



August 17, 2010

TO: Mary K. Wakefield, Ph.D., R.N.
Administrator
Health Resources and Services Administration

FROM: /Lori S. Pilcher/
Assistant Inspector General for Grants, Internal Activities,
and Information Technology Audits

SUBJECT: Results of Limited Scope Review of Peak Vista Community Health Centers
(A-07-10-02754)

The attached final report provides the results of our limited scope review of Peak Vista Community Health Centers. This review is part of an ongoing series of reviews performed by the Office of Inspector General (OIG) to provide oversight of funds provided by the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Recovery Act).

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that the OIG post its publicly available reports on the OIG Web site. Accordingly, the final report will be posted at <http://oig.hhs.gov>.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to contact me at (202) 619-1175 or through email at Lori.Pilcher@oig.hhs.gov. Please refer to report number A-07-10-02754 in all correspondence.

Attachment

Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**RESULTS OF
LIMITED SCOPE REVIEW OF
PEAK VISTA COMMUNITY
HEALTH CENTERS**



Daniel R. Levinson
Inspector General

August 2010
A-07-10-02754

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health & Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The Health Centers Consolidation Act of 1996 (P.L. No. 104–299) consolidated the Health Center Program under Section 330 of the Public Health Service Act (PHS Act), codified at 42 U.S.C. § 254(b). Pursuant to 42 U.S.C. § 254(b), the Health Center Program is a national program designed to provide comprehensive primary health care services to medically underserved populations through planning and operating grants to health centers. Within the U.S. Department of Health & Human Services, the Health Resources and Services Administration (HRSA) administers the Health Center Program. The HRSA health centers are community-based and patient-directed organizations that serve populations with limited access to health care.

Under the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Recovery Act), enacted February 17, 2009, HRSA received \$2.5 billion, including \$2 billion to expand the Health Center Program to serve more patients, stimulate new jobs, and meet the significant increase in demand for primary health care services among the Nation’s uninsured and underserved populations. These appropriations included \$500 million for grants to health centers, \$1.5 billion for health center construction, renovation, and equipment and for the acquisition of health information technology systems, and \$500 million to address health professions workforce shortages. HRSA made available four types of Recovery Act grants to health centers: new access points (NAP), increased demand for services (IDS), facilities investment program, and capital improvement program (CIP). Recovery Act grants were provided to both new and existing health centers; moreover, a center was permitted to receive more than one type of grant.

Peak Vista Community Health Centers (Peak Vista) has provided health care to families in El Paso and Teller counties, Colorado, since 1971. On December 18, 2007, Peak Vista applied for Recovery Act NAP grant funding in the amount of \$1,300,000. According to Peak Vista’s NAP grant application, the funding would be used to create a Mobile Family Care Clinic that would enable Peak Vista to serve 4,000 new patients. On February 26, 2009, HRSA awarded Peak Vista a Recovery Act NAP grant in the amount of \$1,300,000.

On March 16, 2009, Peak Vista applied for Recovery Act IDS grant funding in the amount of \$776,173 to hire ten full-time employees. According to Peak Vista’s IDS grant application, the funding would enable Peak Vista to serve 371 new uninsured patients. On March 27, 2009, Peak Vista was awarded a Recovery Act IDS grant in the amount of \$776,173.

On June 2, 2009, Peak Vista applied for Recovery Act CIP grant funding in the amount of \$1,880,475. According to Peak Vista’s CIP grant application, the funding would enable Peak Vista to (1) repair the Family Health Center roof and parking; (2) upgrade information technology infrastructure and computer equipment and improve electronic health care records capacity; and (3) renovate the Administrative Center, which would allow some administrative staff to be moved to a new location. On June 25, 2009, Peak Vista was awarded a three-project Recovery Act CIP grant in the amount of \$1,880,475.

OBJECTIVE

Our objective was to assess Peak Vista's financial viability, capacity to manage and account for Federal funds, and capability to operate a community health center in accordance with Federal regulations.

RESULTS OF REVIEW

Based on our assessment, we believe Peak Vista is financially viable, has the capacity to manage and account for Federal funds, and is capable of operating its health center in accordance with Federal regulations. However, we identified several weaknesses in Peak Vista's financial management: NAP funds used for services at unauthorized service sites; funds draw-downs not matching financial system information; payroll costs based on estimates; inadequate segregation of Recovery Act funds in the accounting system; lack of required supporting documentation for salaries; lack of existing formal policies and procedures; and lack of required personnel data.

RECOMMENDATION

When monitoring the Recovery Act funds, we recommend that HRSA consider the information presented in this report in assessing Peak Vista's ability to account for and manage Federal funds and to operate a community health center in accordance with Federal regulations.

AUDITEE COMMENTS

In written comments on our draft report, Peak Vista disagreed with the majority of our findings. Peak Vista provided information as to corrective actions and improvements that it has implemented or is undertaking, as well as additional information related to some of our findings.

Peak Vista's comments, excluding a two-page attachment that contained a copy of one of the HRSA grant awards, appear as the appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

Peak Vista's written comments provided additional information as to corrective actions and improvements that it has implemented or is undertaking, but we did not verify the validity of the additional information provided. Accordingly, we continue to recommend that HRSA consider the information presented in this report, including Peak Vista's comments, in monitoring the Recovery Act funds.

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INTRODUCTION

BACKGROUND

The Health Center Program

The Health Centers Consolidation Act of 1996 (P.L. No. 104–299) consolidated the Health Center Program under Section 330 of the Public Health Service Act (PHS Act), codified at 42 U.S.C. § 254(b). Pursuant to 42 U.S.C. § 254(b), the Health Center Program is a national program designed to provide comprehensive primary health care services to medically underserved populations through planning and operating grants to health centers. Within the U.S. Department of Health & Human Services (HHS), the Health Resources and Services Administration (HRSA) administers grant opportunities for health centers.

The Health Center Program provides grants to nonprofit private or public entities that serve designated medically underserved populations and areas, and vulnerable populations composed of migrant and seasonal farm workers, the homeless, and residents of public housing. Health centers funded by HRSA are community-based and patient-directed organizations meeting the definition of “health center” under 42 U.S.C. § 254(b).

Under the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Recovery Act), enacted February 17, 2009, HRSA received \$2.5 billion, including \$2 billion to expand the Health Center Program to serve more patients, stimulate new jobs, and meet the significant increase in demand for primary health care services among the Nation’s uninsured and underserved populations. These appropriations included \$500 million for grants to health centers, \$1.5 billion for health center construction, renovation, and equipment and for the acquisition of health information technology systems, and \$500 million to address health professions workforce shortages. HRSA made available four types of Recovery Act grants to health centers: new access points (NAP), increased demand for services (IDS), facilities investment program, and capital improvement program (CIP). Recovery Act grants were provided to both new and existing health centers; moreover, a center was permitted to receive more than one type of grant.

Peak Vista Community Health Centers

Established in 1971, Peak Vista Community Health Centers (Peak Vista) is a private, nonprofit organization that provides primary medical, dental, and behavioral health services through a network of health centers to uninsured and underinsured people in Colorado. Peak Vista has 16 health centers at 12 locations in El Paso and Teller counties, including clinics for pediatrics, women’s health, family practice, after-hours immediate care, senior health and homeless health.

On December 18, 2007, Peak Vista applied for Recovery Act NAP grant funding in the amount of \$1,300,000. According to Peak Vista’s NAP grant application, the funding would be used to create a Mobile Family Care Clinic that would enable Peak Vista to serve 4,000 new patients.

On February 26, 2009, HRSA awarded Peak Vista a Recovery Act NAP grant in the amount of \$1,300,000.

On March 16, 2009, Peak Vista applied for Recovery Act IDS grant funding in the amount of \$776,173 to hire ten full-time employees (FTE). According to Peak Vista's IDS grant application, the funding would enable Peak Vista to serve 371 new uninsured patients. On March 27, 2009, Peak Vista was awarded a Recovery Act IDS grant in the amount of \$776,173.

On June 2, 2009, Peak Vista applied for Recovery Act CIP grant funding in the amount of \$1,880,475. According to Peak Vista's CIP grant application, the funding would enable Peak Vista to (1) repair the Family Health Center roof and parking; (2) upgrade information technology infrastructure and computer equipment and improve electronic health care records capacity; and (3) renovate the Administrative Center, which would allow some administrative staff to be moved to a new location. On June 25, 2009, Peak Vista was awarded a three-project Recovery Act CIP grant in the amount of \$1,880,475.

Requirements for Federal Grantees

Nonprofit organizations that receive HRSA funds must comply with Federal cost principles found at 2 CFR pt. 230, *Cost Principles for Non-Profit Organizations* (formerly Office of Management and Budget (OMB) Circular A-122). In addition, 42 U.S.C. § 254(b) defines requirements for health centers under the Health Center Program.

The Standards for Financial Management Systems, found at 45 CFR § 74.21, establish regulations for grantees to maintain financial management systems. Grantees' financial management systems must provide for accurate, current, and complete disclosure of the financial results of each HHS-sponsored project or program (45 CFR § 74.21(b)(1)); must ensure that accounting records are supported by source documentation (§ 74.21(b)(7)); and must provide effective control over and accountability of all funds, property, and other assets so that recipients adequately safeguard all such assets and assure they are used solely for authorized purposes (§ 74.21(b)(3)). Grantees also must have written procedures for determining the reasonableness, allocability, and allowability of costs in accordance with the provisions of the applicable Federal cost principles and the terms and conditions of the award (§ 74.21(b)(6)).

Furthermore, 2 CFR pt. 215, *Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals, and Other Non-Profit Organizations* (formerly OMB Circular A-110), § 215.21(b), requires that a grant recipient's financial management system include written procedures for determining the reasonableness, allocability, and allowability of costs in accordance with the provisions of the applicable Federal cost principles and the terms and conditions of the Federal award. This Federal regulation also requires that grant recipients adequately safeguard all funds, property, and other assets and assure that they are used solely for authorized purposes.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to assess Peak Vista's financial viability, capacity to manage and account for Federal funds, and capability to operate a community health center in accordance with Federal regulations.

Scope

We conducted a limited review of Peak Vista's financial viability, financial management system, and related policies and procedures. Therefore, we did not perform an overall assessment of Peak Vista's internal control structure. Rather, we performed limited tests and other auditing procedures on Peak Vista's financial management system to assess its ability to administer federally funded projects.

We performed our fieldwork at Peak Vista's administrative office in Colorado Springs, Colorado, in January and February 2010.

Methodology

To accomplish our objective, we:

- reviewed relevant Federal laws, regulations, and guidance, to include HRSA program and policy announcements;
- obtained and reviewed Peak Vista's HRSA grant application packages and supporting documentation;
- interviewed Peak Vista personnel to gain an understanding of its accounting systems and internal controls;
- reviewed Peak Vista's audited financial statements, IRS Forms 990, and supporting documentation for the period January 1, 2006, through December 31, 2008;
- performed ratio analyses of Peak Vista's financial statements;
- evaluated Peak Vista's fiscal procedures related to accounting documentation and preparation of financial reports;
- evaluated Peak Vista's current program operations;
- reviewed Peak Vista's administrative procedures related to personnel, record-keeping, conflict resolution, and other non-financial matters;

- reviewed minutes from Peak Vista’s Board of Directors meetings; and
- provided a summary of our findings to Peak Vista’s management on January 29, 2010.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATION

Based on our assessment, we believe Peak Vista is financially viable, has the capacity to manage and account for Federal funds, and is capable of operating its health center in accordance with Federal regulations. However, we identified several weaknesses in Peak Vista’s financial management: NAP funds used for services at unauthorized service sites; funds draw-downs not matching financial system information; payroll costs based on estimates; inadequate segregation of Recovery Act funds in the accounting system; lack of required supporting documentation for salaries; lack of existing formal policies and procedures; and lack of required personnel data.

WEAKNESSES IN FINANCIAL MANAGEMENT

New Access Point Funds Used For Services at Unauthorized Service Sites

Pursuant to the HHS HRSA New Access Points Application Guide (the Guide) 08-077, page 11: “A **SATELLITE** applicant is an organization that **CURRENTLY RECEIVES** grant support under the Health Center Program authorized under section 330 of the PHS Act. All satellite applicants must propose to establish a new access point(s) to serve a new patient population that is outside the applicant’s approved scope of project” (Emphasis in original.)

The Guide further stipulates that satellite applicants may not request funding to support the expansion or addition of services, programs, and/or staff at a site(s) that is currently listed as being a part of the applicants’ approved scope of project under the Consolidated Health Center Program.

Contrary to these Federal guidelines, Peak Vista used NAP funds for services provided at sites not authorized in the Notice of Grant Award (NOGA) terms and conditions. The NOGA listed the approved NAP as the Mobile Care Clinic. However, the majority of the sites where services were provided (using NAP funds) were other, existing sites operated by Peak Vista. Peak Vista used a predetermined physician salary allocation for NAP expenditures rather than an allocation based on new patient population.

Of the \$527,612 charged to the NAP grant during the period March 2009 through December 2009, \$212,995 had been expended for services provided at the site authorized in the NAP grant agreement, the Mobile Care Clinic. The remaining \$314,617 had been expended for

services provided at sites that were not authorized in the NAP grant agreement and that did not meet the definition of a NAP as stated in the Guide.

Even if NAP funds were allowable for providing services to NAP patients at sites other than the Mobile Care Facility, we could not determine from the accounting system information whether these funds were actually being used to treat NAP patients.

Recovery Act Funds Draw-Downs Not Matching Financial System Information

Pursuant to 45 CFR § 74.21, grantees must maintain accounting records that are supported by source documentation and must maintain financial systems that provide for accurate and complete reporting of grant-related financial data.

Peak Vista created tracking sheets to tabulate the salary and benefit costs for NAP and IDS employees and consequently to draw down grant funding. However, these tracking sheets did not accurately report grant-related financial data when compared to Peak Vista's accounting records for these employees; thus, this procedure did not conform to the provisions of 45 CFR § 74.21.

Peak Vista's NAP tracking documentation showed that from March to December 2009, NAP employees received salaries totaling \$651,461. However, the accounting system showed that total salaries paid to those NAP employees for that time period were \$631,261, a difference of \$20,200.

Similarly, Peak Vista's IDS tracking documentation showed that from April to December 2009, IDS employees received salaries totaling \$501,040. However, the accounting system showed that total salaries paid to those IDS employees for that time period were \$495,106, a difference of \$5,933.

An inability to provide effective control over and accountability of all funds, property, and other assets can result in inadequate safeguarding of assets and inadequate assurance that those funds are used solely for authorized purposes.

Payroll Costs Based On Estimates

Pursuant to 2 CFR pt. 230, Appendix B, §§ (8)(m)(1) and (8)(m)(2)(a), the distribution of salaries and wages to awards must be supported by personnel activity reports. The reports must reflect an after-the-fact determination of the actual activity of each employee. Budget estimates (*i.e.*, estimates determined before the services are performed) do not qualify as support for charges to awards.

Contrary to these Federal requirements, Peak Vista calculated NAP and IDS payroll costs on the basis of budget estimates and not on the basis of the actual time employees worked on grant-approved activities. Specifically, in lieu of tracking the actual time Peak Vista employees

worked on grant-approved activities, Peak Vista multiplied each employee's salary and benefit cost by the pre-determined grant FTE allocation. The use of budget estimates rather than actual costs could result in improper allocation of Recovery Act grant funding.

Inadequate Segregation of Recovery Act Funds in the Accounting System

Pursuant to 45 CFR § 74.21, grantees must maintain accounting records that are supported by source documentation and must maintain financial systems that provide for accurate and complete reporting of grant-related financial data.

Furthermore, 2 CFR § 215.21(b)(1) states that a grantee's financial management system must provide "[a]ccurate, current, and complete disclosure of the financial results of each federally-sponsored project or program"

Contrary to these Federal requirements, Peak Vista's accounting system did not adequately accumulate and segregate costs for the NAP and IDS grants. Employee salary cost that was charged to the NAP and IDS grants was not always assigned to a NAP or IDS sub-account code in the financial system. Moreover, some of the salary costs for NAP and IDS employees were recorded in non-grant-related sub-accounts. Inadequate segregation of funds could result in delay or inability to detect accounting inaccuracies and/or misappropriation of assets by theft or fraud.

Lack of Required Supporting Documentation for Salaries

Pursuant to 2 CFR pt. 230, Appendix B, §§ (8)(m)(1) and (8)(m)(2), charges to awards for salaries and wages, whether treated as direct costs or indirect costs, will be based on documented payrolls approved by a responsible official of the organization. The distribution of salaries and wages to awards must be supported by personnel activity reports; and reports reflecting the distribution of activity of each employee must be maintained for all staff members (professionals and nonprofessionals) whose compensation is charged, in whole or in part, directly to awards.

From a random sample of 23 professional and nonprofessional employees, Peak Vista was unable to furnish Provider Tracking Sheets (certification of time worked) for three employees. The absence of these certifications indicates that Peak Vista's salaries were not fully documented and supported pursuant to 2 CFR pt. 230, Appendix B.

An inability to provide effective control over and accountability of all funds, property, and other assets can result in inadequate safeguarding of assets and inadequate assurance that those funds are used solely for authorized purposes.

Lack of Existing Formal Policies and Procedures

Pursuant to 2 CFR § 215.21(b)(3), grant recipients are required to adequately safeguard all funds, property, and other assets and assure that they are used solely for authorized purposes. Similar language appears in 45 CFR § 74.21(b)(3).

Contrary to these Federal requirements, Peak Vista did not have written policies and procedures for the following categories at the start of our audit: cash management, miscellaneous revenues, and journal entries. The absence of policies and procedures regarding the management and proper use of funds, property, and other assets could result in delay or inability to detect accounting inaccuracies and/or misappropriation of assets by theft or fraud.

Prior to completion of our audit fieldwork, Peak Vista provided the auditors with formal, written policies and procedures for the above categories.

Lack of Required Personnel Data

Pursuant to 42 U.S.C. § 233(h)(2), health service entities are required to review and verify the professional credentials, references, claims history, fitness, professional review organization findings, and license status of their physicians and other licensed or certified health care practitioners, and, where necessary, obtain permission from these individuals to gain access to this information.

Contrary to these Federal requirements, Peak Vista did not always maintain sufficient and current information to support placement in the position assigned. Incomplete personnel data as to background checks, reference checks, professional credentials, and licensing status could lead to situations in which people receive health care services from individuals who are not authorized or accredited to perform those services.

Of 23 sampled personnel files, 3 were missing information. Two of the personnel files were initially missing background checks and authorizations; however, Peak Vista completed the checks and authorizations and provided the documentation to us prior to the completion of our audit fieldwork. The third personnel file was missing an employee reference check.

RECOMMENDATION

When monitoring the Recovery Act funds, we recommend that HRSA consider the information presented in this report in assessing Peak Vista's ability to account for and manage Federal funds and to operate a community health center in accordance with Federal regulations.

AUDITEE COMMENTS

In written comments on our draft report, Peak Vista disagreed with the majority of our findings. Peak Vista provided information as to corrective actions and improvements that it has implemented or is undertaking, as well as additional information related to some of our findings.

Peak Vista agreed with our finding regarding the inadequate segregation of Recovery Act funds in the accounting system. Peak Vista acknowledged that its "current accounting software package was not adequate to maintain and track the many various required categories [of costs]. To mitigate this ... we put in place sets of manual spreadsheets and other processes, recognizing that this could not be our long-term solution." Peak Vista also described a "comprehensive software upgrade" that it planned to implement as a long-term solution.

With respect to the use of NAP funds for services at unauthorized service sites, Peak Vista disagreed with our finding and stated that it met the conditions of HRSA's grant award regarding the use of NAP funds. Specifically:

- Peak Vista acknowledged that NAP funds were used for clients treated at facilities other than the mobile care unit listed in Peak Vista's NAP application, and identified two reasons why this use of NAP funds at its existing service sites met the grant award conditions. First, Peak Vista stated that it "... was at clinical capacity prior to the NAP award, and would not have been readily able to absorb the additional NAP patients within the current system." Second, Peak Vista said that due to remote deployments, weather, and mechanical breakdowns, the mobile care unit was not available for NAP patients at all times. Peak Vista stated that for these reasons, it used existing points of service to provide a "... full range of required primary, preventative, enabling and supplemental medical health care services ..." as specified in CFDA No. 93.224.
- In response to our statement that we could not determine whether NAP funds were actually being used to treat NAP patients, Peak Vista provided information on its interpretation of the NOGA conditions and on the methodology used by its accounting system to track new patients and encounters.

With respect to our finding that Peak Vista's draw-downs of Recovery Act funds did not match Peak Vista's financial system information, Peak Vista stated that its funds tracking sheets were accurate, and added that differences between its worksheets and ours applied only to the first payroll period included after the grant start date and were not repeated thereafter.

With respect to the calculation of payroll costs on the basis of budget estimates, Peak Vista said that it used an estimate-based methodology only on six part-time, exempt employees, and added that all hourly employees used an automated timekeeping system to record their hours worked.

Peak Vista's comments, excluding a two-page attachment that contained a copy of one of the HRSA grant awards, appear as the appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

Peak Vista's written comments provided additional information as to corrective actions and improvements that it has implemented or is undertaking, but we did not verify the validity of the additional information provided. Our responses to the more specific issues put forth by Peak Vista in its written comments appear below.

With respect to the use of NAP funds for services at unauthorized service sites, we recognize the complexity of Federal requirements and guidelines that inadvertently work at cross-purposes in terms of the guidance they provide for the use of grant funds. In keeping, therefore, with both our audit objective and our recommendation that HRSA consider the information presented in this report, we offer the following points:

- The Guide states that satellite applicants may not request funding to support the expansion or addition of services, programs, and/or staff at a site(s) that is currently listed as being a part of the applicants' approved scope of project under the Consolidated Health Center Program. In the case of Peak Vista, this guideline applied to all existing service sites other than the mobile care unit listed in Peak Vista's NAP application. Although Peak Vista said that it acted in compliance with CFDA No. 93.224 by providing services at sites not authorized in the NOGA terms and conditions, it appeared that NAP funding supported an expansion of services at existing sites. We were not able to determine, within the constraints of this limited scope review, whether the expansion served an existing population or patients generated as the result of the implementation of the mobile care unit.
- We concur that Peak Vista has the capability to track new patients and encounters; however, Peak Vista did not use this methodology in the physician salary allocation. Therefore, we could not determine whether the NAP funding was actually being used to treat NAP patients.

With respect to our finding that Peak Vista's draw-downs of Recovery Act funds did not match Peak Vista's financial system information, during our fieldwork we found variances between payroll information in the accounting system and the tracking sheets used by Peak Vista for its draw-downs of Recovery Act funds. The funds tracking sheets to which Peak Vista alluded in its comments refer to worksheet revisions done while we were on site. Although Peak Vista stated that the differences between its worksheets and ours were primarily confined to the first payroll period included after the grant start date, we believe that the differences occurred primarily because Peak Vista included salaries from the second pay period of April 2009 in the May 2009 salaries.

With respect to the calculation of payroll costs on the basis of budget estimates, Peak Vista acknowledged in its written comments that it used an estimate-based methodology to calculate salary and benefit costs for six part-time, exempt employees. However, Peak Vista's use of an estimate-based methodology to calculate salary and benefit costs extended beyond those six employees. In fact, for exempt employees whose duties included work related to the grants, Peak Vista determined in advance (based on FTE allocations specified in the HRSA-approved grant applications) how much of each employee's time and related salary costs would be allocated to the grant. Exempt employees' payroll costs were then allocated on a percentage to the particular grant-funded program(s). This methodology, based on estimation rather than an after-the-fact determination of the actual activity of each employee, did not allow for adequate support of the distribution of salary and wage costs. For example, exempt providers certified the hours worked but did not specify the department(s) in which the work occurred. Similarly, clinical and dental schedules showed the locations where providers worked, but not the program(s) worked.

In light of these considerations, we continue to recommend that HRSA consider the information presented in this report, including Peak Vista's comments, in monitoring the Recovery Act funds.

APPENDIX

APPENDIX: AUDITEE COMMENTS



PROVIDING EXCEPTIONAL HEALTHCARE FOR PEOPLE FACING ACCESS BARRIERS
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May 24, 2010

Patrick Cogley
HHS/OIG/Audit Services
601 East 12th Street, Room 0429
Richard Bolling Federal Bldg.
Kansas City, MO 64106

Re: Peak Vista Community Health Centers Response to Draft Report A-07-10-02754

Dear Mr. Cogley:

Please find attached our response to the Office of Inspector General's draft results of the limited scope review of Peak Vista Community Health Centers.

As one of the first centers to undergo this process, we appreciate the opportunity to receive feedback and feel validated that the OIG found that "Peak Vista is financially viable, has the capacity to manage and account for Federal funds, and is capable of operating its health center in accordance with Federal regulations".

Sincerely,

A handwritten signature in blue ink, appearing to read "BJ Scott", with a long horizontal flourish extending to the right.

Ms. BJ Scott
President and CEO

Peak Vista Community Health Centers Response to Draft Report A-07-10-02754

From OIG Draft Report:

We conducted a limited review of Peak Vista's financial viability, financial management system, and related policies and procedures. Therefore, we did not perform an overall assessment of Peak Vista's internal control structure. Rather, we performed limited tests and other auditing procedures on Peak Vista's financial management system to assess its ability to administer federally funded projects.

We performed our fieldwork at Peak Vista's administrative office in Colorado Springs, Colorado, in January and February 2010.

Peak Vista's Clarification of Timeline and Process:

Peak Vista was contacted in December 2009 and asked if December 2009 or January 2010 would be best for the OIG field work. At that time, Peak Vista confirmed that the field work could take place the week of December 14, 2009. However, due to OIG scheduling conflicts, the field work was scheduled for January 2010. The original field work was completed by the four OIG staff over the time period of Monday, January 25, 2010 through Friday, January 29, 2010. On Friday, the exit interview was conducted and we were advised we would receive the summary OARS report approximately 5 days. Peak Vista was then contacted by the OIG on February 10, 2010, and told not all field work was completed. Two of the OIG auditors were on site at Peak Vista again February 12, 2010 for one day. At that time, Peak Vista was told again that a summary report would be sent in approximately five days, with the draft report to follow. The summary OARS was subsequently received on March 25, 2010. An electronic copy of the draft report was received on May 18, 2010 and the hard copy was received on May 19th, 2010.

Given the lapse of time between the field work and the draft report, Peak Vista was able to put new processes in place for the identified weaknesses.

From OIG Draft Report:

New Access Point Funds Used For Services at Unauthorized Service Sites

Pursuant to the HHS HRSA New Access Points Application Guide (the Guide) 08-077, page 11: "A SATELLITE applicant is an organization that CURRENTLY RECEIVES grant support under the Health Center Program authorized under section 330 of the PHS Act. All satellite applicants must propose to establish a new access point(s) to serve a new patient population that is outside the applicant's approved scope of project ..."

The Guide further stipulates that satellite applicants may not request funding to support the expansion or addition of services, programs, and/or staff at a site(s) that is currently listed as being a part of the applicants' approved scope of project under the Consolidated Health Center Program.

Contrary to these Federal guidelines, Peak Vista used NAP funds for services provided at sites not authorized in the Notice of Grant Award (NOGA) terms and conditions. The NOGA listed the approved NAP as the Mobile Care Clinic. However, the majority of the sites where services were provided (using NAP funds) were other, existing sites operated by Peak Vista. Peak Vista used a predetermined physician salary allocation for NAP expenditures rather than an allocation based on new patient population.

Of the \$527,612 charged to the NAP grant during the period March 2009 through December 2009, \$212,995 had been expended for services provided at the site authorized in the NAP grant agreement, the Mobile Care Clinic. The remaining \$314,617 had been expended for services provided at sites that were not authorized in the NAP grant agreement and that did not meet the definition of a NAP as stated in the Guide.

Even if NAP funds were allowable for providing services to NAP patients at sites other than the Mobile Care Facility, we could not determine from the accounting system information whether these funds were actually being used to treat NAP patients.

Peak Vista Response:

Peak Vista disagrees with this finding as we met Notice of Grant Award conditions per HRSA's notice dated 12/23/2009.

First it must be noted that Peak Vista's Mobile Care Facility New Access Point application was originally submitted in December 2007 through the normal HRSA site expansion process. In September 2008 we received notice that the NAP application had not been funded. In February 2009 we received notification that the Mobile Care Facility NAP application had been picked up for funding through the new ARRA NAP process. Between September 2008 and February 2009, we implemented a leaner model of mobile care without additional Federal Funds. Changes to our model were communicated to HRSA when the ARRA NAP was funded and all conditions related to this strategy were released by HRSA with the NOGA dated 12/23/2009 (NOGA is attached as Attachment A).

Per the CFDA No 93.224, the definition of a new access point is a new service site for the provision of comprehensive primary and preventive health care services. It further states that all new access point applications are expected to:

- a) Demonstrate that all persons will have ready access to the full range of required primary, preventive, enabling and supplemental medical health care services, such as oral health care, mental health care and substance abuse services, either directly on-site or through established arrangements without regard to ability to pay.

Peak Vista interpreted this statement to mean that we were required to provide the full range of required services either on the mobile van or through other means. The unique mobile care model, by its very nature, requires referrals through other arrangements to assure that access to the full scope of services is available in a timely, consistent manner.

A good example of this unique model follows: The mobile van was used to provide dental care for two weeks in a small rural town located in the mountains. Because of distance and challenging mountainous driving, the van was taken there, set up, and remained there for a total of 14 days. This community had never received such an opportunity and during the patient visits the dentist and dental hygienist found that many of the users had gone years without any dental care, even though they were in desperate need. The good news is that 168 patients received preventative and restorative dental care. Peak Vista would not have been able to offer this without the NAP grant funding and all the opportunities and relationships that have come with the mobile van. This particular community actually installed permanent shore power to allow future visits by the mobile van.

During the mobile van's remote deployments, Peak Vista still needs to assure that other new NAP users continue to have access to care when the vehicle is not available to them. It would not be reasonable to ask patients to find transportation and travel to be seen on the mobile van in such a remote area or to wait until the van returns to a closer location. It is also important for the patients to have access to care at the time the care is needed. The best way for Peak Vista to assure this is to provide access at our existing clinics, utilizing NAP funded providers, who are not on the van at the time, to see these new NAP patients.

Peak Vista was at clinical capacity prior to the NAP award, and would not have been readily able to absorb the additional NAP patients within the current system. Peak Vista measures clinical capacity several ways. First, we practice a health care home model, which means each patient is assigned to a primary care provider (PCP). We strive for that patient to see their PCP, but if that is not possible for any reason, we work to assure an alternative provider is available. At the time of the NAP award, all provider panels were at capacity. Second, we measure encounters per provider per year. Per the 2008 UDS report, PV's medical teams were averaging 4629 encounters per team, which is well above the BPHC standard of 4200 per medical team.

In keeping with our interpretation of the NAP requirement to provide *"ready access to the full range of required primary, preventive, enabling and supplemental medical health care services, either directly on-site or through established arrangements"* (HRSA 08-077), we exercised the option of providing the care both directly on-site, and through a referral process to other sites, primarily in the form of behavioral health services and primary medical care when the mobile van was deployed in the field. Limited space and the ability to provide services in far-reaching locations are unique aspects of the mobile care model.

Also unique to mobile care is a dependence on the weather for deployment. In the first 14 months of operations, Peak Vista frequently had to deal with harsh Colorado winter weather conditions. On numerous occasions, the mobile van was forced to remain docked due to snow, ice and wind making the roads impassable. Again, on those days, mobile van staff was relocated to other sites and patients were notified they could be seen at an alternative location. As always, access to quality care was the priority.

Finally, the mobile van is a vehicle, and is therefore subject to breakdown. Our early deployments were marked by a great deal of difficulty with our generator and other mechanical features. Apparently this is common to new mobile van start up, and the repair services were covered by our warranty. But again, under these circumstances mobile staff was relocated and patients were rescheduled from the mobile van to the clinics so the NAP patients could still have access.

When designing the NAP mobile van program, the patient was always the priority focus. Peak Vista has worked to assure the new patients served under the NAP grant have access to all HRSA required services in a reasonable time period, and that quality and patient safety are always paramount.

From OIG Draft Report:

In regards to the report "... we could not determine from the accounting system information whether these funds were actually being used to treat NAP patients".

Peak Vista Response:

Peak Vista used the following method, with data gathered from our automated patient management system, to count new patients and number of encounters for the NAP grant:

1. Users were only counted if they had never been seen at Peak Vista.
2. Only new users that were seen by providers being paid by NAP dollars were counted.
3. Each user had to have a face to face encounter that was documented in the health record, for a clinical visit that required independent judgment by a licensed provider.
4. Only encounters provided to identified NAP users are counted toward NAP encounter rate.

Peak Vista has provided this information on the HCQR health center quarterly reports and can be documented in detail. To date, the NAP grant has allowed 3618 patients, or 90% of our target access to care.

From OIG Draft Report:

“On December 18, 2007, Peak Vista applied for Recovery Act NAP grant funding in the amount of \$1,300,000. According to Peak Vista’s NAP grant application, the funding would be used to create a Mobile Family Care Clinic that would enable Peak Vista to serve 4,000 new patients.”

Peak Vista Response:

To clarify, Peak Vista stated 4,000 as a year 3 goal in the original NAP application. Peak Vista stated 3,225 as a 2 year goal and ARRA NAP is only 2-year funding.

From OIG Draft Report:

Recovery Act Funds Draw-Downs Not Matching Financial System Information

Pursuant to 45 CFR § 74.21, grantees must maintain accounting records that are supported by source documentation and must maintain financial systems that provide for accurate and complete reporting of grant-related financial data.

Peak Vista created tracking sheets to tabulate the salary and benefit costs for NAP and IDS employees and consequently to draw down grant funding. However, these tracking sheets did not accurately report grant-related financial data when compared to Peak Vista’s accounting records for these employees; thus, this procedure did not conform to the provisions of 45 CFR § 74.21.

Peak Vista Response:

Peak Vista disagrees with this finding.

The employee data was accurately reported on the tracking sheets. The difference between Peak Vista’s worksheet and the OIG worksheet is due to consideration of what data is appropriate to include. Also, the drawdown amounts were always less than the total amounts represented on the worksheets, because Peak Vista is maintaining a process whereby the funds are drawn down on a level basis over the 2 year period of the grants to assure sustainability of the grant funded projects.

From OIG Draft Report:

Peak Vista’s NAP tracking documentation showed that from March to December 2009, NAP employees received salaries totaling \$651,461. However, the accounting system showed that total salaries paid to those NAP employees for that time period were \$631,261, a difference of \$20,200.

Peak Vista Response:

Peak Vista disagrees with this finding.

The Peak Vista worksheet totaling \$651,461 recorded wages paid to NAP grant employees after the grant start date of March 1, 2009 included a payroll paid on March 6th. This payroll of \$15,716 included wages earned in February prior to the NAP grant start date. While the auditors were on

site, we revised the worksheet to exclude this payroll. The Peak Vista worksheet also included \$1,677 to a contract provider who provided behavioral health services, as allowed for in the grant. The OIG worksheet did not include this payment and also excluded other payments of \$2,807 as unallowable. Going forward, we will continue to accurately record the employee information on the tracking worksheets and review the data to remove any payments not allowable under the ARRA grant. The issue regarding the first payroll after the grant start date was only applicable at the beginning of the grant period and was not repeated.

From OIG Draft Report:

Similarly, Peak Vista's IDS tracking documentation showed that from April to December 2009, IDS employees received salaries totaling \$501,040. However, the accounting system showed that total salaries paid to those IDS employees for that time period were \$495,106, a difference of \$5,933.

Peak Vista Response:

Peak Vista disagrees with this finding.

The Peak Vista worksheet totaling \$501,040 recorded wages paid to IDS grant employees after the grant start date of March 27, 2009, including a payroll paid on April 3rd. This payroll of \$5,933 was for wages earned in March. Again, we revised the worksheet to exclude this payroll while the auditors were on site. Going forward, we will continue to accurately record the employee information on the tracking worksheets. The issue regarding the first payroll after the grant start date was only applicable at the beginning of the grant period and was not repeated.

From OIG Draft Report:

Payroll Costs Based On Estimates

Pursuant to 2 CFR pt. 230, Appendix B, §§ (8)(m)(1) and (8)(m)(2)(a), the distribution of salaries and wages to awards must be supported by personnel activity reports. The reports must reflect an after-the-fact determination of the actual activity of each employee. Budget estimates (*i.e.*, estimates determined before the services are performed) do not qualify as support for charges to awards.

Contrary to these Federal requirements, Peak Vista calculated NAP and IDS payroll costs on the basis of budget estimates and not on the basis of the actual time employees worked on grant-approved activities. Specifically, in lieu of tracking the actual time Peak Vista employees worked on grant-approved activities, Peak Vista multiplied each employee's salary and benefit cost by the pre-determined grant FTE allocation. The use of budget estimates rather than actual costs could result in improper allocation of Recovery Act grant funding.

Peak Vista Response:

Peak Vista disagrees with the blanket nature of this finding, as an estimate-based methodology was utilized only on 6 part-time, exempt employees, accounting for less than 5% of grant funded FTE's. Peak Vista did not multiply each employee's payroll information by the pre-determined grant FTE allocation. There are four categories of employees: Full-time hourly (non-exempt) employees, part-time non-exempt employees, full-time professional (exempt) employees, and part-time exempt employees.

All hourly employees use an automated time keeping system to record their worked hours. This system is used to calculate their wages. If either a full-time or part-time hourly employee works

more hours than allowed for in the grant budget, then the hours expensed to the budget are limited to the FTE prescribed in the grant budget.

All professional employees reported their payroll information on a manual timesheet. If the hours reported were greater than allowed for in the grant budget, then the hours expensed to the budget were limited to the FTE prescribed in the grant budget.

From OIG Draft Report:

Inadequate Segregation of Recovery Act Funds in the Accounting System

Pursuant to 45 CFR § 74.21, grantees must maintain accounting records that are supported by source documentation and must maintain financial systems that provide for accurate and complete reporting of grant-related financial data.

Furthermore, 2 CFR § 215.21(b)(1) states that a grantee's financial management system must provide "accurate, current, and complete disclosure of the financial results of each federally-sponsored project or program"

Contrary to these Federal requirements, Peak Vista's accounting system did not adequately accumulate and segregate costs for the NAP and IDS grants. Employee salary cost that was charged to the NAP and IDS grants was not always assigned to a NAP or IDS sub-account code in the financial system. Moreover, some of the salary costs for NAP and IDS employees were recorded in non-grant-related sub-accounts. Inadequate segregation of funds could result in delay or inability to detect accounting inaccuracies and/or misappropriation of assets by theft or fraud.

Peak Vista Response:

Peak Vista agrees with this statement and has initiated corrective processes.

Prior to the field work, Peak Vista recognized that the complexity of our programming was increasing and that our current accounting software package was not adequate to maintain and track the many various required categories. To mitigate this in the short term, we put in place sets of manual spreadsheets and other processes, recognizing that this could not be our long-term solution. We had planned and scheduled a comprehensive software upgrade for second quarter 2010, to allow us to complete our year-end processes (fiscal year end close out, W-2 generation, annual audit in February) and to host the OIG audit.

The objective of the System Upgrade is to improve the accuracy and timely financial reporting to all stakeholders at Peak Vista Community Health Centers (PVCHC). As the General Ledger, Accounts Payable, Payroll, Human Resource and Purchase Order software is being upgraded, process, procedure and internal control functions are being reviewed, updated and tested prior to the conversion to the new software version.

This upgrade will be accomplished in 2 Phases.

Phase 1 of the Upgrade includes:

- Updating the system to a version that will be fully supported by Microsoft. This will assure compliance with data recovery policies.
- Single User Sign-on allows for passwords to be properly managed with parameters and expiration of passwords.

- Phase 1 will also include a full review of process and procedure including documentation of the system and how it is being utilized by Finance Department, Material Management Department and Human Resource (HR) Department. Review and update of these procedures and internal control function, allows for the enhancements to be documented and made in Phase 2.

Phase 2 of the Upgrade includes:

- Custom Reports have been identified in the areas of HR and Finance Department that will be built to help bring efficiency and consistency to several processes.
- Reconciliation of the General Ledger to the source of posting. A report will be set up that can be ran frequently to determine sub-systems (Accounts Payable, Purchasing, Cash, and Payroll) are being reconciled to GL.
- GAAP compliance is being maintained through the system processes to help support manual process currently being done. This would include additional automation of the Purchase Receiving function and in the Cash Management function.
- Full integration with the Purchase Order System to the General Ledger will be done.
- Integration of the Fixed Asset System will be accomplished through an Import function to the Sage System.
- Improvement of the Cash Management process including recognition of long term and short term cash flow needs.
- Enhancement to Dual Controls to both General Ledger and Sub-system postings between departments.
- Improved efficiency and consistency when reporting to others on Peak Vista Community Health Centers Financial Statements and Grant/Contract Reconciliation.

The results of this upgrade will meet the objective and set Peak Vista Community Health Centers up to manage growth of the grant processes and assure compliance with segregation and reporting requirements. The efficiency recognized month not requiring multiple reclassifications of transactions will bring both enhanced control and reporting of the financial statements produced.

From OIG Draft Report:

Lack of Required Supporting Documentation for Salaries

Pursuant to 2 CFR pt. 230, Appendix B, §§ (8)(m)(1) and (8)(m)(2), charges to awards for salaries and wages, whether treated as direct costs or indirect costs, will be based on documented payrolls approved by a responsible official of the organization. The distribution of salaries and wages to awards must be supported by personnel activity reports; and reports reflecting the distribution of activity of each employee must be maintained for all staff members (professionals and nonprofessionals) whose compensation is charged, in whole or in part, directly to awards.

From a random sample of 23 professional and nonprofessional employees, Peak Vista was unable to furnish Provider Tracking Sheets (certification of time worked) for three employees. The absence of these certifications indicates that Peak Vista's salaries were not fully documented and supported pursuant to 2 CFR pt. 230, Appendix B.

An inability to provide effective control over and accountability of all funds, property, and other assets can result in inadequate safeguarding of assets and inadequate assurance that those funds are used solely for authorized purposes.

Peak Vista Response:

Peak Vista agrees with this statement and has implemented corrective processes.

As noted previously, Peak Vista maintains four categories of employees: Full-time hourly (non-exempt) employees, part-time non-exempt employees, full-time professional (exempt) employees, and part-time exempt employees.

All hourly employees use an automated time keeping system to record their worked hours. This system is used to calculate their wages and can be used to track work location by department code.

Prior to OIG field work, all professional employees reported their payroll information on a manual system consisting of individual timesheets. For providers (physicians, physician assistants, advanced nurse practitioners, certified nurse mid-wives, dentists, hygienist, psychologists, and behavioral health counselors), that manual sheet was then compared to the patient appointment schedule by location and program, and any discrepancies were investigated and resolved. If that sheet was missing, provider time was verified by generating an appointment schedule by provider code to validate time worked.

Since the field work, we have implemented a process whereby each provider's time is tracked daily through the automated timekeeping system that had previously been used only by the hourly and administrative staff. This allows us to monitor and review provider time on a real time basis. In addition, the automated system allows tracking of time by work location and program.

From OIG Draft Report:**Lack of Existing Formal Policies and Procedures**

Pursuant to 2 CFR § 215.21(b)(3), grant recipients are required to adequately safeguard all funds, property, and other assets and assure that they are used solely for authorized purposes. Similar language appears in 45 CFR § 74.21(b)(3).

Contrary to these Federal requirements, Peak Vista did not have written policies and procedures for the following categories at the start of our audit: cash management, miscellaneous revenues, and journal entries. The absence of policies and procedures regarding the management and proper use of funds, property, and other assets could result in delay or inability to detect accounting inaccuracies and/or misappropriation of assets by theft or fraud.

Prior to completion of our audit fieldwork, Peak Vista provided the auditors with formal, written policies and procedures for the above categories.

Peak Vista Response:

Peak Vista disagrees with this finding as we thoroughly document procedures for safe-guarding funds, property and other assets.

Neither 2 CFR § 215.21(b)(3) nor 45 CFR § 74.21(b)(3) reference that written policies and procedures need to be maintained. As stated above, we are "*required to adequately safeguard all funds, property, and other assets and assure that they are used solely for authorized purposes*". This language does not specify the exact mechanism for "safe-guarding funds assets".

Peak Vista safe-guards funds, property and other assets through detailed instruction manuals, department-specific policy documents, and through formalized Policy and Procedures (P&P)

documents. Most of the policies identified above represent department-specific documents or training manuals. However, as noted in the above comments from OIG, we did seek to comply with OIG expectations by formalizing several of the policies in question during their field work. The Cash Management policy in question has always been a formal P&P, and is thus subject to our formal review process.

As part of our on-going quality assurance process, each P&P is reviewed, and updated as necessary, on its anniversary date to assure accuracy and compliance. If changes are required in the interim, those are codified and the anniversary is updated. The cash policy was undergoing this review process at the time of our OIG audit and was completed during the field work period. This timing apparently gave the auditors the impression that the policy was just being created.

To meet the spirit of OIG's recommendations, Peak Vista is now reviewing our criteria for determining which policies require formalization versus inclusion in departmental training manuals and/or policies. All P&Ps will continue to receive annual review to assure maximum control and compliance.

From OIG Draft Report:

Lack of Required Personnel Data

Pursuant to 42 U.S.C. § 233(h)(2), health service entities are required to review and verify the professional credentials, references, claims history, fitness, professional review organization findings, and license status of their physicians and other licensed or certified health care practitioners, and, where necessary, obtain permission from these individuals to gain access to this information.

Contrary to these Federal requirements, Peak Vista did not always maintain sufficient and current information to support placement in the position assigned. Incomplete personnel data as to background checks, reference checks, professional credentials, and licensing status could lead to situations in which people receive health care services from individuals who are not authorized or accredited to perform those services.

Of 23 sampled personnel files, 3 were missing information. Two of the personnel files were initially missing background checks and authorizations; however, Peak Vista completed the checks and authorizations and provided the documentation to us prior to the completion of our audit fieldwork. The third personnel file was missing an employee reference check.

Peak Vista Response:

Peak Vista challenge's the above statement. Peak Vista routinely conducts criminal background checks on in-coming staff and in conjunction with our provider credentialing process.

The following documents are completed or copied through our routine credentialing process:

Application for Appointment	Professional Diploma
National Provider Identification	CPR certification (if applicable)
Curriculum Vitae/Resume	Current Malpractice Insurance
Continuing Medical Education Credits	Health Status Questionnaire
Colorado Application Form	License and expiration date
Board Certification (copy of certificate)	DEA Certificate and expiration date,
Continuing education documents	Authorization for Release of Information

Further validation is sought through primary source verification:

National Practitioner Data Bank	Office of Inspector General Database
State License program	Excluded Parties List System
Specialty Training (Residency/Fellowship)	Board Certification
3 Peer References	Verification of diploma from the University
Privileges request verified (scope and training)	Background check
Program Director (if attended Residency < 5 yrs)	Department Chair (for all Hospital appointments)
Hospital Affiliations (Date of Affiliation, Status, Dept)	

What became apparent to us through the audit process, however, is the need to more consistently cross reference documentation between employee files in Human Resources and the final Credentialing Packets.

As stated above, three of the 23 files audited lacked data. Of the three cases cited, two were physicians. During the course of field work, we did perform the necessary back ground checks to assure compliance of these records. Upon subsequent internal auditing, we discovered that the Provider Credentialing packets included the criminal back ground reports, but that these were not referenced in the Employee Records maintained in Human Resources. We have now implemented a routine internal auditing process to assure that all Employee files contain complete cross references as necessary.

The third incomplete file was missing professional reference check reporting. The employee had been with Peak Vista for over 10 years. While the personal reference checks were performed, the professional reference requirement was waived at the time because the employee was the wife of a military person and had spent the previous 15 years raising children and therefore lacked current professional references. Because we had no process at the time to document this, it was not included in her file. This information was gathered in subsequent conversations with her manager at the time.

A process has now been implemented to assure that if for any reason reference checks are not completed, this will be documented in the employee's file as well as any alternative reference processes used instead.

In summary, Peak Vista notes that it was ultimately found to be financially viable as stated in the OIG's draft results of the limited scope review, "Based on our assessment, we believe Peak Vista is financially viable, has the capacity to manage and account for Federal funds, and is capable of operating its health center in accordance with Federal regulations." The exceptions found in our processes have been addressed and we will continue to improve our compliance and internal auditing processes going forward.