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MEMORANDUM

Date: November 21, 2007

To: Members of the Legislative Audit Committee

From: Sally Symanski, CPA
State Auditor

Re: 2007 Executive Summary on Performance Audits of Tobacco Settlement Programs

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The purpose of this memo is provide an executive summary on evaluations conducted on tobacco settlement programs as required under Section 2-3-113(5), C.R.S., for evaluations completed in Calendar Year 2007. Section 2-3-113(2), C.R.S., requires the Office of the State Auditor (OSA) to conduct or cause to be conducted program reviews and performance evaluations of each state program receiving funding from the tobacco settlement agreement. The purpose of the reviews is to assess whether the tobacco settlement program meets its stated goals efficiently and effectively. Pursuant to this statute, the OSA is to submit an annual executive summary of the program reviews to the Legislative Audit Committee, the Governor, the Attorney General, the Joint Budget Committee, the House and the Senate Health, Environment, Welfare, and Institutions Committees, and various state agencies.

During 2007 the OSA completed a performance audit of the Comprehensive Primary and Preventive Care Grant Program (May 2007). The report summary and recommendation locator are attached to this memo. In addition the OSA began a performance audit of the Children's Basic Health Plan. This audit will be completed in 2008.

The list below summarizes the programs and the dates of the most recent performance audits conducted by the OSA. Reports on the subsequent status of implementation are available upon request.

- Children's Basic Health Plan Trust (July 2000)
- Read to Achieve (July 2006)
- Nurse Home Visitor Program (May 2006)
- Veterans Trust Fund (June 2003)
- Comprehensive Primary and Preventive Care Grant Program (May 2007)
- Dental Loan Repayment Program (April 2004)
- Tobacco Education, Prevention, and Cessation Grant Program (December 2004)[1]

All reports are available on the OSA Web site at www.state.co.us/auditor.

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[1] Funding for this program with Tobacco Settlement monies was eliminated beginning in Fiscal Year 2006 and replaced with funding from the Tobacco Excise Tax authorized by Amendment 35.

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STATE OF COLORADO
OFFICE OF THE STATE AUDITOR
SALLY SYMANSKI, CPA
State Auditor

REPORT SUMMARY

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

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A bound report may be obtained by calling the
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Please refer to the Report Control Number below when requesting this report.

Report Control Number 1917