site monitoring, in identifying CHC strengths and weaknesses, and in establishing corrective action plans. The guide covers four areas: clinical, fiscal, administration, and governance. Each review area has its own set of instructions for use of regional staff.

We noted that this guide places limited emphasis on many of the deficiency categories revealed in the nonfederal audit reports. We plan to follow up later on the Department's regional monitoring of grantees, and particularly, evaluate the adequacy of HRSA's guidance to the regional staff.

## RECOMMENDATIONS

We recommend that HRSA strengthen its monitoring procedures to improve CHCs' accountability. Additionally, HRSA should revise the program monitoring guide, "Primary Care Effectiveness Review" to include internal control systems, accounting records and procedures, patient revenue systems, cash management practices, and other deficiencies noted in nonfederal audit reports. The HRSA should provide greater emphasis on the guide through training workshops for regional staff, emphasizing areas identified as problems by the nonfederal audit reports. The HRSA should also consider using Model systems and techniques in the workshops to improve CHC accountability.

## PHS COMMENTS

The PHS concurred with the recommendations and have indicated that corrective action will be taken.

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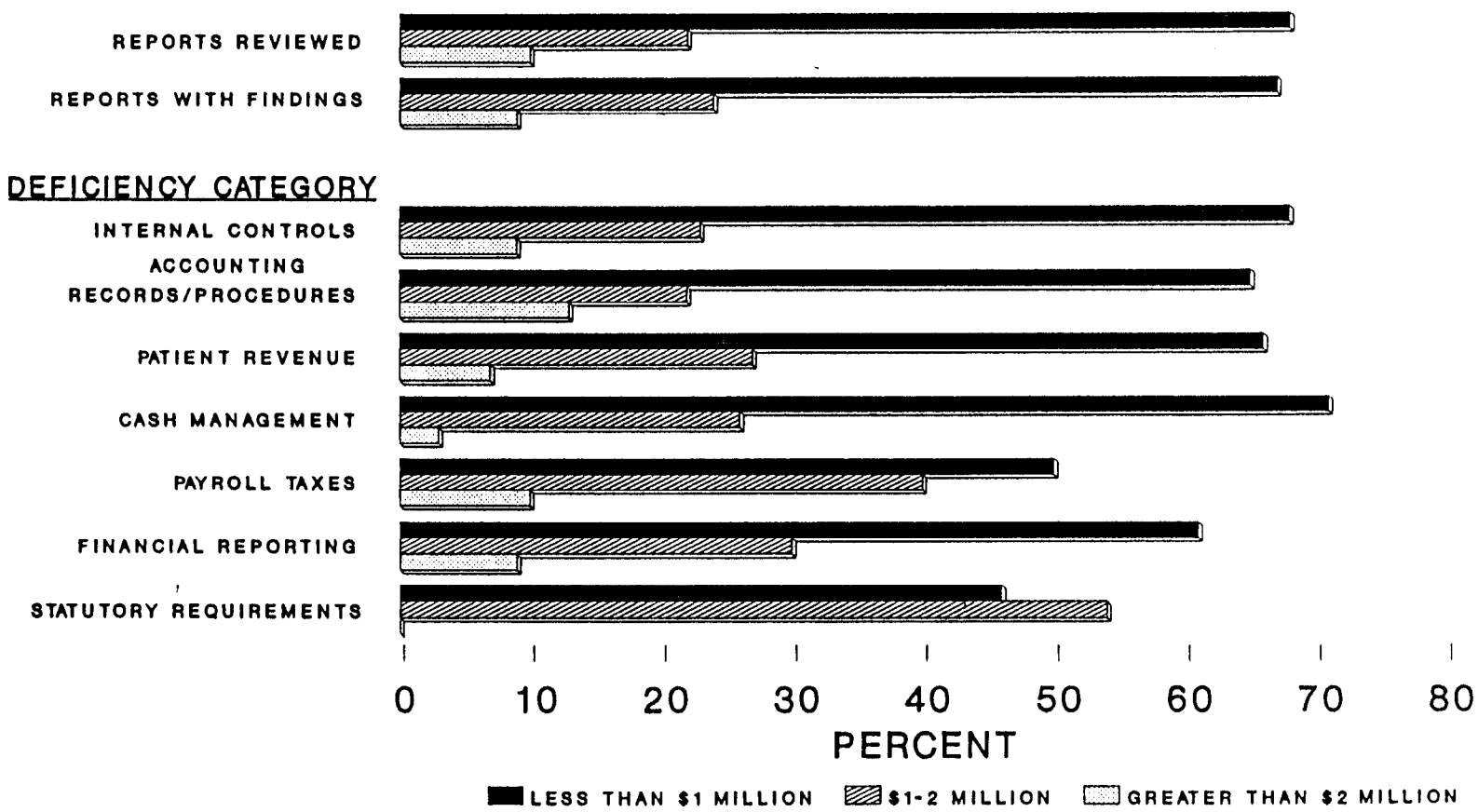
We would appreciate being advised within 60 days on the status of corrective action taken or planned on each recommendation. Please refer to Common Identification Number A-15-91-00002 to facilitate identification in all correspondence relating to this report. If you wish to discuss our findings further, please call me or have your staff contact Daniel W. Blades, Assistant Inspector General for Public Health Service Audits at (301)443-3583.

# APPENDICES

APPENDIX A

# DISTRIBUTION OF REPORTS AND FINDINGS BY ANNUAL SECTION 330 FUNDING LEVEL



**DISTRIBUTION OF CHCs
WITH ONE OR MORE FINDINGS
PER DEFICIENCY CATEGORY
DISCLOSED IN
NONFEDERAL AUDIT REPORTS
MAY 1, 1990 THROUGH SEPTEMBER 30, 1991**

| Deficiency Category | (1) Number of CHCs * | (2) Percent of Total CHCs Reviewed * |
|---|---|---|
| Internal Controls | 78 | 46 |
| Accounting Records and Procedures | 85 | 50 |
| Patient Revenue | 62 | 36 |
| Cash Management | 34 | 20 |
| Payroll Taxes | 10 | 6 |
| Financial Reporting | 46 | 27 |
| Statutory Requirements | 11 | 6 |

* Column (1) represents the number of CHCs with 1 or more findings in the specified deficiency category, and column (2) represents the ratio of column (1) to the total 171 CHCs reviewed. Because a CHC often has findings in more than one deficiency category, these columns are not subject to summation.

**APPENDIX C**

**CHC**

**NONFEDERAL AUDIT REPORTS**

**ISSUED BY REGION VII**

**DURING THE PERIOD**

**MAY 1, 1990 THROUGH SEPTEMBER 30, 1991**

| Region | Region VII Assumption Date | Reports | Number of CHCs | Report Findings |
|---|---|---|---|---|
| I | July 1, 1991 | 1 | 1 | 4 |
| II | July 1, 1990 | 51 | 41 | 225 |
| III | May 1, 1990 | 68 | 51 | 174 |
| V | April 1, 1991 | 16 | 16 | 90 |
| VI | March 1, 1991 | 21 | 20 | 80 |
| VII | (Not Applicable) | 20 | 16 | 75 |
| VIII | (Not Applicable) | 35 | 26 | 40 |
| Total | | 212 | 171 | 688 |

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

# Memorandum

Date OCT 2 1992

From Assistant Secretary for Health

Subject Office of Inspector General (OIG) Draft Report Entitled "Report on Selected Community Health Center Grantee Audit Findings," A-07-92-00518

To Acting Inspector General, OS

Attached are the Public Health Service's comments on the subject OIG report. We concur with the recommendation and have taken or plan to take actions to implement it.

James O. Mason

James O. Mason, M.D., Dr.P.H.

Attachment

IG
PDIG
DIG-AS
DIG-EI
DIG-OI
AIG-MP
OGC/IG
EXSEC
DATE SENT 10/5

PUBLIC HEALTH SERVICE (PHS) COMMENTS ON THE OFFICE OF INSPECTOR GENERAL (OIG) DRAFT REPORT ENTITLED "REPORT ON SELECTED COMMUNITY HEALTH CENTER GRANTEE AUDIT FINDINGS," A-07-92-00518

General Comments

The OIG performed this evaluation as part of its comprehensive review of the community health centers (CHC) program. OIG reviewed the audit reports of 171 CHCs which were performed by certified public accountants and other non-Federal auditors. The objective of this review was to identify and summarize noncompliance issues and internal control weaknesses disclosed in these audit reports.

The findings reported by OIG corroborate those in a June 1992 PHS Office of Management (OM) report that analyzed non-Federal audits of CHCs. The OM review also discussed the efforts of the Health Resources and Services Administration (HRSA) to (1) ensure that all CHCs were audited annually as stated in the statute, (2) resolve audit findings disclosed in the audits of the CHCs, and (3) follow-up on corrective actions to ensure that the findings had been adequately addressed.

The OM report concluded that HRSA (1) had made significant progress in ensuring that CHC grantees were complying with the annual audit requirement, (2) should strengthen its pre-award financial evaluations and obtain recipient capability audit support from OIG, as appropriate, to ensure that grantees have adequate financial management systems in place, and (3) should revise and strengthen its audit resolution and follow-up procedures to ensure that CHC grantees correct the deficiencies cited in the non-Federal audit reports. HRSA generally agreed with the OM report's findings and recommendations. HRSA is taking actions to address the OM report's recommendations.

An important adjunct to the pre-award financial evaluations are in-depth evaluations of: (1) the adequacy of the business management systems and financial capability of first time recipients of CHC funds, and (2) the allowability, allocability, and reasonableness of budget proposals received from current or prospective CHC grantees. Therefore, PHS will continue to request that OIG consider performing additional recipient capability audits and pre-award reviews. The need for these OIG efforts will continue to grow as HRSA solicits proposals from an ever-widening pool of potential CHC grantees.

OIG Recommendation

We recommend that HRSA strengthen its monitoring procedures to improve CHCs' accountability. Additionally, HRSA should revise the program monitoring guide "Primary Care Effectiveness Review" (PCER) to include internal control systems, accounting

records and procedures, patient revenue systems, cash management practices, and other deficiencies noted in non-federal audit reports. HRSA should provide greater emphasis on the guide through training workshops for regional staff, emphasizing areas identified as problems by the non-federal audit reports. HRSA should also consider using model systems and techniques in the workshops to improve CHCs' accountability.

PHS Comments

We concur. We agree that monitoring procedures to improve CHC's accountability should be strengthened. Efforts to strengthen monitoring procedures of CHC grantees began in December 1990 when a national workshop was held to develop the initial framework for improving HRSA's Bureau of Primary Health Care's (BPHC) monitoring capability.

The BPHC has revised and issued the final version of the PCER on-site monitoring guide. The guide's fiscal systems review protocol module, which was finalized in May 1992, addresses the OIG's areas of concern, particularly internal control systems, accounting records and procedures, patient revenue systems and cash management practices.

In addition, BPHC has undertaken a new initiative, the peer on-site review, to strengthen monitoring of CHC grantees by shifting emphasis from a review of applications to on-site reviews. Building on the PCER, comprehensive reviews of CHC grantees' financial management systems will be conducted as part of the on-site review. These on-site reviews will begin in Fiscal Year (FY) 1994. Once this initiative is fully operational, one-third of the CHC grantees will receive on-site reviews each year.

Training workshops for regional staff as well as for other non-Federal personnel who serve as PCER reviewers have begun. Three of the 10 regional offices have received a PCER session. BPHC plans to hold one PCER training workshop in each of the remaining seven regions during FY 1993.

Furthermore, BPHC will provide the recommended technical assistance to CHCs for the development of appropriate corrective action plans for internal accounting system control or other system deficiencies noted through the PCER review process. BPHC will monitor progress in accordance with these plans. In addition, the annual non-Federal audit of each CHC grantee will continue to be used to both identify problem areas and monitor progress toward correcting noted deficiencies.