AUG 26 2004

TO: Elizabeth M. Duke, Ph.D.
Administrator
Health Resources and Services Administration

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Nationwide Audit of State and Local Government Efforts To Record and Monitor Subrecipients' Use of Bioterrorism Hospital Preparedness Program Funds (A-05-04-00028)

Attached are two copies of the U.S. Department of Health and Human Services, Office of Inspector General's final report entitled "Nationwide Audit of State and Local Government Efforts To Record and Monitor Subrecipients' Use of Bioterrorism Hospital Preparedness Program Funds."

Under the Bioterrorism Hospital Preparedness Program, State or territorial health departments and municipal governments or health departments received funding from the Health Resources and Services Administration (HRSA) to upgrade the preparedness of the Nation's hospitals and collaborating entities to respond to bioterrorism. Since April 1, 2002, HRSA has awarded $623 million to 59 State, territorial, and selected municipal offices of public health. For this self-initiated audit, we reviewed bioterrorism grant programs in 14 States and 4 major metropolitan areas.

The objectives of our audit were to determine whether awardees:

- recorded, summarized, and reported hospital preparedness program transactions in accordance with their cooperative agreements
- established procedures to monitor subrecipient expenditures
- had unobligated fund balances as of August 30, 2003

Of the 18 audited awardees, we found that:

- None of the awardees recorded program transactions in a manner that fully supported budgetary restrictions as detailed in their cooperative agreements. Through additional audit procedures, we determined that 16 awardees complied with the budget restrictions but could not determine whether the other 2 complied. However, all awardees will need to modify their accounting systems to meet the new requirement to track expenditures by

priority planning area, critical benchmark, and funds allocated to hospitals and other health care entities.

- Twelve awardees had developed procedures to track and monitor subrecipient expenditures, but there were opportunities for improvement.

- All 18 awardees had unobligated balances of Federal bioterrorism funds as of August 30, 2003 totaling approximately $19.2 million, or 23 percent of the $83.1 million awarded.

Improvements are needed to ensure that bioterrorism program funds are efficiently and effectively utilized.

We recommend that HRSA:

- identify awardees not meeting budget restrictions and ensure that all awardees account for funds in accordance with their cooperative agreements

- provide guidance to awardees on monitoring subrecipient expenditures and measuring subrecipient performance, including emphasizing the need for awardees to make site visits to directly review subrecipients' expenditures and assess subrecipients' progress in improving bioterrorism preparedness

- identify the reasons for large unobligated balances and assist the awardees in overcoming barriers to a more timely use of funds

Officials in your office have concurred with our recommendations, set forth on page 7 of the attached report, and have taken, or agreed to take, corrective action. We appreciate the cooperation given us in this audit.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please do not hesitate to call me, or have your staff call Peter J. Koenig, Acting Assistant Inspector General for Grants and Internal Activities, at 202-619-3191 or through e-mail at Peter.Koenig@oig.hhs.gov. Please refer to report number A-05-04-00028 in all correspondence.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NATIONWIDE AUDIT OF STATE AND LOCAL GOVERNMENT EFFORTS TO RECORD AND MONITOR SUBRECIPIENTS' USE OF BIOTERRORISM HOSPITAL PREPAREDNESS PROGRAM FUNDS

AUGUST 2004
A-05-04-00028

Office of Inspector General

http://oig.hhs.gov

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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

BACKGROUND

Under the Bioterrorism Hospital Preparedness Program, State or territorial health departments and municipal governments or health departments receive funding from the Health Resources and Services Administration (HRSA) to upgrade the preparedness of the Nation's hospitals and collaborating entities to respond to bioterrorism. Since April 1, 2002, HRSA has awarded $623 million to 59 State, territorial, and selected municipal offices of public health. The funding instrument used for the program is a cooperative agreement because substantial HRSA programmatic collaboration with awardees was anticipated during the performance of the project.

On August 15, 2003, the Office of Inspector General (OIG) issued a report on California's accounting for Centers for Disease Control and Prevention (CDC) bioterrorism program funds (A-09-02-01007). The report, entitled "State of California: Review of Public Health Preparedness and Response for Bioterrorism Program Funds," stated that California did not account for program funds by focus area and could not adequately support expenditures on Financial Status Reports submitted to CDC.

The conditions we found in California led us to perform this nationwide audit to determine if HRSA awardees were properly recording hospital preparedness program funds. We have since reviewed programs in 14 States and 4 major metropolitan areas (Appendix A) selected primarily based on their dollar funding levels. This rollup report presents the results of the reviews.

OBJECTIVES

The objectives of our audit were to determine whether awardees:

- recorded, summarized, and reported hospital preparedness program transactions in accordance with their cooperative agreements
- established procedures to monitor subrecipient expenditures
- had unobligated fund balances as of August 30, 2003

SUMMARY OF FINDINGS

Recording, Summarizing, and Reporting Program Funds

The HRSA Cooperative Agreement Guidance required awardees to allocate 50 percent of Phase I funding and 80 percent of Phase II funding to hospitals and other health care providers. None of the awardees recorded program funding in a manner that fully supported these budgetary restrictions. Through additional audit procedures, we were able to satisfy ourselves that 16 of the 18 awardees were in compliance with these budget restrictions. We were unable to determine whether the remaining two were in compliance.

New HRSA guidelines, effective August 2003, require awardees to maintain an accounting system to track expenditures by priority planning area, critical benchmark, and funds allocated to hospitals and other health care entities. At the time we completed our review, none of the awardees' accounting systems were set up to track expenditures in this manner. However, all awardees indicated that they would comply with the new requirement.

Monitoring Subrecipient Expenditures

Monitoring of grants made to local health departments and community groups (subrecipients) by an awardee is an important process to ensure that program objectives are met and that project funds are properly spent. We found that:

- Six awardees developed adequate procedures to oversee awards to subrecipients.

- Twelve awardees had established procedures to track and monitor subrecipient expenditures, but there were opportunities for improvement.

Regulations at 45 CFR § 92.40 require that awardees monitor grant- and subgrant-supported activities to ensure compliance with applicable Federal requirements and that performance goals are being met. The Public Health Service Grants Policy Statement, which applies to grantees and subrecipients, requires them to "establish sound and effective business management systems to assure proper stewardship of funds and activities . . . ."

We noted opportunities for improvements, including implementation of a site visit component to the awardees' auditing procedures and random audits of the subrecipients' hospital preparedness fund expenditures.

Unobligated Fund Balances

Reported unobligated balances of hospital preparedness program funds for the 18 audited awardees totaled $19.2 million as of August 30, 2003. This amount represented 23 percent of the $83.1 million awarded to the 18 awardees. The percentage of unobligated program funds varied substantially, as follows:

- Four awardees had unobligated balances greater than 71 percent.

- Two awardees had unobligated balances ranging from 33 to 52 percent.

- Three awardees had unobligated balances ranging from 11 to 16 percent.

- Nine awardees had unobligated balances less than 11 percent.

These unobligated balances represented 15.4 percent of the $125 million awarded during the first program year of the hospital preparedness program, covering April 1, 2002 through August 30, 2003. Large unobligated balances may indicate that hospital preparedness program goals were not being met and may indicate a need for stronger program oversight by HRSA. As future

program funding increases, the unobligated balances could increase even more. In its Program Period 2 Cooperative Agreement Guidance, HRSA stated that "If 2002 funds are still unobligated, 2003 funds for similar priority areas will likely be awarded with a funding restriction attached. This restriction will be lifted when 2002 implementation efforts on specific priority areas are complete." Additional appropriations could be restricted, thus reducing the amounts provided for awardee program goals.

RECOMMENDATIONS

We recommend that HRSA:

- identify awardees not meeting budget restrictions and ensure that all awardees account for funds in accordance with their cooperative agreements

- provide guidance to awardees on monitoring subrecipient expenditures and measuring subrecipient performance, including emphasizing the need for awardees to make site visits to directly review subrecipients' expenditures and assess subrecipients' progress in improving bioterrorism preparedness

- identify the reasons for large unobligated balances and assist the awardees in overcoming barriers to a more timely use of funds

AUDITEE COMMENTS AND OIG RESPONSE

In a written response to our draft report dated July 26, 2004, HRSA officials concurred with our findings and recommendations. The officials suggested changes in the wording of the report for clarification of specific regulations and guidelines. We reviewed the comments and made appropriate changes to the report. The HRSA response is included in its entirety as Appendix B to this report.

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INTRODUCTION

BACKGROUND

Bioterrorism Hospital Preparedness Program

Under the Bioterrorism Hospital Preparedness Program, State or territorial health departments and municipal governments or health departments received HRSA funding to upgrade the preparedness of the Nation's hospitals and collaborating entities to respond to bioterrorism. 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.

Under Cooperative Agreement Guidance issued February 15, 2002, HRSA initiated cooperative agreements with awardees for the period April 1, 2002 through March 31, 2004. This period has since been revised to end August 31, 2003. The funding instrument used for the program is a cooperative agreement because substantial HRSA programmatic collaboration with awardees was anticipated during the performance of the project.

The cooperative agreements covered two phases. Phase I, Needs Assessment, Planning, and Initial Implementation, provided 20 percent of the total award for immediate use. The remaining 80 percent was not made available until HRSA approved the required implementation plans, at which point Phase II, Implementation, could begin.

The cooperative agreements also identified two sets of priority planning areas to be addressed with Phase II program funds. The first priority planning areas included:

- Medication and Vaccines
- Personal Protection, Quarantine, and Decontamination
- Communications
- Biological Disaster Drills

The second priority planning areas included:

- Personnel (including emergency increases in staffing)
- Training
- Patient Transfer

Subject to Federal requirements in Office of Management and Budget Circulars A-87, Cost Principles for State, Local, and Indian Tribal Governments; and A-102, Grants and Cooperative Agreements With State and Local Governments, awardees were required to establish financial management systems to account for the use of Federal funds.

In addition, 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 . . . ."

Hospital Preparedness Program Funding and Awardees

Funding for the hospital preparedness program began on April 1, 2002. Since that time, HRSA has awarded $623 million to the 50 States; the District of Columbia; the Commonwealths of Puerto Rico and the Northern Mariana Islands; American Samoa; Guam; the U.S. Virgin Islands; and the Nation's three largest municipalities, New York, Chicago, and Los Angeles County. Individual hospitals, emergency medical services systems, health centers, and poison control centers work with the applicable health department for funding through the hospital preparedness program.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The objectives of our audit were to determine whether awardees:

- recorded, summarized, and reported hospital preparedness program transactions in accordance with their cooperative agreements
- established procedures to monitor subrecipient expenditures
- had unobligated fund balances as of August 30, 2003

Scope

This rollup report consolidates the results of our reviews of hospital preparedness programs in 14 States and 4 major metropolitan areas. We selected awardees primarily on the basis of the dollar funding level. We reviewed hospital preparedness programs in California, Florida, Georgia, Illinois, Maryland, Massachusetts, Michigan, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Texas, Virginia, Chicago, the District of Columbia, Los Angeles County, and New York City. Our reviews covered bioterrorism funding for the period April 1, 2002 through August 30, 2003. Our audit was not designed to determine whether costs charged to the hospital bioterrorism program were allowable under Federal cost principles or to assess the status of awardee preparedness. A planned second phase of the review will examine costs claimed by selected awardees to determine whether they were allowable.

We did not review the overall internal control structure at each of the selected awardees. Our internal control review was limited to obtaining an understanding of each awardee's subrecipient monitoring procedures. We performed our fieldwork at awardee offices between April and August 2003.

Methodology

We developed a questionnaire to address the objectives of the review. The questionnaire, which we provided to the awardees to complete prior to our fieldwork, solicited information in the areas of awardee organization, hospital preparedness program funding, accounting for expenditures, subrecipient monitoring, and supplanting. To accomplish our objectives, we:

- reconciled hospital preparedness program funds awarded, expended, and obligated, as reported by the awardees on the completed questionnaire, to awardees' accounting records

- reviewed awardees' policies and procedures for monitoring subrecipient expenditures of hospital preparedness program funds

We obtained information on unobligated balances as of August 30, 2003 directly from Financial Status Reports (FSRs) filed with HRSA.

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

FINDINGS AND RECOMMENDATIONS

Of the 18 audited awardees receiving HRSA hospital preparedness funding, we found that:

- None of the awardees recorded program transactions in a manner that fully supported budgetary restrictions as detailed in their cooperative agreements. Through additional audit procedures, we determined that 16 awardees complied with the budget restrictions but could not determine whether the other 2 complied. However, all awardees will need to modify their accounting systems to meet the new requirement to track expenditures by priority planning area.

- Twelve awardees had developed procedures to track and monitor subrecipient expenditures, but there were opportunities for improvement.

- All 18 awardees had unobligated balances of Federal bioterrorism funds as of August 30, 2003 totaling approximately $19.2 million, or 23 percent of the $83.1 million awarded.

Improvements are needed to ensure that bioterrorism program funds are efficiently and effectively utilized.

RECORDING, SUMMARIZING, AND REPORTING PROGRAM FUNDS

Awardees Must Comply With Budget Restrictions

Although awardees were not specifically required to segregate 2002 program funds and expenditures in their accounting systems, budgeting restrictions for Phase I and II funds were set forth by HRSA. Without segregation of funds, awardees had no assurance that funds expended did not exceed budgeting restrictions.

Specific budgetary restrictions in the 2002 Cooperative Agreement Guidance were:

- 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 percent) of the Phase I award must be allocated to hospitals and other health care entities to begin implementation of their plans.

- Indirect costs will be limited to 10 percent of the Phase I and Phase II total.

Regarding Phase II funds, the 2002 Summary Application Guidance for Award and First Allocation states, "Awardees 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 . . . ."

Compliance With Budget Restrictions

None of the awardees recorded program transactions in a manner that fully supported budgetary restrictions on the use of funds as detailed in their 2002 cooperative agreements. However, through limited and varying reviews of awardees' accounting systems, we were able to satisfy ourselves that 16 of the 18 awardees were in compliance with the budget restrictions. We were unable to determine whether two awardees, the District of Columbia and Georgia, were in compliance with the budget restrictions.

Changes in Tracking Expenditures

Although our review focused on the 2002 fund guidelines, on May 2, 2003, HRSA released the 2003 Cooperative Agreement Guidance containing new requirements for program year two, effective August 31, 2003. The guidance stated that each awardee 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 . . . ."

At the time of our review, none of the awardees' accounting systems were set up to track expenditures in accordance with the proposed 2003 guidelines. Although all awardees indicated that they would modify their accounting systems to comply with the new guidelines, several expressed their concerns about implementing the new requirement. For example, one awardee stated that segregation would be "extremely difficult to track accurately due to the overlap and cross over of responsibilities. The method of dividing expenditures between critical benchmarks would be too subjective due to the fact that many activities completed are related to several critical benchmarks."

Incomplete Accounting Impairs Program Oversight

An essential aspect of the bioterrorism hospital prepardness program is the need for awardees to accurately and fully account for program funds. Without accurate and complete accounting of program funds, HRSA does not have sufficiently detailed data to ensure that funds are being spent

for the intended purposes and that program objectives are being met. In addition, segregation of hospital preparedness program transactions could allow awardees to assure HRSA that expended program funds did not exceed the budgeting restrictions set forth in the Cooperative Agreement Guidance.

MONITORING SUBRECIPIENT EXPENDITURES

Awardees Required To Monitor Their Subrecipients

Awardees were required to monitor their subrecipients. Regulations at 45 CFR § 92.40 require that awardees monitor grant- and subgrant-supported activities to ensure compliance with applicable Federal requirements and that performance goals are being met.

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." It states that recipients must "establish sound and effective business management systems to assure proper stewardship of funds and activities . . . ."

The Policy Statement also provides that grant requirements apply to grantees and their subrecipients "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 . . . ."

Opportunities To Improve Subrecipient Monitoring Procedures

Subrecipient monitoring procedures varied among the audited awardees. We found that:

- Six awardees (Chicago, Illinois, Maryland, Michigan, North Carolina, and Texas) had developed adequate procedures to oversee awards to subrecipients.

- Twelve awardees had developed procedures to track and monitor subrecipient expenditures, but there were opportunities for improvement. Specifically, we found that nine awardees (District of Columbia, Florida, Georgia, New Jersey, New York State, New York City, Ohio, Pennsylvania, and Virginia) did not include a site visit component in their current auditing procedures. California had not implemented the site visit component of its auditing procedures. Los Angeles County had not performed site visits because subrecipient agreements were not finalized and, therefore, were not ready for evaluation. Massachusetts did not conduct random audits of subrecipients.

Guidance From HRSA Could Help Ensure That Funds Were Spent Properly

HRSA could help ensure that program objectives are met and that project funds are properly spent by encouraging awardees to conduct subrecipient site visits that include a review of expenditure documentation.

UNOBLIGATED FUND BALANCES

Funds Awarded but Not Committed

Obligated funds are funds the awardees have committed to spend for services, supplies, staff, local public health agency support, or anything else related to bioterrorism preparedness activities. Unobligated funds are awards that an awardee has not committed to a specified liability or expenditure. These funds are generally available for use during a specified timeframe and should be expended for program purposes. For example, funds available for Program Period 1 should have been committed for specific purposes by August 30, 2003.

$19.2 Million in Program Funds Not Committed as of August 30, 2003

Table 1 shows awarded and unobligated hospital preparedness program amounts, as reported on the FSRs, and the percentage remaining unobligated as of August 30, 2003.

Table 1: Awarded and Unobligated Program Fund Amounts

Awardee	Awarded	Unobligated	Percentage
Massachusetts	$4,742,678	$4,084,390	86
Georgia	3,421,481	2,715,558	79
District of Columbia[1]	721,619	541,887	75
Ohio	4,648,274	3,297,580	71
New York	8,094,438	4,208,368	52
Los Angeles County	3,659,172	1,192,994	33
New Jersey	3,842,590	619,963	16
Chicago	1,371,934	195,991	14
North Carolina	3,368,351	367,801	11
Maryland	2,412,622	218,917	9
Florida	6,411,669	549,058	9
Virginia	3,119,617	205,950	7
California	9,962,905	487,800	5
New York City	5,922,855	263,944	4
Pennsylvania	5,007,754	195,999	4
Illinois	3,939,374	57,736	1
Texas	8,328,119	15,634	0
Michigan	4,100,212	1,988	0
Total	**$83,075,664**	**$19,221,558**	**23%**

As Table 1 shows, reported unobligated balances of hospital preparedness program funds for the 18 audited awardees totaled $19.2 million as of August 30, 2003. This amount represented 23 percent of the $83.1 million awarded to the 18 awardees. The percentage of unobligated program funds varied substantially, as follows:

- Four awardees had unobligated balances greater than 71 percent.

[1] Amounts shown for the District of Columbia were as of March 31, 2003.

- Two awardees had unobligated balances ranging from 33 to 52 percent.

- Three awardees had unobligated balances ranging from 11 to 16 percent.

- Nine awardees had unobligated balances less than 11 percent.

These unobligated balances represented 15.4 percent of the $125 million awarded during the first program year of the hospital preparedness program, covering April 1, 2002 through August 30, 2003.

Funds Were Not Obligated for a Variety of Reasons

Awardee officials indicated that unobligated program funds resulted from delays and difficulties in the following areas: recruiting and hiring personnel, coordinating the startup of new activities, executing contracts, and posting of expenditures. Staffing changes and hiring freezes delayed recruiting and hiring while an extensive needs assessment process delayed the startup of new activities. HRSA also substantially increased funding from $125 million in 2002 to $498 million in 2003; the 2003 funding covered a 12-month budget period and a 5-year project period.

Program Funds Not Fully Utilized

Large unobligated balances suggest that funds were not fully utilized to meet important bioterrorism preparedness program goals and may indicate a need for stronger program oversight by HRSA.

Recognizing the significance of continuing unobligated fund balances, HRSA stated in its Program Period 2 Cooperative Agreement Guidance, "If 2002 funds are still unobligated, 2003 funds for similar priority areas will likely be awarded with a funding restriction attached. This restriction will be lifted when 2002 implementation efforts on specific priority areas are complete." Additional appropriations could be restricted, thus reducing the amounts provided for awardee program goals.

RECOMMENDATIONS

We recommend that HRSA:

- identify awardees not meeting budget restrictions and ensure that all awardees account for funds in accordance with their cooperative agreements

- provide guidance to awardees on monitoring subrecipient expenditures and measuring subrecipient performance, including emphasizing the need for awardees to make site visits to directly review subrecipients' expenditures and assess subrecipients' progress in improving bioterrorism preparedness

- identify the reasons for large unobligated balances and assist the awardees in overcoming barriers to a more timely use of funds

AUDITEE COMMENTS AND OIG RESPONSE

In a written response to our draft report, dated July 26, 2004, HRSA officials concurred with our findings and recommendations. The officials suggested changes in the wording of the report for clarification of specific regulations and guidelines. We reviewed the comments and made appropriate changes to the report. The HRSA response is included in its entirety as Appendix B to this report.

OTHER MATTER: SUPPLANTING OF FUNDS

Program funds were to be used to augment current funding and focus on bioterrorism hospital preparedness activities under the HRSA Cooperative Agreement. The funds were not to be used to supplant existing Federal, State, or local public health funds available for emergency activities to combat threats to public health. The Cooperative Agreement Guidance states that "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 nonfederal funds that would otherwise be made available for this activity . . . ."

In response to our questionnaire and during our onsite interviews, officials from all 18 awardees asserted that Federal bioterrorism hospital preparedness program funding had not supplanted existing State or local bioterrorism programs, as prohibited by the HRSA Cooperative Agreement Guidance. We did not validate their assertions. We have scheduled in-depth reviews at selected awardees that will include an analysis of the supplanting issue.

APPENDICES

APPENDIX A

ISSUED AUDIT REPORTS BY AUDIT REPORT NUMBER AND AWARDEE

A-09-03-01020	California Department of Health Services
A-05-03-00089	City of Chicago Department of Public Health
A-03-03-00386	District of Columbia Department of Health
A-04-03-01008	Florida Department of Health
A-04-03-01012	Georgia Department of Human Resources
A-05-03-00081	Illinois Department of Public Health
A-09-03-01021	Los Angeles County Department of Health Services
A-03-03-00392	Maryland Department of Health and Mental Hygiene
A-01-03-01505	Massachusetts Department of Public Health
A-05-03-00079	Michigan Department of Community Health
A-02-03-02014	New Jersey Department of Health and Senior Services
A-02-03-02013	New York City Department of Health and Mental Hygiene
A-02-03-02012	New York State Department of Health
A-04-03-01010	North Carolina Division of Public Health
A-05-03-00078	Ohio Department of Health
A-03-03-00382	Pennsylvania Department of Health
A-06-03-00058	Texas Department of Health
A-03-03-00384	Virginia Department of Health

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Resources and Services Administration

Rockville MD 20857

JUL 26 2004

TO: Joseph E. Vengrin
Deputy Inspector General for Audit Services

FROM: Administrator

SUBJECT: Office of Inspector General Draft Report, "Nationwide Audit of State and Local Government Efforts to Record and Monitor Subrecipients' Use of Bioterrorism Hospital Preparedness Program Grant Funds." (A-05-04-00028)

Attached please find the Health Resources and Services Administration's comments on this draft report. Staff questions may be referred to Ms. Gail Lipton at (301) 443-6509.

Betty James Duke

Betty James Duke

Attachment

Comments of the Health Resources and Services Administration on the Office of the Inspector General Draft Report, "Nationwide Audit of State and Local Government Efforts to Record and Monitor Subrecipients' Use of Bioterrorism Hospital Preparedness Program Grant Funds" (A-05-04-00028)

General Comments

In general, this is a well written report and we concur with the overall findings.

On May 2, 2003, HRSA released the 2003 Cooperative Agreement Guidance (2003 Guidance) with language stating that each awardee must: "develop and maintain a financial system...." This critical benchmark was to be achieved during the FY 2003 budget period which began on August 31, 2003. Technically, the States could not have started this work until the formal notification of funds which were made available i.e., August 31, 2003. Therefore, HRSA believes that the OIG should acknowledge that States were not funded for this activity at the time of the OIG review and that reporting during this period was less formal and more ad hoc. HRSA agrees with the OIG that the lower level of reporting was not sufficient and hence the inclusion of the critical benchmark to develop a more specific financial tracking system in the 2003 Guidance.

OIG Recommendation

That HRSA identify awardees not meeting budget restrictions and ensure that all awardees account for funds in accordance with their cooperative agreements.

HRSA Response

We concur with this recommendation. Program staff has been working closely with States to correct reporting on FY 2002 funds to comply with guidance standards.

OIG Recommendation

That HRSA provide guidance to awardees on monitoring subrecipient expenditures and measuring subrecipient performance, including emphasizing the need for awardees to make site visits to directly review subrecipients' expenditures and assess subrecipients' progress in improving bioterrorism preparedness.

HRSA Response

We concur with this recommendation. In addition to reinforcing to awardees their responsibility in monitoring subrecipients, the Division of Grants Management Operations will develop guidance on awardees' responsibilities and disseminate to awardees. In addition, technical assistance sessions will be conducted at grantee meetings on monitoring

subrecipient expenditures and measuring subrecipient performance.

OIG Recommendation

That HRSA identify the reasons for large unobligated balances and assist the awardees in overcoming barriers to a more timely use of funds.

HRSA Response

We concur with this recommendation. However, we would like to add that our program visits have identified additional issues, other than those identified in this report, that contribute to the delay in obligating funds. In fact, State processes often contribute to the delay and there is limited Federal authority to intervene in these processes.

Technical Comments

Page i: Executive Summary, 1st line, change: "State and major local health departments" to State or territorial health departments and to the municipal governments or health departments."

Page ii: Executive Summary, under heading, "Recording, Summarizing, and Reporting Program Funds," 2nd paragraph, end of the first sentence, add after hospital "and other health care entities."

Page 1 of the Report: Under Heading, "Bioterrorism Hospital Preparedness Program," 2nd paragraph: 2nd line, change "April 1, 2002 through March 31, 2003" to "April 1, 2003 to March 31, 2004."

Page 1 of the Report: Under Heading, "Bioterrorism Hospital Preparedness Program," 2nd paragraph: 3rd line, change "extended" to "reduced back" and "August 30" to "August 31."

Page 8 of the Report: top of the page, 3rd line, after 2003 funding covers, change "four-year period" to "twelve month budget period, five-year project period."

ACKNOWLEDGMENTS

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