DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

October 17, 2003

Report Number: A-04-03-01010

Dr. Steve Cline
Epidemiology Section
Division of Public Health
1902 Mail Service Center
Raleigh, North Carolina 27699-1902

Dear Dr. Cline:

The enclosed report provides the results of our self-initiated review of the ***State of North Carolina's Efforts to Account for and Monitor Sub-recipient's Use of Bioterrorism Hospital Preparedness Program Funds, North Carolina Division of Public Health***.

Our objectives were to determine whether the North Carolina Division of Public Health (North Carolina): (i) properly recorded, summarized and reported bioterrorism preparedness transactions in accordance with the terms and conditions of the cooperative agreements and (ii) whether North Carolina established controls and procedures to monitor subrecipient expenditures of the Program funds. In addition, we inquired as to whether the Bioterrorism Hospital Preparedness Program (Program) funding supplanted programs previously provided by other organizational sources.

Based on our validation of the questionnaire completed by North Carolina and our site visit, we determined that North Carolina generally accounted for program funds in accordance with the terms and conditions of the cooperative agreement and applicable departmental regulations and guidelines. However, North Carolina did not track expenditures by phase, within phase, or by Priority Planning Area in its accounting system. Although segregation was not required, budget restrictions were specified in the cooperative agreement. North Carolina officials acknowledged the importance of tracking expenditures in order to comply with the budget restrictions. In addition, North Carolina mentioned that it plans to make changes to their accounting system to comply with the new requirements in the Health Resources Services Administration (HRSA) guidance, dated May 2, 2003, which require grantees to 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. North Carolina's monitoring procedures, which includes on-site visits and its advanced accounting system, the North Carolina Accounting System, facilitated the tracking and monitoring of subrecipient activities and expenditures. Further, in response to our inquiry as to whether North Carolina reduced funding to existing public health programs, Division officials stated that HRSA funding had not been used to supplant programs previously provided by other organizational sources.

We recommend North Carolina make changes to its accounting system and begin tracking expenditures by priority area, by critical benchmark, and by funds allocated to hospitals and other health care entities.

Final determination as to actions taken on all matters reported will be made by the Department of Health and Human Services (HHS) action official named below. We would appreciate your views and the status of any further action taken or contemplated on our recommendations within 15 days. 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 United States Code 552, as amended by Public Law 104-231), Office of Inspector General reports 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 Code of Federal Regulations Part 5.)

If you have any questions or comments about this report, please contact Donald Czyzewski, Audit Manager, at 305-536-5309.

To facilitate identification, please refer to report number A-04-03-01010 in all correspondence relating to this report.

Sincerely,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosures – as stated

Direct Reply to HHS Action Official:

Nancy J. McGinness
Director, Office of Financial Policy and Oversight
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Rockville, Maryland 20857

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

REVIEW OF THE STATE OF NORTH CAROLINA'S EFFORTS TO ACCOUNT FOR AND MONITOR SUB-RECIPIENT'S USE OF BIOTERRORISM HOSPITAL PREPAREDNESS PROGRAM FUNDS

NORTH CAROLINA DIVISION OF PUBLIC HEALTH

October 2003
A-04-03-01010

Notices

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OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

OBJECTIVES

Our objectives were to determine whether the North Carolina Division of Public Health (North Carolina) properly recorded, summarized and reported bioterrorism preparedness transactions in accordance with the terms and conditions of the cooperative agreements and whether North Carolina established controls and procedures to monitor subrecipient expenditures of the program funds. In addition, we inquired as to whether the Bioterrorism Hospital Preparedness Program (Program) funding supplanted programs previously provided by other organizational sources.

FINDINGS

Based on our validation of the questionnaire completed by North Carolina and our site visit, we determined that North Carolina generally accounted for program funds in accordance with the terms and conditions of the cooperative agreement and applicable departmental regulations and guidelines. However, North Carolina did not track expenditures by phase, within phase, or by Priority Planning Area (PPA) in its accounting system. Although segregation was not required, budget restrictions were specified in the cooperative agreement. North Carolina officials acknowledged the importance of tracking expenditures in order to comply with the budget restrictions. In addition, North Carolina mentioned that it plans to make changes to their accounting system to comply with the new requirements in the Health Resources and Services Administration (HRSA) guidance, dated May 2, 2003, which require grantees to 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. North Carolina's monitoring procedures, which includes on-site visits and its advanced accounting system, the North Carolina Accounting System, facilitated the tracking and monitoring of subrecipient activities and expenditures. Further, in response to our inquiry as to whether North Carolina reduced funding to existing public health programs, North Carolina officials stated that HRSA funding had not been used to supplant programs previously provided by other organizational sources.

RECOMMENDATION

We recommend North Carolina make changes to its accounting system and begin tracking expenditures by priority area, by critical benchmark, and by funds allocated to hospitals and other health care entities.

NORTH CAROLINA'S COMMENTS

North Carolina generally concurred with our findings and recommendation and stated it would take the necessary steps to fully comply with the HRSA grant guidelines. However, in its written response, North Carolina stated it did not see the cost-benefit of tracking expenditures by Critical Benchmark. The complete text of North Carolina's written comments is included as an appendix to this report.

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INTRODUCTION

BACKGROUND

Bioterrorism Hospital Preparedness Program

Since September 2001, Department of Health and Human Services (Department) has significantly increased its spending for public health preparedness and response to bioterrorism. For fiscal years (FY) 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, 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 the 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 medical services (EMS) 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.

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. The cooperative agreements covered two phases during the Program year. 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 were not to exceed the remaining 20 percent of Phase II funds.

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 3 largest municipalities (New York, Chicago, and Los Angeles County). Those eligible to apply included the health departments of States. Individual hospitals, EMS systems, health centers and poison control centers work with the applicable health department for funding through the Program.

North Carolina Division of Public Health Funding

For budget Year 1, the period April 1, 2002 through March 31, 2004, the amount of the North Carolina Division of Public Health (North Carolina) program funding awarded to North Carolina was $3.37 million. The following table details the funding for budget Year 1.

Program Amounts for Budget Year 1			
	Awarded	**Expended**	**Unobligated**
Year 1	$3,368,351 (1)	826,285 (2)	463,555 (3)

(1) Amount verified to the Notice of Cooperative Agreement
(2) Amount reconciled to the accounting records
(3) Unobligated funds as of March 31, 2003 are for training and routine support costs (i.e., travel, subsistence, printing, phone, office supplies and equipment)

OBJECTIVE, SCOPE AND METHODOLOGY

Objectives

Our objectives were to determine whether North Carolina properly recorded, summarized and reported bioterrorism preparedness transactions in accordance with the terms and conditions of the cooperative agreements and whether North Carolina established controls and procedures to monitor subrecipient expenditures of the Program funds. In addition, we inquired as to whether the 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 North Carolina's policies and procedures, financial reports, and accounting transactions during the period of April 1, 2002 through current operations.

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

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) other organizational bioterrorism activities; and (v) subrecipient monitoring. Prior to our fieldwork, we provided the questionnaire for North Carolina to complete. During our on-site visit, we interviewed North Carolina staff and obtained supporting documentation to validate the responses on the questionnaire.

Fieldwork was conducted at the State's offices in Raleigh, North Carolina, and the Miami, Florida field office from May to July 2003. North Carolina's comments on the draft report are included in their entirety as an appendix to this report. A summary of North Carolina's comments and our response follow the Findings and Recommendations section.

FINDINGS AND RECOMMENDATIONS

Based on our validation of the questionnaire completed by North Carolina and our site visit, we determined that North Carolina generally accounted for program funds in accordance with the terms and conditions of the cooperative agreement and applicable departmental regulations and guidelines. However, North Carolina did not track expenditures by phase, within phase, or by PPA in its accounting system. Although segregation was not required, budget restrictions were specified in the cooperative agreement. North Carolina officials acknowledged the importance of tracking expenditures in order to comply with the budget restrictions. In addition, North Carolina mentioned that it plans to make changes to their accounting system to comply with the new requirements in HRSA guidance, dated May 2, 2003, which require grantees to 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. North Carolina's monitoring procedures, which includes on-site visits and its advanced accounting system, the North Carolina Accounting System, facilitated the tracking and monitoring of subrecipient activities and expenditures. Further, in response to our inquiry as to whether North Carolina reduced funding to existing public health programs, North Carolina officials stated that HRSA funding had not been used to supplant programs previously provided by other organizational sources.

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 the Program funds provide HRSA a means to measure the extent the Program is being implemented and that the objectives are being met. Although North Carolina was not required to segregate expenditures in its accounting system by phase, within phase, or by PPA, 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….

North Carolina did not segregate expenditures in the central accounting system by phase, within phase, or by PPA. Although segregation was not required, budget restrictions were specified in the cooperative agreement. Without segregation of funds in its accounting system, North Carolina could not easily identify if funds expended exceeded budgeting restrictions. Specifically, expenditures for health department infrastructure and planning were not to exceed 50 percent of Phase I and 20 percent of Phase II funds. Additional analysis, outside its accounting system, was required by North Carolina to determine if funds expended exceeded the budgeting restrictions. Our review of North Carolina's additional analysis showed North Carolina was in compliance with the budget restrictions. We also noted that North Carolina did not claim any indirect costs.

North Carolina officials acknowledged the importance of tracking expenditures in order to ensure compliance with budget restrictions. In addition, North Carolina mentioned that it plans to make changes to their accounting system to comply with the new requirements in the HRSA guidance, dated May 2, 2003, which require grantees to 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.

Subrecipient Monitoring

Recipients of the Program grant funds were required to monitor their subrecipients. 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….

North Carolina's monitoring procedures for contracts and its advanced accounting system, the North Carolina Accounting System, facilitated the tracking and monitoring of subrecipient activities and expenditures. North Carolina required that contracts be awarded based on a competitive process. The subrecipients would then invoice North Carolina for work performed. Program staff review the invoices to ensure that they are accurate, that services have been rendered and that reports have been received from the contractor. Program staff makes these determinations based on information provided by the contractor and regular on-site visits. Once program staff have approved the invoice, they submit it for payment. The North Carolina Accounting System was used to track and verify that invoices did not exceed encumbered funds for said expenditures.

Supplanting

The Program funds were to be used to augment current funding and focus on bioterrorism hospital preparedness activities under the HRSA Cooperative Agreement. Specifically, funds were not to be used to replace 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….

The Office of Management and Budget 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 subrecipients….

Based on the results of the questionnaire and interviews with North Carolina officials, North Carolina did not have bioterrorism programs in existence prior to the Program funding. Further, in response to our inquiry as to whether North Carolina reduced funding to existing public health programs, North Carolina officials stated that HRSA funding had not been used to supplant existing Federal, State, or local funds for bioterrorism, infectious disease outbreaks, other public health threats and emergencies, and public health infrastructure in North Carolina.

RECOMMENDATION

We recommend North Carolina make changes to its accounting system and begin tracking expenditures by priority area, by critical benchmark, and by funds allocated to hospitals and other health care entities.

NORTH CAROLINA'S COMMENTS

North Carolina generally concurred with our findings and recommendation and stated it would take the necessary steps to fully comply with the HRSA grant guidelines. However, in its written response, North Carolina stated it did not see the cost-benefit of tracking expenditures by Critical Benchmark. See the appendix for the complete text of North Carolina's comments.

North Carolina stated that HRSA's guidelines for tracking expenditures are inconsistent to the tracking methods used for the CDC grant. In addition, it would take considerable expansion of the state's accounting system and would be very time consuming and difficult to manage.

OIG'S RESPONSE

North Carolina's response to our report was well considered and shows its intent to comply with HRSA's guidelines. While North Carolina does not see a cost benefit in tracking fund expenditures by Critical Benchmark, we encourage North Carolina to provide HRSA with the documentation that presents its position and work with HRSA to possibly develop a more efficient method to meet HRSA's guidelines.

APPENDIX

North Carolina Department of Health and Human Services
2001 Mail Service Center • Raleigh, North Carolina 27699-2001
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Michael F. Easley, Governor

Carmen Hooker Odom, Secretary

August 28, 2003

Transmit via fax:
404-562-7795

Reference: CIN: A-04-03-01010

Mr. Charles J. Curtis
Regional Inspector General for Audit Services, Region IV
Room 3T41, Atlanta Federal Center
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

Dear Mr. Curtis:

Our office is in receipt of your letter dated August 15, 2003 accompanying the draft report, ***State of North Carolina's Efforts to Account for and Monitor Sub-recipient's Use of Bioterrorism Hospital Preparedness Program Funds, North Carolina DHHS - Division of Public Health***. In accordance with your request, the N.C. Department of Health and Human Services management has reviewed the report and offers the following comments relative to the draft report recommendations.

Response to OIG Draft Report

Finding A. Accounting for Expenditures

We understand the rationale for expenditure tracking by Priority Area and as a result of the review, plans are underway to expand the existing accounting system to accommodate the tracking of the six Priority Areas outlined in the 2003-2004 HRSA grant guidance. North Carolina will take the necessary steps to fully comply with the HRSA grant guidelines including the allocation of funds to hospitals and other health care entities.

Although we understand the need to track expenditures by priority area, we do not see the cost-benefit of tracking expenditures by Critical Benchmark. To accomplish this level of

tracking, it will not only take considerable expansion of the state's accounting system, the process will be very time consuming and difficult to manage. In addition, tracking expenditures by Critical Benchmark for the HRSA Bioterrorism Hospital Preparedness Program Funds is inconsistent with the tracking methods used for the CDC grant. The CDC project officer has indicated that expenditures are to be tracked only by Focus Areas and not Critical Benchmarks.

The US DHHS is attempting to ensure consistency in the CDC and HRSA grant projects by requiring states to show cross-cutting activities; however, this is not the case in the tracking of expenditures. We encourage HRSA to reconsider the requirement of tracking expenditures by Critical Benchmark to be consistent with the CDC monitoring requirements.

Finding B. Subrecipient Monitoring

No finding indicated in report.

Finding C. Supplanting

No finding indicated in report.

We trust that the foregoing responses address the various report recommendation(s). If additional information is needed, please contact Dan Stewart, Director of NCDHHS Office of the Internal Auditor, at (919) 715-4791 or Dan.Stewart@ncmail.net.

Sincerely,

Carmen Hooker Odom

CHO:ds

Cc: Lanier M. Cansler
Allyn Guffey
Honorable Ralph Campbell
Dr. Leah Devlin
Dan Stewart
Dr. Steve Cline
Laketha Miller