
# REPORT OF

# THE

# STATE AUDITOR

**Comprehensive Primary and Preventive Care Grant Program**
**Department of Health Care Policy and Financing**

**Performance Audit**
**May 2007**

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Members of the Legislative Audit Committee:

This report contains the results of a performance audit of the Colorado Comprehensive Primary and Preventive Care Grant Program within the Department of Health Care Policy and Financing. 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 tobacco settlement program. The purpose of the audit was to determine if the 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.

# TABLE OF CONTENTS

**STATE OF COLORADO**
**OFFICE OF THE STATE AUDITOR** **REPORT SUMMARY**

**SALLY SYMANSKI, CPA**
**State Auditor**

# Comprehensive Primary and Preventive Care Grant Program
# Department of Health Care Policy and Financing
# Performance Audit
# May 2007

## Authority, Purpose, and Scope

This performance audit of the Colorado Comprehensive Primary and Preventive Care Grant Program 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 tobacco settlement program. The purpose of the audit was to determine if the program is effectively and efficiently meeting its stated goals. The audit was conducted in accordance with generally accepted government auditing standards. The audit work was performed between July 2006 and March 2007. As part of our audit work, we interviewed personnel in the Department of Health Care Policy and Financing, contacted a sample of grant recipients, and reviewed grant files. The Office of the State Auditor contracted with Kaye Kendrick Enterprises, LLC to perform some of the audit work.

## Overview

The Comprehensive Primary and Preventive Care Grant Program (CPPC Program or Program) provides grants to health care providers to expand preventive and primary care services to Colorado's low-income or uninsured residents. The CPPC Program is authorized under Section 25.5-3-201 through 207, C.R.S. (formerly 26-4-1001 through 1007, C.R.S.) and is funded with a portion of the monies the State receives under the 1998 Tobacco Master Settlement Agreement. For purposes of this Program, statutes define "comprehensive primary care" as basic, entry-level health care that includes, at a minimum, maternity and prenatal care; preventive, developmental, and diagnostic services for children; adult preventive services; diagnostic laboratory and radiology services; emergency care for minor trauma; pharmaceutical services; and coordination and follow-up for hospital care. All services must be provided on a year-round basis. In addition, to apply for CPPC Program funds, statutes require that a provider: (1) offer comprehensive primary care services; (2) serve all patients regardless of ability to pay; (3) serve a medically underserved population or area that lacks adequate health care for low-income and uninsured persons; (4) demonstrate a record of providing cost-effective care; (5) serve all ages; and (6) screen and make referrals for Medicaid, the Children's Basic Health Plan, and other relevant government health care programs.

The Department of Health Care Policy and Financing (Department) manages the CPPC Program and the Medical Services Board promulgates Program rules. In addition, a seven-member Advisory Council, which includes qualified providers and other health care and community representatives, makes recommendations to the Department on the grant application and award process. The CPPC Program awards funds for both operating and capital projects. Providers may apply for funding for up to three years in a single application, and some providers receive multiple grants in a given year.

In Fiscal Years 2001 through 2004, the CPPC Program was authorized in statute to receive 6 percent of the total amount of tobacco settlement funds received by the State each year, not to exceed $6 million annually. Beginning in Fiscal Year 2005, the General Assembly reduced the amount of tobacco settlement monies allocated to the Program to 3 percent each year, not to exceed $5 million annually. By statute, the Department is allowed to retain up to 1 percent of the amount appropriated each year for Program administration. In Fiscal Year 2007 the Program was appropriated about $2.6 million of which an estimated $26,000 was spent to administer the Program and over $2.5 million was awarded to nine grant applicants. In general, we found that the projects funded with CPPC grants were used to support the Program goals of increasing access to health care, creating or expanding services, and establishing new health care sites to serve uninsured or medically indigent patients.

## Key Findings

### Distribution of Grants

Section 25.5-3-205(6), C.R.S., requires the Department to "consider geographic distribution of funds among urban and rural areas in the state when making funding decisions." We analyzed the distribution of grant awards across nine geographic regions in the State for Fiscal Years 2004 through 2007. We found that the distribution of CPPC grant funds is not always geographically consistent with the distribution of families living below the poverty level. In particular, the Northeast and Northwest regions of the State have about 3.4 percent of the State's total population of families below poverty but have received no grants over the last four years. In fact, no providers in the Northeast or Northwest regions have applied for or received any CPPC grant monies since the inception of the Program in 2001.

In Fiscal Year 2004 the Department began adding up to five extra points to the scores of applicants that intended to provide services in cities with populations of less than 50,000. However, awarding extra points based solely on population may not help rural providers. For example, we found the Department awarded extra points to providers in Englewood and Lafayette, even though these are not rural locations. Further, we found that the extra points are insufficient to help any applicant receive a CPPC grant.

To help providers in more rural areas, the Department could consider options such as using a streamlined application for small, rural providers; designating a certain portion of each year's appropriation of CPPC funds to be allocated to rural providers and allowing other providers to compete for the remaining portion; or distributing funds on a formula basis to all providers that meet the statutory eligibility requirements.

**Project Goals and Contract Deliverables**

The Department's contracts with CPPC providers include details such as the amount of the award, the time frame of the project, and the contract deliverables. Most contract deliverables require providers to serve a specific number of patients and provide a specified number of visits or services. The Department disburses grant funds to providers each quarter after receiving a required quarterly report that includes information on the achievement of the deliverables. The Department may deny a portion of funds if a grantee does not meet all contract deliverables as of the end of the year.

Out of a sample of 17 grants awarded in Fiscal Years 2004 through 2007, we found that the contract deliverables for 11 grants were lower than the goals set by the grantees in their applications, although the applicants were awarded full funding for each grant contract period. For example, one of the applicants had set goals of providing 1,596 medical visits to 600 patients but the contract deliverables required the grantee to provide 1,035 visits (65 percent of the goal) to 450 patients (75 percent of the goal). Setting contract deliverables below the application goals creates a risk that grantees are not held accountable for the outcomes they included in their applications and for which they were funded. Further, there may be a perception of inequity in the level of performance required of different grantees because the contract deliverables for some providers are reduced significantly from the goals established in their applications.

In addition, the Department has no written policy or procedure for determining on what basis and to what extent grant funds should be denied when grantees do not achieve all deliverables. Out of a sample of 13 grants that began in Fiscal Years 2004 through 2006, we found 3 instances in which grantees reported they had not met 100 percent of their contract deliverables. For all three grants the providers received less than the full grant award amount, but the reduction was due to the grantee having spent less than planned, not to the failure to meet the deliverables. For example, one provider had served 94 percent of the patients and provided 83 percent of the medical visits specified in the contract deliverables and the Department distributed 98 percent of the total grant amount to the grantee. The Department should have written guidelines relating to reimbursements to ensure consistent and equitable management of the grants.

**Independent Review Process**

The Department requires grant recipients to hire independent reviewers to conduct quarterly evaluations of their CPPC grant projects. The independent reviewers verify the information the grantee provides in quarterly reports to the Department and assess whether the grantee is compliant

with Program requirements, applicable laws, and the grant contract. Grantees may use up to 2 percent of their annual grant awards to hire independent reviewers.

CPPC Program grant award amounts and the types of projects vary widely; grants awarded in Fiscal Years 2004 through 2007 ranged from about $25,000 to $500,000 and were for a variety of activities such as hiring medical staff, purchasing equipment, and completing construction projects. The Department requires the same frequency and intensity of reviews for all types of grant projects rather than using a risk based approach. Requiring less frequent and/or less extensive reviews for smaller and less complex projects, and establishing a maximum dollar amount along with the 2 percent limit on the cost of the reviews, could be more cost effective and help ensure that the amount of grant funds used for the reviews is minimized.

Our recommendations and the Department's responses can be found in the Recommendation Locator and in the body of this report.

## RECOMMENDATION LOCATOR
## Agency Addressed: Department of Health Care Policy and Financing

| Rec. No. | Page No. | Recommendation Summary | Agency Response | Implementation Date |
|---|---|---|---|---|
| 1 | 21 | Work with the Advisory Council to consider alternative structures for the Comprehensive Primary and Preventive Care Grant Program (CPPC Program) such as allocating some funds on a formula basis and/or streamlining the application for small, rural providers to help ensure they have access to grant funds. | Agree | Spring 2008 |
| 2 | 22 | If the structure of the CPPC Program is not changed, expand efforts to distribute funds to rural areas by continuing to work with providers to ensure processes are equitable to all regions, reevaluating the awarding of extra rural points, formally defining a rural provider, and strengthening supervisory review of the scoring process. | Agree | Spring 2008 |
| 3 | 26 | Improve contract negotiation and reimbursement processes for the CPPC Program by evaluating the process for setting contract deliverables to ensure consistency, documenting negotiations to demonstrate the basis for contract deliverables, and establishing written guidance for when and why reimbursements will be reduced or denied. | Agree | Spring 2007 |
| 4 | 29 | Reevaluate the independent review process for CPPC Program grants and consider developing a risk-based approach for the independent review requirement, compiling and analyzing the actual costs of the reviews, and discussing with the Advisory Council whether a dollar cap should be placed on the amount grantees may spend for independent reviews. | Agree | March 2007 |

# Description of the Comprehensive Primary and Preventive Care Grant Program

The Colorado Comprehensive Primary and Preventive Care Grant Program (CPPC Program or Program) was established in Fiscal Year 2001 to provide grants to health care providers to expand preventive and primary care services to Colorado's low-income or uninsured residents. The Program is authorized under Section 25.5-3-201 through 207, C.R.S., (formerly 26-4-1001 through 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 Program is funded with a portion of the monies the State receives under the 1998 Master Settlement Agreement (Agreement) between the tobacco industry and 46 states, 5 commonwealths and territories, and the District of Columbia. The Agreement was established to resolve all past, present, and future tobacco-related health claims at the state level. Colorado is scheduled to receive annual tobacco settlement monies for an estimated period of 25 years or more.

For purposes of this Program, the statutes define "comprehensive primary care" as basic, entry-level health care that is generally provided in an outpatient setting and includes, at a minimum, providing or arranging for the provision of the following services on a year-round basis: primary health care; maternity and prenatal care; preventive, developmental, and diagnostic services for infants and children; adult preventive services; diagnostic laboratory and radiology services; emergency care for minor trauma; pharmaceutical services; and coordination and follow-up for hospital care. Statutes also state that grants shall be used only to:

- Increase access to comprehensive primary care services for uninsured or medically indigent patients.

- Create new services or augment existing services to uninsured or medically indigent patients.

- Establish new sites that offer comprehensive primary care services in medically underserved areas of the State or to medically underserved populations.

According to statute, grant monies shall not be used to supplant federal funds traditionally received by qualified providers, for land or real estate investments, or to finance or satisfy any existing debt.

Any qualified provider in Colorado may apply for a CPPC Program grant. Statute defines a qualified provider as an entity that:

- Provides comprehensive primary care services;
- Accepts all patients regardless of ability to pay and uses a sliding fee schedule for payments or provides comprehensive primary care services free of charge;
- Serves a designated medically underserved area or population as defined by federal law or demonstrates that it 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 eligibility screening for the state medical assistance program, the Children's Basic Health Plan, and any other relevant government health care program, and makes referrals to the appropriate agency for eligibility determination.

Finally, statute defines an uninsured or medically indigent patient as one whose family income is below 200 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 through private health insurance.

# Program Administration

The Department of Health Care Policy and Financing (Department) manages the CPPC Program. By statute [Section 25.5-3-205, C.R.S.], this responsibility includes developing procedures and applications to govern how grants will be awarded and establishing an audit procedure to ensure that grant monies are used to provide and expand coverage to uninsured and medically indigent patients. The Department also offers training regarding the competitive grant process, distributes the grant awards to providers, collects program data, and prepares an annual report regarding the

Program. The Medical Services Board promulgates rules related to the operation of the Program.

Section 25.5-3-205, C.R.S., also requires the Executive Director of the Department to appoint an advisory council to make recommendations to the Department on the protocols used to award grants and on the design and content of the grant application and the evaluation process. The council comprises the following:

- 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 serves to medically underserved populations.
- A representative of a nonprofit, community-based health care organization or business.

The Colorado Department of Public Health and Environment is required to monitor the operation and effectiveness of all the tobacco settlement programs, including the CPPC Program. Pursuant to Section 25-1-108.5, C.R.S., each program funded with tobacco settlement monies is required to submit an annual report to the Department of Public Health and Environment describing the amount of tobacco settlement money received for the fiscal year, the program's goals, the number of persons served by the program, the services the program provided, and information on the effectiveness of the program in achieving its stated goals. The Department of Public Health and Environment then submits a combined annual report on all tobacco settlement programs to the General Assembly, the Attorney General, and the Governor.

# Program Funding

Statute sets forth the funding formula that is used to determine annual appropriation amounts for all tobacco settlement programs, including the CPPC Program. From its inception in Fiscal Year 2001 through Fiscal Year 2004, the CPPC Program was authorized in statute to receive 6 percent of the total amount of tobacco settlement funds received by the State each year, not to exceed $6 million annually. Beginning

in Fiscal Year 2005, the General Assembly reduced the amount of tobacco settlement monies allocated to the Program to 3 percent each year, not to exceed $5 million annually [Section 24-75-1104.5, C.R.S.]. CPPC Program funding is deposited into the Comprehensive Primary and Preventive Care Fund (Fund) each year. All interest earned remains in the Fund, but monies not expended or encumbered at year-end are transferred to the Tobacco Litigation Settlement Trust Fund. By statute, the Department is allowed to retain up to 1 percent of the amount annually appropriated from the Fund for administering the Program [Section 25.5-3-207, C.R.S.].

The following table shows the Program's appropriations and expenditures for Fiscal Years 2004 through 2007.

**Department of Health Care Policy and Financing**
**Comprehensive Primary and Preventive Care Grant Program**
**Appropriations and Expenditures**
**Fiscal Years 2004 Through 2007**

| | 2004 | 2005 | 2006 | 2007[1] | Total |
|---|---|---|---|---|---|
| **Appropriation** | $5,419,000 | $2,578,700 | 2,615,900 | $2,621,700 | $13,235,300 |
| **Expenditures** | | | | | |
| Grant Distributions | $5,019,000 | $2,439,100 | $2,570,600 | $2,550,800 | $12,579,500 |
| Department Administration | $37,700 | $14,300 | $20,200 | $26,200 | $98,400 |
| Transfer to the Department of Public Health & Environment[2] | $7,600 | $1,200 | $1,400 | $2,600 | $12,800 |
| Reversions[3] | $354,700 | $124,100 | $23,700 | $42,100 | $544,600 |
| **Total Expenditures & Reversions** | **$5,419,000** | **$2,578,700** | **$2,615,900** | **$2,621,700** | **$13,235,300** |

**Source:** Data from the Colorado Financial Reporting System and the Department of Health Care Policy and Financing.
[1] Expenditures were estimated by the Department for Fiscal Year 2007.
[2] Funds are transferred to the Department of Public Health and Environment to cover oversight costs as authorized by the General Assembly. Each program funded with tobacco settlement monies pays a share of the Department of Public Health and Environment's costs to oversee the programs based on the amount of funds each tobacco settlement program is appropriated.
[3] Some amounts initially awarded as grants are not disbursed due to a grantee not meeting its contract deliverables or not spending all funds, or the Department experiencing budget cuts after the grants were awarded. By statute, any amounts not spent at the end of the fiscal year revert to the Tobacco Litigation Settlement Trust Fund.

As the table shows, about $12.6 million in grant funding was disbursed to providers and about $98,000 has been spent to administer the Program over the last four fiscal years. In accordance with changes in the tobacco settlement statute noted above, appropriations for the CPPC Program declined significantly beginning in Fiscal Year 2005.

# Program Statistics

The CPPC Program allows providers to apply for funding for up to three years in a single application. In response to each application, the Department may "pre-award" funds for up to two years following the year in which the initial award is made. For example, in their 2005-2006 applications, which were submitted by June 3, 2005, providers were allowed to request funds for Fiscal Years 2005-2006, 2006-2007, and 2007-2008. When the Department pre-awards a grant, it makes a commitment to provide the promised funds in one or more subsequent years if funds are appropriated for the Program. Some providers receive multiple grants in a given year. The following table shows the number of grants in each of the last four years as well as the number of different providers with CPPC grant funding.

**Department of Health Care Policy and Financing**
**Comprehensive Primary and Preventive Care Grant Program**
**Number of Grants and Providers***
**Fiscal Years 2004 Through 2007**

| | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|
| Number of Grants | 21 | 16 | 15 | 15 |
| Number of Providers | 14 | 10 | 11 | 9 |

**Source:** Information provided by the Department of Health Care Policy and Financing.
***** Numbers include grants awarded each year as well as grants pre-awarded in prior years.

# Audit Scope and Methodology

In accordance with Section 2-3-113, C.R.S., the purpose of this audit was to evaluate the efficiency and effectiveness of Colorado's Comprehensive Primary and Preventive Care Grant Program in meeting its stated goals. This audit also followed up on prior audit recommendations from the June 2003 performance audit conducted by the Office of the State Auditor. The implementation status of prior audit recommendations for the Program is summarized in Appendix A.

To conduct the audit, we reviewed documentation and interviewed personnel at the Department of Health Care Policy and Financing with respect to Program policies, procedures, operations, and oversight. In addition, we reviewed a sample of the Department's files for the CPPC Program and conducted site visits to a sample of providers that received grants. We reviewed the overall administration of the Program, the application process, budgeting procedures, and reporting requirements. The Office of the State Auditor contracted with Kaye Kendrick Enterprises, LLC to perform some of the audit work.

# Program Operations

## Chapter 1

According to Section 25.5-3-202, C.R.S., the purpose of the Comprehensive Primary and Preventive Care Grant Program (CPPC Program or Program) is to "expand prevention and primary care services to Colorado's low-income, uninsured populations." In accordance with statutory direction in Section 25.5-3-205, C.R.S., the goals of the Program are 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.
- Establish new sites that offer comprehensive primary care services in medically underserved areas of the State or to medically underserved populations.

We reviewed a sample of 17 grant files for grant projects in operation during Fiscal Years 2004 through 2007, conducted interviews with Department of Health Care Policy and Financing (Department) staff, and conducted site visits to six grantees to assess whether the CPPC Program is accomplishing its purpose. In general, we found that the grant projects funded with CPPC monies were used to support the goals of increasing access to health care, creating or expanding services, and establishing new health care sites to serve uninsured or medically indigent patients. The six facilities we visited, which offered a variety of services, including primary medical care, laboratory, X-ray, and pharmacy, were able to establish facilities and purchase equipment through this Program that should allow the provision of comprehensive services to their patients for many years. The following table summarizes the outcomes of projects funded with CPPC grants during Fiscal Years 2004 through 2006.

**Department of Health Care Policy and Financing**
**Comprehensive Primary and Preventive Care Grant Program**
**Summary of Reported Accomplishments From Grant Projects[1]**
**Fiscal Years 2004 Through 2006**

| Patients/Services Provided | Fiscal Year 2004 | Fiscal Year 2005 | Fiscal Year 2006 | 3-Year Total |
|---|---|---|---|---|
| Number of Patients Provided Medical Services | 15,300 | 10,000 | 6,900 | 32,200 |
| Number of Medical Visits Provided | 41,200 | 25,100 | 24,100 | 90,400 |
| Number of Patients Provided Dental Services | 5,500 | 7,100 | 100 | 12,700 |
| Number of Dental Visits Provided | 10,500 | 12,400 | 100 | 23,000 |
| Number of Patients Provided Prescriptions | 2,000 | 1,900 | 900 | 4,800 |
| Number of Prescriptions Provided | Not Reported | 6,300 | 5,900 | 12,200 |
| Number of Patients Provided Eye Exams/Glasses | 200 | 100 | 200 | 500 |
| Number of Mental Health Visits Provided | N/A | 700 | 1,200 | 1,900 |
| Number of Other Health Services Provided[2] | 100 | 500 | 400 | 1,000 |

**Source:** Data provided by the Department of Health Care Policy and Financing.
[1] Figures in the table were reported by grant recipients to the Department. Grant recipients hire external evaluators to verify the numbers reported to the Department.
[2] Other services include health screenings and health education classes/sessions.

In addition to the patient services in the table above, grant recipients reported completing a variety of capital projects using CPPC grant funds. For example, providers reported that they completed 13 clinic construction or remodeling projects in Fiscal Years 2004 through 2006 and 7 purchases of medical or dental equipment in preparation for providing new or expanded services to patients.

Our audit reviewed the Department's administration of the CPPC Program, including the grant application, evaluation, and approval processes; the distribution of grant funds; and the establishment of contracts with grantees. We identified three general areas where the Department could strengthen the operations of the Program, as discussed in the report.

# Distribution of Grants

Over the past four fiscal years (2004 through 2007), the Department has awarded a total of about $12.6 million in CPPC grants. Section 25.5-3-205(6), C.R.S., requires the Department to "consider geographic distribution of funds among urban and rural areas in the state when making funding decisions." We combined counties in the State to create nine geographic regions and analyzed the distribution of grant awards across the regions over this period. We also determined the distribution of the State's total population and the population of families below 100 percent of the federal poverty level across the regions. The population of families below the poverty level in each region may serve as an indicator of the proportion of the

population that is medically indigent and/or uninsured and may therefore be in need of primary care services. We found that CPPC Program funding may not be benefiting some of the neediest uninsured and medically indigent individuals, particularly in some rural areas of the State.

The following table shows that the distribution of grant funds is not always geographically consistent with the distribution of families living below the poverty level. In particular, although the Northeast and Northwest regions of the State have families living below the poverty level (about 3.4 percent of the total population of families below poverty, according to the 2000 census), these two regions received no grants over the last four years. In fact, no providers in the Northeast or Northwest regions have applied for or received any CPPC grant monies since the inception of the Program in 2001. Further, although the Northern Front Range region has about 9.4 percent of all the families living below the poverty level, providers in this region have received less than 2 percent of all grant funds awarded during Fiscal Years 2004 through 2007. The Northern Front Range region did receive about $2.2 million in grants in the first three years of the Program (Fiscal Years 2001 through 2003). Conversely, the table shows that the West region, which represents 5.5 percent of all Colorado families living below poverty, received over 15 percent of all grant monies awarded in Fiscal Years 2004 through 2007.

**Department of Health Care Policy and Financing**
**Distribution of Comprehensive Primary and Preventive Care Grant Monies Among Regions**
**Fiscal Years 2004 Through 2007**

| Region | Counties | Percent of State Population Living in Region | Percent of Families Below Poverty Level in Region | Grant Awards | Percent of Total Grant Awards in Region |
|---|---|---|---|---|---|
| Denver Metro | Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson | 56.2% | 48.6% | $5,588,700 | 44.4% |
| Southern Front Range | El Paso, Park, Pueblo, Teller | 16.0% | 18.1% | $2,864,400 | 22.8% |
| West | Delta, Mesa, Montrose | 4.1% | 5.5% | $1,927,300 | 15.3% |
| Southwest | Alamosa, Archuleta, Chaffee, Conejos, Costilla, Custer, Dolores, Fremont, Gunnison, Hinsdale, La Plata, Lake, Mineral, Montezuma, Ouray, Rio Grande, Saguache, San Juan, San Miguel | 5.1% | 8.4% | $1,416,400 | 11.3% |
| Mountain | Clear Creek, Garfield, Gilpin, Eagle, Pitkin, Summit | 3.2% | 1.8% | $345,500 | 2.7% |
| Northern Front Range | Larimer, Weld | 10.0% | 9.4% | $229,300 | 1.8% |
| Southeast | Baca, Bent, Cheyenne, Crowley, Elbert, Huerfano, Kiowa, Kit Carson, Las Animas, Lincoln, Otero, Prowers | 2.6% | 4.8% | $207,900 | 1.7% |
| Northeast | Logan, Morgan, Phillips, Sedgwick, Washington, Yuma | 1.6% | 2.3% | $0 | 0% |
| Northwest | Grand, Jackson, Moffat, Rio Blanco, Routt | 1.2% | 1.1% | $0 | 0% |
| TOTAL | | 100.0% | 100.0% | $12,579,500 | 100.0% |

**Source:** Office of the State Auditor analysis of data from the U.S. Census Bureau and the Department of Health Care Policy and Financing.

According to the Department, one reason that some geographic regions have received little or no grant funding is that there are few or no providers in those areas that meet the statutory qualifications. Section 25.5-3-203, C.R.S., requires that all CPPC Program applicants meet the following minimum qualifications:

- Providing comprehensive primary care services;
- Serving all patients regardless of ability to pay;
- Serving a population or area that is designated as medically underserved as defined by federal law or that lacks adequate health care services for low-income and uninsured persons;
- Having a demonstrated track record of providing cost-effective care;
- Providing or arranging for services for all ages; and
- Conducting initial screening for eligibility and making referrals for Medicaid, the Children's Basic Health Plan, and other relevant government health care programs.

We found there are Federally Qualified Health Centers and/or rural health clinics (both of which are Medicare-certified health care centers located in areas where there are shortages of medical services available) in one or more of the counties within each region in the table above. There are also hospitals in each region. Although we could not determine if all these providers meet all the statutory criteria described above, it is possible there are qualified providers that have not applied for CPPC grants.

# Extra Rural Points

In our June 2003 audit of the CPPC Program, we noted that several regions of the State in more rural areas had received little or no CPPC grant funding, in some cases because they had not applied for funds. In that audit we recommended that the Department reassess the grant awarding process to ensure rural providers were fairly considered in the awards process. The Department agreed with the recommendation and began adding extra points to the scores of some applicants beginning with the Fiscal Year 2004 grants. According to Program documents, extra rural points are awarded to applicants based on the population (according to the 2000 census) of the city in which the applicant plans to provide services, as shown in the following table.

| Department of Health Care Policy and Financing<br>Comprehensive Primary and Preventive Care Grant Program<br>Extra Rural Points Available to Grant Applicants<br>Fiscal Year 2007 | |
|---|---|
| **Population of City Where Services Will Be Provided** | **Number of Extra Rural Points Assigned** |
| 1 to 9,999 | 5 |
| 10,000 to 19,999 | 4 |
| 20,000 to 29,999 | 3 |
| 30,000 to 39,999 | 2 |
| 40,000 to 49,999 | 1 |
| **Source:** Data provided by the Department of Health Care Policy & Financing. | |

In our current audit, we identified three problems with the use of additional rural points, as follows:

- **No formalized definition of a rural provider.** Assigning additional points based solely on the population of the city where services will be provided, without taking into account the surrounding area or distance to other providers, does not effectively ensure that only rural providers benefit from the points. In Fiscal Year 2004 two Denver area applicants received extra rural points because the populations of the cities where they planned to provide services (Englewood and Lafayette) both had populations under 50,000. We found that according to the 2000 census, more than a dozen Metro-area cities have a population of less than 50,000, including Littleton, Broomfield, Wheat Ridge, Northglenn, Parker, Lafayette, Brighton, and Golden.

  According to staff, the Department realized after the 2003-2004 grant round that using only a city's population to award extra points was problematic and, the following year, began considering the location of the city as well. However, there is no formalized, written definition of a rural provider and no written guidelines about other factors that should be used to determine when and how many extra rural points should be added to an applicant's score. The form used to document the technical review of the grant applications for 2006-2007 (the most recent grant round), which indicates the number of extra points to assign for each population range, does not reflect the change in how extra points are awarded. In other words, the form does not state that the geographic location of the city or the distance to other primary care providers is considered in awarding extra points.

  The Department should formally define and document the factors that are considered in determining whether an applicant should be considered to be

in a rural area for purposes of awarding extra points. For example, the Department's rules related to nursing home reimbursements consider both the size and the proximity of the county or city where a nursing facility is located to a larger city in determining whether a nursing facility is located in a rural community. Specifically, a rural community is defined as "a county of less than 15,000 population or a municipality of less than 15,000 population which is located 10 miles or more from a municipality of over 15,000 population or the unincorporated part of a county 10 miles or more from a municipality of 15,000 or more."

- **Effect of extra rural points on funding.** Over the last four years the additional points awarded to applicants serving a rural area have represented no more than 2 to 5 percent of the total maximum score available to any applicant. We reviewed the grant application scores for these four years and found that the extra points did not affect any applicant's being approved for a CPPC grant over this period. The Department should consider whether the additional rural points available represent a significant enough percentage of the total score to actually benefit rural applicants.

- **Errors in awarding extra rural points.** In reviewing the scores assigned to grant applicants in Fiscal Years 2004 through 2007, we found two errors. First, one provider was awarded different levels of extra rural points in different years. This provider received no extra rural points in 2004-2005 to provide services in Grand Junction but did receive extra points in 2005-2006 and 2006-2007 to expand services in Grand Junction. Second, the Department erroneously omitted the extra rural points when calculating the total score for one provider in 2003-2004 (which did not affect the final ranking of applicants for funding purposes). According to Program staff, the application scoring calculations undergo a supervisory review, but the errors and inconsistent application of rural points we found had not been identified during this review process. The Department should strengthen the review process to ensure all scores are correctly calculated.

# Grant Program Structure

In addition to strengthening some of the application scoring procedures, the Department should consider other structures for the CPPC Program, some of which may require statutory change. In particular, to help providers in more rural areas acquire CPPC funds, the Department should consider options such as:

- Developing a streamlined application for small, rural providers. For example, the Department could allow providers in designated areas or serving communities of a specified size to apply for funds by demonstrating

that they meet the statutory definition of a qualified provider and certifying that funds will be used in compliance with statute. The Department could then fund such applications based on either a requested amount or an allocation of funds for each patient to be served.

- Designating a certain portion of each year's appropriation of CPPC funds to be allocated to rural providers and allowing other providers to compete for the remaining portion. This approach would ensure that small, rural providers receive some CPPC funds without the time and expense of completing the application and review process but would allow all providers an opportunity to obtain additional funding.

- Distributing funds on a formula basis to all providers that meet the statutory eligibility requirements. This is the process currently used to award Primary Care Fund monies. The Primary Care Fund receives a portion of the monies generated from taxes imposed on tobacco products. By law, these monies are allocated to health care providers that meet essentially the same requirements as those that are eligible to apply for CPPC funds.

If the Department and the Medical Services Board choose to continue the CPPC Program as a strictly competitive grant program, the Department should take further steps to identify and work with small rural providers to help them successfully apply for grant monies. Currently the Department sends emails to a wide variety of providers each year to notify them when grant applications will be accepted and to invite them to pre-application workshops. The providers contacted include representatives of FQHCs, school-based health clinics, the Colorado Community Health Network (an association representing Colorado's community health centers), and other providers that have had contact with the CPPC Program administrator. The Department could expand its efforts to specifically contact providers that have not applied for funds in the past to request information on why they have not submitted proposals. The Department could also contact providers that have been denied funds to help determine what aspects of the current process make it difficult for these providers to obtain grant awards. The Department could use this information to determine if the current grant process should be modified. Additionally, the Department should address the issues discussed above to improve the process of awarding extra points to rural providers.

## Recommendation No. 1:

The Department of Health Care Policy and Financing should work with the Advisory Council to consider alternative structures for the CPPC Grant Program to help ensure providers in small, rural areas have access to grant funds. The options could include allocating some of the funds on a formula basis and/or streamlining the application for small, rural providers. Some of these options may require the Department to seek statutory change.

### Department of Health Care Policy and Financing Response:

Agree. Implementation Date: Spring 2008. The audit report presents an analysis that not all geographical areas have received funding from the CPPC Grant Program but does not document any substantial evidence that the competitive application process, as it is administered for this program, has not reached the providers intended within the original legislation. The Department has not received applications from providers operating in the counties identified as having received no funding through the CPPC Grant Program, and, therefore, has no evidence that there are providers in those areas of the State that meet the complete criteria set forth for this Program. The Department communicates with a large number of health care providers in multiple ways in order to publicize the CPPC Grant Program. Although the Department attempts to notify all health care providers within the State of Colorado that meet all of the eligibility criteria established for the Program, it is possible that some health care providers may not be aware of the CPPC Grant Program. The Department annually discusses with the CPPC Grant Program Advisory Council the application process and the accessibility to this funding by rural health care providers. The Department will continue to address this issue and the possibility of utilizing alternative structures for awarding funds with the CPPC Grant Program Advisory Council, but the Department cannot assure that alternative structures to distribute the grant funding will be made or that statutory changes will be requested. The Department will pursue reasonable recommendations suggested by the CPPC Grant Program Advisory Council. The next CPPC Grant Program Advisory Council meeting will be held in the Spring of 2008 and recommendations will be considered for Fiscal Year 2008-2009 awards.

### *Auditor Addendum*

***Statutes clearly indicate the intent that CPPC Program funds be distributed throughout the State by requiring the Department to consider the distribution of funds among urban and rural areas when making funding decisions. The audit found that in two outlying rural regions of Colorado no providers have applied for or received grant monies since the inception of the Program in 2001. Alternative funding structures could help additional providers obtain CPPC funding to provide primary and preventive care services to uninsured or medically indigent patients in outlying rural areas.***

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## Recommendation No. 2:

If the Department of Health Care Policy and Financing determines that the CPPC Program should remain as a competitive grant program, the Department should expand efforts to distribute CPPC Program grant funds to rural areas by:

a. Continuing to work with health care providers to identify ways to ensure the grant processes are equitable to all regions.

b. Reevaluating whether the number of extra points available to rural providers is sufficient to help rural providers in the grant awarding process.

c. Developing a formalized definition of a rural provider that accounts for both the size and location of the provider.

d. Strengthening the supervisory review of the scoring process to prevent errors.

## Department of Health Care Policy and Financing Response:

Agree.

a. Implementation Date: Spring 2008. The Department annually discusses with the CPPC Grant Program Advisory Council the application process and the accessibility to this funding by rural health care providers. The Department will pursue recommendations suggested by the CPPC Grant Program Advisory Council. The next CPPC Grant Program Advisory Council meeting will be held in the Spring of 2008 and any reasonable recommendations will be implemented for Fiscal Year 2008-2009

awards. Until the scope of the program and the administration budget for the program is expanded, the Department is limited in its ability to develop and implement a more formal provider outreach plan.

b. Implementation Date: Spring 2008. The Department annually discusses with the CPPC Grant Program Advisory Council the application process and the accessibility to this funding by rural health care providers. The Department will pursue recommendations suggested by the CPPC Grant Program Advisory Council; however, the Department must evaluate the impact of awarding additional points to applications proposing to serve a rural area so that the quality and financial integrity of all funded projects is not compromised. The next CPPC Grant Program Advisory Council meeting will be held in the Spring of 2008 and any reasonable recommendations will be considered for Fiscal Year 2008-2009 awards.

c. Implementation Date: Spring 2007. The Department currently assigns extra points to applications with projects proposed to increase access to health care services in a rural area, which is documented for the internal review process. The Department will create a more formalized definition of a "rural area" for the CPPC Grant Program that will include considerations for the location or region the proposed project covers. This will be utilized in the evaluation process for the Fiscal Year 2007-2008 awards.

d. Implementation Date: Spring 2007. To strengthen the current the supervisory review of the scoring process, the Department will have the application evaluation committee verify that the points have been awarded correctly in the evaluation process for the Fiscal Year 2007-2008 awards.

# Project Goals and Contract Deliverables

Once the Department has approved a CPPC Program grant application, it executes a contract with the provider that includes details such as the amount of the award, the time frame of the project, and the contract deliverables. Through the contract negotiation process, the Department establishes performance measures, referred to as contract deliverables, for each grant contract. According to the Department, it considers a variety of factors when negotiating contract deliverables, such as how the funds are intended to be used, the timeline of the project, what portion of the project will be paid for with CPPC Program monies, the type of project (i.e., capital or operations), and the Department's past experience with grant project outcomes.

Most contracts include a specific number of uninsured or medically indigent patients the provider will serve over the course of the contract period and the number of visits or services provided. In some cases, the contracts require the completion of a capital project as the contract deliverable.

Grantees must report to the Department on a quarterly basis, and at the end of each fiscal year, on their progress in meeting the deliverables and their grant expenses to date. The Department disburses grant funds to providers each quarter only after the Department receives the required quarterly report. The Department limits its quarterly disbursements to no more than 25 percent of the total grant amount for the first quarter, 50 percent for the second quarter, and 75 percent for the third quarter. In addition, the Department will only disburse funds up to the amount actually spent and may deny a portion of funds if the grantee did not meet all its contract deliverables as of the end of the year.

We reviewed the application goals/objectives, the contract deliverables, the year-end reports, and the disbursements made by the Department for a sample of 17 grants awarded in Fiscal Years 2004 through 2007 and identified two concerns, as described below.

**Consistency in Setting Contract Deliverables.** We found that for 11 of the 17 grants we reviewed, the contract deliverables were lower than the goals set by the grantees in their applications although the grantees were awarded full funding for each grant contract period. Specifically:

- For five grants (29 percent of the 17 grants reviewed), all the contract deliverables were between 75 and 90 percent of the goals the applicant had established. For example, one applicant had set goals of serving 7,890 patients and providing 15,795 new prescriptions to these patients over the three years of the grant. The contract deliverables required the grantee to serve 6,000 patients (76 percent of the goal) and provide 13,500 prescriptions (85 percent of the goal) over the period of the contract.

- For two grants (12 percent), all the contract deliverables were at or below 75 percent of the goals the applicant had set. For example, one applicant had set goals of providing 1,596 medical visits to 600 new patients over the three years of the grant. The contract deliverables required the grantee to provide 1,035 visits (65 percent of the goal) to 450 new patients (75 percent of the goal) over the period of the contract.

- For two grants (12 percent), some of the contract deliverables were within 90 percent of the goals the applicant had set, but other deliverables were less than 75 percent of the goals. For example, one applicant had set goals of

enrolling 310 patients in a health program and providing 4,340 health care visits to those patients over the three years of the grant. The contract deliverables required the grantee to enroll 295 patients in the program (95 percent of the goal) and provide 2,950 health care visits (68 percent of the goal) over the period of the contract.

- For two grants (12 percent), the contract deliverables related only to completing capital projects (such as remodeling), but the applicants had included specific goals to provide services to patients in addition to completing construction, remodeling, or renovation efforts.

According to the Department, setting the contract deliverables below the applicants' goals is intended to recognize that a grantee may spend all its grant funds in compliance with the contract but still not reach its original goals due to events outside the grantee's control. In addition, both the Department and the grantees we spoke with noted that it can be difficult to accurately estimate the number of patients to be served or services to be provided through a grant project. To account for the difficulty in estimating outcomes and to avoid having to deny a grantee any of its grant award, the Department typically uses contract deliverables that are lower than the original goals set by the grantee. However, we found that of the 34 providers that have applied for grants since the inception of the Program, 22 (65 percent) have applied more than once and 15 (44 percent) have applied three or more times. Further, 7 of the 8 providers who were awarded grants in Fiscal Year 2007 had been awarded grants in at least one prior year since the Program began. It is reasonable to expect that these repeat applicants would gain familiarity with the Program and be able to accurately set their goals.

The current process for establishing contract deliverables creates a risk that grantees are not held accountable for the outcomes they included in their applications and on which the applications were evaluated and approved. Further, there may be inequities in the level of performance required of different grantees because the contract deliverables for some providers are reduced significantly from the goals they established, but not for all providers. Although some deliverables were very similar to the goals the grantees had established in their applications, others were more than 50 percent lower. We also found little documentation of the negotiation process to help explain how the deliverables were set.

**Standards for Reimbursement.** Department staff indicated that grantees will not be provided all their awarded funds if they do not meet the contract deliverables. However, the Department has no written policy or procedure for determining on what basis and to what extent grant funds should be denied when grantees do not achieve all deliverables. Of the 17 grant files we reviewed, 13 were for grants that began in Fiscal Years 2004 through 2006 and therefore had at least one year-end

report at the time of our audit. The grants that began in Fiscal Year 2007 will not complete their first full year until June 30, 2007. In these 13 files, we found three instances in which grantees reported they had not met 100 percent of their contract deliverables for the year being reported on. For all three grants the providers received less than the full grant award amount, but the reduction was due to the grantee having spent less than anticipated, not to the failure to meet the deliverables. For example, for one grant the provider had served 94 percent of the patients and provided 83 percent of the medical visits included in the contract deliverables. The Department distributed 98 percent of the total grant amount awarded based on the grantee's reported expenses.

The Department stated that it works with the grantees and tries to be flexible before denying or reducing funding because of the difficulty in accurately projecting the number of patients that will be seen and because funds that are denied revert to the Tobacco Settlement Trust Fund and are therefore not used to help expand primary care services. To ensure consistent and equitable management of the grants, the Department should reevaluate the process it uses to set contract deliverables and develop written guidelines relating to how and why grant reimbursements should be reduced or denied.

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## Recommendation No. 3:

The Department of Health Care Policy and Financing should improve the contract negotiation and reimbursement processes for CPPC Program grant projects by:

a. Evaluating the process used to establish contract deliverables to ensure consistency across different grantees and projects.

b. Documenting the negotiation process to clearly demonstrate the basis for the contract deliverables for each grant contract.

c. Establishing written guidance regarding when and why grant reimbursements will be reduced or denied.

### Department of Health Care Policy and Financing Response:

Agree. Implementation Date: Spring 2007.

a. The Department believes that the CPPC Grant Program has adequate accountability standards and that the money awarded has been used for

the designated purposes. The audit recommendation focuses solely on the period of negotiation from when a grant has been awarded following a competitive bid to when the contract is finalized. The negotiated contract deliverables are different for each grantee because each grant-funded project is unique and each health care provider has distinct operational capabilities. The Department will continue to monitor the contract negotiation process to ensure that all awardees receive consistent consideration when negotiating and developing the contracted deliverables.

b. The negotiation of contract deliverables is different for each grantee because each grant-funded project is unique. Beginning with the Fiscal Year 2007-2008 awards, the Department will include any pertinent documentation, in addition to the original grant application response, within the contract file for each grant contract to clearly demonstrate the basis for the contracted deliverables.

c. The Department maintains documentation within the contract files to explain the circumstances pertaining to how or why specific grant reimbursements were reduced or denied. Beginning with the Fiscal Year 2007-2008 awards, the Department will consider similar circumstances among projects and contracts and, when appropriate, use previous actions to create a list of considerations to be used as a reference when determining if a grant award should be reduced or cancelled.

# Independent Review Process

In our 2003 audit we found the Department needed to increase oversight of and accountability for program outcomes and recommended the Department conduct on-site visits of grant recipients to verify reported data and ensure funds were spent in accordance with the grant awards. The Department stated that it did not have sufficient resources to conduct such visits. To increase accountability for the CPPC Program, the Department began requiring grant recipients to hire independent reviewers to conduct quarterly evaluations of the grantees' CPPC grant projects. This requirement was effective beginning with grants awarded in Fiscal Year 2005. The independent reviewers are required to assess whether the grantee is compliant with Program requirements (including laws and regulations related to the CPPC Program, the grant application form and proposal, and the grant contract) and verify the information the grantee provides in its quarterly reports to the Department. The Department allows grantees to use up to 2 percent of their annual grant awards to hire independent reviewers for this purpose. For Fiscal Years 2005 through 2007,

grantees were allowed to spend a total of about $151,000 on these independent reviews ($7.56 million granted over the period x 2 percent). Although grant recipients include the amounts they spend to hire independent reviewers on their quarterly reports, the Department does not compile these amounts to determine the total actual amount of grant funds spent on reviewers each year.

The Department, as well as grantees we interviewed, reported that the required reviews have been helpful in ensuring that grantees have adequate performance data collection procedures, and we commend the Department for implementing the review requirement to increase accountability for the Program. During the audit we identified three ways in which the Department could increase the cost-effectiveness of the process.

First, the amount available to grantees to hire a reviewer varies widely and does not necessarily reflect the amount of work required. For example, grants awarded during Fiscal Years 2004 through 2007 ranged in amount from about $25,000 to $500,000. This means that some grantees had as little as $500 ($25,000 x 2 percent) to hire an independent reviewer to conduct four separate reviews (one in each of the four quarters of the year), while others had as much as $10,000 for the same purpose. However, the review requirements are the same regardless of the type or size of the project or the grant amount. Specifically, the Department requires that the reviews be conducted by agencies or professionals that have experience in auditing or in working directly with Medicaid or similar services for the medically indigent. Further, the reviewers are required to verify that the grantee is using the grant award in accordance with all applicable requirements and that the information reported by the grantee to the Department is accurate, including expense data. Some of the grantees we interviewed indicated they are able to coordinate these reviews with their annual financial audits to reduce their costs. However, requiring the same frequency and intensity of reviews for all types of grant projects may not be necessary.

Second, we found there is no dollar maximum placed on the amount grantees may use to hire an independent reviewer. Over the four years we reviewed, the Department did limit the annual amount it would award for any given application to no more than $500,000 for capital projects and $250,000 for projects to cover operational costs. As a result, the maximum amount any provider could spend to hire an independent reviewer for a single grant project was $10,000. Establishing a maximum dollar amount along with the 2 percent limit for the independent reviews could help ensure that the amount of grant funds used for these reviews is minimized.

Finally, each grant project is ultimately held accountable for its outcomes and expenses at the end of the grant year, not at the end of each quarter. Specifically, the Department establishes annual, not quarterly, deliverables for each grant and only

adjusts or denies funding if a grantee does not meet the contract deliverables at year-end. Thus, while the quarterly reviews provide an indication of the progress of the grant, the true point of accountability occurs at year-end. As such, quarterly reviews may not be necessary for every type of grant project.

We believe the Department should reevaluate the independent review requirement to ensure it is cost-effective and determine whether any cost savings could be achieved. Specifically, the Department should solicit input from providers on the optimum frequency for conducting independent reviews and implement a risk-based approach to applying the independent review requirement. The risk-based approach should consider factors such as the nature of the project and the amount of the grant award in determining how often an independent review must be completed and the scope of the review. For example, the Department could consider whether annual reviews, combined with the providers' annual audits, should be the standard requirement while, for some projects, such as a high-dollar grant that involves various activities (e.g., completing capital projects, hiring staff, and purchasing supplies), the Department could require more frequent reviews covering all aspects of the project. The Department should also analyze the actual costs of providers hiring independent reviewers. The Department should discuss this analysis with the Program's Advisory Council to determine whether a dollar cap should be established for the amount a provider can spend for its independent reviews.

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## Recommendation No. 4:

The Department of Health Care Policy and Financing should reevaluate the independent review process for CPPC Program grants including:

a. Developing a risk-based approach to establish the frequency and scope of the reviews for each grant.

b. Compiling and analyzing the actual costs of the reviews since the requirement was instituted and discussing with the CPPC Program Advisory Council whether a cap should be placed on the dollar amount a grantee may spend for its independent reviews.

### Department of Health Care Policy and Financing Response:

Agree. Implementation Date: Spring 2008.

a. When the Department first implemented the independent review process for the CPPC Grant Program it was unique and innovative. The Department consulted with several different professionals for ideas and input and received opposing opinions stating that grant programs should not be subject to audits or that the Department should ask the General Assembly for funding so that the audits could be performed internally. The benefit of the quarterly program reviews has been realized by both the Department and the grantees and the Department believes this process should be a model for consideration for similar programs statewide. The Department will discuss the need to modify the frequency and scope of the reviews for each grant with the CPPC Grant Program Advisory Council to determine if there are grant-funded projects where the requirement for a quarterly program review can be reduced. The next CPPC Grant Program Advisory Council meeting will be held in the Spring of 2008 and any reasonable recommendations will be considered beginning with the Fiscal Year 2008-2009 awards.

b. A cap on the dollar amount a grantee may spend for its independent reviews has been in effect since the inception of the independent review process. Grantees are able to allocate up to 2 percent of their total grant award for these reviews. Through the years of implementing this review practice, the Department has determined that this amount provides the flexibility needed to address the individual operations of the providers and the wide range of contracted deliverables for the unique projects. The Department does not require the provider to utilize the full 2 percent and has received feedback from grantees that, at times, the 2 percent is not enough to cover the reviews in multiple-year awards when funding is reduced in the second and third year. For the Fiscal Year 2006-2007 and 2007-2008 grant awards, the Department will compile and analyze the total costs of the reviews. The Department will discuss the need to modify the review process for each grant with the CPPC Grant Advisory Council to determine if any changes are necessary. The next CPPC Grant Program Advisory Council meeting will be held in the Spring of 2008 and any reasonable recommendations will be considered beginning with the Fiscal Year 2008-2009 awards.

**APPENDIX A**

| Status of Audit Recommendations<br>From the June 2003 Comprehensive Primary and Preventive Care Grant Program Performance Audit<br>As of May 2007 | | |
|---|---|---|
| **Prior Audit Recommendation** | **Agency Response** | **Disposition as of May 2007** |
| **Recommendation No. 1:** Continue to reassess the grant awarding process to ensure that rural providers are fairly considered in the awarding of grants. | Agree | **Partially Implemented.** Beginning in 2004 the Department made additional points available to providers based on the population of the city where they proposed to provide services. However, some rural areas of the State have received few or no grants, and we noted problems with the application of the extra points. The Department and CPPC Program Advisory Council should consider other options for the structure of the grant program and/or strengthen procedures to help rural providers successfully access CPPC funds. **See Recommendations No. 1 and 2 of the May 2007 audit report**. |
| **Recommendation No. 2:** Improve oversight and monitoring of the Program by: (a) developing benchmark data and improving the consistency and accuracy of reporting to better evaluate the effectiveness and efficiency of the Program; (b) enforcing contract provisions regarding negative consequences when a project is not likely to achieve the 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 | **Partially Implemented.** We found no errors in the reporting of program data and the Department has instituted an independent review process to help improve accountability for program data and results. The Department has established limits on distributing funds awarded and includes annual deliverables in its contracts with grantees. However, the Department needs to establish formalized guidelines for setting contract deliverables and should consider a risk-based approach to applying the independent review requirement. **See Recommendations No. 3 and No. 4 of the May 2007 audit report.** |
| **Recommendation No. 3:** Improve management of the Program by providing adequate feedback to applicants upon denial of an application. | Partially Agree | **Implemented.** The Department notifies applicants of any specific minimum qualifications they did not meet when denying grant funds and discusses details of the funding decisions with applicants on request. The Department also offers pre-bid workshops and technical assistance to providers on request. The sample of providers we spoke with did not cite a lack of feedback as a concern with the Program. |

**APPENDIX A**

| Status of Audit Recommendations<br>From the June 2003 Comprehensive Primary and Preventive Care Grant Program Performance Audit<br>As of May 2007 | | |
|---|---|---|
| **Prior Audit Recommendation** | **Agency Response** | **Disposition as of May 2007** |
| **Recommendation No. 4:** Consider working with the General Assembly to clarify statutes regarding the Advisory Council's responsibility to review applications and make recommendations to the Department on grant awards. | Agree | **Implemented.** House Bill 04-1027 clarified statutes to specify that the role of the Advisory Council is to review and make recommendations on the grant program protocols, rather than on the awarding of grant funds. |
| **Recommendation No. 5:** Improve oversight of Program expenditures by: (a) ensuring that grant funds are used for expenses incurred by paying on a reimbursement basis; (b) establishing guidelines on interest earned by grantees on their grant funds and requiring that funds be used within a defined period; and (c) recovering monies not expended by grantees and reverting the funds to the Tobacco Settlement Fund. | Agree | **Implemented.** Beginning with fiscal year 2004 the Department changed its policy to distribute funds to grantees on a reimbursement basis each quarter. As a result, grantees are not provided funds in advance of making expenditures and do not earn interest on their grant funds. |
| **Recommendation No. 6:** Develop audit procedures for the Program by reconciling grant expenditures with each project's budget, developing procedures to visit a sample of grantees, and establishing a schedule by December 31, 2003 for periodic onsite audits. | Partially Agree | **Implemented.** The Department reviews the quarterly expenses reported by each grantee and has set limits on the percentage of the grant that will be distributed each quarter. The Department also requires grantees to hire independent evaluators to review their data tracking procedures and verify the quarterly reports. The Department instituted this requirement in place of conducting onsite visits to grantees to improve oversight of the grants. |
| **Recommendation No. 7**: Improve oversight and monitoring of the Program by: (a) changing the structure of quarterly reports to ensure that sites submit accurate outcome and expenditure figures; and (b) requiring sites to submit budget-to-actual statements at the end of the grant period. | Agree | **Implemented.** Beginning in Fiscal Year 2004 the Department distributes funds to grantees based on reported quarterly expenses incurred. The reports include the original budget for the project. These quarterly reports are reviewed by independent reviewers hired by the grantees. |
| **Recommendation No. 8:** Ensure that Program files are complete by maintaining copies of all proposals, all documentation relating to contract negotiations, and all correspondence with grantees after the contracts are signed. | Agree | **Partially Implemented.** Our review of Program files identified no missing grant proposals or general correspondence. We did find that files contained limited documentation related to the contract negotiation process and the establishment of contract deliverables. **See Recommendation No. 3 of the May 2007 audit report.** |

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