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COMPREHENSIVE PRIMARY AND PREVENTIVE CARE GRANT PROGRAM

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

PERFORMANCE AUDIT
JUNE 2003

Submitted to the Office of the State Auditor

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June 13, 2003

Members of the Legislative Audit Committee:

This report contains the results of a performance audit of the Comprehensive Primary and Preventive Care Grant Program within the Department of Health Care Policy and Financing. The Office of the State Auditor contracted with Pacey Economics Group to conduct this audit. The audit was conducted pursuant to Section 2-3-113, C.R.S., which requires the State Auditor to conduct or cause to be conducted program reviews and evaluations of the performance of each program funded by tobacco settlement monies to determine if that program is effectively and efficiently meeting its stated goals. The report presents our findings, conclusions, and recommendations, and the responses of the Department of Health Care Policy and Financing.

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REPORT SUMMARY

COMPREHENSIVE PRIMARY AND PREVENTIVE CARE GRANT PROGRAM

Department of Health Care Policy and Financing

Performance Audit
June 2003

Authority, Purpose, and Scope

This performance audit of the Comprehensive Primary and Preventive Care Grant Program (Program) was conducted under the authority of Section 2-3-113, C.R.S., which requires the State Auditor to conduct or cause to be conducted program reviews and evaluations of the performance of each tobacco settlement program to determine if that program is effectively and efficiently meeting its stated goals. The Office of the State Auditor contracted with Pacey Economics Group to perform this audit. The audit was conducted in accordance with generally accepted auditing standards. The audit work was performed between November 2002 and June 2003.

To evaluate the Program we gathered information through document review, interviews, site visits, and analysis of data. We also developed a questionnaire for the onsite visits to gather the responses of staff at some of the Program sites to a number of questions regarding the overall administration of the Program, the application process, budgeting issues, and reporting requirements.

We would like to acknowledge the efforts and assistance extended by the Department of Health Care Policy and Financing and the Program grant recipients.

Comprehensive Primary and Preventive Care Grant Program

The Comprehensive Primary and Preventive Care Grant Program is authorized by the addition of Part 10 to the Medical Assistance Act, Sections 26-4-1001 through 26-4-1007, C.R.S. The Program provides grants to health care providers in order to expand primary and preventive health care services to Colorado's low-income, uninsured residents.

Section 24-75-1104, C.R.S., established that this Program would receive six percent of the total amount of tobacco settlement monies annually received by the State although the amount appropriated to this Program shall not exceed $6 million in any fiscal year. Since

the inception of the Program in Fiscal Year 2001 through Fiscal Year 2003, the Department has awarded a total of $15.6 million in grant funding. In addition, the Department has pre-awarded $2.2 million and $1.2 million for Fiscal Years 2004 and 2005, respectively, (contingent upon the availability of funds). For Fiscal Years 2001 and 2002, a total of 14 contracts were awarded to 14 different health care providers while in Fiscal Year 2003 18 different contracts were awarded to 13 different health care providers.

Key Findings

Grant Award Process and Outcomes

- There are no quantitative benchmarks associated with the Program objectives making it difficult to evaluate the effectiveness of the Program as a whole. In addition, the Department reports that different methodologies were utilized for reporting the number of patients served between the first and second grant cycles, making it difficult to evaluate the actual number of clients served on a consistent basis. As such, the Department needs to develop examples of benchmark data and continue its efforts to improve the accuracy of reporting figures for the number of patients served to better evaluate the effectiveness of the Program as a whole.

- During our review we found that a few sites were not meeting their goals as outlined in their contracts and that negative consequences were not enforced for these sites. For example, for the grant period April 2001 to June 2002 one site was initially granted $612,175 (which was later amended to $582,175) to implement a startup program. The site had proposed serving 250 to 300 individuals over the course of the grant period. However, the site was unable to fill several personnel positions by the contracted time frame and experienced enrollment problems. Rather than reduce or cease funding to this site, the Department amended the site's contract, after the fact, to reflect the actual hiring dates of the personnel as outlined in a letter from the site to the Department. The site served only 48 clients, which is less than 20 percent of the number proposed, and as such, the actual cost per client served was about $12,100. We believe the Department should enforce its contract provisions regarding negative consequences (e.g., termination of the contract or withholding of payment) to prevent sites from continuing to spend money for a project that is not likely to achieve the underlying goals identified in the proposal. In addition, the contracts need to be written with deliverables that reflect the portion of the monies being spent by the State so that the scope of the grant work can be completed within one fiscal year or in established phases.

- The Department needs to improve feedback to the sites whose proposals were denied funding. Sites are not aware that the scoring sheets are available for review and the time frame for a site to grieve the award process is short.

- Section 26-4-1005(4), C.R.S., states that the Advisory Council should review applications and make award recommendations to the Department. The Department has established a three-person Application Evaluation Committee comprised of Department staff to perform these duties. The Department believes its process ensures that there are no conflicts of interest during the grant awarding process. The Department should consider working with the General Assembly to seek statutory clarification of the role of the Advisory Council.

Grant Disbursement, Expenditures, and Grantee Reporting

- The Department disburses grant funds to the sites in equal quarterly installments. There are two areas of concern arising from this method: the Department pays these installments regardless of how much money was actually spent, and the State unnecessarily loses interest earnings. The Department should pay the sites on a reimbursement of expenses basis and establish guidelines regarding interest earned on grant funds by the sites in the instances where upfront monies are paid to the sites. Any monies not expended by the grantees should revert back to the Tobacco Settlement Fund.

- Expenditure information provided by the sites in quarterly expenditure statements did not necessarily reconcile with the total grant award amount. In addition, the Department has not implemented audit procedures as required by Section 26-4-1005(5), C.R.S., which states that the Department shall develop "an audit procedure to assure that service grant moneys are used to provide and expand coverage to uninsured and medically indigent patients."

- Finally, we recommend that the Department change the structure of the quarterly reporting requirement so that sites can report current and updated figures and require that the sites submit a fiscal year-end budget to actual statement.

A summary of the recommendations and the Department's responses can be found in the Recommendation Locator on page 5. Our complete audit findings and recommendations and the responses of the Department of Health Care Policy and Financing can be found in the body of the audit report.

RECOMMENDATION LOCATOR

All recommendations are addressed to the Department of Health Care Policy and Financing

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
1	23	Continue to assess the grant awarding process to ensure that rural providers are fairly considered in the awarding of grants.	Agree	Implemented and Ongoing
2	27	Improve oversight and monitoring of the Program by: a. developing benchmark data and improving reporting methods to better evaluate the effectiveness of the Program; b. enforcing the contract provision regarding negative consequences if a project is not likely to achieve the underlying goals identified in the proposal; and c. ensuring that contracts are written so that the scope of grant work can be completed within one fiscal year or in established phases.	Agree	Implemented and Ongoing
3	29	Improve management of the Program by providing adequate feedback to the applicants upon denial of an application.	Partially Agree	Implemented and Ongoing
4	31	Consider working with the General Assembly to clarify statutory requirements regarding the Advisory Council's responsibility to review applications and make recommendations to the Department on grant awards.	Agree	2004 Session
5	35	Improve oversight of Program by: a. paying on a reimbursement of expenses basis; b. establishing guidelines regarding interest earned by sites on grant funds; and c. recovering monies not expended by grantees and reverting those funds to the Tobacco Settlement Fund.	Agree	Fiscal Year 2004
6	37	Develop audit procedures for the Program by: a. reconciling grant expenditures with the project's budget; and b. developing procedures to visit a sample of grantees and establishing a schedule by December 31, 2003 for periodic onsite audits.	Partially Agree	Fiscal Year 2004
7	38	Improve oversight and monitoring of the Program by: a. changing the structure of quarterly reports; and b. requiring sites to submit a budget-to-actual statement.	Agree	Fiscal Year 2004
8	40	Ensure that the files for applicants and grantees are complete by: a. maintaining copies of all proposals; b. including correspondence to and from the site following the signing of the contract; and c. including documents related to agreements during negotiations.	Agree	Implemented and Ongoing

Description of the Comprehensive Primary and Preventive Care Grant Program

Background on the Program

The Comprehensive Primary and Preventive Care Grant Program (Program) was established to provide grants to health care providers to expand primary and preventive care services to Colorado's low-income, uninsured residents. The Program is funded with monies received by the State under the Master Settlement Agreement. This Agreement was established to resolve all past, present and future tobacco-related claims at the state level.

The Program is authorized by the addition of Part 10 to the Medical Assistance Act, Section 26-4-1001through Section 26-4-1007, C.R.S., and is intended to increase medical services to low income individuals who are not eligible for other governmental programs or private insurance. The statute defines "comprehensive primary care" as the basic, entry-level health care provided by health care practitioners or non-physician health care practitioners that is generally provided in an outpatient setting and states that the grants shall be used only to:

- increase access to comprehensive primary care services for uninsured or medically indigent patients who are served by such providers;
- create new services or augment existing services provided to uninsured or medically indigent patients; or
- establish new sites that offer comprehensive primary care services in medically underserved areas of the state or to medically underserved populations.

The Program rules state that, in addition to the above uses, grant monies can also be utilized to maintain increased access, capacity or services previously funded by Comprehensive Primary and Preventive Care Grants.

According to the statute, grant monies shall not be used:

- to supplant federal funds traditionally received by such qualified providers, but shall be used to supplement such funds;
- for land or real estate investments;
- to finance or satisfy any existing debt; or
- unless the qualified provider specifically complies with the definition of qualified provider contained in Section 26-4-1003 (5), C.R.S.

As described above, only health care providers who meet the qualifications outlined in the statute are eligible to receive grants. Section 26-4-1003(5), C.R.S., states that a qualified provider is one that provides comprehensive primary care services and that:

- accepts all patients regardless of their ability to pay and uses a sliding fee schedule for payments or that provides comprehensive primary care services free of charge;
- services a designated medically under served area or population, as provided in Section 330(b) of the federal "Public Health Service Act", 42 U.S.C. Sec. 254b, or demonstrates to the state department that the entity serves a population or area that lacks adequate health care services for low-income, uninsured persons;
- has a demonstrated track record of providing cost-effective care;
- provides or arranges for the provision of comprehensive primary care services to persons of all ages; and
- completes initial screening for eligibility for the state Medical Assistance Program, the Children's Basic Health Plan, and any other relevant government health care program and referral to the appropriate agency for eligibility determination.

An uninsured or medically indigent patient is defined in Section 26-4-1003(7), C.R.S., as a patient whose family income is below two hundred percent of the federal poverty level and who is not eligible for Medicaid, Medicare, or any other type of governmental reimbursement for health care costs. In addition, the patient must not be receiving third-party payments such as private health insurance. For 2003, the federal poverty level for a

family of four in the 48 contiguous states is $18,400. As such, a family of four with an annual household income less than $36,800 would be eligible for services under a grant from this Program. Although this Program is not part of the Colorado Indigent Care Program (CICP), it is closely related, as the two programs serve a similar population and according to the Department of Health Care Policy and Financing, many of the qualified providers under the Comprehensive Primary and Preventive Care Grant Program also participate in CICP.

Agencies Monitoring the Program and Grantees

This section briefly describes the departments involved with the administration and evaluation of the Comprehensive Primary and Preventive Care Grant Program as well as the local sites that receive the grants and provide medical services directly to the uninsured, medically indigent population.

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

THE DEPARTMENT

The Department of Health Care Policy and Financing (Department) became responsible for the Comprehensive Primary and Preventive Care Grant Program on July 1, 2000, the date the Program was established. Initially, the Department developed rules and appointed an Advisory Council. In addition, the Department is also responsible for overseeing the development of the grant application, reviewing the proposals for minimum requirements, writing contracts with qualified providers, reviewing progress reports, and paying of award monies to the grantees. The Executive Director of the Department makes the final decision regarding grant awards to applicants based on recommendations from a committee. The statute also states that the Department shall develop an audit procedure to assure that service grant monies are used to provide and expand coverage to uninsured, medically indigent patients.

MEDICAL SERVICES BOARD

The Medical Services Board was created as of July 1, 1994. The 11-member board is appointed by the Governor and confirmed by the Senate. The Board has the authority to adopt rules to govern the Colorado Medicaid program and the Children's Basic Health Plan, marketed as Child Health Plan Plus program, and also has authority over the medically indigent, adult foster care and home care allowance programs. Section 26-4-1005(1), C.R.S., instructs the Medical Services Board to adopt rules for implementation of the Comprehensive Primary

and Preventive Care Grant Program with regard to grant procedures and other criteria. Rules for this Program were heard by the Medical Services Board in October and November 2000 and became effective January 1, 2001. Changes to these rules were adopted to reflect the modifications that were made to the enabling statute during the 2001 legislative session as well as the recent change from a Request for Proposal (RFP) process to an application process for Program grant awards.

ADVISORY COUNCIL

Section 26-4-1005(4)(a), C.R.S., requires that the Executive Director of the Department of Health Care Policy and Financing appoint an Advisory Council to review and make recommendations on the awarding of any service grants under this Program to qualified providers. The Department has appointed the Advisory Council and has given the Council other duties, which include providing input regarding Program rules and providing assistance in the development of the grant application. The Council has also provided ongoing assistance in amending the application as well as establishing guidelines regarding the maximum grant amounts for different types of projects. The statute states that the Advisory Council will consist of the following members:

- one employee of the Department;
- one employee of the Department of Public Health and Environment;
- a representative of a qualified provider;
- two consumers who currently receive health care services from a qualified provider;
- a health care provider who is not affiliated with a qualified provider or an agency of the state, but who has training and expertise in providing comprehensive primary care services to medically under served populations; and
- a representative of a nonprofit, community-based health care organization or business.

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

The Colorado Department of Public Health and Environment is responsible for monitoring the operation and effectiveness of programs receiving tobacco settlement funds. Pursuant to Section 25-1-108.5, C.R.S., the Colorado Department of Public Health and Environment must receive an annual report from each of the eight tobacco settlement programs. This Department then submits a

combined annual report to the General Assembly and others which provides information on the amount of tobacco settlement money received by each tobacco settlement program, a description of the program, and an evaluation of the program's effectiveness in achieving its stated goals.

STATE BOARD OF HEALTH

The State Board of Health consists of nine members appointed by the Governor and confirmed by the Senate. The duties of the State Board of Health include making recommendations concerning funding decisions for tobacco settlement programs.

GRANTEES

The grantees under the Comprehensive Primary and Preventive Care Grant Program are, for the most part, community/family health clinics that specialize in providing medical and dental care to medically indigent individuals. In addition, a school-based health center and a facility that serves the homeless population have received grants. The majority of the qualified providers that have received funding to date are federally qualified health centers (FQHCs), a federal designation for providers under the Medicare laws, who are members of the Colorado Community Health Network (CCHN), an association representing community health centers since 1982.

Program Funding

This section describes how the Program is funded and provides background information on the grant awards made since the inception of the Program.

FUNDING TO THE PROGRAM

Section 24-75-1104, C.R.S., sets forth the funding formula that is used to determine annual appropriation amounts for all tobacco settlement programs, including the Comprehensive Primary and Preventive Care Grant Program. This Program receives six percent of the total amount of tobacco settlement monies annually received by the State except that the amount appropriated to this Program shall not exceed $6 million in any fiscal year. The Department may retain up to one percent, or up to $60,000, of the amount annually appropriated for the actual costs incurred by the Department in implementing and administering this Program.

The majority of the monies appropriated for this Program are utilized for grants to qualified providers. Since the inception of the Program through Fiscal Year 2003, about $15.8 million has been appropriated for the Program and about $15.6 million has been

awarded in grants. The Department has budgeted about $74,400 in total for administration over the period. Table I identifies the budget for the Comprehensive Primary and Preventive Care Grant Program for each fiscal year.

Table I. Comprehensive Primary and Preventive Care Grant Program Appropriation by Fiscal Year

	FY 2001	FY 2002	FY 2003
Awards	$4,598,992	$5,131,389	$5,854,153
Administrative	$4,635	$10,627	$59,131
Tobacco Settlement Trust Reversion	$147,861		
Other[1]		$14,516	$25,763
Total Appropriation	**$4,751,488**	**$5,156,532**	**$5,939,047**

Note: These figures do not reflect the decrease of $679,130 in appropriation for Fiscal Year 2003 enacted by the General Assembly in the 2003 legislative session.

[1] *These amounts include appropriations for the Stroke Prevention Board, the Department of Public Health and Environment, and the Office of the State Auditor.*

Source: Comprehensive Primary and Preventive Care Grant Program Fiscal Year 2001-02 Annual Report, issued November 2002.

GRANT AWARDS

For the first two grant cycles, the Department issued a Request for Proposal (RFP) under the State procurement process to award grants to local sites. However, the RFP process did not allow the Department to interact with the local sites until after the awards are made. Therefore, the Department decided that an application process would be more appropriate for Fiscal Year 2004 so the rules governing the Program were modified to reflect this change. As such, grants will be awarded through an application process for Fiscal Year 2004 and beyond.

The monies available for awards for the first two Fiscal Years, 2001 and 2002, were combined and the contracts were written for a 15-month period that ended June 30, 2002. Therefore, the Department awarded $9.7 million in grants from April 2001 through June 2002. For Fiscal Year 2003, due to statewide budget constraints, approval for awarding grants was delayed and, therefore, contracts were not awarded until September 1, 2002 and they continue through June 30, 2003. As such, the Department made the decision to prorate the amount of grant awards for projects requesting monies for operations for the 10-month contract period. This allowed the Department to allocate grant monies for two additional proposals. In total, the Department awarded about $5.9 million to grantees in Fiscal Year 2003.

After the first distribution of grant monies in Fiscal Years 2001 and 2002, the Department realized that providing funding for start-up projects for only one year could make it difficult for the facility to maintain a program beyond the term of the grant. Therefore, for Fiscal Year 2003, the RFP provided an opportunity to request funding for a project for up to three years, but at a decreasing amount over those three years. This allows sites some continued funding to sustain a project while they pursue other funding sources. Therefore, the State has pre-awarded $2.2 million and $1.2 million for Fiscal Years 2004 and 2005, respectively. As such, the State has awarded a total of $18.9 million in grants since the inception of the Program, although the pre-awarded amounts are contingent upon the availability of future funds. Table II identifies each provider's funding since the inception of the Comprehensive Primary and Preventive Care Grant Program.

Table II. Comprehensive Primary and Preventive Care Grant Program Funding by Health Care Provider

Health Care Provider	Service Location	FY 2001 & FY 2002 (4/01-6/02)	FY 2003 (9/02-6/03)	Amount Pre-Awarded	Total
Catholic Health Initiatives	Pueblo/ Denver	$141,520	$840,364	$532,836/FY 04 $150,000/FY 05	$1,664,720
Clinica Campensina Family Health Services	Thornton/ Lafayette	$525,955	$500,000		$1,025,955
Colorado Coalition for the Homeless	Denver	$899,020	$440,000	$250,000/FY 04 $150,000/FY 05	$1,739,020
Columbine Family Health Center	Glenwood Springs/ Nederland	$358,661	$436,535		$795,196
Community Health System	Colorado Springs	$900,000			$900,000
Denver Health and Hospital Authority	Denver	$582,175			$582,175
Inner City Health Center	Denver	$282,819	$439,262	$383,662/FY 04 $290,170/FY 05	$1,395,913
Marillac Clinic	Grand Junction	$870,000	$600,000	$500,000/FY 04 $300,000/FY 05	$2,270,000
Metro Community Provider Network	Lakewood/ Englewood	$900,000	$500,000	$250,000/FY 04 $150,000/FY 05	$1,800,000
Parkview Medical Center	Pueblo	$690,931			$690,931
People's Clinic	Boulder		$246,925		$246,925
Plan De Salud del Valle	Frederick/ Longmont	$900,000	$500,000	$250,000/FY 04 $150,000/FY 05	$1,800,000
Pueblo Community Health Center	Pueblo	$898,600	$424,917		$1,323,517
Sunrise Community Health Center	Greeley	$880,700	$415,000		$1,295,700
Uncompahgre Medical Center	Norwood		$175,000		$175,000
University of Colorado Hospital	Aurora		$336,150		$336,150
Valley-Wide Health Services	Durango (several counties)	$900,000			$900,000
	Total:	**$9,730,381**	**$5,854,153**	**$2,166,498/FY04 $1,190,170/FY05**	**$18,941,202**

Note: These figures do not reflect the decrease in appropriation of $679,130 for Fiscal Year 2003 enacted by the General Assembly in the 2003 legislative session under Senate Bill 03-190. The Department is in the process of renegotiating contracts with each of the sites to decrease the funding to each site for Fiscal Year 2003.

Source: Comprehensive Primary and Preventive Care Grant Program Fiscal Year 2001-02 Annual Report, issued November 2002.

The number of contracts awarded grew from the first grant cycle to the second grant cycle. For Fiscal Years 2001 and 2002, a total of 14 contracts were awarded to 14 different health care providers, while in Fiscal Year 2003 18 different contracts were awarded to 13 different health care providers. It should be noted that although the number of contracts grew, the amount of money granted actually decreased from $9.7 million to $5.9 million and the upper limit on individual award amounts was decreased from $900,000 to $500,000.

Program Status

According to Section 26-4-1006, C.R.S., the Department shall submit a report on or before January 1st of each year describing the operation and the effectiveness of the Program. The Department's most recent annual report, issued in November 2002, provides a summary of operations since the inception of the Program and reports on the accomplishments of the Program. These accomplishments are summarized in Table III below.

Table III. Data for Comprehensive Primary and Preventive Care Grant Program

	FY 2001 & FY 2002 (4/01-6/02)	FY 2003 (7/02-6/03)[1] projected
Medical Services		
Number of patients	41,986	11,775
Number of visits or encounters	76,178	N/A[2]
Dental Services		
Number of patients	5,242	1,550
Number of visits or encounters	11,654	N/A[2]
Total Number of Construction Projects	11	8
Number of remodels	8	N/A[2]
Number of new buildings	3	N/A[2]

1. *Due to delays in approvals, grantees did not begin to receive award monies until September 2002.*
2. *Projected numbers not available from the Department of Health Care Policy and Financing.*

Source: Comprehensive Primary and Preventive Care Grant Program Fiscal Year 2001-02 Annual Report, issued November 2002.

The Department indicates that a direct comparison cannot be made between the number of patients who received services in the first grant period and the projected number of patients to receive services in the second grant period for several reasons. First, the contracts covered different time frames. During the first grant cycle, the contracts covered 15 months while for the second grant cycle, contracts covered 10 months. Second, the definition of the numbers that the Department requested that the sites report changed from the first grant period to the second. For the first grant period, the Department asked for the number of patients served or services provided that were directly attributable to the Comprehensive Primary and Preventive Care Grant funds. In the second grant cycle, the Department asked for the sites to report specifically on the increased number of patients served (i.e., only new patients) with grant funds.

Department staff report that they have recently been further refining the wording in their requests to the sites for reporting of patients served and patient visits. They anticipate that this will provide them with more comparable numbers on a year-to-year basis. Department staff indicate that they plan to request that sites that received grants in the past provide them with numbers using the new definitions. This should provide the Department with comparable yearly numbers from the inception of the Program.

Legislative Changes

Three Senate Bills, enacted in the 2003 legislative session, impact this Program. The first bill, Senate Bill 03-190, decreases the total appropriation to the Comprehensive Primary and Preventive Care Grant Program in Fiscal Year 2003 by $679,100, an 11.4 percent decrease in the original appropriation. Because the Department awarded grants for the full amount of the original appropriation, this decrease requires the Department to renegotiate the current contracts with the sites. Department staff indicate that they plan to reduce each site's grant by the same percentage amount (approximately 11.4 percent).

The second bill enacted by the General Assembly in 2003, Senate Bill 03-013, clarifies language in the enabling statute regarding the types of services, hours and referral systems that a provider must have to qualify for grants under this Program. In addition, this bill specifies that the Department and the Advisory Council shall consider geographic distribution of funds among urban and rural areas when awarding grants under this Program.

Finally, the Fiscal Year 2004 appropriation to the Comprehensive Primary and Preventive Care Grant Program was about $5.4 million.

Audit Scope and Methodology

We reviewed documentation and interviewed personnel associated with the Comprehensive Primary and Preventive Care Grant Program at the Department of Health Care Policy and Financing with respect to Program policies, procedures, operations, and oversight. We interviewed individuals from 8 of the 17 different local sites and conducted a survey of the staff at these sites, which included a number of questions regarding the overall administration of the Program, the application process, budgeting issues, and reporting requirements. The following chapters describe in detail the major audit findings and the corresponding recommendations resulting from our audit.

Grant Award Process

Chapter 1

Background

The process of awarding grants begins with the release of the application (Request for Proposal in Fiscal Years 2001/2002 and 2003) which is developed by the Department and the Advisory Council. To be considered for a grant award, sites submit a detailed proposal describing their facility, the proposed project or operations, and the intended population to be served. These proposals are reviewed for minimum qualifications and are then scored according to guidelines developed by the Department and the Advisory Council. Once scored, the proposals are ranked from highest to lowest and grants are awarded to the higher scoring proposals until funds have all been expended.

We reviewed the process for awarding grants and found issues associated with the distribution of the awards, the outcomes associated with the grants, and the application process itself.

Geographic Distribution of Awards

We reviewed the geographic distribution of the awards granted to date. Senate Bill 03-013, recently enacted, requires that the Advisory Council and the Department consider the geographic distribution of funds among urban and rural areas in the State when making funding decisions. As such, we analyzed the statewide distribution of grant monies awarded since the inception of this Program.

We divided the State into several regions based on population centers and counties served by the various grantees and compared the grant awards to the estimated percentage of uninsured individuals in each region. Estimates for the percentage of uninsured individuals per county were obtained from the 2001 Colorado Health Data Book issued by the *Colorado Coalition for the Medically Underserved*. Given that it is difficult to develop accurate uninsured data at the county level because of sample size problems, three methods were presented in the 2001 Colorado Health Data Book. The first is based on unemployment data as a proxy for uninsured rates. The second estimate cited by the 2001 Colorado Health Data Book is based on a model which developed uninsured rate estimates at the county level related to key demographic data for counties such as poverty rates, ethnicity data. The third method estimates uninsured rates based on actual responses to a survey developed by the Colorado Department of Public Health and Environment. However, the survey did not provide estimates for counties which had

fewer than 50 survey respondents. Therefore, we utilized an average of the first two estimates to identify the percentage uninsured in each county. The percentages were then applied to county population estimates for July 2001 provided by the Colorado Demography Section to obtain the percentage of the State's population that was uninsured in each region.

Table IV below summarizes the results of our analysis. The table shows the amount of grant monies requested and awarded for each region of the State. In addition, the percent of the total grant monies awarded and the percent of total estimated uninsured are provided for each region. The table does not include monies that have been pre-awarded for Fiscal Year 2004 and 2005 as the pre-awarded monies represent only a portion of the monies that will be granted to the sites during the upcoming fiscal years. As can be seen from Table IV, there are two regions of the State (Northeast and Northwest) in which there were no providers that submitted proposals and, as such, no grants were awarded in those regions. The Southeast regions requested $1.8 million but was not awarded a grant.

Table IV. Distribution of Comprehensive Primary and Preventive Care Grant Monies Among State Regions (April 2001 – June 2003)

		Grant Awards			Estimated Uninsured	
Region	**Counties**	**Amount Requested[1]**	**Amount Awarded[1,2]**	**Percent of Total Awarded**	**Number**	**Percent of Total Uninsured**
Denver-Boulder Metro Area	Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson	$10,251,925	$6,792,670	43.6%	314,117	51.8%
Southern Front Range	El Paso, Park, Pueblo, Teller	$4,925,066	$3,555,968	22.8%	107,426	17.7%
Northern Front Range	Larimer, Weld	$2,380,700	$2,195,700	14.1%	66,835	11.0%
West	Delta, Mesa, Montrose	$1,598,700	$1,470,000	9.4%	28,992	4.8%
Mountain	Clear Creek, Garfield, Gilpin, Eagle, Pitkin, Summit	$523,161	$495,196	3.2%	18,592	3.1%
Northeast	Logan, Morgan, Phillips, Sedgwick, Washington, Yuma	$0	$0	0%	10,664	1.8%
Northwest	Grand, Jackson, Moffat, Rio Blanco, Routt	$0	$0	0%	7,573	1.2%
Southwest	Alamosa, Archuleta, Chaffee, Conejos, Costilla, Custer, Dolores, Fremont, Gunnison, Hinsdale, La Plata, Lake, Mineral, Montezuma, Ouray, Rio Grande, Saguache, San Juan, San Miguel	$2,390,800	$1,075,000	6.9%	33,542	5.5%
Southeast	Baca, Bent, Cheyenne, Crowley, Elbert, Huerfano, Kiowa, Kit Carson, Las Animas, Lincoln, Otero, Prowers	$1,833,444	$0	0%	18,812	3.1%
	Total	$23,903,796	$15,584,534	100%	606,553	100%

Notes:

1. *Amounts were assigned to a certain region based on where the majority of the monies were proposed to be spent.*
2. *These figures do not reflect the decrease in appropriation of $679,130 for Fiscal Year 2003 enacted by the General Assembly in the 2003 legislative session under Senate Bill 03-190. The Department is in the process of renegotiating contracts with each of the sites to decrease the funding to each site for Fiscal Year 2003.*

Source: Pacey Economics Group's analysis of 2001 population data from the Colorado Demographer's Office, the 2001 Colorado Health Data Book, and the Comprehensive Primary and Preventive Care Grant Program Fiscal Year 2001-02 Annual Report, Issued November 2002.

It should be noted that the 2001 Colorado Health Data Book reports it is extremely difficult to obtain good estimates of uninsured rates at the county level and the estimates provided have extremely wide confidence intervals. As such, the information provided in the table above should be utilized with this in mind. In addition, these figures do not break down the uninsured by income level. Therefore, Table IV above may include additional individuals that are not eligible for services under this Program.

In addition to the analysis described above, we reviewed the application process itself to determine if rural areas were at a disadvantage in the process. The application developed by the Department and the Advisory Council does provide some assistance to rural providers. First, the application is scored on the percentage of uninsured, medically indigent population served by a provider and not on the actual number of patients served. That is, rural locations that serve a smaller total number of patients are not necessarily at a disadvantage in terms of this section of the application as long as they serve the same percentage of uninsured, medically indigent individuals as a larger, more urban location. Second, the most recent application for Fiscal Year 2004 allows evaluators to add up to 10 extra points if the applicant is proposing to serve a rural area. These 10 points are related to the size of the city's population. For example, if the proposal intends to serve a city with a population of 4,999 or fewer, the proposal would receive 10 extra points. If the applicant intends to serve a town with a population of 5,000-9,999, the proposal would receive nine extra points and so on. The lowest additional point available (one point) is for a city size of 45,000-50,000 residents.

The 10-point addition will assist rural locations somewhat although it will not dramatically impact their scores. The total available points in this application process is 500 (with rural sites having up to 510 points). The evaluators score the proposals based on a scoring sheet developed by the Advisory Council and the Department. Once the proposals are scored, they are ranked in order of highest to lowest points and the higher scores are funded until all of the available monies have been granted. For a proposal to receive a score of 500, the evaluators must give each and every portion of the application the highest score. The total points for all of the proposals submitted in Fiscal Year 2003 ranged from 292 to 437.33. Applicants who scored above 379 were funded. Therefore, if a rural site's proposal was at the very bottom of the range, the additional 10 points would not be enough to place it high enough for it to be funded. However, in Fiscal Year 2003 one rural applicant scored just below the 379-point level and would have received grant monies had they received the full ten additional points. (It should be noted that this point level threshold above which applicants are funded varies from year to year depending upon several factors including total funding available, each applicant's score, and the dollar amount requested in each of the proposals.)

Although the application does provide some assistance to rural providers, we believe that in light of Senate Bill 03-013, the Department should continue to reassess its grant awarding process to ensure that rural providers are fairly considered in the awarding of

grants. This could include interviewing rural providers to obtain their input regarding the application and grant awarding process and providing feedback on ways to help these providers improve their grant applications.

Recommendation No. 1:

The Department of Health Care Policy and Financing should continue to reassess its grant awarding process to ensure that rural providers are fairly considered in the awarding of grants.

Department of Health Care Policy and Financing Response:

Agree. The Department is continuously examining ways to support rural health care providers. Unfortunately, in rural areas there are few providers qualified to apply for the Comprehensive Primary and Preventive Care (CPPC) grant funding. The Department has already implemented steps that indicate an awareness of the differences in county demographics, but will not grant funding solely based on the provider's location. The quality of the proposal and the project must remain the focus of the grant awards. In addition to what is stated in the audit narrative, the Department has solicited feedback from the CPPC Advisory Council as to the necessary information to be requested in the application. This input has been utilized to formulate and assign point values to questions on the application. A member of the CPPC Advisory Council represents a rural qualified provider and, therefore, provides insight and suggestions pertaining to rural providers' needs and concerns. Also, for the most recent application process, the Department made itself available to address questions or comments on the application by holding two pre-bid conferences and one application workshop. Detailed notes were taken at the pre-bid conferences and workshop which were then made available to all interested parties via the Department's website. Of course the Department will comply with SB 03-013, enacted by the General Assembly in the 2003 legislative session and signed by the Governor in April 2003, after the majority of this audit was completed.

Implementation Date: Implemented and ongoing

Program Outcomes

Section 2-3-113(2), C.R.S., requires that the Office of the State Auditor determine whether the programs funded by the Tobacco Settlement monies, including the

Comprehensive Primary and Preventive Care Grant Program, are effectively and efficiently meeting their stated goals. To do this, we reviewed the Department's files, interviewed Department staff, and interviewed staff at the local sites. We have identified the goals of the Program by referring to the Program rules, which state that the Program grants shall be used to:

1) increase access to comprehensive primary care services for uninsured or medically indigent patients who are served by such providers;

2) create new services or augment existing services provided to uninsured or medically indigent patients; or

3) establish new sites that offer comprehensive primary care services in medically underserved areas of the state or to medically underserved populations;

4) maintain increased access, capacity or services previously funded by Comprehensive Primary and Preventive Care (CPPC) Grants.

It appears that the Program has been administered such that the grant recipients represent a wide variety of projects that have addressed the Program goals stated above. For instance, the projects have included expanding medical and dental services, new construction, remodeling existing buildings, purchasing equipment, developing a diabetic clinic, providing pharmaceutical services.

However, there are no quantitative benchmarks attached to the objectives noted above. Without specific benchmarks, it is difficult to quantify the effectiveness of the Program. Possible benchmarks could include estimates of the percentage of the target population being served and/or cost per patient figures for the variety of services offered. The variation in different types of projects funded by this Program likely lends itself to evaluating a number of comparative measures to demonstrate that the Program is effectively addressing the goals of the legislation. At a minimum, the Department could estimate the percent of the uninsured population it serves with CPPC monies once definitive patient count data is obtained (as discussed below). Furthermore, an evaluation could be performed to analyze cost per client information, recognizing that there may be the need to categorize costs by type of service provided, such as routine medical or dental services, patients served in diabetic clinics. Due to the variation in the services provided from site to site and project to project, it may be more relevant for the Department to identify a reasonable range of cost per client figures that broadly represents the variety of services offered.

We recognize that the unique structure of this Program and the variety of projects funded do not lend to the use of one broad benchmark measure to evaluate the effectiveness of

the Program. However, the Department staff and the Advisory Council could utilize their public health expertise to select measures which demonstrate the effectiveness of the Program, i.e. measures which demonstrate that the Program is improving the health of individuals in the community in a cost-effective manner. Of course, the Department and the Advisory Council would have the knowledge and flexibility to determine which measures would best represent the projects funded by CPPC grants.

In addition, the Department also reported that different methodologies were utilized for reporting number of patients served between the first and second grant cycles. The Department noted in their 2001-2002 Annual Report that at least 41,986 patients had received medical services, and at least 5,242 had received dental services through Fiscal Year 2002. During this first cycle (through Fiscal Year 2002), sites reported on the number of patient served that could be directly attributed to CPPC funding. As a result, this measure did not necessarily reflect additional patients served, as certain patients could have already been receiving services from the provider, and would not be a new or additional patients served because of CPPC funding. For Fiscal Year 2003, the Department has projected that the Program will serve an additional 11,775 medical patients, and 1,550 dental patients. Obviously, this estimate of the population served is much less than that reported through Fiscal Year 2002, largely because of the difference in methodologies used to calculate the figures. In addition, the contracts for the first grant cycle covered 15 months, while the second cycle covers only 10 months.

As mentioned previously, Department staff report that they have recently been working to further define the wording in their requests to the sites for reporting of patients served and patient visits and that they plan to request that sites that received grants in the past provide them with numbers using the new definitions. This should provide the Department with comparable yearly numbers from the inception of the Program.

Finally, Section 26-4-1006(2), C.R.S., requires that each "qualified provider receiving a service grant shall report annually to the state department concerning the number of additional uninsured and medically indigent patients that are cared for and the types of services that are provided." Department staff indicated that they use the information provided in the sites' final quarterly reports for the annual reporting figures required by statute and also use that same information in their required annual report to the State Board of Health and the Colorado Department of Public Health and Environment. We reviewed the quarterly progress reports and expenditure statements from the 14 grantees during the first grant cycle from April 2001 through June 2002 and found that the Department does not require accurate reporting of outcomes or expenditures for the entire grant period. As such, we believe that the Department is not fully complying with the requirements outlined in the statute.

We recommend that the Department develop examples of benchmark data that could be used to evaluate the effectiveness of the Program as a whole. The Department also needs

to continue its efforts to improve the consistency and accuracy of reporting figures for number of patients served, as well as ensuring that data collected reflects the entirety of the grant period. Until these tools are in place, we believe it is difficult to properly measure the efficiency and effectiveness of the Program.

We also examined the success of the grantees in meeting the goals outlined in their respective contracts. We found that a few sites were not meeting their goals as outlined in their contracts and that negative consequences associated with this were not enforced. For example, for the grant period April 2001 to June 2002 (15 months) one site was initially granted $612,175 to implement a startup program. (This award contract was amended in November 2001 to decrease the grant by $30,000 to reflect a lower appropriation to the Program than had been projected.) The site had proposed serving 250 to 300 individuals over the course of the grant period by providing transitional case management for inmates with chronic medical conditions by connecting them with primary care providers in the community. The contract specified that the site would hire various personnel for the case management program by certain dates. However, the site experienced hiring difficulties and was unable to fill several positions by the contracted time frame. Rather than reduce or cease funding this program, the Department amended the site's contract, after the fact, to reflect the actual hiring dates of the personnel as outlined in a letter from the site to the Department. In addition to the hiring difficulties, this site also experienced enrollment problems. These two difficulties resulted in the site serving only 48 clients which is less than 20 percent of the number proposed. The actual cost per client served was about $12,100. Therefore, we believe that the site was unsuccessful in cost-effectively serving the intended population. The Department states that they were obligated to pay the site the full amount ($582,175) because the site had met all of the goals as outlined in the contract. However, the site succeeded in fulfilling the scope of work in the contract because the Department amended the contract to reflect the actual hiring dates. The Department should enforce the negative consequences of the contract (e.g., termination of contract or withholding of payment) rather than rewriting contracts to reflect actual events.

A few of the sites had deliverables in their contracts that could not be completed in one fiscal year. For example, with construction projects it is sometimes difficult to obtain suitable architectural drawings, procure the necessary permits and construct the building all in one fiscal year. However, it appears that the State is rarely the only source of funding for construction projects and, therefore, the contracts need to be written with deliverables that reflect the portion of the construction project that the State is paying for. That is, if the grant through the Comprehensive Primary and Preventive Care Grant Program is for only half of the total funding needed to construct a new facility, having the contract require that the entire building be built puts an unfair burden on the site. The Department needs to include deliverables in a site's contract that reflect the portion of monies being spent for the project. For construction projects this may include items such

as obtaining architectural drawings or pouring the foundation rather than the completion of a new building.

Recommendation No. 2:

The Department of Health Care Policy and Financing should improve its oversight and monitoring of the Comprehensive Primary and Preventive Care Grant Program by:

a. developing benchmark data and improving the consistency and accuracy of reporting figures to better evaluate the effectiveness and efficiency of the Program as a whole;

b. enforcing the contract provisions regarding negative consequences (e.g., termination of the contract or withholding of payment) to prevent sites from continuing to spend money for a project that is not likely to achieve the underlying goals identified in the proposal;

c. ensuring that contracts are written so that the scope of the grant work can be completed within one fiscal year or in established phases.

Department of Health Care Policy and Financing Response:

Agree. The Department and the CPPC Advisory Council will continue to examine developing benchmark data and improving the consistency and accuracy of reporting figures to better evaluate the effectiveness and efficiency of the CPPC Grant Program as a whole. Due to the multiple variables that occur between the projects from contract to contract and year-to-year, there is not a benchmarking system that would uniformly measure performance of such disparate proposals; therefore, specific recommendations have not been useful for that reason. What is established one year as a benchmark for the Program would not necessarily apply to the next year because the nature and quantity of the projects awarded will probably be different. Each contract is monitored to its individual performance commitments. The Department has already implemented new language in the contract to better measure the number of individuals directly served with CPPC grant funds. At the discretion of the Department, the contract issue cited in this audit report was resolved in a series of complex negotiations over several months. The provider completed the scope of work stated in the contract. The Department currently monitors all grantees' performances and, as circumstances dictate, enforces negative consequences. If a provider is unable to fulfill any portion of the contract then money will be withheld or the contract terminated, as is standard contract management by the Department. Also, the Department currently negotiates the contract deliverables with more specific goals

and more specified timeframes in order to pinpoint completion dates in accordance with the State fiscal year.

Implementation Date: Implemented and ongoing

Application Process

We reviewed the Department's process of awarding grants and found that the Department does not provide feedback to the sites if their application is denied and does not comply with statutory requirements regarding the review of applications.

The first issue associated with the application process involves feedback from the Department to the sites whose proposals were denied. Sites that were denied funding in prior fiscal years received a form letter informing them of the denial of any grant monies. However, there was no further explanation of the reasons for the denial of the site's proposal or guidance for areas to improve upon in future applications. During our visits with staff at the sites, several sites stated that they did not receive any feedback from the Department regarding their proposal.

Department staff indicate that they provide assistance to the sites by providing workshops as well as question and answer sessions during the proposal preparation. However, our concern is that there is no feedback to the sites once the proposal has been evaluated.

Department staff state that the sites have the opportunity to review the scoring sheets and file a grievance if they have an issue with the scoring procedure. We reviewed the letters that have been sent to the sites regarding the awarding or denying of proposals and found two issues with the Department's method. First, the most recent letter sent to the sites on May 14, 2003 discussing the awards for Fiscal Year 2004 does not mention that the sites have the right to review the scoring sheets and where they can go to do so. Second, the May 14, 2003 letter states that the sites have five business days after receipt of notification to file a grievance in writing. The time frame for grieving the award decision is short and, therefore, to make it the site's responsibility to obtain a copy of the scoring sheet seems unreasonable.

We also believe that feedback to the site is important for assisting sites in developing future applications. This may be especially helpful to rural sites as they often do not have a professional grant writer on staff. During our review of the application and scoring process we found at least two instances in which feedback from the Department regarding a proposal would likely assist the sites when submitting future applications. In Fiscal Year 2002, one site's proposal was determined by the Department to not contain

enough information to even be scored by the evaluators. That is, the application was not complete enough for the Department to have a good understanding of the proposed project. The second example involves a proposal that was denied for the omission of some basic information rather than because the proposed project was inferior to those that received funding. In conducting a review of the scoring evaluation sheets, we found that one site received zero points from all three evaluators for the section "identifying the current number of uninsured or medically indigent patients served by the Offeror" because, although the proposal had given figures for the number of uninsured patients expected to be served as well as the total number of patients, the proposal did not provide in percentage form (as was requested in the application) the proportion of the population that was uninsured. Given the weighting of points assigned to this section and the ranking of each site by the number of points received, this site was denied funding. Had staff at the site identified the percentage figure in their proposal, their score would have increased enough to have been eligible for funding in that grant cycle. As such, we believe that it is important to provide feedback to the sites regarding what areas in their application were lacking such that they have sufficient information to improve their grant application in future grant cycles.

Other state agencies have improved their feedback to grant applicants. For example, in June 2001 the Office of the State Auditor issued a performance audit on the Department of Education. One of the programs reviewed was the Read to Achieve grant program. In response to an audit recommendation to improve feedback to schools, the Department reported that it provided individualized feedback to more than 700 applicants during the 2001-2002 school year. The Department reports that the feedback to the applicants is intended to clarify program and budget issues, to be consistent, and to provide assistance on the continuing process of the grant program.

Recommendation No. 3:

The Department of Health Care Policy and Financing should improve its management of the Comprehensive Primary and Preventive Care Grant Program by providing adequate feedback to the applicants upon denial of an application. This could include either a letter outlining the sections of the application that were scored low or providing a copy of the scoring sheet to the site.

Department of Health Care Policy and Financing Response:

Partially Agree. The Department already allows for conversation and feedback to any applicant not awarded funding at any time during the year, upon the request of the applicant. Automatically providing a listing of sections of the application that received a low score or a copy of the scoring sheet to an applicant would not

necessarily translate into an applicant receiving funding during the next application process. Factors such as no time or interest on the applicants' part in comparing the feedback to the application response, the situations where different people or positions write the application responses from year to year, and the fact that the Department's statutory designation of only 1% of the total CPPC Grant Program allocation be used for administration make the determination to provide such detail on a request-only basis a prudent decision for the Department. CPPC Grant Program staff contact information appears more than once within the application and it appears on the Program's website. In addition, the appeals process and timeline, which was reviewed by the CPPC Advisory Council, is detailed in the application and can be utilized for applicant's future reference or planning, should an applicant want to grieve any part of the application process. Also, on all correspondence, letters or e-mails, a contact name and, at a minimum, a telephone number is provided. The Department has discussed how to strengthen proposals and simplify the application process with the CPPC Advisory Council and the bidding community and will continue to do so.

Implementation Date: Implemented and ongoing

Review of Applications

For the second issue related to the application process, Section 26-4-1005(4), C.R.S., states that the Executive Director of the Department "shall appoint an advisory council to review and make recommendations to the state department on the awarding of any service grants to qualified providers." Under statutes, the Advisory Council is composed of two consumers who receive health care services from qualified providers, one qualified provider, one non-qualified provider, a representative of a nonprofit community-based healthcare organization, and one representative each from the Department of Health Care Policy and Financing and the Department of Public Health and Environment. The Department has appointed an Advisory Council; however, this Council does not review the grant applications or make awarding recommendations to the Department. The Department utilizes the Advisory Council to establish the structure of grant monies (e.g., capping the amount for construction projects at $500,000 and operational projects at $250,000), develop the application, and create the scoring guidelines for evaluating the application.

The Department established a three-person Application Evaluation Committee to perform the function of reviewing the applications and making recommendations regarding awards. Department staff serve on this committee. Department staff believe this

structure ensures that there are no conflicts of interest during the grant awarding process as none of the individuals on the committee are potential grantees.

Conflict of interest concerns are common among state agencies that award funds to other entities and organizations. These programs may have potential grantees on a council or committee making award recommendations. This structure is often used with the intent to gather input from a broader group of individuals than just state agency personnel. Programs typically develop conflict of interest policies that require council or committee members to abstain from evaluating proposals where there is a direct or indirect financial, business, or personal interest.

In the case of the Program, the Department believes that the conflict of interest issues with regard to the Advisory Council making award recommendations are irreconcilable. We recommend that the Department consider working with the General Assembly to seek statutory clarification of the role of the Advisory Council.

Recommendation No. 4:

The Department of Health Care Policy and Financing should consider working with the General Assembly to clarify statutory requirements regarding the Advisory Council's responsibility to review applications and make recommendations to the Department on grant awards.

Department of Health Care Policy and Financing Response:

Agree. The Department is receptive to working with the General Assembly to clarify statutory requirements regarding the Advisory Council's responsibility to review applications and make recommendations to the Department on grant awards. In order to avoid a real or perceived conflict of interest that might result from the statutory language that stipulates the construction of the Advisory Committee, the CPPC Advisory Council makes recommendations to the Department on the protocols related to the awarding of any service grant to qualified providers by providing feedback on the design and content of the application and the application and evaluation processes. Application questions are retained, added, revised or deleted based upon the relevance and importance agreed upon by the CPPC Advisory Council. This input is utilized when creating and assigning point values on the application scoring materials. As stated in the Program's rules, "In no case shall a member of the Application Evaluation Committee or any subject matter experts have a conflict of interest, or the appearance of a conflict of interest, created by their participation." Therefore, the Department believes there is an inherent as well as a perceived conflict of interest

if members of the CPPC Advisory Council were to participate in the evaluation and award recommendation process. The CPPC Advisory Council agrees with the Department's interpretation of statute.

Therefore, should the General Assembly wish to clarify statute to reflect the practices in place at present, the Department would be in support of such a clarification.

Implementation Date: 2004 Session

Grant Disbursement, Expenditures, and Grantee Reporting

Chapter 2

Background

After a site has been awarded a grant, Department staff and staff at the local site negotiate a contract which specifies the scope of work and the manner in which the grant award will be distributed. The Department typically pays the grant amount in equal quarterly payments. In order to receive these payments, each site is required to submit a quarterly report outlining the progress made towards the contracted goals. These quarterly progress reports are typically due on the last day of the quarter. Department staff indicated that they review the quarterly reports, and if they determine that satisfactory progress is being made, the quarterly installment is then paid to the site. The Department reports the information from the sites' last quarterly reports as achievements for the Program in its annual report. In addition to reporting on their progress in reaching proposed goals, each site also submits summary information regarding the amount spent each quarter. The expense report is broken down by the following categories: Personnel Costs, Administrative Costs, Capital Expenses, Indirect Costs, and Other Expenses.

Section 26-4-1007(3), C.R.S., states that the Department may retain up to one percent of the amount annually appropriated from the fund for the actual costs incurred by the Department in implementing the Program. Because the maximum appropriation to this Program is $6 million in any one year, the annual maximum that can be utilized for administering the Program is approximately $60,000.

We reviewed the disbursement of funds and reporting requirements of the local sites. We found several issues regarding how the Department of Health Care Policy and Financing monitors local site operations with respect to controls over disbursement of grant award monies, controls over expenditures by the sites, reporting by grantees, and file maintenance.

Controls Over Disbursement of Grants

We reviewed 32 contracts for Fiscal Years 2001, 2002, and 2003. Fourteen were contracts for the grantees who received awards for the first grant cycle spanning Fiscal Years 2001 and 2002, and 18 were for the second grant cycle in Fiscal Year 2003. We found that the Department has not established adequate controls over the disbursement of grant funds. As discussed above, the Department typically disburses grant monies in

equal quarterly installments. The Department staff stated that this method is utilized because they consider the contracts to be for "grants," and they are not necessarily concerned about the expenditures as long as the site is reporting progress toward its contract goals. That is, once the grant is awarded, the Department believes that the grantee is authorized to receive the entire award amount without being required to substantiate the actual cost of the project. We found two areas of concern arising from the structure of the disbursement of funds in equal quarterly installments. First, the Department pays these quarterly payments regardless of how much money was actually spent by the provider, and second, the State loses interest earnings on monies that are disbursed prior to actual expenditures.

We found several examples where the Department had disbursed funds prior to the site actually incurring expenses. Two of those examples are described here to illustrate our concerns. In the first example, there were at least three quarters when, due to delays in the start-up of a construction project, a site submitted quarterly expenditure reports with zero dollars listed as the amount spent during the previous quarter. However, due to the contractual arrangement with the Department, the quarterly installments of $180,000 were still paid. We estimate that the State lost at least $9,900 in interest earnings.

In a second similar example, another site structured its contract with the Department so that it received $212,114 of its total grant award of $282,819 as an upfront payment. However, the site was unable to account for expenses that totaled the upfront amount until the last quarter of the Fiscal Year 2002 grant cycle. In other words, the State paid $212,114 to the site as an upfront cost (circa April 2001), although it appears that the site did not reach that level of expenditure until almost a year later, in the second quarter of 2002. As a result, the State lost approximate interest earnings of at least $2,600.

The present method of disbursing grant monies limits the Department's control over the actions of the grantees. Even if the grantee has not incurred any expenses or if it is spending the grant monies in an inappropriate manner or costs are less than anticipated, the Department is still issuing the quarterly installment. We believe the Department should change the method of disbursing grant monies to a reimbursement method. This method would pay the grantees for the actual expenditures incurred during the prior quarter.

We recognize that there may be instances in which the Department may want to allow for upfront monies to be paid (e.g., large construction or equipment expenditures), but the upfront costs do need to be documented and accounted for within a specific timeframe. In addition, the Department needs to establish guidelines for any interest earned on grant funds by the site in this instance.

Recommendation No. 5:

The Department of Health Care Policy and Financing should improve its oversight of expenditures for the Comprehensive Primary and Preventive Care Grant Program by:

a. ensuring that the grant funds are used to pay for expenses incurred by paying on a reimbursement basis;

b. establishing guidelines regarding interest earned on grant funds in the instances where upfront monies are paid to the sites and requiring that funds be utilized within a defined period; and

c. recovering monies not expended by the grantees and reverting those funds to the Tobacco Settlement Fund.

Department of Health Care Policy and Financing Response:

Agree. The Department is implementing a cost-incurred basis of reimbursement with the Fiscal Year 2003-04 contracts. Grantees will be required to submit a budget and a summary of project expenditures prior to the State's disbursement of a quarterly payment. The Department will no longer automatically disburse grant funds in equal quarterly installments. If a grantee has a legitimate request for upfront monies, which is approved by the Department and the Office of the State Controller, the Department will establish guidelines that the money must be spent in a reasonable timeframe to minimize the loss of any interest earned by the Tobacco Settlement Fund. The Department already has in place a process for recovering monies, when applicable, from providers who will not fully complete their contract deliverables. In these situations, if there is adequate time to implement a proposed project, the Department attempts to divert the recovered monies to the provider with the next highest score on the application that did not receive funding. However, usually the recovery of unused funds occurs during the last half of the fiscal year; making the reverting of the unused funds to the Tobacco Settlement Fund the only application for the funds. This reverting of funds happens automatically at the end of the fiscal year.

Implementation Date: Fiscal Year 2004

Controls Over Expenditures

We reviewed the quarterly reports and expenditure statements for the 14 grants awarded during the first grant cycle from April 2001 through June 2002. We found that the Department does not have controls in place to ensure that grant monies are spent in accordance with the statute and contract provisions.

We believe that the Department's present review of grant expenditures is, at best, cursory. The Department has not implemented audit procedures as required by Section 26-4-1005(5), C.R.S., which states that the Department shall develop "an audit procedure to assure that service grant moneys are used to provide and expand coverage to uninsured and medically indigent patients." Presently, the Department does not reconcile the self-reported information from the sites and in addition, does not perform any independent verification of the information reported. The present oversight provided by the Department does not ensure that the intent of the statute is being met and, therefore, does not sufficiently meet the audit requirement as stated in the statute and rules.

We found that the expenditure information provided by the sites in the quarterly expenditure statements did not always reconcile with the total grant award. That is, when adding up the expenditures listed by the sites in their quarterly statements, there were at least 5 contracts out of 14 that documented total expenses which were less than their total grant award amount. For example, one site did not account for almost $76,000 out of a grant of $900,000. As such, the Department needs to reconcile the expenditure statements provided by the site and any monies unaccounted for should not be paid to the sites.

Beginning in Fiscal Year 2003, the Department began granting multiple year awards. In light of this, it is imperative that the Department reconcile the expenditures and the contract goals provided in the quarterly reports with the contract, as well as monitor the progress of sites to see if continued funding to a site is appropriate. If a site is not meeting its contract goals or is not serving the number of patients that it had initially proposed, it may be that the monies can be better spent elsewhere. The Department could choose to fund a proposal that was initially denied funding, or it could have several "standby" projects that could utilize the monies on a short time frame. At the end of the fiscal year, unspent award monies need to be reverted back to the Tobacco Settlement Fund.

In addition, the Department does not visit grantees periodically or at the end of the project to ensure funds were spent in accordance with the award. It is possible that in attempting to accomplish their goals staff at sites may spend the grant monies in a manner different from that identified in their proposed budget. For example, one site was implementing a start-up program with the grant monies and submitted a revised budget

when renegotiating its contract after the program had commenced. This revised budget included some different and additional expenses that were unknown by the staff when proposing the start-up program. Had the staff at the site and the Department not renegotiated the contract, the Department would not have received a revised budget and, therefore, would not have been aware that the monies were being spent in a manner different than initially proposed. As well as providing assurance that funds are appropriately spent, site visits would enable Department staff to find out if grantees are experiencing difficulties or delays in the project.

The Department should have in place basic audit controls including periodic site visits where supporting documentation for expenses and outcomes are reviewed as well as desk audits where progress and expenditures are reviewed and reconciled with project goals and total grant amount, as specified in the contracts. In addition, the Department should ensure that the sites are tracking the grant monies and patients served as well as performing eligibility screenings as stated in the Program's statute.

Recommendation No. 6:

The Department of Health Care Policy and Financing should develop audit procedures for the Comprehensive Primary and Preventive Care Grant Program by:

a. reconciling grant expenditures with the project's budget; and

b. developing procedures to visit a sample of grantees and establishing a schedule by December 31, 2003 for periodic onsite audits.

Department of Health Care Policy and Financing Response:

Partially Agree. As stated in the response to Recommendation No. 5, the Department believes that by implementing a cost-incurred basis of reimbursement practice it will have the ability to more closely track a grantee's expenditures compared to the budget agreed upon at the time the contract is issued. In this way, costs will be reconciled. To its ability, the Department has implemented an audit procedure per Section 26-4-1005, C.R.S. The administration budget is limited to 1% of the total budget and approximately 90% of the 1% administration budget is expended on the single FTE needed to administer the program. Therefore, the Department's ability to travel and perform onsite audits is limited. The Department does not believe it wise to develop procedures to visit a sample of grantees or establish a schedule for periodic onsite visits if, in fact, these visits could not occur. The Department has absorbed much of the workload and direct costs associated with managing the Program. In addition, the Department absorbs indirect costs related to the Program of approximately $6,000 per quarter. Having

said that, the Department will work to establish an ongoing presence and environment of accountability with grantees.

Implementation Date: Fiscal Year 2004

Grantee Reporting

Staff at some of the sites we visited indicated that they cannot provide accurate costs and/or outcome figures for the entire quarter because the reports are due on the last day of the quarter. They indicated that they do not have enough time to compile quarterly figures and submit the report before the due date. As such, some sites estimate figures for the last few weeks of the quarter. Others use a rolling quarter system where the figures for the last week or two of the quarter show up in the next quarter. Additionally, some sites simply do not report the numbers for the last portion of the quarter.

The Department needs to change the reporting requirement so that sites can report accurate figures. The Department could change the date that the progress reports are due to allow enough time for the sites to provide accurate figures. Staff at one site that we visited indicated that the 20th day following the end of the quarter might be appropriate; however, input from other sites may be necessary to determine the appropriate date.

In addition to changing the reporting requirement regarding quarterly progress reports, we believe that the sites should submit a fiscal year-end budget to actual statement. As mentioned previously, in the course of the first grant cycle, one site submitted a revised budget when renegotiating their contract after the program had commenced. This revised budget included some different and additional expenses that were unknown by the staff when proposing the start-up program. Had the staff at the site and the Department not renegotiated the contact, the Department would not have received a revised budget and, therefore, would not have been aware that the monies were being spent in a manner different than initially proposed.

Recommendation No. 7:

The Department of Health Care Policy and Financing should improve its oversight and monitoring of the Comprehensive Primary and Preventive Care Grant Program by:

a. changing the structure of quarterly reports to ensure that the sites are submitting accurate outcome and expenditure figures; and

b. requiring that the sites submit a budget-to-actual upon the completion of the grant period.

Department of Health Care Policy and Financing Response:

Agree. The Department will revise the structure of the quarterly reporting methods in order to obtain more accurate reporting on the progress of contract deliverables and project expenditures related to CPPC funds. Also, with the Fiscal Year 2003-04 contracts, the Department will require a final report, after the last quarterly report is due, in order to increase the accuracy of the final statistics for the annual report without delaying payment to the grantee. The Department will revise the current invoice form that grantees are required to submit with the quarterly reports and will request, in summary, a recounting of expenditures by the grantee.

Implementation Date: Fiscal Year 2004

File Maintenance

The Department maintains files on each of the operating sites as well as those sites that applied for funding but did not receive grants. During our audit we found these files to be incomplete. We found the following.

- **Missing files**: The Department could not located three of the four proposals that were denied funding in the first grant cycle (Fiscal Years 2001 and 2002).

- **Missing documentation:** The Department's files did not include all copies of the correspondence with grantees. For example, the Department's files did not include correspondence from a site on the issue of the deliverables in the site's contract (after the contract had been signed). This correspondence was a formal memorandum to the Department explaining that the contract that had been signed had an incorrect figure in the scope of work section of the contract. This correspondence is not in the Department's file and there is no indication in the file that there was an issue with the contract.

Department staff also indicated that they do not keep correspondence between the Department and the sites during contract negotiations (prior to the contract being signed). Although we understand that all of the documentation during the negotiation process is not necessarily important, we believe that the Department should keep correspondence relating to what the site and Department has agreed to for the scope of work section of

the contract. This documentation would be especially important for any grievance action. At a minimum, the Department should keep this documentation until the grant cycle is completed.

Recommendation No. 8:

The Department of Health Care Policy and Financing should ensure that files for both applicants and grantees are complete by:

a. maintaining copies of all proposals;
b. including correspondence to and from the site following the signing of the contract; and
c. including documents relating to what was agreed to by the site and Department during negotiations that take place prior to the signing of the contract.

Department of Health Care Policy and Financing Response:

Agree. Maintaining necessary official records and documentation is a continuous goal for the Department of Health Care Policy and Financing. The Department agrees to maintain copies of all proposals for an adequate amount of time. The Department may not maintain all correspondence to and from the site following signing of the contract; however, it will maintain all pertinent correspondence or documentation between the grantee and the Department. The contract is the result of successful negotiations between the grantee and the Department and it reflects what the grantee and the Department agreed to during the negotiations. As such, the Department does not believe all documentation relating to the contract negotiation period needs to be included in the files.

Implementation Date: Implemented and ongoing

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