REPORT NUMBER 2020-4

HIV-AIDS Program Performance Audit
April 2020
The Colorado Department of Public Health & Environment’s (CDPHE or department) Internal Audit function, as defined by the Institute of Internal Auditors, is an independent, objective, assurance and consulting activity designed to add value and improve an organization’s operations. It helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve effectiveness of risk management, control and governance processes. Internal Audit is free from internal and external influences in order to provide objective and independent assessments and is responsible for examining and evaluating CDPHE’s various operations in order to improve efficiency and effectiveness.

Furthermore, CDPHE Internal Audit operates as a stand-alone unit within the Office of Legal and Regulatory Compliance and reports directly to the Director of the Office of Legal and Regulatory Compliance. This structure is important in order to promote audit objectivity, independence from divisions and programs, and an impartial assessment of the area under audit review.

CDPHE Internal Audit uses the Generally Accepted Government Auditing Standards, International Standards for the Professional Practice of Internal Auditing and CDPHE Internal Audit Procedures to the extent possible, as the principal guidelines for how audits are conducted. This review emphasized but was not limited to compliance with federal rules and guidance, Colorado Revised Statutes, (C.R.S.), and State Fiscal Rules, as well as department policies and division procedures.

Audit Unit Staff

Melissa Canaday, Internal Auditor, CGAP
Lynne Swanson, Audit Specialist
DATE: April 3, 2020
TO: Karin McGowan, Deputy Executive Director CDPHE
FROM: Melissa Canaday, Internal Auditor
SUBJECT: HIV/AIDS Program Performance Audit

As requested by executive leadership within the department, Internal Audit has performed a performance audit of the HIV/AIDS Program branch within the Division of Disease Control and Public Health Response of the CDPHE. During our audit, we identified several areas where the branch can make improvements. These areas of concern relate to:

1. Documented Procedures, including Roles and Responsibilities
2. Organizational Structure
3. Priority Setting
4. Data System Management
5. Record Retention
6. Procurement Processes
7. Funding Stream Tracking and Grant Management
8. Rebate Tracking and Management
9. Budgeting
10. Expenditures
11. Monitoring and Oversight
12. Reporting
13. Time and Effort Reporting
14. Relationships with Advisory Committees
15. Transparency and Implementation
16. Conflict of Interest

Our report provides details about these areas along with our recommendations.

We conducted our review in accordance with generally accepted government audit standards (GAGAS). Those standards require that we plan and perform the audit in order to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings, conclusions, and recommendations, which are further discussed within this report, along with management’s responses.

We appreciate the time and assistance of various individuals during our review. If you have any questions or need additional information, please contact me at 303-692-2874.
Executive Summary:
Internal Audit has assessed the adequacy of the oversight of the HIV/AIDS Program and reviewed the use of related sources of funding. Overall, we found that oversight was inadequate and that some funds were not expended appropriately. As a result, Internal Audit identified numerous opportunities for improvement.

Internal Audit is unable to remove substantial doubts about whether the accounting data reported within CORE for the HIV/AIDS program are correct for our audit period. We are relying on them in order to communicate our findings; however, they are unaudited and we are unable to opine on the validity of the amounts reported in CORE. Thus, dollar amounts communicated within this audit report may not be free from material misstatement. In addition, Internal Audit did not receive all of the supporting information that we requested from the branch, division or specific contractors and subrecipients. As a result, the report includes detail of when we were unable to conclude on specific areas of concern. We have made several recommendations related to the division conducting an analysis in these particular areas.

Our audit scope did not include a review of any personnel matters or related decisions that may have occurred during the audit period.

Internal Audit provided 56 audit recommendations related to findings and two others related to other considerations surrounding options for the management of rebates and the program. Specific audit recommendations include updating policies and procedures, creating desk manuals, conducting staff training, updating employee position descriptions, considering the purchase of a new database, implementing proper encumbrance procedures, revising coding in CORE, developing performance measures, and revising contracts among others. For further information on the recommendations, please refer to each section in the report detail below.
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Objective:

The objectives of our audit were to determine the adequacy of CDPHE’s oversight of the HIV/AIDS Program, and whether HIV/AIDS Program sources of funding were expended in accordance with applicable laws and regulations. Our mission is to provide the department with information about past performance and to provide recommendations to improve current performance.

Scope and Methodology:

Our audit covers the specific period of fiscal years 2017, 2018 and 2019 but also provides relevant additional information that may have occurred prior to or after the audit period. Our scope was limited to the HIV/STI branch; it does not specifically include other branches within the division.

Methods used to achieve our objectives included, but were not limited to:

- Reviewed Colorado Revised Statutes and other legislation.
- Reviewed Colorado State Fiscal Rules.
- Reviewed department policies.
- Reviewed Ryan White federal legislation, such as Public Law 111-87, and related federal websites.
- Reviewed HRSA site visit from April 2017 and the branch response.

1 The division includes various branches including the HIV/STI branch and the Operations Branch. The Operations Branch provides services to the other branches within the division, including financial and contract monitoring services.
• Reviewed funding streams’ activity, including allocation methodology, encumbrances, budgeting, and fiscal tracking, division/branch determination of allowable expenditures, rebate activity and use, and federal reporting, in addition to the related coding in the department’s accounting system.
• Reviewed Program oversight procedures, including the effectiveness of contract and subrecipient monitoring and the determination and approval processes for reversions of federal funding.
• Reviewed prior audits of the Program to determine current compliance.
• Reviewed subrecipient detail, such as contracts and awards, and related reimbursable vendor invoices.
• Benchmarking with HIV/AIDS Programs within public health departments in Massachusetts, Indiana and California. Refer to Appendix G.
• Reviewed rebate and other fiscal data.
• Reviewed samples of contracts, invoices and related supporting documentation.
• Reviewed samples of site visit reports, both program and fiscally related.
• Reviewed advisory committee documentation related to the Colorado HIV Alliance for Prevention, Care and Treatment, Colorado HIV and AIDS Prevention Grant Program (CHAPP), and the State Drug Assistance Program Advisory Committee (SDAP2)
• Interviews with relevant division and departmental management and staff, former CDPHE employees, members of the community, NASTAD and HRSA leadership and others as necessary.

Background

Legal Framework. The Health Resources and Services Administration’s (HRSA) Ryan White HIV/AIDS Program provides a comprehensive system of HIV primary medical care, essential support services, and medications for low-income people living with HIV/AIDS who are uninsured and underserved. The Program funds grants to states, cities/counties, and local community-based organizations to provide care and treatment services to people living with HIV/AIDS to improve health outcomes and reduce HIV transmission among hard-to-reach populations. Over the last 28 years, HRSA’s Ryan White HIV/AIDS Program has played a critical role in the United States’ public health response to HIV/AIDS. The Program serves as an important source of ongoing access to HIV/AIDS medication that can enable people living with HIV/AIDS to live close to normal lifespans. In 2017, 85.9 percent of the national Ryan White HIV/AIDS

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2 SDAP is the state of Colorado’s AIDS Drug Assistance Program group (ADAP) and the terminology “Colorado AIDS Drug Assistance Program (ADAP) is often used interchangeably.
Program clients had high viral suppression rates, exceeding the national average of 59.8 percent.³

CDPHE receives Part B funding to improve the quality, availability, and organization of HIV health care and support services, in addition to grants for the AIDS Drug Assistance Program (ADAP)⁴. In 2018, Colorado was home to 6,938 clients served by the Ryan White HIV/AIDS Program of which the majority are white males between 25 - 64 years old. Refer to the charts below for actual percentages in 2018.⁵

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³ https://hab.hrsa.gov/about-ryan-white-hivaids-program/about-ryan-white-hivaids-program
⁴ 42 U.S.C. § 300ff21-37
As a grantee of federal Ryan White Part B funds, the division is required to comply with all federal requirements for this Program. These funds may be spent for core medical services, support services, and administrative services for the benefit of eligible individuals. 42 U.S.C. § 300ff-22. To be eligible to receive services through the Ryan White Part B Program, an individual must have a medical diagnosis of HIV/AIDS and be a low-income individual, as defined by the State. Core medical services include all of the following:

- Outpatient and ambulatory health services.
- AIDS Drug Assistance Program treatments in accordance with section 300ff-26 of this title.
- AIDS pharmaceutical assistance.
- Oral health care.
- Early intervention services described in subsection (d).
- Health insurance premium and cost sharing assistance for low-income individuals in accordance with section 300ff-25 of this title.
- Home health care.
- Medical nutrition therapy.
- Hospice services.
- Home and community-based health services as defined under section 300ff-24(c) of this title.
- Mental health services.
- Substance abuse outpatient care.
- Medical case management, including treatment adherence services.
Support services include services, subject to the approval of the Secretary, that are needed for individuals with HIV/AIDS to achieve their medical outcomes, including respite care for persons caring for individuals with HIV/AIDS, outreach services, medical transportation, linguistic services, and referrals for health care and support services. Administrative services, capped at ten percent (10%), include routine grant administration and monitoring activities, subcontractor administrative costs, and clinical quality management, as stated in HRSA PCN 15-01.

Additionally, participation in the Ryan White Part B Program authorizes the receipt of additional funding through the rebate program, and further requires that these rebate funds are used to support Program activities. 42 U.S.C. § 300ff-26(g). HRSA also issues Policy Clarification Notices (PCN) to further elaborate on the requirements of the Program, and has issued two notices that address these rebates, PCN 15-04 and 16-02. The National Association of State and Territorial AIDS Directors (NASTAD), a leading non-partisan non-profit association that represents public health officials who administer HIV/AIDS and hepatitis programs in the U.S. and around the world, has also issued clarifying guidance concerning the use of rebate funds associated with this Program. NASTAD has a cooperative agreement with HRSA for technical assistance and other guidance to HIV/AIDS Programs.

State statute also authorizes the department’s participation in the Ryan White Part B Program, and includes requirements concerning the expenditure of State Drug Assistance Program (SDAP) funds. C.R.S. § 25-4-1401. SDAP is the AIDS Drug Assistance Program (ADAP) administered by the department for Colorado. The state statute authorizes the use of SDAP funds for screening, general medical, preventive, and pharmaceutical costs for eligible individuals. C.R.S. § 25-4-1401(2)(a). In late 2015, the statute that funds the ADAP was altered in two major ways. First, funds previously restricted to the ADAP were authorized to be expended on other HIV/STI medical and prescription prevention services such as PrEP and for the treatment of viral hepatitis for mono-infected low-income individuals. The statute broadens eligibility for the SDAP to include the prevention of HIV for eligible individuals, who are defined to include individuals who meet the state’s income eligibility requirements and have a prescription from a provider with prescriptive authority for a pharmaceutical in the SDAP drug formulary. C.R.S. § 25-4-1401(3). Colorado’s income eligibility cap for this Program is 500% of the federal poverty level. In addition, the statute further designates that all money received in excess of the federal price agreement are considered a donation. C.R.S. § 25-4-1401(2)(d).

HRSA PCNs implement the Ryan White HIV/AIDS Program legislation, last revised in 2009, and provide guidance to recipients in understanding and implementing

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legislative requirements. Specifically, PCNs 15-03⁸, 15-04⁹, 16-02¹⁰ and a related FAQ document¹¹ provide guidance on how to utilize pharmaceutical rebates received. The 340B Drug Discount Program is a federal government program that requires drug manufacturers to provide outpatient drugs to eligible health care organizations or covered entities at significantly reduced prices. In addition to the 340B price reduction, ADAPs have negotiated deeper discounts on antiretroviral therapies through the ADAP Crisis Task Force (ACTF). ACTF discounts received as rebates are also referred to as “supplemental rebates.” HRSA requirements state that rebates must be used for the “purposes for which the award was made,” for otherwise allowable costs under the award. Therefore, rebates can be used for the following: core medical services, support services, clinical quality management and may be used for otherwise allowable costs not included in the Ryan White Part B implementation plan; priority should be given to placing rebates back into ADAP but is not required.¹² Specific requirements¹³ are as follows:

- **PCN 15-04:**
  - Rebates must be spent in the grant year in which they are received and prior to drawing down grant funds.
  - Recipients must track and account for all rebate funds, and must be able to account for the rebate funds in any statewide single audit¹⁴
  - Prohibition on sharing ADAP rebates with any other entities

- **PHSA 2616.300ff-26(g)¹⁵:**
  - Rebates must be applied to Part B activities, with priority given to ADAP

HRSA also emphasizes that per the regulations at 45 CFR § 75.305(b)(5), all federal funded recipients, including states with an ADAP that is collecting rebates, are required to spend their available rebates prior to drawing down grant funds from the Payment Management System. Once available rebates have been expended, recipients should spend grant funds. Recipients should not delay spending grant funds in anticipation of receiving rebates.¹⁶

**Advisory Committees.** CDPHE has three advisory committees related to their HIV/AIDS Program: The Colorado HIV and AIDS Prevention Grant Program (CHAPP), the State

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⁸ Clarifications Regarding the Ryan White HIV/AIDS Program and Program Income
⁹ Utilization and Reporting of Pharmaceutical Rebates, revised January 2019
¹⁰ Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds, revised October 2018
¹² Language obtained from HRSA training presentation on the use of rebates, dated August 2017, obtained directly from HRSA ADAP Program.
¹³ ADAP Manual, 2016 – Appendix 1: ADAP Requirements Table
¹⁴ The Statewide Single Audit is conducted by each State Auditor’s Office for the Major Program 93.917 and is often on a 3-year cycle in Colorado.
¹⁵ 340B Drug Pricing Program Omnibus Guidance - HRSA administers section 340B of the Public Health Service Act (PHSA), which is referred to as the “340B Drug Pricing Program”
Advisory Drug Program (SDAP) Review Committee and the Colorado HIV Alliance for Prevention, Care and Treatment (the Alliance). In addition, there are other working groups related to HIV, such as the HIV Testing Working Group, the PrEP\(^{17}\) Working Group and the PWID Working Group, also known as Services for People Who Inject Drugs. These advisory groups assist the department in identifying funding needs for people living with HIV and prevention approaches within Colorado. None of these committees or working groups are rule-making Type 1 boards within the State of Colorado but instead are advisory in nature to the department. Refer to Appendix E for more details of the difference between Type 1 and Type 2 boards.

Furthermore, the Colorado HIV and AIDS Strategy (COHAS) 2017-2021 and the Colorado Statewide Coordinated Statement of Need 2016 are collaborative plans that were developed by the department along with the collaboration of stakeholders, some of which participate in these other working groups or committees. These plans are extremely important in the assistance of determining priority setting and defining the needs of the community.

House Bill 06-1054 established CHAPP during the 2006 legislation session\(^ {18}\) and CDPHE administers the Program. The purpose of this advisory committee is to address local community needs in the areas of HIV/AIDS prevention and education through a competitive grant process. The Executive Director of the CDPHE appoints seven members to the CHAPP committee who can participate for two terms. CHAPP receives 3.5 percent of the tobacco settlement moneys (Master Settlement Agreement or MSA), per C.R.S. § 25-4-1405.

SDAP assists individuals living with HIV/AIDS to pay for their HIV related medications. The Program is open to Colorado residents living with HIV who have an income of less than 500% of the federal poverty level and must have their eligibility reevaluated every six months. The SDAP Review Committee’s purpose is to provide advice, to consult with, to make recommendations, and, together with CDPHE, to determine how the monies derived from the MSA moneys are allocated for the purposes of the Program, as established in C.R.S. § 25-4-1401.\(^ {19}\) The drug assistance program was created in C.R.S. § 25-4-1401 and receives five percent of the settlement moneys.

\(^{17}\) Pre-exposure prophylaxis (PrEP) is medication provided to people at risk for HIV to take daily to prevent HIV.

\(^{18}\) Colorado Revised Statute Title 25, Article 4, Part 14 which includes: C.R.S. § 25-4-1402 (Definitions), CRS § 25-4-1403 (Program), CRS § 25-4-1404 (Grant Program - Conflict of Interest) and C.R.S. § 25-4-1405 (Cash Fund - Administration - Limitation)

\(^{19}\) As stated in the “Conflict of Interest - Definition & Guidance for SDAP Advisory Committee Members” document prepared by CHAPP.
As stated on the CDPHE website\(^{20}\), the Alliance comprises of 16 members, of which the Governor appoints nine members, who initially are appointed for two or three-year terms and thereafter, can each serve for two additional years for a maximum of two terms. The Alliance was created in the early 2000’s and was recently re-created via Executive Order B 2014-004 in 2014. This committee works with the department to determine the best ways to prevent, care for and treat HIV and AIDS in Colorado. In addition, it promotes statewide collaboration and information sharing among HIV/AIDS service providers, public health agencies, community members, those affected by HIV and medical, behavioral and social scientists. In addition to voting members, members of the community often also attend these meetings.

**Organization Structure and Funding.** The HIV/AIDS Program (Program) is included within CDPHE’s HIV/STI branch (branch)\(^{21}\) of the Division of Disease Control and Public Health Response (DCPHR or division), which used to be called the Division of Disease Control and Environmental Epidemiology, or DCEED. Refer to the graph and table below for a visual of the total revenue and total expenditures for our audit period and the legend for the relevant program codes.\(^{22}\)


\(^{20}\) The current interim director for this branch is Deputy Executive Director Karin McGowan.

\(^{21}\) Source - Auditor prepared from program code data from CORE using total revenue rather than the budget column to prevent including the carryover amount twice. The program also receives other funding, including General Funds, which cover operating and personnel costs. While the branch receives other funding, our audit focused on the funding streams identified as areas of concern. Internal Audit does not confirm that these numbers are accurate.
In state FY19, the Colorado Ryan White HIV/AIDS Program Part B Program received a total of $14,516,090 in funding, which included a pending unobligated balance carryover of $1,341,896 from April 1, 2018 - March 31, 2019 to April 1, 2019 - March 31, 2020. It appears that 64 percent of its funding was contracted out in state FY19 for delivery of Core Medical and Support Services.

The HIV/STI Program also received a three-year award (and a one year extension) of $6,109,774 from The Centers for Disease Control and Prevention (CDC) to reduce HIV infections and improve engagement in HIV medical care among men with a project period of September 30, 2015 - September 29, 2019. We were unable to confirm the carryover amount in CORE from the initial award for state FY19, because it appears that the program did not set up the previous year’s amounts correctly.

Additionally, the HIV/STI Program received a four-year award of $1,777,228 from CDC for the National HIV Behavioral Surveillance System with a project period of January 1, 2016 through January 1, 2020. For state FY19, the amount was $447,110.

The HIV/STI Program also received a five-year award from CDC for HIV/STI: Integrated HIV Surveillance and Prevention with a project period 01/01/2018 through 12/31/2022 and annual budget periods. In calendar year (CY) 2018 the Program received $5,217,100, CY2019 $5,217,100, and the current year (CY20) the Program received

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23 Ryan White dollars are in funding stream program code QT within CORE. This data came from NOA.
24 Pending in this particular situation means that it was not yet been entered into CORE.
25 $9,358,757 includes ADAP contracts, base contracts, ADAP and MAI (Minority AIDS Initiative) divided by $14,516,090 = 64 percent. Internal Audit confirmed numbers with central accounting. Additionally, this amount should be at least 75% by March 31, 2020 per Program requirements.
26 These CDC dollars are in funding stream program code GK within CORE.
27 Internal Audit confirmed with central accounting that this budget was not set up correctly in CORE.
28 These CDC dollars are in funding stream program code GR within CORE.
$1,304,278. The Program is currently expending funds from the 01/01/20-12/31/20 budget period and has received $11,738,478.00 to date.\textsuperscript{29}

Colorado also receives annual Tobacco Master Settlement Agreement (MSA) revenue dollars via a statutory formula provided to a wide variety of programs. Revenue from the MSA is the result of a 1998 legal settlement between tobacco manufacturers and the states who sued the tobacco manufacturers to recover Medicaid and other health related costs incurred by the states because of treating smoking related illnesses.\textsuperscript{30} The MSA payment that the state receives each April dictates the allocation of moneys to MSA-funded programs for the fiscal year beginning in the following July.\textsuperscript{31} Between fiscal years 2015 - 2020, $13,781,014 in MSA dollars went to CDPHE for CHAPP purposes and $20,825,766 was transferred to CDPHE for SDAP. Refer to Appendix A for further detail of the distribution of Tobacco MSA payments under HB 16-1408 and the 2017 - 2019 Tobacco MSA Distribution Forecast tables. For state FY19, CDPHE received $2,947,193 in CHAPP MSA dollars and $4,210,275 in SDAP MSA dollars.

The branch also receives rebate dollars from pharmaceutical companies. The purchase of FDA-approved medications for low-income individuals with HIV disease who have limited or no coverage from private insurance, Medicaid, or Medicare is the core historical component of ADAPs. The passage of the Affordable Care Act of 2010 resulted in over 1,500 Colorado ADAP members shifting to Medicaid, drastically decreasing the cost of providing medication assistance for uninsured members.

\textbf{Conclusion}

Internal Audit has assessed the adequacy of the oversight of the HIV/AIDS Program and reviewed the use of related sources of funding. Overall, we found that oversight was inadequate and that some funds were not expended appropriately. As a result, Internal Audit identified numerous opportunities for improvement.

Internal Audit is unable to remove substantial doubts about whether the accounting data reported within CORE for the HIV/AIDS Program are correct for our audit period. We are relying on this data in order to communicate our findings; however, the data are unaudited and we are unable to opine on the validity of the amounts reported in CORE. Thus, dollar amounts communicated within this audit report may not be free from material misstatement. In addition, Internal Audit did not receive all of the supporting information that we requested from the branch, the division and specific contractors and subrecipients.\textsuperscript{32} As a result, the report includes detail of when we were unable to conclude on specific areas of concern. We have made several

\textsuperscript{29} These CDC dollars are in funding stream program code EI-EO-JO within CORE.
\textsuperscript{30} Overview of Tobacco Master Settlement Agreement, State Budget Briefing, November 14, 2017
\textsuperscript{31} Effective beginning in FY17 under CRS 24-75-1104.5(1.7)
\textsuperscript{32} For simplicity in the report, the term “contractor” refers to both contractors and subrecipients, meaning any entity where the branch has a commitment voucher relationship. We did not review the subrecipient determination tools for these entities.
recommendations related to the branch conducting an analysis in these particular areas.

Finally, our audit scope did not include a review of any personnel matters or related decisions that may have occurred during the audit period.

Results of Review

During the course of this audit, we found several areas of improvement that when addressed could improve the administration and management of the HIV/AIDS Program. In addition, any deficiencies in internal control that are significant within the context of our audit objectives are included in the summary of findings based upon the audit work performed. Although we did not find any instances of fraud during our audit, fraud risk factors naturally increase when internal controls are lacking or ineffective.

Below we address each of the identified areas of concern and provide recommendations for consideration by the appropriate authority, including the branch, human resources, and central accounting. Unless otherwise specifically noted, the recommendations are to the branch.

A. Lack of Documented Procedures, Including Roles and Responsibilities

Issues Identified. Internal Audit requested documented procedures from the Division, Branch and Program for the period of state FY17- FY19 and received general program procedures from the Ryan White HIV/AIDS Program website such as Standards of Care and HIV Prevention Standards guidance. We also received a few documented program procedures prepared by the department such as Reporting Requirements for HIV Care and Treatment Contractors and Standards of Care for Prevention Services for People Who Use Drugs, v11202019. However, branch management could not provide branch specific, written policies and/or procedures related to the program or the fiscal side of the HIV/AIDS Program, such as a methodology of how rebates are used, when to prepare a journal voucher (JV), etc. Since we did not receive these requested items from branch management, we cannot fully conclude on the existence or effectiveness of these written procedures; however, combined with information from interviews with current staff, it appears that these requested written procedures and desk manuals do not exist.

33 An effective internal control system can improve the overall management of the program. Refer to CRS 24-17-102, State Agencies Responsibilities and the State Controller Policy, Internal Control System - revised February 10, 2016 and 2 CFR 200 OMB Uniform Guidance.
We also noted that some branch employees acquired new positions and responsibilities during various reorganizations that occurred during the audit period but were not provided desk manuals, other documented procedures or revised position descriptions (PDs) to assist them in their transition into new roles. For example, some program staff had to perform fiscal duties but did not have the training or background for an effective shift into this new role.

We also found that there was inadequate succession planning for positions within the Program. When individuals in specific key positions either left the department or moved into a new position, there appears to have been a lack of effective transition and understanding of the complexities of the program. Although important for daily productivity and consistency within the branch, documented policies and procedures, outlining clear roles and responsibilities are essential during reorganizations.

**Why It Matters.** Accurate and up to date documentation of procedures and processes is critical to standardize processes, train employees, communicate internal controls and establish consistent organizational practices. In addition, when documented procedures do not exist and seasoned employees leave the department, their knowledge leaves with them. Effective internal controls also move forward the strategic plan, goals and objectives of the organization and serves to safeguard assets and funding integrity.34

Without proper training, clear expectations and staff feedback, the reorganization may not be as effective or successful as it could be. Detailed communication prior to the reorganization is essential; employees must be able to rely on written materials such as desk manuals or other documented procedures and training to be successful with their expected job duties. This combined with a loss of key supervisor/managerial employees with extensive knowledge of the Program and factoring in the learning curve of new leadership, likely assisted in the confusion regarding how to track the funding streams and proper internal controls to ensure accurate reporting.

**Recommendations.**

1. Establish and implement formal written policies and procedures for all branch business practices, including, not but limited to:
   a) Roles and responsibilities
   b) Figure setting
   c) Fiscal staff procedures
   d) Program staff procedures
   e) Invoice review and approval process

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34 US General Accounting Office (GAO) Green Book OVI.03 Standards for Internal Control
f) Funding stream methodology  
g) Rebate tracking methodology  
h) Journal voucher preparation and review processes  
i) Indirect costs determination methodology  
j) Managing encumbrances  
k) Operations support  
l) Communications and interactions with central accounting

2. Create desk manuals for each position within the branch to support succession planning and to provide staff a reference for guidance.

3. Provide adequate training to staff over the implemented policies and procedures, Ryan White specific grant requirements and desk manuals.

4. Review employee PDs and update as appropriate to align with current job duties.

B. Challenges with Organizational Structure

Issues Identified. A well-designed work unit organizational structure assists in ensuring that effective workplace communication, collaboration and productivity can thrive. Throughout the audit period, there were many changes to the organizational structure of the HIV/STI branch along with significant turnover in key manager positions. Examples of positions experiencing significant change during the audit period include the Operations Branch Chief, HIV/STI Branch Chief, Deputy HIV/STI Branch Chief, Care and Prevention Healthcare Access Unit Supervisor and the Care and Services Program Manager. Of these positions, the only permanently filled position is the Operations Branch Chief. Current division employees have the interim roles as the branch chief and deputy branch chief effective in mid-2019 but they also have other responsibilities for the division.

In December 2017, division leadership determined that the Deputy Branch Chief Position was no longer necessary and reallocated the position to the Operations branch. The division also eliminated the PHCO Branch Planning & Development Unit Supervisor position and moved the employees under this position to the Operations Unit. The Care and Prevention Healthcare Access Unit Supervisor position was also eliminated. According to a memo provided to the executive director, this position was responsible for maintaining “the complex invoicing and tracking of the rebates” but that “it takes a great deal of time and division leadership feels that those tasks are better handled by fiscal staff.” This decision likely led to confusion in roles and responsibilities in

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35 Memo from the division director to the executive director of CDPHE, December 22, 2017
addition to a large learning curve related to the department pharmaceutical rebates procedures and processes.

In a January 2018 memo to the Alliance from divisional leadership, it was stated that “division leadership has identified that consolidating overall fiscal oversight into one area within the division will ensure consistent application of state fiscal rules, adherence to federal guidelines and sound internal controls, in addition to enabling better, more comprehensive financial reporting to leadership.” Although this approach in itself sounds promising, over time existing teams develop strong identities that they may be reluctant to give up. Talking in depth about how employees see their role within the branch or division along with specific support and training would have been a valuable tool when creating change. During interviews with current employees, Internal Audit learned that although informational newsletters provide updates to organizational changes were distributed to employees, many employees still felt uncertain and that frequent, individual and targeted communication as they moved forward together in new roles would have been a better approach as the fiscal oversight was moved into one area. Additionally, employees needed specific training on the Ryan White Program as this Program has strict requirements for spending that some were not familiar with. To date, many feel that additional training regarding Ryan White requirements would make them more successful.

In June 2018, a vacancy hold was instituted by division leadership due to a state comparison of other HIV/STI Programs’ staffing, disease burden and funding based on 2016 data. According to division leadership, the purpose of the vacancy hold was to allow for more targeted review, understand the differences between the state programs, avoid potential layoffs within these currently vacant positions and evaluate proper Program alignment and fiduciary responsibility. The vacancy hold was in place for approximately a year. Although the branch posted the Care and Services Program Manager position in November 2019, they decided not to fill the position and notified applicants during February 2020. Other positions are also still vacant to date.

**Why It Matters.** Modifications to key positions and other organizational structural changes within a division in a short period can cause uncertainty, fear and a lack of buy in for employees. While organizations can move forward with substantial changes without employee buy in or support, best practice suggests that it is more likely to be a successful reorganization if the employees are included in the process and effective

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36 Memo from division leadership to the CDPHE executive director, dated June 2018.
37 The Care and Services Manager is a new position that would include the Health Care Access Supervisor, the Care Continuum Supervisor and the Ryan White Part B Manager into one position.
38 Government Finance Officers Association (GFOA) Key Issues in Succession Planning best practices
change management occurs, such as using the ADKAR\textsuperscript{39} model. In addition, without effective training, clear roles and responsibilities, reasonable timeframes for implementation and support from supervisors and management; it is difficult to expect a successful transition into a new organizational structure.

**Recommendations.**

5. Revise the branch/division organizational chart to reflect current staffing.

6. Mitigate change management problems with regard to the organizational changes by creating a change management plan, including implementation of a support structure and measuring the business impact of the changes.

**C. Lack of Effective Priority Setting**

Priority setting is the process of making decisions about how to best allocate limited resources. Priority setting is a complex and inherently political process involving a variety of stakeholders, decision-makers, and other interested parties whose motivations and actions may not be in alignment. Effective priority setting addresses these differing interests and motivations through a clear process focused on the use of evidence, transparency, and participation to identify the most appropriate programs and interventions to address population health needs.\textsuperscript{40} Refer to the example below for an example of an effective priority setting process.

\textsuperscript{39} ADKAR: A Model for Change in Business, Government and Our Community - How To Implement Successful Change in Our Personal Lives and Professional Careers by Jeffrey M. Hiatt

\textsuperscript{40} Primary Health Care Performance Initiative, https://improvingphc.org/priority-setting
Internal Audit requested the priority setting documentation related to the HIV/STI branch for our audit period. We did not receive this information. Interviews with current and former employees indicate that the division and branch has not prepared a specific priority setting methodology or identified set criteria in how they prioritize their spending of the funding streams. Additionally, it does not appear that the advisory committees (Alliance, CHAPP and SDAP) have always provided clear priority setting suggestions or preferences in their communications with the branch.

States are required to undertake needs assessment, priority setting, and resource allocation activities as integral parts of the Ryan White HIV/AIDS Program Part B planning process. Based on testing performed during the audit, it appears that CDPHE is currently not effective in planning, coordinating, and overseeing the priority setting process prior to setting their budget and establishing their funding needs.

Why It Matters. Having relevant and reliable data on hand is necessary to support a systematic approach to priority setting. Without effective priority setting, the risk increases that funding may not be focused in the areas it is most needed. Best practice models include seven components: innovation, identification, inequalities,
incorporation, importance, influences, and interventions to assist public health agencies to identify and manage priorities.

**Recommendation.**

7. Determine practical priority setting methodology for the department’s effective utilization of federal funding and rebate dollars prior to setting budgets. The branch/division should work with the advisory committees to determine priority setting. Document this methodology and train appropriate staff and advisory committee members.

8. Develop branch/division specific performance measures, for use in the priority setting process, and in overall branch goal setting. Consider developing a dashboard for proactive communication and public transparency.

**D. Ineffective Data System Management**

The Ryan White HIV/AIDS Program Services Report (RSR) is a client-level data-reporting requirement that monitors the characteristics of Ryan White HIV/AIDS Program Parts recipients, providers, and clients served. All Ryan White HIV/AIDS Program-funded recipients Parts A-D and their contracted service providers (subrecipients) are required to report client-level data annually to the HIV/AIDS Bureau through the RSR.\(^{43}\) CDPHE is required to complete The Recipient Report. Each Ryan White HIV/AIDS Program recipient completes a separate Recipient Report for each program grant the recipient receives from HRSA. The recipient completes the online report through the HRSA Electronic Handbooks (EHB) using a web-based data entry system. Ryan White HIV/AIDS Program Data Support is available to address RSR-related content and submission questions. Topics include:\(^{44}\):

- Interpretation of the RSR Instruction Manual and reporting requirements.
- Policy questions related to the data reporting requirements.
- Data-related validation questions.
- Recipient-provider relationships and the implications for data reporting.

The client-level data reported by recipients and subrecipients is important to:\(^{45}\):

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\(^{43}\) Refer to Appendix B for diagram of recipient and subrecipients working together to submit the RSR.


• Monitor health outcomes of clients living with HIV receiving care and treatment services through Program recipients and subrecipients.
• Address the impact of HIV in communities disproportionately affected, by assessing organizational capacity and service utilization.
• Monitor the use of the Ryan White HIV/AIDS Program to address HIV in the United States.
• Track progress toward achieving the goals identified in the National HIV/AIDS Strategy: Updated to 2020.

In order to be able to effectively track and analyze data, it is necessary to utilize a working database. The branch originally entered into a contract in 2009 with a vendor to create, support and maintain a database system for the Ryan White Program called the AIDS Regional Information and Evaluation System (ARIES). Several amendments occurred to extend the contractual arrangement over the years. The branch utilized rebate dollars to fund this project, which is reasonable; however, it appears that the contractor did not provide deliverables as expected and contract-monitoring oversight was inadequate. Although the branch identified many bugs throughout the years, and the branch realized that they could not utilize this database effectively, the contract continued until its final amendment expired on March 31, 2018. Internal Audit did not conduct a system IT audit on the databases utilized by the branch, such as ARIES, PRISM\textsuperscript{46} or RedCap,\textsuperscript{47} as this is outside the scope of this audit.

HRSA conducted a site visit in 2013 and their report states, “until the ARIES system is fully implemented and utilized by all funded sub-grantees, the Ryan White HIV/AIDS Part B Program does not have the ability to utilize client-level data for program, grant, or fiscal monitoring, provider or contract monitoring or quality management.” Further, the report states that although the program staff are aware of the limitations of the current data collection and the requirement to collect and utilize the client level data, they are not compliant with the client level data reporting, as required. Additionally, HRSA provided compliance corrective action stating, “while client-level data is currently not collected and used for a quality management program, there is an infrastructure in place to manage a quality management program, including a plan and subcommittees to analyze and review data and case manager trainings. Once the Ryan White HIV/AIDS Part B Program can properly receive client-level data from the funded providers, the actual implementation of a clinical quality management program can be completed.” The branch responded to the finding by providing an implementation date

\textsuperscript{46} Patient Reporting Investigating Surveillance Manager (PRISM)
\textsuperscript{47} Research Electronic Data Capture (REDCap) is a web-based application that captures data, creates databases, and is HIPAA compliant, highly secure and intuitive to use; Analysis of database prepared by the US National Library of Medicine, National Institutes of Health
of March 31, 2014 for when the ARIES system would be fully functional for all subgrantees to enter their data or they should submit monthly uploads to the branch for importing into ARIES. However, areas of concern continued to exist and this item was an ongoing follow up item for HRSA. Per discussion with the HRSA Project Officer, the only outstanding item requiring long-term follow up at this time relates to the replacement for ARIES.

According to branch staff, most contractors were able to upload their client data into ARIES as required; however, at least three contractors could not upload their data. Providers who had an Electronic Medical Record (EMR) system did not have an existing bridge that would allow an easy transfer of data from their EMR system into ARIES. The expectation from the branch is that all providers would upload data into ARIES on a monthly basis. The branch had to input the data into the database due to these system limitations and since there were no internal controls in place related to a secondary level of review of the data entry by the branch, it increased the risk of inaccurate data entry. Even though there was no contract with the vendor, the branch continued to use ARIES until March 2019 and no one has been able to enter data into ARIES since that time. The branch chose REDCap to replace ARIES and began customizing it while waiting for their contract with the ARIES vendor to expire. The branch explored other database options but settled on this one for now. Advantages are that it is free, accessible online, security compliant, allows for fast development for basic data entry and does not require database development and programming skills. Disadvantages to using REDCap as reported by users are that there is a large learning curve, it is easy to unintentionally delete records, it is not a relational database development tool, the design of query building tools is not user friendly, and it can be difficult in managing data and extremely difficult to conduct data quality control.48

Another option for use is CAREWare version 6, which is a free, electronic health information system for HRSA’s Ryan White HIV/AIDS Bureau and first released in 2000.49 This version has a new user interface that runs in any internet browser and includes free technical assistance by HRSA to manage the Ryan White data. Multiple webinars are also available and reports are easy to develop and access. Although some technical issues frustrated users a few years ago, NASTAD informed us during interviews that

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48 Data Management and Database Tools in Research, Bi-National Health Risk Seminar Series, November 2014
49 https://hab.hrsa.gov/program-grants-management/careware
HRSA addressed these issues and that a number of states utilize CAREWare since it is the preferred option.\textsuperscript{50}

An additional concern related to the data systems as voiced by branch staff is that there does not appear to be enforcement options for them if contractors are not timely entering data into the database. It is sometimes difficult to set deadlines for others but explaining the requirements behind the branch requests may assist in compliance. In addition, communications by the contract monitor of expectations can promote consistency in the branch communication.

\textbf{Why It Matters.} Effective data management is the foundation of an organization’s information, knowledge and decision making capabilities. However, if data is inaccurate, mismanaged or error prone, it can lead to inefficiencies and inaccurate reporting to both internal and external customers. One way to identify opportunities for improved delivery of services is by using a strong analytics structure.\textsuperscript{51} Best practice is that well documented data that is easily accessible will reduce redundant work and add value.

\textbf{Recommendations.}

9. Continue to work through challenges that contractors have when submitting client data in order to properly report to the federal government.

10. Consider utilizing a different database or procuring a new system in order to effectively and efficiently keep track of client data.

\textbf{E. Inadequate Record Retention}

The division maintains a records retention schedule for each of the branches, as required by Colorado State Archives.\textsuperscript{52} The division maintains an overall retention schedule that is dated 2017; however, a review of the branch retention schedules show that it is out of date. Specifically, the HIV/STI branch’s retention schedule, dated October 2004, includes outdated retention requirements, a result of the schedule being out of date. In addition, the division’s most recent fiscal and budget records retention schedule is from July 2004 and management does not have a copy of this document reflecting the signatures and approval of the State Archivist, Attorney General’s Office and the State Auditor. According to division management, “A need for comprehensive

\textsuperscript{50} For example, New Mexico utilizes CAREWare, which is one of the states in our benchmarking results below.

\textsuperscript{51} Government Finance Officers Association (GFOA) Master Data Management: A Framework for the Public Sector, August 2018

\textsuperscript{52} CRS 24-80-101 State Archives and Public Records Act
Division-wide updates had been identified in 2018; one senior staff and one junior staff member were tasked with this work. The senior staff member left the Division in 2019 and the junior staff was terminated in 2019 as well; backfilling this work is pending DCPHR re-organization.53” Not adhering to or having an outdated retention schedule increases the risk of not being able to fulfill a request through the Colorado Open Records Act or through state auditors.

As noted above, the branch was unable to provide Internal Audit with various documents that we requested in order to complete this audit; thus, we are unable to conclude on various aspects of questions that we have.54 The majority of items that we did not receive relate to fiscal requests. Examples include program processes for figure setting, analysis of vacancy savings on open positions and related plans for how these funds are to be used within the division, branch performance measures and analysis for all funded service categories, and the department approved SDAP emergency preparedness plan utilized during our audit period.

**Why It Matters.** Sufficient record keeping is important because it maintains information for transparent decision-making, proper tracking and organization of supporting documentation. An organization’s retention plan should be detailed and reasonable timelines established. State statute requires all state agencies to create a records management program and adhere to records management schedules. 55 The Department of Personnel and Administration’s Division of Finance and Procurement prepares the State’s Records Management Manual, which includes the State Controller’s Office Financial Records Retention Guidelines for Financial Related Documents56 along with other required state agency records. Departments must adhere to these retention guidelines as approved by their Records Management Officer, State Archivist, Attorney General’s Office and the State Auditor. A review of these guidelines should occur regularly.

Department policy states that each “records disposition schedule shall be reviewed every two years and shall be updated when there has been a new business process adopted that necessitates an earlier review, or every five years if no changes are identified.”57

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53 Statement made in division’s response to Internal Audit’s document request for current document retention schedules.
54 Internal Audit has provided recommendations for the branch to conduct analysis based on these questions.
55 C.R.S. §24-80-101 et seq.
56 Refer to Schedule No. 2 “Budget Records,” Schedule No. 7 “Financial Records”
57 CDPHE Policy 2.15, Records Retention, last revised January 2016
Recommendations.

11. Retain all documentation as required in the Statewide Records Management Manual and submit a revised version of the branch retention schedule for approval.

F. Ineffective Procurement Processes

**Moving funds between event types.** Encumbrances established for the current year of the commitment voucher should use the event type PR05 so that funds are properly obligated in CORE. For multi-year commitment vouchers, event type PR08 may be utilized on the commodity lines that pertain to state fiscal years. Special care should be taken to ensure that the future fiscal year lines are set up correctly so that they will correctly role during the year-end roll process. PR08’s are only allowed under these circumstances. Division staff are responsible for monitoring any multi-year commitment vouchers to ensure adequate funding will be received prior to rolling forward the document into the next fiscal year.\(^{58}\) Additionally, PR07\(^{59}\) event types should not be used unless the same funds have already been encumbered on a different encumbrance document.\(^{60}\)

During our audit, we found numerous instances of PR05 and PR08 usage over the course of the audit period through review of the CORE report PROC-037 report. However, we are unable to identify how often funds move from PR08 to PR05 and tried to find a report within CORE to assist us. We wanted to view when the funds “moved” when the branch receives an invoice to pay. We could not locate this and per discussion with central accounting, we are unable to do so. Central accounting has made a request to CORE tech support to see if they can modify what is reportable from encumbrances. The issue is that PR08\(^{61}\) live in the procurement module, and the PR05\(^{62}\) reside in the finance module and they do not currently connect. At this time, central accounting cannot see the posting impacts from a PR08 to a PR05 line. It would likely take significant time cross-referencing two different reports and looking into CORE documents. The CORE PROC-37 report shows the encumbrances by event type and modification number in line totals, not changed amounts. By not following guidance from central accounting on proper procedures and not creating a transparent trail of the funds, the risk of inaccurate financial reporting, confusion in the tracking methodology, lack of funding to cover obligations and lag time of paying of invoices

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58 Standard and approved CDPHE accounting practice.
59 CORE event type code, which does not post to the accounting journal in CORE.
60 Public Health & Environment Fiscal Procedures Manual, version 2.0, revised 2020
61 CORE event type code used for recording multi-year contracts and does not post in the accounting journal. It also turns into a PR05 during the year-end roll-forward process.
62 CORE event type code, which posts into the accounting journal and obligates funds.
increases. It should be noted that this approach was discussed with central accounting in FY19 and initially approved but then it was determined that this methodology was not appropriate. In addition, due to the system limitation in reporting encumbrances in CORE, there are restricted internal controls over moving funds around which increases the potential for fraud and inappropriate management of the funds. Central accounting recently sent out additional guidance to the department fiscal service managers about encumbrances and the added internal control of approving an encumbrance.63

**Under-Encumbering Funds.** During our audit, we found examples where the branch is not effectively encumbering funds. Per our review of CORE, confirmation with central accounting and substantiation with interviews of current employees, we have identified that not always encumbering funds has been standard practice within the branch. Appendix C includes an example64 that shows the branch is not encumbering funds and is using an instrument other than the financial system of record to document financial obligations. In this division prepared FY19 spreadsheet, the total encumbered amount for the division is $39,751,855.63 while the extended amount is $46,195,259.93, leaving an under-encumbered amount of $5,093,162.78 for the division. We were not able to tie these encumbrances to CORE nor are they mathematically accurate. In some instances, the timing of federal awards are such that the branch doesn’t receive the Notice of Award until after the grant period commences. In this case, the branch may utilize the estimated spending authority but generally, the department controller would not approve more than 75 percent of the anticipated funding. Internal Audit did not receive any evidence of this from the branch.

Another example of the process to add funding to CORE to fully encumber the contract after the fact relates to a contractor posted major program OU19CH. The description states “adding $17,704.50 to fully encumber OU19CH” using event type PR05. Another example relates to HIV/STI mixed funding contracts where invoices need payment but funds were not available to process the invoice. In this case, an Encumbrance Modification Request Form (EMR) was prepared. This process puts the invoice in a “queue” for payment when funds are available. Interviews with current staff informed us that there are usually five or six EMRs a month. Invoices are sent by program to the fiscal monitors who then process the EMR if they realize funds are not available. They refer to PR05 as “the bank.” Refer to the detail below for a visual example of an EMR.

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63 Quick reference guide for Encumbrance Approvers, dated March 2020
64 Internal Audit did not include the column A “Vendor Name” since this is proprietary information. This detail includes other programs as well to show the overall trend of not encumbering within the branch.
Additionally, interviews with central accounting staff have informed us that communications to the division occurred throughout the audit period regarding proper encumbering of funds. Central accounting has communicated with many divisions about the use of PR05/PR07/PR08 event types. They do not want any encumbrances created that do not obligate funds (unless they are for future fiscal years). Additionally, central accounting has notified the division that they are not allowed to spend without an encumbrance, which is a violation of State Fiscal Rule 2-1. Interviews with division staff have substantiated this information.

It is our understanding that communications regarding this issue also occurred prior to our audit period and that at times within other divisions of the department as well. The procedures in the department’s fiscal procedures manual are to provide employees with a general understanding of the responsibilities and processes that employees have regarding procurement to maintain consistencies. Central accounting updated the CDPHE fiscal procedures manual procurement section for this purpose. The example below is communication that occurred via email between central accounting and the division in July 2018 related to overspending without a proper encumbrance.

Original email from central accounting:

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65 Names are intentionally not included in this example.
Response from the division:

Thanks for letting me know about this. I suspect that it is because things have been encumbered against GK18 while the program waits to get the official carry forward of funds NCA from GK17. We requested a carry forward of around $1.2 million and it has been processing for a while now. The program officers are pretty sure that it will be awarded soon. Having said all of this, they should have encumbered ahead of the award and put the cash before the horses. I will confirm that that is what is causing the over expenditure and let you know.

Additional response from the division two days later:

I just wanted to follow up with you on this issue. It is because of encumbrances related to the anticipated carry forward. Luckily, we received the NCA for that carry forward yesterday afternoon. It is for $1,559,381. I have attached a copy of it for you and will have my team work on getting it set up in Core. Do you know when you might be able to finish the Interim FFR? For GK18? Now that we have the Carry Forward award, I think CDC wants us to submit the No Cost Extension as soon as we can.

Solicitations. The branch did not always go through a formal solicitation process to provide funds when trying to spend down excess funding, nor does it appear that the division had a formal review process to determine which contractors should receive the additional dollars. For example, to assist with the division’s spending down of rebate
funding, around $614,000 of additional funding went to approximately 20 contracts using supplemental rebate dollars through amendments for general STI purposes. The amendments did not change the scope of the contract. Although the division providing these dollars to existing contracts may have had good intentions while trying to spend down the balance, there was no formal solicitation process to determine which contractors received the additional funding but rather subjective assignment of the funding to which the contractor would not turn it down. All of the additional funding was over the amount requested and/or awarded in the federal grant funding. Another example of statements of work that did not change for a new award relates to spending down additional money for local planning and support. The branch only used the grant funding change letter to increase funds, and the idea was that the HIV/STI work fell under the core public health services referenced in the first section of the work plan under Local Planning and Support so a new contract was not necessary and funding could be provided more timely during the spend down. The typical process is for the branch to enter into a contract with the local public health agency for these funds detailing the scope of work for these funds. Other contractors received contract amendments to continue their scope of work, for $10,000 each, to assist in spending down the funds but it is unclear what criteria was used in the selection process for these entities receiving additional funding. In addition, there does not appear to be a mechanism in place for monitoring and receiving deliverables, which increases the risk of unreasonable spending.

Another important part of the procurement process is the division’s request for proposals and awards so that they can award contracts using a competitive grant agreement process. We discussed the division’s processes with current employees and again noted that there are no specific division processes documented. As the division is aware that department guidance is available, division employees have stated that they follow these procedures. However, Internal Audit became aware of a Request for Award (RFA) process that was significantly delayed. Specifically, an RFA announcement related to vans for mobile testing of HIV and other STI went out to the public on February 20, 2019. The division reviewed proposals through an evaluation committee and notified three vendors that they were chosen for the award, but this never moved forward. The awardees each followed up with the division numerous times over the years asking about the status. Inadequate communication was provided to the awardees by not providing reasons for the delay. Internal Audit spoke with one of these individuals who sat on the review committee and they stated that they were informed that discussions had been held at advisory committee meetings regarding the purpose of the vans and innovative ways to spend supplemental rebate dollars. A draft scope of work was prepared and was approved by the division along with the budget detail in February

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2019; Internal Audit was provided the scope of work. We noted that the scope of work mentioned that a PO was planned for use even though the dollar amount was $800,000 and would require a contract instead since the division would be reimbursing the awardees for the vans and they weren’t sure how many and what the cost would be per van. The division later realized the awards should be in contract form verses a PO. Interviews with the division informed Internal Audit that the primary reason for the delay was that they were unsure if there was adequate funding to fund these contracts, but no official word went out to cancel the awards.

In fact, the Procurement and Contracts Unit (PCU) was not aware that the announcement was issued. Discussions were held with department contracting staff in August 2018 and with final permission to release given on October 15, 2018. However, PCU was later told that this RFA was put on hold indefinitely. PCU communicated that it would need to review and approve again prior to a release. In December 2019, PCU followed up with the division informing them that they needed to review the RFA before it went out but never received an update that it had already been released earlier that year. Thus, the RFA did not receive final approval from the PCU prior announcing or informing the awardees of their selection. Additionally, it was never officially communicated to the awardees that they were not moving forward with the RFA. The department has posted specific program responsibilities including review committees and awarding applicant processes on the CDPHE intranet since 2017[67], well before the van RFA was released, which the division should have followed. In addition, the Outgoing Grants Management Officer in PCU provides training[68] to divisions and programs on the RFA procedures. The last training received by the division contracting and procurement staff was in July 2019 and trainees were provided a document handout called “RFA Process: Step by Step” which walks program staff through the process. The division did not follow the department procedures for implementing an RFA and did not adequately communicate with the awardees that the RFA would not continue. The awardees did not receive official word of the award cancellation until an advisory committee meeting in February 2020.

**Contracts with Combined Funding Crossing Budget and Fiscal Years.** Additionally, Internal Audit has concerns with the way that contracts[69] have been set up for these awards since they are combining funding streams into one contract where funding crosses over the federal budget and state fiscal years. Although creating one contract for the entity may appear to be more efficient and streamlined, it actually has led to confusion since there may also be more than one grant period included and different requirements for the different funding streams. For example, the federal budget period runs April 1 - March 31 but the state fiscal year runs July 1 - June 30. Another example

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[67] https://login.microsoftonline.com/login.srf?client-request-id=2181419f-a00a-9000-9b6d-80938ea725d
[68] CDPHE training called “RFA: Start To Finish”
[69] State Fiscal Rules 3-3 State Contracts
is that the Ryan White budget period ends on March 31 and the CDC PrEP budget period ended September 29. As a result, contract periods that were through December 31 should have had PrEP dollars end on September 29 but instead were paid out through December 31 resulting in other dollars being used to fund the PrEP services, which took away from other contracts. A review of journal vouchers (JVs) showing movement to the end of the period appears to show $348,387 moved to the end of the period to cover these GK funds. By separating out the funding streams on different contracts (written by fund), it would be easier for the division to monitor timelines, keep better track of which dollars come out of the funding stream on the contract and ensure the correct matching of invoices seeking reimbursement to the correct funding stream. It would also benefit contractors who have sub-contractor relationships funded with these dollars to have the contract separated out by funding stream.

Additionally, during our cursory review of the budget detail, we noticed that most contracts with mixed funding just show totals broken down by Ryan White categories and rebate categories with subtotals for each. More specific guidance can be outlined in the budget detail as to how these dollars can be spent, which would decrease the risk of inappropriate spending and clarify funding stream use. We also identified items in another contract budget during FY18 related to the use of carryover dollars. The proposed budget related to PrEP includes a $20,000 administrative fee that isn’t explained as well as an “agency rush fee” of $49,915 if the budget is approved later than expected. There is also language stating that they reserve the right to decline deliverables if the budget is approved with less than 8 weeks until budget expiration. We reviewed the final budget attached to the signed contract and noted that although these fees are not specified as in the proposal, it appears that they may have been incorporated into other line items within the budget.

**Scopes of Work.** We also found that the scopes of work within some contracts are sometimes vague or include inappropriate direction. Interviews with current employees confirmed that often the scope of work is not overly detailed so that it allows flexibility for the contractors to complete the work. While it may allow flexibility, it also may restrict the control of the division in monitoring the contract and the Program requirements. Although any contractor receiving Ryan White dollars or rebates from the Program must follow Program requirements, without effective contract monitoring by the division, there is increased risk of not meeting these requirements.

In addition, we identified a scope of work for a contractor for the period of January – December 2017 that was authorized to use the CDPHE FedEx account to distribute said

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70 Program code GK in CORE.
71 Purchase Order request is from funding stream GK, which is appropriate for the PrEP grant.
72 Referring to contract monitoring unit within the division.
items in the contract. We did not receive documentation that a reconciliation occurred related to the total amount to identify if the related expenditures were reasonable and appropriate to the particular contract.

**Indirect Rates.** We identified that there were instances of some contracts being set up inconsistently related to indirect charges and different rates were applied to contracts. For example, within the same contract some indirect rates were identified as flow through, exempt or on-site. We reviewed the CORE PROC-37 report for activity within our audit period and created a pivot table to filter on fiscal year, vendor name, commitment voucher (PO or CT) and the indirect amount to review further. During our review, we noted that there were 38 instances where indirect amounts had different activity codes and amounts within the same contract and on some, one of these activity codes was exempt but the purchase request form showed as flow through. For example, we reviewed one contract that had indirect flow through of $1,145,028 but appeared to have under-collected indirect costs of approximately $70,000, as we learned that this amount may have been miscoded as exempt on the contract. Effective internal controls should be in place to overall reduce the risk of inaccurate contract coding and to clearly document there is a reason for multiple indirect rates within the same contract. Specifically, the division should conduct regular analysis of these differences to identify if there were any miscoding related to indirect costs and correct the contracts as necessary. The result may be that the program is not contributing its fair share to cover the indirect expenses associated with running the program.

**Statutory Violations.** We also identified several statutory violations that occurred within the division during the audit period. Statutory violations occur when liabilities incurred or payments made on the state’s behalf without prior approval or a commitment voucher in place. Departments are required to notify the Office of the State Controller (OSC) if statutory violations related to contracts or purchase orders occur, and the OSC will decide to ratify them or not after reviewing the explanation provided. If ratified, the OSC can allow payment for the services already performed. Specifically, seven of the eleven department reported violations during FY19 occurred within the division totaling roughly $46,000. Of the seven, five related to work outside a purchase order (PO), one overspent the PO, and the other one did not have a contract in place. In addition, the division has two statutory violations so far in FY20 for approximately $25,000. Divisions can minimize statutory violations by effective contract monitoring and communication with the contractor.

**Why It Matters.** Responsible management of public funds is vital when implementing the state’s procurement process. As stated in the department’s fiscal procedures

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73 Contractor name removed since it is proprietary; however, detail is in the SOW, work plan, Primary activity #1, sub-activities #1, #4.

74 CRS 24-30-202(1) and or (3), State Fiscal Rule 3-1, section 8,
manual, in accordance with Fiscal Rule 3-1, section 3.2.3, encumbrances should be executed prior to, or concurrently with, the execution of the Commitment Voucher. The amount of an encumbrance for a particular state fiscal year should equal the amount documented on the face of the commitment voucher. Generally, OSC guidance is that an award must be known and received prior to obligating any of its available funds. Additionally, it is essential that the division comply with federal regulations related to procurement standards, such as awarding contracts only to responsible contractors possessing the ability to perform successfully. Federal recipients are solely responsible for good administrative practices and sound business judgment, and for the settlement of all contractual and administrative issues arising out of procurements.

**Recommendations.**

12. Develop a methodology to encumber funds that is consistent with the department fiscal procedures manual and state fiscal rules. Document this methodology and provide training to appropriate staff.

13. Revise contracts related to this Program to include only one funding stream and/or one budget period to simplify the contracts, the monitoring process and to promote greater accountability with the contractor.

14. Develop and implement written procedures to mitigate the risk of statutory violations and reduce instances of work outside of a commitment voucher.

15. Develop and implement written procedures to ensure that the RFA process is in accordance with department guidance.

**G. Inadequate Funding Stream Tracking and Grant Management**

**Fund Coding and Movement of Funds.** The HIV/STI branch currently receives various funding including Ryan White grant dollars, Tobacco Master Settlement Agreement (MSA) funds, pharmaceutical rebates (federal and state generated) and other grant awards.

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75 Contract or Purchase Order (PO)
76 2 CFR 200.317-200.326 OMG Federal Guidance Procurement Standards
77 Ryan White grant dollars are specifically for providing HIV/AIDS care and treatment services to low-income people living with HIV/AIDS who are uninsured or underserved.
78 Colorado receives a fixed percentage of the national MSA payment each April. Most of this money funds health care programs across the state. HB16-048 changed the statutory formula for allocations from the MSA payment to various state cash funds and programs. SDAP receives 5 percent of the settlement money while the CHAPP receives 3.5 percent annually.
State departments currently utilize CORE\textsuperscript{79} to enter their financial transactions and should have controls in place within each division to reflect clear processes to avoid confusion, mitigate the risk of improper use of the codes, and to ensure accurate reporting. During the change from the state’s accounting system COFRS to CORE in 2014, the department central accounting unit had communicated that there were challenges with customizing coding department wide.\textsuperscript{80} Due to the need to align data with federal reporting, staff continued to use spreadsheets utilized during the COFRS period, to keep track of financial and program data. It appears financial and program-tracking sheets were not always reconciled to each other. It also appears that monthly reconciliations between these spreadsheets and CORE did not always occur.\textsuperscript{81} We also noted a lack of effective time management between the division and central accounting over the course of our audit period regarding effective reviews of funding stream data needed for annual FFR reporting; this lack of proactive approach in data reviews likely led to many rushed jobs in putting together the data for federal reporting and meeting deadlines.\textsuperscript{82}

When a new funding source is determined, including when grants are awarded to divisions, best practice is to work with the relevant leadership and the central accounting unit \textsuperscript{83} in determining how best to initially set up adequate coding for efficient reporting. It is also best practice to review the coding streams periodically to ensure that the method used is still relevant or if a better way to organize exists. We found that the current coding is not the same as coding used throughout the audit period and that current employees are not always clear in how the prior coding interacts with the current coding within the funding stream. Central accounting had recommended streamlining coding, as the ones in use contributed to a “convoluted tracking system.” In addition, every division used department code FAAA up until approximately 2018 and now the divisions have their own department coding, such as FHHA (for DCPHR) \textsuperscript{84}. Unit codes have always been a requirement. The expanded appropriation code just recently started in the last six months, is primarily isolated to DCPHR due to past coding and tracking concerns and is not a requirement of the entire department at this time. As there had been funding stream tracking concerns during discussions with central accounting for the past two years, central accounting gave DCPHR the option to change them to something that was a little more intuitive based on the other coding changes that they wanted to make. They are currently working with

\textsuperscript{79} The Colorado Operations Resource Engine (CORE) is the state’s accounting system in place since 2014; COFRS is the name of the accounting system used for many years prior to the change to CORE.

\textsuperscript{80} Internal Audit could not confirm these statements as fact, but is aware that numerous departments had initial issues with CORE coding set up and that communications from central accounting at that time

\textsuperscript{81} Internal Audit did not receive fiscal tracking sheet data from the branch as requested during this audit.

\textsuperscript{82} Refer to the reporting section of this report for further details on late federal reporting.

\textsuperscript{83} Public Health and Environment Department Fiscal Procedures Manual section 7.4 Grant Reporting & Close-Out, v.2 - last revised 2020 - Accounting is responsible for “oversight of the department’s grants, including upcoming deadlines related thereto.”

\textsuperscript{84} DCPHR stands for the newly combined division with DCPHE: Division of Disease Control and Public Health Response (in the past known as DCEED).
the division to make these changes. We also noted during our expenditure testing that coding in CORE does not always line up with program codes on the invoices, which makes it very difficult to track.

The delay in timing to resolve the coding changes may have contributed to confusion for staff in gathering appropriate data for use in decision-making, determining accurate funding stream amounts available to fund contracts and for communicating with stakeholders. We also found that there was little training received on the use of coding streams and there are no documented procedures for employees when needing to refer back. Refer to the legend below for further information on program codes.

<table>
<thead>
<tr>
<th>Program Code</th>
<th>Name of Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>4C16*</td>
<td>Cash Pharmaceutical Drug Rebates</td>
</tr>
<tr>
<td>EI</td>
<td>Integrated HIV Surveillance &amp; Prevention</td>
</tr>
<tr>
<td>EO</td>
<td>Integrated HIV Surveillance &amp; Prevention</td>
</tr>
<tr>
<td>GK</td>
<td>Reduce HIV Infections in Medical Care (PrEP)</td>
</tr>
<tr>
<td>GR</td>
<td>National HIV Behavioral Surveillance (PrEP)</td>
</tr>
<tr>
<td>JO</td>
<td>Integrated HIV Surveillance &amp; Prevention (PrEP)</td>
</tr>
<tr>
<td>OU</td>
<td>CHAPP MSA</td>
</tr>
<tr>
<td>QT</td>
<td>Ryan White Care Act Title II Project</td>
</tr>
<tr>
<td>YT**</td>
<td>Pharmaceutical Rebate Funds</td>
</tr>
</tbody>
</table>

* Supplemental Funds (Federal and State)
** Standard Funds

Source: Auditor Prepared - for illustrative purposes

Not only is it important for the funding streams to be easily identifiable from year to year but also important for allowable expenditures netted against the correct funding stream. During our audit, we found instances of expenditures that were questionable and may not be allowable against certain funding streams. Separate funding streams and clear expectations of how these are used is critical to avoid unallowable expenditures.

As the reporting requirements for the Ryan White grant did not align with reports generated by CORE, staff created journal entries (JVs 86 or CHCs 87) to record the information into CORE. JVs are also prepared to correct errors. Descriptions for JVs should be clear so that an adequate trail exists to follow the money. During our audit, we noted that there were some JVs with adequate descriptions while many others did

85 Refer to the Unallowable and Questionable Expenditure section of this report for further detail.
86 A JVC, or JV, is used to create journal entries in CORE that can affect expenditure, revenue, and balance sheet accounts.
87 A CHC is another way to create journal entries in CORE and is the preferred method for correcting expenditures only, as this method automatically accounts for the cash side of the entry.
not have that level of detail. For example, we found some to be blank, vague in the description or some without supporting documentation attached in the system. This lack of internal control makes it difficult to follow the money and increases the risk of not identifying errors.

In addition, central accounting generates some JVs while the division generates others. However, all JVs for all divisions are approved in CORE by central accounting. All journal corrections should use a sub-activity code to clarify the purpose of the entry. We found that there is a not an adequate review of JVs at a division level and that often the required supporting documentation is not included in CORE. We also found that although central accounting has an internal process in place to review the division’s correction of accounting records, often they send it through without checking for reasonableness. This may be due to the many grants within the department, lack of understanding of the specifics of these grants, the decentralized organizational structure and the need to rely on the division for accurate reporting. However, without proper controls in place to effectively conduct a high-level review of the reasons for a division generated JV, identify trends in the generation of and types of JVs, and to create necessary training opportunities, we determined that there is inadequate overall departmental oversight during our audit period.

It also may be difficult for central accounting to conduct a thorough review of JVs since the number of JVs have increased over the years. We found that DCPHR made up fifteen percent of the JVs during our audit period compared to the other divisions. Refer to the table below for a comparative analysis of the number of JVs for the division.

![Journal Vouchers Created by FY](image)

Source - Auditor prepared based upon CORE data

We found that the branch appeared to move money around from funding stream to funding stream using JVs. If invoices related to contracts need to be paid and there is not enough money in the appropriate funding stream to cover the contracts, the

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88 Public Health and Environment Department Fiscal Procedures Manual v2, section 4.17, last revised 2020
expenditures were sometimes paid out of another funding stream (which may not be appropriate) to cover the shortfall and then a JV was generated to move the money back when available. If this occurs often, then it may be difficult to properly track. In essence, moving money around to cover certain funding streams risks not being able to keep track of all of the shifts, which can lead to errors, mismanagement of funding, paying unallowable expenditures from a particular funding stream, and not having enough funding left in a particular stream to properly fund contracts. In addition, if a secondary level of review/approval by a supervisor does not identify if the JV is inappropriate, then the procedure for a supervisor review is not an effective internal control. The final approval of the JV occurs within CORE by central accounting; however, if this final review does not identify if a JV is inappropriate or not and no back up documentation is included for their review, then this is also not an effective internal control.

Ineffective internal controls surrounding accounting adjustments, including a lack of an effective secondary review of the purpose and accuracy of the adjustment and adequate supporting documentation, creates an opportunity for fraud.

While Internal Audit did not identify any cases of fraud during our audit, the JVs that move money around to various funding streams but are difficult to trace through without detailed explanations or attached supporting documentation, are concerning. The lack of a clear trail of accounting adjustments in complex funding streams increases the risk of an employee committing fraud or collusion with an outside entity. During our audit, we reviewed JV activity in CORE and found many instances of difficulty tracing the JV through CORE. We noted that in many instances, back up supporting documentation was not included with the JV. For example, JVC FAAA FHHA2017*015 has no attached supporting documentation and the line descriptions shows that this JV is moving $73,537 from RW13 to YT13. We also are able to tell from the object code used that this is a contract for a non-governmental agency, but we can’t identify which contract or agency this is for. We also identified a similar example for JVC FAAA FHHA2018*006. The Program moved around $1.8 million with no back up attached. Although it has the PRM document ID in the description box, it is difficult to trace because one would have to look at every document description to trace it back to the original expenditure. We did not identify specific examples during our review for FY19 and this may have been because central accounting had tightened up requirements during this fiscal year to require back up supporting documentation be included with proposed JV entries. We did not review all JVs for the branch that occurred during FY19 due to the amount and inadequate documentation trail; therefore, we cannot be sure that others were not missing supporting documentation.

It is our understanding that concerns with the overall division’s coding had occurred prior to the audit period but they were in use for a number of years without effective changes to make them more streamlined. It appears that due to the department’s decentralized processes and the fact that the division fiscal managers do not report directly to the centralized accounting unit, it is difficult for central accounting to
enforce and mandate specific changes; however, per state fiscal rules\(^89\), they are responsible for the overall accounting of the department. Currently, central accounting sends out monthly coding reconciliations of potential coding errors for divisions to review. According to interviews with central accounting staff, the division does not always address these potential errors. Discussions with central accounting have also informed us that there have been concerns with this branch and division not sharing accurate information for a number of years, even prior to our audit period. In addition, division leadership acknowledged that they met with accounting and budget in November 2017 to discuss concerns and the complex funding stream but action has yet to take place to finalize a plan to make these codes more clear and to resolve the concerns. Although there is joint responsibility between the division and central accounting to resolve any coding errors, the primary responsibility remains with the branch and division. Further, division leadership reported to executive management\(^90\) the need to evaluate the “appropriate use and accurate reporting of all funding streams.” Due to the importance of accurate reporting, this area should have been a priority for the department to resolve. By not taking timely action in this area, the risk of inappropriate use increases.

**Spending Down Funds.** Another example of inadequate funding stream management relates to the “spend down plan” dated October 2018 for funding related to the MSA dollars and to related supplemental rebate dollars. From interviews conducted with current and former employees, we learned that the branch appeared to have been concerned about spending down the MSA and CHAPP cash funds and supplemental rebates balance even though this type of fund is exempt from the maximum reserve.

“Maximum reserve” refers to “16.5 percent of the amount expended from a cash fund during the fiscal year”\(^91\) and creates a limit on the uncommitted reserves in a cash fund at the end of the fiscal year.\(^92\) Although priority setting and determining a plan for spending\(^93\) are important budgetary tools, the urgency to spend down the balance was unnecessary. In fact, budgeting and setting aside dollars for unexpected costs is reasonable. Dollars allocated to ADAP and CHAPP through MSA moneys did not need rapid spend down (including supplemental rebate dollars)\(^94\), as there is no legislative requirement to do so. HB06-1054 refers to C.R.S. § 25-4-1415 Cash Fund - administration - limitation, which reads, “any unexpended and unencumbered moneys remaining in the fund at the end of a fiscal year shall remain in the fund and shall not be credited or transferred to the general fund or another fund.” Documented explanations of the increase in fund balance for the funds show that this reserve was in case changes occurred to the Affordable Care Act due to new federal administration.

\(^89\) CDPHE department policy “State Fiscal Rules,“ 1.1, “All department employees will comply with the State of Colorado Fiscal Rules.”

\(^90\) Memo from division to executive director, dated December 22, 2017.

\(^91\) C.R.S. § 24-75-402, Cash Funds - Limit on Uncommitted Reserves

\(^92\) Example: State agency spends $1,000,000 from a cash fund during the year; the maximum amount that left in the cash fund at the end of the year should be $165,000.

\(^93\) CHAPP had prepared a 5 year detailed plan to reduce the existing cash fund.

\(^94\) Refer to more information in the rebate tracking and management section of the audit report.
The branch and division experienced management leadership changes, which led to a different approach in the fund balance management. Although the legislation is clear that these funds are exempt from this limitation, the division leadership held concerns of high fund balances for MSA and CHAPP\textsuperscript{95}. It is reasonable for new management to reassess the situation and to decide to increase the spending to somewhat reduce the balances in order to avoid the appearance of reserving “too much.”\textsuperscript{96} However, ongoing discussions with the advisory committees on how to best support the people living with HIV/AIDS with the directed spend down would have been appropriate to support a good working relationship. Although discussions about initial spending of the funds took place with the advisory committees in October and November 2017, it appears that advisory committees were not involved in further discussions due to the division/department’s urgent timing to spend down the funds. Not including the advisory committees in additional discussions, especially since the division decided that some of the funding would be used in other areas not related to persons living with HIV/AIDS, caused tension due to a lack of transparency with government spending or in accordance with grant requirements.\textsuperscript{97} Additionally, monitoring of these funds may have been challenging due to changes in management and the management approach. However, legislation specifically exempted this cash fund from this requirement. Internal Audit requested supporting documentation for the spend-down plans for supplemental rebates and MSA dollars. We received a draft of both plans from May 2018 and a final version of the supplemental rebate plan, dated October 2018.

In reviewing the draft version, we noted that the division planned to spend down between August 2018 and June 2019 and adjust many current contracts by issuing grant fund change letters, task orders or amendments, in addition to creating request for proposals (RFP) and memos of understanding (MOU). Examples of new projects to be funded were: PSD vaping campaign $500,000, lab PCR\textsuperscript{98} machine for $500,000, HAZ\textsuperscript{99} Oracle database $160,000 and OPPI-STI response to local public health agencies of $1,009,641\textsuperscript{100}. Examples of existing contracts and expenses to be funded were: hepatitis-related expenses of approximately $83,000, various funding to counties for STI outreach of approximately $28,000, and other moneys to counties that were not

\textsuperscript{95} Refers to fund balances of 94\% for SDAP and 126\% for CHAPP as stated in a memo to the Alliance in December 2017 from the department.
\textsuperscript{96} The division/department has not put a threshold in place by the division/department as to what makes the MSA and CHAPP fund balances too large for their comfort level.
\textsuperscript{97} Refer to the expenditures section of the report for additional information.
\textsuperscript{98} A thermal cycler (also known as a PCR machine) is most commonly used to amplify segments of DNA through the polymerase chain reaction (PCR). PCR tests are used to detect HIV’s genetic material, called RNA. These tests can be used to screen the donated blood support and to detect very early infections before antibodies have been developed. This test may be performed just days or weeks after exposure to HIV. This machine may be used for other things besides HIV testing purposes but no evidence of allocation to other uses was found. Source of description: Stanfordhealthcare.org.
\textsuperscript{99} CDPHE Hazardous Materials and Waste Management Division
\textsuperscript{100} Internal Audit learned that these funds were not effectively monitored due to the miscommunication regarding an agreement that the division was going to conduct the contract monitoring. However, it appears that no staff from the HIV/STI Program were acting as contract monitors for these dollars. We did not receive evidence of monitoring related to this item.
designated on the plan to be related to STI totaling approximately $668,000. Internal Audit reviewed a sample of contracts and amendments and further detail is located in the expenditure section of this report. Internal Audit requested the methodology behind the spend-down plan and did not receive it from the branch or division.

Another example of ineffective funding stream management relates to the $521,000 in “spend down” money in the family planning collaboration. In August 2018, leadership directed the PSD Family Planning Program (FFP) to spend the branch’s funds for STI programs by June 30, 2019. As directed, FPP embedded the STI funding in 19 federal family planning amendments in September 2018 but during October 2018, they were notified that the branch funding for the $521,000 was not secured and that the branch did not have the funding in hand. This meant that they could not input the FPP contract amendments that included the STI money in CORE and fully execute. The FPP was concerned that if they did not receive the funding soon they would have to cancel the current amendments and reconstruct all of the contracting documents to take out the STI funds. This would delay the contracts for the other FPP funding that needed to go out. In late October 2018, the funding became available and the CORE BQ90’s were submitted in CORE so that the spending authority would exist for all contracts. Even when trying to spend down funding that was seen as excessive, when it came time to utilize this funding, it was not actually available.

In addition, we noted that the May 2018 spend-down plan draft contained columns for Supplemental Rebates101, Rebate, Ryan White HRSA, MSA-CHAPP, MSA-ADAP and the Total. The Rebate column reflects standard rebates, but there was no separation related to federal or state supplemental rebates, as they just combined into one amount. This is important to note because some expenditures may not be allowable using federally generated funding. Prior to the release of the July 2017 rebate clarification memo from NASTAD,102 many states did not separate out the federally funded or state funded supplemental rebates. In fact, some states to date still do not separate out the federal and state funded portion but take a conservative approach in spending these dollars aligning it back to Ryan White Part B service categories. However, after the release of the NASTAD memo, states that receive state funding for their HIV/AIDS Programs were expected by NASTAD to fall in line with the guidance. It is our understanding, based upon internal emails reviewed and interviews with current and former employees, that the branch or division leadership was not aware of the release of the July 2017 NASTAD guidance; therefore, the branch did not take steps to determine how to separate out these funds. Separating the supplemental rebate funding ensures that the use of funding is appropriate and proper. Additional

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101 In addition to the 340B price reduction, ADAPs have negotiated deeper discounts on antiviral therapies through the ADAP Crisis Task Force. These discounts as rebates may be referred to as supplemental rebates. HRSA training on Pharmaceutical Rebates, August 2017. More information on rebates can be found in the audit report section rebate tracking and management.

102 https://www.nastad.org/about - NASTAD is a leading non-partisan non-profit association that represents public health officials who administer HIV and hepatitis programs in the U.S. and around the world. They also have a cooperative agreement with HRSA for technical assistance and other guidance to HIV/AIDS Programs.
information regarding rebates, tracking and management is included in the section below.

**Draw Down of Grant Funds and Collection of Unclaimed Deposits.** Another area we reviewed was the drawdown schedule for HIV/AIDS Program awards. Per a review of the terms of these awards, we did not identify specific draw down timing requirements; however, the department provides guidance that draws are generally on a monthly basis based on administrative determinations. Additionally, it is best practice to draw down and claim funding as needed in order to have funds available for use. During our three-year audit period, we noted that there were 72 draws made for the Program totaling $60,470,365 of which the majority related to the Ryan White program. Of these, 65 draws, or 90 percent, occurred in less than 30 days. Refer to the table below for additional detail.

![Number of Draws between SFY17 and SF19](image)

Source: Auditor prepared based on data from CORE

However, we also identified that there was available funding not drawn during the audit period resulting in reversion to the federal programs. Interviews with current and former employees substantiated the fact that some of these draws did not occur because rebate dollars needed to be used prior to the Ryan White grant funding. In addition, interviews with NASTAD and HRSA verified that reversions are not unusual for recipients since there are restrictions in place requiring the use of rebate dollars before Ryan White grant funding. Many other states deobligate (revert) dollars back to the federal program because of this reason and the reversion has not affected future funding. 103 Additionally, Ryan White Part B carryovers 104 are also not unusual and sometimes states cannot utilize their carryover fully and these are reverted. Grantees are required to submit an Estimated Carryover Request along with an estimated unobligated balance 60 days before the end of the grant year. Failure to submit a timely

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103 Internal Audit discussed reversions with various states during our benchmarking.
104 Ryan White Part B Manual, revised 2015 - Chapter 5, Tracking and Reporting Unobligated Balances
carryover request and estimated unobligated balance in the electronic handbook portal will result in the grantee being ineligible to receive carryover funds, even if they later identify and report unobligated Ryan White formula funds in the FFR.

Further discussions with NASTAD and HRSA confirm that they would rather the federal funding be reverted so that it can be used in other states for people living with HIV rather than the money be spent down on unrelated programs or unallowable costs. The total federal funding appropriations for all part B recipients for FY19 was $1,315,005,000, any dollars reverted may go into their emergency supplemental awards or be re-appropriated to other HIV related programs as necessary. Thus, these funds are not wasted, but are used for the purpose in which they are intended, even if they are used outside of Colorado. Effective priority setting, budgeting, determining needs, managing of the rebates and funding streams while working with the related advisory committees will minimize the need to revert funding and will assist in ensuring that people living with HIV/AIDS in Colorado have the resources they need. We performed a cursory review of the deobligated Ryan White funding as well as the carryover amounts for the award periods of 2015 - 2020. Between these years, there were $11,069,238 dollars carried forward (QT - Ryan White Part B, ADAP and MAI) and a total of $17,475,429 deobligated funds as noted in CORE. We were able to agree the carryover funds to the Notice of Awards and this detail to the tracking sheet maintained by central accounting without exception. Refer to table below for detail per year.

<table>
<thead>
<tr>
<th>Award Period</th>
<th>Carryforward Funds</th>
<th>Deobligated Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>19/20</td>
<td>$1,341,896.00</td>
<td></td>
</tr>
<tr>
<td>18/19</td>
<td>$2,326,857.00</td>
<td></td>
</tr>
<tr>
<td>17/18</td>
<td>$1,111,000.00</td>
<td>($357,349.72)</td>
</tr>
<tr>
<td>17/18</td>
<td></td>
<td>($2,494,691.48)</td>
</tr>
<tr>
<td>16/17</td>
<td></td>
<td>($4,308,735.80)</td>
</tr>
<tr>
<td>15/16</td>
<td>$4,561,387.00</td>
<td>($5,318,994.32)</td>
</tr>
<tr>
<td>14/15</td>
<td></td>
<td>($4,995,657.56)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$11,069,238.00</strong></td>
<td><strong>($17,475,428.88)</strong></td>
</tr>
</tbody>
</table>

Source: Auditor prepared based on data from Notice of Awards.

We also scanned the February 2020 listing of the unclaimed deposits from the Colorado Department of Treasury and noted that many appeared to belong to CDPHE. Unclaimed deposits are moneys that are drawn down by the department but are unclaimed from

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105 https://hab.hrsa.gov/program-grants-management/ryan-white-hiv-aids-program-funding
106 Data pulled from CORE, rounded to nearest dollar.
107 Central accounting tracking sheet called “CDPHE STI_HIV Federal Reversions Info.xlsx” Internal Audit performed a reconciliation between the NOA, CORE and the central accounting tracking sheet and noted no differences.
Treasury sends this listing to central accounting each month. The unclaimed deposits amounts on this list from Treasury range from one penny to $599,950 during the period of 2017 - 2019 and include departments other than CDPHE. Interviews with current employees states that they do not always conduct a detailed review of this information. Due to the somewhat vague descriptions, Internal Audit agrees that it is difficult to identify potentially unclaimed deposit amounts specific to the Program. Because of this fact and our unfamiliarity of the abbreviations, Internal Audit was unable to identify if any of the items on the list related to the HIV/STI Program. However, an effective review of the unclaimed deposits listing by the Program as an internal control can ensure that any moneys owed are obtained; therefore, central accounting can provide the unclaimed deposit reports to divisions on a regular basis in order to communicate what needs claimed in order to assist in maximizing the funding due to the division. In addition, branches and divisions should be proactive in thoroughly reviewing the unclaimed deposit amounts during their cash management procedures.

**Why It Matters.** Multiple funding streams offer opportunities for a broader base of funding, but can produce challenges including varying stakeholder expectations, unaligned grant cycles and differing grant requirements in spending. Strong oversight and strategic planning are essential in effective management of various funding streams utilized within the same Program. Additionally, central accounting provides guidance relating to grant reporting and close out procedures, which should be followed by branches and divisions in order to promote correct reporting and consistency in processes.\(^{108}\)

**Recommendations**

16. Work with central accounting to determine and implement appropriate revised coding in CORE to ensure proper tracking all funding streams, rebate types, expenditures and appropriate reporting requirements. Additionally:

   a) Provide training to all necessary staff on how to utilize the new coding structure
   b) Conduct regular reviews in order to ensure proper use of the coding.

17. Develop criteria and written procedures for staff to prepare journal entries, including a standard description methodology, attached supporting documentation, supervisor reviews and a clear trail of the accounting adjustment.

18. Consider a self-imposed cap or threshold for MSA fund balances in conjunction with priority setting and budget preparation to assist in meeting spending goals. Work with the advisory committees to determine needs, goals for the budget period and the definition of an adequate reserve. Document these procedures and re-evaluate as needed.

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\(^{108}\) CDPHE Fiscal Procedures Manual, Section 7.4 Grant Reporting & Close-Out
19. Actively research other funding opportunities\textsuperscript{109} for innovative projects related to HIV/AIDS, Hepatitis C, PrEP, IV drug use, etc. so that funding streams can be better aligned.

**Recommendation for CDPHE Central Accounting Unit**

20. Enhance oversight process over divisions’ financial transfers and JV procedures.

**H. Inadequate Rebate Tracking and Management**

Under the pharmaceutical Dual Purchase model that Colorado utilizes, an ADAP purchases and dispenses medications through its own pharmacy or a single contract pharmacy service provider, known as a Direct Purchase model\textsuperscript{110}, and the ADAP also pays for drugs acquired at retail pharmacies and then submits rebate claims to manufacturers for these purchases. For payments to retail pharmacies, if the client is uninsured, the ADAP pays the standard pharmacy price for the drug, as under the Rebate model.\textsuperscript{111} However, if the client is insured through either private insurance or Medicare Part D, the ADAP will only pay the pharmacy the co-payment or co-insurance for the drug as required by the client’s insurance. In both instances, the ADAP will submit a rebate claim to the manufacturer for the full discount amount (340B ceiling price\textsuperscript{112} or negotiated sub-ceiling discount). Since 2000, ADAPs have been allowed to purchase private insurance for their clients, and ADAPs use manufacturer rebates to pay both the insurance premiums and the required co-payments or co-insurance for their clients. According to Internal Audit’s discussions with NASTAD, ADAPs should conduct periodic cost-benefit analysis to determine the most cost effective mechanism for purchasing medications. The analysis should include the costs of medications and all administrative costs and fees associated with purchasing and distribution.

HRSA provides a number of webinars, conferences and topic trainings throughout the year. In addition, the project officer is a good resource for technical assistance. Internal Audit held interviews with HRSA ADAP leadership as well as the project officer during

\textsuperscript{109} For example, grant opportunities can be located at https://www.hiv.gov/federal-response/funding/federal-funding and may be available with the new cross-agency initiative Ending The Epidemic Program; refer to https://www.cdc.gov/endhiv/index.html for more information.

\textsuperscript{110} Under a direct purchase model, a covered entity pays a discounted (340B plus any additional discounts) price for each drug at the point of purchase. ADAPs may purchase drugs directly from manufacturers, wholesalers, or through a purchasing agent, such as a Pharmacy Benefits Manager. ADAP Manual dated 2016.

\textsuperscript{111} Under a rebate model, ADAPs submit claims to drug manufacturers for rebates on medications that were purchased through a retail pharmacy network at a price higher than the 340B price. ADAP Manual dated 2016.

\textsuperscript{112} The 340B ceiling price is based on quarterly pricing data reporting to the Centers for Medicare & Medicaid Services (CMS) and is calculated by subtracting the Unit Rebate Amount (URA) from the Average Manufacturer Price (AMP). ADAP Manual dated 2016.
the course of our audit. Specifically, we discussed the methodology behind the use of the rebate dollars. HRSA advised that to be reflective of the purpose of the rebate dollars, these rebate funds should be put back into the Ryan White Program with emphasis in the ADAP Program. They also informed us that they receive many questions from various states regarding funding for PrEP. They expressed that Ryan White dollars cannot pay for PrEP medications or the related medical services as the person using PrEP is not diagnosed with HIV prior to the exposure; therefore, PrEP services are not eligible as a Ryan White funded medication. Consequently, federally generated rebates cannot be used to pay for PrEP medication. Additional examples of costs for which federal rebates cannot be used include:

- Sterile needles or syringes for the hypodermic injection of any illegal drug.
- Construction and/or major alteration or renovation.
- Cash payments to intended recipients of Ryan White services.
- Programs or the development of materials designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual.

According to HRSA regulations, rebate dollars can be used to provide services such as hiring more case managers and providing more outpatient substance abuse care even if such activities were not in the approved project scope and budget, in accordance with PCN 16-02. Additionally, recipients may only use rebates for the purposes and under the conditions of the Ryan White Part B Program, such as for core medical services including ADAPs, support services, clinical quality management, state match requirement, state maintenance of effort requirement and administrative expenses, including planning and evaluation. As stated in the grant’s Notice of Awards, it should also be noted that recipients will not be penalized if they have an unobligated balance greater than five percent because they spent drug rebates prior to drawing down grant funds. It is our understanding through interviews with current employees, that this has been a concern within the branch in spending rebate dollars; however, proper management and budgeting can ensure that any unobligated balances remain greater than five percent in order to avoid the penalty. Further discussions with HRSA informed us that they have advised other states in how to manage this through their technical assistance program.

To make matters more complicated, some states, such as Colorado, receive state funding for their ADAP Programs and some medications are purchased using these state dollars. Although the Program does not appear to have used Ryan White dollars for PrEP based on our limited review, it has been common practice for the state generated rebate dollars and state generated supplemental rebate dollars to be used for this purpose. There was no separation of state and federally generated rebates by the

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113 Language also obtained from HRSA training presentation on the use of rebates, dated August 2017, obtained directly from HRSA ADAP Program.
114 Public Health Service Act, Section 2612(a)
115 Public Health Service Act, Section 2622(d)
branch since they were not aware of this need. However, HRSA’s position\textsuperscript{116} is that if not for the federal dollars originally used to set up the ADAP Program, there would not be an ADAP Program, thus \textit{all} rebate dollars should go back into the Ryan White Program with an emphasis in ADAP. As stated later in Appendix G’s benchmarking results, other states receive state dollars towards their programs and receive rebates that were generated from state dollars. Since these states have had trouble separating out state and federal generated rebates in their accounting systems, they have chosen to take a conservative approach and not use any rebate dollars for PrEP or for other services for those not already living with HIV. However, they do use state dollars received towards PrEP funding in addition to applying for other federal grants, such as funding opportunities made available by the CDC since requests for awards are frequently posted.

Not only does HRSA provide technical assistance on how to utilize Ryan White dollars and related rebates, they have a 5-year cooperative agreement with NASTAD to provide technical assistance specifically for public health officials within the United States.

In July 2017, NASTAD released a memo regarding guidance on how to spend rebate dollars in response to multiple states’ request for assistance. According to the branch and division leadership, they were not aware of this memo until late 2018. Within this memo, NASTAD provides information related to managing multiple funding streams, spending rebates “first” and various uses of rebate funds. They recommend that at the beginning of the year, often in April to correspond with the RWHAP Part B and ADAP budget period, states, in conjunction with their fiscal team, should project the amount of rebates expected that year and develop a budget based on that amount. States should assign allowable costs (contracts, personnel, medications, supplies, etc.) to this budget. Part B recipients should also work with their subrecipients to develop a comprehensive plan to utilize all Program funding available, including rebates. Best practice\textsuperscript{117} suggests that looking at subrecipients from a needs-based approach versus a more defined set of services, has allowed for an increase in fund allocation and more timely expenditure of funds so that there is not a rush in spending down funds towards the end of the year. A more thoughtful approach that considers the entire funding year is better for the community that receives services with this funding.

Internal Audit held interviews with various HRSA leadership and staff to discuss their views on this memo. They stated that this memo is NASTAD guidance, it reflects their perspective and HRSA did not approve it for distribution; however, they did let us know that they had conducted a review of the memo before its release. Additionally, there had been discussion between HRSA and NASTAD on a joint guidance document but this idea never moved forward. HRSA is currently in the process of updating their Ryan White Part B Manual and anticipates release sometime during 2020. HRSA had discussed inserting further guidance related to spending rebate dollars to align more with NASTAD’s four categories of rebates but ultimately decided not to update the manual

\textsuperscript{116} HRSA has not put this in writing and during our discussions stated that they preferred to discuss verbally.

\textsuperscript{117} Best practice as defined by states’ feedback to NASTAD.
in this manner. Although they state that their perspective has evolved over time, HRSA has intentionally remained silent on the guidance on how to utilize rebate funding, especially in relation to rebates generated from state dollars. Additionally, their PCN documents do not specify the difference between federal versus state generated rebate dollars. When asked by Ryan White Part B recipients, they advise ADAPs to track rebates by funding stream and by generation of rebates. Internal Audit’s discussions with other states during our benchmarking\textsuperscript{118} found that HRSA gave a presentation at a recent conference in December 2018 and discussions took place regarding the four categories and the practical use of them. We followed up with the HRSA presenter who stated that the presentation materials were not shared with the attendees after the conference and that discussion’s purpose was to gather information for them to review when revising the Ryan White Part B Manual. He further stated that they see the fourth category to be a 2\textsuperscript{nd} generation rebate but would not be explicit in funding stream interpretations.

Refer to the four categories of rebates below as noted in the NASTAD guidance memo:

1. Rebates generated from a federal ADAP dollar to the 340B price.
2. Rebates generated from a federal ADAP dollar from the 340B price to the ADAP Crisis Task Force price.
3. Rebates generated from a state dollar allocated to ADAP to the 340B price.
4. Rebates generated from a state dollar allocated to ADAP from the 340B price to the ADAP Crisis Task Force price.

The NASTAD memo further states as follows:

“Rebates from categories 1 and 2 must be used in accordance with federal regulations and RWHAP policy and guidance, as they are directly generated by a supported activity or earned because of the federal award. Rebates from category 3 should be used in accordance with federal policy and guidance, as ADAP would not qualify for the 340B Drug Pricing Program without the initial federal investment in the Program. Rebates from category 4 do not need to be used in accordance with federal policy and guidance; many states use these funds to bolster HIV Programs in their state outside of the RWHAP Part B Program. Health department HIV/AIDS Programs have an opportunity to utilize the full gamut of resources across the entire HIV Care Continuum to meet program funding needs; category 4 presents a unique opportunity for funding generated from a treatment service to benefit individuals not living with HIV. For HIV prevention, programs experiencing funding reductions, HIV care and treatment programs can bridge the gap in the loss of funding to support HIV prevention efforts, as possible.” Category 2 and Category 4 dollars are supplemental rebate dollars. These rebates come from the pharmaceutical companies Merck and Gilead.

HRSA’s expectation is that the rebate projections will be incorporated into the planning for service based on the comprehensive HIV care and treatment needs in the

\textsuperscript{118} Refer to the Benchmarking Results section included in this audit report.
community. NASTAD determined that categories 1, 2 and 3 must be utilized within the Part B Program, with a priority given to ADAP. As HRSA’s guidance on how to use rebates was issued prior to the NASTAD memo in 2017, all rebates should have been used in the same manner, put back into ADAP. The branch did not separate out federal and state rebates as there was no guidance to at that time, and HRSA did not issue direction to do so. In speaking with HRSA regarding the differences in the guidance between HRSA and NASTAD, HRSA has stated that they will remain silent on the regulation but will assist individual states by reviewing individual methodologies on how to spend category 4 dollars.

The branch works with a Pharmacy Benefit Management company and can pull reports from their data. From these reports, they can tell which rebates are state generated or federally generated. For example, code 001 represents state generated rebates (Medicaid group) while code 003 represents federally generated rebates (individual insurance or on exchange). In addition, the data can also be broken down into standard versus supplemental rebates based on the status of the pharmacy where the client picks up their medication. For example, the pharmacy level “non-PHS” stands for retail pharmacies (standard rebates) while “PHS” represents pharmacies already receiving a discount on pills they have distributed (supplemental).

Internal Audit interviewed former and current employees and discovered that tracking of these rebates occur in CORE under program code YT (standard rebate) and 4C (supplemental rebate), but that state and federal separation did not always occur. Tracking sheets were maintained in Excel but the individual who prepares them didn’t have access to CORE until 2018. It was also confirmed through interviews and a lack of reconciliation documentation that this was another example of program and fiscal not communicating effectively; thus, no reconciliation between the spreadsheet and CORE occurred. The spreadsheet can be pivoted to use for rebate projections. Although projections are not exact since there are numerous factors involved, basic projections such as type of pill and number of pill distribution can provide rough estimates for projections in order to better plan for rebates. The branch is continuing to work on determining best methods in projections for these rebate funds. We found that there was a lack of secondary review over the rebate calculations and coding added to the checks before given to central accounting for deposit. This lack of internal control over a large funding stream increases the risk for errors, overall inaccurate financial data for rebates, and overextending rebate program codes as invoices may not be able to be paid from the correct funding stream.

Typically, rebate checks arrive within 90 days of the branch making the claim to the pharmaceutical company. During our audit period, rebates checks received were not always deposited timely for a variety of reasons. For example, rebate checks physically received were held at one point during 2018, affecting FY18 and FY19, to avoid having to utilize these funds in that grant budget year with the plan to deposit them in April for the next budget year. As a result of the prior instance of holding rebates checks, now all checks are sent directly to central accounting. Additionally, $900,000 in rebates checks were
held for approximately 3 weeks during January 2020 because the Program and central accounting were not sure where to code these in CORE.

Consistent procedures are in place related to the rebate check process for all pharmaceutical companies; however, these procedures are not documented and are considered necessary due to a lack of cash flow for the Program. Internal Audit conducted interviews with key individuals involved with this process to gather this information and performed a walkthrough of the majority of the process. Each pharmaceutical company provides the department with a Reconciliation of State Invoice (ROSI) when they release the rebate checks. The Rebate Estimation Workbook (branch spreadsheet) is then updated and central accounting is notified that the checks are on their way. Once central accounting receives the checks they make a copy and provide it back to the branch for them to add the appropriate coding, either YT19H or 4C16H. Once the CR document is created in CORE for the checks, they will complete a budget modification form and submit the BGA90 to create spending authority and the BGG94 to book the budget into the program lines. At this point, an operations branch employee notifies fiscal that there are available funds in the programs. The branch fiscal staff will then work with the fiscal contract monitors to determine which contracts need the rebate funds the most. In some cases they might be holding onto an invoice waiting for cash in the bank. The fiscal contract monitors will complete any Encumbrance Modification Requests (EMR) asking to move funds from a PR08 (pre-encumbrance) to a PR05 (encumbrance) line in the contract and provide them to the branch employee mentioned above. The employee then tracks the amounts received and approves the EMR. It then goes back to fiscal and entered into CORE. Reconciliations do not occur between the workbook spreadsheet and CORE to ensure proper data entry, nor does a secondary level of review take place.

In February 2020, CDPHE requested guidance from the Colorado Office of the State Controller (OSC) regarding spending authority for the actual rebates deposited and claimed to have a waiver from the federal government to allow congruent spending with Ryan White dollars. The department communicated that since their waiver “ends soon,” CDPHE will then need to spend rebate funds before spending federal funding, which creates a timing issue. Additionally, CDPHE has requested to receive spending authority based on historical data and trends; however, since the rebate amounts vary, the OSC is concerned that “granting spending authority could result in over expenditures and as a result, OSC will not grant the request to provide CDPHE with estimated spending authority for these programs.” Internal Audit requested all waivers

footnotes:

119 We were unable to observe the process where coding is added to the check copy since there were no rebate checks received at the time of our walkthrough; however, we did review a copy of the check with coding used as an example for observation purposes.
120 The code changes from year to year depending on the fiscal year, such as YT19H represents FY19.
121 The code does not change from year to year as this balance rolls from year to year.
122 None are ever denied as the contracts need funding & invoices are not reviewed alongside the EMR.
123 Refer to email response “Spending Authority question” dated February 11, 2020 from the Office of the State Controller.
received from the branch but did not receive any. A follow up inquiry to central accounting also identified that they did not have a copy of any waiver documents for this Program. Internal Audit reached out to HRSA and confirmed that they do not issue waivers for this purpose nor was there any verbal discussion providing permission for the rebate dollars and the Ryan White funding allowing them to expend at the same time. It is HRSA’s position that all rebate dollars must be spent before federal funding. Therefore, CDPHE’s action of spending rebate dollars concurrently with any federal funding was out of compliance with federal requirements. CDPHE will need to determine their budget, tracking and spending methodology to ensure that rebates expend before Ryan White dollars.

Other Matters Related to Rebate Dollars:

NASTAD’s 2017 memo has caused a lot of confusion for states, including Colorado, in how to utilize rebate dollars. HRSA maintains that 42 U.S.C. § 300ff-26(g) and their PCNs are considered law whereas the NASTAD memo and other correspondence are considered guidance. Because HRSA funds NASTAD through a cooperative agreement to provide guidance to Part B recipients, one would expect that the message would be the same. However, HRSA continues to communicate that NASTAD’s memo reflects the interpretation of NASTAD rather than law from HRSA and HRSA will not go on record to state that they agree with NASTAD’s interpretation.

In the summer of 2019, department asked the Colorado Attorney General’s Office (AG’s office) for guidance regarding legal interpretation. Although an official opinion was not provided, an analysis was performed and results provided to the department. Internal Audit reviewed the analysis performed by the AG’s office and related legislation, and agrees with their analysis performed. Specifically:

- There are restrictions on the use of funds that CDPHE receives as supplemental rebates through ADAP authorized under C.R.S. § 25-4-1401, depending on whether the supplemental rebates were obtained from drugs purchased with federal or state funds.
  
  - **Federal funds**: ADAP is governed by 42 U.S.C. § 300ff-26 that states that the purpose of the Program is to provide therapeutics to treat HIV/AIDS or prevent the serious deterioration of health arising from HIV/AIDS in eligible individuals, including measures for the prevention and treatment of opportunistic infections. Per 42 USC § 300ff-26(g), a “State shall ensure that any drug rebates received on drugs purchased from funds provided pursuant to this section are applied to activities supported under this subpart, with priority given to activities described under this section.” As the statute does not make any distinction between standard and
supplemental rebates, it is reasonable that this applies to both since both rebates are related to drugs purchased with federal funds. \(^{124}\) This interpretation is in line with HRSA requirements.

- **State funds:** Supplemental rebates received from drugs purchased with state funds can be used in accordance with C.R.S. § 25-4-1401. In addition, Senate Bill 2015-247 expanded the drug assistance program to include “qualifying individuals of lower income who have medical of preventative needs concerning AIDS or HIV, viral hepatitis, or a sexually transmitted infection.” SB15-247 also added a provision that “any moneys received in excess of a federal price agreement are a donation.” Classifying funds as “donations” allows the department to spend the funds without an appropriation but the funds still need to be spent in accordance with the Program requirements of the statute.

- **Use of some supplemental funds:** During 2019, the department inquired to the AG’s office about the use of supplemental rebate dollars. For example, there were questions related to funds sent to local public health agencies to increase STI awareness, prevention, testing and treatment, and funds used to address questions surrounding IV drug use and HIV/STI. These appear to be in line with using state supplemental rebate dollars (due to the expansion of services provided under the ADAP in SB15-247) if they were provided to eligible individuals under the Program. However, if used for general public health messaging, then the expenditures would not be in line with statute because the services must be provided to low income *eligible individuals*. Additionally, the anti-vaping campaign targeted to LGBTQ youth is not in line with the state statute, unless the vaping was directly tied to HIV, STI or hepatitis. Internal Audit agrees with the AG’s office interpretation that these expenditures would not tie to state statute. Additionally, Internal Audit conducted a review of the contracts and supporting documentation surrounding these expenditures and found that they were not solely provided to eligible individuals.\(^ {125}\)

**Why It Matters.** HRSA defines a “rebate” as a return of a part of a payment and that rebate funds are spent prior to drawing down grant funds from the PMS system.\(^ {126}\) HRSA has also determined that “recipients can spend rebate funds in the grant year in which they are received and prior to drawing down grant funds; the regulations do not require that rebate funds be spent in the year in which they are generated. If rebates

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\(^{124}\) The AG’s office also pointed out that this is consistent with how the Department of Health Care Policy and Financing treats supplemental rebates since the drugs were purchased with federal funds.

\(^{125}\) Refer to the expenditures section of the audit report.

\(^{126}\) 45 C.F.R. § 92.21(f)(2)
are received at the end of a grant year, PCN 15-04 states that recipients can spend those rebates in the subsequent grant year, prior to the expenditure of new Ryan White funds.” This is how many states account for their rebate budgeting. However, in Colorado, revenues must be estimated and accrued in accordance with GAAP and the revenue recognition criteria applicable to the fund for which the accrual is made. HRSA and NASTAD can both offer technical assistance on how to address rebates using this method of accounting.

Recommendations.

21. Develop and implement written budgeting and tracking procedures to avoid overcommitting rebate funding in contracts.

22. Develop and implement written procedures to effectively budget funding so that carryovers and rebates are spent prior to other federal funding to avoid unintended reversion.

23. Develop and implement written procedures to ensure proper tracking and the accuracy of federal and state supplemental rebates since they are to be used for different purposes.

24. Continue to research best practices in projecting rebate dollars and utilize projections in the branch’s budgeting methodology. Also, consider asking individual pharmaceutical companies if rebate checks can be converted to an EFT payment to deliver these rebates directly into the department bank account in order to expedite receipt of the rebate check and promote efficiency.

25. Consider contacting technical assistance support from HRSA and NASTAD on developing procedures and strategies to assist in funding stream and rebate tracking management. Also, consider other training such as webinars, conferences, and seminars to further the branch and division’s understanding of the Ryan White Part B Program requirements.

26. In cooperation with the advisory committees, determine a reasonable methodology for using the category #4 state supplemental rebate dollars that includes consideration of a conservative approach of putting the funding back into the ADAP.

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127 HRSA ADAP Manual, Section 1.5.D Rebates, page 13
128 Generally Accepted Accounting Principles
129 Colorado State Fiscal Procedures Manual, Section 3.1.2, last revised March 2019
130 For example, HRSA conducted a training called “Evaluating the Financial Health of Your HRSA Grant” in May 2019 and their training materials are available for review at https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/audits/part-c/institutefamily2014.pdf
Program or a more innovative approach. Document any innovative methodology and consider conferring with NASTAD and/or HRSA prior to implementation.

I. Lack of Effective Budgeting

Division staff are required to establish budgets in CORE to aid in the management of the award. Divisions must establish an Expense Budget and a Grant Budget to track awards and must establish a Legal Budget. The legal level of expenditure control, or “Spending Authority,” resides at the Legal Budget level and is required. Inadequate spending authority at the legal budget level prevents expenditures and/or encumbrances from being posted to an appropriation. Spending authority should be viewed as something to not exceed, as this is the amount listed in the Notice of Award. Internal Audit requested documented budgets and related reconciliations of grants and spending authority to the legal awards and then reconciled to CORE but did not receive these for our audit period. Therefore, we cannot conclude if these reconciliations were prepared.

Fund 19S0 is MSA money for SDAP, which does not include personnel services but earns interest that stays in the fund. Fund 27N0 is used for MSA funding for CHAPP and includes personnel services but does not earn interest. Refer to the tables below for a breakdown of the transfers to CDPHE. Per our review, the expenditures recorded in CORE are larger than the transfers for both funds during fiscal years 2018, 2019 and as of the end of February 2020 in FY20. As unspent balances remains in the cash funds and the appropriation is set annually to equal fund balance plus anticipated revenue, the Program needs to ensure that expenditures stay within the annual appropriation and cash fund balances.

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Transfers to CDPHE</th>
<th>Expenditures</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>1,780,741.00</td>
<td>1,542,710.00</td>
<td>238,031.00</td>
</tr>
<tr>
<td>2016</td>
<td>1,761,585.00</td>
<td>1,708,449.42</td>
<td>53,135.58</td>
</tr>
<tr>
<td>2017</td>
<td>3,231,234.00</td>
<td>1,447,034.26</td>
<td>1,784,199.74</td>
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<tr>
<td>2018</td>
<td>2,664,090.00</td>
<td>2,680,573.37</td>
<td>(16,483.37)</td>
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<tr>
<td>2019</td>
<td>2,947,193.00</td>
<td>3,730,758.08</td>
<td>(783,565.08)</td>
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<tr>
<td>2020</td>
<td>1,396,171.00</td>
<td>2,156,133.42</td>
<td>(759,962.42)</td>
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<tr>
<td>Grand Total</td>
<td>13,781,014.00</td>
<td>13,265,658.55</td>
<td>515,355.45</td>
</tr>
</tbody>
</table>

131 Colorado State Fiscal Rule 7-1: Spending Authority
132 Public Health and Environment Department Fiscal Procedures Manual v.2, last revised 2020
133 C.R.S. § 25-4-1415
134 C.R.S. § 25-4-1401(7)(a)
### MSA Funds 27N0

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Transfers to CDPHE</th>
<th>Expenditures</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>$3,116,297.00</td>
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<td>2016</td>
<td>$3,082,773.00</td>
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<td>2017</td>
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<td>2018</td>
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<tr>
<td>Grand Total</td>
<td>$20,825,766.00</td>
<td>$20,147,353.08</td>
<td>$678,412.92</td>
</tr>
</tbody>
</table>

Source for both tables - CORE GA-999 Detailed Transaction Listing\(^{135}\), which provides transaction level data of activities that post to the general ledger - These are unaudited numbers.

HRSA also provides guidance for states related to budgeting for and spending rebate dollars. To the extent that they are available, recipients and subrecipients must spend rebates prior to drawing grant funds. Rebates received at the end of a project period must be spent before requesting and expending Ryan White funds awarded (including any carryover of unobligated balances) in the subsequent budget year. As part of the overall planning and budgeting, HRSA requires that recipients anticipate rebates and determine when Ryan White funds will be needed during the upcoming budget period. Internal Audit conducted an interview with HRSA and learned that many states find it challenging to spend rebates first and then spend their grant funds within the budget period; their advice is that the recipient needs to effectively budget. HRSA further indicates that to do this states need to “develop a reasonable and transparent process (written methodology) for budgeting and expending federal funds and related rebates that balances both the Program requirements for programmatic reporting and fiscal requirements for expending the funds. Recipients must proactively project the extent to which rebates will be received, and budget accordingly.”\(^{136}\)

For specific guidance on ways to set up the budgets and tracking, states can reach out to HRSA or NASTAD to develop a methodology. Our audit found that although monthly calls occur with the program’s project officer at HRSA, discussions did not occur related to budgeting, including how to project rebate dollars, budget the use and ensure they are expended prior to the use of Ryan White dollars. However, during our discussions with the HRSA Project Officer, she advised that the branch should look at services and areas where they tend to overspend and use grant funds to meet these needs for that particular service category when they budget for the next budget period. HRSA also advises states not to be so aggressive in their requests for funding if their budgeting

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\(^{135}\) Central Accounting prefers using the GA999 General Accounting Report since it captures all transactions, whereas the CA999 is a cost accounting report but only captures transactions using cost accounting elements, such as program and major program codes and can miss certain data sets.

\(^{136}\) HRSA training materials from August 2017 presentation at annual HRSA conference.
processes are not strong so that they cannot spend it all effectively or are constantly putting out fires in cash management.

We also reviewed the electronic handbook to identify if initial grant budgets were set up properly in the Notice of Award and CORE; we were unable to tie these all out since the breakout of items in CORE is difficult to reconcile. Additionally, we are not aware of a reconciliation document or process to support these numbers and to reconcile these numbers against any outside tracking spreadsheets used for federal reporting in the electronic handbook.

When reviewing recipient’s carryover requests, HRSA will assess that the intended purpose and budget justification for the request is included. Internal Audit obtained the carryover requests for the Ryan White funding for FY15 through FY19. In FY15, CDPHE requested to carry forward $7,213,000 of which $5,000,000 of it was to go to the AIDS Drugs Assistance - Medication and Insurance service category. In FY16, they requested a carry forward of $4,800,000 of which $4,300,000 went to this same service category and $350,000 to Housing Services. A carry forward request was prepared for FY17 for $2,766,093 with $1,886,093 for AIDS Drugs Assistance Program and in FY18 for $3,452,516 with the majority of $1,500,000 going to Oral Health Care and AIDS Drug Assistance Program for $1,115,912. In FY19, there was no carry forward requested. All of these carry over requests were approved by HRSA.

During our review, we also noted that the unobligated $1,341,896 from budget period April 1, 2018 through March 31, 2019 (QT18) was approved by HRSA on September 29, 2019 to carryforward to budget period April 1, 2019 through March 31, 2020 (QT19) which brings the total award for QT19 to $14,516,090. However, as of March 18, 2020, central accounting did not see where the carryforward was reduced from the budget for QT18 by the branch and added to the budget for QT19 in CORE. The budget in CORE for QT19 still reflects $13,174,194. Since the branch has not yet added the carryover to QT19H in CORE, then the branch paid all expenditures so far from the annual award, which does not include the carryover. We were able to verify these carryover amounts of $1.3 million and the new total of $14.5 million were the same as the budget transaction detail in HRSA’s electronic handbook. Central accounting confirmed that the information for QT15 - QT18 is correct and that it aligns with their records in CORE. Not properly allocating carryforwards to the correct funding year in the state’s accounting system and preparing reconciliations to identify differences causes inaccuracies in financial records and in any reports used in making funding decisions.

Not only is it important to properly budget within CORE, it is important to ensure that any tracking spreadsheets used for budgeting are properly reconciled to CORE. We were not able to review any reconciliations, as we did not receive these from the branch.
However, interviews with current employees revealed that they were not aware of reconciliations prepared for this purpose.

During our audit, we found that due to not having adequate funding in certain funding streams to pay out invoices to contractors, the branch had to hold onto invoices, sometimes up to six weeks, so that they would have funding to pay them. The branch did not effectively budget their expenditures for payment related to the revenue streams coming in. In order to provide invoice reimbursement to some contractors, we were informed that the branch would shift money around from one funding stream to another by JV and then move it back when the funding came in, or were utilizing event types PR08 and PR05 in CORE. The PR08 was described to Internal Audit as a “savings account” and then when the money comes in, such as a rebate check, the money is moved to PR05 or the “checking account” and paid from there. Management of funds to pay invoices in this manner is not a preferred approach; this methodology is likely to increase the risk of tracking errors, and is subjective in which contractor to prioritize funding needs with what is available.

Effective budgeting of priorities requires monitoring, control over expenditures and being able to investigate or identify problematic areas and then to rectify them. In late calendar 2017 and early 2018, division leadership identified numerous areas that needed improvement, such as, the evaluation of internal controls, adherence to state fiscal rules and the appropriate use and accurate reporting of all funding streams, and communicated this to executive leadership as well as to the advisory boards. There had been a lot of management turnover within this time and a lack of documented procedures, and it appears that these identified areas proved complex to tackle. Although these areas were identified as needing improvement, the areas of concern mentioned in the memos have taken an extensive amount of time to address and our audit review reveals that even to date, these areas have not been completely addressed. Documented processes and procedures have yet to be created or implemented. By not documenting the procedures and effectively prioritizing the areas to be addressed, missed opportunities occurred to proactively make change and the identified problems will continue to occur without proper follow through. According to interviews conducted, we found that a lack of trust occurred within the branch and in the advisory committees due to the perceived appearance of “talk and no action” by leadership over time. A revised action plan and milestone setting shared with others, as appropriate, may help in rebuilding trust that proper action and resolution is taking place.

\footnote{State Fiscal Rule Chapter 2 Disbursement, Section 2-3 Payment Terms, Rule 3.2 states that if valid invoices are held for more than 45 days, the department may be liable for interest charges.}
Why It Matters. When it comes to budgeting, identifying areas of weakness helps the organization allocate resources in a useful and sustainable manner. It is important for the government to ensure that funds reach where they are required the most. Proper budgeting also relies on establishing goals and priority setting in addition to using data from past years to anticipate needs for future years. Budgets are an important part of maintaining control of finances and are a means of achieving the financial reporting objective of accountability. Additionally, monitoring the budget is not only required but also is considered a best practice to ensure accountability related to spending.

Recommendations.

27. Develop and implement written procedures to ensure that proper legal spending authority is accurate in CORE and that reconciliations occur to identify differences in grant budgets and spending authority to avoid overcommitting of funds.

28. Develop and implement written procedures to ensure that carryover funds are used for the purpose intended, as provided in the HRSA electronic handbook.

J. Unallowable and Questionable Expenditures

HRSA requires written procedures for determining allowable costs. Internal Audit requested documented procedures related to the determination of allowable costs but did not receive this documentation. Interviews with current program and fiscal staff substantiated that they were not aware of any specific written procedures related to the branch’s methodology for determining allowable costs. Often times, it appears to them that a decision on payment of an invoice is sometimes subjective, discussed with several individuals to determine if it is allowable and at times decisions are made to allow an unallowable cost.

For example, one contractor recently requested to purchase three laptops for HIV testing for a total of $3,900. The contract monitor receiving the request asked which funding stream line the contractor would like to use. This is a lack of proper internal control by having the contractor dictate the funding stream rather than the branch maintaining control over how invoices are paid. The contractor requested purchasing

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138 Best practice and training provided on government budgeting through [www.researchgate.net](http://www.researchgate.net)
139 CDPHE Fiscal Procedures Manual, Section 7.3 Grant Financial Management
140 Government Finance Officers Association (GFOA) Budget Monitoring, March 2018
141 [https://www.hrsa.gov/grants/manage-your-grant/training/how-to-manage-grant-guide](https://www.hrsa.gov/grants/manage-your-grant/training/how-to-manage-grant-guide)
142 Refer to lack of documentation procedures, including roles and responsibilities section of the report.
143 This discussion occurred during November 2019, which is outside of the audit scope but proves to be a good example of the discussions surrounding the approval of expenditures and the use of Ryan White dollars (YT).
these items using Ryan White dollars (code YT33, specifically the rebate equipment line). The contract-monitoring unit then determined that it was not appropriate to use Ryan White dollars for laptops to be used for HIV testing, as these expenditures would not be used for eligible individuals who already living with HIV. Thus, an internal discussion began to determine which funds they could use to pay for this purchase. The program contract monitors received confirmation that they could not use YT funding because of the AG’s guidance on rebates from earlier in 2019,\textsuperscript{144} and that the computers do not align with how the rebate funds are intended to be used. Additionally, they were to follow up with the contractor and ask which other funds they would want to use for this purpose. However, the contractor disagreed with the determination and replied that YT funds were the ones that they wanted to use; ultimately, the department agreed despite the inappropriateness of the use of this funding stream. From interviews conducted, we have learned that this is a common practice with some of the HIV/STI contracts. The contract-monitoring unit communicated that they are not comfortable signing off on these questionable invoices due to the use of the funding stream to cover the expenditure, and has asked division management to sign off instead since circumvention of the controls appears to have occurred.\textsuperscript{145} Internal controls are ineffective if circumvented by management override.

Also during our audit, we reviewed a variety of expenditures\textsuperscript{146} and related supporting documentation by sampling inherently high-risk areas. For example, our samples include the use of official functions forms using state commercial card transactions\textsuperscript{147} (p-card) for food purchases, and supporting documentation reviews for invoices submitted and reimbursed to entities that are under contract with the branch, including some from the “spend down” plan. Consequently, during our review we identified questionable costs.\textsuperscript{148}

State Official Functions are department-sponsored meetings, conferences, trainings or other functions held for official state business purposes.\textsuperscript{149} The cost of these functions must be held to a minimum necessary to achieve the purpose of each particular function and to ensure the efficient and effective use of public monies. The request form provides guidance that “the department executive director of designee must approve

\begin{itemize}
  \item \textsuperscript{144} Refer to “Other Matters Related to Rebate Dollars” for further detail on AG’s guidance.
  \item \textsuperscript{145} As of the date of this report, the division has not received an invoice for processing.
  \item \textsuperscript{146} Internal Audit selected a judgmental sample to review during our audit. Due to the time constraints in performing this audit, we had to limit our sample size. Future internal audits included in our approved audit plan include p-cards and contract monitoring on a departmental level including divisional samples.
  \item \textsuperscript{147} State Fiscal Rule 2-7
  \item \textsuperscript{148} Questionable costs, generally, are those costs for which the contractor was unable to provide adequate support, or where the nature, purpose, and reasonableness of the expenditure is in question. US General Accounting Office (GAO) auditing standard language and 2 CFR 200.84
  \item \textsuperscript{149} Colorado Office of the State Controller Policy “Official Functions,” revised effective date May 2019 and State Fiscal Rule 2-4
\end{itemize}
an official function. Office functions estimated to exceed $100 must be authorized prior
to its occurrence. An official function estimated to cost $100 or less may be approved
after it occurs.” External stakeholders, department personnel and other state personnel
may attend these functions. Division directors are authorized to approve official
functions estimated to cost less than $5,000 but those over $5,000 need additional
signature from a higher authority within the department. 150 Additionally, the Office of
the State Controller provides clarification of what are considered permitted official
functions, such as training/development functions, employee appreciation/ recognition
functions, business collaboration/working functions, and multi-unit or multi-campus
events that include an expenditure of state funds. 151

Department p-card holders use their p-card152 to pay for the Official Function events
and are supposed to submit these in their p-card packet electronically to central
accounting on a monthly basis. We requested supporting documentation related to p-
card and official function activity from the branch and only received a portion of
supporting items. Therefore, we identified branch related p-card holders for FY19 in
order to select a sample of the most recent official function forms to review. We also
contacted central accounting to obtain the remainder of our sampled employee p-card
packets; they had not received all of the p-card packets from the division either. We
also did not receive a written methodology, policies, or procedures from the branch
related to the program’s use of these forms, or a written methodology in how they
determine proper coding to program funding streams.

During our audit, we reviewed 26 official function documentation items for the HIV/STI
branch and found the following:

- Of the 26 samples reviewed, 10 were coded to YT, two were coded to 4C, and
  the others were coded to EI and general fund.
- The 10 forms coded to YT were for food purchases of $2,230 and were to
  restaurants such as Biscuits & Berries, Qdoba and Gourmet to Go.
- Two receipts were coded to 4C were also for food purchases totaling $133 at
  Panera but did not have attached official function forms. Five other receipts
  were for food purchases and coded but also did not have attached Official
  Function forms attached.

150 CDPHE department policy “Official Functions And Purchase of Food and Beverages,” 1.3, revised
March 2013
151 Colorado Office of the State Controller Policy “Official Functions,,” revised effective date May 2019
152 Internal Audit did not conduct specific testing on p-card transactions nor did we assess if p-card
purchases were reasonable and appropriate. Internal Audit will be conducting an internal audit on the
department’s p-card activity and procedures during FY21 and samples will be selected from all
divisions within the department.
They properly contained all of the proper signatures to approve the event for the dollar amount of the official function.

Some of the official function forms contained expanded dates for a period listed in the “date of function” box rather than using a separate official function form for the individual dates for the event. For example, the date of function on one form was 7/1/18-12/31/18 and another form included the period of 1/1/19 - 6/30/19. Additionally, large dollar amounts were included on each of these official functions, $4,800 and $4,900, respectively.

All of the purchases made related to food and a few meeting room charges.

Some of the forms list multiple events on one official function form.

Most of the forms reviewed contained estimated dollar amounts that were slightly under the $5,000 threshold, which would have required additional approval by a higher level within the department per department policy.

None of the forms reviewed included an attendee listing for the event.

One form was prepared with catering purchase receipts attached but the community calendar showed that the event had been cancelled.

Most of the forms had vague general descriptions of the event and listed numerous external organizations in attendance, such as AIDS Service Organizations, Behavioral, Medical, Medical Providers, affected community members.

Some of the forms had a justification to purchase food listed as “the majority of the members have medical conditions that require them to take their medications with food and beverages.”

Based upon our review of branch related Official Function forms, it appears that they are not utilizing official function as intended and are not always prudent with public monies. We did not identify any official functions charged to Ryan White QT funds during our sample testing; however, we did identify charging to the standard and supplemental rebates. During FY17, a total of $4,639, or 48 percent of the official function charges were for food purchases for meetings. While the charges decreased in FY18 with only $335 or 18 percent for food purchases, they jumped to $5,726 in FY19 or 100 percent of the official function approvals going to food. Just for these three years, this is a total of $10,700 in food charges that could have been used to further assist the needs of those living with HIV.

We also noted that there were some p-card expenditures made using an employee’s Venmo and PayPal personal accounts because this was a vendor’s preferred method.

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Information from CORE, report CA999 for YT. These amounts are not included within the questionable cost total.

Venmo amount $2,060 using 4C for honorarium expenses and PayPal amount $1,390 using YT for conference registration, membership renewal and a GoDaddy subscription.
of payment. Since the state does not authorize department Venmo and PayPal accounts, the p-card holder linked their account number to their personal Venmo and PayPal accounts. This approach increases the risk of personal purchases made to p-cards. During our interview with said p-card holder, we learned that this did occur a few times but the p-card holder was able to cancel the transaction. We also learned that there were no receipts associated with these charges other than the credit card statement vendor name. However, both Venmo and PayPal email confirmations to the payer in order to confirm the payment and lists the account name of the payee but the p-card holder was not sure that these emails had been maintained. The only way to see the reason for the payment is if the payer adds information to the comment box. The branch does not have internal controls over this process, and this is not an approved department or state method of payment.

In addition, recipients must monitor the activities of their subrecipients\(^\text{155}\) as necessary to ensure that the subaward is used for authorized purposes, in compliance with federal statutes, Ryan White HIV/AIDS program legislative requirements, regulations, and the terms and conditions of the subaward; and must also monitor to ensure that subaward performance goals are achieved. Recipients must ensure that subrecipients track, appropriately use, and report any program income generated by the subaward. Recipients must also ensure that subrecipient expenditures adhere to legislative mandates regarding the distribution of funds through effective contract monitoring procedures.\(^\text{156}\)

During our audit, we requested more than 140 invoices associated with 80 contracts from 35 judgmentally selected entities receiving HIV/STI program funding during the FY17 - FY19 and conducted a review of all of the documentation received. All but four entities submitted documentation as requested within our audit timeframe. One of these four informed Internal Audit that they do not have supporting documentation for any invoices submitted to the branch and stated that program staff told them that they did not have to keep receipts and other supporting documentation.

During our review, we found that not all of the contractors are maintaining receipts and other supporting documentation to validate expenditures. We also found that there were many questionable and unallowable expenditures. This is likely due to a lack of effective contract monitoring, ineffective internal controls, lack of supporting documentation included with invoice and a lack of overall oversight of funding expended to contractors and subrecipients. Although many of the contractors have a current low risk rating, evidence of this review may lead to an increased risk assessment\(^\text{157}\) rating, which should result in more robust contract monitoring.

\(^{155}\) HRSA definition of all entities receiving Ryan White or rebate funding from CDPHE.

\(^{156}\) 45 C.F.R. § 75.351-353 and Ryan White Notice of Award, Grant Specific Terms No. 25

\(^{157}\) Risk assessments are required by 2 CFR 200 Uniform Guidance.
instances, we noted that the contractors risk ratings were higher but additional contract monitoring did not occur. The division should realize the importance of effective contract monitoring and multiple invoice reviews to ensure the proper use of the program’s funding. Refer to the tables below for summary of questionable cost categories and related authority.

<table>
<thead>
<tr>
<th>State Fiscal Rules Rule 3-1: Commitment Vouchers 10. Requirements for Person Services Commitment Vouchers 10.2 Monitoring</th>
<th>§200.438 Entertainment costs.</th>
<th>Division Use of Incentives Guidelines 05/2016</th>
<th>§200.403 Factors affecting allowability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equipment purchases at the end of the budget period</td>
<td>Staff meals</td>
<td>Gift Cards/Incentives</td>
<td>Computers at the end of the budget period</td>
</tr>
<tr>
<td>Staff meals</td>
<td>Gifts for staff</td>
<td></td>
<td>Purchases outside the budget period</td>
</tr>
<tr>
<td>Gift Cards/Incentives</td>
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<td>Purchases outside the budget period</td>
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</tr>
</thead>
<tbody>
<tr>
<td>Computers at the end of the budget period</td>
<td>Xcel Energy Bills</td>
<td>Printing costs for fundraising materials</td>
<td>DEA license</td>
<td>Memberships to various interest groups (allowable with prior approval)</td>
</tr>
<tr>
<td>Large quantities of gift cards and/or bus passes at the end of the budget period</td>
<td>Water Bills</td>
<td>Secretary of State Filings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Computer Purchases</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Auditor prepared through analysis of sample expenditure testing of contractor records.

**Questioned Costs - Contractor.** Included in the amount that we question, we found the following examples in reviewing the contractor supporting documentation:158

- Gift card incentives purchased for use in the next performance period or held for future use and no supporting documentation of how they were used.
- Food purchases for offices.
- Trainings without supporting documentation.

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158 Specific entity names not listed in report for proprietary purposes. “Questioned costs” - questioned by an auditor because of an audit finding which resulted from a possible violation of a statute, regulation or the terms and conditions of a federal award; where the costs, at the time of the audit, are not supported by adequate documentation; or where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances.
• Food delivery services, such as Door Dash and Grub Hub.
• Staff appreciation events.
• Large Amazon purchases without supporting documentation, some of which occurred at the end of the performance period.
• Laptops and other computer equipment purchased near end of grant period, delivery did not occur until the next performance period.
• Operating expenses such as Secretary of State filing.
• State x-ray dues to CDPHE.
• Company holiday cards.
• DEA license for three years.
• Direct mailing expenses.
• New baby gift.
• Prepaid rent, specifically for April, the first day of the next performance period.
• Install drain line for future sink (not clear if construction or renovation?)
• Water bill for period outside of contract.
• BBQ and other social supplies documentation without receipts.
• End of the month spending on large birthday card assortment.
• Printing charges for fundraisers.
• Client and partner paid transportation.
• 100 percent of accountant bill without evidence of program allocation of cost.
• Final invoice purchased 30 RTD bus passes for next performance period.
• Subscriptions for software after contract end date.
• Rent not allocated properly.
• Workshop costs but no support or evidence of attendance at the training.
• Snacks and office supplies purchased at end of period.
• Salary charges with inadequate documentation of CDPHE approval and allocation.
• Incentives for focus groups with no quantity of participants or amounts listed and no supporting documentation of participation.
• Food specified for employees while working, including lunch and dinner.
• GoDaddy subscription.
• Giveaways for Pride events, possible excessive dollar amounts charged.
• Vaping campaign, with only a portion targeted to LGBTQ youth.
• Patient fees.
• Purchased large dollar amounts in equipment on last day of performance period for delivery in the next performance period.
• Syringe purchases from rebate dollars.
• Duplicate invoices submitted to CDPHE in two different months (not clear if resolved, no supporting documentation to clarify).
• Long Acting Reversible Contraception (LARC) research project to test all patients under age 25 for presence of STI.
• Billing fee for service with no documentation to support costs for number of years.
• Smart phones without evidence of program allocation of cost.

During our review of these expenditures, we were unable to determine the funding sources for some of these items due lack of supporting documentation. Additionally, the way contractors are documenting their coding and/or allocation detail on the available supporting documentation, and the coding on the invoice (such as YT10 or GK23) makes it difficult to determine where the expense should be. Consequently, for some of these, we are unable to provide a total of the questionable costs. However, for the items where we could determine the cost, we have identified at least $918,885 in total questioned costs were expended for our sample reviewed. These costs do not appear to have been spent from Ryan White (QT) dollars. Rather they were expended from codes MSA CHAPP (OU), prevention PrEP grant (GK), rebate funds (YT), supplemental rebates funds (4C).

**Questioned Expenditures - Program.** We also identified numerous questionable expenditures by the program to various other groups within the department mostly due to the “spend down” plan using supplemental rebates (4C) totaling approximately $3,662,952. Included in the amount that we question are:

• Lab equipment without evidence of program allocation of cost.
• Lab supplies without evidence of program allocation of cost.
• General STI work using funds combined with two other program’s existing funds.
• Reproductive health services to reduce unintended pregnancy not directed at women with HIV provided to eight entities.
• Health leadership conference in Denver that does not appear to have a direct HIV/STI relationship and related expenses.
• Oracle database within another division within the department.
• Phones for HR funded positions.
• Lab data system without evidence of program allocation of cost.
• Vaping campaign.
• Three FTE positions funded within two different divisions within the department.

Due to the results of our limited testing over contractors’ invoice supporting documentation and internal funding movement of HIV/STI related dollars to other divisions, Internal Audit identified a combined total of $4,581,837 in questioned costs. Internal Audit believes that this amount is higher and that the branch would benefit from their fiscal operations unit also performing a detailed analysis into their recent
expenditures to identify and document any unallowable and/or further questionable costs paid out with HIV/STI related funding. Internal controls, effective contract monitoring and oversight are important in maintaining the integrity of the funding and fiscal responsibility by the department.

**Why It Matters.** Written procedures allow for consistency, accountability and clear communication of expectations around what funding streams to utilize for expenditures. Accounting controls are the processes and procedures used by an organization to ensure accurate and valid financial reporting, aid in receiving information in an accurate and timely manner, and increase operating efficiencies. The State Controller’s Policy, “Internal Control System,” 159 advises that every state department and each state employee is responsible for internal controls, including performing assigned internal control activities, complying with all policies and procedures, laws, rules and regulations relating to their jobs, and reporting significant internal control deficiencies to their supervisors if necessary. Management override is a method in which to sidestep the internal control in place. An ineffective internal control system can also result in a loss of stakeholder confidence in the organization’s ability to manage the resources. Therefore, successful internal controls provide reasonable assurance to leadership and stakeholders that resources are effectively used. 160

Specifically related to the Financial Risk Management System (FRMS) 161, low rated local public health agencies are not required to submit supporting documentation for invoice reviews or when seeking reimbursement but it is encouraged for programs to ask for this documentation when deliverables or activities may be in question. Additionally, regardless if subrecipients are required to submit this information during a review, they are still required to maintain the records for potential audit. 162

**Recommendations.**

29. Develop and implement written procedures to ensure timely reimbursement payment to contractors and criteria to determine priority of reimbursement if needed.

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159 State Controller’s Policy was created to ensure compliance with CRS 24.17-102 and 2 CFR 200 OMB Guidance. This policy also cites the Standards for Internal Control in the Federal Government (Green Book).

160 Integrated Framework: Executive Summary, Committee of Sponsoring Organizations of the Treadway Commission (COSO) May 2013

161 FRMS is a CDPHE program that assesses the financial risk factors of local public health agencies.

162 2 C.F.R. § 200.331 OMB Federal Guidance - Requirements for Pass-Through Entities
30. Develop and implement procedures to ensure that the department maintains control over the funding source used for expenditures paid to contractors and provide training to contractors related to the limitations of such funding sources.

31. Develop and implement procedures related to improving the branch’s preparation and use of Official Function Forms. These should include the manner in which they will be used, requiring one event per request form, identifying the proper funding streams and coding used, and requiring an attached list of attendees.

32. Ensure that only department-approved methods of payment are used in expending funds to vendors and that adequate supporting documentation for all p-card activity is properly maintained and submitted to central accounting timely.

33. Ensure that adequate contract monitoring procedures are performed as appropriate per their risk rating. As necessary, increase the risk ratings in order to perform a more thorough and extensive review.

34. Perform a detailed analysis of expenditures to identify and document any unallowable and/or further questionable costs paid out with HIV/STI related funding. Based on the results of this analysis, correct funding errors in CORE.

35. Consider requesting a refund from contractors for disallowed costs or arrange to net the questionable costs from future invoices. Ensure proper tracking of refunds or netted amounts to the correct funding stream.

36. Consider requesting a refund from other programs and divisions within the department related to funding given for salaries and purchases, in addition to funding directed to them for use in contracts. Ensure proper tracking or refunds to the correct funding stream.

37. Develop and implement encumbrance monitoring procedures to avoid letting contracts expire with encumbered but unspent funds.

Recommendations for CDPHE Central Accounting Unit:

38. CDPHE Official Functions and Purchase of Food and Beverages Policy 1.3:

a) Reduce the threshold of estimated events for executive level leadership approval from $5,000 to $1,000 to promote greater accountability and oversight of official function expenditures.

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163 Including unsupported costs and those billed for services or purchases made outside the contract period. In addition, Internal Audit recognizes that contractors may not be financially able to provide a lump sum refund depending on the dollar amount identified.

**K. Lack of Effective Monitoring and Oversight**

In April 2017, the branch received a site visit from their HRSA RWHAP project officer related to the HIV/AIDS Program. The budget period of the site visit was for April 1, 2017 – March 31, 2018 and was specific to the Ryan White HIV/AIDS Part B Program and the AIDS Drug Assistance Program (ADAP). There were several findings and recommendations from HRSA in their July 2017 report because of this review. For example, findings included:

- Not exhausting pharmaceutical rebates first before drawing funds from the Payment Management System (PMS)
- Subrecipients providing RWHAP funded services to ineligible clients
- A lack of identified performance measures for all funded service categories
- Services not correctly aligned to HRSA/HAB Service Category definitions
- Fiscal monitoring processes lacking compliance testing
- No efforts reporting policy
- Costs not allocated to the correct service category
- A position at a subrecipient who was 100% funded by RWHAP (Parts A & B) but was providing PrEP counseling and tracking retention.

HRSA did not find it necessary to provide technical assistance to CDPHE regarding these findings, as they sometimes recommend, but instead advised the department to communicate with the project officer for any identified technical assistance needed during the implementation process. CDPHE participated in monthly calls with the project officer in working through implementation of the items within the corrective action plan. Internal Audit substantiated this collaboration in discussion with the project officer. While there was discussion and the implementation of improvements by the branch in 2017, these findings continue to be areas of general concern;

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164 To our knowledge, no other audits or site visits occurred during our audit period; a HRSA site visit also occurred in 2013, the Colorado Office of the State Auditor conducted a performance audit of CHAPP in 2013, and the Centers for Disease Control (CDC) conducted site visits in 2014 and 2018.
166 Internal Audit also noted. Refer to the section of this audit report that discusses rebate management.
167 Internal Audit also noted. Refer to the section of this audit report that discusses priority setting.
168 Internal Audit also noted. Refer to the section of the audit report that discusses time and effort reporting.
169 Internal Audit also noted. Refer to the section of the audit report that discusses expenditures.
specifically, the contract monitoring duties of branch staff over subrecipients and contractors.\textsuperscript{170}

Contract monitoring including fiscal, program and site visits are requirements\textsuperscript{171} of the Ryan White Part B and ADAP grant. Interviews with various staff informed Internal Audit that fiscal site visits were supposed to occur annually during our audit period; however, we did not receive consistent documentation from branch management, as we requested, so Internal Audit could not verify that all of the required site visits for our audit period did occur. Interviews have informed us that due to the lack of staffing within the contract monitoring section of the branch, staff were supposed to concentrate on conducting the Ryan White fiscal site visits over other contract monitoring responsibilities for other contractors or conducting desk audits\textsuperscript{172} of one invoice reviews rather than more thorough reviews of contractor processes and fiscal monitoring reviews. Interviews also informed us that there was confusion related to contractor monitor roles and responsibilities related to the fiscal, program and compliance division wide monitors. Although it is not unusual for a grantee to distribute monitoring functions across the division, communication between the three teams may be ineffective if not streamlined and consistent. During the reorganizations that occurred within our audit period, there were no longer contract monitors assigned specifically to a branch, but rather for the entire division.

During our interviews with former and current employees, we learned that there have often been disagreements between program and fiscal staff surrounding allowable costs, the specific funding stream to use and whether accurate budgets \textsuperscript{173} were provided to programs. Adding another type of contract monitor to focus on compliance may add further confusion and duplicate efforts for the external customer. This confusion or disagreement increases both the risk of different messages and unallowable expenditure reimbursement by the branch, as well as the potential for contractors to be required to pay back funding used for inappropriate expenditures. \textsuperscript{174} As the department is ultimately responsible for subrecipient and contractor use of the funding that flows through CDPHE, it is crucial that effective monitoring and oversight of the branch exists. Consistency in the communication delivered to the contractor, especially related to allowable expenditures, is essential in maintaining the integrity of the expenditures reimbursed by the branch. Having

\textsuperscript{170} Interviews also revealed that contract monitors do not always test for the NOA’s Program Specific Terms section reminds the grantee to review subrecipient administrative costs to ensure that they do not exceed the 15% limit. Internal Audit did not receive documentation to attest otherwise.

\textsuperscript{171} Ryan White Part B Manual, Chapter 5: Monitoring of RWHAP Part B Subrecipients by Grantee or Designee

\textsuperscript{172} HRSA Ryan White Part B Manual, dated 2015, states that desk audits are not a substitute for comprehensive annual site visits.

\textsuperscript{173} Refer to the section of the audit report that discusses ineffective budgeting.

\textsuperscript{174} Refer to the section of the audit report that discusses expenditures.
contract monitors for the entire division rather than by branch or program reduces the effectiveness if they have not been adequately trained and do not have a thorough understanding of the Program and related grant requirements.

During our audit, we reviewed the risk assessment tracker and found that there were some contractors, eight out of 69, or 12 percent, who had received a medium risk rating but it appears that the risk rating was not considered during their monitoring assessments or approach. Some of these annual risk ratings expired in 2019 and others in 2020. By not reviewing the higher risk entities as appropriate, the branch is not adhering to the contract monitoring expectations and responsibilities in the required manner.

As noted above, Internal Audit did not receive any documented branch specific contract monitoring procedures from branch management that were in effect for the audit period. The department’s Procurement and Contracts Section, Contract Performance Monitoring Unit (CPMU), conducted an evaluation in late 2017 related to the branch. Within this report, they mention that they reviewed a document titled “Contract Monitoring Procedures and Communication Plan 2017,” that related mostly to fiscal monitoring. There were some recommendations by the CPMU to update these procedures to be more inclusive and to include programmatic details as well. Although outside of our audit period, the branch also received a Compliance Improvement Plan (CIP) by CPMU during December 2019 because of a specific contract monitoring review. The CIP includes corrective action, some of which are as follows:

- Provide updated communication plans to contractors.
- Prepare overall written procedures for proper training.
- Prepare written action plan to streamline procedures.
- Provide transmittal email to contractor for all deliverables.
- Provide deliverable tracking tool and written instructions for use of the tool.
- Provide written procedures that include the elements of a site visit, preparation of the site visit report, documenting formal and informal meetings to include due dates and timelines.
- Provide written procedures that detail how contract performance reviews are completed and monitored.

Because of the CIP, the contract-monitoring unit prepared a Handbook of Procedures for Contract Monitoring, dated January 2020. Upon review, we found that it states that

175 A financial risk assessment is a requirement for the pass-through entities to conduct for all subrecipients of federal funds during the procurement process. CDPHE conducts this assessment on all recipients/subrecipients since the department has elected to treat all funding the same. Risk assessments scored as medium or high risk require more thorough and frequent monitoring, and the financial risk assessment score should be considered when reviewing and scoring applicants. 2CFR 200.331 and Internal Audit guidance document.

176 Refer to the section of the audit report that discusses documented procedures, including roles and responsibilities.
it is the responsibility of the program staff within each branch of the division to understand the specific rules and regulations of their Program, but that the Operations Branch staff also need to understand the rules and regulations as well. The handbook includes information related to establishing the monitor/monitoring team, determining the business relationship, risk assessments, post-award meetings, financial risk management system, document review, site visits, resolution of non-compliance, archive documentation, and contractor performance evaluation and certification. Since there was not a manual in place containing approved procedures prior to January 2020, it is likely that confusion and inconsistencies in monitoring approach occurred.

In order to assist all Ryan White Part B grant recipients in monitoring organizations that they provide funding to, HRSA developed National Fiscal Monitoring Standards, National Program Monitoring Standards and National Universal Monitoring Standards (contains both fiscal and program) for Ryan White B Grantees in 2013. The branch currently does not appear to utilize these models in order to ensure that they are using appropriate contract monitoring procedures as required by HRSA. Internal Audit obtained a Fiscal Compliance Unit Documentation Review Report prepared by fiscal contract monitoring staff from May 2017 and compared it to the National Fiscal Monitoring Standards noting that the report did not contain information relevant to all of the standards. The Review Report does provide a section on concerns and recommendations; however, in this instance the report did not contain any of the concerns of their sampled invoice. Per our review of the support, there was a $1,000 expense to an employee with a notation “no check copy for this amount,” and a $100 expense to a gas station with a note stating that “did find $10 receipt for gas from 7-Eleven” but no other notations related to supporting documentation for the other $90. Likely, the reason for this limited review is due to lack of time to complete reviews, staffing limitations and ineffective training for the contract monitors, some of which were moved to new positions during the reorganizations within the division during our audit period.

In addition, CFDA #93.917 Ryan White Part B HIV Care Grant Program has specific compliance requirements that the Office of Management and Budget (OMB) has set forth for guidance in implementing the Program. These are the testing requirements for the Program when a single audit occurs on the Program, typically on a cyclical basis by the state auditor’s office. Per review of the OMB Compliance Supplement, dated April 2017, there were 11 of the 12 compliance requirements that applied to this CFDA, such as Activities Allowed or Unallowed, Allowable Costs/Cost Principles, Eligibility, Period of Performance, Reporting and Subrecipient Monitoring. To our knowledge, these topics were not included in the contract monitoring, branch monitoring or oversight processes. In June 2019, the OMB revised the matrix of compliance requirements to six of the twelve requirements for CFDA #93.917, including the removal of Period of Performance and Reporting. Interviews substantiated that these revisions from 2019, were not included in contract
monitoring reviews. These compliance requirements will assist the branch to be more prepared for the next cyclical single audit related to this federal program.\textsuperscript{177}

As noted earlier in the audit report\textsuperscript{178}, a staffing study related to the Operations Unit within the Disease Control and Environmental Epidemiology Division (DCCED) occurred during 2018. The report\textsuperscript{179} states that the need for clear expectations for program staff regarding contracting and fiscal management and compliance, along with expectations for meeting agreed upon deadlines was important. Additionally, some employees expressed on-going confusion regarding roles and responsibilities and expressed the need for written policies and procedures and other forms of guidance, including historical and current methodology and operational approaches. It does not appear that the staffing study involved any outside customers to identify if there were any challenges to take into account during the reorganizations of the contract-monitoring unit. By not conducting a survey or providing key information as to the changes made internally, it can be confusing and inefficient for the external customers in working with the branch. As the division went through the loss of working with employees with experience working within this Program, various process changes and organizational structure changes, effective change management and training by division leadership is necessary to support, motivate and mentor employees.

Division leadership authorized a staffing study during our audit period and conducted a full assessment of the contract monitoring functions across the division during 2019. Although the findings are at a high level to incorporate the entire division, the HIV/STI Program can benefit from these recommendations. Specifically, the assessment determined a need for defined roles and responsibilities for the three different types of contract monitoring, a defined plan for necessary communications throughout the life of the contract and fiscal cycles, and enhanced internal controls and stewardship of pass through funding. The division created an invoice checklist to use as a pilot for contracts, which started January 1, 2020. The purpose of which is to accompany reimbursement requests from the subrecipients and contractors to document that all deliverables have been met. The checklist requires the three types of contract monitors to review the detail submitted and sign off attesting to their agreement. By requiring all three types of contract monitors to agree, it will compel the alignment of the contract-monitoring unit. However, in order for this approach to be successful, the division needs to ensure that common program goals, definitions of allowable costs and compliance requirements are agreed-upon. In addition, clear definitions of the

\textsuperscript{17} OSA conducted a Single Audit for FY17 and Management Letter comments were provided. These do not require a management response and do not rise to the level of a formal audit recommendation. Concerns related to untimely receipt of documentation requested, staff resources and decentralization. They also noted that if these areas were not resolved, the effectiveness of the staff would continue to be diminished leading to an increase of financial statement errors or misstatements, noncompliance or continued turnover.

\textsuperscript{178} Refer to the section in the audit report that discusses the organizational structure.

\textsuperscript{179} Summary of Staff Key Informant Interviews, DCEED, June 2018
difference between these three types of contract monitors should be established and determination if the approach is in fact effective. Developing a consistent approach in an effective and efficient manner will reduce the risk of disagreement and circumvention of procedures and/or internal controls.

Not only is the contract monitoring process important to achieve effective monitoring and oversight but also internal controls should be in place related to supervisory reviews, periodic sampling of employees’ work product and overall management oversight. For example, Internal Audit did not receive any evidence that supports that supervisory reviews related to fiscal, program or operations work product occurred. Review of another’s work not only is an effective control in have in place for training purposes but also can assist in the reduction of errors, misinterpretation and an inaccurate final work product. Inaccurate work product can lead to decisions made on utilizing this data or the realization that funding is not available to fulfill contract obligations.

Another example of ineffective monitoring and oversight relates to an example of diversion of medication in 2018. The individuals who are defined as “patients” of the covered entity can only utilize drugs purchased under the 340B Program. As such, individuals meeting an ADAP’s financial and medical eligibility criteria and enrolled as active ADAP clients are deemed “patients” of the ADAP for the purposes of the 340B Program guidelines. ADAPs can avoid drug diversion to ineligible patients by implementing administrative controls that carefully track enrollees (in terms of eligibility requirements, initial enrollment, and recertification of eligibility) as well as drug purchases and inventory (including when and to whom drugs are dispensed). Additionally, a 340B covered entity is prohibited from obtaining 340B pricing (either through a rebate or through a direct purchase) on a drug purchased by another covered entity at or below the 340B ceiling price. A recent webinar sponsored by HRSA informed the viewers they should ensure they have procedures for effective oversight and monitoring of Part B recipients to avoid diversion and duplicate discounts.

Internal Audit was informed that a 340B pharmacy that contracts with CDPHE had placed an order of medication to the Pharmacy Benefit Management (PBM) and it was denied. They placed the order again and they received twice the amount of the first request. This continued with future orders until approximately 280 were diverted. The PBM eventually noticed the situation in their system and placed a stop on future orders. Apparently, these medications were provided to other clients not in the ADAP Program. Once CDPHE was notified, discussions occurred with the pharmacy about their

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180 As stated in the HRSA ADAP Manual 2016 - Prohibition on Diversion of 340B Drugs
181 Webinar: 340B Drug Pricing Program, HRSA, February 2020
182 The pharmacy informed CDPHE that this resulted as a “glitch” in the PBM system; however, it is unclear if the pharmacy had internal controls in place to identify and mitigate the risk of this issue.
plan to buy their own drugs and then give them to the ADAP clients. It is our understanding that the pharmacy was directed to pay these funds back to the PBM but the branch did not request evidence that they were paid back, accepted the verbal statement that it was paid back and did not conduct an inventory observation to verify any remaining product.

Internal Audit requested other supporting documentation from the branch and the pharmacy related to this occurrence but did not receive it. As a result, Internal Audit did not perform an investigation at the branch level or at the pharmacy to review their records and internal controls. Therefore, we cannot conclude if the matter was resolved appropriately or not. It is the responsibility of the branch\textsuperscript{183} to conduct a thorough investigation to review any intent, to ensure that the resolution was appropriate and to develop effective internal controls and monitoring processes to reduce the risk of this situation occurring in the future. The department is considering referring this matter to the appropriate authorities.

ADAPs can avoid drug diversion to ineligible patients by implementing administrative controls that carefully track enrollees (in terms of eligibility requirements, initial enrollment, and recertification of eligibility) as well as drug purchases and inventory (including when and to whom drugs are dispensed).

Internal Audit was informed that the branch has since developed a draft Drug Diversion Policy not yet been approved by division leadership and that one had not been in place prior to this instance. Internal Audit obtained a copy of the draft policy and supporting documentation from the branch and reviewed it for reasonableness. The draft states that a materiality threshold should be determined; we have confirmed that a threshold has not been set up to date. Overall, we found the draft policy to be a good start and noted that testing procedures are outlined in the draft. These testing procedures would assist in maintaining effective monitoring and oversight of the pharmacies. Specifically, the draft policy would require the branch to\textsuperscript{184}:

- Conduct routine internal reviews of each registered contract pharmacy for compliance with 340B Program requirements.
- Conduct quarterly reviews of the virtual inventory to reconcile with claims, shipment records, and wholesaler records.

Finally, effective oversight of the branch and division also includes awareness of the financial activities at a higher level. Quarterly financial performance review meetings facilitated by central accounting have been in place for period of time including prior to our audit period. In 2019, they were revised to include more standardized financial reporting for all divisions in order to provide division directors specific information on

\textsuperscript{183}Best practice is to ensure an adequate review by an independent and objective reviewer with no relationship to the pharmacy.

\textsuperscript{184}HRSA ADAP best practice as stated to Internal Audit in an interview.
their division’s performance. The last meeting was in February 2020 and central accounting shared financial data from CORE that is included on the financial services’ internal financial dashboard\(^{185}\) information. The purpose of these meetings is to inform division directors and other attending divisional leadership of any trends, concerns or warning signals that may need addressing while walking through the high level financial information. Some examples of the information provided are:

- Proportion of Budget and Expense by Fund Type
- Grant Budget Snapshot
- Cash Balances through December 2019
- Personal Services Object Code Expenses by Operating Line and Personal Services

Division leadership or their designee should consider attending these meetings to obtain an overview of the financial status of their division and obtain a better understanding of any areas that they may need to address.

Why It Matters. Oversight focuses at a high level on implementation of policy, programs and operations while monitoring tracks the progress in the implementation of functions, programs and operations. Both are important for the success of an organization. Not only should the department provide oversight and monitoring within, they are responsible for conducting effective monitoring and oversight of their subrecipients and contractors.\(^ {186}\)

Federal regulations explicitly state that grant recipients must monitor and report program performance to ensure they are using their federal grant program funds in accordance with program requirements. \(^ {187}\) Specifically, the non-federal entity is responsible for oversight of the operations of the federal award supported activities. The non-federal entity must monitor its activities under federal awards to assure compliance with applicable federal requirements and to achieve performance expectations. Monitoring by the non-Federal entity must cover each program, function or activity. The federal regulations \(^ {188}\) additionally impose subrecipient monitoring requirements. All pass-through entities must monitor the activities of the subrecipient to ensure that the funding serves the authorized purpose, that they are compliant with federal statutes, regulations, and terms and conditions; and that they have met their performance goals. Likewise, HRSA is responsible for monitoring and reporting the

\(^{185}\) Intranet financial dashboard located at https://colooit.sharepoint.com/sites/DPHE-accounting/SitePages/Financial-Dashboards.aspx

\(^{186}\) 2 C.F.R. § 200.331 Requirements for Pass Through Entities and the Colorado State Controller Guide for State Agency Compliance with the OMB Guidance

\(^{187}\) The rules and requirements that govern the administration of HHS grants are set forth in the regulations found in the Uniform Administrative Requirements, Cost Principles and Audit Requirements for HHS Awards, 45 C.F.R. part 75.342(a) and 75.342(d).

\(^{188}\) 2 C.F.R 200 Performance and Financial Monitoring Reporting, Subrecipient Monitoring and Management, and Cost Principles
program performance of its recipients and its subrecipients, the RWHAP service providers.

As stated in department policy 13.5 “Contract Monitoring,” dated 2014, CDPHE is responsible for administrative oversight, including program and fiscal monitoring, of all contracts it issues. This policy is important to ensure the department monitors contracts in a consistent and standardized way. Standardization of monitoring practices establishes department-wide expectations; reduces duplicative efforts, allowing the department to use resources more efficiently; provides contractors with a consistent experience; and demonstrates good stewardship of all funds. If additional requirements are necessary through the grant agreement, these should be included in planning as well.

Recommendations.

40. Ensure that appropriate contract monitoring procedures are performed sufficiently for any medium or high-risk contractors, as stated in the risk assessment tracker to be compliant with department contract monitoring procedures.

41. Review current contract-monitoring procedures and revise to add HRSA’s National Contract Monitoring Universal Standards, for both program, compliance and fiscal monitors and to the department contract monitoring procedures.

42. Review the CPMU December 2019 Compliance Improvement Plan and implement the corrective action items for all contracts. Ensure that these items in the branch specific contract monitoring revised procedures.

43. Review the CFDA #93.917 requirements in the OMB Compliance Matrix revised 2019 and update written procedures and processes to incorporate improvements to these areas. This will assist in preparation for the next Single Audit performed by the Colorado Office of the State Auditor.

44. Assess contract monitoring staff needed to provide the necessary contracting services and adjust as necessary to allow for more robust contract-monitoring. Provide detailed program training to contract monitors to ensure a thorough understanding of the Ryan White grant requirements and rebate restrictions.

45. Consider assigning contract monitors to various branches so that they have a more specialized skill set over the program and arrange for rotation every three or five years to avoid the appearance of inappropriate relationships with the contractors.

46. Finalize the “Drug Diversion Policy” and include routine internal reviews of each registered pharmacy for compliance with 340B requirements, and conduct quarterly
reviews of the virtual inventory to reconcile with claims, shipment records and wholesaler records.

L. Ineffective Reporting

According to the Ryan White Part B Manual, the Federal Financial Report (FFR) is due after the budget period ends as outlined in the Notice of Award under the FFR section in the terms and conditions. HRSA allows additional time to submit the FFR if necessary and recipients are to complete a Request for Extension via the Electronic Handbook. Interviews with the HRSA project officer substantiated that it is acceptable to request an extension if needed and include the proposed submission date and the justification for the delayed submission. A grants specialist will then contact the recipient to discuss the request further, and they will either approve or deny the request. During our audit, we found that four of six, or roughly 67 percent, of the FFRs submitted during the budget periods April 1, 2016 - March 31, 2019 were submitted late. Two of these late submittals were approved by HRSA to have an extension and CDPHE submitted them by the agreed upon revised date.

Internal Audit reviewed the CDPHE access to HRSA’s online Electronic Handbook in January 2020 and discovered that there were two former employees who still had access even though they have not been with the department for almost two years. Internal Audit notified central accounting and they removed their access rights at that time. According to interviews with central accounting and division leadership, there is not a procedure currently in place to review the access rights on a regular basis or to ensure the proper removal of access when employees no longer work for the Program. By not having system internal controls in place, the branch runs the risk of unauthorized access and integrity issues with the reported data.

We also identified that the contact information on the Notice of Awards (NOA) was not always current for the budget period during the three fiscal years reviewed in our audit. We found that when there was a change to the grant specific terms, such as an adjustment for carryover of funds or changes in principal investigator or de-obligation of funds, there was only one person’s name as the contact. We also noted that some of the employees who were no longer participating in the Program or no longer with the department were still on the contact information. Specifically, we found this to have occurred throughout the audit period and into FY20. Internal Audit notified branch leadership of the current contact names on the most recent NOA and they began working on notifying HRSA to update this contact information. By not having up to date contact information, any notifications and communications from HRSA may not timely be provided to the correct employee or may be provided inappropriately to an employee who no longer works within the branch.
At the time of our review, the posted data\textsuperscript{189} was limited as we noted that some of the information was only for the first half of 2019. A data request form is available for completion by community members to express their needs but if current data is not available to the branch, their request may not be possible. Additionally, the data type historically shared may not be what the community needs currently to conduct their analysis. Refer to Appendix D for an example of a HIV surveillance report from Colorado.

The Program may benefit from reviewing other state public health HIV/STI Program data webpages for additional ideas regarding how to make the data and other information more relevant and easier to read. For example, the California public health department HIV Program’s data page lists surveillance reports using graphs and other visual aids to communicate the data. Refer to Appendix D for another example of a HIV surveillance report from California, as well as for an example of an effective surveillance process for data needs.

\textbf{Why It Matters.} Reporting of relevant data\textsuperscript{190} on the CDPHE webpage is very important for the branch, division, subrecipients, contractors and other stakeholders to utilize in order to better plan and budget for projects and to develop a more specific scope of work and priority setting. It may also assist the advisory committees in setting priorities for funding recommendations by understanding what the past and current data trends are. By not including the community in asking what data is relevant to their needs, the department may be communicating irrelevant or sharing specific data in a way that is not as helpful. Additionally, accurate federal reporting is requirement of the Ryan White Program\textsuperscript{191} and is a necessary and required part of grant management.\textsuperscript{192}

\textbf{Recommendations.}

47. Develop and implement written procedures to ensure the planning of the FFR reporting occurs timely so that proper support and reconciliations can be reviewed to ensure that accurate data is reported to HRSA. Additionally, work with central accounting to align branch/division procedures with department procedures.

48. Work with central accounting to develop and implement written access procedures to periodically review the Electronic Handbook and:

\begin{itemize}
  \item \textsuperscript{189} https://www.colorado.gov/pacific/cdphe/sti-hiv-data; It should be noted that 3\textsuperscript{rd} quarter 2019 HIV report data was posted January 2020 and 4\textsuperscript{th} quarter data was posted in April 2020 due to time needed to review and cleansing of the data.
  \item \textsuperscript{190} Refers to data that CDPHE obtained from the Patient Reporting Investigating Surveillance Manager (PRISM).
  \item \textsuperscript{191} https://hab.hrsa.gov/program-grants-management/data-reporting-requirements-and-technical-assistance
  \item \textsuperscript{192} CDPHE Fiscal Procedures Manual, Section 7.4 Grant Reporting & Close Out as well as 2 CFR 200 OMB Guidance Subpart D, Post Federal Award Requirements Standards for Financial and Program Management
\end{itemize}
a) Remove employees’ access rights who no longer need access, such as those who have left the branch, division or department, as appropriate.
b) Ensure that appropriate contact information is included within the Electronic Handbook so that the correct individuals receive important notifications.

49. Provide surveys to contractors in order to determine their data needs and what type of data reporting they would like to see on the CDPHE website. Determine if the branch can meet these needs and create a strategic plan related to practical and relevant data sharing and transparency. Consider creating an inner/outward facing page in order to view dashboard detail.

**M. Unsupported Time and Effort Reporting**

Internal Audit requested records for our audit period of FY17-FY19 related to Program labor distribution in order to review the funding sources\(^\text{193}\) allocated to employees. Branch management was unable to provide detail for our review but informed us that they are currently working on a revised personnel allocation spreadsheet to align work performed to proper funding sources for the current period. Regular assessments of personnel allocation should occur to ensure that the allocation percentages are reasonable and appropriate. In addition, the state may not use more than 10 percent of the amounts received under the grant for administration\(^\text{194}\) and should review personnel costs to be compliant with this requirement.\(^\text{195}\) Interviews with former and current employees mention that personnel allocation spreadsheets were often hard to create and manage due to a lack of consistency in job duties and reorganizations within the audit period.

Although we did not receive the requested personnel allocations spreadsheets or related documented methodology from the branch, we obtained labor distribution reports from CORE\(^\text{196}\) for our audit period to conduct a cursory review. During our review, we identified various employees charged against a variety of HIV/AIDS Program funding streams, such as YT, GK, and QT.

Without knowing the methodology for charging employees to particular funding streams, it is difficult to assess the appropriateness or if their KRONOS time sheet recording is appropriate. For example, per our review of the labor distribution for all divisions within the department, we found that some employees had allocations to YT (standard rebates), QT (Ryan White) and 4C16 (supplemental rebates) on a monthly basis but was inconsistent month to month, meaning that some months their salary was charged against these codes and other times they were not. Thus, there is inconsistency

\(^{193}\text{Funding source is the cost objective or grant that provides funding for an activity, as stated in CDPHE’s Time and Effort Recording Policy 1.5, dated July 2012.}\)

\(^{194}\text{HRSA Policy Clarification Notice 15-01, Treatment of Costs under the 10% Administrative Cap}\)

\(^{195}\text{42 UCS 300ff-28(b)(3)(A), Office of Management and Budget Compliance Supplement CFDA #93.917 and HRSA Policy Clarification Notice #16-02}\)

\(^{196}\text{Report name is LDC007 report in CORE}\)
within CORE and since there are no standard written methodologies in place, the risk of inaccurate charging to grant or rebate funds increases; thus, utilization of grant funding may be inappropriate. In addition, per review of the labor distribution detail within CORE from FY15 – FY19, there were large numbers of employees with portions of salary charged against program code QT (Ryan White), including 84 employees during FY15, 68 employees during FY16, 76 employees during FY17, 80 employees during FY18 and 79 employees during FY19. Although there may be appropriate reasoning for these funding allocations, it is questionable whether all of these employees performed job duties related to the Ryan White Program.

Furthermore, we conducted a review of the labor distribution report for YT (standard rebate) and noted a large number of employees funded by this code as well for periods FY17 to FY19. It does not appear that labor allocations occurred to this funding code during FY15 or FY16. In FY17, however, there were 63 employees charged to YT, 42 employees in FY18 and 41 employees in FY19. Regarding the 4C16 (supplemental rebates) we identified that personnel were not charged against this code in FY17 and FY18. However, in FY19, 30 employees’ salaries were charged against 4C16, including some in administration. Per review of the CORE data and substantiated with interviews, we became aware that in FY19, division leadership had communicated with the administration division that they had money to spend down from code 4C (supplemental rebates). They provided around $100,000 to CDPHE’s Office of Planning, Partnerships and Improvement (OPPI) and Administration for salaries and also fully funded a full-time position in HR (HR trainer) and a grant accountant position in central accounting; both included full operation costs. Internal Audit could not confirm the total dollar amount of the two full time positions but estimate the amount as $107,000.197

Discretionary pay or other personnel charges may contribute to an inappropriate use of program dollars. For example, HRSA funds may not be used to pay the salary of an individual at a rate in excess of $179,700.198 We found some personnel costs during our review of current salary schedules that may exceed this limitation but did not receive adequate supporting documentation or percentage allocation schedules for employees from the branch to be able to conclude as to the appropriateness. General Provisions in Division H, section 202, of the Consolidated Appropriations Act, 2017 (PL 115-31) limits the salary rate that may be awarded and charged to HHS grants. Salary expenses in excess of the Executive Level II rate are unallowable costs. HRSA directs that this salary rate limitation also applies to Ryan White subrecipients and should be included in each subaward agreement and/or contract. Per a review of contracts entered into related to Ryan White funding, we did not see this information in the contract terms and conditions. Internal Audit also inquired as to if there were any discretionary pay awards that utilized Ryan White, MSA or related rebate money during the audit period. The branch did not have this information tracked and could not provide us the

197 Supported by a review of CORE data of employee salaries charged to 4C16.
information. We inquired to Human Resources (HR) but the only tracking of pay increases would be on the Personnel Action Forms, which are included in each employee’s hardcopy personnel file, and this would be time extensive for HR to search for this over the three-year period. Although it is reasonable that some discretionary pay increases may have occurred for specific purposes, a review to ensure appropriateness, funding stream labor allocation, significance and adequate timing promotes transparency and accountability of the funds. By not conducting personnel services assessments of positions charged to the grant on a regular basis, the branch increases their risk of unallowable costs, administrative cap violations, or unreasonable allocation percentages based upon duties performed. Refer to the unsupported time and effort reporting section above for further details.

Thorough analysis by branch leadership of the charges to Ryan White, rebate and supplemental rebate funding most likely will result in necessary adjustments to these allocations of current CDPHE employees to correct any inappropriate labor allocations and to ensure proper and supported allocation.

Individuals also stated during interviews that work performed was not always in line with position descriptions (PDs), as many did not receive an update when duties changed. Internal Audit did not review a sample of PDs to validate the statements made by the many interviewees but encourage branch staff and leadership to review and update these as appropriate when updating their personnel allocation spreadsheets currently under review.

**Why It Matters.** Records that accurately reflect the work performed and that are supported by a system of internal controls must support labor distribution and time keeping. These controls should provide reasonable assurances that the charges are accurate, allowable, reasonable and properly allocated. Records should be clear in order to support the labor distribution allocation of employees and retained by the organization as required.

The Uniform Guidance Section 200.430 states: “Charges to Federal awards for salaries and wages must be based on records that accurately reflect the work performed. These records must be supported by a system of internal control which provides reasonable assurance that the changes are accurate, allowable, and properly allocated.”

The department policy 1.5 “Time and Effort Recording” from 2012 details the expectations for employees to properly record their time in KRONOS. Specifically,

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199 Discretionary pay does not include annual pay increases due to cost of living or pay for performance.
200 2 CFR 200.430 Compensation - Personal Services, Standards for Documentation of Personnel Services
201 KRONOS is the department’s official timekeeping/activity tracking and reporting system. If a division/program uses a supplemental system to record more time and effort detail that system must
expectations on the reporting, recording, signoff and/or certification of effort expended by staff regardless of the funding mechanism. In addition, the policy states, “any changes or corrections and reconciliations must be done at least on a quarterly basis. Any error or adjustment discovered after the expiration of the quarterly correction period may be allowed only if there is adequate documentation of the error and the correction is approved in writing by the department controller or their designee. This will ensure accurate reporting and full compliance…”

**Recommendations.**

50. Develop written methodologies for current labor distribution allocations for all positions that are paid from HIV/STI related funding to ensure that funding is appropriate, reasonable and in compliance with regulations and grant requirements. Maintain accurate record of any changes. Ensure that KRONOS time codes are accurately used and provide training to employees as necessary.

51. Conduct an analysis of discretionary pay provided to employees that was paid from HIV/STI Program related funding and ensure that the funding used was appropriate, reasonable, and in compliance with regulations and grant requirements.

**N. Relationships and Roles with Advisory Committees**

In general, an advisory committee is a group of individuals who provide unique knowledge and experience to an organization and can provide “real world” examples of how to better support the program. The advisory committees are extremely valuable in the success of the HIV/STI Program by assisting in the formation of strategic goals and priority setting, as well as effectively communicating the needs of the communities served by the Program.

Overall, during our audit, we noted inconsistencies related to the administration of the committees. For example, CHAPP and the Alliance both have completed program rules and/or bylaws, which they have posted on the CDPHE webpage under “community involvement.” Although SDAP provides applicant information such as qualifications, coverage guidelines, agendas, meeting minutes and other general information online, there are currently no bylaws or rules posted for this advisory committee. Not only are these items not transparent online, discussion on a draft version of the bylaws has occurred for a number of years along with a discussion with the department on what constitutes a member, the responsibilities of the committee and the department’s expectations. The department reviewed the draft version of the SDAP bylaws in 2019.

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interface with KRONOS in compliance with this policy, as stated in CDPHE’s Time and Effort Recording Policy 1.5 dated July 2012.

202 https://www.colorado.gov/pacific/cdphe/chapp
and comments and tracked changes were provided to the committee by the department. To date, the SDAP committee has not finalized the draft of the bylaws, nor has the department agreed to the final version or posted it online for transparency. By not having current bylaws and other administrative guidance related to the roles and responsibilities of the committee in place, miscommunication, confusion and resentment can occur along with a lack of clear direction and boundaries.

In 2013, the Colorado Office of the State Auditor conducted a performance audit of CHAPP and noted that there were concerns about the scope of the advisory committee’s authority and responsibility. They recommended that the department work with the Board of Health and the advisory committee to ensure that Program rules and bylaws properly reflect the status of the committee to be only advisory in nature. The department responded that they would assist the committee in updating these items. Per our cursory review, it appears that the department has implemented this recommendation. Furthermore, it is reasonable that this recommendation also apply to the other two advisory committees since they too are advisory in nature. Additionally, the department worked with the AG’s office to confirm the advisory nature of the ADAP advisory committee. Since there is no Type 1 transfer in the SDAP statute, an advisory group can only serve in an advisory role while the department is authorized to implement and administer the drug assistance program. Internal Audit agrees with this analysis. However, in order for the Program to thrive, the ADAP committee is a vital component to this program and should be involved in an advisory capacity in a mutually beneficial manner.

A review of various recordings from committee meetings during our audit period have shown a gradual progression of frustration between committee members and department staff. Working together to establish common goals and priorities, handling disagreements in a professional manner, practicing patience while the department undergoes process improvements and redefining roles and responsibilities will assist in the rebuilding of positive relations and trust.

**Why It Matters.** While it is crucial and necessary for the advisory committees to provide priority-setting recommendations to the department based upon their community involvement and experiences, it is also important to acknowledge that the department is ultimately responsible for the funding and that the department has a fiduciary duty to make all final decisions after weighing all discussions and input. Transparency in decision-making is essential. The erosion of public trust if public information and actions are not credible and reliable undermines the public sector’s legitimacy and

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203 CRS 25-4-1404
ability to govern. Equally important is the department’s fiduciary responsibility in properly managing the funding.

Advisory committees are Type 2 committees as defined in C.R.S. § 24-1-105. All three advisory bodies to the Program are required by law, either executive order or statute, to perform certain functions related to the Program. All boards and commissions are required to implement written bylaws and receiving training on a number of topics, including identifying and managing conflicts of interest. C.R.S. §24-3.7-102.

Not only are there state advisory boards related to HIV prevention, the CDC and HRSA joined forces to create a CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment for the sole purpose of supporting agencies in their development of responses to emerging health needs related to HIV, Viral Hepatitis and other STDs. This advisory committee is another practical resource in effective grant management.

Recommendations.

52. Collaborate with the SDAP advisory committee in finalizing the bylaws, including conflict of interest precautions, voting rules, membership criteria and clarity in roles and responsibilities and post on department webpage for transparency.

53. Work with the SDAP advisory committee to periodically conduct a cost-benefit analysis to determine the most cost effective approach for purchasing medications, which should include the costs of medications and all administrative costs and fees associated with purchasing and distribution.

54. Collaborate with the advisory committees in determining which financial and programmatic information is necessary for priority and goal setting, and relevant decision-making.

O. Lack of Effective Transparency and Implementation

In January 2018, the department prepared a memo to the Alliance outlining several departmental concerns related to the HIV/AIDS Program and an action plan to address these concerns. Specifically, the memo states that because the branch has several complex funding streams, a variety of detailed requirements related to funding and contracts and various tracking processes, the department determined that a phased approach would be the most effective method of evaluation. It further states that the

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204 Institute of Internal Auditor’s “Environment, Health & Safety Knowledge Brief,” 2018

205 www.CDC.gov
evaluation would focus on establishing internal controls, adherence to state fiscal rules, appropriate use and accurate reporting of all funding streams and identifying conflicts of interest with regard to contracts. Additionally, improvement steps noted related to monthly reconciliation of grant expenditures and encumbrances, revenue forecasting and expense budgeting and staffing, workload and assignment of duties. The department gave a follow up memo to the Alliance in May 2019 with an additional update of concerns and related action plans. Again, in September 2019 the department provided another memo to the Alliance outlining concerns and providing related action plans.

In November 2019, the department provided additional information to the advisory committees and community related to the fact that they did not have adequate funding. This furthered the belief of ineffective transparency and implementation of previous stated action plans.

Interviews with members of the community have expressed that although they initially appreciated the information and transparency, they were expecting resolution in a timely manner and felt that the timing was inefficient in fixing the problems noted. Additionally, because some of the community members were former employees within the branch, they were aware of communications and specific circumstances that occurred within the department during the fall of 2017. It appears that this also led to the community’s feelings of a lack of trust and belief of ineffective transparency of what was happening within the branch. Overall, the timing between the initial communication with the community and financial problems occurring within the branch to date without resolution have led to distrust and a lack of confidence in branch leadership. By not having an effective implementation plan within a reasonable time, the department also lacked effective transparency and accountability.

**Why It Matters.** Transparency fosters trust. Transparency within government is especially important since the department has a fiduciary duty to act responsibly with taxpayer dollars.\(^{206}\) Government is obligated to share information with citizens that so that they can make informed decisions and hold officials accountable for the people’s business.\(^ {207}\) While there may be instances where the department does not share specific information with those outside of the department, perhaps due to personnel or proprietary situations, relevant information shared with the advisory committees in a concise and consistent manner will help to move priorities and common goals forward. Although it is important to communicate the problems and concerns, follow through and timely implementation of the action plan is even more important when trying to “fix” a problem.

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\(^{206}\) The Federal Funding Accountability and Transparent Act of 2006 (FFATA)

\(^{207}\) Transparency and Government Accountability Act Summary, American Legislative Exchange Council
Recommendation.

55. Develop a timely action plan for identified areas of concern, along with milestone due dates, to ensure timely implementation and communicate this action plan as appropriate to promote accountability and transparency.

P. Perceived and Actual Conflict of Interest

Although CDPHE, their contractors, and members of the advisory committees and the community, all have the shared goal of supporting individuals living with HIV and preventing future cases of HIV, their roles are different and clear guidelines are necessary in keeping appropriate separation. In addition, actual or perceived conflicts of interest can result in reputational risk, a failure to act in the best interest of the entity, and poor governance, especially when individuals are passionate about their cause. During our audit, we found a variety of instances of potential, perceived or actual conflicts of interest.

For example, it appears that during our audit period, some CDPHE employees provided departmental level communication to outside influencers. Information may be propriety and any “inside information” is not appropriate to share with individuals outside the department, particularly if lacking supervisory or management approval, especially with organizations to which CDPHE provides funding. Any appearance of impropriety is not appropriate.

We also found instances of perceived organizational conflict of interest within the advisory committees. As mentioned above, the SDAP Review Committee does not have current final and approved bylaws in place to date or written guidelines that set forth the criteria of who can be a voting member. As the public is welcome to attend these meetings, it has been common practice for the committee to track attendance so that regular attendees of three of more meetings can participate in a vote but this is not listed on the SDAP website or has been provided to CDPHE. Without set criteria approved by the department and a set membership listing so that one knows how many individuals are considered voting members, it is difficult to establish a quorum when a vote is necessary. It is also difficult to be able to distinguish any potential conflicts of interest that may occur. During our audit period, there were instances where votes occurred related to specific contractors. Without set criteria, a perception may exist that individuals attend specific meetings when they know that a vote will occur for something that would positively affect themselves or their place of employment. In addition, controls should be in place to protect the integrity of the vote by having individuals with conflicts of interest remove themselves from discussions and/or abstain from a particular vote. Meeting minutes should adequately reflect any conflicts of interest and the specific circumstances surrounding the vote to provide transparency.
We also identified concerns related to board memberships and complicated relationships with CDPHE. For example, a board member of a CDPHE advisory committee is also a board member of a CDPHE contractor and owns a pharmacy (#2) that also contracts with CDPHE for ADAP funding. This individual would minimally have an appearance of a conflict of interest, if not an actual conflict of interest, by both receiving funding from CDPHE for the individual’s business, and sitting on the Board of a contractor that also receives CDPHE funding. The contractor offers health access programs by providing assistance with medications for people living with HIV and those who utilize PrEP as an HIV prevention strategy. There have been instances reported to CDPHE since 2015 that the contractor also advised clients to fill their prescriptions at this particular pharmacy #2 rather than pharmacy #1 where they were established. In fact, over 25 clients of pharmacy #1 informed CDPHE during the audit period that they were contacted by the pharmacy #2 that they needed to move their prescriptions to their pharmacy due to insurance reasons when in fact that does not appear to be the case. Internal Audit obtained a letter from CDPHE written by a former employee in a key position who decided to end a relationship with the pharmacy #1 and terminate the 340B contract pharmacy relationship effective January 1, 2016 and moved the clients to a pharmacy #2. Although the reason for the change is not stated in the letter September 1, 2015 letter, the appearance of a conflict of interest is strong. Additionally, this former CDPHE employee now works for the contractor where the board member from pharmacy #2 sits on the board. In addition, complaints also occurred during 2017 that clients were also moved from their pharmacy to the pharmacy #2. Board members should not have a direct interest in the organization that they help guide, as there is a perceived conflict of interest and an increased risk of actual conflict of interest. In addition, Internal Audit identified that pharmacy #2 was chosen through a sole source process in 2014 for a five-year contract from FY2015-2019. Although CDPHE cannot control who sits on the board of a contractor, they can actively manage conflicts of interest by asking the contractor to abstain from a vote during an advisory meeting that would directly affect the board member’s pharmacy. Any appearance of reciprocal relationships is inappropriate.

Additionally, we found instances of conflict of interest relating to former CDPHE employees working at organizations that the department is under contract with to perform services. Both C.R.S. § 24-18-105 and C.R.S. § 24-18-201 state that an employee should wait at least 6 months before the former state employee should be placed in a role with a new employer where there is a potential for a conflict of interest. We found that at least two former employees obtained employment at a contractor during our audit period that receives large funding dollars from CDPHE immediately

\(^{208}\) Names are not included but referred to as #1 and #2 since the information is proprietary.

\(^{209}\) Ethical principles for public officers, local government officials and employees

\(^{210}\) Interests in contracts
after they left the department. Ultimately, division management asked the new employer to ensure that the former employees not be placed in roles where they could have a perceived conflict of interest. Although employees receive notice of these laws during their exit meeting and/or upon departure in their exit packet from CDPHE Human Resources, employees may not be aware of this limitation while searching for and accepting another job outside the department. Internal Audit learned that it is up to the division director’s discretion as to enforce these statutes; however, this process appears to be undocumented or standardized. The department has a department policy in place related to employee separation\(^{211}\) but it does not contain language related to these statutes. By informing employees earlier in their employment with the department, such as during onboarding, it may reduce the risk of employees accepting positions with contractors that may pose a conflict of interest. In addition, outlining these department expectations within a department policy or standard contract wording ensures consistency among divisions in how they mitigate these circumstances.

**Why It Matters.** Conflict of interest ethic policies\(^{212}\) exist in organizations to reduce the risk of inappropriate relationships and the appearance of any impropriety. However, in organizations where it is essential to collaborate with others in order to maximize the effect of shared strategic plans, it becomes even more important to have controls in place to mitigate the appearance of, or any actual biases that may occur. Because it is sometimes difficult to define conflict of interest and the perception by others may be subjective, it is important to establish clear rules and guidelines\(^{213}\) so that expectations are set forth and appropriate behaviors are followed.\(^{214}\)

**Recommendation for CDPHE Human Resources**

56. **CDPHE Employee Separation Policy 10.7:**
   b) Standardize the process across the department in how divisions address employees accepting positions at organizations that contract with the department within six months of ending employment at CDPHE.
   c) Provide information to employees during onboarding.
   d) Provide training to current employees.

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\(^{211}\) CDPHE “Employee Separation” Policy 10.7, revised April 2013

\(^{212}\) Colorado State Controller Policy, Procurement Conflicts of Interest, revised date of September 2017 and CDPHE Conflicts of Interest Policy 13.6, revised date of June 2017.

\(^{213}\) 2 CFR 200 OMG Uniform Guidance - Subpart B Post Federal Award Requirements Standards for Financial and Program Management

\(^{214}\) Federal basic criminal conflict of interest statute is 18 U.S.C 208 prohibits government employees from participating personally and substantially, where they have a financial interest. Additionally, the US Office of Government Ethics provides training materials to state departments assessing potential conflict of interest scenarios.
Other Suggestions for Consideration:

57. Consider the following about rebates:
   a) Purchase a grant management system for the Program using rebate dollars.
   b) Only participate in the rebate program with certain pharmaceutical companies rather than all to control the funding stream with smaller projections.
   c) Not participating in the rebate program for a certain length of time to focus on getting the funding streams updated in CORE, reprioritizing goals and priority setting, long range budgeting and determining how many dollars the Program actually needs in funding, etc.
   d) Not participating in the rebate program at all due to Program requirements, staffing size and complexity of tracking and projections.
   e) Not separating out federal and state generated rebate dollars and only using rebates for Ryan White purposes with the priority of putting the funding back into ADAP.

58. Consider the following about the Program:
   a) Seek further statutory revisions related to the use of the MSA dollars and state generated rebates dollars as appropriate.
   b) Hire a third party administrator to manage the rebates.
   c) Collaborate or seek information from the Department of Health Care Policy and Financing since they administer Medicaid and have experience with rebates to help form the CDPHE model going forward.
   d) Refer to Appendix G for state benchmarking results for additional ideas.
Appendix A:
Tobacco Master Settlement Agreement Dollars

Distribution of Tobacco MSA Payment under HB 16-1408
Effective beginning in FY 2016-17 under Section 24-75-1104.5 (1.7), C.R.S.

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<tr>
<td>HIV Prevention</td>
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<tr>
<td>Immunizations</td>
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<td>Health Services Corps</td>
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<tr>
<td>Total Funds Distributed</td>
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¹Of this share, 2.0 percent must be expended for tobacco-related in-state cancer research.

The remaining 1.5 percent of each year’s MSA payment remains in the Tobacco Litigation Settlement Cash Fund and is used to reduce the following year’s accelerated payment.
### 2017 Tobacco MSA Distribution Forecast

**Dollars in Millions**

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*Source: Department of the Treasury and Legislative Council Staff Forecast.*

\(^1\)For FY 2016-17, these programs received appropriations from the Marijuana Tax Cash Fund under House Bill 16-1408. The General Assembly may choose to fund these programs from marijuana tax revenue in coming years.

\(^2\)For FY 2016-17 and subsequent years, a share of this amount is required to be spent for tobacco-related in-state cancer research.

\(^3\)For FY 2016-17 and subsequent years, the audit is no longer funded pursuant to House Bill 16-1408.
## 2018 Tobacco MSA Distribution Forecast

*Dollars in Millions*

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*Source: Department of the Treasury and Legislative Council Staff Forecast.*

¹For FY 2016-17 and subsequent years, a share of this amount is required to be spent for tobacco-related in-state cancer research.

²For FY 2018-19 only, includes $19.7 million of $20.0 million transferred from the General Fund pursuant to SB 18-280, and $0.2 million transferred from the Department of Law in conjunction with the 2014 NPM dispute.
### 2019 Tobacco MSA Distribution Forecast

**Dollars in Millions**

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Source: Department of the Treasury and Legislative Council Staff Forecast.

1For FY 2016-17 and subsequent years, a share of this amount is required to be spent for tobacco-related in-state cancer research.

2For FY 2019-19 only, includes $19.7 million of $20.0 million transferred from the General Fund pursuant to SB 18-280, and $0.2 million transferred from the Department of Law in conjunction with the 2014 NPM dispute.
Appendix B:
Recipient and Subrecipient Relationships in Submitting the RSR

(RECIPENT AND SUBRECIPIENT RELATIONSHIPS

(Last Updated: September 19, 2019)

Recipients and subrecipients work together to quickly and easily submit the RSR. Figures 1–4 offer illustrations and definitions of recipient and subrecipient relationships.

Figure 1. Recipient-Provider

A recipient-provider, which is a service provider that also is a recipient, must complete a Recipient Report and a Provider Report. A recipient-provider of core medical or support services must also upload client-level data.

Figure 2. Subrecipient

A service organization that has a contract with a recipient is considered a subrecipient. A subrecipient must complete a Provider Report and, if it provides core medical or support services, upload client-level data.

Figure 3. Second-Level Provider

Occasionally, recipients will use an administrative agent to award and/or monitor the use of their RW/HP funds. In this situation, the administrative agent (or fiscal intermediary service provider) is the recipient’s subrecipient. When the recipient’s subrecipient (administrative agent or fiscal intermediary provider) enters into a contract with another provider to use the recipient’s funds to deliver services, that provider is considered a second-level provider to the recipient. A second-level provider must complete a Provider Report and, if it provides core medical or support services, upload client-level data.

Figure 4. Multi-Level Provider

If a service organization is a multilevel provider (a second-level provider to one recipient and a subrecipient to another recipient), it must complete a single Provider Report and, if it provides core medical or support services, upload client-level data. The provider must include client data for all its RW/HP contracts.
# Appendix C: Example of Under-Encumbered DCHPR Contracts Tracker

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<th>Encumberance Amount</th>
<th>Extended Desc Amount</th>
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<td>62,291.47</td>
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<td>$7,500.00</td>
<td>(1,986.17)</td>
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<td>Marijuana / Dabbing</td>
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<tr>
<td>DSI / Food Safety</td>
<td>$791,696.38</td>
<td>$925,480.38</td>
<td>(133,784.00)</td>
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<tr>
<td>DSI - HAI</td>
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<td>$244,389.00</td>
<td>62,291.47</td>
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<td></td>
<td></td>
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<td>$6,491.00</td>
<td>(5,490.00)</td>
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<td>HIV Clinical Services / LTC</td>
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<td>$286,428.00</td>
<td>(86,428.00)</td>
<td>Ends 1/31/19. YT 18CH is 86% encumbered. Will do EMR.</td>
<td></td>
<td>$841,529.14</td>
<td>Contract expired - no EMR</td>
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<td>CT,FAAA,20180000349.5</td>
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<td>OEPR</td>
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<td>Grand Total</td>
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<td>(6,443,374.33)</td>
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</table>

Source: Division/branch prepared. Internal Audit did not audit these numbers.
### Appendix D - Examples of Surveillance Reporting

#### HIV SURVEILLANCE QUARTERLY REPORT, 1st Quarter 2019

STI/HIV/Viral Hepatitis Surveillance Program, Published August 2019

HIV diagnoses and AIDS diagnoses occurring January 1, 2019 through March 31, 2019; and people diagnosed with HIV, reported in Colorado, and presumed to be living as of March 31, 2019.

<table>
<thead>
<tr>
<th>Sex at birth</th>
<th>Total</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>New AIDS diagnoses</th>
<th>PLHIVdX as of 3/31/19</th>
<th>Viral Suppression</th>
</tr>
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<tbody>
<tr>
<td>Male</td>
<td>119</td>
<td>84</td>
<td>98</td>
<td>84</td>
<td>21</td>
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<td>4</td>
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<tr>
<td>Race and Hispanic Origin</td>
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<td>White</td>
<td>64</td>
<td>45</td>
<td>54</td>
<td>47</td>
<td>10</td>
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<td>40</td>
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<td>Multiple Race/Unknown</td>
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<td>Age group (years)</td>
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<td>13-19</td>
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<td>60 and over</td>
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<td>Denver TGA</td>
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<td>16</td>
<td>64</td>
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<td>Non-TGA Urban</td>
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<td>61</td>
<td>53</td>
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<td>MSM &amp; IDU</td>
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<td>5</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>8</td>
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<td>Heterosexual contact</td>
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</tr>
<tr>
<td>No Identified Risk</td>
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<td>38</td>
<td>44</td>
<td>38</td>
<td>9</td>
<td>36</td>
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<tr>
<td>HIV dx only</td>
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<td>N/A</td>
<td>N/A</td>
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</tr>
<tr>
<td>AIDS dx, ever</td>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
| Data Source: Enhanced HIV/AIDS Reporting System (EHRS). EHRS Sample: Living with HIV/AIDS, diagnosed, AIDS, and PLHIVdX, applicable. All percentages are column percent unless otherwise indicated and may not equal 100% due to rounding. For events reported by June 30, 2019. HIV diagnosed concurrently with AIDS (within 30 days of HIV diagnosis). Row percent is percent of total HIV diagnoses that were concurrent with AIDS diagnoses. AIDS Stage 1, diagnosed with a CD4 count ≥500 or in the absence of a CD4 count, a CD4 percent <14. Includes concurrent AIDS diagnoses and those that progressed to AIDS. PLHIVdX includes those labs from the previous 12 months. Suppressed includes viral load <100 cells/mL. Row percent of PLHIVdX as of 3/31/19. For HIV and AIDS diagnoses, age at diagnosis; for PLHIVdX and vi suppression, age at March 31, 2019. For HIV and AIDS diagnoses, residence at diagnosis; for PLHIVdX and vi suppression, residence at March 31, 2019. Includes Adams, Arapahoe, Boulder, Denver, Douglas, and Jefferson counties. Includes Boulder, El Paso, Larimer, Mesa, Pueblo, and Weld counties. Pediatric cases are individuals under age 13 years at the time of diagnosis. Identified Risk cases are residents of Adams County. Colorado Department of Public Health and Environment acknowledges that social, economic, and environmental inequities result in adverse health outcomes and have a greater impact than individual choices. Reducing health disparities through systems change can help improve opportunities for all Coloradans.

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HIV Trends among Gay Men and Other MSM

This fact sheet provides 2008-2017 trend data for HIV transmissions attributable to male to male sexual contact (MMSC), including individuals reporting both male to male sexual contact and injection drug use (MMSC/IDU).

Of the 4,791 new HIV diagnoses in California in 2017, 3,154 (65.8%) were attributable to male to male sexual contact (MMSC), including 3.5% MMSC/IDU.

Nearly half of new HIV diagnoses attributable to MMSC were Latinx.

Among new diagnoses attributable to MMSC, Black/African Americans had the highest rate.

Among new diagnoses attributable to MMSC in 2017, 80 percent were linked to care within one month of diagnosis and 65 percent were virally suppressed within six months of diagnosis. Compared to other transmission categories, MMSC new diagnoses are much closer to meeting the Getting to Zero (GTZ) 2021 health outcome objectives for linkage to care and viral suppression.

*Traditionally, disease rates take the form of "X number of cases per 100,000" of the population group specified. However, for some populations, such as MSM, it can be difficult to accurately estimate population denominators. For that reason, the rates reported on this fact sheet represent the number of MMSC cases per 100,000 males within the specified race/ethnicity and/or age group.

Source: California State Public Health Department intranet as of March 9, 2020:
https://www.cdph.ca.gov/Programs/CID/DDA/Pages/OA_case_surveillance_reports.aspx
Source - Primary Health Care Performance Initiative, https://improvingphc.org/surveillance
Appendix E:
Differences between Independent Type 1 and Advisory Type 2 Boards

The Administrative Organization Act of 1968 distinguishes between entities, including boards, that are independent and those that are advisory. The table below helps one determine if their entity is Type 1 or Type 2 by comparing the board enabling statute with the Act in CRS 24-1-105. Absent statutorily defined authority, the board acts in an advisory capacity to the department.

<table>
<thead>
<tr>
<th>Type-1 “Independent” Decision-making</th>
<th>Type-2 Advisory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administered under the direction/supervision of the principal department, but exercises its statutory powers, duties... independently of the head of the principal department (Section 24-1-105, C.R.S.).</td>
<td>Advisors that can assist the department as the department develops requirements and practices</td>
</tr>
<tr>
<td>Often Governor appointed, confirmed by the Senate.</td>
<td>Provide recommendations to the program area/Department</td>
</tr>
<tr>
<td>Type 1 boards often have rulemaking authority, and may have adjudicatory authority.</td>
<td>Often appointed by an Executive Director, his/her designee or by a Type 1 Board.</td>
</tr>
<tr>
<td>Consults and may coordinate with the Department prior to release or publication of any formal product of the board.</td>
<td>Any formal product of the board is reviewed by the Department prior to release or publication.</td>
</tr>
</tbody>
</table>

Source: CDPHE, Legal, Guidance and Review of Statutory Mandates for Boards and Board Members, Section II
Appendix F: Tip Sheet for HRSA Grantees


Each year, the Health Resources and Services Administration (HRSA) works with some of our federal recipients to return grant funds spent on unallowable costs. This impacts the recipient's ability to accomplish its important health mission. Here are some tips to help recipients avoid misspending grant funds on unallowable expenditures or activities:

**Common reasons for unallowable costs:**
- Not adequately documented (the most frequent)
- Not compliant
- Not reasonable
- Not related to the HRSA grant

**Stick to your plan**
- Use the approved grant application and budget as your guide to spending your HRSA grant funds.
- If you need to adjust your plan, contact your HRSA Project Officer and Grants Management Specialist.
- Track your actual use of HRSA funds and reconcile that with your approved plan. Reconciling frequently, quarterly or even monthly, will help you identify issues closer to when they occur, which makes them easier to address.

**Follow the flow**
- The flow of HRSA grant funds through your organization needs to be clear and well-documented. Ensure you can identify and provide accurate, current, and complete disclosure of each federal award you receive.
- Maintain written procedures for your accounting and financial management system practices.
- Separate employee responsibilities and, when possible, build in layers of review to help prevent issues of fraud, waste, or abuse. **NOTE:** Flow charts for procedures and responsibilities are helpful in providing a visual representation of your systems and can also highlight missing links or areas or practices that might be strengthened.

**Keep your receipts**
- Expenses must clearly document the flow of the money from the approved grant budget, to accounting records, to receipts and other supporting documentation.
- For activities not within the scope of your HRSA grant, ensure that your financial procedures identify, segregate, and track all costs associated with those activities so that they are NOT charged to the HRSA grant.

**Fix problems**
- Good planning and internal controls help you provide reasonable assurance that you are in compliance with the regulations and terms of each federal award received.
- You must have effective internal controls, including taking prompt action when instances of noncompliance are identified.
- Minor errors, such as unallowable costs accidentally charged to the federal award account, should be addressed as soon as they are identified. Consider having a pre-established procedure for addressing errors, such as writing a memorandum (with a management official's signature and date) explaining the error and the corrective actions.
- For more significant errors, such as charging the HRSA grant for something already paid for by another federal award or funding source, contact your HRSA Project Officer and Grants Management Specialist immediately for information on corrective actions and how to repay any misspent funds.

**Tools & resources**
- Want more information on managing your HRSA grants? Check out the Manage Your Grant webpage.
- For more information related to financial management, refer to Title 45 part 75 of the Code of Federal Regulations, the HHS Grants Policy Statement, and your Notice of Award terms and conditions.

Source: https://www.hrsa.gov/grants/manage-your-grant
Appendix G: Benchmarking Results

Benchmarking is an important tool in identifying ways to improve current procedures. Specifically, discussions with other state departments’ HIV/AIDS Programs can assist with identifying best practices and practical approaches to improving operations. Internal Audit conducted initial benchmarking conversations with various states’ HIV/AIDS Program, NASTAD and HRSA\textsuperscript{215} leadership. Internal Audit contacted NASTAD to identify specific states who receive federal and state dollars related to their HIV/STI Program. Although the results of these discussions are outlined below\textsuperscript{216}, the branch would benefit from further discussions with appropriate individuals when establishing new processes and implementing Internal Audit’s recommendations. Refer to the outlined information from the following state health department HIV/AIDS Program:

California:
- They no longer receive state dollars for the Program as of FY10 due to budget shortfalls. Prior to that timeframe, they did not separate out federal and state generated rebates. However, they developed a four-bucket system in approximately FY15 for their federal rebates; separated by coding inspired by NASTAD guidance\textsuperscript{217} and approved by HRSA after lengthy discussion and the sharing of their methodology. For example:
  - Bucket #1 reflects any rebates from federal dollars and is spent first
  - Bucket #2 refers to 340B and is considered 2\textsuperscript{nd} generation meaning that the rebate received back from bucket #1 goes into bucket #2
  - Bucket #3 include 1\textsuperscript{st} generation supplemental rebates\textsuperscript{218}
  - Bucket #4 include 2\textsuperscript{nd} generation funding, meaning that the rebate received back from bucket #3 and these dollars are used for HIV prevention such as PrEP, TAsP\textsuperscript{219}, and emergency funding in an outbreak.
- They expressed that it is a challenge to spend rebate dollars before Ryan White dollars but have determined a way through their procurement methods to better keep track and stay in line with the requirements. For example, they

\textsuperscript{215} HRSA leadership recommended the division review their online “Managing Your Grant” tips sheet. Refer to Appendix F for detail. Source: https://www.hrsa.gov/grants/manage-your-grant
\textsuperscript{216} The state of Maryland receives state dollars for their HIV/STI program. They did not respond to our requests for further information, however, per our discussions with NASTAD, Maryland is currently not separating out rebates generated from federal and state dollars and taking a conservative approach in putting all many back into the program.
\textsuperscript{217} NASTAD Rebate memo, July 2017
\textsuperscript{218} Supplemental rebates are provided by Gilliad and Merck Pharmaceuticals
\textsuperscript{219} Treatment as prevention (TasP) refers to HIV prevention methods and programs that use antiretroviral treatment (ART) to decrease the risk of HIV transmission, as stated at https://www.avert.org/professionals/hiv-programming/prevention/treatment-as-prevention
moved to zero dollar contracts so that they do not have to encumber funds and then bill for activity so there are no pre-encumbrances to spend down to zero.

- Ryan White dollars are dedicated to local public health agencies.
- They utilize the AES system\(^{220}\) that generates an invoice to contractors and then the Program pays the contractor, utilizing a fee for service model.\(^{221}\)
- They have a large volume of expenditures due to the number of individuals living with HIV in the state, approximately $140 million in ADAP and care services in FY19. Contracts are funded by enrollment fee schedules and then contract monitors review actual expenditure detail on site visits and sampled requested desk audits throughout the year.

**Indiana:**

- They do not separate out the rebate dollars based on the funding source that the rebates are generated from and take a conservative approach in ensuring that rebate dollars go back into the Ryan White service categories. They do receive state generated rebate funds.
- They determined that they were having trouble managing the rebates a few years back and trying to figure out how to spend them before utilizing the Ryan White dollars so they decided not to claim them for a while until they set up a proper approach for tracking, projecting and ensuring that they used the rebate dollars first.
- After deciding to claim them again, they hired a third party administrator to process and manage the rebates and then monitor the contract. In order to ensure that they utilize the rebate dollars prior to Ryan White funding, the third party administrator claims the rebates on behalf of the Program and then sends a check at the agreed upon time to avoid any timing issues.
- Since they receive many rebate dollars, they often revert federal funding back so that other states and organizations who have a higher need have enough funding. This is not viewed as a failure to the Program.
- They also created a foundation inside the department of health to monitor a lot of the HIV work and maintain the contracts. The foundation handles the contracts through them so that they do not have to adhere to the state procurement rules. These rebate funds are given to the foundation so that they are spent right away before federal funds.
- They utilize supplemental rebate dollars (those from Gilliad and Merck) to maintain one stop models, such as paying for Meals on Wheels, Volunteers of America related to mental health, substance abuse and Indiana Legal Services for legal advice for those living with HIV.

\(^{220}\) California Enhanced HIV/AIDS Case Reporting System
\(^{221}\) Sounds similar to the ECaST system the CDPHE WWC program utilizes.
Massachusetts:
- They do not separate out the rebate dollars based on the funding source that the rebates were generated from and take a conservative approach in ensuring that rebate dollars go back into the Ryan White service categories.
- They have a legislative cap on the amount of rebates that they can retain and plan their budgets accordingly.
- They receive state funding for the Program and use this towards PrEP. They discussed their approach with HRSA since they have interpreted the PrEP need to be HIV related services of care and prevention and that the community that needs PrEP services is very closely tied to the HIV community and not the general public.

New Mexico:
- They take a conservative approach and all Ryan White dollars, state and general fund dollars go back into the Ryan White service categories.
- They do not submit claims to the pharmaceutical companies for rebates. This is due to their small amount of Program staff and their concern and lack of understanding about how to track, project and utilize rebates in accordance with HRSA requirements.
- They developed a “revenue model” methodology that HRSA determined was acceptable. This model includes a program-contracted pharmacy, utilizing 340B pricing, who bills insurance companies the actual cost of the medication for them and then provides the pharmacy a check monthly. The Program then receives checks directly from the pharmacy at least quarterly.
- They utilize general fund dollars for hepatitis and hard reduction needs.
- A medical advisory committee meets two times per year and provides feedback for priority setting and drug use preferences. The legislature does not direct this committee; it is comprised of doctors, pharmacists and community members.
- They utilize CAREWare.

Washington State:
- They do not track the rebate dollars based on the funding source that the rebates were generated from; all rebate dollars conservatively go back into the Ryan White service categories. They have not received a finding related to this during their most recent HRSA site visit, as they take a conservative approach.
- The Program does receive state dollars, however, since 2015, they have directed those dollars to create and support the PrEP Drug Assistance Plan.
Appendix H: Management’s Responses

HIV/AIDS Program Performance Audit #2020-4

May 14, 2020

Internal Auditor

Please find attached the STI/HIV/VH Branch responses to the HIV-AIDS Program Performance Audit, April 2020.

We would like to acknowledge the large amount of information and documentation that was reviewed for this audit. At the same time, the Branch would like to acknowledge that the audit may be incomplete due to the short turn-around time in which to collect information and report it out, coupled with the limited audit timeframe (FY17-FY20). It is quite possible that some of the deficiencies noted in the audit were present before the audit timeframe. It should also be noted that in instances where information was not provided, it does not necessarily mean it did not, or does not exist.

Overall, the Branch agrees that improvements should be made around budgeting, contracting, personnel processes, strategic planning, transparency, and collaboration. However, it is important to note that the responses contained in this attachment belong solely to the STI/HIV/VH Branch. Disease Control and Public Health Response Division leadership, while offered the opportunity to review the Branch’s responses to the 56 identified deficiencies, did not do so, citing time constraints (leadership did provide feedback on the audit itself and this was shared with the auditor). Branch responses are also limited in that some of the findings relate to functions or processes that no longer reside within the Branch but in a centralized operations function connected to, but outside of, the Branch itself. In these instances, where the functions remain outside the Branch, the Branch cannot respond as to how these deficiencies will be addressed. The Branch also responded to the operational deficiencies - as if those responsibilities were to return to the Branch.

We find most of the recommendations address the implementation of basic standards for personnel, budget, accounting, and contracting processes. We look forward to working with our staff and community to make the proper and necessary improvements to address the audit recommendations.

Sincerely,

Karla McGowan
Deputy Executive Director
Director of Community Relations Division
Analysis of Management’s Response:

Overall, management agrees with the recommendations contained in this report. Internal Audit considers management’s comments responsive to the recommendations and believes that if implemented, these responses should resolve the concerns identified in this report.

Management Responses:

Recommendation No. 1:

Establish and implement formal written policies and procedures for all branch business practices, including, not but limited to:

a) Roles and responsibilities  
b) Figure setting  
c) Fiscal staff procedures  
d) Program staff procedures  
e) Invoice review and approval process  
f) Funding stream methodology  
g) Rebate tracking methodology  
h) Journal voucher preparation and review processes  
i) Indirect costs determination methodology  
j) Managing encumbrances  
k) Operations support  
l) Communications and interactions with central accounting  

Management Agrees, Partially Agrees, or Disagrees:  Agrees

Implementation Date:  December 31, 2020

Management Response:

We agree with this finding. We will ensure that appropriate manuals, desk manuals, processes and procedures, etc. will be put into place.

a) PDs, desk manuals, decision trees, training  
b) JBC, how to budget for rebate and use of the funds. Appropriate budgets in place.  
c) desk manuals, decision trees, training  
d) desk manuals, decision trees, training  
e) fiscal and programmatic priority planning, federal/state rules and standards
f) fiscal and programmatic priority planning, federal/state rules and standards

g) JV process

h) contract vs subrecipient form, decision trees, training

i) fiscal and programmatic priority planning, federal/state rules and standards

j) hiring plan

k) talk with others; processes and decision trees, training

**Recommendation No. 2:**

Create desk manuals for each position within the branch to support succession planning and to provide staff a reference for guidance.

Management Agrees, Partially Agrees, or Disagrees: **Agrees**

Implementation Date: December 31, 2020

Management Response:

Management agrees and will create templates for desk manuals and ensure they are completed. We will also create succession planning for each position.

Desk audits and work analysis; monitor job for 2 weeks.

**Recommendation No. 3:**

Provide adequate training to staff over the implemented policies and procedures, Ryan White specific grant requirements and desk manuals.

Management Agrees, Partially Agrees, or Disagrees: **Agrees**

Implementation Date: March 31, 2021

Management Response:

Management agrees and will ensure that appropriate training is provided for each position and employee, at all levels within the Branches. This will include both internal and external training, i.e. RW annual conference.

After desk manuals, desk audits and PDs are updated Training will occur with all levels of staff within the branches. A tracking mechanism will be created to ensure who has taken training and which trainings have been completed. Internal and external processes and rules.

**Recommendation No. 4:**

Review employee PDs and update as appropriate to align with current job duties.

Management Agrees, Partially Agrees, or Disagrees: **Agrees**

Implementation Date: December 31, 2020
Management Response:
Management agrees and will work with supervisors to update and/or create PDs. Desk audits and work analysis; monitor job for 2 weeks.

**Recommendation No. 5:**

Revise the branch/division organizational chart to reflect current staffing.

Management Agrees, Partially Agrees, or Disagrees: **Agrees**

Implementation Date: April 30, 2020

Management Response:

Management agrees, and for the STI/HIV/VH branch, an updated organizational chart is in place.

Post current Branch org chart and share with HR and staff Updated org charts will be shared and posted in a timely manner

**Recommendation No. 6:**

Mitigate change management problems with regard to the organizational changes by creating a change management plan, including implementation of a support structure and measuring the business impact of the changes.

Management Agrees, Partially Agrees, or Disagrees: **Partially Agrees**

Implementation Date: March 31, 2021

Management Response:

Management acknowledges that some staff were not happy with the restructure that took place in 2019. Staff were not involved in the decision making about the restructure and messaging was not clear on the reasons for the restructure. The branch has been trained on ADKAR and management will continue to utilize this model as well as others that may be appropriate for additional branch management changes.

Evaluate the current structure and determine if any changes should be made. Utilizing desk audits and work analyses to inform this process.

**Recommendation No. 7:**

Determine practical priority setting methodology for the department’s effective utilization of federal funding and rebate dollars prior to setting budgets. The branch/division should work with the advisory committees to determine priority setting. Document this methodology and train appropriate staff and advisory committee members.
Management Agrees, Partially Agrees, or Disagrees:  **Agrees**

Implementation Date: September 30, 2020

Management Response:

Management agrees. A timeline already is in place with internal staff and with community advisory boards and community. We are also partnering with Part A to ensure a thoughtful and appropriate Statewide Coordinated Statement of Need (SCSN). Guidance from HRSA, NASTAD and CDC will be utilized as needed.

https://drive.google.com/file/d/1l_k7qZIYAnOjEHib6TwMPs0Np5k9Qy5u/view?usp=sharing

**Recommendation No. 8:**

Develop branch/division specific performance measures, for use in the priority setting process, and in overall branch goal setting. Consider developing a dashboard for proactive communication and public transparency.

Management Agrees, Partially Agrees, or Disagrees:  **Agrees**

Implementation Date: January 1, 2022

Management Response:

Management agrees and goals and strategies exist in the COHAS for HIV and a dashboard is in development to share status of the goals. A new SCSN and COHAS is in development and will be produced in alignment with federal standards i.e. 1/1/2022. A RFP has been developed and released by Part A. A contractor will be in place in June 2020. That contractor will first develop the SCSN through 2020. The COHAS will then be developed with internal staff, community and the community advisory boards through fall 2021. The integrated plan will be shared with our federal partners Fall 2021 and be the new plan will be in effect 1/1/2022. For STI and VH, goals need to be developed and a method for tracking and monitoring those goals.

A RFP has been developed and released by Part A. A contractor will be in place in June 2020. That contractor will first develop the SCSN through 2020. The COHAS will then be developed with internal staff, community and the community advisory boards through fall 2021. The integrated plan will be shared with our federal partners Fall 2021 and be the new plan will be in effect 1/1/2022. Management will work with internal staff and community groups for the development of STI and VH goals and the best way to visually represent those goals.

**Recommendation No. 9:**

Continue to work through challenges that contractors have when submitting client data in order to properly report to the federal government.
Management Agrees, Partially Agrees, or Disagrees: **Agrees**

Implementation Date: April 30, 2020 and then ongoing for each annual submission

Management Response:

Management agrees and the data team will continue to provide technical assistance throughout this reporting period. Training and development as well as technical assistance will be an ongoing process. Training will also take place with contract monitors to ensure an understanding of the data reporting requirements so they can enforce with the contractors.

Support staff in the completion of the RSR due 4/30/2020. Work with staff to determine needs for the future concerning the submission of the RSR. Work with contract monitors so they understand the data requirements so that they can verify that information is being added to the system in a timely manner by contractors. Work with contract monitors to ensure enforcement of data submission requirements by contractors. Work with contract monitors so they know when technical assistance is needed by contractors and staff can provide individual and/or group TA as needed.

**Recommendation No. 10:**

Consider utilizing a different database or procuring a new system in order to effectively and efficiently keep track of client data.

Management Agrees, Partially Agrees, or Disagrees: **Agrees**

Implementation Date: January 31, 2021

Management Response:

Management agrees and the creation of a new data system is already in development with staff input. The new system will house RW data, STI, HIV and laboratory data. Contractor input has been solicited and will continue to be solicited for the outward facing portions of the system, i.e. RW data.

Continue to have internal teams work with informatics group for the requirements and development of the new data system. Conversations will be held with the fiscal/operations group to explore consistency across this system and CORE.

**Recommendation No. 11:**

Retain all documentation as required in the Statewide Records Management Manual and submit a revised version of the branch retention schedule for approval.

Management Agrees, Partially Agrees, or Disagrees: **Agrees**

Implementation Date: October 31, 2020
Management Response:

Management agrees and recognizes the need for updating retention schedules for the branch. There was an email dated February 7, 2020 stating that the DCEED Policy and Performance team was creating a plan for updating retention schedules.

Shannon Rositer has been tasked to work on this for DCPHR and has set a meeting in July to work through this, including Monica Wilkerson. Due to COVID response the Division meeting was reschedule to later in the year. However, a branch specific meeting will take place in May.

**Recommendation No. 12:**

Develop a methodology to encumber funds that is consistent with the department fiscal procedures manual and state fiscal rules. Document this methodology and provide training to appropriate staff.

Management Agrees, Partially Agrees, or Disagrees:  **Agrees**

Implementation Date: December 31, 2020

Management Response:

Management agrees and recognizes that there is a need for a change in how funds are encumbered in contracts. All processes developed will be in accordance with Department standards and the Department fiscal procedures manual.

Use the Department fiscal procedures manual as a base for the development of the processes for the operations team, i.e. standardizing line descriptions. Creation of supporting documentation and a training plan developed by operations and in communication/collaboration with STI/HIV/VH branch staff.

**Recommendation No. 13:**

Revise contracts related to this Program to include only one funding stream and/or one budget period to simplify the contracts, the monitoring process and to promote greater accountability with the contractor.

Management Agrees, Partially Agrees, or Disagrees:  **Partially Agrees**

Implementation Date: December 31, 2020

Management Response:

Management partially agrees with this. Each contract will be looked at and aligned with intention of the funding source; this could include a contract with multiple funding sources if the activities are in alignment.

Contracts will be reviewed for the activities involved and STI/HIV/VH staff will work
with Operations staff to streamline contracts where possible. However, if activities are not in alignment and different funding sources are utilized, separate contracts will be developed.

**Recommendation No. 14:**

Develop and implement written procedures to mitigate the risk of statutory violations and reduce instances of work outside of a commitment voucher.

Management Agrees, Partially Agrees, or Disagrees:  **Agrees**

Implementation Date: December 31, 2020

Management Response:

Management agrees and will ensure that appropriate desk manuals and procedures will be put into place to mitigate risk. This includes both programmatic and operational oversight and checks and balances.

- PDs, desk manuals, decision trees, training
- Appropriate budgets in place.
- Fiscal and programmatic priority planning, federal/state rules and standards
- Talk with others to ensure appropriate training and defined roles and responsibilities
- Tracking mechanisms and notification about contracts start/end dates and other reminders about the status of the contract

**Recommendation No. 15:**

Develop and implement written procedures to ensure that the RFA process is in accordance with department guidance.

Management Agrees, Partially Agrees, or Disagrees:  **Agrees**

Implementation Date: December 31, 2020

Management Response:

Management agrees and will align DCPHR/STI/HIV/VH procurement processes with CDPHE procurement protocols.

- Operations and STI/HIV/VH team will be trained on procurement protocols
- Written procedures will be completed in alignment with CDPHE procurement rule (which may include using the CDPHE rules and developing a branch specific protocol document for any procurements specific to the branch i.e. CHAPP)
Recommendation No. 16:

Work with central accounting to determine and implement appropriate revised coding in CORE to ensure proper tracking all funding streams, rebate types, expenditures and appropriate reporting requirements. Additionally:

a) Provide training to all necessary staff on how to utilize the new coding structure
b) Conduct regular reviews in order to ensure proper use of the coding.

Management Agrees, Partially Agrees, or Disagrees:  Agrees

Implementation Date: July 1, 2020

Management Response:

Management agrees and is currently in the process of changing CORE coding to align with central accounting rules and practices.

All staff using CORE and staff within the STI/HIV/VH branch with fiscal oversight will be trained on chart of accounts and new coding for all funding sources.

Recommendation No. 17:

Develop criteria and written procedures for staff to prepare journal entries, including a standard description methodology, attached supporting documentation, supervisor reviews and a clear trail of the accounting adjustment.

Management Agrees, Partially Agrees, or Disagrees:  Agrees

Implementation Date: December 31, 2020

Management Response:

Management agrees and recognizes the need for a standard JV process including defined supporting documentation requirements and supervisory approval.

- Creation of process for JVs that is part of the desk manuals and roles and responsibilities.
- All fiscal receive training on the determined process.
- Monthly fiscal and programmatic meetings between program and operations staff will allow for the recognition of issues prior to the need for some of the JVs

Recommendation No. 18:

Consider a self-imposed cap or threshold for MSA fund balances in conjunction with priority setting and budget preparation to assist in meeting spending goals. Work with the
advisory committees to determine needs, goals for the budget period and the definition of an adequate reserve. Document these procedures and re-evaluate as needed.

Management Agrees, Partially Agrees, or Disagrees:  **Agrees**

Implementation Date: September 30, 2020

Management Response:

Management agrees and recognizes the need for consensus with CABs about the cap for MSA fund balances. Current priority setting discussions are underway with CABs and community and will include goals for the budget period, priority setting, and defining adequate reserves.

- Continue with priority setting timeline with CABs which is scheduled to be completed by September 2020
- Explore the adequate reserve discussion with the Alliance Fiscal Advisement Work Group

**Recommendation No. 19:**

Actively research other funding opportunities for innovative projects related to HIV/AIDS, Hepatitis C, PrEP, IV drug use, etc. so that funding streams can be better aligned.

Management Agrees, Partially Agrees, or Disagrees:  **Agrees**

Implementation Date:  July 1, 2020 and ongoing

Management Response:

Management agrees and will continue to encourage staff to explore other funding opportunities with leadership.

STI/HIV/VH leadership will formalize the process and decision tree for new funding opportunities in alignment with CDPHE rules. Considerations include appropriateness of funds, deliverables, new FTE and space.

**Recommendation No. 21:**

Develop and implement written budgeting and tracking procedures to avoid overcommitting rebate funding in contracts.

Management Agrees, Partially Agrees, or Disagrees:  **Agrees**

Implementation Date:  July 31, 2020
Management Response:

Management agrees and is currently developing working budgets and dashboards to track personnel, contractor spending, and anticipated changes. This will include standard process documents to outline expectations of staff.

- Budget development through the use of a standard budget template moving forward. Desk manuals/PDs will include any fiscal responsibility related to budget development and/or budget maintenance
- Standard reporting dashboard will be created to track spending related to each budget and will include personnel, contractual, as well as any other category defined in the budget
- Operations reporting back to program staff and/or Branch Chief about the status of funds. Branch leadership will update federal partners as appropriate.

Recommendation No. 22:

Develop and implement written procedures to effectively budget funding so that carryovers and rebates are spent prior to other federal funding to avoid unintended reversion.

Management Agrees, Partially Agrees, or Disagrees: Agrees

Implementation Date: July 31, 2020

Management Response:

Management agrees and is currently developing working budgets and dashboards to track personnel, contractor spending, and anticipated changes. This will ensure that all budgets are tracked in real time in order to anticipate any carryover or possible reversions.

- Budget development through the use of a standard budget template moving forward.
- Desk manuals/PDs will include any fiscal responsibility related to budget development and/or budget maintenance
- Standard reporting dashboard will be created to track spending related to each budget and will include personnel, contractual, as well as any other category defined in the budget
- Operations reporting back to program staff and/or Branch Chief about the status of funds. Branch leadership will update federal partners as appropriate.
**Recommendation No. 23:**

Develop and implement written procedures to ensure proper tracking and the accuracy of federal and state supplemental rebates since they are to be used for different purposes.

Management Agrees, Partially Agrees, or Disagrees: **Agrees**

Implementation Date: July 31, 2020

Management Response:

Management agrees and is currently developing working budgets and dashboards to track personnel, contractor spending, and anticipated changes. This will ensure that all budgets are tracked in real time in order to anticipate any carryover or possible reversions.

- Budget development through the use of a standard budget template moving forward. Desk manuals/PDs will include any fiscal responsibility related to budget development and/or budget maintenance
- Standard reporting dashboard will be created to track spending related to each budget and will include personnel, contractual, as well as any other category defined in the budget
- Operations reporting back to program staff and/or Branch Chief about the status of funds. Branch leadership will update federal partners as appropriate.

**Recommendation No. 24:**

Continue to research best practices in projecting rebate dollars and utilize projections in the branch’s budgeting methodology. Also, consider asking individual pharmaceutical companies if rebate checks can be converted to an EFT payment to deliver these rebates directly into the department bank account in order to expedite receipt of the rebate check and promote efficiency.

Management Agrees, Partially Agrees, or Disagrees: **Agrees**

Implementation Date: October 31, 2020

Management Response:

Management agrees and is currently exploring the best methods for rebate projection as well as the ability to receive any rebate revenue through EFT (some rebate providers are not willing to provide payment through EFT).

- Staff have been tasked with discussing EFT payment with each pharmaceutical company.
- Staff will explore the need for an actuary AND/OR historical income when determining yearly rebate projections
**Recommendation No. 25:**

Consider contacting technical assistance support from HRSA and NASTAD on developing procedures and strategies to assist in funding stream and rebate tracking management. Also, consider other training such as webinars, conferences, and seminars to further the branch and division’s understanding of the Ryan White Part B Program requirements.

Management Agrees, Partially Agrees, or Disagrees: **Agrees**

Implementation Date: December 31, 2020

Management Response:

Management agrees and is currently consulting with NASTAD and HRSA for technical assistance. Consultation will continue as new questions and needs are identified. Leadership and staff will identify trainings provided by NASTAD, HRSA, and other partners.

- Continued consultation with NASTAD (Tim Horn)
- Continued consultation with HRSA (Captain Edelman)
- Ryan White conference (may be postponed and/or virtual due to COVID)
- Anticipated site visit from Ryan White in 2021 (may be postponed due to COVID)

**Recommendation No. 26:**

In cooperation with the advisory committees, determine a reasonable methodology for using the category #4 state supplemental rebate dollars that includes consideration of a conservative approach of putting the funding back into the ADAP Program or a more innovative approach. Document any innovative methodology and consider conferring with NASTAD and/or HRSA prior to implementation.

Management Agrees, Partially Agrees, or Disagrees: **Agrees**

Implementation Date: December 31, 2020

Management Response:

Management agrees and STI/HIV/VH and Operations leadership are currently developing a funding matrix in partnership with the CABs that will outline agreed upon allowable expenses for state supplemental rebate, as well as all other funding sources. This will be used in priority setting and will serve as guidance moving forward for all staff.

- Finalize funding matrix and defined allowable expenses for all funding sources with the Alliance Fiscal Advisement Work Group and all CABs
**Recommendation No. 27:**

Develop and implement written procedures to ensure that proper legal spending authority is accurate in CORE and that reconciliations occur to identify differences in grant budgets and spending authority to avoid overcommitting of funds.

Management Agrees, Partially Agrees, or Disagrees: **Agrees**

Implementation Date: July 1, 2020

Management Response:

Management agrees and is currently in the process of changing CORE coding to align with central accounting rules and practices. This will ensure that grant budgets are held to the legal limit in CORE.

- Been in development over the past year; anticipated completion date of 7/1/2020.
- Outstanding funding streams include Ryan White (FY20) and Standard Rebate (FY20).
- Operations reporting back to program staff and/or Branch Chief about the status of funds and what data is in CORE and providing CORE reports, at least quarterly. This may also include the use of dashboards.

**Recommendation No. 28:**

Develop and implement written procedures to ensure that carryover funds are used for the purpose intended, as provided in the HRSA electronic handbook.

Management Agrees, Partially Agrees, or Disagrees: **Agrees**

Implementation Date: September 30, 2020

Management Response:

Management agrees and will use the priorities identified during priority setting with staff, CABs, and community when requesting carryover.

- Work with community and staff to complete priority setting.
- Create approval process for fiscal and branch program staff and/or Branch Chief with program having sign off on all spending. These approvals will be documented and saved.
- Complete desk manuals and training for staff, including training on EHB.
**Recommendation No. 29:**

Develop and implement written procedures to ensure timely reimbursement payment to contractors and criteria to determine priority of reimbursement if needed.

Management Agrees, Partially Agrees, or Disagrees: **Agrees**

Implementation Date: December 31, 2020

Management Response:

Management agrees and will work to ensure that appropriate manuals, desk manuals, processes and procedures, etc. will be put into place. We will also ensure that any funds encumbered in a contract are available for reimbursement to the contractor.

- PDs, desk manuals, decision trees, training
- Hiring plan
- Ensure that funding is available before entering into a contract

**Recommendation No. 30:**

Develop and implement procedures to ensure that the department maintains control over the funding source used for expenditures paid to contractors and provide training to contractors related to the limitations of such funding sources.

Management Agrees, Partially Agrees, or Disagrees: **Agrees**

Implementation Date: December 31, 2020

Management Response:

Management agrees and will work to develop standardized and appropriate monitoring and evaluation protocols for contracts in alignment with CDPHE rules/standards. This will include training for both staff and contractors on allowable expenses, required documentation, data collection requirements, and evaluation processes.

- Updated PDs, desk manuals, decision trees, training for staff
- Hiring plan
- Creation of a standard training for contractors (variations may include different requirements per a funding source)
- Standard invoice template development
- Standard evaluation process
**Recommendation No. 31:**

Develop and implement procedures related to improving the branch’s preparation and use of Official Function Forms. These should include the manner in which they will be used, requiring one event per request form, identifying the proper funding streams and coding used, and requiring an attached list of attendees.

Management Agrees, Partially Agrees, or Disagrees: **Partially Agrees**

Implementation Date: July 31, 2020

Management Response:

Management partially agrees that more supporting documentation is necessary for each OFF event, including attendance lists. We would like to explore if an overall OFF can be used for meetings that occur monthly/more regularly with adequate tracking/supporting documentation.

- Staff will research standard process for OFF through CDPHE rule/standards, including federal rules/standards and ensure that branch staff are aware and trained of the OFF process.
- Supporting document requirements will be implemented for OFF utilization and reconciliation will occur for all OFFs

**Recommendation No. 32:**

Ensure that only department-approved methods of payment are used in expending funds to vendors and that adequate supporting documentation for all p-card activity is properly maintained and submitted to central accounting timely.

Management Agrees, Partially Agrees, or Disagrees: **Agree**

Implementation Date: July 31, 2020

Management Response:

Management agrees and will only use approved methods of payment moving forward and will require adequate supporting documentation before any purchases are made.

- Staff training to understand the appropriate payment methods (both Operations and STI/HIV/VH staff)
- Staff training to understand allowable activities (i.e. food, gift cards, etc.)
**Recommendation No. 33:**

Ensure that adequate contract monitoring procedures are performed as appropriate per their risk rating. As necessary, increase the risk ratings in order to perform a more thorough and extensive review.

Management Agrees, Partially Agrees, or Disagrees:  **Agrees**

Implementation Date: December 31, 2020

Management Response:

Management agrees and will be implementing standard processes and requirements for supporting documentation from contractors, including expanded documentation for those contractors deemed a higher risk. Risk will be evaluated on a yearly basis and expectations around that evaluation will be clearly communicated to contractors at the beginning of their contract period.

- CDPHE standardized contract manual will be consulted; all staff will be trained/retrained on the process
- Hiring plan for operations; the work cannot be adequately completed without staff
- Evaluation expectations will be clearly communicated to contractors during post-award meetings
- Standard supporting documentation will be added to all contracts starting 1/1/2021 - requirements will be different based on risk

**Recommendation No. 34:**

Perform a detailed analysis of expenditures to identify and document any unallowable and/or further questionable costs paid out with HIV/STI related funding. Based on the results of this analysis, correct funding errors in CORE.

Management Agrees, Partially Agrees, or Disagrees:  **Agrees**

Implementation Date: July 31, 2020

Management Response:

Management agrees and is currently developing working budgets and dashboards to track personnel, contractor spending, and anticipated changes. This will ensure that all budgets are tracked in real time in order to identify any unallowable charges and to correct those charges.

- Budget development through the use of a standard budget template moving forward. Desk manuals/PDs will include any fiscal responsibility related to budget development and/or budget maintenance
- Standard reporting dashboard will be created to track spending related to each budget and will include personnel, contractual, as well as any other category defined in the budget and shared in monthly meetings with Branch staff
- Regular meetings between fiscal/contracts staff and programmatic staff for check-ins

**Recommendation No. 35:**

Consider requesting a refund from contractors for disallowed costs or arrange to net the questionable costs from future invoices. Ensure proper tracking of refunds or netted amounts to the correct funding stream.

Management Agrees, Partially Agrees, or Disagrees: **Agrees**

Implementation Date: January 31, 2021

Management Response: Management agrees. Using the definition provided by the auditor for a questionable expense, the Branch will review the contracts in question for next steps.

**Recommendation No. 36:**

Consider requesting a refund from other programs and divisions within the department related to funding given for salaries and purchases, in addition to funding directed to them for use in contracts. Ensure proper tracking or refunds to the correct funding stream.

Management Agrees, Partially Agrees, or Disagrees: **Agrees**

Implementation Date: January 31, 2021

Management Response: Management agrees. Using the definition provided by the auditor for a questionable expense, the Branch will review the contracts in question for next steps.

**Recommendation No. 37:**

Develop and implement encumbrance monitoring procedures to avoid letting contracts expire with encumbered but unspent funds.

Management Agrees, Partially Agrees, or Disagrees: **Agrees**

Implementation Date: December 31, 2020
Management Response:

Management agrees and recognizes that there is a need for a change in how funds are encumbered in contracts. All processes developed will be in accordance with Department standards and the Department fiscal procedures manual.

- Use the Department fiscal procedures manual as a base for the development of the processes for the operations team, i.e. standardizing line descriptions.
- Collaborate with Department fiscal staff on the development of these processes
- Creation of supporting documentation and a training plan for operations and STI/HIV/VH branch staff.

**Recommendation No. 40:**

Ensure that appropriate contract monitoring procedures are performed sufficiently for any medium or high-risk contractors, as stated in the risk assessment tracker to be compliant with department contract monitoring procedures.

**Management Agrees, Partially Agrees, or Disagrees:**  Agrees

**Implementation Date:** December 31, 2020

Management Response:

Management agrees and will be implementing standard processes and requirements for supporting documentation from contractors, including expanded documentation for those contractors deemed a higher risk. Risk will be evaluated on a yearly basis and expectations around that evaluation will be clearly communicated to contractors at the beginning of their contract period.

- CDPHE standardized contract manual will be consulted; all staff will be trained (possibly retrained) on the process
- Hiring plan for operations; the work cannot be adequately completed without staff
- Evaluation expectations will be clearly communicated to contractors during post-award meetings
- Standard supporting documentation will be added to all contracts starting 1/1/2021 - requirements will be different based on risk

**Recommendation No. 41:**

Review current contract-monitoring procedures and revise to add HRSA’s National Contract Monitoring Universal procedures, for both program, compliance and fiscal monitors and to the department contract monitoring procedures.

**Management Agrees, Partially Agrees, or Disagrees:**  Agrees

**Implementation Date:** December 31, 2020
Management Response:

Management agrees and will work to ensure Division contract procedure documentation/manual includes HRSA and CDC contract monitoring procedures.

- Review CDC and HRSA contract monitoring procedures and integrate them into current contract monitoring procedures.
- Hiring plan for operations; the work cannot be adequately completed without staff

**Recommendation No. 42:**

Review the CPMU December 2019 Compliance Improvement Plan and implement the corrective action items for all contracts. Ensure that these items in the branch specific contract monitoring revised procedures.

Management Agrees, Partially Agrees, or Disagrees: **Agrees**

Implementation Date: December 31, 2020

Management Response:

Management agrees and will implement the correct action items from the compliance improvement plan.

- Operations will review the corrective action items and put processes in place to correct.
- Operations staff will implement and enforce the processes

**Recommendation No. 43:**

Review the CFDA #93.917 requirements in the OMB Compliance Matrix revised 2017 and update written procedures and processes to incorporate improvements to these areas. This will assist in preparation for the next Single Audit performed by the Colorado Office of the State Auditor.

Management Agrees, Partially Agrees, or Disagrees: **Agrees**

Implementation Date: December 31, 2020

Management Response:

Management agrees and will implement OMB compliance matrix and update written procedures and processes.

- Operations will review the OMB compliance matrix and put processes in place.
**Recommendation No. 44:**
Assess contract monitoring staff needed to provide the necessary contracting services and adjust as necessary to allow for more robust contract-monitoring. Provide detailed program training to contract monitors to ensure a thorough understanding of the Ryan White grant requirements and rebate restrictions.

Management Agrees, Partially Agrees, or Disagrees: **Agrees**

Implementation Date: December 31, 2020

Management Response:
We agree with this finding. We will ensure that appropriate manuals, desk manuals, processes and procedures, etc. will be put into place.

- Desk manuals, decision trees, training and hiring plan

**Recommendation No. 45:**
Consider assigning contract monitors to various branches so that they have a more specialized skill set over the program and arrange for rotation every three or five years to avoid the appearance of inappropriate relationships with the contractors.

Management Agrees, Partially Agrees, or Disagrees: **Partially Agrees**

Implementation Date: December 31, 2021

Management Response:
Management partially agrees. There is very specific knowledge that is necessary to oversee the contracts in the STI/HIV/VH Branch so moving people in and out across branches creates a deficit in knowledge and creates undue burden. However, we do think it is important to move branch contract monitors to oversee different contracts over time to allow for redundancy, learning and to allow for no appearance of inappropriate relationships or bias.

This can only be completed over time. We first need to have a fully staffed contract monitoring team who is fully trained. Once that is in place, we can work on creating redundancy of knowledge amongst that team.
**Recommendation No. 46:**

Finalize the “Drug Diversion Policy” and include routine internal reviews of each registered pharmacy for compliance with 340B requirements, and conduct quarterly reviews of the virtual inventory to reconcile with claims, shipment records and wholesaler records.

Management Agrees, Partially Agrees, or Disagrees:  **Agrees**

Implementation Date: July 31, 2020

Management Response:

Management agrees that having a "drug diversion policy" is important and will allow for increased oversight of the 340B program. Management will create finalize the policy.

- Finalization of drug diversion policy that includes best practices from NASTAD
- Creation of algorithms of the process to allow for proper monitoring
- Ensure contract with Ramsell includes monitoring for drug diversions and oversight of the 340B program

**Recommendation No. 47:**

Develop and implement written procedures to ensure the planning of the FFR reporting occurs timely so that proper support and reconciliations can be reviewed to ensure that accurate data is reported to HRSA. Additionally, work with central accounting to align branch/division procedures with department procedures.

Management Agrees, Partially Agrees, or Disagrees:  **Agrees**

Implementation Date: July 31, 2020

Management Response:

Management agrees that the written policies for FFRs is necessary and important. The reconciliation of FFR to CORE coding elements/chart of account elements is necessary to ensure program requirements are in alignment with fiscal requirements.

- Coding elements are needed in CORE to reconcile FFRs
- Development of policies that can be added to procedural manuals
- Monthly meetings between Operations and STI/HIV/VH Branch to review status of the grants and timelines will allow teams to catch concerns in a more timely manner.
- Review of final FFR by STI/HIV/VH program staff and/or branch chief before submission.
**Recommendation No. 48:**

Work with central accounting to develop and implement written access procedures to periodically review the Electronic Handbook and:

a) Remove employees’ access rights who no longer need access, such as those who have left the branch, division or department, as appropriate.

b) Ensure that appropriate contact information is included within the Electronic Handbook so that the correct individuals receive important notifications.

Management Agrees, Partially Agrees, or Disagrees:  **Agrees**

Implementation Date: July 31, 2020

Management Response:

Management agrees and has already been working with HRSA to ensure the correct personnel are listed in EHB. However, changes requested have not been implemented. Management will continue to monitor the system and continue to ask for updates as necessary. Management will include this point as part of the Division off boarding process.

- Review EHB to ensure that recently requested changes have been implemented by HRSA. If not, request again.

- Creation of a branch specific off boarding document, alongside HR's document, that is specific to "point of contact" and data system accesses to be removed or changed.

**Recommendation No. 49:**

Provide surveys to contractors in order to determine their data needs and what type of data reporting they would like to see on the CDPHE website. Determine if the branch can meet these needs and create a strategic plan related to practical and relevant data sharing and transparency. Consider creating an inner/outward facing page in order to view dashboard detail.

Management Agrees, Partially Agrees, or Disagrees:  **Partially Agrees**

Implementation Date: April 30, 2020 and ongoing

Management Response:

Management partially agrees with this recommendation. The Branch believes in the importance of the data products being useful to community and contractors. The data team has already been in communication with community about what data products are available, access to that data and limitations of the data. Interactive data dashboards have been created and shared with local public health departments. Management will continue the ongoing dialogue with community about data products.
- The data team will continue to create interactive data dashboards and determine new ways in which this data can be used and shared.
- Staff will continue to evaluate data products available from other states and assess other ways to present STI/HIV/VH data.
- Staff will incorporate the information learned from these processes and alter data reports as needed.
- Data reports that are more up to date than referenced in the audit can be found at: https://www.colorado.gov/pacific/cdphe/sti-hiv

Recommendation No. 50:

Develop written methodologies for current labor distribution allocations for all positions that are paid from HIV/STI related funding to ensure that funding is appropriate, reasonable and in compliance with regulations and grant requirements. Maintain accurate record of any changes. Ensure that KRONOS time codes are accurately used and provide training to employees as necessary.

Management Agrees, Partially Agrees, or Disagrees: Agrees

Implementation Date: April 30, 2020 and ongoing

Management Response:

Management agrees and personnel budgets are being finalized. Management is already in the process of cleaning up Kronos codes and cleaning up options of what staff can select, making those codes be more intuitive to the user about which funding stream is being selected. Staff will also be trained on proper use of Kronos and codes.

- Staff will finalize personnel budgets - Personnel budgets will be shared with staff
- Operations staff will complete Kronos clean up and develop a guidance document for the proper use of the different Kronos codes.
- Staff will be trained on the proper use of Kronos codes and use of the guidance document.

Recommendation No. 51:

Conduct an analysis of discretionary pay provided to employees that was paid from HIV/STI Program related funding and ensure that the funding used was appropriate, reasonable, and in compliance with regulations and grant requirements.

Management Agrees, Partially Agrees, or Disagrees: Agrees

Implementation Date: July 31, 2020
Management Response:

Management agrees that all funding sources should be spent on appropriate personnel and will ensure that pay differentials are for staff supporting HIV/STI/VH activities.

- Moving forward, pay differentials will only be allowed at the % a person is working for the STI/HIV/VH branch.
- A guidance document outlining necessary information and approval process for a pay differential will be created in alignment with CDPHE rules/standards.

**Recommendation No. 52:**

Collaborate with the SDAP advisory committee in finalizing the bylaws, including conflict of interest precautions, voting rules, membership criteria and clarity in roles and responsibilities and post on department webpage for transparency.

**Management Agrees, Partially Agrees, or Disagrees:**  **Agrees**

**Implementation Date:** December 31, 2020

**Management Response:**

Management agrees and has already started discussions with the SDAP Co-Chairs about the need for bylaws. Management will work to solidify a timeline for completion of the bylaws in consultation with the SDAP Co-Chairs and the CDPHE legal team.

- Consult with CDPHE Legal team about creating standard requirements for bylaws (including requirements from house bill about advisory committees)
- Will ask SDAP Co-Chairs to produce previous bylaws

**Recommendation No. 53:**

Work with the SDAP advisory committee to periodically conduct a cost-benefit analysis to determine the most cost effective approach for purchasing medications, which should include the costs of medications and all administrative costs and fees associated with purchasing and distribution.

**Management Agrees, Partially Agrees, or Disagrees:**  **Partially Agrees**

**Implementation Date:** December 31, 2020

**Management Response:**

Management partially agrees. A cost analysis is done each time an individual signs up for a plan. Management agrees that an important role with SDAP is to review, perhaps annually, the most cost effective approach to purchasing medications and utilizing health insurance plans.
- CDPHE will work with internal staff
- CDPHE will consult with Co-Chairs
- CDPHE will consult with NASTAD

**Recommendation No. 54:**

Collaborate with the advisory committees in determining which financial and programmatic information is necessary for priority and goal setting, and relevant decision-making.

Management Agrees, Partially Agrees, or Disagrees: **Agrees**

Implementation Date: September 30, 2020

Management Response:

Management agrees and is currently working with staff, CABs, and community members to determine the necessary methodology, timeline, and supporting documentation for priority setting.

- Establish timeline and needs for priority setting with staff and community

**Recommendation No. 55:**

Develop a timely action plan for identified areas of concern, along with milestone due dates, to ensure timely implementation and communicate this action plan as appropriate to promote accountability and transparency.

Management Agrees, Partially Agrees, or Disagrees: **Agrees**

Implementation Date: April 30, 2020

Management Response:

Management agrees and will have an action plan and next steps in place by 4/30/2020.

- Audit shared with Branch Program managers and some supervisors on 5/4/20
- Final audit will be shared with branch staff and community on 5/15/20
- Audit will be presented to branch staff on 5/20/20
- Audit will be presented to community, CABs on 5/21/20
Management Responses:

Other Suggestions for Consideration:

57. Consider the following about rebates:

a) Purchase a grant management system for the Program using rebate dollars.
b) Only participate in the rebate program with certain pharmaceutical companies rather than all to control the funding stream with smaller projections.
c) Not participating in the rebate program for a certain length of time to focus on getting the funding streams updated in CORE, reprioritizing goals and priority setting, long range budgeting and determining how many dollars the Program actually needs in funding, etc.
d) Not participating in the rebate program at all due to Program requirements, staffing size and complexity of tracking and projections.
e) Not separating out federal and state generated rebate dollars and only using rebates for Ryan White purposes with the priority of putting the funding back into ADAP.

Management Agrees, Partially Agrees, or Disagrees: Disagrees

Implementation Date: December 31, 2020

Management Response:

Management does not agree with these recommendations in their entirety. They will be considered and referenced during further planning for the Branch.

58. Consider the following about the Program:

a) Seek further statutory revisions related to the use of the MSA dollars and state generated rebates dollars as appropriate.
b) Hire a third party administrator to manage the rebates.
c) Collaborate or seek information from the Department of Health Care Policy and Financing since they administer Medicaid and have experience with rebates to help form the CDPHE model going forward.
d) Refer to Appendix G for state benchmarking results for additional ideas.

Management Agrees, Partially Agrees, or Disagrees: Partially Agrees

Implementation Date: December 31, 2020

Management Response: Management does not agree with these recommendations in their entirety. They will be considered and referenced during further planning for the Branch.
Management Responses:

Central Accounting Unit:

Internal Audit also provided the following recommendations for CDPHE’s Central Accounting Unit related to enhancing oversight and official function forms.

**Recommendation No. 20:**

Enhance oversight process over divisions’ financial transfers and JV procedures.

Management Agrees, Partially Agrees, or Disagrees: *Agrees*

Implementation Date: September 30, 2020

Management Response:

We believe that Central Accounting has already made some strides in this regard. Historically, journal entries have primarily gone through a Controller-level review prior to it being approved. We are currently working on instituting a change where the respective grant accountants will be responsible for reviewing and approving journal entries for their assigned Division. Prior to implementing this, one of accounting’s new supervisors will be conducting a training to accounting staff for things to consider when reviewing a journal entry. We believe that this will spread some of the workload and will place the responsibility on staff that oversee more of the day-to-day activities of their respective programs.

Additionally, a change was recently implemented in the Department that required a second-level review at the division. [This document](#) shows the step-by-step process and is linked from the Department Fiscal Procedures Manual Section 4.17. The Department currently has a request pending with the CORE Governance Committee to add an additional level of review for all journal entries within CORE. If approved, accounting will likely request that level 1 approvals (Division-level approvals) will be required in the system prior to routing for final accounting review.

**Recommendation No. 38:**

CDPHE Official Functions and Purchase of Food and Beverages Policy 1.3:

a) Reduce the threshold of estimated events for executive level leadership approval from $5,000 to $1,000 to promote greater accountability and oversight of official function expenditures.

Management Agrees, Partially Agrees, or Disagrees: *Agrees*

Implementation Date: September 30, 2020
Management Response:

A proposed threshold of $1,000 is consistent with other Executive Branch departments.

**Recommendation No. 39:**

Standardize the use of Official Function forms within the department’s Fiscal Procedures Manual.

Management Agrees, Partially Agrees, or Disagrees: **Agrees**

Implementation Date: September 30, 2020

Management Response:

Financial Services has already gone through the effort of updating the standardized form and is linked from the Department Fiscal Procedures Manual section 3.6.D. Additionally, Financial Services has added some Frequently Asked Questions that is linked from the same section of the Department Fiscal Procedures Manual.
Management Responses:

Human Resources:

Internal Audit also provided the following recommendation for CDPHE Human Resources related to department policies.

Recommendation No. 56:

CDPHE Employee Separation Policy 10.7:


b) Standardize the process across the department in how divisions address employees accepting positions at organizations that contract with the department within six months of ending employment at CDPHE.

c) Provide information to employees during onboarding.

d) Provide training to current employees.

Management Agrees, Partially Agrees, or Disagrees: Refer to each part below for status.

Implementation Date: All recommendations are already in place or management; listed below as partially agrees, or disagrees.

Management Response:

a) On January 28, 2015, the Office of Human Resources created a document with both statutes cited and has been providing to all employees who separate both C.R.S. § 24-18-105 and C.R.S. § 24-18-201 on one page to remind employees of the statute (form attached below). This is either hand delivered during the separation meeting between the departing employee and the HR Specialist, or it is sent as an attachment to email to the separating employee for those who are not able to meet in person. While the provision of statutes to employees may be unusual, the Office of Human Resources does so as a customer service. We do not think statutory citations for separated employees needs to be included in policy and doing so would be overly broad. Management partially agrees.

Auditor Addendum:

We have considered the response to this recommendation and maintain that the recommendation remains valid. While Internal Audit recognizes that the document that Human Resources provides to outgoing employees is value-added, it is not provided to the departing employee until their separation meeting or until after they have left the department. By including the statutory citations and department expectations in the CDPHE Employee Separation Policy 10.7, employees can take these under consideration when looking for a change in employment.

b) Current CDPHE management and employees may not be aware of employment
agreements, business ownerships, or other contracted services that separated employees may enter into with outside entities. Under current statute, separated employees have no duty to report or disclose such an illegal relationship to CDPHE management or employees. Each circumstance is handled on a case by case basis. For example, a former employee may go work for an entity that contracts with CDPHE but that former employee is not assigned to state work. This issue rarely comes up and management does not believe that a standardized process is warranted. Employees are encouraged to report ethics violations either directly to management or anonymously through the Ethical Advocate by phone or online. Employees have access to the Ethical Advocate reporting system that is published on the intranet (https://coloit.sharepoint.com/sites/DPHE-hr/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2FDPHE%2Dhr%2FShared%20Documents%2FEthical%20Advocate%20Instructions%2Epdf&parent=%2Fsites%2FDPHE%2Dhr%2FShared%20Documents) and posted on bulletin boards throughout the department. The span of control into outside businesses does not exist and including in CDPHE HR policy is overly broad. Management disagrees.

Auditor Addendum:

We have considered the response to this recommendation and maintain that the recommendation remains valid. In order to avoid the appearance of inconsistent treatment of departing employees accepting employment at a contractor, a standardized process of how to approach the situation may assist supervisors in addressing their specific situations if they become aware of this concern.

c) The CDPHE Onboarding Checklist, page 3 of 5, includes the requirement that the supervisor discusses the Ethical Principles and Code of Conduct with employee and have employee sign and submit the completed form to cdphe.humanresources@state.co.us. The checklist also goes further and includes the Statement of Understanding and the Conflict of Interest Disclosure Form that require employee signatures. The onboarding checklist was vetted through a management review process led by Heather Weir. Including all of the requirements identified in the Onboarding Checklist in policy is overly broad and is satisfactorily addressed through a checklist process. The Onboarding Checklist is available to all employees on the CDPHE intranet at: https://coloit.sharepoint.com/sites/DPHE-hr/SitePages/Onboarding.aspx Management partially agrees.

Auditor Addendum:

We have considered the response to this recommendation and maintain that the recommendation remains valid. Although the on-boarding checklist requires the supervisor to discuss the Ethical Principles and Code of Conduct with the employee, it doesn’t currently reference the Conflict of Interest policy, only a disclosure form for any current Conflict of Interest. Information related to the statutory requirements can be added to the disclosure form for annual employee acknowledgement or a row can be added to the department onboarding checklist to provide them notice. New employees to the state may not be aware of these statutory limitations to possible future employment with a contractor.
d) All department employees are trained on this topic annually- C.R.S. § 24-18-105 and C.R.S. § 24-18-201, specifically conflicts of interest. The Office of Human Resources in theory could add additional training at the separation of employment on conflicts of interest but considering the limited resources and training staff available, it is not feasible to do so at this time. It is also redundant because it is covered under paragraph (a).

Additionally, there is a flowchart provided to staff through the department intranet on how to approach a possible conflict of interest. The Conflict of Interest piece is also talked about in the department’s Code of Conduct Acknowledgement which is also signed by every person we onboard. The documents are sent to HR to be placed in the employee's file. Specifically, Section 1, subsection d relates to the Conflict of Interest and employee's responsibility (form attached below).

In addition to the employee acknowledgements, there is CDPHE Policy 13.6 that specifically speaks to Conflicts of Interest. Also, in the State Employee Handbook, page 10 speaks to Conflict of Interest, specifically Outside Employment.

Additionally, we link to all department policies through the New Employee Intranet resource site that links new employees to all of the resources discussed at Orientation. During Orientation (when classroom based Orientation), all employees where directed to policies and tasked with making themselves familiar with all CDPHE policies.

Finally, all new employees are required to complete DPA's online course titled Ethics and Conflict of Interest, which includes a post-assessment for knowledge retention and is due within the new employee's first 30 days. In addition to completing this course within the new hire's first 30 days, all department staff are required to complete this training annually. HR has transcripts indicating staff completion and each employee has the ability to check transcripts for completion and score of post-assessment. The annual training has been completed by all department staff on September 30, 2019 and May 2, 2018.

Prior to May 2, 2018, the department did not require this training annually and only relied on the documentation for Conflict of Interest through New Employee Onboarding.

Going forward with Orientation, a link to Conflict of Interest will be in the online modules and will continue to require new employees complete the DPA online course and post-assessment. Additionally, all employees will continue to be required to complete DPA's online course on an annual basis. Management partially agrees.