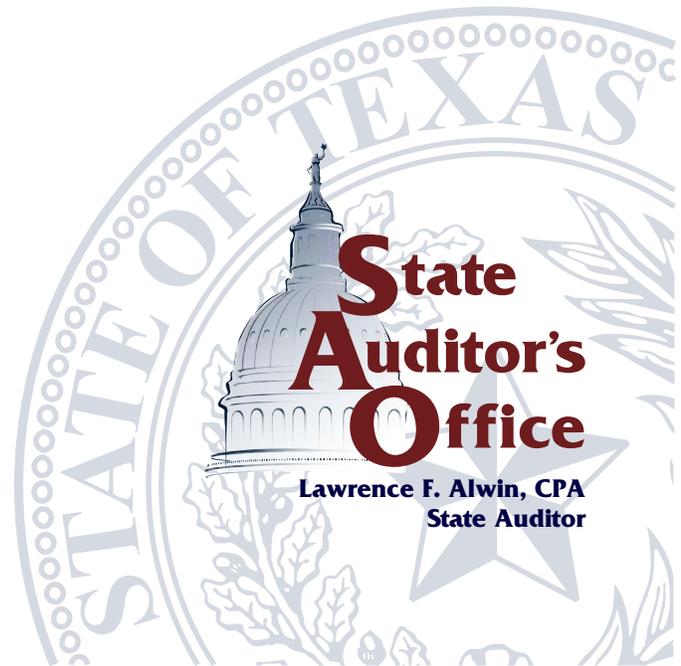


An Audit Report on

The Department of Health's Implementation of Its Bioterrorism Preparedness Plans

June 2004

Report No. 04-036



The Department of Health's Implementation of Its Bioterrorism Preparedness Plans

Overall Conclusion

The Department of Health (Department) has made substantial progress in implementing bioterrorism preparedness plans specified in its cooperative agreements with two federal agencies that fund its bioterrorism preparedness activities. However, the Department's contracting and other internal processes did not ensure adequate accountability for how bioterrorism preparedness funds were used. In particular, the Department should improve its processes for contract development and monitoring, as well as for ensuring compliance with all applicable federal requirements. The Department should also correct specific weaknesses related to its Health Alert Network's (HAN) functionality and security.

The U.S. Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) awarded approximately \$62 million to the Department in 2002 to be spent through fiscal year 2003. About 64 percent (\$24 million) of the Department's grant expenditures went to subrecipients through contracts in fiscal year 2003.

Background Information

Following international and domestic terrorist events in the fall of 2001, the federal government allocated hundreds of millions of dollars for distribution to improve preparedness for bioterrorism. As part of that effort, the U.S. Department of Health and Human Services funded states to enable them to improve bioterrorism preparedness in certain areas.

The Texas Department of Health was awarded \$54 million by the CDC and \$8 million by HRSA in fiscal year 2002 to be used through fiscal year 2003. Both grants required development of a cooperative agreement that addressed federally defined benchmarks and capacities and asked the Department to define additional strategies and activities to accomplish grant objectives. The Department relied to a great extent on contracts with local health departments and other entities to further grant objectives at the local level.

Key Points

The Department has made good progress toward accomplishing critical benchmarks established by the Centers for Disease Control and Prevention (CDC) and, to a lesser extent, the Health Resources and Services Administration (HRSA).

- The Department performed well against 14 benchmarks that CDC established in fiscal year 2002. Specifically, the Department accomplished nine of these benchmarks by the end of fiscal year 2003 and partially completed the remaining five. The Department's accomplishments against CDC benchmarks also compared well with other states' progress as reported by the U.S. General Accounting Office (GAO).
- The nine benchmarks accomplished by the Department ensured that it had an organizational structure dedicated to bioterrorism preparedness and specific plans in place for state-level responsiveness in key areas. Planning efforts included development of a statewide bioterrorism preparedness and response plan, an interim risk communication plan, and an interim plan to distribute pharmaceuticals during a bioterrorism event.



- The Department has only partially accomplished five CDC benchmarks, including an assessment of public health capacity and the development of regional response plans.
- The Department achieved three benchmarks it expected to complete during the initial phase of its HRSA grant, but it has been slow to ensure that HRSA funds are reaching hospitals and are spent in support of preparedness for a bioterrorism event.

The Department's processes for contract development, contract monitoring, and compliance with federal requirements were not adequate and did not ensure accountability for the use of program funds.

- We have previously reported on weaknesses in the Department's contract monitoring.¹ With respect to the bioterrorism preparedness program, the Department did not ensure that contracts contained clear deliverables, did not adequately monitor contracts through which it awarded grant funds, did not hold contractors accountable for timely completion of deliverables, and did not have adequate controls to ensure that funds were spent appropriately.
- The Department was not in full compliance with federal regulations for subrecipient monitoring, payroll allocation and certification, performance reporting, and cash management related to its CDC grant. The Department has also not complied with cash management requirements associated with its HRSA grant.

While the Health Alert Network (HAN) is generally functioning as intended, our audit identified certain weaknesses related to testing, staffing, and security.

- The Department did not have adequate testing procedures to determine the precise level of HAN coverage statewide.
- Staffing and training of HAN administration at the local level were not always adequate and local testing was not always being performed.
- Specific security issues associated with the HAN were also noted.

Summary of Management's Response

Management generally agrees with our recommendations. The Department reports that implementation of many of the recommendations is in progress and that significant improvements have already been made. The Department also states that it "will continue to work with contracting and monitoring staff to address any issues of accountability for all federal programs." Appendix 2 contains the Department's full response.

¹ See *An Audit Report on the Department of Health's Monitoring of Program Service Contractors' Financial Operations*, State Auditor's Office Report No. 04-029, April 2004.

Summary of Information Technology Review

Our review of information technology was limited to our review of aspects of security, business continuity planning, backup and recovery, and functionality of the HAN. As discussed in more detail in Chapter 3, we identified certain deficiencies in the HAN's physical security, controls over user access, business continuity planning, and functionality.

We did not perform any additional testing of the Department's automated accounting systems. Two information technology systems—the Laboratory Information Management System (LIMS) and the National Electronic Disease Surveillance System (NEDSS)—have not yet been fully implemented in Texas; therefore, we did not audit these systems.

Summary of Objective, Scope, and Methodology

Our overall objective was to determine whether the Department is efficiently and effectively implementing a bioterrorism preparedness plan.

To address this objective, we performed audit work to determine whether:

- The Department is implementing its bioterrorism preparedness plan in accordance with its agreements with the CDC and HRSA.
- The Department has adequate internal processes to achieve timely implementation.
- Contingencies are in place if implementation goals are not being met.
- Funds are being used as intended.
- The HAN is functioning as intended.

In addition, we performed audit work to determine whether the Department complied with federal requirements under the Single Audit Act of 1996 and the U.S. Office of Management and Budget (OMB) Circular A-133 related to the Catalog of Federal Domestic Assistance (CFDA) 93.283 (Centers for Disease Control and Prevention—Investigations and Technical Assistance) in fiscal year 2003.

The scope of this audit covered fiscal year 2002 through fiscal year 2003, although relevant historical and current information was included where appropriate to provide context and balance. We focused on activities and requirements pertaining to specific cooperative agreements with the CDC and HRSA, which are both components of the U.S. Department of Health and Human Services. We performed more extensive testing of the agreement with CDC because of its larger scope, its larger award size, and our additional objective to issue an opinion on compliance with CFDA 93.283. Our testing of the agreement with HRSA was limited to a review of the expenditure patterns and to reporting the Department's progress on certain milestones.

The audit methodology consisted of collecting information, performing selected tests and other procedures, analyzing and evaluating the results against established criteria, and conducting interviews with federal and local officials and Department management and

staff. We performed site visits to assess contract compliance and the use of funds by a sample of contractors,² and we conducted additional electronic and phone surveys of grant recipients. Our test of the Department's compliance with federal requirements included assessing timekeeping practices of Department staff, assessing controls over cash management and subrecipient monitoring, and testing financial and performance reporting.

 Table of Results and Recommendations
 denotes entry is related to information technology

The Department has made substantial progress in implementing its bioterrorism preparedness plans, and it should continue efforts to complete outstanding benchmarks. (Page 1)

The Department should:

- Develop and document a methodology and procedures for measuring and testing the coverage of the HAN and strategies to ensure 90 percent coverage. It should also obtain and document clarification, if needed, from the CDC regarding the benchmark's intent.
- Complete its statewide public health capacities assessment and re-evaluate Department and contractor activities based on the assessment's results.
- Evaluate the completion rate of regional plans prior to the current deadline of August 31, 2004, to troubleshoot and, as needed, add resources to ensure the completion of regional plans in a timely manner.
- Develop a plan to evaluate the uses of HRSA grant funds and to ensure the rapid and appropriate use of remaining HRSA funds.
- Evaluate the status of its statewide epidemic response plan for hospitals and identify strategies to ensure timely completion of the plan.

The Department did not adequately develop or monitor bioterrorism contracts, and contract activities were delayed. (Page 4)

The Department should:

- Ensure that meaningful performance measures are included in all contracts associated with bioterrorism and hospital preparedness.
- Ensure that all bioterrorism-related contracts contain deliverables that are clear and quantifiable and have associated timeframes for completion.
- Amend existing bioterrorism contracts to define specific deliverables or measurable results to be achieved by the end of the current contract period of August 31, 2004.
- Improve contract monitoring by ensuring that it uses contractors' progress reports to identify and request corrective actions in a timely manner.

The Department did not have an effective system for ensuring that contractors used funds as required, which was important particularly for contractors that deviated from original contract specifications. (Page 7)

The Department should:

- Consider whether the practice of restricting budget categories or specific purchases is necessary; if continued, ensure that adequate controls are in place to ensure that payments are not made on "restricted" items.
- Develop policies and procedures to require that, before contractors are paid, contractors submit more detailed information and that appropriate Department staff review the information to provide greater assurance that reimbursement requests conform to contract terms and federal requirements.
- Require that bioterrorism contractors implement additional controls over timekeeping and payroll systems to ensure that grant-funded contractors' salaries are properly documented and charged, especially in the cases of contract personnel who may spend time on activities not related to the contract.

² The term "contractor," as used in this report, can include subrecipients as defined in OMB Circular A-133.

Table of Results and Recommendations
 denotes entry is related to information technology

- Review exceptions noted above in which reimbursements to contractors have been questioned and make appropriate adjustments.

The Department's controls were insufficient to ensure that it followed cash management regulations applicable to its HRSA grant. (Page 9)

The Department should:

- Ensure that it complies with cash management requirements for timeliness when drawing down federal funds.
- Ensure that subrecipients, such as RACs and hospitals, implement adequate procedures to minimize the time between the receipt and the expenditure of funds when advances are made.
- Ensure that subrecipients, such as RACs and hospitals, comply with applicable regulations regarding the refund of interest earned on advances from federal grants.

The Department did not comply with all federal regulations applicable to its CDC grant. (Page 9)

(See Appendix 6 for all related findings, recommendations, and management's responses.)

 The HAN is generally functioning as intended, but the Department should strengthen certain aspects of HAN functionality and security. (Page 11)

In addition to addressing the HAN testing recommendation made in Chapter 1 of this report, the Department should:

- Develop, document, and implement policies and procedures to ensure that periodic testing of the HAN's coverage is performed and that the results are documented and analyzed by Department staff. The policies should define frequency of testing.
- Ensure that each local health department with which it has a bioterrorism-related contract designates one of its employees as a HAN administrator.
- Ensure that each local HAN administrator receives proper training to use the HAN.
- Ensure that local HAN administrators regularly test HAN functionality and take corrective actions, if necessary, based on test results.
- Ensure that password policies for the HAN are changed and enforced to comply with Department policy.
- Evaluate physical security risks at the HAN backup site and implement a cost-effective approach to mitigate them. This could involve either improving the physical security at the current site or moving it to a more secure location.
- Specify the correct HAN backup site in the HAN business continuity plan and add detailed recovery procedures to the plan.
- Ensure that the HAN business continuity plan is tested and updated at least annually.
- Evaluate the risks of having primary and backup sites too close together and consider moving at least one of these sites.

Recent SAO Work

Number	Product Name	Release Date
04-029	An Audit Report on the Department of Health's Monitoring of Program Service Contractors' Financial Operations	April 2004

Contents

Detailed Results

Chapter 1	
The Department Has Made Substantial Progress in Implementing Its Bioterrorism Preparedness Plans, and It Should Continue Efforts to Complete Outstanding Benchmarks	1
Chapter 2	
The Department's Internal Systems and Controls, Especially Those Related to Contract Development and Monitoring, Did Not Ensure Adequate Accountability for How Funds Were Used	4
Chapter 3	
The HAN Is Generally Functioning as Intended, but the Department Should Strengthen Certain Aspects of HAN Functionality and Security	11

Appendices

Appendix 1	
Objective, Scope, and Methodology	14
Appendix 2	
Management's Responses	18
Appendix 3	
Critical Capacities Identified by the CDC	31
Appendix 4	
Summary of the Department's Progress in Accomplishing Critical Benchmarks Established by the CDC	33
Appendix 5	
Summary of the Department's Progress in Fulfilling HRSA Benchmarks and Requirements	34
Appendix 6	
Results of Federal Compliance Testing	35

Detailed Results

Chapter 1

The Department Has Made Substantial Progress in Implementing Its Bioterrorism Preparedness Plans, and It Should Continue Efforts to Complete Outstanding Benchmarks

The Department's Bioterrorism Preparedness Plans

The Department's bioterrorism preparedness plans can be described as:

- Activities funded by the CDC through a comprehensive grant that covered six focus areas in fiscal years 2002 and 2003 and totaled \$54 million during that period.
- Activities funded by HRSA in a much smaller grant aimed at improving preparedness of hospitals for a bioterrorism event. In fiscal year 2002, \$8 million was allocated to the Department under this grant to be spent through fiscal year 2003.

Both grants required the Department to meet specific benchmarks or milestones defined by the federal grantors and to define and propose activities and strategies the Department believed would improve its preparedness levels and capacity for response. The CDC defined critical capacities (see Appendix 3) that served as an overall framework around which the Department organized its activities and strategies.

The Department of Health (Department) performed well against bioterrorism preparedness benchmarks established by the U.S. Centers for Disease Control (CDC) for all states. The Department accomplished 9 of 14 benchmarks by the end of fiscal year 2003 and, in most cases, it matched or exceeded what other states have accomplished as reported in a U.S. General Accounting Office (GAO) study.³ In accomplishing these benchmarks, the Department ensured that it had an organizational structure dedicated to bioterrorism preparedness and specific plans in place for state-level responsiveness in key areas. However, the Department still needs to complete certain preparedness activities to meet critical benchmarks and fulfill its cooperative agreements with the CDC and the U.S. Health Resources and Services Administration (HRSA). Appendix 4 provides more details on the Department's progress on each of the CDC's 14 benchmarks and compares the Department's progress with results from the GAO's study. Appendix 5 provides information on the status of HRSA benchmarks and grant requirements.

The Department has made substantial progress in implementing its bioterrorism preparedness plans and generally matches or exceeds progress reported by other states.

The Department has accomplished significant components of its bioterrorism preparedness plans. In addition to creating an organizational structure dedicated to bioterrorism response, the Department has completed a statewide bioterrorism preparedness and response plan; an interim risk communication plan; an interim plan to distribute pharmaceuticals during a bioterrorism event; an assessment of relevant statutes, regulations, and ordinances; and a time line for assessing staff training needs. It also has enhanced important systems such as the Health Alert Network (HAN) and a 24-hour system for communicating urgent disease reports.

Further, the Department's progress is generally equal to or better than that of other states. A February 2004 GAO study found that:

- Most states reported that they had accomplished four CDC benchmarks (primarily "start up" activities).

³ *HHS Bioterrorism Preparedness Programs*, GAO-04-360R, U.S. General Accounting Office, February 10, 2004.

- About half the states reported that they had accomplished eight additional CDC benchmarks.
- Only a few states reported that they had completed state and regional response plans.

By comparison, our audit verified that the Department accomplished nine CDC benchmarks, including one benchmark accomplished by only a few states and five benchmarks accomplished by only about half of the states. The Department has partially completed all other CDC benchmarks. See Appendix 4 for additional details. In addition, according to an official at the CDC, Texas is among the first of the states (after the beta test group) to implement the National Electronic Disease Surveillance System (NEDSS) software for disease surveillance, based on its ability to show readiness for implementation.

The Department should continue its efforts to achieve outstanding CDC benchmarks, especially benchmarks related to the HAN, the assessment of local capacity, and regional response planning.

The Department has not completed one benchmark that most states reported they had completed: ensuring that the HAN covered 90 percent of the appropriate parties statewide. The Department may have achieved 90 percent coverage, but due to inadequate test data, we could not confirm this. Specific HAN testing deficiencies are discussed in Chapter 3 of this report.

The Department has also not completed two other important benchmarks: (1) an assessment of statewide public health capacities and (2) regional response plans. Both of these benchmarks should be considered high priorities for completion in this fiscal year. The assessment is important for planning optimal use of resources, while regional response plans are a key component to making the statewide response plan operational.

Although it has also fulfilled several important HRSA benchmarks and requirements, the Department's progress in fulfilling the intent of its HRSA grant to enhance hospital preparedness appears to be slow.

The Department has achieved two of the three benchmarks HRSA established for improving hospital preparedness, and it has completed one other requirement of Phase 1 of the grant: developing an implementation plan. However, it appears to be making slow progress on its requirement to ensure that funds are distributed to hospitals and spent appropriately. Specifically, because of inadequate monitoring processes, the Department could not report how much of the HRSA grant funding has been used to support hospitals or what items were purchased with those funds. These funds are intended for purchasing equipment and supplies that would help hospitals be prepared for a large-scale event, such as the release of a highly contagious agent affecting large numbers of people.

However, amounts spent by eight Regional Advisory Councils (RAC)⁴ we interviewed averaged 57.5 percent of the HRSA funds they had received, thus

⁴ "Regional Advisory Council" refers to 1 of 22 Trauma Service Area Regional Advisory Councils (RACs) in the state. These nonprofit organizations plan and coordinate trauma services with hospitals in their regions toward an overall goal of improving patient outcomes.

leaving a substantial proportion of funds unspent. In addition, one RAC we interviewed that had been awarded \$270,000 could not provide any information on how much of those funds it had spent.

A third HRSA benchmark—developing a plan for statewide response to an epidemic involving 500 patients or more—is not expected to be complete for at least another year. The GAO found that none of the 50 states had completed this benchmark at the time of its study; however, given the importance of this benchmark to overall preparedness, the Department should be especially proactive in its efforts to ensure that this plan is completed on schedule. See Appendix 5 for a summary of the Department's status in accomplishing specific benchmarks and requirements associated with its HRSA grant.

Recommendations

The Department should:

- Develop and document a methodology and procedures for measuring and testing the coverage of the HAN and strategies to ensure 90 percent coverage. It should also obtain and document clarification, if needed, from the CDC regarding the benchmark's intent.
- Complete its statewide public health capacities assessment and re-evaluate Department and contractor activities based on the assessment's results.
- Evaluate the completion rate of regional plans prior to the current deadline of August 31, 2004, to troubleshoot and, as needed, add resources to ensure the completion of regional plans in a timely manner.
- Develop a plan to evaluate the uses of HRSA grant funds and to ensure the rapid and appropriate use of remaining HRSA funds.
- Evaluate the status of its statewide epidemic response plan for hospitals and identify strategies to ensure timely completion of the plan.

The Department's Internal Systems and Controls, Especially Those Related to Contract Development and Monitoring, Did Not Ensure Adequate Accountability for How Funds Were Used

The Department did not always ensure that bioterrorism-related contracts contained clear deliverables and performance measures. Moreover, the Department did not adequately monitor contractors'⁵ progress on contract deliverables, and it did not have adequate controls to ensure that program funds were used appropriately. This resulted in a lack of accountability for delays in contractor progress and in some bioterrorism contractors' making unauthorized expenditures and inappropriately charging personnel costs to grants. The Department used contracts with local health departments and others to further grant objectives at the local level.

As we reported in April 2004, the Department has had long-standing weaknesses in its monitoring of contractors' financial operations.⁶ Our testing of the Department's compliance with federal regulations also identified weaknesses in the Department's monitoring of bioterrorism-related contractors, payroll allocation, certification of program staff, and performance reporting associated with bioterrorism-related funds. Weaknesses in cash management associated with both the CDC and HRSA grants were also identified.

Chapter 2-A

The Department Did Not Adequately Develop or Monitor Bioterrorism Contracts, and Contract Activities Were Delayed

The Department's processes associated with the development of bioterrorism contract deliverables and performance measures, as well as with contract monitoring (including progress reporting), were not adequate. Moreover, contractors failed to provide some deliverables or complete some activities specified in their fiscal year 2003 contracts. The adequate development of bioterrorism contracts and the monitoring of contractors are important because these contractors received the majority of grant funds. In fiscal year 2003, the Department reported distributing 69 percent of its CDC grant funds to local health departments and public health regions through contracts or other agreements. In the same year, the Department disbursed 96 percent of its HRSA grant funds to RACs through contracts.

Contracts did not consistently contain clear deliverables or performance measures.

Some of the Department's contracts did not contain clear deliverables or performance measures, which made assessing contractor performance difficult. For example, the Department's primary HAN contract (a \$3 million contract awarded in fiscal year 2002) contained vaguely described deliverables and no performance measures. In this case, the contractor was responsible for "expanding the HAN system" without specifications as to the number of new network participants that would fulfill its

⁵ The term "contractor," as used in this report, can include subrecipients as defined in OMB Circular A-133.

⁶ See *An Audit Report on the Department of Health's Monitoring of Program Service Contractors' Financial Operations*, State Auditor's Office Report No. 04-029, April 2004.

contract obligations. In addition, the Department awarded this contract using a sole source process that was predicated on its original sole source award in fiscal year 2000; however, the original sole source award process was not approved by the Health and Human Services Commission as required. Furthermore, this contract did not include all the activities the Department stated that this contractor would perform in the Department's cooperative agreement with CDC.

The Department's contracts with RACs also contained no performance measures and only vaguely defined reporting requirements. One RAC delegated its responsibility for facilitating hospitals' purchases to another nonprofit entity without the benefit of a written contract.

Contracts that did contain measures, such as contracts with local health departments, used the CDC's critical benchmarks and critical capacities as performance measures. However, these performance measures were often not precise enough to measure short-term performance. See Appendix 3 for a list of critical capacities.

The Department's monitoring of local health departments and other entities to which it awarded contracts was inadequate, partly due to insufficient progress reporting.

The Department's program and financial monitoring of contractors was inadequate. Specifically, it performed only a small number of site visits at contractors and did not collect and assess sufficient information to evaluate contractors' expenditures and performance. For example:

- In fiscal year 2003, the Department performed site visits to evaluate contract compliance or performance at only 5 of more than 50 local health departments to which it awarded bioterrorism preparedness funds and at only two of the nine regional labs that received bioterrorism preparedness funds.
- The Department's files lacked information about the number and type of subcontracts awarded by one large local health department we visited, despite the fact that this department spent approximately 21 percent of its bioterrorism award on 13 subcontracts in fiscal year 2003.
- For one public health region we visited, contractors were not required to submit progress reports, and no monitoring activities were documented for the eight contracts that were supposed to be completed in fiscal year 2003. Moreover, of the 16 "high-risk" deliverables we tested, only 6 (38 percent) had been received at the time of our review, which was several months after the close of the fiscal year.
- The Department did not consistently collect or analyze data on the progress achieved in using HRSA funds to equip hospitals. However, its cooperative agreement with HRSA required the Department to "monitor the expenditure of these funds by the hospitals to ensure that they are being spent on services or materials that are approved by TDH." Its contracts with RACs also contained a requirement that RACs submit expenditure data to the Department on a monthly basis.

- Some progress reports that contractors submitted did not provide status information for all original contract activities and deliverables. For example, we tested six fourth-quarter progress reports against the original contracts and found that five contractors failed to report on at least one deliverable tested; one local health department failed to report on ten (56 percent) items tested.

Local health departments and other contractors we tested were generally making progress but frequently did not accomplish all goals and activities specified in their bioterrorism contracts with the Department.

In three site visits we made to local health departments, we found that, while they generally had not completed everything in their original workplans, local officials were making substantial progress toward achieving appropriate goals and grant objectives. However, the sample of contractor progress reports we analyzed indicated that none of these contractors had completed all their contract deliverables within proposed timeframes. Moreover, five of these reported completing 50 percent or less of contract deliverables included in our testing by the fourth quarter of the contract period.

Several factors may have contributed to this lack of completion. Some of the contracts with local health departments we reviewed specified a large number of deliverables in contract workplans, which may not have been realistic. Further, the Department did not require contractors to prioritize deliverables they proposed in their contracts for fiscal year 2003.

The Department's primary HAN contractor also had not accomplished one contract activity and had only partially accomplished three of five contract activities included in our analysis as of the end of its fiscal year 2003 contract term. This was due in part to the Department's redirection of some activities that was not reflected in contract documents.

As discussed elsewhere in this report, the Department could not specify the extent to which contractors that received HRSA funds had accomplished contract objectives, but progress appeared to be slow.

Recommendations

The Department should:

- Ensure that meaningful performance measures are included in all contracts associated with bioterrorism and hospital preparedness.
- Ensure that all bioterrorism-related contracts contain deliverables that are clear and quantifiable and have associated timeframes for completion.
- Amend existing bioterrorism contracts to define specific deliverables or measurable results to be achieved by the end of the current contract period of August 31, 2004.
- Improve contract monitoring by ensuring that it uses contractors' progress reports to identify and request corrective actions in a timely manner.

The Department Did Not Have an Effective System for Ensuring That Contractors Used Funds as Required, Which Was Important Particularly for Contractors That Deviated from Original Contract Specifications

During fiscal year 2003, the Department frequently amended its bioterrorism-related contracts, particularly in the area of equipment purchases. However, it did not have adequate controls in place to ensure that (1) its reimbursements to contractors were allowable under federal grant requirements or (2) contractors' purchases adhered to either original or revised contract terms. This is because the Department did not require contractors to submit detailed information to support their reimbursement requests. Instead, the Department relied on financial monitoring visits and program monitoring visits to audit expenditures and determine, after the fact, whether they were appropriate and allowable under the contract. However, as discussed in Chapter 2-A, the Department's program and financial monitoring visits were not sufficient to verify that contractors' expenditures were appropriate.

Our tests at bioterrorism contractors identified the following exceptions:

- The Department's primary HAN contractor spent \$1,016,000 (about one-third of its total contract award) on equipment and other items without the Department's formal authorization. Specifically, the contractor was regularly reimbursed for equipment purchases and other expenditures that had been "restricted." The Department reported that it gave informal approval of purchases during the contract period and instituted formal approval for these purchases retroactively. We reported this same issue in our April 2004 report.

The Department's contract development and monitoring process also did not ensure that this contractor had controls in place for properly allocating salaries to the bioterrorism grant. The salary charges that were made are currently under review by the Department,⁷ and some or all of them may be disallowed.

This contractor also included a budget for indirect costs that was inappropriate due to the nature of the direct charges allowed in the contract. Again, the Department lacked controls that would have prevented the improper inclusion of these costs in the budget. The contractor sought reimbursement for \$2,500 in indirect costs—charges which are also currently under review by the Department and may be disallowed.

This contractor also double-billed the Department and, therefore, received \$25,910 in duplicate payments. These payments are under review by the Department and should be disallowed.

- One local health department charged approximately \$82,000 in personnel costs to its bioterrorism contract for positions that were not approved in the personnel budget that was part of its contract with the Department.

⁷ These types of reviews, previously performed by the Grants Management Division of the Department, are currently performed by the Office of Inspector General at the Health and Human Services Commission.

This local health department also inappropriately spent \$1,050 when it paid a subcontractor for services not related to bioterrorism preparedness.

In addition, this local health department collected reimbursements for \$91,328 in *projected* expenditures, violating Department policy. Actual expenses were only \$88,602, which caused this local health department to receive an overpayment of \$2,726 that must be refunded.

The Department has begun to implement a number of improvements that may address some of these weaknesses. For example, the Department created the Center for Public Health Preparedness and Response to integrate activities and functions related to bioterrorism preparedness and other public health threats or emergencies. In addition, the Department has redesigned contracts with local health departments and service level agreements with public health regions to provide for additional performance reporting and accountability. It has also devised a schedule of monitoring visits to local health departments and public health regions and has issued reports on two of the five monitoring visits it reports it has completed. In our April 2004 report, we made other, specific recommendations to improve financial monitoring, and the Department generally agreed with those recommendations.

Recommendations

The Department should:

- Consider whether the practice of restricting budget categories or specific purchases is necessary; if continued, ensure that adequate controls are in place to ensure that payments are not made on “restricted” items.
- Develop policies and procedures to require that, before contractors are paid, contractors submit more detailed information and that appropriate Department staff review the information to provide greater assurance that reimbursement requests conform to contract terms and federal requirements.
- Require that bioterrorism contractors implement additional controls over timekeeping and payroll systems to ensure that grant-funded contractors’ salaries are properly documented and charged, especially in the cases of contract personnel who may spend time on activities not related to the contract.
- Review exceptions noted above in which reimbursements to contractors have been questioned and make appropriate adjustments.

The Department's Controls Were Insufficient to Ensure That It Followed Cash Management Regulations Applicable to Its HRSA Grant

The Department did not comply with cash management requirements when it received HRSA funding, and it failed to ensure that the subrecipients to which it disbursed funding complied with federal cash management regulations. Specifically, the Code of Federal Regulations specifies that the Department must minimize the time between its drawdown of federal funds and its disbursement of those funds for program purposes. The timing and amount of funds transfers must be as close as is administratively feasible to the actual cash outlay for direct program costs and the proportionate share of any allowable indirect costs. Furthermore, Office of Management and Budget (OMB) Circular A-133, Compliance Supplement, Part C, states that when advance payment procedures are used, recipients such as the Department must establish similar procedures for subrecipients.

However, the Department drew its HRSA funds down based on estimated, rather than actual, immediate cash requirements. Moreover, much of the funding it advanced to RACs in June 2003 remained in their bank accounts at the time of our audit. Furthermore, some hospitals that had received lump sums from RACs had not spent these in a timely manner. As a result, the Department may owe to HRSA the interest earned on advances that were made to RACs or hospitals and that were not spent in a timely manner. However, the Department has not (1) taken steps to ensure that RACs comply with timing requirements after they receive funds or (2) ensured that interest earned on these funds is properly refunded.

Recommendations

The Department should:

- Ensure that it complies with cash management requirements for timeliness when drawing down federal funds.
- Ensure that subrecipients, such as RACs and hospitals, implement adequate procedures to minimize the time between receipt and expenditure of funds when advances are made.
- Ensure that subrecipients, such as RACs and hospitals, comply with applicable regulations regarding the refund of interest earned on advances from federal grants.

The Department Did Not Comply with All Federal Regulations Applicable to Its CDC Grant

Our test of the Department's compliance with federal regulations applicable to its CDC grant indicated that the Department has several weaknesses in controls. The Department did not have adequate controls over monitoring of subrecipients, the accuracy of performance reports it submitted to the CDC, allocation and certification of payroll expenditures for salaries charged to the CDC grant, or cash management.

We performed this work as part of the State's compliance with the Single Audit Act of 1996 and OMB Circular A-133. The results of this work are incorporated in the *State of Texas Federal Portion of the Statewide Single Audit Report for the Year Ended August 31, 2003* (issued by KPMG, LLP in March 2004). See Appendix 6 for the full text of the opinion issued by the State Auditor, related findings, recommendations, and the Department's responses.

The HAN Is Generally Functioning as Intended, but the Department Should Strengthen Certain Aspects of HAN Functionality and Security

The HAN, a critical system for bioterrorism preparedness, is generally functioning as intended. The system is stable and functional in sending and receiving health alerts. In addition, it is being used to a limited extent for disease reporting, and this use will be expanded with the implementation of the National Electronic Disease Surveillance System (NEDSS), using the HAN as a platform. However, we identified certain weakness associated with the HAN in the areas of system testing, training, administration, security, and business continuity planning that must be addressed. Weaknesses in testing and security-related matters increase the risk that the HAN will not function as expected during a bioterrorism event or other public health emergency.

HAN administrators at the Department, in the regions, and in local health departments perform important functions such as testing HAN contact information to ensure that it is accurate and complete, training HAN users, sending or forwarding health alerts, and ensuring that key personnel have access to the HAN and/or receive health alerts. If these functions are not successfully performed, then appropriate personnel might not receive health alerts. If HAN administrators are not designated at regional and local levels, then procedural information (such as policies, procedures, and security updates) might not be properly incorporated by local HAN users, which could impair the functionality of the system. We identified the following specific weaknesses:

- Testing of the HAN has been inadequate to verify the extent of statewide coverage,⁸ and the testing process needs to be better defined and documented. Specifically, the Department has not established a clear and consistent process for testing HAN functionality (that is, the successful transmission of alerts to intended audiences). Staff reported following different testing practices at different times, including performing monthly, quarterly, or ad hoc tests.

The Department also has not implemented corrective actions on unsuccessful transmissions according to a consistent procedure or schedule. Timely correction of erroneous contact information is important to HAN functionality. For example, in a recent test of selected HAN areas performed by the Department, 21 percent of the alerts were not successfully transmitted, and 54 percent of the records accessed to perform the test lacked at least one piece of “vital information” such as an e-mail address, street address, or telephone number. Furthermore, staff could not consistently provide documentation of test procedures that they reported they had performed. Moreover, the Department does not have written procedures in place that describe the testing procedures to be performed to precisely determine the level of statewide coverage, which is an important component of meeting CDC’s benchmark of 90 percent coverage. In conjunction with that, the Department also does not have written policies and

⁸ The term “coverage” was previously not clearly defined by the CDC. In fiscal year 2004, CDC defined it as “the percentage of the state’s population that lives in jurisdictions covered by the HAN.” Using this definition, the Department reported that the HAN had achieved 87 percent coverage in June 2003; however, subsequent testing indicated that coverage was only 80 percent for a sample of jurisdictions that were not necessarily representative of the population.

procedures to ensure that HAN contact information is accurate and that inaccuracies are corrected in a timely manner.

- Not all local health departments that are HAN participants had designated HAN administrators, nor did the Department require them to do so. Specifically, 23 of the 70⁹ local health departments at which the HAN was installed did not have HAN administrators. This included one of the largest local health departments, which stated that it did not have the budget for a HAN administrator. In addition, not all individuals designated as HAN administrators have received adequate training on the use of the HAN or are performing functionality testing of their area HAN on a regular basis.
- We also identified several weaknesses related to the security and continuity of the HAN:
 - ♦ No password history is being maintained. As a result, the same password can be reused after a certain period of time. The practice of not maintaining password histories and not preventing the reuse of passwords increases the risk of a breach of security. The Department's Security Policy 7.03.14.1.e requires that a password history be kept to prevent the reuse of a password.
 - ♦ There were several physical security issues involving the HAN backup server site. These included a lack of physical security (unlocked doors), the lack of a fire suppression system, and the lack of a separate cooling system to protect equipment from damage that could be caused by high temperatures.
 - ♦ Two primary HAN sites and one backup site are close to one another, thus increasing the risk that several or all sites could be damaged or destroyed by a single event such as a natural disaster.
 - ♦ The HAN business continuity plan lacks detailed recovery procedures for HAN-related information technology systems and contains contradictory information regarding a backup site for the system.

Recommendations

In addition to addressing the HAN testing recommendation made in Chapter 1 of this report, the Department should:

- Develop, document, and implement policies and procedures to ensure that periodic testing of the HAN's coverage is performed and that the results are documented and analyzed by Department staff. The policies should define frequency of testing.
- Ensure that each local health department with which it has a bioterrorism-related contract designates one of its employees as a HAN administrator.

⁹ According to the Texas Association of Local Health Officials, there are 70 participating local health departments.

- Ensure that each local HAN administrator receives proper training to use the HAN.
- Ensure that local HAN administrators regularly test HAN functionality and take corrective actions, if necessary, based on test results.
- Ensure that password policies for the HAN are changed and enforced to comply with Department policy.
- Evaluate physical security risks at the HAN backup site and implement a cost-effective approach to mitigate them. This could involve either improving the physical security at the current site or moving it to a more secure location.
- Specify the correct HAN backup site in the HAN business continuity plan and add detailed recovery procedures to the plan.
- Ensure that the HAN business continuity plan is tested and updated at least annually.
- Evaluate the risks of having primary and backup sites too close together and consider moving at least one of these sites.

Appendices

Appendix 1

Objective, Scope, and Methodology

Objective

Our objective was to determine whether the Department of Health (Department) is efficiently and effectively implementing a bioterrorism preparedness plan.

To address this objective, we performed audit work to determine whether:

- The Department is implementing its bioterrorism preparedness plan in accordance with its agreements with the U.S. Centers for Disease Control and Prevention (CDC) and the U.S. Health Resources and Services Administration (HRSA).
- The Department has adequate internal processes to achieve timely implementation.
- Contingencies are in place if implementation goals are not being met.
- Funds are being used as intended.
- The Health Alert Network (HAN) system is functioning as intended.

In addition, we performed audit work to determine whether the Department complied with federal requirements under the Single Audit Act of 1996 and the U.S. Office of Management and Budget (OMB) Circular A-133 related to the Catalog of Federal Domestic Assistance (CFDA) 93.283 (Centers for Disease Control and Prevention Investigations and Technical Assistance) in fiscal year 2003.

Scope

Our scope included fiscal year 2002 through fiscal year 2003, although relevant historical and current information was included where appropriate to provide context and balance. We focused on activities and requirements pertaining to specific cooperative agreements with the CDC and HRSA, which are both components of the U.S. Department of Health and Human Services. We performed more extensive testing of the agreement with CDC because of its larger scope, its larger award size, and our additional objective regarding issuing an opinion on compliance with CFDA 93.283. Our testing of the agreement with HRSA was limited to a review of the expenditure patterns and to report on progress on certain milestones. We reviewed program activities within the Department's Office of the State Epidemiologist, the Office of Public Health Practice, the Bureau of Laboratories, and other Department divisions as applicable at Department headquarters in Austin. We also reviewed relevant program activities within public health regions.

We reviewed grant agreements, contracts, performance reports, job descriptions, financial records, timekeeping records, policies, procedures, and relevant support

documentation for all of these. We interviewed federal officials, Department staff and management, contractors, local officials, and other individuals as relevant. We physically inspected equipment supporting the HAN and equipment purchased by Department staff in regions and local health department officials with grant funds.

Methodology

We performed site reviews at one public health region and three local health departments. At those locations, we tested expenditures, inspected equipment and laboratory renovations, and assessed performance associated with bioterrorism grant contract deliverables. We also performed expenditure testing of the Department's bioterrorism-related contracts with the Texas Association of Local Health Officials and assessed performance against contract deliverables for that contractor. In addition, we evaluated progress reports against contracts for four additional local health departments receiving funding to evaluate completeness of reporting and levels of reported progress.

Our review of information technology was limited to our review of aspects of security, business continuity planning, backup and recovery, and functionality of the HAN. This review included conducting a survey of local health departments regarding their experience with the HAN and conducting phone interviews of eight HAN administrators around the state. In addition, we performed physical inspections and user tests to assess physical security and user access to the HAN.

We performed telephone surveys of 8 of the 22 Regional Advisory Councils (RAC) responsible for distributing HRSA funds. We also interviewed federal officials about the Department's federal programs in general and its cooperative agreements in particular.

This work was in addition to work performed to assess the Department's internal controls and compliance with federal requirements with respect to bioterrorism funding, which resulted in our opinion letter of February 23, 2004 (see Appendix 6). The federal compliance work included assessing timekeeping practices of Departmental staff, assessing controls over cash management and contractor monitoring, and testing financial and performance reporting. Our test of performance reporting included verification of the status of 40 activities that the Department reported as completed to the CDC.

Information collected included the following:

- Interviews
- Physical observations
- Documentary evidence such as:
 - ♦ Policies and procedures
 - ♦ Contracts, grant applications, and grant award correspondence
 - ♦ Reimbursement vouchers, receipts, canceled checks, financial status reports, and other financial records

- ♦ Performance reports, progress reports, and project summaries
- ♦ Planning documents, rosters, job descriptions, time sheets, meeting minutes, and fact sheets

Procedures and tests conducted included the following:

- Analyzed staff duties and responsibilities
- Analyzed and tested specific expenditures for allowability and appropriateness; specifically, we tested judgmental samples of expenditures at three local health departments that had bioterrorism contracts with the Department and one public health region that received bioterrorism funding
- Assessed controls over contract development, monitoring, and applicable federal compliance requirements
- Analyzed progress reports from contractors and the Department for completeness and accuracy
- Verified progress for selected Department- and contractor-reported goals and activities
- Assessed controls over security, user access, disaster recovery, and functionality of the HAN

Information resources reviewed included the following:

- Federal regulations, requirements, and grant agreements
- Texas statutes and applicable mandates

Criteria used included the following:

- The Department's cooperative agreements with the CDC and HRSA
- Federal requirements under OMB Circular A-133
- Industry standards regarding information technology security and functionality, including standards contained in Texas Administrative Code, Title 1, Chapter 202
- Department policies and procedures
- Industry standards and state laws related to contract development, monitoring, and payment

Other Information

We conducted fieldwork from October 2003 through April 2004. This audit was conducted in accordance with generally accepted government auditing standards.

The following members of the State Auditor's staff performed the audit work:

- Margaret Nicklas, MPAff (Project Manager)
- Dorvin Handrick, CISA, CDP
- Janet Macdonald
- Kim McDonald
- Joseph Mungai
- Ann Paul, CPA, MPA
- Max Viescas, CPA
- Leslie Ashton, CPA (Quality Control Reviewer)
- Susan Riley, CPA (Audit Manager)
- Frank Vito, CPA (Audit Director)

Management's Responses

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Eduardo J. Sanchez, M.D., M.P.H.
Commissioner of Health

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Randy Fritz, M.P.A.
Chief Operating Officer

Nick Curry, M.D., M.P.H.
Executive Deputy Commissioner

June 4, 2004

Margaret Nicklas, Project Manager
State Auditor's Office
P.O. Box 12067
Austin, Texas 78711-2067

Dear Ms. Nicklas:

In response to your letter of May 14, 2004, regarding an audit report on the Texas Department of Health's (TDH) implementation of bioterrorism preparedness plans, we are pleased to provide you with our formal response. We are appreciative of the time you and your staff spent collecting data and other information, and in the preparation of your report.

In your draft report there are three key points. The first, indicating that we have "...made good progress toward accomplishing critical benchmarks established by the CDC, and to a lesser extent, HRSA" acknowledges the efforts of staff in making positive strides toward meeting benchmarks identified by CDC and HRSA.

Your second key point concerned the contract development, contract monitoring and compliance with federal requirements. As noted in our management response, TDH has made great strides in addressing the reported inadequacies in these areas, to include increased monitoring activity and more accurate drawdown of federal funds. In addition, we will continue to work with contracting and monitoring staff to address any issues of accountability for all federal programs.

The final key point is on the Health Alert Network (HAN), and we agree with your findings. We have been working aggressively to correct these shortcomings in the areas of testing, staffing, and security.

In your report there are twenty-five recommendations, and except as noted, we agree with those recommendations. An attached chart provides the status on each recommendation, the timetable for each, and the responsible person(s).

We look forward to working with you as we implement corrective actions to address your recommendations. Should you have questions regarding our response, please contact Mark Scott, TDH Internal Auditor, at 458-7111 ext. 7354.

Sincerely,



Eduardo J. Sanchez, M.D., M.P.H.
Commissioner of Health

Attachment

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**SAO Recommendations
May 2004**

The Department should:

Recommendation	Response	Assigned To
<p>1. Develop and document a methodology and procedures for measuring and testing the coverage of the HAN and strategies to ensure 90% coverage. Obtain and document clarification, if needed, from the CDC regarding the benchmark's intent.</p>	<p><input type="checkbox"/> Done Date Completed: _____ Product:</p> <p><input checked="" type="checkbox"/> In progress Expected Date of Completion: <u>31 May 2004</u> Product: <i>HAN staff is developing the methodology and procedures for measuring and testing the coverage of the HAN and strategies to ensure 90% coverage.</i></p> <p><input type="checkbox"/> Not implemented/implementation not planned. Explanation:</p>	<p>HAN Director*</p>
<p>2. Complete its statewide PH capacities assessment & re-evaluate departmental & contractor activities based on the assessment's results.</p>	<p><input type="checkbox"/> Done Date Completed: _____ Product:</p> <p><input checked="" type="checkbox"/> In progress Expected Date of Completion: <u>On or before 8-31-04</u> Product: <i>Local capacity assessment inventories submitted to TDH. Data Manager who will be responsible for analyzing this information was hired in May, 2004. TDH plans to evaluate the local capacity assessment inventories by 8-31-04. For FY05 another tool that will be used for developing departmental and contractor activities will be the CDC developed performance measures to ensure that Texas appropriately measures and responds to CDC guidelines.</i></p> <p><input type="checkbox"/> Not implemented/implementation not planned. Explanation:</p>	<p>Deputy State Epidemiologist*</p>
<p>3. Evaluate the completion rate of regional plans prior to the current deadline of August 31, 2004, to troubleshoot and, as needed, add resources to ensure completion of regional plans in a timely manner.</p>	<p><input type="checkbox"/> Done Date Completed: _____ Product:</p> <p><input checked="" type="checkbox"/> In progress <u>Expected Date of Completion: May 31, 2004</u> Product: <i>Status tracking sheet has been developed for each region. Progress will be updated bi-weekly through July 31, 2004 and weekly after August 1, 2004. All regional planners have been contacted by Public Health Preparedness Coordinator (new position). Requests for assistance are answered promptly and documented.</i></p> <p><input type="checkbox"/> Not implemented/implementation not planned. Explanation:</p>	<p>Public Health Preparedness Coordinator*</p>

Recommendation	Response	Assigned To
<p>4. Develop a plan to evaluate the uses of HRSA grant funds & ensure rapid & appropriate use of remaining HRSA funds.</p>	<p><input type="checkbox"/> Done Date Completed: _____ Product:</p> <p><input checked="" type="checkbox"/> In progress Expected Date of Completion: <u>August 31, 2004</u> Product: <i>Revised process for accountability of expenditures is being developed that will include progress in regional plan development and expenditures of HRSA funds for hospital preparedness.</i></p> <p><input type="checkbox"/> Not implemented/implementation not planned. Explanation:</p>	<p>Manager, Hospital Preparedness Program</p>
<p>5. Evaluate the status of its statewide epidemic response plan for hospitals and identify strategies to ensure timely completion of the plan.</p>	<p><input type="checkbox"/> Done Date Completed: _____ Product:</p> <p><input checked="" type="checkbox"/> In progress Expected Date of Completion: <u>Ongoing</u> Product: <i>Draft plans submitted as deliverable with contract for next round of funding due August 31, 2004. Evaluation of status will occur with the submission of the next draft.</i></p> <p><input type="checkbox"/> Not implemented/implementation not planned. Explanation:</p>	<p>Manager, Hospital Preparedness Program</p>

Recommendation	Response	Assigned To
<p>6. Ensure that meaningful performance measures are included in all contracts associated with bioterrorism and hospital preparedness.</p>	<p><input type="checkbox"/> Done Date Completed: _____ Product:</p> <p><input checked="" type="checkbox"/> In progress Expected Date of Completion: <u>8-31-04 for FY05 grant application; September 04 for revised QA tools</u></p> <p>Product: <i>FY04 contract language includes scope of work, application, renewal guidelines and instructions. FY05 contract renewal forms to include scope of work, application, renewal guidelines and instructions. In FY 04, TDH required local and regional health departments to achieve the CDC critical benchmarks and key smallpox activities. The benchmarks/smallpox activities provided a better mechanism for measuring enhanced capacity.</i></p> <p>FY05 contract renewal forms to include scope of work, application, renewal guidelines and instructions, QA tools. (Bioterrorism) TDH plans to implement CDC performance measures into the FY 05 renewal applications for funding for all contracts. FY 05 QA tools will be revised to address the new performance measures</p> <p><input type="checkbox"/> Not implemented/implementation not planned. Explanation:</p>	<p>Manager, Hospital Preparedness Program*</p> <p>Deputy State Epidemiologist*</p>
<p>7. Ensure that all bioterrorism-related contracts contain deliverables that are clear and quantifiable and have associated timeframes.</p>	<p><input type="checkbox"/> Done Date Completed: _____ Product:</p> <p><input checked="" type="checkbox"/> In progress Expected Date of Completion: <u>7-15-04</u> Product: <i>FY05 contract renewal forms to include scope of work, application, renewal guidelines and instructions. TDH will develop and require standardized deliverables with associated timelines to be met by local and regional health departments receiving FY05 funds.</i></p> <p><input type="checkbox"/> Not implemented/implementation not planned. Explanation:</p>	<p>Deputy State Epidemiologist*</p>

Recommendation	Response	Assigned To
<p>8. Amend existing bioterrorism contracts to define specific deliverables or measurable results to be achieved by the end of the current contract period of August 31, 2004</p>	<p><input type="checkbox"/> Done Date Completed: _____ Product:</p> <p><input checked="" type="checkbox"/> In progress Expected Date of Completion: <u>7-15-04</u> Product: <i>FY05 contract renewal forms to include scope of work, application, renewal guidelines and instructions. TDH is in the process of finalizing the last contract amendments for FY04. TDH will implement standardized, measurable deliverables with appropriate timelines for FY05 funds.</i></p> <p><i>The TALHO contract is currently being revised and will include specific deliverables for FY 04.</i></p> <p><input type="checkbox"/> Not implemented/implementation not planned. Explanation:</p>	<p>Deputy State Epidemiologist*</p>
<p>9. Improve contract monitoring by ensuring that it uses contractors' progress reports to identify and request corrective actions in a timely manner.</p>	<p><input checked="" type="checkbox"/> Done Date Completed: <u>January 2004</u></p> <p>Product: <i>QA tools and procedures. The QA process implemented in FY 04 includes review and analysis of the quarterly reports, and additional followup to verify information from the quarterly report during the on-site reviews, including whether corrective action has been taken when deficiencies are reported.</i></p> <p><input type="checkbox"/> In progress Expected Date of Completion: _____</p> <p>Product: <input type="checkbox"/> Not implemented/implementation not planned. Explanation:</p>	<p>Deputy State Epidemiologist*</p>

Recommendation	Response	Assigned To
<p>10. Consider discontinuing the practice of restricting budget categories or specific purchases; if this is not feasible, ensure adequate controls are in place to ensure that payments are not made on “restricted” items.</p>	<p><input type="checkbox"/> Done Date Completed: _____ Product:</p> <p><input checked="" type="checkbox"/> In progress Expected Date of Completion: <u>On or before 8-31-04</u> Product: <i>FY05 contract renewal forms to include scope of work application, renewal guidelines and instructions. In addition a second higher level contract administrator will be hired by 8-31-04. Revised QA tools by September 2004.</i></p> <p><i>TDH will work with HHSC staff to establish stronger controls to enforce and monitor expenditures in the development and standardization of contract language. We are in the process of implementing these changes for FY05 contracts.</i></p> <p><i>The restriction process will be retained. Through the centralization of Quality Assurance/Quality Assurance and Contract Monitoring in the Center for Public Health Preparedness and Response, staff will be delegated to ensure the proper controls are in place and implemented consistently. A facet of the coordination of QA/AC and contract monitoring will be quarterly meetings between the staff of these two areas.</i></p> <p><i>In addition, the program will work with contracting staff to outline reporting requirements from subrecipients to provide for additional internal controls and better monitoring. This will include hiring new staff with a higher skill level and more experience/knowledge of the TDH fiscal processes, and providing more detailed information regarding restriction requirements, guidelines and procedures. In addition, these activities will be reflected in the QA tools and process.</i></p> <p><input type="checkbox"/> Not implemented/implementation not planned. Explanation:</p>	<p>Chief Financial Officer</p>

Recommendation	Response	Assigned To
<p>11. Develop policies and procedures to require that, before contractors are paid, contractors submit more detailed information and appropriate departmental staff review that information to provide greater assurance that reimbursement requests conform to contract terms and federal requirements.</p>	<p><input type="checkbox"/> Done Date Completed: _____ Product:</p> <p><input checked="" type="checkbox"/> In progress Expected Date of Completion: <u>July 15, 2004</u> Product: <i>The Department will work with the Health and Human Services Commission to establish standardized contracts that address the necessary documentation required for reimbursement. We will work with HHSC contracting staff to establish requirements that conform to the federal policies and procedures.</i></p> <p><input type="checkbox"/> Not implemented/implementation not planned. Explanation:</p>	<p>Chief Financial Officer</p>
<p>12. Require that BT contractors implement additional controls over timekeeping & payroll systems to ensure that grant-funded contractors' salaries are properly documented and charged, especially in the cases of contract personnel who may spend time on activities not related to the contract.</p>	<p><input type="checkbox"/> Done Date Completed: _____ Product:</p> <p><input checked="" type="checkbox"/> In progress Expected Date of Completion: <u>8-31-05 for FY05 grant renewal process; September 2004 (revised QA process)</u> Product: <i>FY04 contract language to include scope of work, application, renewal guidelines and instruction. Revised QA procedures and tools. FY05 contract renewal forms to include scope of work, application, renewal guidelines and instruction.</i></p> <p><i>For FY04, additional controls were implemented that required contractors to submit job descriptions showing public health preparedness responsibilities and time allocations for various focus areas. The QA process verifies this information during on-site reviews.</i></p> <p>For FY05, additional controls will be put in place such as required time sheets and documentation regarding specific public health preparedness grant responsibilities. When developed, the QA tools and processes will be revised to address this issue.</p> <p><input type="checkbox"/> Not implemented/implementation not planned. Explanation:</p>	<p>Deputy State Epidemiologist*</p>

Recommendation	Response	Assigned To
<p>13. Review exceptions noted above in which reimbursements to contractors have been questioned and make appropriate adjustments.</p>	<p><input type="checkbox"/> Done Date Completed: _____ Product:</p> <p><input checked="" type="checkbox"/> In progress Expected Date of Completion: <u>July 31, 2004</u> Product: <i>Written approvals and QA tools and procedures</i></p> <p><i>The Department has implemented improvements to address these weaknesses. For example, in FY 03, local health department and regional funding requests were approved at the regional level. During FY04, Center for Public Health Preparedness and Response (CPHPR) staff reviewed and approved/disapproved local health department and regional funding requests. In FY05, CPHPR staff will approve funding requests on all contracts attached to the public health preparedness grant and will issue written approvals.</i></p> <p><i>Currently the QA process is being used to identify and address questionable reimbursements. However, this occurs after the reimbursement has been processed.</i></p> <p><i>Re referenced case 1: TDH will remedy such situations by requiring written approvals.</i></p> <p><i>Re all other cases, current TDH policy does not allow CPHPR staff to review and approve expenditures prior to payment.</i></p> <p><i>If reimbursements to contractors are questioned, TDH will evaluate the questioned costs. If it is determined that the costs are unallowable, TDH has two (2) options to make the necessary adjustments. Future vouchers will be off-set by the amount of disallowed costs, or a refund will be requested.</i></p> <p><i>Plans for addressing this issue in FY05 will be dependent on DSHS policies/procedures regarding contractor reimbursements. At that time Local PHP Grant staff will make adjustments to their policies and procedures as appropriate.</i></p> <p><input type="checkbox"/> Not implemented/implementation not planned. Explanation:</p>	<p>Deputy State Epidemiologist*</p>

Recommendation	Response	Assigned To
<p>14. Ensure compliance with cash management requirements for timeliness when drawing down federal funds.</p>	<p><input checked="" type="checkbox"/> Done Date Completed: <u>September 1, 2003</u></p> <p>Product: <i>Financial staff implemented procedures on September 1, 2003, for an accurate drawdown of federal funds. This new procedure replaced the estimated draw process. A daily report is generated to Cash Management staff that provides the pending payables so that only the necessary federal funds are drawn each day in compliance with the Cash Management Improvement Act (CMIA)</i></p> <p><input type="checkbox"/> Not implemented/implementation not planned. Explanation:</p>	<p>Chief Financial Officer</p>
<p>15. Ensure that contractors, such as RACs and hospitals that receive advance funds from federal grants, implement adequate procedures to minimize the time elapsed between receipt and expenditure of funds</p>	<p><input type="checkbox"/> Done Date Completed: _____ Product:</p> <p><input checked="" type="checkbox"/> In progress Expected Date of Completion: <u>Sept 1, 2004</u></p> <p>Product: <i>A series of meetings is being held with TDH staff and stakeholders over the next three months to develop elements to be incorporated into contracts for the next round of funding, and closer coordination with TDH CFO as well as quality assurance/quality control will be a part of new year's program. These new elements in the contracts will address the federal requirements for timely distribution of federal funds in compliance with the Cash Management Improvement Act (CMIA).</i></p> <p><input type="checkbox"/> Not implemented/implementation not planned. Explanation:</p>	<p>Manager, Hospital Preparedness Program*</p>

Recommendation	Response	Assigned To
<p>16. Ensure that contractors, such as RACs and hospitals, comply with applicable regulations regarding the refund of interest earned on advances from federal grants.</p>	<p><input type="checkbox"/> Done Date Completed: _____ Product:</p> <p><input checked="" type="checkbox"/> In progress Expected Date of Completion: <u>Sept 1, 2004</u> Product: <i>A series of meetings is being held with TDH staff and stakeholders over the next three months to develop elements to be incorporated into contracts for the next round of funding, and closer coordination with TDH CFO as well as quality assurance/quality control will be a part of new year's program. These new elements in the contracts will address the federal requirements for timely distribution of federal funds in compliance with the Cash Management Improvement Act (CMIA).</i></p> <p><input type="checkbox"/> Not implemented/implementation not planned. Explanation:</p>	<p>Manager, Hospital Preparedness Program*</p>
<p>17. Develop, document, & implement policies and procedures to ensure that periodic testing of the HAN's coverage is performed & that the results are documented & analyzed by department staff. The policies should define frequency of testing.</p>	<p><input type="checkbox"/> Done Date Completed: _____ Product:</p> <p><input checked="" type="checkbox"/> In progress Expected Date of Completion: <u>On or before 8-31-04</u> Product: <i>The Health Alert Network (HAN) team is currently revising testing parameters and documentation procedures for periodic testing of HAN coverage and response. New parameters are in development that will allow tests to be measured for accuracy. Additionally, response times of key personnel to acknowledge receipt of alerts will be captured.</i></p> <p><input type="checkbox"/> Not implemented/implementation not planned. Explanation:</p>	<p>HAN Director*</p>

Recommendation	Response	Assigned To
<p>18. Ensure that each LHD with which it has a BT-related contract designates one of its employees as a HAN administrator.</p>	<p><input type="checkbox"/> Done Date Completed: _____ Product:</p> <p><input checked="" type="checkbox"/> In progress Expected Date of Completion: <u>October 2004</u> Product: <i>This is a requirement in the '04 quarterly report and was also required in the '04 guidance provided to all contractors. Delays in getting details from the quarterly reports are all that stands in the way of a full assessment of compliance. This will continue to be a deliverable in '05. Failure to comply will impact future funding for LHD's for FA-E.</i></p> <p><input type="checkbox"/> Not implemented/implementation not planned. Explanation:</p>	<p>HAN Director*</p>
<p>19. Ensure that each local HAN administrator receives proper training to use the HAN.</p>	<p><input type="checkbox"/> Done Date Completed: _____ Product:</p> <p><input checked="" type="checkbox"/> In progress Expected Date of Completion: <u>August 31, 2005</u> Product: <i>Training is offered to all HAN administrators. Approximately 50% of all HAN administrators have received training. This requirement will be added to '05 deliverables for contractors. We will approach Focus Area G lead for assistance in completing this demand.</i></p> <p><input type="checkbox"/> Not implemented/implementation not planned. Explanation:</p>	<p>HAN Director*</p>
<p>20. Ensure that local HAN administrators regularly test HAN functionality and take corrective actions, if necessary, based on test results.</p>	<p><input type="checkbox"/> Done Date Completed: _____ Product:</p> <p><input checked="" type="checkbox"/> In progress Expected Date of Completion: <u>August 31, 2004</u> Product: <i>This is already a deliverable and is tracked through the quarterly reports. Delays in getting details from the quarterly reports are all that stands in the way of a full assessment of compliance. This will continue to be a deliverable in '05. Failure to comply will impact future funding for LHD's for FA-E.</i></p> <p><input type="checkbox"/> Not implemented/implementation not planned. Explanation:</p>	<p>HAN Director</p>

Recommendation	Response	Assigned To
<p>21. Ensure that password policies for the HAN are changed & enforced to comply with department policy.</p>	<p><input checked="" type="checkbox"/> Done Date Completed: <u>February 2004</u></p> <p>Product: <i>HAN password policy is more strict than TDH policy. The SAO asked us to keep a password history to prevent reuse of passwords. We complied immediately. This item has been completed since February 2004.</i></p> <p><input type="checkbox"/> In progress Expected Date of Completion: _____</p> <p>Product: _____</p> <p><input type="checkbox"/> Not implemented/implementation not planned.</p> <p>Explanation: _____</p>	<p>HAN Director*</p>
<p>22. Evaluate physical security risks at the HAN backup site & implement a cost-effective approach to mitigate them. This could involve either improving the physical security at the current site or moving it to a more secure location.</p>	<p><input checked="" type="checkbox"/> Done Date Completed: <u>March 2004</u></p> <p>Product: <i>Security upgrades have been made to the 3rd floor HAN offices that auto-lock all doors and require a swipe pass in order to enter the server rooms, which also provides an access log to vital systems. Nonetheless, since there was not a cost effective way to address the fire suppression issues (this bldg. does not have any automated fire suppression) and it was also not cost efficient to build additional ventilation to control temperatures in the server room, we decided to move all HAN backup functions formerly installed at the Tower Bldg. to a new location. All services for backup have been moved to an offsite location hosted by an independent Application Service Provider in Ohio.</i></p> <p><input type="checkbox"/> In progress Expected Date of Completion: _____</p> <p>Product: _____</p> <p><input type="checkbox"/> Not implemented/implementation not planned.</p> <p>Explanation: _____</p>	<p>HAN Director*</p>
<p>23. Specify the correct HAN backup site in the HAN business continuity plan and add detailed recovery procedures to the plan.</p>	<p><input type="checkbox"/> Done Date Completed: _____</p> <p>Product: _____</p> <p><input checked="" type="checkbox"/> In progress Expected Date of Completion: <u>On or before 8-31-04</u></p> <p>Product: <i>Language in the business continuity plan for the TDH will be modified to succinctly identify primary and backup locations for the Health Alert Network.</i></p> <p><input type="checkbox"/> Not implemented/implementation not planned.</p> <p>Explanation: _____</p>	<p>HAN Director*</p>

Recommendation	Response	Assigned To
24. Ensure that the HAN business continuity plan is tested and updated at least annually.	<input type="checkbox"/> Done Date Completed: _____ Product: <input checked="" type="checkbox"/> In progress Expected Date of Completion: <u>May 31, 2004</u> Product: <i>A detailed recovery plan is under development by HAN staff. Upon completion of the HAN backup center's move to Kramer, as well as other vital upgrades planned for the year, plans will be implemented and tested no later than August 31, 2005.</i> <input type="checkbox"/> Not implemented/implementation not planned. Explanation:	HAN Director*
25. Evaluate the risks of having primary and backup sites too close together and consider moving at least one of these sites.	<input type="checkbox"/> Done Date Completed: _____ Product: <input checked="" type="checkbox"/> In progress Expected Date of Completion: <u>June 15, 2004</u> Product: <i>Arrangements have been completed and a plan is in place with AIS to move the HAN backup location offsite to the Kramer Lane facility by June 15, 2004.</i> <input type="checkbox"/> Not implemented/implementation not planned. Explanation:	HAN Director*

* Position titles may change effective September 1, 2004.

Critical Capacities Identified by the CDC

The U.S. Centers for Disease Control (CDC) specified the following critical capacities in the cooperative agreement with the Department of Health. The Department used this as an overall framework to organize its activities and strategies.

Focus Area A

- **Critical Capacity #1.** To establish a process for strategic leadership, direction, coordination, and assessment of activities to ensure state and local readiness, interagency collaboration, and preparedness.
- **Critical Capacity #2.** To conduct integrated assessments of public health system capacities related to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies to aid and improve planning, coordination, and implementation.
- **Critical Capacity #3.** To respond to emergencies caused by bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies through the development and exercise of a comprehensive emergency preparedness and response plan.
- **Critical Capacity #4.** To ensure that state, local, and regional preparedness for and response to bioterrorism, other infectious outbreaks, and other public health threats and emergencies are effectively coordinated with federal response assets.
- **Critical Capacity #5.** To effectively manage the CDC National Pharmaceutical Stockpile (NPS), should it be deployed—translating NPS plans into firm preparations, periodic testing of NPS preparedness, and periodic training for entities and individuals that are part of NPS preparedness.

Focus Area B

- **Critical Capacity #6.** To rapidly detect a terrorist event through a highly functioning, mandatory reportable disease surveillance system, as evidenced by ongoing timely and complete reporting by providers and laboratories in a jurisdiction, especially of illnesses and conditions possibly resulting from bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies.
- **Critical Capacity #7.** To rapidly and effectively investigate and respond to a potential terrorist event as evidenced by a comprehensive and exercised epidemiologic response plan that addresses surge capacity, delivery of mass prophylaxis and immunizations, and pre-event development of specific epidemiologic investigation and response needs.
- **Critical Capacity #8.** To rapidly and effectively investigate and respond to a potential terrorist event, as evidenced by ongoing effective state and local response to naturally occurring individual cases of urgent public health importance, outbreaks of disease, and emergency public health interventions such as emergency chemoprophylaxis or immunization activities.

Focus Area C

- **Critical Capacity #9.** To develop and implement a statewide program to provide rapid and effective laboratory services in support of the response to bioterrorism, other infectious disease outbreaks, and other public health threats.
- **Critical Capacity #10.** As an LRN member, to ensure adequate and secure laboratory facilities, reagents, and equipment to rapidly detect and correctly identify biological agents likely to be used in a bioterrorist incident.

Focus Area E¹⁰

- **Critical Capacity #11.** To ensure effective communications connectivity among public health departments, healthcare organizations, law enforcement organizations, public officials, and others as evidenced by: a) continuous, high speed connectivity to the Internet; b) routine use of e-mail for notification of alerts and other critical communication; and c) a directory of public health participants (including primary clinical personnel), their roles, and contact information covering all jurisdictions.
- **Critical Capacity #12.** To ensure a method of emergency communication for participants in public health emergency response that is fully redundant with e-mail.
- **Critical Capacity #13.** To ensure the ongoing protection of critical data and information systems and capabilities for continuity of operations.
- **Critical Capacity #14.** To ensure secure electronic exchange of clinical, laboratory, environmental, and other public health information in standard formats between the computer systems of public health partners. Achieve this capacity according to the relevant IT Functions and Specifications.

Focus Area F

- **Critical Capacity #15.** To provide needed health/risk information to the public and key partners during a terrorism event by establishing critical baseline information about the current communication needs and barriers within individual communities, and identifying effective channels of communication for reaching the general public and special populations during public health threats and emergencies.

Focus Area G

- **Critical Capacity #16.** To ensure the delivery of appropriate education and training to key public health professionals, infectious disease specialists, emergency department personnel, and other health care providers in preparedness for and response to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies, either directly or through the use (where possible) of existing curricula and other sources, including schools of public health and medicine, academic health centers, CDC training networks, and other providers.

¹⁰ There were no funded activities for Focus Area D in fiscal year 2002 or 2003.

Summary of the Department's Progress in Accomplishing Critical Benchmarks Established by the CDC

Summary of the Department's Progress in Accomplishing Critical Benchmarks Established by the CDC		
Critical Benchmark	Implementation Status by August 31, 2003	Completion Rates Per GAO
1 - Designate an executive director of the bioterrorism preparedness and response program.	Complete	Most states have completed
2 - Establish a bioterrorism advisory committee.	Complete	Most states have completed
3 - Assess public health capacities related to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies.	Partially Complete	About half the states have completed
4 - Assess statutes, regulations, and ordinances that provide for credentialing, licensure, and delegation of authority for executing emergency public health measures.	Complete	About half the states have completed
5 - Develop a statewide response plan and provisions for exercising the plan.	Complete	Few states have completed
6 - Develop regional response plans.	Partially Complete	Few states have completed
7 - Develop an interim plan to receive and manage items from the strategic national stockpile (SNS).	Complete	About half the states have completed
8 - Develop a system to receive and evaluate urgent disease reports on a 24 hour a day, seven days a week basis.	Complete	About half the states have completed
9 - Ensure there is at least one epidemiologist for each metropolitan statistical area.	Complete	Most states have completed
10 - Develop a plan to improve working relationships and communication between clinical laboratories and higher level Laboratory Response Network (LRN) labs.	Partially Complete	About half the states have completed
11 - Ensure that 90 percent of the users of health alert information are covered by the Health Alert Network.	Partially Complete ^a	Most states have completed
12 - Develop a communications system that provides a 24 hour per day, 7 day per week flow of critical health information.	Partially Complete ^b	About half the states have completed
13 - Develop an interim plan for risk communication and information dissemination.	Completed	About half the states have completed
14 - Prepare a time line for assessing training needs.	Completed	About half the states have completed
<p>^a The Department has a well-developed Health Alert Network; however, due to inadequate testing methodologies, we could not verify that 90 percent coverage of relevant users has been established.</p> <p>^b The HAN allows for adequate sending of alerts and receipt of alerts from the CDC; however, testing has not been done to determine the extent to which the Department can receive critical health information from local entities such as hospital emergency departments, law enforcement officers, or other state and local officials.</p>		

Sources: State Auditor's Office analysis and HHS Bioterrorism Preparedness Programs, Report Number GAO-04-360R, U.S. General Accounting Office, February 10, 2004.

Summary of the Department's Progress in Fulfilling HRSA Benchmarks and Requirements

Summary of the Department's Progress in Accomplishing Benchmarks and Requirements Associated with Its HRSA Grant	
Benchmarks and Requirements	Implementation Status (as of August 31, 2003)
Phase 1	
Designate a hospital preparedness planning coordinator.	Completed
Establish a hospital preparedness planning committee.	Completed
Complete statewide needs assessment of hospitals and implementation planning.	Completed
Phase 2	
Ensure fiscal year 2002 and 2003 funds are distributed to hospitals and spent by March 31, 2004.	Not Completed ^a
Develop a plan for hospitals in the state to respond to an epidemic involving at least 500 patients.	Not Completed
^a Status information is projected based on incompleteness of distribution in early March 2004, when we concluded our testing. The Department established a goal that funds would be distributed no later than March 31, 2004.	

Sources: State Auditor's Office analysis

Results of Federal Compliance Testing



Independent Auditors' Report on Compliance with Requirements Applicable to the Federal Program and on Internal Control over Compliance in Accordance with OMB Circular A-133

The Honorable Rick Perry, Governor,
and Members of the Texas State Legislature
for the State of Texas:

Compliance

We have audited the compliance of the State of Texas (the State) with the types of compliance requirements described in the U.S. Office of Management and Budget (OMB) Circular A-133 Compliance Supplement that are applicable to the U.S. Centers for Disease Control and Prevention–Investigations and Technical Assistance Grant (CFDA Number 93.283) for the year ended August 31, 2003. Compliance with the requirements of laws, regulations, contracts, and grants applicable to its major federal program is the responsibility of the State's management. Our responsibility is to express an opinion on the State's compliance based on our audit.

Except as discussed in the last paragraph, we conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Those standards and OMB Circular A-133 require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on CFDA Number 93.283 occurred. An audit includes examining, on a test basis, evidence about the State's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion. Our audit does not provide a legal determination of the State's compliance with those requirements.

As identified below and described in the accompanying Schedule of Findings and Questioned Costs, the State did not comply with certain compliance requirements that are applicable to CFDA Number 93.283. Compliance with such requirements is necessary, in our opinion, for the State to comply with requirements applicable to the identified major federal program. The results of our auditing procedures are described in the accompanying Schedule of Findings and Questioned Costs as:

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Compliance Requirement	Finding Number
Subrecipient Monitoring	04-27

SAO No. 04-315

In our opinion, except for the noncompliance described in the preceding paragraph, the State complied in all material respects with the requirements referred to above that are applicable to CFDA Number 93.283 for the year ended August 31, 2003.

Internal Control over Compliance

The management of the State is responsible for establishing and maintaining effective internal control over compliance with the requirements of laws, regulations, contracts, and grants applicable to federal programs. In planning and performing our audit, we considered the State's internal control over compliance with requirements that could have a direct and material effect on a major federal program in order to determine our auditing procedures for the purpose of expressing our opinion on compliance and to test and report on the internal control over compliance in accordance with OMB Circular A-133.

We noted certain matters involving the internal control over compliance and its operation that we consider to be reportable conditions. Reportable conditions involve matters coming to our attention that relate to significant deficiencies in the design or operation of the internal control over compliance that, in our judgment, could adversely affect the State's ability to administer a major federal program in accordance with the applicable requirements of laws, regulations, contracts, and grants. Reportable conditions are described in the accompanying Schedule of Findings and Questioned Costs as items:

Compliance Requirement	Finding Number
Subrecipient Monitoring	04-27
Allowable Cost/Cost Principles	04-06
Reporting	04-61
Cash Management	04-13

A material weakness is a condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that noncompliance with the applicable requirements of laws, regulations, contracts, and grants that would be material in relation to a major federal program being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Our consideration of the internal control over compliance would not necessarily disclose all matters in the internal control that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses.

However, of the reportable conditions described above, we consider the following to be material weaknesses:

Compliance Requirement	Finding Number
Subrecipient Monitoring	04-27
Allowable Costs/Cost Principles	04-06
Cash Management	04-13

This report is intended solely for the information and use of the Governor, the members of the Texas State Legislature, the Legislative Audit Committee, the management of Texas Department of Health, and the Department of Health and Human Services. However, this report is a matter of public record, and its distribution is not limited. We have chosen not to comply with a reporting standard that specifies the wording to be used in discussing restrictions on the use of the report. We believe this wording is not in alignment with our role as a legislative audit function.

February 23, 2004

Schedule of Findings and Questioned Costs

*The Texas Department of Health's
Compliance with Federal Requirements
for Its U.S. Centers for Disease Control
and Prevention – Investigations
and Technical Assistance Grant (CFDA
No. 93.283) for the Year Ended
August 31, 2003*

Summary of Auditor's Results

Financial Statements

The Texas State Auditor's Office will issue a separate report on the financial portion of the statewide single audit for the year ended August 31, 2003.

Federal Awards

1. Internal control over major programs:
 - a. Material weakness(es) identified? Yes
 - b. Reportable condition(s) identified not considered to be material weaknesses? Yes
2. Type of auditor's report issued on compliance for major programs? Qualification
3. Any audit findings disclosed that are required to be reported in accordance with OMB Circular A-133, Section 510(a)? Yes
4. Dollar threshold used to distinguish between Type A and Type B programs? \$44,119,126
5. Auditee qualified as low-risk auditee? No
6. Identification of major programs

CFDA Number	Name of Federal Program or Cluster
93.283	Centers for Disease Control and Prevention—Investigations and Technical Assistance

For all other federal awards for fiscal year 2003, federal award information has been issued in a separate report. See *State of Texas Federal Portion of the Statewide Single Audit Report for the Year Ended August 31, 2002*, by KPMG LLP, dated February 23, 2004.

Federal Award Findings and Questioned Costs

This section identifies reportable conditions, material weaknesses, and instances of noncompliance, including questioned costs, as required to be reported by Office of Management and Budget Circular A-133, Section .510(a), for the Texas Department of Health, Catalog of Federal Domestic Assistance 93.283, Centers for Disease Control and Prevention–Investigations and Technical Assistance Grant.

Department of Health

Reference No. 04-27

Subrecipient Monitoring

**CFDA 93.283 – Center for Disease Control and Prevention-Investigations and Technical Assistance
Type of Finding – Material Weakness Control and Material Non-Compliance**

Payments to subrecipients totaled \$21.6 million (or 59 percent) of the \$36.3 million in expenditures for CFDA 93.283 in fiscal year 2003 at the Texas Department of Health (TDH). Within this CFDA, our audit work focused on the Bioterrorism program, which represented 84 percent of expenditures by TDH for CFDA 93.283. Despite the large share of dollars awarded to subrecipients, TDH’s monitoring of those expenditures was inadequate because it did not perform sufficient financial and program monitoring site visits at Bioterrorism program subrecipients during fiscal year 2003. As a result, TDH could not ensure that subrecipients administered awards in compliance with Federal laws, regulations, and grant requirements. In addition, subrecipient reporting was inadequate for TDH to accurately assess progress on the Bioterrorism program’s performance goals. Furthermore, because TDH is not requiring audit reports from all appropriate program subrecipients, it may be unaware of important deficiencies that may exist at subrecipients. Additionally, TDH does not have adequate controls to ensure that subrecipients correct deficiencies identified through audits in a timely manner to prevent further performance and accountability issues.

Questioned Cost: \$ 0

U.S. Department of Health and
Human Services

Financial and Program Monitoring

After TDH awards Federal funds to a subrecipient, it is responsible for monitoring the subrecipient’s use of Federal awards through site visits or other means to provide reasonable assurance that (1) the subrecipient administers Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements and (2) performance goals are achieved. While TDH reviewed progress reports that Bioterrorism program subrecipients submitted during fiscal year 2003 and engaged in numerous contacts with subrecipients, those activities alone did not provide adequate assurance of subrecipients’ compliance with Federal laws, regulations, and grant requirements.

During fiscal year 2003, TDH’s Contract Policy and Monitoring Division (CPMD) was responsible for conducting financial monitoring site visits to ensure that subrecipients’ expenditures were allowable and made in compliance with Federal and state requirements. During that time, however, CPMD conducted financial monitoring site visits at only 5 of the 59 local health departments that had Bioterrorism program contracts. Financial monitoring site visits are particularly important because TDH’s subrecipient reimbursement process does not include a review of subrecipients’ supporting documentation (such as receipts). TDH reviews vouchers and quarterly Financial Status Reports that subrecipients submit, but those documents provide only summary level information regarding the nature of subrecipients’ expenditures. In general, TDH relies on CPMD’s financial monitoring site visits to verify that it reimburses subrecipients for only allowable expenditures. TDH sometimes performs desk audits if “red flags” are identified; however, in fiscal year 2003, TDH did not perform any desk audits for subrecipients that received Bioterrorism funding.

HEALTH, DEPARTMENT OF

TDH Bioterrorism program staff are responsible for monitoring subrecipients to provide reasonable assurance that subrecipients comply with Federal requirements and achieve performance goals. However, Bioterrorism program staff conducted only two program monitoring site visits at the 59 local health departments that had Bioterrorism program contracts in fiscal year 2003; program staff conducted five program monitoring site visits in 2002. All seven of those site visits were to local health department laboratories. Staff did not perform any site visits in fiscal year 2001. TDH's fiscal year 2003 Bioterrorism program awards to local health department subrecipients ranged from less than \$10,000 to \$2.8 million.

Although Bioterrorism program staff received and reviewed progress reports for Bioterrorism program subrecipients during fiscal year 2003, the reporting mechanisms in place were not adequate for them to monitor subrecipient compliance and performance. Specifically, in fiscal year 2003, progress reports that local health departments submitted did not consistently provide adequate information to enable Bioterrorism program staff to assess progress on goals or compliance with contract terms. In some cases, TDH did not require subrecipients to submit progress reports. In addition, one large local health department's end-of-year progress report did not report on all planned activities and deliverables identified in the contract.

Obtaining and Following Up on OMB Circular A-133 Audit Reports

OMB Circular A-133 requires TDH to (1) ensure that a subrecipient that spends \$300,000 or more in federal funds during the subrecipient's fiscal year submits an OMB Circular A-133 audit report and (2) issue a management decision on audit findings within six months after receipt of the subrecipient's audit report and ensures that the subrecipient takes appropriate and timely corrective action. However, in fiscal year 2003, TDH's procedure for identifying subrecipients that were required to submit OMB Circular A-133 audit reports erroneously took into account only the amount of funding that subrecipients received from TDH; it did not consider the amount of funding the subrecipients received from any Federal source. In addition, during that time, TDH did not monitor and follow up on deficiencies identified in OMB Circular A-133 audit reports that Bioterrorism program subrecipients submitted. Specifically, two subrecipients that received Bioterrorism program funding in fiscal year 2002 submitted OMB Circular A-133 audit reports that contained findings related to TDH. These subrecipients submitted their OMB Circular A-133 audit reports in June 2003 and July 2003; however, as of January 2004, TDH had not yet followed up on those findings.

Recommendation

TDH should ensure that it conducts an adequate number of financial monitoring and program site visits at Bioterrorism program subrecipients. In determining which sites to visit, TDH should consider various factors that may affect the nature, timing, and extent of monitoring while the subrecipient is receiving funds. These factors could include program complexity, percentage of program awards passed through to subrecipients, amounts of awards, and level of subrecipient risk. Furthermore, TDH should improve subrecipient progress reporting to ensure that it receives and reviews progress reports for all Bioterrorism program subrecipients and that those reports clearly refer to contract activities and deliverables.

In all contracts with subrecipients receiving Federal funds, TDH should include a requirement that the subrecipients submit OMB Circular A-133 audit reports in a timely manner when they spend at least \$300,000 in Federal funds in total from all sources. TDH should also require subrecipients that spend less than \$300,000 in Federal funds to submit documentation demonstrating that an OMB Circular A-133 audit was not required. Finally, TDH should strengthen its process for identifying relevant findings from OMB Circular A-133 audit reports and following up to ensure that subrecipients resolve those findings in a timely manner.

Management Response and Corrective Action Plan:

TDH conducts a financial risk assessment each year to determine subrecipient compliance monitoring. Based on this assessment, on-site audits and desk reviews are performed for selected subrecipients to test and sample for overall performance. TDH recognized the need for more direct examination and in fiscal year 2003 and fiscal year 2004 developed plans to enhance financial compliance monitoring through additional on-site reviews, increased desk reviews, and procurement of limited scope audits. During fiscal year 2003 and early fiscal year 2004, increased staffing resulted in a higher number of desk reviews being completed. Increased travel funding in fiscal year 2004 has allowed for additional on-site examinations to be conducted. In addition, TDH prepared a request for information (RFI) to solicit limit scope audits. Responses to that RFI are being reviewed by the Office of Inspector General at the Health and Human Services Commission as this function transferred effective January 1, 2004. It is anticipated that the consolidation of the compliance and audit functions across the Health and Human Services agencies will result in an increase in monitoring in continuation of our goals.

TDH Quality Assurance was begun in late fiscal year 2003 and provided thorough review and analysis of quarterly reports, budget/spending reviews, conference calls, and provision of technical assistance. The plan, in fiscal year 2004, is to conduct much more in-depth quality assurance of the contracts. The fiscal year 2004 plan includes 1) approximately 10 on-site visits by August 31, 2004, 2) ongoing review and analysis of quarterly reports to identify compliance with contractual requirements and progress in building public health preparedness contracts, and 3) conducting tabletop and functional exercises to evaluate local, regional and state bioterrorism response plans and systems developed with bioterrorism contract funds.

The A-133/Single Audit function transferred to Health and Human Services Commission (HHSC) on September 1, 2002. HHSC is developing procedures to track the subrecipients who expended more than \$300,000 in federal funds from all sources of funding.

Implementation Date: August 31, 2004

Responsible Person: Mary Ann Roberts, HHSC, and Suzanne Sparks

Reference No. 04-06

Allowable Costs/Cost Principles**CFDA 93.283 – Center for Disease Control and Prevention-Investigations and Technical Assistance
Type of Finding – Material Weakness Control**

Payroll expenditures represented 26 percent of total fiscal year 2003 expenditures for CFDA 93.283 at the Texas Department of Health (TDH). Our audit work focused on payroll within the Bioterrorism program, as this program represented 84 percent of TDH's total expenditures under this CFDA in fiscal year 2003. We did not identify any unallowable payroll expenditures associated with the Bioterrorism program. TDH used a monthly payroll certification process to help ensure that employees charged their time appropriately to the Bioterrorism program in fiscal year 2003. Furthermore, the majority of the employees in the sample we tested spent 100 percent of their time on the Bioterrorism program. However, we found the following exceptions.

Questioned Cost: \$ 0

U.S. Department of Health and
Human Services

- Two employees stated that they sometimes worked on projects other than the Bioterrorism grant-funded activities although their primary responsibilities and most of their work hours related to Bioterrorism. These deviations were not reflected in payroll certification documents.

HEALTH, DEPARTMENT OF

- In addition, for one of the Bioterrorism-related divisions we reviewed, the signer of the payroll affidavits was not properly authorized to certify payroll during the first four months of fiscal year 2003. This occurred because TDH lacks a process for reviewing signature authorization forms to ensure that an authorized individual properly completes them.

Without adequate controls to ensure that all grant-funded employee hours are charged properly and that payroll certifications are properly authorized, TDH may not have sufficient and accurate information to support the payroll expenditures it charges to the Bioterrorism program.

Recommendation

TDH should implement additional controls over time keeping and payroll systems to ensure that grant-funded employee time is properly documented and charged, especially in the cases of employees who may spend time on non-grant-related activities. It should also implement additional controls over the establishment of signature authority for payroll certifications to ensure that only appropriate individuals are given signature authority. These controls could include guidelines, procedures, policies, and training on how individuals who certify payroll should be designated and what they should review during the certification process.

Management Response and Corrective Action Plan:

TDH has recently implemented additional controls over time keeping and payroll systems to ensure that grant-funded employee time is properly documented and charged. TDH will research the issues provided and make appropriate changes to reflect any time that should have been charged to another funding source.

In addition, TDH will conduct a review of payroll affidavit signature authority and establish procedures for periodic agency-wide updates and confirmations to include training to staff on the certification process.

Implementation Date: June 1, 2004

Responsible Person: Wilson Day

Reference No. 04-61

Reporting**CFDA 93.283 – Center for Disease Control and Prevention-Investigations and Technical Assistance****Type of Finding – Reportable Condition Control**

The Bioterrorism program represented 84 percent of the Texas Department of Health's (TDH) expenditures under CFDA 93.283 in fiscal year 2003. TDH was not able to support all accomplishments it reported in the Bioterrorism program end-of-year progress report it submitted to the U.S. Centers for Disease Control and Prevention (CDC). Specifically, we could not fully verify the status of 10 of 40 activities that TDH reported to CDC as having been completed.

Questioned Cost: \$ 0

U.S. Department of Health and
Human Services

Federal grant recipients are required to submit performance reports at least annually, but not more frequently than quarterly. For each award, performance reports generally contain a comparison of actual accomplishments with the goals and objectives established for the period; reasons the established goals were not met, if appropriate; and other pertinent information including, when appropriate, analysis and explanation of cost overruns or high unit costs. We tested activities reported as complete for Focus Areas A (Preparedness Planning and Readiness Assessment), B (Surveillance and Epidemiology Capacity), C (Laboratory Capacity–Biologic Agents), E (Health Alert Network/Communication and Information Technology), F (Risk Communication and Health Information Dissemination), and G (Education and Training) in the Bioterrorism program end-of-year progress report that TDH submitted to CDC in October 2003.

TDH could not supply adequate evidence to support completion of all activities it reported as completed. Of the 40 items TDH reported it had completed, we found that 30 were completed, 9 were partially completed, and 1 was not complete. For example, TDH reported that its surveillance pilots and the installation of CDC's NEDSS Based System (NBS) for disease surveillance were completed. However, our testing indicated that, while surveillance pilots were underway, TDH had not yet installed NBS and, therefore, TDH was not using NBS with the surveillance pilots. Similarly, while TDH reported to CDC that "all appropriate labs" had applied for Select Agent Rule certification, our testing indicated that 8 of the 10 regional labs had applied for this certification and that 2 were still in the process of applying. Select Agency Rule certification is important because it authorizes laboratory researchers to work with biological agents and toxins that have the potential to pose a severe threat to public health and safety.

Inadequate quality assurance processes within TDH led to the errors in its end-of-year progress report. Specifically, although management reviewed the report before it was submitted to CDC, management did not review the support for statements the report made to ensure consistency in the quality of those statements. Turnover among key staff and a lack of clear instructions regarding how the report should be compiled may also have contributed to staff's inability to provide support for all statements in the report.

Recommendation

TDH should institute a quality control review process to ensure that all statements included in its progress reports are properly supported before it submits those reports to CDC. TDH should also ensure that it maintains adequate records and conducts cross training to ensure that staff turnover does not result in program managers' being unable to provide consistency and continuity in reporting. In addition, TDH should obtain clarification from CDC regarding the purpose of and expectations for completing progress reports, and it should document the results of those communications.

HEALTH, DEPARTMENT OF

Management Response and Corrective Action Plan:

As noted, due to miscommunications, the end-of-year progress report reflects completion of a number of projects that were not completed until fiscal year 2004. TDH will verify with the cognizant agency if an amended end-of-year progress report is required.

The Center for Public Health Preparedness and Response will develop a procedure to review all responses to progress reports for accuracy and to adequately document all responses prior to submitting for program management approval and subsequent submission to the requesting agency.

Implementation Date: March 1, 2004

Responsible Person: Rolando Garza

Reference No. 04-13

Cash Management

**CFDA 93.283 – Center for Disease Control and Prevention-Investigations and Technical Assistance
Type of Finding – Material Weakness Control**

The Bioterrorism program at the Texas Department of Health (TDH) represented 84 percent of CFDA 93.283 funds received in fiscal year 2003; therefore, the Bioterrorism program was the focus of our audit work regarding cash management for CFDA 93.283.

Questioned Cost: \$ 0

U.S. Department of Health and
Human Services

The Cash Management Improvement Act of 1990 requires state recipients to enter into Treasury-State agreements that prescribe specific methods of drawing down Federal funds (funding techniques) for selected large programs. The Bioterrorism program is not covered by a Treasury-State agreement but is subject to procedures prescribed by Treasury in Subpart B of 31 Code of Federal Regulations (CFR), Part 205, Section 33. In fiscal year 2003, TDH did not comply with those cash management regulations. Specifically, TDH routinely rounded up cash amounts that it drew down from the Federal government. This led TDH to draw down amounts of Federal funds that exceeded the determined cash needs for the Bioterrorism program. For example, in January 2003, TDH processed a draw down request for \$500,000 for the Bioterrorism program; however, that amount exceeded the Bioterrorism program's identified cash needs by \$20,633.79. In addition, TDH had no assurance that it complied with the requirement to minimize the time between draw down requests and disbursement. It did not have controls in place to measure and minimize this time. TDH also lacked formal, approved policies and procedures for its cash management process.

The CFR requires that a Federal program agency must limit funds transferred to a state to the minimum amounts that state needs. It also requires that disbursement of funds must be made in accordance with the actual, immediate cash requirements of a state in carrying out a Federal assistance program or project. Federal requirements also specify that a state must minimize the time between draw down requests and the disbursement of funds for Federal program purposes. The timing and amount of fund transfers must be as close as is administratively feasible to a state's actual cash outlay for direct program costs and the proportionate share of any allowable indirect costs.

Recommendation:

TDH should comply with the CFR by requesting only fund amounts that equal actual cash needs and by ensuring that the time between draw down requests and disbursements is minimized. It should also implement formal, approved policies and procedures for its cash management process.

Management Response and Corrective Action Plan:

In fiscal year 2003, TDH drew down federal funds based on estimated usage. In some circumstances, this resulted in either insufficient or excess federal funds available for allowable expenditures. To better manage the federal funds, on September 1, 2003, TDH implemented procedures to ensure accurate and timely draw down. A report was developed during fiscal year 2003 to capture pending accounts payable transactions. This report has allowed staff to draw only those amounts needed for processing of federally funded payments.

Implementation Date: September 1, 2003

Responsible Person: Machel Pharr

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