



DEPARTMENT OF WEALTH AND HUMAN SERVICES

Office of Inspector General

Office of Audit Services
Region IX
50 United Nations Plaza, Room 171
San Francisco, California 94102

October 1, 2003

Report Number: A-09-03-01020

Diana M. Bonta, R.N., Dr. P.H.
Director, California Department of Health Services
Post Office Box 942732
Sacramento, California 94234-7320

Dear Dr. Bonta:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General's final report titled "State of California's Efforts to Account for the Use of Bioterrorism Hospital Preparedness Program Funds and Monitoring of Subrecipients."

Our objectives were to determine whether the California Department of Health Services (State agency): (i) properly recorded, summarized and reported bioterrorism preparedness transactions in accordance with the terms and conditions of the cooperative agreement and (ii) established controls and procedures to monitor subrecipient expenditures of Health Resources and Services Administration funds. In addition, we inquired as to whether Bioterrorism Hospital Preparedness Program (Program) funding was used to supplant funds previously provided by other sources.

Based on our validation of the questionnaire completed by the State agency, 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

The State agency segregated costs by phase, but did not segregate expenditures by priority planning area. Although segregation was not required, budget restrictions were specified in the cooperative agreement. State agency officials acknowledged the importance of tracking expenditures in order to comply with the budget restrictions. State agency officials informed us that they have elected to make necessary changes to the accounting system by using object codes that will provide for segregating costs by priority planning areas and critical benchmarks.

State agency officials stated that a complete audit plan is being developed to review compliance of subrecipients. The plan will include questionnaires, conferences and follow-up visits. State agency officials stated they plan to begin the audits approximately 6 to 12 months after allocations are distributed to recipients. Although State agency officials have not made any site visits to date, we believe that the development of the site visit component and the existing monitoring procedures will provide adequate monitoring and oversight of the State agency's subrecipients.

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 funds.

In our draft report, we recommended that that the State agency: (1) segregate expenditures by priority planning area, benchmarks and type of provider as planned; and (2) implement the audit plan being developed for monitoring subrecipients and address problem areas, if any are identified. In written comments to our draft report, State agency officials concurred with the conclusions of the report and had no questions or additions.

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.

Your formal response to the draft report was summarized in the body of our final report and included in its entirety as an appendix. 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 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.) As such, within 10 business days after the final report is issued, it will be posted on the Internet at <http://oig.hhs.gov>.

To facilitate identification, please refer to Report Number A-09-03-01020 in all correspondence relating to this report.

Sincerely,



Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures

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Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**STATE OF CALIFORNIA'S EFFORTS
TO ACCOUNT FOR THE
USE OF BIOTERRORISM HOSPITAL
PREPAREDNESS PROGRAM FUNDS
AND MONITORING OF
SUBRECIPIENTS**



**OCTOBER 2003
A-09-03-01020**

Office of Inspector General

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OAS FINDINGS AND OPINIONS

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



EXECUTIVE SUMMARY

OBJECTIVES

Our objectives were to determine whether the California Department of Health Services (State agency): (i) properly recorded, summarized and reported bioterrorism preparedness transactions in accordance with the terms and conditions of the cooperative agreement and (ii) established controls and procedures to monitor subrecipient expenditures of Health Resources and Services Administration funds. In addition, we inquired as to whether Bioterrorism Hospital Preparedness Program (Program) funding was used to supplant funds previously provided by other sources.

FINDINGS

Based on our validation of the questionnaire completed by the State agency, 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.

The State agency segregated costs by phase, but did not segregate expenditures by priority planning area. Although segregation was not required, budget restrictions were specified in the cooperative agreement. State agency officials acknowledged the importance of tracking expenditures in order to comply with the budget restrictions. State agency officials informed us that they have elected to make necessary changes to the accounting system by using object codes that will provide for segregating costs by priority planning areas and critical benchmarks.

State agency officials stated that a complete audit plan is being developed to review compliance of subrecipients. The plan will include questionnaires, conferences and follow-up visits. State agency officials stated they plan to begin the audits approximately 6 to 12 months after allocations are distributed to recipients. Although State agency officials have not made any site visits to date, we believe the development of the site visit component and the existing monitoring procedures will provide adequate monitoring and oversight of its subrecipients.

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 funds.

RECOMMENDATIONS

We recommend that the State agency:

- segregate expenditures by priority planning area, benchmarks and type of provider as planned; and
- implement the audit plan being developed for monitoring subrecipients and address problem areas, if any are identified.

STATE AGENCY'S COMMENTS

State agency officials concurred with our findings and recommendations. The complete text of the State agency's written comments is included as an appendix to this report.

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INTRODUCTION

BACKGROUND

The Program

Since September 2001, the U.S. Department of Health and Human Services (Department) has significantly increased its spending for public health preparedness and response to bioterrorism. For fiscal years 2002 and 2003, the Department awarded amounts for bioterrorism preparedness, totaling \$2.98 and \$4.32 billion, respectively. Through this funding, 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 Public Law 107-117 (Department of Defense and Emergency Supplemental Appropriations for Recovery from and Response to Terrorist Attacks on the United States Act, 2002). As part of this initiative, the Health Resources and Services Administration (HRSA) made available approximately \$125 million in fiscal year 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 (Program). The purpose of the 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 medical services 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. The Program was subsequently extended through March 31, 2004.

Budget Restrictions

During the Program year, the cooperative agreements covered two phases. Phase 1, *Needs Assessment, Planning and Initial Implementation*, provided 20 percent of the total award (\$25 million) for immediate use. Up to one-half of Phase 1 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 2, *Implementation*, could begin. Grantees were allowed to use unobligated Phase 1 funds in Phase 2. Grantees were

required to allocate at least 80 percent of Phase 2 funds to hospitals and their collaborating entities through contractual awards to upgrade their abilities to respond to bioterrorism events. Funds expended for health department infrastructure and planning were not to exceed 20 percent of Phase 2 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, emergency medical services systems, health centers and poison control centers work with the applicable health department for funding through the Program.

State Agency Funding

The State agency, in collaboration with the California Emergency Medical Services Authority, received funding of \$9.96 million (\$1.99 million for Phase 1 and \$7.97 million for Phase 2) for the period April 1, 2002 through March 31, 2003. In December 2003, the grant was extended through March 31, 2004.

OBJECTIVES, SCOPE AND METHODOLOGY

Objectives

Our objectives were to determine whether the State agency: (i) properly recorded, summarized and reported bioterrorism preparedness transactions in accordance with the terms and conditions of the cooperative agreement and (ii) established controls and procedures to monitor subrecipient expenditures of HRSA funds. In addition, we inquired as to whether Program funding supplanted funds previously provided by other organizational sources.

Scope

Our review included an examination of State agency policies and procedures, financial reports, and accounting transactions during the period April 1, 2002 through June 30, 2003.

Our review was limited in scope, 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.

Methodology

We developed a questionnaire to address the objectives of the review. The questionnaire covered five areas: (i) the grantee organization, (ii) funding, (iii) accounting for expenditures, (iv) other organizational bioterrorism activities (supplanting), and (v) subrecipient of grant funds

(monitoring). Prior to our fieldwork, we provided the questionnaire for the State agency to complete. During our on-site visits, we interviewed State agency officials and obtained supporting documentation to validate the responses on the questionnaire.

Our fieldwork was conducted during June through August 2003 and included site visits to the offices of the Emergency Medical Services Authority in Sacramento, California. 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, 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.

The State agency segregated costs by phase, but did not segregate expenditures by priority planning area. Although segregation was not required, budget restrictions were specified in the cooperative agreement. State agency officials acknowledged the importance of tracking expenditures in order to comply with the budget restrictions. State agency officials informed us that they have elected to make necessary changes to the accounting system by using object codes that will provide for segregating costs by priority planning area and critical benchmark.

State agency officials stated that a complete audit plan is being developed to review compliance of subrecipients. The plan will include questionnaires, conferences and follow-up visits. State agency officials stated they plan to begin the audits approximately 6 to 12 months after allocations are distributed to recipients. Although State agency officials have not made any site visits to date, we believe that the development of the site visit component and the existing monitoring procedures will provide adequate monitoring and oversight of the State agency's subrecipients.

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 funds.

ACCOUNTING FOR EXPENDITURES

Accurate and complete accounting of Program funds provides HRSA with a means to measure the extent that the Program is implemented and objectives are met. Although the State agency was not required to segregate expenditures in the accounting system by phase or by priority planning area, there are budgeting restrictions set forth in HRSA's (i) Summary Application Guidance for Award and First Allocation, and (ii) Cooperative Agreement Guidance.

For Phase 1, the Summary Application Guidance for Award and First Allocation provides for 20 percent of a grantee's total award be made available for this phase. Further, the Cooperative Agreement Guidance requires that at least 50 percent of these funds must be allocated to hospitals and other health care entities to begin implementation of their plans. For Phase 2, the

Summary Application Guidance for Award and First Allocation requires grantees to allocate at least 80 percent of the funds to hospitals through written contractual agreements.

State agency officials acknowledged that expenditures for health department infrastructure and planning were not to exceed 50 percent for Phase 1 or 20 percent for Phase 2. They stated that all funds expended as of June 30, 2003 were for Phase 1. The State agency was also aware that for subsequent budget periods, the cooperative agreement was budgeted by priority planning area.

Our review showed the State agency was in compliance with budget restrictions. An analysis of expenses at June 30, 2003 showed 60 percent of the State agency's expenditures were for hospitals and other health care entities. In addition, the State agency has projected expenditures of \$8.3 million for hospitals and other health care entities through the program period ended March 31, 2004. The State agency provided a list of contracts and planned contracts which indicated that 83 percent of total projected grant costs of \$9.96 million (phases 1 and 2) are with hospitals and other health care entities. This is in compliance with Program specifications.

Although State agency officials could identify expenditures by priority area using object codes from financial reports, they did not segregate these costs by priority planning areas and critical benchmarks. This occurred because there was no requirement to segregate costs by these areas at the time State agency officials completed our questionnaire.

State agency officials acknowledged the importance of tracking expenditures in order to comply with the budget restrictions and are in the process of adding additional object codes that will enable them to accumulate costs by priority planning areas and critical benchmarks within these areas.

SUBRECIPIENT MONITORING

Recipients of Program funds are required to monitor their subrecipients. The Public Health Service Grants Policy Statement requires that "grantees employ sound management practices to ensure that program objectives are met and that project funds are properly spent." In addition, Public Health Service policy 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....

State agency officials stated that a complete audit plan is being developed to review compliance of subrecipients. The plan will include questionnaires, conferences and follow up-visits. State agency officials stated they plan to begin the audits approximately 6 to 12 months after allocations are distributed to recipients. Although State agency officials have not made any site visits to date, we believe that the development of the site visit component and the existing

monitoring procedures will provide adequate monitoring and oversight of the State agency's subrecipients.

SUPPLANTING

Program funds were to be used to supplement current funding and to 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 public health funds available for emergency activities to combat threats to public health. 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.

Office of Management and Budget Circular A-87, Cost Principles for State, Local, and Indian Tribal Governments, Attachment A.A.3.e.(3) states: "...funds are not to be used for general expenses required to carry out other responsibilities of a State or its subrecipients."

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 funds.

RECOMMENDATIONS

We recommend that the State agency:

- segregate expenditures by priority planning area, benchmarks and type of provider as planned; and
- implement the audit plan being developed for monitoring subrecipients and address problem areas, if any are identified.

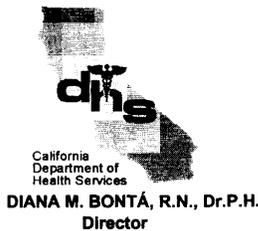
STATE AGENCY'S COMMENTS

State agency officials concurred with our findings and recommendations. The complete text of the State agency's written comments is included as an appendix to this report.

OIG'S RESPONSE

The State agency's response to our report was well considered and provides a clear statement of corrective actions to be taken in response to the recommendations included in our report. The State agency must continue to work towards implementing our recommendations.

APPENDIX



State of California—Health and Human Services Agency
Department of Health Services



GRAY DAVIS
Governor

September 15, 2003

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



Dear Ms. Ahlstrand:

Thank you for the opportunity to respond to the Office of Inspector General's report on the "State of California's Efforts To Account For the Use of Bioterrorism Hospital Preparedness Program Funds and Monitoring of Subrecipients." This review included an examination of our agency policies and procedures, financial reports, and accounting transactions during the period of April 1, 2002 through June 30, 2003. This period covered Year 1 of the Hospital Bioterrorism Preparedness Cooperative Agreement under review.

We concur with the conclusions of the report and have no questions or additions. We are pleased that the review found no discrepancies or areas to be improved.

The report recommends that the State of California implement existing plans to 1) segregate expenditures by priority planning area, benchmarks, and type of provider for the next fiscal year and; 2) conduct audits and monitoring of subrecipients and address problem areas, if any are identified.

The California Hospital Bioterrorism Preparedness Program will implement these planned activities. The segregating of expenditures will begin with receipt of the 2003-04 Health Resources and Services Administration (HRSA), Year 2 funding. The segregation of expenditures by priority planning area, benchmark, and type of provider



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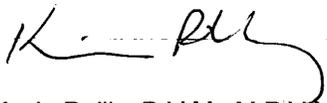


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Ms. Lori A. Ahlstrand
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are requirements of the Year 2 HRSA funding, and were not required of Year 1 recipients. The auditing and monitoring of subrecipients will begin in February or March 2004, as equipment and supplies for the subrecipients will not be distributed until October and November 2003.

Sincerely,



Kevin Reilly, D.V.M., M.P.V.M.
Deputy Director
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ACKNOWLEDGMENTS

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