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OFFICE OF INSPECTOR GENERAL
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FEB - 2 2004

Report Number: A-03-03-00386

Ronald E. Lewis
Chief Operating Officer
District of Columbia Department of Health
825 North Capital Street, NE
Washington, D. C. 20001

Dear Mr. Lewis:

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

A copy of this report will be forwarded to the action official noted below for her review and any action deemed necessary. Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG reports issued to the department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the department chooses to exercise. (See 45 CFR Part 5.)

If you have any questions or comments about this report, please do not hesitate to call me or Leon Skros, Audit Manager, at 215-861-4472 or through e-mail at lskros@oig.hhs.gov. To facilitate identification, please refer to report number A-03-03-00386 in all correspondence.

Sincerely yours,

FOR Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosures - as stated

Direct Reply to HHS Action Official:

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

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

DISTRICT OF COLUMBIA

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

FEBRUARY 2004
A-03-03-00386

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

OBJECTIVE

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

FINDINGS

Based on our validation of the questionnaire completed by the District and our site visit, we determined that the District generally accounted for Program funds in accordance with the terms and conditions of the cooperative agreement and applicable departmental regulations and guidelines. The District segregated expenditures by phase and within phase, but not by priority area. Although segregation was not required, budget restrictions were specified in the cooperative agreement. The District reported that its accounting system has the capability to separately account for different funding sources, if necessary. However, due to the District's reliance on a waiver for meeting certain Program funding requirements initially granted and subsequently recinded by the U.S. Department of Health and Human Services (HHS) Office of Public Health Preparedness (Health Preparedness), we have concerns regarding whether the District will be able to meet the requirement to allocate at least 80 percent of the Phase II funds to hospitals through written contractual agreements. Also, the District had not begun disbursment of funds awarded by HRSA to hospital sub-recipients as required by the cooperative agreement guidance.

The District had a reporting system to track and monitor sub-recipient activities. However, the District did not have a site visit component as part of the reporting system. We believe that a site visit component, combined with the reporting system, would provide adequate monitoring and oversight of District sub-recipients.

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

RECOMMENDATIONS

We recommend that the District:

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

2. ensure that at least 80 percent of the Phase II funds are allocated to hospitals in accordance with the cooperative agreement guidance, and expedite the disbursement of Program funds to hospitals.

3. consider implementing site reviews of Program funds to the current sub-recipient reporting system and address problem areas, as they are identified.

DISTRICT'S COMMENTS

In a written response to our draft report, the District concurred with our findings and our recommendations. However, in response to our second recommendation, the District stated that the balance of its Year 1 HRSA funds will be allocated to hospitals through the purchase of a rash diagnostic system for each facility that will allow hospitals to diagnose rashes that may be related to biological or chemical weapons of mass destruction. Also, the District stated that it used Department of Defense (DOD) funds to fulfill HRSA grant objectives for hospitals. The District's response is included in its entirety as an appendix to this report.

OIG COMMENT

We are concerned with the District's response to our second recommendation. The District's planned purchase of rash diagnostic systems and subsequent transfer of the systems rather than HRSA funds to hospitals may not meet the intent of the HRSA cooperative agreement guidance. Prior to purchasing the rash diagnostic systems, the District should consult with HRSA to ensure that their purchase meets the intent of the guidance since it appears that the District has determined the need for the hospitals instead of allowing each hospital to determine its own need.

The District acknowledges in its response that *"seven to 28 percent of all visits to outpatient care clinics are for dermatologic of (sic) related conditions."* This appears to justify a need for the diagnostic rash systems unrelated to bioterrorism. Also, in it's response, the District is not clear on the amount of funding to be used for the systems and whether it has ensured that at least 80 percent of the Phase II funds are allocated to hospitals in accordance with the cooperative agreement guidance. The District needs to ensure that this requirement is met. This is especially concerning since the District states that it used DOD funds to fulfill HRSA grant objectives for hospitals.

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INTRODUCTION

BACKGROUND

The Program

Since September 2001, HHS has significantly increased its spending for public health preparedness and response to bioterrorism. For FYs 2002 and 2003, HHS 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 Program Cooperative Agreement Guidance issued February 15, 2002. These awards provided funds for the development and implementation of regional plans to improve the capacity of hospitals, their emergency departments, outpatient centers, emergency management systems and other collaborating health care entities for responding to incidents requiring mass immunization, treatment, isolation and quarantine in the aftermath of bioterrorism or other outbreaks of infectious disease.

Annual Program Funding

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

Budget Restrictions

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

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

Eligible Recipients

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

District Funding

The following table details Program funding for budget year one:

Program Year 1 Amounts			
	Awarded	**Expended**	**Unobligated**
Year 1	$721,619	$ 82,732 [1]	$ 583,887 [1]

[1] These amounts are as of March 31, 2003 and were provided by the District. These amounts were not traced to the District's accounting records.

OBJECTIVE, SCOPE AND METHODOLOGY

Objectives

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

Scope

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

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

Methodology

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

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

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

FINDINGS AND RECOMMENDATIONS

Based on our validation of the questionnaire completed by the District and our site visit, we determined that the District generally accounted for Program funds in accordance with the terms and conditions of the cooperative agreement and applicable departmental regulations and guidelines. The District segregated expenditures by phase, within phase but not by priority area. Although segregation was not required, budget restrictions were specified in the cooperative agreement. The District reported that its accounting system has the capability to separately account for different funding sources, if necessary. However, due to the District's reliance on a waiver for meeting certain Program funding requirements initially granted and subsequently recinded by Health Preparedness, we have concerns regarding whether the District will be able to meet the requirement to allocate at least 80 percent of the Phase II funds to hospitals through written contractual agreements. Also, the District had not begun disbursment of funds awarded by HRSA to hospital sub-recipients as required by the cooperative agreement guidance.

The District had a reporting system to track and monitor sub-recipient activities. However, the District did not have a site visit component as part of the reporting system. We believe that a site visit component, combined with the reporting system, would provide adequate monitoring and oversight of District sub-recipients.

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

Accounting for Expenditures

An essential aspect of the Program is the need for the grantee to accurately and fully account for bioterrorism funds. Accurate and complete accounting of Program funds provides HRSA a means to measure the extent the program is being implemented and that the objectives are being met. Although the District was not required to segregate expenditures in the accounting system

by phase, within phase, or by priority area, there are budgeting restrictions set forth in the HRSA Program Cooperative Agreement Guidance and Summary Application Guidance for Award and First Allocation. Twenty percent of a grantee's total award will be made available in Phase I. 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, the Summary Application Guidance for Award and First Allocation states:

> ...Grantees will be required to allocate at least 80 percent 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....

Expenditures at the District were segregated in the central accounting system by phase and within phase, but not by priority area. Although segregation was not required, budget restrictions were specified in the cooperative agreement. Specifically, expenditures for health department infrastructure and planning were not to exceed 50 percent of Phase I and 20 percent of Phase II funds. The District reported that its accounting system has the capability to separately account for different funding sources, if necessary. Initially, due to the large amount of Department of Defense bioterrorism funding received by the District, Health Preparedness provided a waiver to the District for meeting the 80 percent requirement. In its June 20, 2002 letter granting the waiver, Health Preparedness stated "to enable DC to take advantage of this unique opportunity, HRSA will waive its requirement that 80% of its Phase II funds be used for implementation of hospital preparedness enhancements." The District relied on this waiver, when determining planned expenditures. However, according to District's Office of Emergency Health Administrative Officer, that waiver was subsequently rescinded. In response to our inquiry as to the amount of expenditures for Program funds, the District provided budget data for planned expenditures. Based on our review of the data we have concerns whether the District will be able to meet the requirement to allocate at least 80 percent of the Phase II funds to hospitals through written contractual agreements.

As of the date of our audit, the District had not disbursed funds awarded by HRSA to hospital sub-recipients as required by the cooperative agreement guidance. The District received funding of approximately $721,000 for the first year of the Program beginning April 1, 2003 and ending March 31, 2003. The ending date was subsequently extended to March 31, 2004. According to the questionnaire completed by the District, approximately $ 584,000 (81 percent) was unobligated as of May 31, 2003 due to delays in disbursement of Program funds to hospital sub-recipientsb

Sub-recipient Monitoring

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

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

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

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

The District had a reporting system to track and monitor sub-recipient activities. The Administrative office provided technical direction and programmatic, fiscal and quality assurance monitoring on a monthly basis of its sub-recipients by requesting itemized monthly reports. The District did not have a site visit component as part of the reporting system. We believe that a site visit component, combined with the reporting system, would provide adequate monitoring and oversight of the District sub-recipients.

Supplanting

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

> ...Given the responsibilities of Federal, State, and local governments to protect the public in the event of bioterrorism, funds from this grant must be used to supplement and not supplant the non-Federal funds that would otherwise be made available for this activity....

OMB Circular A-87 also states:

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

In response to our inquiry as to whether the District reduced funding to existing public health programs, District officials replied that HRSA funding had not been used to supplant existing

State or local programs for bioterrorism, infectious disease outbreaks, other public health threats and emergencies.

RECOMMENDATIONS

We recommend that the District:

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

2. ensure that at least 80 percent of the Phase II funds are allocated to hospitals in accordance with the cooperative agreement guidance, and expedite the disbursement of Program funds to hospitals.

3. consider implementing site reviews of Program funds to the current sub-recipient reporting system and address problem areas, as they are identified.

DISTRICT'S COMMENTS

In a written response to our draft report, the District concurred with our findings and our recommendations. However, in response to our second recommendation, the District stated that the balance of its Year 1 HRSA Funds would be allocated to hospitals through the purchase of a rash diagnostic system for each facility that will allow hospitals to diagnose rashes that may be related to biological or chemical weapons of mass destruction. Also, the District stated that it used DOD funds to fulfill HRSA grant objectives for hospitals. The District's response is included in its entirety as an appendix to this report.

OIG COMMENT

We are concerned with the District's response to our second recommendation. The District's planned purchase of rash diagnostic systems and subsequent transfer of the systems rather than HRSA funds to hospitals may not meet the intent of the HRSA cooperative agreement guidance. Prior to purchasing the rash diagnostic systems, the District should consult with HRSA to ensure that their purchase meets the intent of the guidance since it appears that the District has determined the need for the hospitals instead of allowing each hospital to determine its own need.

The District acknowledges in its response that *"seven to 28 percent of all visits to outpatient care clinics are for dermatologic of (sic) related conditions."* This appears to justify a need for the diagnostic rash systems unrelated to bioterrorism. Also, in it's response, the District is not clear on the amount of funding to be used for the systems and whether it has ensured that at least 80 percent of the Phase II funds are allocated to hospitals in accordance with the cooperative agreement guidance. The District needs to ensure that this requirement is met. This is especially concerning since the District states that it used DOD funds to fulfill HRSA grant objectives for hospitals.

APPENDIX

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

Office of the Director

January 8, 2004

Stephen Virbitsky
DHHS-OIG Office of Audit Services
150 South Independence Mall West, Suite 316
Philadelphia, PA 19106

RE: Report Number A-03-03-00386

Dear Mr. Virbitsky:

We are in receipt of the draft report on the results of your self-initiated review of the "District of Columbia's Efforts to Account For and Monitor Sub-Recipients' use of Bioterrorism Hospital Preparedness Program Funds." Your objective were to determine whether the District properly recorded, summarized and reported bioterrorism preparedness transactions in accordance with the terms and condition of the cooperative agreement and whether the District has established controls and procedures to monitor sub-recipient expenditures of HRSA funds. In addition, you inquired as to whether Program funding supplanted programs previously provided by other organization sources. The following is the District's response to your findings and recommendations.

Response to Findings and Recommendations:

Finding 1: The District segregated expenditures by phase and within phase, but not by priority area.

Recommendation: *Segregate Program Expenditures by phase, within phase, and by priority area.*

Response: Though the District has implemented expenditure tracking by phase and within phase, we are currently developing the process for tracking by priority area, as required under the grant for Year two.

Finding 2: Due to the District's reliance on a waiver for meeting certain Program funding requirements initially granted and subsequently rescinded by HHS, we

have concerns regarding whether the District will be able to meet the requirement to allocate at least 80 percent of the Phase II funds to hospitals through written contractual agreements. Also, the District had not begun disbursement of funds awarded by HRSA to hospital sub-recipients as required by the cooperative agreement guidance.

Recommendation: *Ensure that at least 80 percent of the Phase II funds are allocated to hospitals in accordance with the cooperative guidance, and expedite the disbursement of program funds to hospitals.*

Response: The provision of dermatologic and dermatologically related diagnostic capabilities is important to the District for weapons of mass destruction preparedness and medical standard of care capability in hospitals and clinics. Seven to 28 percent of all visits to outpatient care clinics are for dermatologic of related conditions. The balance of Year 1 Funds will be allocated to hospitals through the purchase of a rash diagnostic system for each facility. This system will allow hospitals to diagnose rashes which may be related to biological or chemical weapons of mass destruction

Further delay in expending this funding was due to the District's unique budget process. Congress must approve the District's budget as one of the 13 annual federal appropriations bills. Due to the FY 2003 Continuing Resolution, EHMSA did not have access to the full budget awarded by HRSA until March 2003. However, during that period, the Department of Health - EHMSA was fortunate to have access to the Department of Defense (DoD) fund, and used some of those funds to fulfill HRSA grant objectives for hospitals. The DOH received DoD funds of approximately $24 million. This one-time appropriation had to be spent by September 2003 and there are no opportunities to carryover those funds. DOH also has the ability to expeditiously disburse funds to hospitals through its sub grant process.

<u>Finding 3</u>: The District did not have a site visit component as part of the reporting system. We believe that a site visit component, combined with reporting system, would provide adequate monitoring and oversight of District sub-recipients.

Recommendation: *Consider implementing site reviews of program funds to the current sub-recipient reporting system and address problem areas, as they are identified.*

Response: With an increase in staffing, DOH will conduct site reviews in Program Year two. Problems will be addressed as they are identified and negotiated with sub-recipient for resolution.

I trust that this will address your findings and recommendations. If you have further questions please do not hesitate to call me at 202.442.5959.

Sincerely,

Ronald E. Lewis
Chief Operating Officer
District of Columbia
Department of Health