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NEWS RELEASE

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FOR RELEASE November 5, 2010

Auditor of State David A. Vaudt today released a report on the Local Public Health Services Grant (Grant) administered by the Bureau of Local Public Health Services, a division of Health Promotion and Chronic Disease Prevention of the Iowa Department of Public Health (IDPH). The review was conducted to determine whether providers receiving Grant funds were supplying services and submitting claims in accordance with IDPH requirements and to evaluate program controls.

IDPH dispersed $10,638,947.00 of Grant monies to the 99 Iowa counties in both fiscal years 2007 and 2008 for a total of $21,277,894.00. The Grant funds are primarily used to provide services to income-eligible clients in the areas of home care aide and public health nursing. The Grant is a funder of last resort, only paying for eligible expenses not covered by another funding source, such as Medicaid, Medicare or private insurance. The Grant covers expenses associated with management of core public health issues, administration of local boards of health, public health nursing services and home care aide services.

The Grant is funded by 3 appropriations. While all 3 appropriations were tested, the use of the largest appropriation of the 3, for elderly wellness, was the primary focus of the report. The language for the elderly wellness appropriation, which funds 87% of the Grant, stated the funding in fiscal year 2007 was to be used "for optimizing the health of persons 60 years of age and older" and funding in fiscal year 2008 was to be used "for promotion of healthy aging and optimization of health care of older adults." Vaudt reported fiscal year 2007 and 2008 Grant funds were used for populations other than "persons 60 years of age or older" or "older adults" as required by the appropriation language found in the Acts of the General Assembly.

IDPH officials responded historical use of the funds and appropriation language for fiscal year 1998, which was codified into law in 1999, authorized the Department to fund services for populations other than the elderly from the elderly wellness appropriation. However, the 1999 *Code* was subsequently modified to remove references to the fiscal year 1998 appropriation language. IDPH officials also stated rules found in the Iowa Administrative Code authorized the Department to provide services to populations other than the elderly with elderly wellness appropriations. However, these rules do not comply with the appropriation language enacted by the General Assembly for the years tested. In accordance with section 4.8 of the *Code of Iowa*, "If statutes enacted at the same or different sessions of the legislature are irreconcilable, the

statute latest in date of enactment by the general assembly prevails. If provisions of the same Act are irreconcilable, the provision listed last in the Act prevails."

The 99 counties to which Grant funds are distributed are divided into 6 regions and IDPH employs a Regional Community Health Consultant (RCHC) to cover each region. The RCHC is responsible for conducting compliance evaluations of each provider within the region every other year, in addition to duties of keeping member counties updated on Grant requirements, changes and reporting requirements.

Vaudt reported records were tested for 1 county in each of the 6 regions for a limited number of months during fiscal years 2007 and 2008. The selected counties received 20.72% of Grant disbursements in fiscal years 2007 and 2008. Vaudt identified the following during review of the 6 counties selected for testing:

- Based on service descriptions and testing, at least 20% of the appropriation for elderly wellness was most likely used for non-elderly services.
- Client financial assessments required for qualification for Grant services were inadequate. IDPH did not require any supporting records to substantiate the reported financial eligibility of clients.
- Significant billing problems associated with inadequate supporting records, billings in excess of Grant limitations, billings for costs unallowable for specific appropriations within the Grant and billings for expenditures which were not consistent with the appropriation language enacted by the General Assembly.
- Significant deficiencies in records maintained to document costs billed to the Grant, such as indirect rates and non-labor additional costs. There were also specific Grant limitations on costs, such as indirect costs and technology costs, which several providers violated.
- Inadequate internal controls at IDPH's Central Office, including general lack of guidance and lack of consistency.
- Inconsistency between RCHCs leading to significant variations in spending patterns from region to region and unapproved activity Central Office was unaware of.
- Conflict of interest in the responsibilities of the RCHCs to both consult with and monitor program compliance of the counties in the RCHC's region.
- Project Directors, who are employees of county providers designated at each county to submit monthly billings for the county and ensure providers maintain documentation of services provided, failed to adequately ensure the providers within their regions were maintaining required documentation.

Vaudt reported similar findings would likely have been identified if more providers had been tested from the remaining 93 counties or if additional months had been tested. Vaudt also

reported other concerns may have been identified if additional testing had been performed. Based on results of testing performed in only 6 of Iowa's 99 counties, Vaudt recommended IDPH:

- Work with members of the General Assembly to ensure the appropriation language approved each year clearly specifies the intent of how Grant funds are to be spent.
- Ensure administrative rules do not allow Grant funds to be used for purposes not specifically approved by the General Assembly in the annual appropriation language.
- Propose an elderly wellness appropriation amount to be spent only for elderly services to avoid diversion of funds to other populations.
- Implement Grant eligibility requirements consistent with other financial assistance programs.
- Implement increased accountability and controls regarding Grant components, such as client eligibility, cost allocations according to appropriation and labor and non-labor costs submitted for payment from the Grant.
- Increase emphasis on compliance reports to include independent evaluation and more thorough testing of billing support.

Vaudt reported IDPH was receptive to the review and proactively worked to implement improvements prior to issuance of the report. Although the changes made and the resulting effects were not included in the testing, Vaudt reported some of the changes IDPH planned to make in fiscal year 2010 and commented on those changes.

A copy of the report is available for review in the Office of Auditor of State and on the Auditor of State's web site at http://auditor.iowa.gov/specials/0960-5880-B0P1.pdf.

# # #

A REVIEW OF THE
LOCAL PUBLIC HEALTH SERVICES GRANT
ADMINISTERED BY THE IOWA DEPARTMENT OF PUBLIC HEALTH

FOR THE PERIOD JULY 1, 2006 THROUGH JUNE 30, 2008

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Auditor's Transmittal Letter

To the Governor, Members of the General Assembly and
the Director of the Iowa Department of Public Health:

In conjunction with our audit of the financial statements of the State of Iowa and in accordance with Chapter 11 of the *Code of Iowa*, we conducted a review of the Local Public Health Services Grant (Grant) administered by the Iowa Department of Public Health (IDPH) through the Division of Health Promotion and Chronic Disease Prevention for the period July 1, 2006 through June 30, 2008. During this period, the Grant was funded by 3 appropriations. While all 3 appropriations were tested, the use of the largest appropriation of the 3, for elderly wellness, was the primary focus of the review. The language for the elderly wellness appropriation, which funded 87% of the Grant, stated the funding in fiscal year 2007 was to be used "for optimizing the health of persons 60 years of age and older" and the funding in fiscal year 2008 was to be used "for promotion of healthy aging and optimization of health care of older adults."

We reviewed certain Grant activity, including compliance with requirements established by the *Code of Iowa* and administrative rules, and financial records and assessed the controls over the application, monitoring and reporting processes. We also performed a limited review of the billings, client files and staff qualifications of a selection of counties receiving Grant funds. Based on a review of relevant information, the *Code of Iowa* and administrative rules governing the Grant, we performed the following procedures:

(1) Interviewed IDPH staff responsible for administering the Grant to obtain an understanding of the administration, policies and procedures, controls, monitoring and Grant goals and expectations.

(2) Reviewed and evaluated Grant procedures and controls for adequacy.

(3) Reviewed applicable laws, rules and guidelines.

(4) Selected 1 county from each of the 6 IDPH regions and performed a site visit to determine compliance with the *Code of Iowa*, Iowa Administrative Code (IAC) and IDPH policies and guidelines. Specifically, we:

  (a) Evaluated procedures and controls at each county to obtain an understanding of how the counties ensure activities funded by the Grant are in accordance with Grant requirements.

  (b) Determined whether staff members of providers possessed the qualifications necessary to meet Grant requirements and provide services to clients in an appropriate manner.

  (c) Determined if clients receiving state aid met eligibility requirements and were billed the appropriate sliding fees as required by the Grant.

  (d) Determined if the Local Boards of Health complied with the IAC.

  (e) Interviewed provider staff members to determine if the Grant was used as the funder of last resort in accordance with Grant requirements.

(f) Compared provider contracts with IDPH to billing documentation to determine if the providers are operating in accordance with their contracts.

(g) Reviewed monthly utilization reports (MUR's) (i.e. monthly billings) submitted to IDPH, performed interviews and reviewed supporting documentation to determine whether costs claimed by counties are supported and allowable for reimbursement by the Grant.

(h) Interviewed Regional Health Community Consultants (RCHCs) to obtain an understanding of their role at each county. We also reviewed county compliance reports which they complete and related supporting documentation.

(5) Met with IDPH officials to discuss preliminary report findings and IDPH's response to preliminary report findings.

(6) Met with a representative of the Legislative Services Agency (LSA) to discuss specific elements of IDPH's response to preliminary report findings.

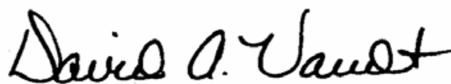
Based on these procedures, we determined IDPH's interpretation of allowable costs for Grant reimbursement is not consistent with the appropriation language enacted by the General Assembly for the elderly wellness appropriation which funded 87% of the Grant. As previously stated, the language specifies the appropriation was to be used for elderly services. Responding to this finding, IDPH officials stated historical use of the funds and appropriation language for fiscal year 1998, which was codified into law in 1999, authorized the Department to fund services for populations other than the elderly. However, the 1999 *Code* was subsequently modified to remove references to the fiscal year 1998 appropriation language. IDPH officials also stated rules found in the Iowa Administrative Code authorized the Department to provide services to populations other than the elderly with elderly wellness appropriations. However, these rules do not comply with the appropriation language enacted by the General Assembly for the years tested.

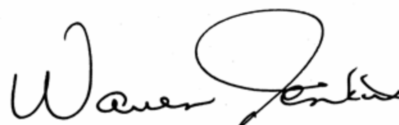
A literal interpretation of the elderly wellness appropriation language would result in services being provided only to elderly clients. Non-elderly services would not be eligible for services provided by elderly wellness appropriations. IDPH's interpretation resulted in at least 20% of the appropriation provided for elderly wellness being diverted to services which appear to be provided to non-elderly populations.

In addition, we determined Grant controls were inadequate and guidance from IDPH was not sufficient or consistent to ensure consistent and compliant use of Grant funds from county to county. We also identified control weaknesses related to billing errors and corrections and inadequate reporting requirements. We have developed certain recommendations and other relevant information we believe should be considered by the Iowa Department of Public Health, the Governor and the General Assembly.

The procedures described above do not constitute an audit of financial statements conducted in accordance with U.S. generally accepted auditing standards. Had we performed additional procedures, or had we performed an audit of the Iowa Department of Public Health, other matters might have come to our attention that would have been reported to you.

We extend our appreciation to the personnel of the Iowa Department of Public Health and the counties selected for testing for the courtesy, cooperation and assistance provided to us during this review.





DAVID A. VAUDT, CPA
Auditor of State

WARREN G. JENKINS, CPA
Chief Deputy Auditor of State

March 31, 2010

EXECUTIVE SUMMARY

The Local Public Health Services Grant (Grant) is administered by the Bureau of Local Public Health Services, a division of Health Promotion and Chronic Disease Prevention of the Iowa Department of Public Health (IDPH). The Grant provides funding for services to clients, primarily in the areas of home care aide and public health nursing. In order to be eligible for Grant-funded services, clients are to complete an annual financial assessment to determine their eligibility for receipt of services. IDPH uses a sliding fee scale to provide all or partial funding for services received based on the financial need of the client. In accordance with the language of the elderly wellness appropriation funding 87% of the grant, funds in fiscal year 2007 were "for optimizing the health of persons 60 years of age and older" and were "for promotion of healthy aging and optimization of health care of older adults" in fiscal year 2008.

We conducted our review to determine whether providers receiving Grant funds supplied services and submitted claims in accordance with IDPH requirements and to evaluate program controls. We reviewed program activity in fiscal years 2007 and 2008, during which time IDPH dispersed $10,638,947.00 of Grant funds annually. The funds were disbursed to the 99 Iowa counties through each county's local board of health based on a formula. The formula required a portion of the Grant be distributed evenly among the counties and a portion be distributed based on county population. The Grant is a funder of last resort, only paying for eligible expenses not covered by another funding source, such as Medicaid, Medicare or private insurance. The Grant covers expenses associated with management of core public health issues, administration of local boards of health, public health nursing services and home care aide services.

The 99 counties are divided into 6 regions and IDPH employs a Regional Community Health Consultant (RCHC) to cover each region. The RCHC is responsible for conducting compliance evaluations of each provider within the region every other year in addition to duties of keeping member counties updated on Grant requirements, changes and reporting requirements. RCHCs conduct regional informational meetings and are available to assist member counties with questions regarding administration of the Grant.

Many county local boards of health contract with multiple providers to supply services. County health departments are often providers for the Grant. In addition, private not-for-profit providers also provide public health nursing, home care aide and chore services to county residents eligible for Grant services.

We tested records for 1 county in each of the 6 regions for fiscal years 2007 and 2008 based on risk factors, including size of county, number of billing corrections and RCHC compliance report comments. The counties selected for testing received 20.72% of Grant funds in fiscal years 2007 and 2008. Grant funding is provided on a reimbursement basis. The 6 counties are summarized in the following table.

		Annual Grant Disbursements	
Region	**County**	**Amount**	**Percent of Total**
1	Polk	$ 1,019,984.00	9.59%
2	Cerro Gordo	173,339.00	1.63%
3	Buena Vista	81,954.00	0.77%
4	Pottawattamie	289,171.00	2.72%
5	Muscatine	161,039.00	1.51%
6	Scott	479,311.00	4.50%
	Total	$2,204,798.00	20.72%

We only attempted to verify the costs reimbursed to providers in the 6 counties for a limited number of months during fiscal years 2007 and 2008. Despite the limited nature of our testing, we identified a number of concerns which relate to the providers. This section of the report briefly highlights specific problems identified at each county. We believe the findings we identified are representative of issues we would have identified at the 93 counties not included in our testing procedures. In addition, it is likely other concerns may have been identified if more counties were selected for testing.

The largest counties included in our testing were Polk, Scott and Pottawattamie. Their combined funding represents 81% of the funds tested and approximately 17% of total Grant disbursements. In the limited amount of testing we performed at these 3 counties, we identified:

- Significant weaknesses in documentation to verify the nature of expenditures or rates billed were appropriate and
- Significant use of Grant funds for alternative services not consistent with the elderly wellness appropriation language enacted by the General Assembly and/or IDPH's approved activities.

The smallest counties included in our testing were Cerro Gordo, Muscatine and Buena Vista. Their combined funding represents 19% of the funds tested and approximately 4% of total Grant disbursements. We identified similar concerns at these counties. In addition, we identified administrative weaknesses in personnel files, billings to clients and use of outdated cost support.

In addition, we identified weaknesses with the administration of the Grant by IDPH. The weaknesses are summarized as follows:

- The most significant findings associated with the Grant were related to IDPH's interpretation of allowable costs for Grant reimbursement. The Grant's elderly wellness appropriation language specifies $9,233,985.00 of the $10,638,947.00 appropriated was for elderly wellness. As previously stated, the appropriation's purpose for fiscal year 2007 was "for optimizing the health of persons 60 years of age and older." In fiscal year 2008, the description was "for promotion of healthy aging and optimization of health care of older adults."

  We identified $731,692.70 of services paid from the elderly wellness appropriation which were not restricted to elderly clients and included a significant amount of services provided to non-elderly clients. These services represent almost 20% of the funds appropriated for elderly wellness. For example, a provider in Polk County provided services for court-ordered protection against abuse and neglect for children through the elderly wellness appropriation.

  According to IDPH officials, the Department was authorized to provide services to non-elderly clients because the *Code* in effect at the time IDPH's administrative rules were established allowed for services to non-elderly clients by referring to appropriation language enacted by the General Assembly for fiscal year 1998. IDPH officials also stated populations other than the elderly were served in years prior to fiscal years 2007 and 2008 and legislators did not take issue with IDPH's continued use of elderly wellness funds for non-elderly clients even though the appropriation language for those years specified the appropriated funds were to be used to provide services to the elderly. According to IDPH officials, the current *Code* gives IDPH broad authority in establishing Grant administrative rules. As a result, the current administrative rules which allow the provision of services to a broader population are not inappropriate. IDPH officials contend the Department acted in good faith and properly used the funds for non-elderly recipients.

While we concur the prior version of the *Code* and the fiscal year 1997 appropriation language allowed services for non-elderly populations, IDPH does not have authority to divert funds from the purposes expressly described in the appropriation language in effect during our review period. IDPH staff should have revised the rules in the IAC to comply with restrictions established by the Acts of the General Assembly.

In addition, in accordance with section 4.8 of the *Code of Iowa*, "If statutes enacted at the same or different sessions of the legislature are irreconcilable, the statute latest in date of enactment by the general assembly prevails. If provisions of the same Act are irreconcilable, the provision listed last in the Act prevails."

IDPH also maintains aging is a "cradle to grave" process and begins at birth. Therefore, the Grant is flexible in providing services to a variety of clients because the appropriation language in effect for fiscal year 2008 authorizes services to promote healthy aging. Examples of services billed to the Grant which could be for non-elderly services include immunizations, health education, screenings and assessments and services for prevention of abuse and neglect. While services for non-elderly clients may be necessary, IDPH does not have authority to divert elderly wellness funds to other clients on the basis of their "cradle to grave" aging interpretation or outdated *Code* requirements. After we met with IDPH officials regarding our preliminary findings, the appropriation language submitted to the 2010 session of the General Assembly by IDPH representatives was modified to more clearly define healthy aging. The proposed language, which was approved by the General Assembly for fiscal year 2011, removes the title "Elderly Wellness" and replaces it with "Healthy Aging." The purpose stated in the appropriation language is:

> "To provide public health services that reduce risks and invest in promoting and protecting good health over the course of a lifetime with a priority given to older Iowans and vulnerable populations."

As a result of the new language, IDPH and county providers utilizing funds have discretion regarding the populations served as the appropriation language does not define the amount of funds which should be used to benefit the elderly and does not define "older Iowans" or "vulnerable populations." While IDPH officials state they do not intend to change the manner in which Grant funds are used, there are no guarantees the funds will be used to ensure the needs of elderly Iowans are met.

In addition, if Grant funding is not primarily used to serve the needs of the elderly, it should be determined if services provided are a duplication of services provided by other programs administered by IDPH or other State agencies.

The remaining portion of the Grant was composed of 2 other appropriations. There were specific restrictions on the use of the appropriations. We identified several creative billing practices which resulted in providers receiving reimbursements for costs not permissible for reimbursement under all 3 appropriations.

- IDPH controls were not sufficient to mitigate control weaknesses in other areas of the Grant administration. RCHCs were not consistent between regions in providing administrative guidance, which lead to significant variations in spending patterns between regions. The RCHCs were the primary means of control over the Grant and they completed compliance evaluations on counties designated to them as part of their regular duties, which resulted in a conflict of interest and a lack of independence. During testing, we informed IDPH officials of our findings and learned they were unaware of the guidance some RCHCs were supplying providers. The guidance provided by some RCHCs resulted in improper billing practices at specific counties which would not have been allowable if IDPH officials had been aware of the practices.
- Project Directors, employees of county providers who are designated at each county to submit monthly billings for the county and ensure providers maintain documentation of

services provided, also failed to adequately ensure the providers within their region were maintaining required documentation. Although RCHCs were conducting biannual compliance reviews, we determined the reviews were not independent and were not adequate to ensure billings were accurate. The RCHCs typically did not release adverse findings. Rather, RCHCs delayed completion of the compliance reviews and allowed providers to make changes so the compliance reviews would show compliance.

- Client financial assessments required for qualification for Grant services were inadequate. Other State and Federal assistance programs consistently included requirements for clients to submit financial records and proof of identification to verify their eligibility for services. However, IDPH did not require any supporting records to substantiate the reported financial eligibility of clients and only 1 provider had policies in place to require support for client financial eligibility for services.
- We identified significant billing problems associated with inadequate supporting records, billings in excess of Grant limitations, billings for costs unallowable for specific appropriations within the Grant and billings for expenditures which were not consistent with the appropriation language enacted by the General Assembly. We also identified significant deficiencies in record maintenance to support costs billed to the Grant, such as indirect cost rates and additional costs. We also identified specific Grant limitations on costs, such as indirect costs and technology costs, which several providers violated.
- Other findings identified during testing included a general lack of guidance and a lack of consistency from IDPH, control weaknesses related to billing errors and corrections and inadequate reporting requirements, which all resulted in findings specific to each county. Details for each finding are included in the report.

Based on the results of testing performed in only 6 of Iowa's 99 counties, we recommend IDPH:

- Work with members of the General Assembly to ensure the appropriation language approved each year clearly specifies the intent of how Grant funds are to be spent.
- Ensure administrative rules do not allow Grant funds to be used for purposes not specifically approved by the General Assembly in the annual appropriation language.
- If elderly recipients are to benefit from a majority of Grant funding, IDPH should clearly define "elderly" and specify the amount of funding set aside specifically for that population. If IDPH and members of the General Assembly do not define the population intended to benefit from the funding, IDPH will not be able to ensure the population intended to benefit from the funding is adequately prioritized. For the remainder of appropriated funds, IDPH should ensure approved services are rendered prior to release of funds.
- Implementing Grant eligibility requirements consistent with other financial assistance programs.
- Implement increased accountability and controls regarding Grant components, such as client eligibility, cost allocations according to appropriation and labor and non-labor costs to be reimbursed by the Grant, and
- Increase emphasis on compliance reports to include periodic independent evaluation and more thorough testing of billing support.

Throughout the review, we periodically met with IDPH officials to discuss our concerns. IDPH was receptive to the review and proactively worked to implement improvements prior to issuance of the report. Although the changes made and the resulting effects were not included in our testing, the changes IDPH planned to make in fiscal year 2010 are reported and commented on in this report.

GRANT SUMMARY

The Bureau of Local Public Health Services (LPHS), established within the Division of Health Promotion and Chronic Disease Prevention of the Iowa Department of Public Health (IDPH), administers state funding through the LPHS Grant (Grant), which is dispersed to local providers to provide services in the areas of public health nursing, home care aide, local board of health and local public health services.

Purpose of the Program per IDPH

According to Chapter 80 of the Iowa Administrative Code (IAC) (641-80.1(135)), the purpose of the Grant is to assist with assuring core public health functions are available, deliver essential public health services and increase the capacity of local boards of health to promote healthy people and healthy communities. According to LPHS' website, the purpose of the Grant's primary services, public health nursing and home care aide, is to prevent inappropriate or early institutionalization of individuals.

According to the IDPH website, services covered by the Grant include, but are not limited to, the following:

Public health nursing – Includes services such as home visit services for assessments, injections, blood draws, wound care and health guidance. In addition, it includes chronic disease management services, health screenings, communicable disease follow-up and prevention of abuse and neglect.

Home care aide – Includes services such as essential shopping assistance, housekeeping, money management, transportation, snow removal and lawn care. In addition, home care aide includes personal care services such as checking consumer's pulse rate and temperature and assistance with prescribed exercises and skin care. Administrative services, including maintenance of records and development of a service plan to meet the needs of the consumer, are also funded by the Grant.

Local board of health and local public health services – Includes provider's expenses related to review of rules, regulations, policies, contracts and activities to assure the health of the public. It also includes limited computer equipment purchases, workforce development and resources such as textbooks, DVDs and training resources. These funds may also be utilized to supplement funds needed for public health nursing and home care aide services.

In addition to direct service-related costs in the service categories listed above, providers may also include non-service costs when submitting their expenses. According to IDPH officials, these costs must be directly related to an approved service. Examples of approved non-service costs are travel expenses and medical supplies required to conduct an approved health clinic.

Legislative Appropriations

IDPH receives appropriations each year for costs associated with the Grant. The largest appropriation, totaling $9,233,985 in both fiscal years 2007 and 2008, was designated for elderly wellness. Appropriation language for fiscal year 2007 stated these funds were "for optimizing the health of persons 60 years of age and older." However, for fiscal year 2008, the appropriation language changed to state the funds were "for promotion of healthy aging and optimization of the health care of older adults."

IDPH allocated each year's elderly wellness appropriation between the service areas of public health nursing and home care aide. Public health nursing received $2,326,981.00 and home care aide received $6,907,004.00 for each fiscal year.

IDPH also received appropriations from the Healthy Iowans Tobacco Trust in the amount of $1,157,482 in fiscal years 2007 and 2008 for essential public health services, contracted through a formula for local boards of health, to enhance health promotion and disease prevention services. These services were defined in fiscal year 2007 to include home health care and public health nursing services. In fiscal year 2008, the services were to promote healthy aging throughout the lifespan. This appropriation funded services defined as LPHS by IDPH. The appropriation also funded $1,000.00 incentive payments to each county for completion and submission of year-end reports.

In addition, appropriations allocated to IDPH for fiscal years 2007 and 2008 included community capacity funds of $247,480 for "strengthening the health care delivery system at the local level." IDPH listed the services funded through these appropriations as local board of health (LBOH).

The total amounts appropriated to IDPH for both fiscal years 2007 and 2008 are summarized in **Table 1**.

Table 1

Service Category	Amount	
Elderly wellness:		
Home care aide	$ 6,907,004	
Public health nursing	2,326,981	$9,233,985.00
Other:		
Local public health services	1,157,482	
Local board of health	247,480	1,404,962.00
Total		$ 10,638,947.00

For fiscal years 2007 and 2008, IDPH allocated $10,638,947.00 of Grant funds each year to the 99 counties based on a formula. A portion of the Grant funds were distributed evenly among the counties and a portion was based on county population. **Table 2** summarizes the formula used by IDPH to determine each county's portion of the Grant for fiscal years 2007 and 2008 combined.

Table 2

	Distributed Evenly		Distributed by Population		
Service Category	%	Amount	%	Amount	Total
Elderly wellness:					
Home care aide	15%	$ 2,072,101.20	85%	11,741,906.80	13,814,008.00
Public health nursing	25%	1,163,490.50	75%	3,490,471.50	4,653,962.00
Other:					
Local public health services^	40%	925,985.60	60%	1,388,978.40	2,314,964.00
Local board of health	30%	148,488.00	70%	346,472.00	494,960.00
Total		$ 4,310,065.30		16,967,828.70	21,277,894.00

^ - This amount includes a $1,000.00 incentive payment to each of the 99 Iowa counties for submission of year-end reports.

Each County's allocation by service category for both fiscal years 2007 and 2008 is detailed in **Schedule 1**.

Distributions by IDPH are to be spent in proportion to the funding sources which provided the various components of the Grant. **Table 3** summarizes how the Grant funds distributed by IDPH were to be allocated between service categories. The distributions are based on the percentage of total appropriations.

Table 3

Service Category	Percent of Funds
Elderly wellness:	
Home care aide	65%
Public health nursing	22%
Other:	
Local public health services	11%
Local board of health	2%
Total	100%

While IDPH distributed funds to counties based on the percentages shown in **Table 3,** the funds may have been reallocated between the categories through submission and approval of alternative plans to IDPH. The alternative plans must outline the specific needs of a county to deviate from the prescribed allocations. Therefore, the actual percentages disbursed to counties may be modified from this initial allocation. An example alternative plan is included in **Appendix A**.

Inconsistencies in Authorizing Language

As previously stated, language included in the appropriation bills providing the majority of Grant funding for fiscal years 2007 and 2008 stated the funds were for the following respective purposes.

- "Optimizing the health of persons 60 years of age and older."
- "Promotion of healthy aging and optimization of the health care of older adults."

Also as previously stated, Chapter 80 of the IAC states the purpose of the Grant is to ensure core public health functions are available, essential public health services are available and local boards of health increase their capacity to promote healthy people and communities. The language found in Chapter 80 of the IAC does not specify elderly clients as the primary beneficiaries of the Grant funds. Therefore, the purpose described in Chapter 80 of the IAC is not consistent with the language included in the fiscal year 2007 and 2008 appropriation bills providing the majority of Grant funding for the purpose of elderly wellness.

As will be discussed in detail in the following sections of this report, we determined fiscal year 2007 and 2008 Grant funds were used for populations other than "persons 60 years of age or older" or "older adults" as required by the appropriation language found in the Acts of the General Assembly.

We met with IDPH staff members and discussed the inconsistency between the appropriation language for fiscal years 2007 and 2008 and the language found in Chapter 80 of the IAC. We also discussed the use of Grant funds for populations other than the

elderly. The IDPH staff members we spoke with stated they believed IDPH used the funds within the parameters of law and provided historical information on the Grant to support their position. According to IDPH staff members, language found in the 1997 Acts of the General Assembly and the 1999 and 2005 versions of the *Code of Iowa* must also be considered to determine the Legislature's intended use of Grant funds in fiscal years 2007 and 2008.

The appropriation language in Chapter 203, Section 5, of the 1997 Iowa Acts specifically allowed for the following services:

- Public health nursing programs – "for elderly and low income persons with the objective of preventing or reducing institutionalization."
- Home care aide/chore – "with an emphasis on services to elderly and persons below the poverty level and children and adults in need of protective services with the objective of preventing or reducing inappropriate institutionalization."
- Senior health program – "to senior health programs located in counties which provide funding on a matching basis for the senior health program."
- Alternative plans – Notwithstanding the program allocations for the above mentioned directives, "a county may submit to the department a plan for an alternate allocation of funding which provided for assuring the delivery of existing services and the essential public health services based on an assessment of community needs and targeted populations to be served under the alternate plan."

Chapter 135.11 (15) of the 1999 *Code of Iowa (Code)* governing use of the appropriated funds stated, "program direction, evaluation requirements, and formula allocation procedures for each of the programs shall be established by the department by rule, consistent with the 1997 Iowa Acts, chapter 203, section 5." At that point, the specific appropriation language of the 1997 Iowa Acts was codified.

During the 2005 legislative session, the language codifying the 1997 Iowa Acts was removed from the *Code.* New language in the *Code* stated "program direction, evaluation requirements, and formula allocation procedures for each of the programs shall be established by the department [IDPH] by rule." According to IDPH staff, the modification was intended to further expand IDPH's discretion over Grant spending and the *Code* allowed IDPH to utilize Grant funds as IDPH directed and as it established through administrative rules. However, the administrative rules were not consistent with the appropriation language contained in the Iowa Acts at that time. The appropriation language for fiscal years 2002 through 2005 enacted by the General Assembly stated the elderly wellness funding was for "optimizing the health of persons 60 years of age and older."

In fiscal year 1998, IDPH established Chapters 79 and 80 of the IAC, which incorporated the purpose of the Grant as described in the 1997 appropriation language. This language remained unchanged through 2007 and was not modified when modifications were made to the *Code* during that period. In 2007, IDPH merged Chapters 79 and 80 into an updated Chapter 80. The content of Chapter 80 did not materially change and remained consistent with the purpose described in the 1997 Iowa Acts.

We reviewed the *Code* sections identified by IDPH staff members and the current and historical IAC chapters to which they referred. We also reviewed the appropriation language prepared and approved by the General Assembly each year during the period covered by the *Code* sections to which IDPH staff referred. The historical information for the *Code* sections, the Acts of the General Assembly and the IAC is summarized in a chart in **Appendix B**.

During our review of this information, we identified a number of inconsistencies and conflicting language between the 3 sources. Specifically:

- The 1999 *Code* refers to the 1997 Acts of the General Assembly which allowed funds to be used for low income persons and children and adults in need of protective services. The 1997 Acts also allowed alternative plans. However, the 1999 Iowa Acts of the General Assembly (effective for fiscal year 2000) significantly changed the target population to be served by the funds when it modified the appropriation language under the title "Elderly Wellness" and stated funding was "for optimizing the health of persons over 55 years of age." This language continued in the 2000 Iowa Acts. From the 2001 to 2006 Iowa Acts, effective for fiscal years 2002 through 2007, the appropriation language was modified to state the elderly wellness funding was "for optimizing the health of persons 60 years of age and older." The 2007 Iowa Acts, effective for fiscal year 2008, were modified to state the purpose of the elderly wellness funds was "for promotion of healthy aging and optimization of the health of older adults."
- As previously stated, according to IDPH staff, the new language in the 2005 *Code* was intended to further expand IDPH's discretion over Grant spending and the *Code* allowed IDPH to utilize Grant funds as IDPH directed and as it established through administrative rules. However, the administrative rules were not consistent with the appropriation language contained in the Iowa Acts at that time. IDPH does not have authority to expand the allowable uses of the Grant as specified in the appropriation language of the Iowa Acts. Rules in the IAC do not supersede restrictions on funds specified in the Acts of the General Assembly adopted by the Legislature.

According to IDPH officials, they believed the 1997 Iowa Acts' purpose for funding populations including elderly, low income, child and adult protective services and alternate community needs as determined by the counties remained in effect through the period of our review. They also stated:

- Since the term elderly wellness was first introduced in the 1999 Iowa Acts when the 1997 Iowa Acts were codified in the 1999 *Code*, the elderly wellness term was not meant "to exhaustively identify the legislative intent for the specific uses of the funds."
- In 2004, the appropriation bill required IDPH to submit a report to the General Assembly which detailed the "provision of services and expenditures for the services" for elderly wellness funding. After submission of the report to the General Assembly, in which IDPH stated funding was used for recipients including those not defined as elderly, IDPH received no objections from the General Assembly indicating IDPH's spending patterns were inappropriate or inconsistent with Legislative intent.
- The more recent appropriation language in the 2007 Iowa Acts includes provision of services for "healthy aging," which IDPH believes connotes a secondary intent to continue to authorize services to non-elderly clients. IDPH stated the term "healthy aging" is understood in public health to include the entire life span of a person, which IDPH described as "cradle to grave" throughout discussions regarding the intent of Grant funds.
- In 2008, when Chapters 79 and 80 of the IAC merged into Chapter 80, the administrative rules continued to include non-elderly populations. Chapter 80 was adopted by the State Board of Health and reviewed by the Legislature's Administrative Rules Review Committee. At that time, no concerns were raised by either body regarding the authorized use of the funds. Once adopted, these rules have the force and effect of law.

- IDPH obtained a letter with signatures from 3 members of the General Assembly who are the co-chairs and the House ranking member of the Health and Human Services Budget Subcommittee which stated appropriation language was condensed under the title "Elderly Wellness," but the intent of the funds was to refer back to the 1997 Iowa Acts language.

We acknowledge IDPH staff members have demonstrated professionalism and willingness to initiate program changes to improve program operation. However, based on our review of requirements established by the *Code of Iowa*, the Acts of the General Assembly and the Iowa Administrative Code, IDPH did not administer all Grant funds in accordance with law established in the *Code* and Iowa Acts.

In addition to reviewing the requirements established by the *Code of Iowa*, the Acts of the General Assembly and the Iowa Administrative Code, we met with a member of the Legislative Services Agency (LSA) to discuss IDPH's position on the historical changes to *Code* language and appropriation language. Based on our discussion with the LSA representative we spoke with:

- In accordance with section 4.8 of the *Code of Iowa*, "If statutes enacted at the same or different sessions of the legislature are irreconcilable, the statute latest in date of enactment by the general assembly prevails. If provisions of the same Act are irreconcilable, the provision listed last in the Act prevails."

  Therefore, beginning in 1999 when the appropriation language in the Acts of the General Assembly designated the Grant funds "for optimizing the health of persons over 55 years of age," Grant funds should have been used to serve that population and the 1997 Iowa Acts referenced in the *Code* should not have been interpreted as the binding law. IDPH officials should have recognized the conflicting language and addressed it with members of the General Assembly to ensure funds were being utilized as intended.

- Although members of the General Assembly and the Legislature's Administrative Rules Review Committee (ARRC) reviewed the reports submitted by IDPH and the updated administrative rules, their role in review is more cursory in nature and their processes do not include in-depth analysis and comparison of administrative rules to *Code* and Iowa Acts language. Particularly in cases where the substance of the administrative rules is not significantly changed, the ARRC's role does not include significant review of historical law. IDPH is responsible for ensuring administrative rules in the IAC are current and in accordance with limitations established in the *Code* and Iowa Acts.

- While the Code language gives IDPH latitude in development of rules to administer the Grant, the authority granted to IDPH in the Code does not authorize IDPH to deviate from appropriation language in the Iowa Acts to fund services to populations not covered in the appropriation language.

- IDPH purports the term "Elderly Wellness" is not intended to strictly limit funds to elderly populations. However, according to the LSA representative we spoke with, Iowa law is designed to work in plain language, so when funds are defined as "Elderly Wellness – for optimizing the health of persons over 55 years of age, it means people 55 years of age and above are supposed to receive the services funded through the appropriation.

  IDPH received support from 3 members of the General Assembly who stated populations covered in the 1997 Iowa Acts language were meant to continue to receive services even when the later Iowa Acts designated persons over 55 of age or

60 years of age and older as the target population to be served. However, we are unable to determine if the remaining members of the General Assembly concurred with the support provided by the 3 members. When appropriation language designates people of a specific age as the population to be served by the funds, those populations are expected to be served by those funds.

As previously stated, the period of our review included fiscal years 2007 and 2008. The *Code* was modified in 2005 and the reference to the 1997 Iowa Acts was eliminated.

- For fiscal year 2007, appropriation language from the 2006 Iowa Acts stated the funds were for "Elderly Wellness – for optimizing the health of persons 60 years of age and older." The *Code* no longer referenced the 1997 Iowa Acts and the services funded by the appropriation should have been utilized to provide services to persons 60 years of age and above.

- The appropriation language for fiscal year 2008, found in the 2007 Acts of the General Assembly, stated the funds were for "Elderly Wellness – for promotion of healthy aging and optimization of the health of older adults." IDPH purports "healthy aging" is a term separate from elderly wellness and gives IDPH authority to serve individuals throughout their life span, as healthy aging is a "cradle to grave" process. However, reading "healthy aging" in the context of the appropriation title and the remaining description for "optimization of health of older adults," it appears the funds were intended for elderly services, not services to persons clearly not defined as elderly.

After discussions with IDPH officials and research of historical law of the Grant, we conclude the *Code* and corresponding Iowa Acts do not support interpretation of spending authority as administered by IDPH. Details of IDPH's use of the funds for purposes not consistent with appropriation language are included throughout the remainder of this report.

Although IDPH officials disagree with our position regarding the purpose of the appropriations, they worked with members of the General Assembly to draft new appropriation language to be considered for fiscal year 2011 to ensure the purpose of the funds was more broad to allow for other populations to be served. The language subsequently submitted to the General Assembly during the 2010 session was as follows:

> Healthy Aging – To provide public health services that reduce risks and invest in promoting and protecting good health over the course of a lifetime with a priority given to older Iowans and vulnerable populations.

The appropriation language adopted for fiscal year 2011 will give IDPH broader authority to utilize the funds for more diverse populations. Had this language been the appropriation language during our review, a majority of concerns raised in this report regarding the use of the funds would not exist. However, the new language does not clearly define the purpose of the funds and gives IDPH full authority to interpret the purpose of the funds as it deems necessary. "Priority to older Iowans" and "vulnerable populations" are not defined. Therefore, because the General Assembly approved the 2010 Iowa Acts language, it agreed to allow IDPH and local providers to determine how much of the funds should be reserved for the "priority" population and how to define "older Iowans" and "vulnerable populations."

It is apparent from the language in the Iowa Acts from 1999 to 2009 the General Assembly intended for elderly populations to be the beneficiaries of the services funded by the elderly wellness portion of the Grant. The 2010 Iowa Acts language, while still emphasizing elderly services, does not provide specific definitions to preclude IDPH or local providers from

emphasizing services to other populations as well, such as those populations perceived as "vulnerable."

Administration

The Grant is administered using a combination of state and local administrators. **Table 4** lists the administrators and their responsibilities.

Table 4

Position	Responsibilities
IDPH Officials	Central Office officials receive monthly reimbursement requests from counties, approve payments, make disbursements, track county spending, approve alternative plans, conduct training and oversee and assist RCHCs.
RCHCs (IDPH)	RCHCs are assigned to cover 1 of 6 Iowa regions in which they provide training, advise counties regarding Grant requirements, conduct biennial compliance reviews of each provider in each county in their region to ensure compliance with Grant requirements and act as IDPH's representative in the field.
LBOH	Each county must designate a Local Board of Health (LBOH) which contracts with IDPH to provide Grant services through county providers or sub-contractors. In some counties, the Board of Supervisors (BOS) acts as the LBOH. The LBOH provides oversight for the financial and administrative matters of the Grant and initiates community planning processes.
Provider	Provide services funded by the Grant, maintain client files and assess clients for Grant eligibility, employ qualified staff, maintain financial records to support Grant billings and administer controls to ensure the Grant is the funder of last resort.
Project Director	Act as the liaison between IDPH and county providers, consolidate and prepare billings to IDPH based on submissions from all county providers. According to IDPH's contract management guide, Project Directors are to ensure contractors retain records of services provided and negotiate program reallocation requests.

In accordance with Chapter 77 of the IAC, each county must utilize the oversight of a Local Board of Health. The Local Board of Health was formed to promote and protect the health of the county's citizens with specific objectives in the areas of assessment, policy development and assurance. As defined by the IAC, responsibilities are:

> Assessment: Regular collection, analysis, interpretation and communication of information about health conditions, risks and assets in a community.
>
> Policy Development: Development, implementation and evaluation of plans and policies for public health in general, and priority health needs in particular, in a manner that incorporates scientific information and community values in accordance with state public health policy.
>
> Assurance: Ensuring by encouragement, regulation or direct action that programs and interventions that maintain and improve health are carried out.

The Local Boards of Health are composed of 5 members and at least 1 member should be a licensed doctor in Iowa. Local Boards of Health are to meet at least quarterly and submit the minutes of its meetings to IDPH within 1 month of the meeting in accordance with Chapter 77 of the IAC. In addition, an annual report of expenditures for the previous fiscal year should be reported to IDPH within 90 days of the close of the fiscal year. We determined some Boards of Supervisors acted as the Local Board of Health for their counties, which IDPH approved.

As part of our analysis of controls, we reviewed Board meeting minutes for each county included in our testing. Of the 6 counties we reviewed, we determined Pottawattamie County did not provide complete records of its minutes. A Pottawatamie County official we

spoke with stated the records were in storage and could not be easily extracted. However, we were able to review 1 month's Board minutes and found them to be consistent with the Board minutes obtained from other counties.

Based on our testing, the minutes of the Local Boards of Health appeared complete and appropriate.

OBJECTIVES, SCOPE AND METHODOLOGY

Objectives

To assess processes and procedures used in managing Grant services, we reviewed IDPH control procedures and program guidance for administration of the Grant and overall program consistency.

To determine whether providers receiving Grant funds supplied services in accordance with program requirements and billings submitted, we selected providers in the following counties: Buena Vista, Cerro Gordo, Muscatine, Polk, Pottawattamie and Scott.

We included all providers receiving Grant funds in each county in our testing, reviewing applicable documentation associated with expenses reimbursed by the Grant during fiscal years 2007 and 2008.

Scope and Methodology

For our review of administration of the Grant, we interviewed IDPH staff responsible for administering the Grant to obtain an understanding of the administration, policies and procedures, controls, monitoring and Grant goals and expectations. We also reviewed the applicable laws, rules and guidelines and reviewed and evaluated Grant procedures and controls for adequacy.

We also selected 1 county from each of the 6 IDPH regions and performed a site visit to determine compliance with the *Code of Iowa*, Iowa Administrative Code (IAC) and IDPH policies and guidelines. Specifically, we:

- Evaluated procedures and controls at each county to obtain an understanding of how the counties ensure activities funded by the Grant are in accordance with Grant requirements.

- Determined whether staff members of providers possessed the qualifications necessary to meet Grant requirements and provide services to clients in an appropriate manner.

- Determined if clients receiving state aid met eligibility requirements and were billed the appropriate sliding fees as required by the Grant.

- Determined if the Local Boards of Health complied with the IAC.

- Interviewed provider staff members to determine if the Grant was used as the funder of last resort in accordance with Grant requirements.

- Compared provider contracts with IDPH to billing documentation to determine if the providers are operating in accordance with their contracts.

- Reviewed monthly utilization reports (MURs) (i.e. monthly billings) submitted to IDPH, performed interviews and reviewed supporting documentation to determine whether costs claimed by counties are supported and allowable for reimbursement by the Grant.

- Interviewed Regional Community Health Consultants (RCHCs) to obtain an understanding of their role at each county. We also reviewed county compliance reports which RCHC's complete and related supporting documentation.

- Met with IDPH officials to discuss preliminary report findings and IDPH's response to preliminary report findings.

- Met with a representative of the Legislative Services Agency (LSA) to discuss specific elements of IDPH's response to preliminary report findings.

A large portion of our testing included evaluation and verification of expenses counties submitted to IDPH in their Monthly Utilization Reports (MURs). **Appendix C** is an example of a MUR submitted to IDPH for reimbursement by a county Project Director. The Project Director is responsible for consolidating MURs from each provider in its county and submitting the consolidated report to IDPH. IDPH then processes the MUR for payment. Our review of MURs included billing rates, alternative cost reports, Grant eligibility and year-end spending. Each of these areas are discussed in detail in the following sections of this report.

In order to obtain adequate information to evaluate county provider expenses, we interviewed IDPH staff who design program operating procedures and oversee and train RCHCs concerning their communications with county providers. We relied on conversations with IDPH officials to discuss allowable versus unallowable uses of Grant monies when documented instruction or detailed guidance on Grant purposes did not exist. These conversations were usually necessary during testing of county provider expenditures when we could not find written instruction or guidance regarding the allowability of specific expenditures identified.

County Selection

IDPH disbursed Grant monies to all 99 Iowa counties in fiscal years 2007 and 2008. Disbursements ranged from $39,281.00 annually to Adams County to $1,019,984 annually to Polk County. The 99 Iowa counties were divided into 6 IDPH regions as shown in **Appendix D** and each IDPH region was assigned to a RCHC. Annual distribution of Grant funds by region is summarized in **Table 5**.

Table 5

Region	Total	Percent of Grant
1	$ 2,529,835.00	23.8%
2	1,309,902.00	12.3%
3	1,316,832.00	12.4%
4	1,283,735.00	12.1%
5	1,498,920.00	14.1%
6	2,699,723.00	25.3%
Total	$ 10,638,947.00	100.00%

We analyzed IDPH files to select a county from each region for additional testing. We selected counties based on certain risk factors identified through review of the IDPH files maintained for each county. The files included copies of RCHC compliance reports, which are bi-annual evaluations RCHCs completed on each provider in each county to ensure compliance with Grant requirements. The files also included billing and correspondence records.

We limited testing to larger providers with consideration of risk factors identified in the files reviewed, such as the number of billing corrections and RCHC compliance report comments. We concluded multiple billing corrections documented in the IDPH files may be a result of lack of compliance with Grant requirements and some RCHC compliance report comments indicated weaknesses in county compliance with Grant requirements.

By selecting a county from each region, we ensured we would review counties which were geographically disbursed and a county for each RCHC. By establishing our selections for testing in this manner, we obtained a diverse representation of counties to test RCHC consistency and regional consistency across the State.

Each county had 1 or more providers with whom contracts had been established to provide services to eligible recipients. The providers were typically non-profit organizations and potentially could provide services to more than 1 county. Counties also may designate their Health Department as a provider. However, contracts were not required to be established between the counties and the Health Departments for administering the Grant since the Local Boards of Health and the Health Departments were both operated out of the county. The counties we selected for testing did not have providers which provided services to more than a county we tested.

The counties selected for testing represent 20.72% of the total annual Grant disbursements of $10,638,947.00. **Table 6** summarizes the amount received by the selected counties and their respective percentage of total funding for fiscal years 2007 and 2008.

Table 6

		Fiscal Years 2007 and 2008	
Region	**County**	**Disbursements**	**% of Total**
1	Polk	$ 1,019,984.00	9.59%
2	Cerro Gordo	173,339.00	1.63%
3	Buena Vista	81,954.00	0.77%
4	Pottawattamie	289,171.00	2.72%
5	Muscatine	161,039.00	1.51%
6	Scott	479,311.00	4.50%
	Total	$ 2,204,798.00	20.72%

Table 7 summarizes the providers included in our testing procedures.

Table 7

Region	**County**	**Provider**
1	Polk	Polk County Health Department*
1	Polk	Visiting Nurse Services
1	Polk	Wesley Community Services
2	Cerro Gordo	Cerro Gordo County Department of Public Health*
3	Buena Vista	Buena Vista County Public Health & Home Care*
4	Pottawattamie	Visiting Nurse Association of Pottawattamie Co.*

4	Pottawattamie	Council Bluffs City Health Department
4	Pottawattamie	Senior Futures, Inc.
5	Muscatine	Unity Health Care*
5	Muscatine	Senior Resources, Inc.
6	Scott	Scott County Health Department*
6	Scott	American Red Cross of the Quad Cities
6	Scott	Genesis Visiting Nurse Association

* - Project Director for county is employed by this provider.

We visited or collected supporting documentation from all 13 providers listed in the **Table**. Our testing procedures included review of internal controls over employee qualifications, client files, board minutes, billings and support for billings.

TESTING SUMMARY

As stated previously, our testing was limited to only 6 of Iowa's 99 counties and the Grant funding distributed to the 6 counties totaled only 20.72% of the total appropriated by the General Assembly. In addition, we only attempted to verify the costs reimbursed to providers in the 6 counties for a limited number of months during fiscal years 2007 and 2008.

As a result of our testing at the 6 counties, we identified a number of concerns related to the providers. This section of the report briefly highlights specific problems identified at each county. Our findings were significant, particularly at the larger counties selected for testing. We believe the findings we identified are representative of issues we would have identified at the 93 counties not included in our testing procedures. In addition, it is likely other concerns may have been identified if more counties were selected for testing.

The largest counties included in our testing were Polk, Scott and Pottawattamie. Their combined funding represents 82% of the funds tested and approximately 17% of total Grant disbursements. In the limited amount of testing we performed at the 3 counties, we identified:

- Significant weaknesses in documentation to verify the nature of expenditures or rates billed were appropriate and
- Significant use of Grant funds for alternative services not consistent with the appropriation language enacted by the General Assembly and/or IDPH's approved activities.

The smallest counties included in our testing were Cerro Gordo, Muscatine and Buena Vista. Their combined funding represents 18% of the funds tested and approximately 4% of total Grant disbursements. We identified concerns at the smallest counties similar to those found at the largest counties tested. In addition, we identified administrative weaknesses in personnel files, billings to clients and use of outdated cost support.

Some of the specific problems identified at each county include:

<u>Polk County</u>:

- $515,379.13 of Grant funds were used for costs not consistent with the appropriation language enacted by the General Assembly.
- Several instances in which the costs claimed were described in a manner which did not allow IDPH to readily determine the composition of the costs. The costs were

submitted by the providers in a manner which made them appear to be allowable when they were not.

- Of the 3 providers tested in Polk County, 2 improperly billed costs to the Grant prior to using other funding sources. In addition, documentation for invoices which were split among funding sources was not adequate to ensure the costs were not claimed multiple times.
- Multiple billing rates tested were not supported.
- A provider improperly used Grant funds to supplement employee salaries.
- A billing error was corrected by a provider without the proper guidance from IDPH officials.

Pottawattamie County:

- $20,698.61 of Grant funds were used for costs not consistent with the appropriation language enacted by the General Assembly.
- Multiple billing rates could not be supported.
- Billed for services using outdated cost analyses.
- Grant billings were not properly reduced by the amount collected from clients.
- Inadequate documentation related to personnel qualifications.

Scott County:

- $136,580.64 of Grant funds were used for costs not consistent with the appropriation language enacted by the General Assembly, including costs associated with tobacco education, sex education and bioterrorism education materials.
- Grant billings were not properly reduced by the amount collected from clients.
- A provider improperly billed costs to the Grant prior to using other funding sources. When the impropriety was identified by the RCHC, the provider was allowed to identify the amount improperly billed and IDPH relied on the provider to accurately report the amount.
- Multiple billing rates charged to the Grant were properly supported, but required documentation was not submitted to or approved by IDPH.
- Year end purchases were made for which adequate support was not available regarding date of delivery.

Buena Vista County:

- $1,622.75 of Grant funds were used for costs not consistent with the appropriation language enacted by the General Assembly.
- Grant limitations were exceeded for certain types of expenditures.
- A billing rate increase was not supported and the maximum allowed for a cost multiplier was billed without adequate support.

Cerro Gordo County:

- $21,306.34 of Grant funds were used for costs not consistent with the appropriation language enacted by the General Assembly.
- Grant billings were not properly reduced by the amount collected from clients. According to a representative of the provider, this had been a practice for a number of years.
- Billed for services which were not approved through an alternative plan, as required.
- Billed for services using outdated cost analyses.
- A billing rate used included a cost multiplier which exceeded the maximum amount allowed.
- Used a billing rate not supported by cost analysis at IDPH's instruction as a result of a prior overbilling.
- Clients who should have paid a fee were not properly charged for services.
- Financial assessment documents were not properly maintained.
- Inadequate documentation related to personnel qualifications.

Muscatine County:

- $36,105.23 of Grant funds were used for costs not consistent with the appropriation language enacted by the General Assembly.
- Alternative plans approved by IDPH and multiple billing rates could not be supported.
- A provider billed for a service at a rate which exceeded the related cost analysis.
- The maximum allowed for a cost multiplier was billed without adequate support and certain billings were not supported.
- Year end purchases were made for which adequate support was not available regarding date of delivery.
- Billed clients for services using outdated sliding fees.
- Financial assessment documents were not properly maintained.

The specific requirements tested and examples of findings identified during testing are detailed in the following sections.

FINDINGS AND RECOMMENDATIONS

As part of our review of the Grant, we reviewed internal controls and identified findings and recommendations for each of the following topics. **Table 8** summarizes each issue discussed in detail in the report.

Table 8

Finding	Issue	Page Number
A.	Grant *Code*, Iowa Acts and IAC	23
B.	Provider personnel qualifications	24
C.	Client financial obligation	26
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A. Grant *Code*, Iowa Acts and IAC

During our testing, we determined Grant funds were used for purposes which were not consistent with the appropriation language enacted by the General Assembly. We discussed our concerns with IDPH officials. As a result, IDPH presented historical law on the Grant to support its position the Grant funds were spent in accordance with law. We reviewed the information IDPH presented and met with a Legislative Services Agency (LSA) representative and concluded Grant funds were not used in a manner consistent with appropriation language of the Iowa Acts.

In accordance with section 4.8 of the *Code of Iowa*, "If statutes enacted at the same or different sessions of the legislature are irreconcilable, the statute latest in date of enactment by the general assembly prevails. If provisions of the same Act are irreconcilable, the provision listed last in the Act prevails."

Findings – As a result of discussion with IDPH and LSA officials and review of historical *Code*, Iowa Acts and IAC pertaining to the Grant, we determined:

- The purpose of the Grant in accordance with the 2006 and 2007 Iowa Acts was to provide services for elderly wellness, defined as those age 60 and above in 2006 and described as "older adults" in 2007. As illustrated by **Appendix B**, the appropriation language for fiscal years 2000 through 2006 specified funding was to provide services to persons over 55 years of age or 60 years of age and older.

However, IDPH administered the Grant to include populations other than the elderly in accordance with the 1997 Iowa Acts, which had been superceded before the period of our review.

- IDPH did not modify the administrative rules to be consistent with *Code* changes throughout the history of the Grant. Specifically, alternative plans were not removed from the IAC when there was no longer a provision for them in the *Code* or the Acts of the General Assembly.

  It is IDPH's responsibility to maintain current administrative rules. IDPH should not rely on the Administrative Rules Review Committee to analyze administrative rules for consistency with the *Code*.

- According to IDPH officials, they believe the authority granted in the *Code* to administer the Grant through the development of administrative rules gave it authority to supercede the purposes of the funds described in the appropriation language in the Iowa Acts. However, IDPH should have developed administrative rules to be consistent with the Iowa Acts.

- The appropriation language for fiscal year 2011 gives IDPH and county providers authority to utilize Grant funds as they choose. Adopted appropriation language does not provide adequate parameters or guidance to clearly define the populations the General Assembly intends to receive services funded by the Grant.

Recommendations - Based on the findings discussed above, we recommend the following:

- IDPH should administer the program as mandated in the *Code* and appropriations contained in the Iowa Acts. Plain language interpretations of the language are necessary in order to ensure funding is used as directed by the General Assembly. If *Code* language and Iowa Acts are modified, the new language takes precedence over all prior language.

- The administrative rules should be updated to accurately reflect restrictions placed on the use of Grant funds by the General Assembly during the annual appropriation process. In addition, all modifications to the *Code* and Iowa Acts should be evaluated and incorporated into the administrative rules governing use of the Grant. It is IDPH's responsibility to ensure consistency between the administrative rules and the *Code* and Iowa Acts.

- The appropriation language for fiscal year 2011 allows IDPH and the local counties to divert funds from elderly to vulnerable populations or any other population in the life span. Giving a population "priority" provides no assurance the population receives the level of services intended by the General Assembly.

  In addition, the appropriation language does not restrict Grant funding to the needs of the elderly. As a result, it should be determined if services to be provided with Grant funds are a duplication of services provided by other programs administered by IDPH or other State agencies.

B. Provider Personnel Qualifications

The Grant provides funding for specific services provided through a variety of healthcare professions. The IAC specifies the minimum qualifications for specific professions approved to provide services using Grant funds. Case management, public health nursing and home care aide services must be provided by personnel who have completed specific education and training to be eligible for Grant reimbursement.

Case management services are used to provide both home care aide services and public health nursing services. Case managers develop and maintain patient service plans to aid in optimizing self-care capabilities of clients and provide access to needed medical services. According to IAC section 641-80.6(135), case management must be performed by individuals meeting 1 of the following criteria:

- Be a registered nurse licensed to practice in the State of Iowa,
- Possess a bachelor's degree in a health or human services related field,
- Be a registered practical nurse with a current Iowa license, or
- Be a home care aide who has the equivalent of 2 years experience and be supervised by either a registered nurse or a registered practical nurse.

Public health nursing services are overseen by public health coordinators or supervisors who must, in accordance with IAC 80.9(4), meet 1 of the following criteria:

- Possess a bachelor's degree or higher from an accredited college or university in public health, health administration, nursing or other applicable field and have 2 years related experience, or
- Be a registered nurse, licensed to practice by the Iowa Board of Nursing, with 2 years related experience and complete a course approved by IDPH within 6 months of employment.

Home care aide services, which are intended to enhance the capacity of clients to attain or maintain their independence, are provided at a number of levels requiring varying levels of education and training. **Table 9** summarizes home care aide requirements.

Table 9

Level	Minimum Requirements	Annual Training*
Chore	Skills to do tasks assigned	none
Home helper	13 hours in-house training on specific home care skills	3 hours
Homemaker	60-hour home care aid training, or 75-hour certified nurse aide course and home helper in-house training, or Home care aide training and IDPH pre-approval	12 hours
Personal care	Same as homemaker	12 hours
Protective worker	Training in a department with an approved curriculum	12 hours

* - Training requirement is annual, prorated to the date of employment.

During our testing at the counties, we tested a selection of employees from each provider serving Grant clients to ensure the employees met the Grant qualification requirements. Education and training requirements vary based on the type of service billed to the Grant.

Findings - Of the 13 providers we visited in the 6 counties tested, 2 could not provide documentation supporting completion of necessary training and education for the employees tested.

- At Genesis Visiting Nurse Association (Genesis VNA) of Scott County, we tested 5 employee records and determined 2 home care aide (personal care) workers billed to the Grant during our testing period did not have evidence of initial training completion in

their employee files. As shown in **Table 9**, home care aide (personal care) workers are required to complete a 60 hour home care aide training course, a 75 hour certified nurse aide course with additional home helper in-home training or home care aide training with IDPH pre-approval. However, all 5 employee files showed completion of 12 hours of required annual training as shown in **Table 9**.

According to the RCHC's files, deficiencies in employee record documentation had been identified during a compliance review in February 2007. The RCHC subsequently received verification the necessary training had been completed. While the deficiencies the RCHC identified had been corrected, we identified additional personnel files which did not include support the required training had been completed.

- Pottawattamie County's Visiting Nurse Association of Omaha (VNA-Omaha), which absorbed Visiting Nurse Association of Pottawattamie County (VNA-PC) in October 2007, was unable to easily locate documentation to verify initial training was completed for 4 of the 6 employees selected for testing. However, VNA-Omaha stated those 4 employees were no longer with VNA-PC. In addition, it explained VNA-PC files were sent to an off-site storage location at the time of the merger and could not be easily located. We verified the RCHC tested employee qualifications at VNA-PC and determined in March 2007 VNA-PC was in compliance with employee qualification requirements. We did not identify any deficiencies in completion of required annual training.

Recommendations - IDPH should implement procedures to ensure all providers are complying with training requirements and verify Genesis VNA of Scott County and VNA-Omaha of Pottawattamie County have all supporting documentation verifying staff billed to the Grant are in compliance with Grant qualification requirements.

C. Client Financial Obligation

Every Iowan is eligible for Grant services when (1) an assessment identifies the need for such services, (2) adequate resources exist to provide the service and (3) no other payment source, such as Medicare, Medicaid or private insurance, is available to the consumer. Providers are required to maintain adequate records to demonstrate clients are eligible for services, services are eligible for reimbursement and costs submitted for reimbursement are in accordance with Grant requirements.

In accordance with Section 80.4(5) of the IAC, fees and donations collected while providing Grant services should be used to supplement Grant funding. The provider is required to deduct all fees and donations collected from the amount of Grant reimbursement requested. This section of the IAC specifically requires:

- Fees for services provided are based on financial assessments updated annually by the provider which determine client financial responsibility.
- The provider must establish a sliding fee scale. The sliding fee scale income levels must be based on federal poverty guidelines. The provider must develop sliding fees based on their specific charges for services.
- Sliding fees or full fees are required when providing the following:
  - Home care aide - personal care.
  - Home care aide – homemaker.
  - Home care aide - home helper.
  - Home care aide – chore.
  - Nursing - disease and disability.
  - Nursing - health maintenance.

- No fee may be charged for protective services or communicable disease follow-up services.

Findings - During testing of sliding fee scale application and evaluation of client financial assessments, we identified the following:

- Of the 13 providers we visited in the 6 counties tested, 12 did not provide documentation to show they consistently verify client financial information. Only 1 of the 13 providers tested had a policy to request supporting documentation to verify financial information provided by clients for use in determining if clients are eligible for free or reduced-fee services. At the time of initial application, the provider sends a representative to do an assessment of a potential client's service needs and financial eligibility. **Appendix E** is an example of the financial assessment worksheet clients complete and sign to verify their financial eligibility.

  IDPH officials stated they currently do not require verification of income eligibility to receive Grant services. Instead, they require a signed financial assessment. IDPH officials stated they consider the signed statement sufficient assurance of financial eligibility and they do not perform verification. Providers stated clients sometimes voluntarily provide bank records when completing their application. In addition, providers knew clients were financially eligible based on the knowledge the clients were receiving other state or federal services for clients with financial needs.

  In the 2-year review period, IDPH distributed $4,409,596.00 to the 6 counties we tested. A majority of these distributions were for services requiring client financial eligibility. Grant services for certain public health nursing services and home care aide services have financial eligibility requirements. **Table 10** summarizes the services requiring income eligibility in accordance with the IAC and the amounts expended by the 6 counties tested for each service. This amount is 77% of the total funding provided by the Grant for the counties tested.

Table 10

Service	Amount
Home care aide - personal care	$ 1,048,671.80
Home care aide - homemaker	1,494,379.92
Home care aide - home helper	-
Home care aide - chore	24,333.51
Nursing - disease and disability	321,954.93
Nursing - health maintenance	508,235.71
Total	$ 3,397,575.87

  We researched financial qualification requirements for certain federal and state assistance programs and determined they consistently require proof of financial eligibility for participation. For example, several programs require copies of pay stubs and proof of funds received through other means. **Table 11** lists financial documentation required by program regulations to complete applications for the federal and state assistance programs we reviewed.

Table 11

Assistance program	Documentation Required
State childcare assistance	• pay stubs from last 30 days, or • letter from employer, or • class schedule
State food assistance program*	• proof of identification • proof of address • proof of childcare costs • proof of money received in last 30 days
State hawk-i program^	• pay stubs from last 30 days, or • letter from employer, or • copy of last tax return • proof of money received through social security, VA benefits or child support
Federal Women, Infants and Children Program (WIC)	• proof of Identification • proof of income or any money coming into household • proof of current address
Federal Medicaid Assistance	• proof of identification • proof of citizenship • proof of application for social security number • proof of health insurance premiums paid • proof of income • proof of child or adult care costs • most recent bank statements • proof of current value of financial assets • proof of current address

* - Formerly known as the Food Stamp program
^ - Health insurance for children

As illustrated by the **Table**, consistent requirements for clients seeking assistance include proof of identification and proof of financial need. Currently, IDPH has no such requirements.

Some providers indicated clients refused to provide support for their financial need. However, there was little support providers are actively pursuing documentation to verify financial needs.

Some providers indicated many of their clients were undocumented residents or were not willing or able to provide proof of identification. One provider explained they can not refuse to provide services based on whether or not a client is a registered citizen. In addition, they expressed concern if they reported such individuals to authorities, the undocumented residents would no longer come to the providers for necessary health services. If undocumented residents did not get proper immunizations or treatment for contagious diseases, it would put the whole population at risk.

We spoke with IDPH personnel regarding undocumented residents. IDPH stated it was unaware of laws specific to serving undocumented residents. They stated they defer to the local providers on whether to serve them or not. However, we believe this decision should be uniform across the state. IDPH stated it has not tracked the amount of funding attributed to services for undocumented residents or the number of undocumented residents served.

- At Muscatine County's Senior Resources, Inc., we determined 3 of 5 client files tested did not include current client financial assessments, which are required to be updated annually. Of the 3 client files identified as not current, 2 had not been updated since September 2006. A Senior Resources, Inc. representative stated a former employee responsible for maintaining these records did not maintain records as directed. In addition, turnover resulted in paperwork backlogs. Also, 1 of the 5 client files selected for testing was not located. Total services billed to the Grant for services to this client were $74.00 and the client was no longer receiving services due to a move to nursing home care. Senior Resources, Inc. received approximately $7,000.00 of Grant funds annually during our review period.
- During testing of Muscatine County's Senior Resources, Inc., we determined the sliding fee scale used was based on fees dating back to 1999. The current fee structure used to request reimbursements from the Grant was less than the actual costs incurred by the provider. As a result, the costs recovered by the provider were less than the actual expenditures to provide the service.
- During a RCHC compliance review, IDPH determined the Cerro Gordo County Department of Public Health (Cerro Gordo County) had not reduced its Grant billings by amounts collected from clients. According to a Cerro Gordo County representative, the RCHC previously instructed them not to reduce billings by client collections. The Cerro Gordo County representative stated in 20 years of service, she didn't recall deducting sliding fees from Grant billings. Rather, the sliding fees were used to supplement their operations. Although IDPH identified this problem in a routine RCHC compliance review, it is significant because a Cerro Gordo representative stated they had been following this improper procedure for 20 years.
- During testing at Cerro Gordo County, we attempted to reconcile a small selection of client billings to sliding fee obligations as shown on its financial assessments. We determined 2 clients required to pay a fee for services did not pay for services rendered. The resulting overbilling to the Grant was $54.00. Cerro Gordo County representatives responded the problem was isolated and was corrected the following billing period.
- During testing at Pottawattamie County, we determined donations received during immunization screenings were not deducted from billings to the Grant. Pottawattamie County's primary provider, VNA-PC, was absorbed by VNA-Omaha in October 2007. The VNA-Omaha officials we spoke with stated they were unaware of the donation reporting requirement and stated the donations collected were minimal. However, since the donations were not reported to IDPH, we could not confirm the extent of the overbillings to the Grant.
- During discussion with the Scott County Health Department (SCHD), SCHD stated it receives donations during execution of specific services, including immunization clinics. The donations are deposited at the County Treasurer's office. However, SCHD failed to deduct donated funds from amounts billed to the Grant as required.

Recommendations – Based on the findings discussed above, we recommend the following:

- To ensure Grant resources are used in the most effective manner possible, IDPH officials should develop program eligibility requirements similar to other financially-based assistance programs. Such requirements would require providers to determine if clients meet certain financial criteria to qualify for free or discounted services funded by the Grant. If such requirements are developed, IDPH officials should also implement procedures which ensure all providers maintain adequate records to support compliance with eligibility requirements.
- IDPH should implement procedures to ensure compliance with IAC requirements regarding sliding fee and donation collections. IDPH should also consider whether

RCHCs should monitor compliance with these requirements by periodically testing related information at the providers.

- IDPH should implement procedures to ensure providers receiving Grant funding maintain client files in accordance with Grant requirements.
- IDPH should develop a policy regarding whether undocumented residents are eligible to receive services funded by the Grant. In making the determination, IDPH officials should consider the issues associated with prevention of the spread of contagious disease. Once a determination has been made, IDPH should ensure guidance is distributed to all providers in an appropriate manner to ensure consistent application throughout the State.

  IDPH should also determine how many undocumented residents are currently served and how much Grant money is spent annually for undocumented resident services.

D. Funder of Last Resort

In accordance with Section 80.4(3) of the IAC, the Grant shall be billed as the last resort. As a result, proceeds from the Grant are not to be used by providers until all other eligible means of payment are exhausted. The IAC includes the following requirements for payments made by the Grant:

- If services are eligible for third-party reimbursement through Medicaid, Medicare, private insurance, approved Iowa waivers or other federal or state funds, the providers should not bill the Grant for those services.
- Providers are required to bill the lesser of the provider's cost or charges.
- The Grant shall not be billed for the balance between the provider cost or charge and the allowed reimbursement from a third-party payer.
- The Grant shall not be billed for fees waived by the provider.

IDPH officials stated the Grant is the funder of last resort prior to use of county funds. Therefore, it is permissible to bill the Grant prior to billing the county for eligible services. However, all other funding sources should be utilized prior to the Grant. IDPH officials described the Grant as a gap filler designed to provide health services not covered by other funding resources.

Findings - To determine if the providers were complying with the funder of last resort requirement, we inquired of providers and reviewed compliance testing performed by RCHCs. Based on these procedures, we determined 3 of the 13 providers tested had improperly billed the Grant when other funding sources were available. Polk County has 2 providers which did not comply with the funder of last resort requirements: Visiting Nurse Services (VNS), a nursing services provider, and Wesley Community Services (Wesley), a home care aide provider. Scott County Genesis VNA also billed the Grant for services eligible for Title XIX or the Frail Elderly Waiver. Because of the amount of expenditures and the number of funding sources, we were unable to readily quantify how much of the Grant was spent for services which could have been paid for from other funding sources.

VNS officials stated their funding sources include United Way, Polk County, Empowerment and the Grant. VNS is not a Medicaid or Medicare provider. VNS officials stated they bill the Grant prior to using other funding sources to maximize funding. The Grant has more limitations than other funding sources, so they use it first in order to ensure they have enough Grant-eligible services to spend down the Grant. The remaining VNS costs can be paid with other funding sources, which allows them to provide more services overall. For

example, VNS officials we spoke with stated they have received additional Grant funds another provider wasn't able to use in prior years. When they received these funds, they would just switch Grant eligible costs previously billed to other sources to the Grant so they would be sure to utilize all Grant funds on eligible costs. VNS representatives stated they expend the funds from all sources each year, so it doesn't matter which funds are used first. However, they are not operating in accordance with Grant funding requirements, and if they utilized the funds in the order they were required to be utilized, services not yet funded at year end may not be eligible for Grant reimbursement, which would require Grant funds to be returned to IDPH.

Wesley officials stated its funding sources after Medicare and Medicaid include the Senior Living Trust, United Way, Polk County and the Grant. They stated the Grant is its primary funding source. Per Wesley officials we spoke with, they interpreted the funder of last resort to be any funder beyond Medicare and Medicaid funding. Currently, they bill the Grant if services are not eligible for Medicare/Medicaid reimbursement. After Grant funds are expended, they bill United Way and the Senior Living Trust. Therefore, they are not in compliance with the Grant's funder of last resort billing requirement.

In February 2007, the RCHC for Scott County issued a letter to Genesis VNA stating customers billed to the Grant may be eligible for Title XIX. According to documentation Genesis VNA provided in response, Genesis VNA only identified 3 clients who should not have been billed to the Grant. The RCHC identified the error and Genesis VNA made corrections. Therefore, we did not pursue review of the billing error. However, IDPH needs to have adequate verification the provider's calculations are accurate and should not rely solely on the provider to identify billing errors.

Recommendations - IDPH should analyze current oversight procedures regarding funder of last resort requirements and ensure RCHC compliance reviews performed biannually are sufficient to detect compliance issues in regard to funder of last resort usage limitations.

Without performing a detailed analysis of all expenditures at the providers from all funding sources, we are unable to determine a financial impact of not using the Grant funds as a "last resort" funding source. Items to be considered during the analysis would include which provider expenditures are allowable uses of Grant funds and other funding sources, the timing of the disbursements and what other funding options were available to the providers.

E. Alternative Plans

In accordance with IAC 641-80.4(2), a plan is required for any alternative use of Grant funds. The plan must be based on an assessment of the community and must receive IDPH approval prior to implementation. The plan must:

- Assure IDPH of the delivery of essential public health services which are the primary purpose of the Grant funds.
- Identify and describe the essential public health services to be delivered.
- Identify outcome measures.

Appendix A is an example of an alternative plan submitted to IDPH. IDPH representatives stated the alternative plan total funds are estimated. The billing rate specified on the alternative plan, however, should be based on supporting documentation. From the date of approval of an alternative plan, counties may bill for services approved on the alternative plan to the extent needed. The providers are not limited by the amount estimated on the alternative plan. For example, if an alternative plan estimates $4,000.00 of Grant funds

need to be diverted, it is allowable to later bill $8,000.00 of costs to the alternative activity, even though it exceeds the initial alternative plan amount of $4,000.00.

Findings - During our review of the 6 counties we tested, we identified the following:

- Alternative plans IDPH approved were often activities which do not meet the purpose of the elderly wellness appropriation language. For example, services for prevention of abuse and neglect of children were an approved alternative plan.
- IDPH often approved alternative plans at the beginning of the fiscal year, which raised the concern of how the providers knew they could accommodate the needs of the elderly for the year.

  For example, on July 1, 2007, Polk County submitted an alternative plan to divert $106,000.00 from the home care aide allocation of the elderly wellness apprpriation to nursing (health maintenance) for use in prevention of abuse and neglect services for children. Diverting funds on the first day of the fiscal year to a service which is not consistent with the elderly wellness appropriation language indicates providers are not taking adequate steps to ensure the elderly are aware of and utilize Grant services they are eligible to receive. In addition, although IDPH administered the program with the assumption prevention of abuse and neglect for children is appropriate since it was part of initial appropriation language in the 1997 Iowa Acts and was codified for several years, the appropriation language for the majority of the Grant funding at the time of the alternative plan specified services were to be provided for elderly wellness.
- IDPH controls over Grant services provided are weakened by allowing providers to request reimbursement in excess of approved alternative plan estimates. Control of services provided transfers to the provider when IDPH allows alternative activities to be billed to the Grant without pre-established limitations.
- Cerro Gordo County included $696.36 in its June 2008 billing, utilizing public health nursing funds for home care aide (personal care) services. However, it did not submit an alternative plan and did not have authority to use public health nursing funds to pay for home care aide services.
- Muscatine County's Unity Health Care (Unity) received approval for an alternative plan to provide foot clinics with home care aide funds in fiscal year 2007 at a rate of $14.89 per hour. Unity was unable to provide documentation to support the rate proposed and subsequently billed to the Grant for foot clinics.
- Muscatine County's Unity received approval for an alternative plan to provide nursing (disease and disability) with home care aide funds in fiscal year 2008 at a rate of $134.00 per hour. Unity was unable to provide documentation to support the rate proposed and subsequently billed to the Grant for nursing (disease and disability).

Recommendations - Based on the findings discussed above, we recommend the following:

- IDPH should not allow the provision of alternative plans as they are no longer specified by the *Code* or current Acts of the General Assembly.
- If IDPH continues to use alternative plans, IDPH should:

  (a) Implement procedures which ensure all approved alternative plans are consistent with the purposes of the appropriations approved by the Legislature. As previously stated, the purpose of the elderly wellness funding is to provide services to the elderly. Services not related to elderly wellness should be funded through other means approved by the Legislature.

(b) Ensure controls are adequate to confirm all services billed which deviate from prescribed service descriptions are approved with an alternative plan prior to Grant reimbursement.

(c) Implement procedures to track and establish limitations on funds diverted from their original purpose in order to control program operation. If not adequately controlled, providers could make their own determination regarding how Grant funds should be utilized. This authority should remain with IDPH officials.

IDPH officials should also consider establishing a set percentage by which the approved alternative plan estimate can be exceeded by the provider without further approval. For example, if IDPH officials establish a 10% tolerable range, a provider who received approval for an alternative plan estimate of $100.00 could divert up to $110.00 without further approval from IDPH.

(d) Require agencies to complete and submit annual cost reports, in accordance with IAC 641(80.4(4), to support billing rates. The same type of support should be provided to IDPH to support billing rates developed for reimbursement of alternative plan activities.

IDPH Recent Changes - We informed IDPH of our initial concerns with the alternative plan prior to completion of fieldwork. As a result, IDPH took proactive steps to improve the alternative plan form for incorporation in fiscal year 2010. Changes IDPH presented to us which it plans to incorporate in fiscal year 2010 are as follows:

- Only 1 activity may be requested per alternative plan form.
- An approved costing methodology must be used and a current cost report supporting the reimbursement rate must be available for review by the RCHC prior to approval.
- The provider must report how the targeted population currently using the funds will be impacted by the alternative use of the funds.
- In the end of year report, providers will be required to report the outcome associated with the activity and the actual impact on the target population.

While we believe these additional procedures will provide additional controls, we believe IDPH should reconsider requiring providers to submit new alternative plan requests if the funds needed to support the alternative activity exceed the original estimate approved by IDPH by more than an established percentage. This added control would ensure IDPH maintains control over the use of the Grant funds.

F. Annual Cost Analysis

According to section 641-80.4(4) of the IAC, each provider is required to complete, at a minimum, an annual cost analysis using a method approved by IDPH and maintain documentation to support administrative costs allocated to the Grant.

Findings - We determined 3 of the 6 counties tested had providers which did not complete adequate cost analyses to support their billed costs. **Table 12** summarizes the findings identified for the annual cost analysis requirements.

Table 12

County	Provider	Notes
Cerro Gordo	Cerro Gordo County Health Department	Billed screenings and assessments in fiscal years 2007 and 2008 based on fiscal year 2006 cost analysis. Home care aide costs in fiscal year 2008 also were not based on annual cost analysis as required.
Muscatine	Senior Resources, Inc.	Billed the Grant the same rate since 1999 and has not completed annual costs analysis for several years.
Pottawattamie	VNA-Omaha	Although costs are developed using Medicare cost reports, VNA-Omaha had not done a cost analysis since 2005.

Recommendations - IDPH should implement procedures to ensure compliance with the IAC requirements. In addition, IDPH should ensure each County's Project Director has verified the providers in their county have completed an annual cost analysis using a method approved by IDPH and supporting documentation has been appropriately maintained. Grant funding should not be distributed until providers are in compliance with cost analysis reporting requirements.

IDPH Recent Changes - In response to preliminary discussions we held with IDPH officials regarding this finding, IDPH made changes to the "Application FY10 Local Public Health Services Contract" form, which each county must complete prior to qualifying for Grant funding. Columns were added to the form in which counties must list the date of the current cost report under the corresponding cost report method for each activity selected to be billed to the Grant. IDPH pre-listed the approved cost reports and providers will have to report the date of the report and the type of report used as the basis of pricing for each activity they plan to bill the Grant.

Requiring providers to list the sources of their pricing based on a pre-approved list should increase provider accountability and make oversight easier for RCHCs because they can request the specific report identified in the application and confirm pricing reconciles to costs billed to the Grant.

G. Capacity Building Technology

As previously stated, up to $2,000.00 of Grant funds can be spent annually by each county for purchases associated with technology. The "Capacity Building Technology" activity is included in the approved Grant activities. Capacity building technology includes purchase of technology items such as computers, software, internet service and cellular phones.

Because the limit is established for the county, even if there are multiple providers in a county, the collective total of capacity building technology costs may not exceed $2,000.00. According to instructions IDPH gave to providers, capacity building technology expenses can be reimbursed to the provider through the LBOH or LPHS appropriated funds. Home care aide (HCA) and Public Health Nursing (PHN) appropriations can not be used for capacity building technology.

Findings - During our review of the 6 counties we tested, we determined Polk County and Buena Vista County received reimbursements in excess of the $2,000.00 annual limitation per county for technology-related purchases.

- In fiscal year 2007, the Polk County nursing services provider, VNS, charged a total of $5,889.00 to the Grant for technology-related products and services, which is $3,889.00 more than allowable under the Grant. Polk County exceeded the allowable amount per county per year for capacity building technology costs, used an unapproved appropriation for the costs and used the materials purchased for purposes which were inconsistent with the intent of the appropriations.

  Table 13 summarizes the technology-related purchases VNS charged to the Grant.

Table 13

Month	Amount	Description
January 2007	$ 3,889.00	2 Gateway laptops
April 2007	2,000.00	Software solutions development of VNS program forms
Total	$ 5,889.00	

VNS did not claim these costs as capacity building technology expenses. Rather, VNS included these costs as additional costs in its calculation of hourly rates billed to the Grant for home care aide (protect), which was reimbursed through home care aide appropriations. As previously stated, the home care aide appropriation is not an approved funding source for capacity building technology expenditures. Misuse of "additional costs" will be discussed in detail in a later section of this report (Additional Costs section).

VNS representatives we spoke with stated they were not aware of the capacity building technology limitation of $2,000.00 per county per year, but IDPH officials stated the requirement was effective during our review period as detailed in the Contract Management Table, which is listed as one of the governing contract documents on the contract with Polk County. As a result, VNS should have been aware of the limitation. **Appendix F** is a copy of the Contract Management Table for fiscal year 2007, which provides descriptions of approved services and approved appropriations for funding each service. Page 88 of the **Appendix** details the capacity building technology limitation of $2,000.00 per county.

According to its contract, VNS received RCHC approval to bill a fluctuating billing rate month to month for home care aide (protect) services because the level of services could not easily be defined and varied significantly from month to month. However, when we reviewed the contract language, it limited allowable costs to salary and benefits of nursing staff. The contract did not include language allowing expenses in addition to salary costs. Therefore, VNS was not authorized to bill capacity building technology or other non-service related costs to the Grant as part of the fluctuating monthly rate. Since fluctuating billing rates were expected, the ineligible costs included in the billing rates went undetected.

In addition, the technology expenses incurred by VNS were related to a child protection program serving children who are removed from their homes. The elderly wellness appropriation language in fiscal year 2007 (which funded the purchase) states it is "for optimizing the health of persons 60 years of age and older." Based on this language, IDPH approval to use the appropriated funds for services and materials for persons under 60 years of age is not consistent with the purpose of the appropriation.

- In fiscal year 2008, Buena Vista County Public Health and Home Care (BVCPH), the only provider in Buena Vista County, submitted $2,885.65 of capacity building technology expenses to IDPH for Grant reimbursement. **Table 14** summarizes the technology-related purchases BVCPH charged to the Grant.

Table 14

Month	Amount	Description
July 2007-June 2008	$ 971.07	Cellular phone services
June 2008	1,914.58	Computer server
Total	$ 2,885.65	

According to BVCPH records, BVCPH requested assistance from the RCHC to ensure it submitted the June 2008 payment request correctly. The RCHC directed BVCPH to include $1,914.58 for server costs in its June 2008 submission for reimbursement. By doing this, BVCPH exceeded the capacity building technology limitation by $885.65. IDPH officials spoke with the RCHC. The RCHC stated she inadvertently approved the year-end capacity building technology allocation and did not realize BVCPH also included cellular phone services in the capacity building technology expenses submitted to the Grant.

IDPH does not individually track capacity building technology expenses to ensure they do not exceed the $2,000.00 limitation per county per year. As a result, IDPH reimbursed BVCPH for the submitted claim.

Recommendations - Based on the findings discussed above, we recommend the following:

- IDPH should implement controls to track capacity building technology submissions by county to ensure technology costs reimbursed are within Grant limitations.

  In addition, IDPH should not allow fluctuating billing rates. Rather, IDPH should develop procedures to ensure billing rates are consistent and properly supported. This recommendation will be discussed in greater detail in a later section of this report.

- IDPH should evaluate monthly billings to the Grant to ensure services provided meet the purposes of the Grant and to avoid use of funds for purposes not in accordance with appropriation language. Specifically, IDPH should evaluate the services currently approved in the Contract Management Table **(Appendix F)** and remove services not meeting the purpose of the appropriations, which are primarily to serve the elderly.

IDPH Recent Changes - In response to preliminary discussions with IDPH officials regarding our concern with fluctuating billing rates, IDPH implemented controls which will be effective for fiscal year 2010. The Contract Management Guide for fiscal year 2010 states reimbursement rates may not be adjusted monthly. In addition, IDPH limited the number of alternative cost reports per activity to semi-annually, with a requirement to complete a cost analysis at least annually.

IDPH also changed alternative cost reports to require line item detail regarding additional costs to increase visibility of costs included in the hourly rates providers bill to the Grant.

IDPH should ensure alternative cost reports are based on 6 months to a year of costs. As discussed later in this report, one-time additional costs can unnaturally increase the hourly rate calculated for use on subsequent billings. Large one-time purchases would be better reimbursed based on actual cost versus inclusion in hourly rates.

H. Billing Rates

As previously stated, providers are required to complete annual cost analyses to develop accurate billing rates to submit to IDPH for Grant reimbursement. Billing rates must be consistent with cost analyses and must be reflective of allowable costs to the Grant. Of the 6 counties tested, 4 counties billed services to the Grant which were not adequately supported by appropriate cost analyses. Specifically, we identified the following as a result of our testing:

Findings - Based on the criteria discussed above, we identified the following:

Pottawattamie County - During the review period, VNA-Omaha took over VNA-PC, a provider and the Project Director for Pottawattamie County. As a result, the Finance Department of VNA-PC was eliminated. The Finance Department had been responsible for calculating and submitting billings to IDPH. VNA-Omaha was unable to provide support for the hours VNA-PC billed to the Grant during our testing period and did not maintain adequate records of work done prior to the merger. In addition, VNA-Omaha did not have documentation to support a large portion of the services billed during our testing period. As a result, we were not able to verify billings to the Grant were accurate.

Table 15 is a listing of service categories not supported by VNA-Omaha. As shown by the **Table**, the hourly rates billed and the rates per immunization changed multiple times during the review period, further complicating the calculation and resulting supporting documentation necessary to support the billed rates.

Table 15

Service	Rates Billed	Service	Rates Billed
Communications and Marketing	$ 34.50	HCA Personal Care^	48.78
Immunization	20.00	Nursing^	130.00
	28.00	Workforce Development	10.00
	45.75		30.00
	25.00		18.50
	15.00		16.43
Screening and Assessment	22.49		15.00
	15.00		22.00
	20.41	Communicable Disease Follow-up	32.00
	16.50		35.00

^ - VNA-PC stated this rate was used in the past. Cost report showed rates supported were higher than the billed amounts.

VNA-Omaha was also unable to locate supporting invoices for 2 months of billings for transportation services. Costs reimbursed by the Grant were $126.50 for July 2006 and $99.48 for December 2006. Although VNA-Omaha did not have supporting documentation, amounts billed to the Grant for transportation in other months which were adequately supported were consistent with the 2 billings not supported by invoices.

VNA-PC's Project Director who administers the Grant for the County routinely billed the Grant for her time related to Grant administration. We requested timesheets to reconcile the hours billed to the Grant for the Project Director's time. Timesheets to support time spent on the Grant were not available. In addition, the Project Director stated the Finance Department, which prepared monthly billings, did not request or maintain timesheet documentation to support hours billed. **Table 16** summarizes June 2007 billings to the Grant for the Project Director's time at a rate of $30.00 to $34.50 per hour.

It is unclear why the Project Director's hourly rate would be greater for communication and marketing than the other services billed. Based on supporting documentation we reviewed, the provider's cost for the Project Director's salary was approximately $41.67 per hour. The amount billed for each service is less than the actual cost.

Table 16

Service Billed to Grant	Hours	Rate	Cost
Local board of health	24.76	$30.00	743.00
Communication and marketing	62.00	34.50	2,139.00
Communicable disease follow-up	20.58	30.00	617.40
Community partnership	29.00	30.00	870.00
Health education	24.00	30.00	720.00
Total	160.34		$ 5,089.40

In June 2007, the Project Director billed the Grant 160.34 hours. Assuming she worked 8 hours per day per 5 day work week, she could have billed a maximum of 168 hours to the Grant. However, during our meeting with the Project Director, she discussed her responsibilities as the lead County Director on a bioterrorism program. Given her description of duties overseeing both the Grant and the bioterrorism program and given she doesn't perform direct services to clients under the Grant, the amount of hours billed to the Grant, which are 95% of her maximum hours in June 2007, appears excessive.

The Council Bluffs City Health Department (CBCHD) billing rate for screening and assessment, $12.50 per person, was not determined based on cost analysis. CBCHD officials could not provide sufficient documentation to determine the basis of the billing rate. They stated the RCHC helped establish the billing rate. The CBCHD representative was unable to explain how the rate was determined or when the last assessment of costs was completed.

CBCHD also billed for tuberculosis visits at a rate of $25.00 per visit. The CBCHD representative we spoke with stated this rate was a contract rate. However, they could not provide documentation to verify the accuracy of the rate.

Buena Vista County - In January 2008, BVCPH increased its nursing (disease and disability) billing rate from $106.00 per hour to $126.00 per hour. We were unable to identify an updated cost analysis or an alternative plan to validate the increased rate.

Muscatine County - We identified several billing rates which were not substantiated by appropriate cost analysis documentation by Muscatine County's Unity. Unity officials stated a former employee was responsible for computing its billing rates and they were unable to recreate the documentation to support the exact rates billed to the Grant. **Table 17** summarizes the service categories billed to the Grant which were not adequately supported by cost analysis documentation.

Table 17

Service	Fiscal Year	Rate Billed
Health hazard investigation - lead	2007	$ 20.00
Health hazard investigation	2008	35.07
Resources	2007	46.75
Nursing (disease and disability - Office)	2007	26.00/28.00
	2008	28.00

In fiscal year 2007, Unity billed $20.00 per hour for health hazard investigation related to lead testing monthly from July 2006 through April 2007. However, in March 2007, Unity completed an alternative cost report, which calculated the billing rate for health hazard investigation to be $35.07 per hour. For the period March 2007 through October 2007, Unity billed for health hazard investigation at $35.07 per hour.

For March and April 2007, Unity billed some health hazard investigation costs at $20.00 per hour and some at $35.07 per hour. When we reviewed the $35.07 rate on the alternative cost report, Unity was unable to substantiate some of the costs included in the development of the new rate. Unity was unable to provide supporting documentation of additional costs included in the calculation.

In addition, Unity stated the indirect rate of 15% it allocated to its costs was provided by the RCHC and it did not have support for the rate. The alternative cost report has a field for overhead. When we spoke with the RCHC, she stated this was not an accurate statement. Representatives we spoke with from some counties stated the field was already filled out for them at 15%, which was the maximum allowed rate at that time. According to the representatives, they believed the 15% was an automatic allowance, even though the form clearly stated it's the maximum allowed.

By reducing the total costs by the unsupported amounts, we determined the calculated rate would have been $27.88 per hour. The elements of alternative cost reports are discussed in detail in a later section of this report.

Unity did not have documentation to substantiate the costs for resources purchased. According to the Contract Management Table, resources are to be billed at actual cost. Because appropriate documentation was not available, we are unable to determine if the $46.75 billed for resources was appropriate.

Unity charged the Grant $26.00 per office visit for nursing (disease and disability – office) in July and August 2006. For the months of September 2006 through July 2007, Unity billed the Grant $28.00 per office visit. This amount is significantly less than the rates charged for nursing (disease and disability) in the clients' homes. Unity was unable to provide supporting documentation for the expenses charged. It provided a sliding fee scale, which substantiated a rate of $26.00 per visit through August 2006 and the $28.00 rate beginning September 1, 2006. However, Unity could not provide documentation of the development of the rates established on the sliding fee scale chart.

In accordance with section 80.4(3)(a) of the IAC, the Grant is to be billed the lesser of a provider's cost or charge. In fiscal year 2008, Unity billed the Grant $134.00 per visit for nursing (disease and disability) each month from September 2007 through June 2008. However, the supporting cost analysis for the same period shows the billing rate calculates to be $124.38.

By applying the difference in the rates to the total claimed by the provider, we determined the Grant was billed $2,982.20 more than appropriate.

Polk County - During testing of billing rates at VNS in Polk County, VNS was unable to provide documentation to support the rates billed to the Grant for foot care clinics and nursing (health maintenance). The VNS official stated the process for determining billing rates is to determine the actual costs for services in the first 4 months of the prior year. However, when VNS ran the report of actual costs as described, the resulting cost rates did not reconcile to the rates billed to the Grant. **Table 18** summarizes the variances between the rates billed in fiscal year 2008 and the rates VNS stated should have been used to develop billing rates.

Table 18

Service	Fiscal Year	Report Rate	Rate Billed
Foot care clinics	2008	$ 28.41	25.35
Nursing (health maintenance)	2008	96.40	91.44

Since the rates based on the cost report were higher than the rates actually billed, it does not appear the Grant was overbilled. However, we did not evaluate the accuracy of the cost report or the allowability of the expenses included. VNS could not provide sufficient support for the rates billed to the Grant for foot care clinics and nursing (health maintenance).

VNS estimated its fringe benefits rate for fiscal year 2008 to be 25%, but the actual expense averaged 23.5%. It is normal for vendors to develop an average billing rate for the next year based on actual costs in the current year. However, given the structure of VNS' billings in which it built its costs based on actual charges to Grant eligible cost centers each month, use of an estimate for fringe benefits while all other costs are charged at actual is inconsistent.

Polk County Health Department's (PCHD's) use of the Grant was inconsistent with other providers. A large portion of its billings were for non-service expenditures for marketing, printing and staff development. Although staff development is allowable at actual cost, non-service costs such as advertising and supplies should be incidental to services provided. Since no labor was associated with these costs, PCHD did not incur expenses on an hourly basis. However, it submitted monthly costs to IDPH to appear as if hourly services had been rendered. **Table 19** provides examples of the billings PCHD submitted to the Grant.

Table 19

Date	Description	Service Billed	Units	Rate	Total
07/07	Advertising – Yellow Book	Community Partnership - Suicide	12	$ 38.50	462.00
08/07	Parade fee, Wal-Mart, Advertising	Community Partnership	3	74.22	222.66
09/07	Advertising, conference service, pamphlets	Community Partnership	30	25.05	751.58
10/07	Salary, advertising, soap dispenser	Screening and Assessment	43	115.87	4,982.47
11/07	Hand soap	Community Partnership – Lead Coalition	1	40.74	40.74

Community partnership activities are defined by IDPH as activities which promote community participation in identifying and solving public health problems. IDPH specifies it is a service which should be billed to the Grant on an hourly basis. PCHD used the activity designation to advertise, participate in a parade and purchase advertising and educational materials and hand soap.

In addition to the inaccurate classification of non-service expenditures as community partnership, PCHD used arbitrary units in its submitted monthly utilization report (MUR) billings and could not provide support for the number of units billed.

PCHD representatives we spoke with stated they worked with the RCHC when developing monthly billings. PCHD representatives also stated they had to submit costs in the approved format in order to get paid. IDPH representatives confirmed they pre-established the approved billing unit type (hourly, per visit, actual cost, etc.). However, they were not aware of the types of expenses PCHD was including in its billings. The PCHD representative we spoke with stated

the RCHC was aware of the types of expenses included by PCHD. However, she is no longer with IDPH, so we were unable to confirm this.

Screening and assessment includes providing tests for clients who may be at risk or have asymptomatic conditions. These are designated as a service billed to the Grant on a cost per client basis. In October 2007, PCHD billed the Grant $3,484.13 for an employee's salary, $997.20 for advertising in the Des Moines Register and $501.14 for testing supplies. PCHD representatives stated during our meetings they billed a portion of the employee's salary to the Grant each month. We reviewed documentation which showed the Grant consistently supplemented a portion of the PCHD employee's salary.

According to IDPH officials, the Grant is to supplement very specific activities serving community clients. For example, employee time should be billed to the Grant based on the number of hours the employee worked during a specific community partnership event. According to IDPH, services billed to the Grant must be directly related to a specific activity described in IDPH's Contract Management Table (a copy of which is included in **Appendix F**). In order to qualify for reimbursement of the employee's time, the PCHD would have to provide documentation to verify all the hours billed to the Grant were directly related to community service activities. The PCHD did not provide documentation to support the 43 hours billed to the Grant.

As previously stated, unallowable costs will be discussed in detail in a later section of this report.

According to IDPH officials, non-labor expenses are to be incidental to services provided. However, as discussed in detail above, PCHD utilized Grant funds largely for non-labor expenses not incidental to services billed to the Grant. Although PCHD retained invoices and supporting documentation for the expenses, PCHD submitted the expenses in a misleading way in order to get the payments approved.

In addition, as stated above, PCHD did not adequately demonstrate salary expenses billed to the Grant were directly related to activities approved for the Grant. Rather, it developed an average percentage of staff salaries to submit for reimbursement from the Grant each month. The RCHC was aware of and approved the system of reimbursement at PCHD. When we brought this to the attention of IDPH officials, they indicated the RCHC had not discussed this practice with them and they were not in agreement with the RCHC's approval of non-service costs.

Scott County - SCHD billing rates fluctuated from month to month and person to person based on which staff member was performing work associated with the Grant. Instead of developing an average billing rate, SCHD billed multiple rates based on the specific salaries of the employees who worked on the Grant for the months reimbursed. SCHD did not base the billed rates on cost analyses or alternative cost reports on file for verification of the accuracy of each billing rate charged. **Table 20** shows an example of the various billing rates SCHD billed to the Grant in fiscal years 2007 and 2008 for communicable disease follow-up.

Table 20

Description	August 2006	October 2007
Employee A	$ 26.90	28.91
Employee B	30.11	32.81
Employee C	29.58	-
Employee D	28.03	-
Employee E	38.15	39.53

SCHD billed for communicable disease follow-up based on the specific employee's salary who was working on Grant services. Although SCHD was able to explain its billing structure, it did not use approved cost analyses or alternative cost reports to justify the rates. In addition, multiple billing rates per month increase the risk of billing errors and decreases the RCHCs' ability to adequately oversee and verify the accuracy of the billings.

Recommendations - Based on the findings discussed above, we recommend the following:

- IDPH should implement procedures which ensure providers maintain support for all billing rate calculations, including cost reports, service reports summarizing units served and invoices. IDPH should consider requesting source documentation utilized by the provider to develop billing rates. Annual review of source documentation should keep providers accountable and provide IDPH with added information to evaluate the utilization of the Grant. By obtaining supporting documentation for costs incorporated into the billing rate, IDPH will be able to identify improper expenditures under the Grant, such as the PCHD advertising costs billed as services.
- IDPH should discourage continual use of alternative cost reports throughout the year. Allowing providers to submit new billing rates each month or several times a year reduces IDPH's ability to oversee costs in the billing rates and adds unnecessary administrative burden. Exceptions should be considered when a new service with a separate billing rate is needed during the fiscal year or when significant cost changes result in inadequate cost recovery.
- IDPH should provide more detailed descriptions of allowable Grant costs to the providers to ensure the guidance provided is sufficient.
- IDPH should ensure RCHCs are consistent in their representation of IDPH requirements. IDPH should consider use of uniform guidance documents to be used by all RCHCs as well as periodic peer review between the RCHCs to ensure consistency among the regions.

IDPH Changes - As a result of preliminary discussions we held with IDPH officials regarding our findings, IDPH implemented additional controls for fiscal year 2010. Specifically:

- When completing their application for Grant reimbursements at the beginning of the year, providers will be required to specify the approved cost report from which they are basing their billing rates, including the date of the report utilized.
- IDPH implemented restrictions on alternative cost reports, only allowing a maximum of 2 annually, which will prevent providers from changing their billing rates frequently.
- IDPH defined additional expenses in their alternative cost report template as expenses incurred which are directly related to the specific activity identified and which cannot be classified elsewhere, such as in indirect costs. In addition, IDPH implemented use of a new form to itemize components included in the total cost so IDPH can readily identify and review the expenses claimed.
- According to IDPH officials we spoke with, IDPH is planning to require RCHCs use standardized instructions and forms when working with providers to ensure all providers receive the same information.

IDPH has increased accountability regarding billing rates by requiring additional detail, such as line item descriptions of the additional costs included on the alternative cost report, to improve controls over Grant funds. However, as previously stated, we caution IDPH to ensure alternative cost reports are based on 6 months to a year of costs. As will be discussed later in the report, one-time additional costs can unnaturally increase the hourly rate calculated for use on subsequent billings. Large one-time purchases would be better reimbursed based on actual cost versus inclusion in hourly rates.

I. Alternative Cost Reports

IDPH allows providers to bill the Grant during the fiscal year for services not included in the initial service agreement if the providers complete an alternative cost report. The alternative cost report is also used to change a billing rate during the year based on changes in costs. **Appendix G** includes an example alternative cost report.

The alternative cost report worksheet has a number of cost elements providers add together to develop a billing rate for the Grant. The billing rate may be utilized for 1 year after completion of the form, regardless of whether the 12-month period extends into the following fiscal year.

Table 21 is an example computation of alternative costs utilizing an alternative cost report. On March 12, 2007, Muscatine County's Unity completed an alternative cost report as demonstrated in the **Table** for Health Hazard Investigation.

Table 21

Description	Amounts
Staff wage	$ 1,953.33
Staff fringe	527.40
Mileage cost	8.30
Additional cost	232.75
Subtotal	2,721.78
Multiplied by cost multiplier (i.e. indirect cost)	x 115%
Subtotal	3,130.05
Divided by total units	89.25
Billing rate per unit	$ 35.07

IDPH does not pre-approve alternative cost reports. The alternative cost report is submitted along with the MUR for the month and the rate from the alternative cost report. In our example, the new billing rate for health hazard investigation for Unity was used on the MUR with which it was submitted. The rate was then used for 12 months or until Unity updated the rate with another alternative cost report.

IDPH's controls over alternative cost reports at the time of our review were limited to biennial compliance reports completed by RCHCs. Several providers included in our testing routinely used alternative cost reports to adjust their billing rates. A provider representative we spoke with stated the fluctuating rates were necessary given the large variances in costs each month. Another provider stated its billings fluctuated monthly due to salary differences between multiple staff providing the services. In order to claim exact costs incurred, it was necessary to submit monthly alternative cost reports. Another provider indicated the alternative cost reports were a burden, but the provider believed they were required to complete them monthly.

According to IDPH officials we spoke with, additional costs are costs incidental to providing a service to clients. For example, when conducting health screenings, medical supplies needed to perform the screenings would be an approved additional cost. We determined this definition was not published and RCHCs and providers had different understandings of additional costs. For example, some counties listed indirect costs, such as building and copier costs, as additional costs. Other providers used the alternative cost report to claim reimbursement for purchases of items, such as condoms and educational materials, not associated with corresponding service costs. In most cases, it appeared the RCHCs were aware of the providers' billing practices. However, IDPH officials were unaware of some of the unique billing practices at the county level.

Findings – Findings identified for the alternative cost reports include IDPH's program oversight, cost multipliers and additional costs included in the alternative cost reports by the providers.

IDPH

- IDPH controls over the alternative cost reports are not effective. During the period of our review, IDPH had not provided adequate guidance to providers regarding the appropriate use of the forms. In addition, RCHCs had varying understanding of appropriate use of alternative cost reports, which led to misuse of the forms and inconsistencies between the providers.

  Biennial compliance reports completed by the same RCHCs advising the county providers does not protect IDPH from RCHC misinterpretations. In addition, some providers we spoke with stated RCHCs do minimal billing reviews during compliance review evaluations. A RCHC we spoke with also stated her nursing background was not adequate training to complete the financial compliance portion of the compliance review.

- IDPH does not require preapproval of alternative cost reports. As a result, oversight of alternative cost reports is minimal. In addition, several providers submitted monthly alternative cost reports, changing their billing rate for specific services each month based on the specific costs incurred in a given month. This practice leads to more oversight burden on the RCHC during their biennial compliance reviews and leads to less control and less understanding of the types of costs actually reimbursed to county providers.

Buena Vista County

- BVCPH charged the Grant the 15% cost multiplier for communicable disease follow-up in fiscal year 2008 without adequate support. According to a BVCPH official, the 15% cost multiplier was an automatic amount provided by the RCHC. However, when we contacted the RCHC, she stated this was not a correct statement. She also stated she holds regional quarterly meetings with providers at which she discusses alternative cost report instructions and requirements.

  The BVCPH official went on to state the cost multiplier was increased to 25% in fiscal year 2009 and the amount was automatically filled into the alternative cost report for BVCPH's use. However, this understanding is inaccurate. The cost multiplier is a maximum allowance and the provider is allowed to claim the lesser of the maximum allowance or the actual indirect cost percentage. The alternative cost report BVCPH used did not disclose this requirement as newer forms do. The RCHC did not identify this error during compliance reviews.

  Documentation to calculate the impact of the use of escalated cost multiplier percentages was not readily available to determine the impact of the overbilling.

Cerro Gordo County

- Cerro Gordo increased its billing rates for home care aide in fiscal years 2007 and 2008 based on RCHC calculations. A representative of CGHD we spoke with stated the RCHC recommended increasing the billing rates because actual costs were higher than costs being billed. The RCHC purports IDPH recommended increasing the sliding fee scale rates because actual costs were higher than the top full fee charge for services. Regardless of the intent of the RCHC, documentation from the RCHC visit verifies the RCHC completed calculations of home care aide costs which CGHD subsequently started billing its customers. However, this rate included a 28.4% cost multiplier, which exceeded the IDPH cost multiplier limitation of 15%.

According to the RCHC, she instructed CGHD to calculate a new billing rate in the future because the RCHC billing rate would not be approved because it was not calculated using a method approved by IDPH. However, CGHD continued to use the RCHC's rate after the RCHC instructed it to use an approved costing method to support its costs. Documentation to calculate the impact of the use of escalated cost multiplier percentages was not readily available to determine the impact of the overbilling.

Muscatine County

- Muscatine County's Unity was unable to substantiate significant additional costs billed to the Grant. In addition, Unity stated the RCHC provided the cost multiplier (i.e. indirect cost) percentage of 15% and could not support the amount. After additional discussions with the RCHC, we determined the cost multiplier used was appropriate. However, Unity did not maintain supporting documentation for the expense as required by IAC 641-80.4(4).

  Table 22 summarizes some of the unsupported additional costs and calculates an adjusted rate by reducing the alternative cost report for the additional costs and cost multiplier percentage which were not supported. In addition, it calculates the amount of overbilling due to lack of adequate support for the alternative cost report numbers.

Table 22

Date~	Activity	Additional Cost	Rate Billed	Adjusted Rate*	Extended Overbilling
03/12/07	Health Hazard Investigation	$ 232.75	35.07	32.08	400.60
05/12/06	Screenings and assessments	3,245.29	48.98	35.70	5,139.36
05/12/06	Health Education (Dental)	2,695.00	54.58	28.75	1,297.96
05/12/06	Foot clinic	132.27	14.89	9.83	202.40
Total					$ 7,040.32

~ - Date of alternative cost report, not date of service.
* - Includes adjustment for unsupported indirect cost of 15% and unsupported additional costs.

Given the number of alternative cost reports and lack of supporting documentation, this summary may not be all inclusive of unsupported costs submitted to the Grant by Unity during our testing period. We did not collect support for all the direct staff wage costs billed. Instead, we relied on the amounts claimed and then adjusted for unsupported indirect and unsupported additional costs.

Polk County

- Polk County's VNS included unallowable costs in the additional costs it claimed. As previously stated, the Polk County BOS signed a contract with VNS allowing it to charge a variable rate for home care aide (protect) services, which relate to prevention of abuse and neglect for both children and adults. We performed limited testing and selected 1 month of additional costs to research. **Table 23** summarizes the additional costs included in the August 2007 alternative cost report.

Table 23

Date	Description	Amount
08/31/07	Business reply envelopes/postage	$ 125.41
08/31/07	Laying cable in building*	641.43
08/31/07	Telephone allocation	29.60
08/21/07	Utility payment client^	149.08
	Total	$ 945.52

* - The description in the accounting system was "copy machine allocation – adult health copier electrical".

^ - Paid client's utility bill for 1 month.

IDPH officials stated VNS was not utilizing the additional cost allocation appropriately. They stated office supplies are allowable if the provider has an accurate accounting system in place to divide project-specific costs and ensure they are not included in overhead.

However, IDPH stated telephone allocations were not allowable unless the vendor could accurately track the percentage of phone usage specifically for Grant services. In addition, laying cable in the building and paying a client's utility bill are not allowable expenses as they cannot be directly allocated to Grant services.

Given the number of unallowable expenses identified in a 1-month period, we are concerned there may be additional claims for unallowable expenses. However, the time and resources required to identify additional specific claims prevented us from extending our testing.

- Polk County's VNS included costs which are not appropriate for the home care aide allocation from the elderly wellness appropriation in its calculation of the variable cost rate. In accordance with its contract with Polk County BOS, VNS billed a variable rate for home care aide (protect) each month to recover actual monthly expenditures rather than an average rate.

  In May 2007, VNS included $320.00 of training costs in its home care aide (protect) billing rate. These costs do not meet the definition of costs incidental to services provided and are more appropriate for workforce development, which is reimbursed through appropriations for local public health services and local board of health, not the home care aide allocation. VNS provided support to verify the costs were incurred for 2 employees to attend a conference on protecting children from abuse. However, including the costs as additional costs billed as home care aide services is improper according to the IDPH Contract Management Table (**Appendix F**).

- As discussed in the Capacity Building Technology section (page 34), VNS also claimed technology costs in its submitted additional costs for January and April 2007. Both months, the capacity building technology costs were improperly classified as additional costs in the alternative cost report billed to home care aide activity rather than capacity building technology, which is billed to local public health services or local board of health appropriations.

  In addition, including these costs in the calculation of hourly billing rates significantly increased the rate. For example, including $3,889.00 of capacity building technology costs in the January 2007 calculation of billing rates resulted in an hourly rate of $58.62 instead of the $38.01 correct amount. In April 2007, including $2,000.00 of capacity building technology costs in the calculation of costs resulted in an hourly rate of $41.22 per hour that month instead of the $35.29 correct amount.

- PCHD billed the Grant for costs it classified as additional costs. However, these costs were rarely directly associated with service costs. The costs did not appear to be improper when reviewing the MUR's because PCHD established a billing rate and units to bill the services so they appeared to be service-related costs.

  For example, in August 2007, PCHD billed the Grant $25.12 for an hour of community partnership. However, the actual expenditure was for conference call services. In accordance with IDPH's definition of additional costs, the $25.12 is not permissible unless it is associated with an approved service. Printing costs, medical and miscellaneous supplies, conference costs and advertising were also billed to the Grant at an hourly rate without associated labor costs as previously discussed. According to a PCHD representative we spoke with, the RCHC assigned to PCHD's region was aware of this practice and approved it to allow PCHD to recover its costs. We were unable to verify this with the RCHC because she retired prior to our review.

Scott County

- SCHD purchased vision screening equipment in June 2008 for $4,802.10 and was reimbursed by the Grant through submission of an alternative cost report. In accordance with IDPH's definition, non-service purchases should be incidental to services provided. SCHD submitted eye screening support for eye screenings previously completed during the period January 11, 2008 through February 29, 2008 as a basis for the purchase. Since the eye screenings were completed well before the equipment was purchased, the equipment was not incidental to eye screening services. The RCHC for SCHD worked with the County and responded the purchase was determined necessary for the following year based on problems identified during eye screenings prior to the purchase.

Recommendations - Based on the findings discussed above, we recommend the following:

- IDPH should implement procedures which ensure providers submit alternative cost plans as required. IDPH should also require supporting documentation be submitted to verify the billing rates and cost multiplier rates requested for reimbursement.

- IDPH officials should consider requiring providers to submit additional costs for reimbursement separately from the hourly direct service costs. Providers should clearly describe the additional costs requested and describe how they relate to services provided. By separating additional costs from billing rates, IDPH would:

  a. Gain oversight and control over the types of additional costs requested for reimbursement.

  b. Ensure large one-time additional costs do not artificially inflate monthly billing rates.

  c. Ensure the appropriations billed for the additional costs are used appropriately.

- IDPH should limit the number of alternative cost reports providers are allowed to submit each year. Providers' billing rates should not fluctuate monthly for regular price adjustments, particularly if IDPH separates reimbursement for additional costs from hourly billing rates. Further, reduction of the number of approved billing rates each year will increase IDPH's ability to oversee the program.

- IDPH should clarify cost multiplier requirements and implement procedures to ensure all providers understand the multiplier is a maximum allowance and actual costs must be claimed if lower than the IDPH limitation. IDPH should require specific reports be maintained to support administrative costs charged to the Grant as required by section 641-80.4(4) of the IAC.

- IDPH should provide training to the RCHCs regarding the financial testing for compliance evaluations. In addition, IDPH should consider independently performing at least 1 compliance review per region per year to ensure objective, unbiased compliance reviews are completed by each RCHC. If IDPH identifies significant issues during the compliance review, it should expand testing to include additional providers within the region to ensure controls are adequate and program requirements are met.
- IDPH should develop procedures to address provider claims which do not have adequate support for components such as cost multipliers or additional costs claimed. Currently, IDPH has no penalties in place for insufficient documentation to give providers an incentive to maintain adequate support for their claims.

IDPH Changes - As a result of preliminary discussions we held with IDPH officials, IDPH shared documentation to demonstrate changes it plans to incorporate in fiscal year 2010, which include:

- IDPH has updated the application and alternative cost reports to require providers to specify the source of their billing rates based on a pre-approved list of allowable sources, such as Medicaid cost reports or IDPH approved alternative cost reports.
- IDPH has developed an updated alternative cost report to require itemization of additional costs based on cost category to provide visibility of the costs included in the calculated rate.
- IDPH has incorporated an instruction to limit alternative cost reports to 2 annually, requiring at least 1 cost analysis annually to ensure compliance with annual cost analysis requirements.
- IDPH added clarity to the alternative cost report to clearly instruct providers to claim the lesser of actual indirect costs or the IDPH limitation when claiming a cost multiplier.

As previously stated, we do not recommend continuation of inclusion of additional costs of a one-time nature in the alternative cost report calculation of an hourly rate because it could cause unnatural inflation of the hourly rate.

J. Grant Eligibility

During testing of billings at each provider's location in the 6 counties we tested, we identified claimed costs which are not appropriate for reimbursement with Grant funds. In order to determine cost eligibility under the Grant, we consulted the IAC, Grant guidance, IDPH officials and legislative appropriation language.

As previously stated, the *Code* requirements and the elderly wellness appropriation language effective for fiscal years 2007 and 2008 which provided 87% of the Grant's funding specified funding was to be used for "optimizing the health of persons 60 years of age and older" and "promotion of healthy aging and optimization of the health of older adults", respectively. As a result, IDPH administrative rules should have limited the use of Grant funds to the elderly population. However, IDPH administrative rules and guidance provided by IDPH allowed for alternative plans. As a result, we reviewed the providers' compliance with the rules established and the guidance provided by IDPH.

Chapter 80 of the IAC summarizes 5 primary service areas, as discussed earlier in this report. They are:

1. Case management – optimizing self-care capabilities of consumers and their families in gaining access to needed medical, social and other services.
2. Local board of health services – increasing the organizational capacity of county boards of health to develop conditions for healthy people and healthy communities through

public health nursing, home care aide, core public health functions and population-based essential public health services in Iowa.

3. Local public health services – increasing local public health capacity by implementing core public health functions and essential public health service to address health inequalities and addressing health inequalities by advocating for population-based policies and services to improve the health of the whole population in an equal way.
4. Public health nursing services – improving the health of the entire community, preventing illness, enhancing the quality of life and providing leadership to safeguard the health and wellness of the community.
5. Home care aide services – reducing, preventing or delaying inappropriate institutionalization of consumers and preserving families through the provision of supportive services by direct care workers who have completed training and are professionally supervised.

IDPH developed a Contract Management Table which is included in **Appendix F**. The Table summarizes IDPH's definitions of allowable expenses for reimbursement under the Grant. For example, an approved activity in fiscal year 2008 was Nursing (Health Maintenance). IDPH described the activity to include teaching and nursing intervention, assisting consumers in managing a chronic condition and maintaining and preventing a worsening of a consumer's condition through a self-care model. In the Table, IDPH defined the billing unit approved by IDPH as hourly, per person, per visit or based on actual cost. IDPH also established which activities are reimbursable according to the appropriations. As previously stated, the appropriations used to fund the Grant are split into 4 areas: local board of health, local public health services, public health nursing and home care aide. The Contract Management Table also lists activities eligible for reimbursement through an alternative appropriation if alternative plans are developed and approved.

As we evaluated expenses during testing, we met with IDPH officials regarding expenses claimed by providers under the Grant. According to IDPH officials we spoke with, IDPH was not aware of many of the expenditures we identified during our testing. In addition, we determined IDPH's published guidance was not adequate to maintain control over the providers' expenditures.

A consistent area of concern we identified in our testing was related to additional costs. IDPH did not publish instructions regarding allowable additional costs. IDPH officials provided their definitions of additional costs to us during meetings throughout the review, but they confirmed they had not published specific guidance on additional costs. As stated previously in this report, IDPH defines additional costs as costs incidental to performing billable services under the Grant and must be directly related to those services.

In addition to our review of information provided by IDPH, we also compared actual expenditures to the description of the purpose of the funding as defined in appropriation documentation. The elderly wellness appropriation funds home care aide services and public health nursing services, represents 87% of total funding of the Grant and is specifically targeted toward elderly populations. Based on the language included in the Iowa Acts, we concluded the elderly were to be the beneficiaries of the appropriations and non-elderly services would not be eligible uses of that portion of the funding for the Grant. However, IDPH officials stated their interpretation of the appropriation language, "for promotion of healthy aging and optimization of the health of older adults," is that "healthy aging" begins at birth. They stated addressing health issues earlier in life will ultimately affect one's health as an older adult. Therefore, providing services to include healthy aging from birth until old age is permissible. In addition, as previously discussed, IDPH administered the program under the assumption outdated *Code* language allowing for additional populations to be served was still permitted. IDPH continued to rely on administrative rules established in accordance with the outdated *Code* language.

IDPH emphasized the elderly population is still the priority and providers must demonstrate elderly service needs are met before utilizing the funds for other purposes. According to IDPH officials we spoke with, they ensure elderly population services are sufficient through use of alternative cost reports, which require providers to explain how the target population will be served while diverting a portion of the target population's funding to another population. However, a review of a few alternative cost reports showed providers were not adequately addressing the impact on the target population in fiscal year 2007. In fiscal year 2008, the alternative cost report was more specific.

The following are examples to demonstrate our concerns:

- In fiscal year 2007, the alternative plan required the provider to "describe how target populations are served if funds are used for non-traditional use." However, when reading through a selection of alternative cost reports, we determined the responses did not always address the impact on the elderly population but further justified the need for diverting the funds. While this wasn't always the case, IDPH approved alternative plans without ensuring elderly population needs were met first.
- In fiscal year 2008, IDPH improved the alternative plan language to "describe how the services for which the funds are intended will continue to be provided once the funds are used for the activity requested." Based on a cursory review of fiscal year 2008 alternative cost reports, providers more consistently addressed the target populations of the Grant. However, we question whether the justifications are adequate to assume there is no need for the funds in the target population. For example, Muscatine County's justification for diverting home care aide funds from the elderly wellness appropriation stated there is no waiting list for home care aide services. In addition, as previously discussed, Polk County diverted $106,000.00 on the first day of a fiscal year and justified the alternative use of the funds by stating the home care aide provider had not fully expended the home care aide funds the last several years. Therefore, all the needs are being met. While these assumptions may be reasonable to the providers, we disagree. Lack of public knowledge of the program or limited types of services offered could be causing limited use of home care aide funding.

By giving providers the option to divert funds to non-elderly populations or loosely related projects, IDPH is compromising the purpose of the funding. If the Legislature believes funding is needed for non-elderly populations or loosely related projects and the full amount appropriated for elderly wellness is too high, it should change appropriations to address the gap in other services. In addition, we question the practice of diverting funds to other populations on a county by county basis until statewide elderly service needs have been fully addressed. For example, in the current system, 1 county can divert funds to non-target populations if elderly populations are adequately served. However, there could be a shortage of elderly service funding in another county. Under the current system, the shortage of elderly service funding in one county is not supplemented with excesses from another county.

Findings - Based on our determination of the purpose of the Grant, we identified the following:

The elderly wellness appropriation language providing 87% of total Grant funding clearly states the funds are to be used for the elderly. The phrase, "for promotion of healthy aging and optimization of the health of older adults" does not include services for children or young adults. The Legislative Appropriations section of this report includes excerpts of the elderly wellness appropriation language funding the Grant. IDPH's interpretation that aging begins at birth is not supported by legislative appropriation language.

We identified a number of services paid for with Grant funds which were not provided to the elderly. The services are listed in **Table 24**. We identified the services based on our review of service descriptions in the alternative plans, interviews with providers and review of supporting documentation.

Table 24

County	Amount FY07	FY08	Total
Home Care Aide (protect)*			
Buena Vista	$ 1,380.75	242.00	1,622.75
Muscatine	-	18,955.26	18,955.26
Polk	71,380.98	-	71,380.98
Community Partnership			
Pottawattamie	660.00		660.00
Muscatine	-	6,045.00	6,045.00
Family Support Home Visits			
Cerro Gordo	-	2,419.56	2,419.56
Health Education			
Cerro Gordo	-	9,289.70	9,289.70
Muscatine	2,742.65	7,899.96	10,642.61
Scott	33,111.10	3,116.50	36,227.60
Health Hazard Investigation			
Cerro Gordo	-	2,620.50	2,620.50
Muscatine	-	462.36	462.36
Regulatory Environmental Health^			
Cerro Gordo	-	6,729.12	6,729.12
Nursing (Health Maintenance)*			
Polk	195,822.23	244,045.92	439,868.15
Prevention of Abuse and Neglect*			
Polk	-	4,130.00	4,130.00
Cerro Gordo	-	247.46	247.46
Immunizations			
Pottawattamie	6,941.00	8,405.00	15,346.00
Scott	32,760.70	18,262.00	51,022.70
Screenings and Assessments			
Pottawattamie	844.83	3,847.78	4,692.61
Protective Services (court ordered)*			
Scott	33,235.47	16,094.87	49,330.34
Total	$ 378,789.71	352,812.99	731,692.70

* - Services related to court-ordered intervention to protect clients from abuse and neglect. Although providers stated these services can be for elderly dependents as well as children, services appeared to be primarily related to children. These services total $585,534.94.

^ - Environmental health is a different area of health and is not included in IDPH-approved health services.

The $731,692.70 of services identified in the **Table** as non-elderly type services include services which were not restricted to elderly clients and included a significant amount of services provided to non-elderly. These services represent almost 20% of the funds appropriated for elderly wellness. However, because we were unable to review all supporting documentation for services provided in our testing selection, we do not believe the **Table** is inclusive of all services provided to non-elderly clients.

The largest portion of the services included in the **Table** are associated with court-ordered services. Polk County spent approximately $500,000.00 on these services in the 2-year period tested. The service is described in a VNS alternative plan as child protective services to address an unmet need of children who need assistance. The services include nurse participation in child removal and team meetings, assuring health records and immunizations are current, performing nursing assessments, making referrals for necessary services, etc. Although the significance of the services is clear, the use of elderly wellness appropriations to fund such activities is improper. A number of programs to ensure children's nutritional, environmental and educational needs are met have been established and are administered by State agencies such as the IDPH, the Department of Human Services and the Department of Education. These programs are funded by their own appropriations, federal sources or other mechanisms.

Some of the other services are preventative in nature or offer community and family learning opportunities. These services may include elderly participants but are most likely directed to younger populations. Specific examples of services included in **Table 24** are summarized in the following paragraphs.

- Muscatine County - Muscatine County submitted $3,545.06 of costs to IDPH for reimbursement for purchases of health education equipment, including DVD players, breastfeeding and healthy living DVDs and DVD cases. It also included a laptop computer and unsupported technology cost for cell phone service. In addition to not being targeted to the elderly, these purchases were not received until the following fiscal year. (Improper year-end spending will be addressed in a later section of this report).
- Scott County – We identified a number of additional costs SCHD submitted to IDPH for reimbursement which are not for elderly wellness. The costs we identified are summarized in **Table 25**. In addition to the costs summarized in the **Table**, we identified $6,499.90 of additional purchases which were not for the elderly and were not received until the following fiscal year. The additional costs are discussed in detail in a subsequent section of this report and are included in **Table 26**.

Table 25

Vendor	Invoice Date	Description	Total
NIMCO, Inc.~	06/05/07	Tobacco education	$ 228.33
Journeyworks Publishing~	06/06/07	Tobacco education	410.30
Health EDCO~	06/07/07	Tobacco education	1,812.66
Global Protection Corp.	06/20/07	Condoms and condom key chains	1,064.60
Learning Seed	06/20/07	Germs DVD	95.00
National Safety Compliance	06/20/07	First Aid DVD	117.95
Health EDCO*~	06/20/07	Tobacco, Sex, Pregnancy education materials	3,670.39
gNeil^	06/21/07	Bloodbourne safety – Hazcom safety	605.99
Health Connection~	06/21/07	Tobacco education	490.59
Marsh Media	06/22/07	Puberty DVD	153.89
ETR Associates	06/22/07	AIDS/Drug DVD	307.89
Polyjohn	06/22/07	Handwashing stands	680.00
Sesame Workshop	06/22/07	Lead education DVD	368.00
Journeyworks Publishing	06/22/07	Sex education materials	396.00
Fidlar Communication Tech.	06/22/07	12,500 tear-off sheets - Tobacco education	1,243.00
Total			$11,644.59

* - Costs were related to the Scott County jail and also included Empowerment expenses.
^ - Bioterrorism related.
~ - Tobacco related.

In addition to non-labor costs not meeting the purpose of the Grant, we identified $1,964.20 of health education staff time which was also not related to elderly wellness. The RCHC stated the staff time was not charged to the Grant, but we confirmed it was included in the staff wages listed in the alternative cost report in June 2007. While some of the additional health education costs may meet the current interpretation of Grant-approved services, topics related to puberty and sex education and childcare provider health education clearly do not meet the purpose of funds to serve the elderly population. Health education staff time not related to elderly wellness included:

- Tobacco education.
- Adolescent Pregnancy Prevention Grant program.
- Careers in food service including job qualifications for inspections.
- DARE program.
- Senior Ambassador Presentation/Senior Salute.
- Presentation on Iowa pool and spa rules.
- Presentations on food inspections.

SCHD officials stated they learned of a subcontractor's inability to use its appropriated funds late in the 2007 fiscal year, which is the reason for less traditional spending. They worked with an RCHC and provided documentation indicating the RCHC was aware of their plans for the funds. However, as illustrated by **Table 25**, the costs claimed were not related to elderly wellness.

In addition, many of the claimed costs were related to services funded through other government funding sources, such as bioterrorism, empowerment and tobacco related claims, and should have been claimed through those funding sources, not the Grant. SCHD officials stated they claimed the costs because other funding sources were expended, thus triggering the Grant's "gap-fill" purpose.

However, we maintain all expenditures under the Grant should be in compliance with appropriation language approved by the Legislature . SCHD is not authorized to use the funds for expenses if they are not directly related to the purpose of the funds. Given the circumstances of the spending and the significant quantities purchased, it appears the primary objective was to spend the appropriations, regardless of the actual needs of the county.

We also identified additional costs which did not meet the purpose of the appropriations. SCHD received reimbursement for the costs through the elderly wellness appropriation allocated to home care aide. The purchases were made at the end of fiscal year 2007 and included items for health education, which is described in the Contract Management Table as activities which provide educational information about physical, behavioral, environmental and other issues affecting health. We determined the additional costs were not incidental to the staff time claimed and they were not appropriate for serving the elderly. These expenditures are discussed in more detail in the Year-end spending section of this report and have been included in **Table 26**.

- In April 2008, SCHD billed the Grant $364.80 for labor costs associated with a staff member's attendance at Empowerment and United Way Board meetings. Both Empowerment and United Way provide Grant funding for public health related costs. However, neither Empowerment nor United Way focus primarily on the elderly, which is the purpose of the appropriations billed (HCA – Community partnership). Further, administrative costs associated with Empowerment and United Way should be paid with Grant proceeds from those organizations.

When we contacted the RCHC for SCHD, she responded these funding sources do not pay for attendance at Board meetings and the Grant allows such activities through community partnership funding. We did not verify Empowerment and United Way do not reimburse for meeting attendance. However, we concluded participation costs associated with other funding sources which do not meet the purpose of the Grant appropriations should not be eligible for Grant reimbursement.

In addition to examples from **Table 24**, we identified additional reimbursements which do not meet the definitions of the Grant in the appropriations for local public health services and local board of health. As reported in the Legislative Appropriations section of this report, the purpose of the appropriation for local public health services is "for essential public health services that promote healthy aging throughout the lifespan…to enhance health promotion and disease prevention services". The purpose of local board of health appropriations is for "strengthening the health care delivery system at the local level."

Examples of reimbursements through local public health services and local board of health appropriations which are inconsistent with the purposes approved by the Legislature include:

- Scott County - For the months of January through March 2008, SCHD billed the Grant $3,092.71 for services and purchases related to wastewater treatment, tanning and tattoo programs. The wastewater treatment expenses included SCHD's environmental health staff attending work sessions to evaluate the wastewater treatment program. The wastewater treatment expenditures were billed to the local public health services portion of the Grant. SCHD, with support from IDPH, stated planning regarding onsite wastewater treatment systems meets the intent of the funds because of the impact failures in wastewater treatment could have on the health of individuals.

  Similar arguments could be made for prevention of air pollution, lead paint removal services or other environmental services. However, it would be difficult to justify the purpose of these services is to provide essential public health functions to promote healthy aging. Continuation of such interpretations puts the program at risk by allowing counties the discretion to use Grant funds for loosely related projects which may impact the health of the general public.

  In addition, the RCHC for SCHD stated there is no other funding source available to fund the work sessions, as funding for wastewater treatment is only funded through fees which are not enough to cover costs. Therefore, since the Grant is a funder of last resort, the expenses were appropriate. The Grant's function as a funder of last resort does not nullify the requirement to use the funds in accordance with the purpose of the appropriations.

- Polk County - As discussed in the Billing Rates section of this report (page 37), PCHD routinely bills both the local board of health and local public health services portions of the Grant for a portion of an employee's salary. According to the Director, PCHD determined the employee worked an average of 62 hours per month on screenings and assessments, which is the activity PCHD billed to the Grant. In the 2-year testing period, the Grant paid salary costs totaling $71,992.66 for the employee. However, PCHD was unable to provide documentation of specific activities the employee performed each month to "provide tests for consumers who may be at risk or have asymptomatic conditions" in accordance with the definition of screenings and assessments activities and, therefore, did not document the salary costs paid were in accordance with the purpose of the Grant.

  PCHD billed the Grant for other staff salaries which were also not adequately supported to show specific health service activities were performed. Based on our limited review, it appears PCHD supplemented its salary budget with the Grant rather than using Grant

funds to sponsor specific approved activities. In addition to the $71,992.66 of salary costs previously identified, PCHD billed the Grant for salary related costs of $54,669.24 in the 2-year testing period.

- PCHD billed the Grant $12,143.62 for advertising costs in fiscal year 2008. However, IDPH removed advertising as an eligible Grant expenditure after fiscal year 2007. PCHD did not bill advertising in accordance with the billing model IDPH developed. Instead of itemizing the advertising expenses clearly on the IDPH billing model, PCHD billed the expenses to the Grant under the community partnership (suicide coalition) activity. The Contract Management Table defines community partnership as activities which promote community participation in identifying and solving public health problems.

  The advertising costs were not associated with any community partnership activities completed by PCHD. PCHD received Grant funds for ineligible advertising costs by misclassifying the costs as approved activities. As stated earlier, the RCHC for Polk County was aware of this billing practice and approved it. When we discussed this concern with IDPH officials, they stated they were not aware this was happening and confirmed the costs were unallowed.

- PCHD billed the Grant $399.37 for food purchases during the 2-year testing period. Food is not an allowable expenditure and IDPH officials stated these costs were improper. The PCHD representative stated the food costs were allowable because they were for community outreach activities.

- PCHD billed the Grant $81.48 for pink hand soap. The Director stated the soap purchase was in connection with lead coalition education. However, in accordance with IDPH's definition of additional costs, the soap should have been associated with service costs and not billed directly to the Grant.

- PCHD billed the Grant $194.18 for costs associated with a parade and Latino Festival in fiscal year 2008 under the community partnership activity. These costs were not incidental to services billed to the Grant. As previously stated, community partnership is defined as activities which promote community participation in identifying and solving public health problems. Parade fees and associated costs are not clearly consistent with the community partnership definition.

- Pottawattamie County - In fiscal year 2008, VNA-PC billed the local public health services portion of the Grant and received reimbursement for transportation costs totaling $4,451.62. However, transportation was not an eligible service for Grant reimbursement in fiscal year 2008.

  IDPH officials stated they removed transportation services from the Grant allowances because the service category was not used frequently. Despite VNA-PC's clear description of the cost in the MUR, controls were not adequate to identify and deny payment of ineligible transportation costs claimed in fiscal year 2008.

Recommendations

- IDPH should reevaluate the services approved for Grant reimbursement as described in the Contract Management Table (**Appendix F**) to ensure all approved services are consistent with the purpose of the related appropriations. As stated previously, the purpose of the elderly wellness appropriations funding 87% of the Grant is to provide services associated with elderly clients. Despite needs of non-elderly clients, IDPH is charged with administering the Grant funds in accordance with the purposes of the appropriations approved by the Legislature.

IDPH should also ensure the approved services comply with appropriation language for the remainder of the Grant funds which states they are for "essential public health services that promote healthy aging throughout the lifespan…to enhance health promotion and disease prevention services" and for "strengthening the health care delivery system at the local level." IDPH should avoid allowing "gap-fill" payments for activities which do not readily comply with the Legislative restrictions for the Grant funds.

- IDPH should develop procedures to evaluate the client base of the Grant and ensure it meets the purpose of the appropriations used to fund the Grant. In addition, IDPH should take corrective action to address improper use of the Grant identified during testing and develop control procedures to ensure compliance with Grant requirements which correspond to the purpose of the appropriations.

- IDPH should implement procedures which ensure costs submitted for reimbursement from the Grant are allowable and meet the definitions of allowable expenses. Procedures considered may include increased scrutiny of expenses claimed, increased guidance on allowable services, increased visibility of cost elements submitted to IDPH and RCHC education and training.

  For the improper expenditures identified during our testing, IDPH should seek corrective action. In addition, IDPH should enhance monitoring procedures to ensure Grant requirements are followed by all counties.

- IDPH should develop and distribute guidelines regarding non-labor costs eligible for Grant reimbursement. The guidance should be consistent across the state. In addition, controls over RCHC approval should be developed and implemented to ensure consistency from region to region.

IDPH Changes - As a result of preliminary discussion with IDPH officials regarding our findings, IDPH implemented or enhanced controls to provide more accountability and visibility of expenses charged to the Grant. As previously stated, for future periods IDPH will require line item detail for additional expenses claimed and has incorporated the language "additional expenses incurred are directly related to the specific activity identified" to the alternative cost report for fiscal year 2010.

IDPH officials maintain the Grant allows all costs associated with aging from the time of birth. According to the IDPH Director of the Division of Health Promotion and Chronic Disease Prevention (Director), responsible for oversight of the Bureau of Local Public Health Services, the Grant's "healthy aging" appropriation language allows more flexibility to offer services "from cradle to grave." IDPH has been operating under this definition since 1998, according to the Director.

As previously stated, IDPH officials contend the historical use of the funds and appropriation language for fiscal year 1998 (which was codified into law in 1999) authorized the Department to fund services for populations other than the elderly. However, the 1999 version of the *Code* was subsequently modified to remove references to the fiscal year 1998 appropriation language. IDPH officials also stated rules found in the Iowa Administrative Code authorized the Department to provide services to populations other than the elderly with Grant funds. However, those rules do not comply with the appropriation language enacted by the General Assembly for the years tested.

IDPH officials stated they have controls in place to ensure elderly wellness is the first priority. They stated they accomplish this through the application process for alternative plans, which requires the providers to address the needs of the target population (elderly) to

ensure the target population needs are sufficiently addressed. Based on limited review of past alternative plans, the justifications for diverting funds do not provide sufficient information to adequately ensure elderly needs are met. In addition, the alternative plan does not address activities IDPH currently lists as approved activities not requiring alternative plans. Some activities currently approved are not services for the elderly.

Although the services provided to non-elderly clients are meeting a need within the State, IDPH should not deviate from the purposes approved by the Legislature through the appropriation language provided for elderly wellness. If a substantial need for child protection services, for example, exists, funding specific to those services should be provided separately and appropriations for the elderly should meet elderly needs. In the same context, environmental health, immunizations, sex education, family support programs and tobacco education costs should be funded by programs specific to those causes. As previously stated, the "gap-fill" nature of the Grant can not be interpreted to allow reimbursements for services which are not consistent with the purpose of the appropriations.

K. Year-end Spending

As part of our testing procedures, we analyzed year-end spending to ensure expenses submitted by providers were reasonable, necessary and purchased and received prior to the end of the fiscal year charged. In addition, we discussed year-end spending with the providers. A provider we spoke with stated IDPH strongly emphasizes to the providers the importance of spending down all funds allocated to them each year.

We identified 2 providers which improperly billed the Grant in a fiscal year for expenses not incurred until the following fiscal year. In accordance with section 8.33 of the *Code of Iowa*, "No payment of an obligation for goods and services shall be charged to an appropriation subsequent to the last day of the fiscal year for which the appropriation is made unless the goods or services are received on or before the last day of the fiscal year." Because IDPH is reimbursing the providers from the funds appropriated to IDPH by the Legislature, these requirements apply to those payments.

SCHD and Unity both requested reimbursements for payments for goods when documentation was not available to verify the items were received prior to the end of the fiscal year. Both counties stated their understanding was the order date was the date which had to be prior to the end of fiscal year. IDPH officials stated they were unaware of this understanding. As a result, they did not instruct providers or RCHCs such expenditures were unallowable. In both instances, the counties learned a significant balance of unused funds was available late in the fiscal year and they had limited time to spend the allocated funds.

In accordance with Department of Administrative Services' (DAS') year end procedures guidance, agencies must retain packing slips, receiving reports or other supporting documentation when the invoice shipment date is June 25 to June 30 or the invoice date is June 25 to July 5 in order to verify the appropriation year of the purchase. In addition, it is recommended agencies retain proof of date of receipt for all invoices between June 15 and July 31 in order to clearly demonstrate which fiscal year the invoice should be charged to.

Table 26 summarizes the purchases we identified which were charged to the incorrect fiscal year by Unity and SCHD.

Table 26

Vendor	Invoice Date	Description	Total
Muscatine County's Unity:			
Injoy Videos	06/30/08	3 DVDs – Breastfeeding and Health	$ 559.85
Best Buy	06/30/08	5 DVD players and DVD cases	984.91
Dell	06/30/08	Laptop Computer	1,933.65
Total			$ 3,478.41
Scott County Health Department:			
Health EDCO	06/27/07	Pamphlets, displays	$ 605.99
Total Access Group	06/25/07	5,000 condoms	315.00
Miller Thermometer Co.	06/27/07	2,000 freeze guide thermometers	3,989.00
Creative Marketing	06/29/07	2,500 preparedness magnets	935.00
Davenport Printing Co.	07/03/07	Sexually transmitted disease handouts	655.00
Total			$ 6,499.90

Unity made 3 purchases on June 30, 2008 and claimed them for fiscal year 2008. However, if the purchases were not physically received on June 30, they should have been charged to the following fiscal year. Unity did not retain documentation to verify the date of receipt of purchased items, which is recommended by DAS when making year-end purchases. The invoices from Injoy Videos and Dell both included an expected delivery date of July 7, 2008. Thus, they were improperly billed to the Grant for fiscal year 2008. The Best Buy invoice did not indicate an estimated delivery date.

In addition, we determined Unity claimed $2,000.00 in June 2008 for technology. Unity officials stated the $1,933.65 purchase of a laptop from Dell was the majority of the cost and they could claim the remainder of the amount using costs which had already been incurred for a computer speaker. However, when Unity was unable to provide support for the speaker purchase, Unity officials stated they would provide a cell phone bill to verify Unity was eligible for the reimbursement. The cell phone bill provided was from 2006. It appears Unity's intent was to provide something which added up to the amount claimed, regardless of whether or not it actually spent that amount during the billing period. The $66.35 difference between the $2,000.00 technology costs claimed and the $1,933.65 Dell purchase is unsupported. Concerns regarding providers using invoices which do not reconcile to the amounts claimed is discussed in detail in the following section of this report.

SCHD submitted Health Education costs totaling $30,447.35 under the home care aide activity in June 2007. Of that amount, we discussed $11,644.59 in **Table 25** because it was not in accordance with the purpose of the appropriation, which is to serve the elderly population. We obtained documentation verifying the RCHC assigned to SCHD at the time of the purchases was in contact with the County regarding its year-end spending situation. However, the RCHC did not adequately review or ensure the items billed to the Grant complied with applicable requirements.

In addition to the invoices listed in **Table 25**, the costs in **Table 26** were incurred between June 25 and July 3 of fiscal years 2007 and 2008. Representatives of SCHD were unable to provide documentation to verify the date of receipt was prior to fiscal year end. The

invoice from Davenport Printing Co. on July 3 was clearly improper since the invoice was after June 30. The other costs were not supported by corresponding shipping receipts to verify they were appropriately received in fiscal year 2007.

In addition, none of the invoices in **Table 26** are consistent with the purpose of the elderly wellness appropriation from which they were paid. The freezer thermometer guides were clearly improper to the Grant because they were for environmental health purposes and were not related to elderly wellness. Also, the preparedness magnets and pamphlets were related to bioterrorism and the condoms and sexual education materials were family support related items. None of the costs were consistent with elderly wellness services.

Recommendations

- IDPH should take corrective action regarding the improper year-end spending practices identified. In addition, IDPH should also implement controls which include testing year-end expenditures to ensure billings are properly submitted and adequately supported.

- In situations in which a provider has excess funds left at the end of a fiscal year, IDPH should work with the provider to ensure proper use of the funds within the confines of the Grant's allowable activities. In addition, if a county is unable to use the funds for allowable expenses, IDPH should take steps to reallocate the funds to other counties as needed or return the funds to the State as required.

- As previously addressed, IDPH should implement procedures which ensure providers are using Grant funds for allowable expenses which comply with the purpose of the appropriation approved by the Legislature. In the findings listed above, Legislative intent for funding was to serve the elderly. IDPH should take corrective action to match approved Grant activities to the purpose of the appropriations.

L. Reimbursement of Actual Costs

We determined many of the providers tested had multiple funding sources to whom they submit costs for reimbursement. Examples of other funding sources include:

- United Way
- Empowerment
- Tobacco grant
- Medicare
- Title XIX
- Counties

As with the IDPH Grant, each funding source has its own set of reimbursement guidelines and limitations and agrees to pay for supported and allowable costs.

Because providers use funding from multiple sources, we requested support from providers to verify costs submitted for payment from the Grant could not also be easily submitted to another funding source. During testing, we determined providers sometimes used invoices and other support for costs which did not agree with the costs claimed. Instead, the invoices used to support the claimed costs supported an amount larger than the claimed amount. Although the invoices provided were sufficient to justify the provider incurred the costs, documentation was not adequate to verify a portion of the invoice was charged to the Grant and another portion was charged to a different funding source.

For example, as discussed in the previous section, Unity needed to provide support for $66.35 claimed for technology expenses and attempted to support the cost by providing an old cell phone bill. Currently, there are no controls in place to ensure the support for costs claimed have not been claimed previously or claimed as a cost which was reimbursed by

another funding source. By allowing providers to submit enough billing support to cover the costs they billed to the Grant without clearly showing the costs were allocated specifically to the Grant, IDPH and the other funding sources are at risk of providers submitting double payment requests.

During discussion with VNS-Polk officials, we became concerned VNS-Polk's goal was to get the Grant funds released to them rather than to provide support for the actual activities billed to the Grant. MUR's routinely did not reconcile to cost reports used as support. Since VNS-Polk had multiple other funding sources, including Title XIX and United Way, there is a risk it could submit identical records to these funding sources to get their funding as well.

For example, employees of VNS-Polk split their time between Title XIX approved services and Grant approved services. They stated Title XIX was very specific on the approved activities. Therefore, the Grant supplemented Title XIX by paying for the time Title XIX did not approve. We attempted to verify the timesheets each nurse split between the 2 funding sources accurately billed hours to each funding source. However, records were not sufficient to readily determine costs were not duplicated when submitted for reimbursement.

We routinely received support for more costs than claimed by the providers when we were testing billing support. While some of this is attributable to the need to claim partial expenses because Grant funds are exhausted at the end of the fiscal year, the lack of clear allocation of expenses could lead to double billings and potential abuse of multiple funding sources.

Recommendations

- IDPH should ensure billings submitted for reimbursement reconcile to the amounts claimed.
- For claims to reimburse the provider the final remaining balance of the Grant, IDPH should develop procedures which require the providers submit final claims which clearly allocate specific costs to the Grant for reimbursement. Costs associated with non-routine services or for the purchase of items not previously claimed should be scrutinized to ensure the claim is appropriate and another funding source hasn't already reimbursed the provider for the cost. For example, if the provider typically does not submit monthly cell phone costs, submission of a bill for 1 month of cell phone service may require follow-up.

M. Billing Error Corrections

We had concerns with corrective procedures taken by Polk County, Cerro Gordo County, Scott County and IDPH when billing errors were identified.

Findings

- Representatives of PCHD stated if they identify an overbilling or billing error, instead of reporting the error to IDPH, they adjust the following month's billing by the amount of the error. We observed this practice when we tested billings. This practice resulted in a lack of adequate documentation of the billing correction. For example, if PCHD erroneously billed the Grant $100.00 in May, the June invoice was reduced by $100.00. However, it was unclear how PCHD determined where to take the $100.00 from in the subsequent month. This practice, without clearly itemizing the adjustment on the MUR, causes the support for submitted costs to be inconsistent with the MUR.

- According to Cerro Gordo County representatives, IDPH instructed them to correct an underbilling by making up a unit to bill the Grant the following month in an amount equal to the amount underbilled. We observed e-mail documentation which agreed with the information provided by Cerro Gordo County representatives. Although Cerro Gordo County was entitled to the additional reimbursement, developing a new billing rate which has not been supported by a cost analysis reduces accountability and results in billings which don't agree with supporting documentation.

- In addition, the RCHC at Cerro Gordo County identified billing errors related to failure to deduct fees collected from clients on the MUR's during the compliance review process in fiscal year 2007. The RCHC requested revised billings to correct the errors to begin at the start of the fiscal year in which the error was identified. However, Cerro Gordo County representatives stated they hadn't been operating in compliance with sliding fee reporting requirements for 20 years. IDPH limited the correction of overbillings to the current fiscal year. In discussion with IDPH officials, they stated they leave the funds with the provider but require the provider to submit documentation in the current fiscal year to verify they've provided services equivalent to the funds overbilled in the prior year.

- SCHD also had some overbilling issues the RCHC identified in February 2007. SCHD investigated the issue and reported overbillings to the Grant totaled $10,553.35. We did not identify evidence the RCHC or IDPH officials reviewed SCHD records to verify the amount SCHD reported was accurate. In addition, we determined the overbillings were only calculated at the beginning of the fiscal year. It is unclear how long prior to the fiscal year beginning the overbillings had occurred. In the RCHC files reviewed, we identified a fiscal year 2005 request for extension of compliance review due to billing concerns, indicating there were compliance issues in prior years. SCHD reduced subsequent claims by the $10,553.35 they calculated.

- IDPH's current procedures for correcting overbillings involve a significant administrative burden and result in a lack of clear documentation of the errors identified. For example, 1 provider identified overbillings spanning several months. IDPH requested it submit emails to IDPH stating the amount it originally billed and the amount it should have billed for each month in error. The county was also required to develop a revised MUR which had the amount the county should have originally billed on it. Then IDPH disposed of the improper MUR's and reduced subsequent monthly claims by the amount overspent in prior months. Although it appears the end result is a reduction of future claims by the amount of the overbilling, the current procedures are unnecessarily burdensome and result in payments to the provider which do not match corresponding invoices.

Recommendations

- IDPH should implement procedures which ensure billing errors are corrected in an appropriate, consistent and documented method. In addition, IDPH should train RCHCs and providers on the proper procedures to handle billing errors.

  If an overbilling occurs, the following month's MUR should have a line item adjustment for billing error correction, linking the adjustment back to the prior month. This practice will leave a clear documentation trail which can easily be traced to supporting documentation. The correction should clearly indicate which activity and appropriation is being adjusted.

- IDPH should implement procedures which prohibit providers from making billing corrections internally. By not including identified billing errors on the MUR, the provider is complicating the problem because supporting records will not match the

MUR's. In addition, appropriate documentation would not be available to support the variance.

- IDPH should develop a policy for correcting billing errors which span multiple fiscal years. IDPH should work with legal counsel or legislative advisors regarding the proper method to address multi-year billing errors and treat them consistently.

N. Billing Controls

During testing, we identified the following billing errors.

- From November 2007 through June 2008, SCHD's billing rate for protective services included fringe benefit costs twice. The resulting overbilling was $2,046.31. There were no controls in place to identify and correct the error.
- SCHD inadvertently billed for 10 hours of service when the actual time spent was 10 minutes in July 2006. The resulting overbilling was $290.87. There were no controls in place to identify and correct the error.
- As previously stated and summarized in **Table 22**, lack of support for billing rates at Unity in fiscal year 2007 resulted in $7,040.32 of unsupported labor costs. There were no controls in place to identify and correct the error.
- At Muscatine County's Senior Resources, we tested controls over billings for June and July 2007. Senior Resources provides chore services to clients. Clients were required to certify the provider completed services at their residence. However, the signature field on some forms was blank or the client was listed as "unavailable" or "not home." Therefore, the controls implemented to ensure verification of services rendered were not adequate. The provider received reimbursement whether it had the required client signature or not. The provider attributed these problems to a former employee.
- As previously stated and summarized in **Table 16**, the Pottawattamie County Project Director's time was billed to the Grant without supporting documentation and the hours billed appeared excessive. There were no controls at VNA-PC to ensure the billed hours were supported, which resulted in unsupported billings of $5,089.40. There were no controls in place to identify and correct the error.

Recommendations

- IDPH should implement procedures which ensure the RCHCs receive proper training regarding the billing rate testing and verification procedures they are to periodically perform. In addition, the RCHCs should be instructed to conduct their procedures in a consistent manner across the State.
- As previously recommended, IDPH should consider independently completing at least 1 compliance review per region per year to ensure the compliance review is completed by an independent and objective party.
- IDPH should implement additional review procedures to verify MURs are accurate and supported. In addition, IDPH should implement procedures to include the MURs in biannual compliance reviews.

  For example, it could require RCHCs to select at least 1 MUR or 1 billing from each provider or activity to trace back to supporting documentation as part of the compliance review. In addition, providers posing more risk, such as providers receiving significant funds or providers with prior year adverse findings, should be tested annually to ensure compliance with IDPH billing standards.

O. IDPH Controls

Currently, IDPH relies on the RCHCs and county Project Directors to monitor and oversee billing practices, documentation maintenance and general program operations at the county level.

The county Project Directors are responsible for communications between IDPH and the county providers on any key issues, maintaining records to ensure expenditures do not exceed approved appropriations and ensuring provider records contain documentation of services provided. During testing, we determined Project Directors did not perform oversight functions. For example:

- At Polk County, the Project Director stated the RCHC was so much more knowledgeable about other providers' billing structures, so he relied on her to ensure other Polk County providers were maintaining necessary records.
- At Pottawattamie County, as a result of the merger, neither the Project Director nor the new management for VNS-Omaha claimed responsibility for maintaining support for billings to IDPH.
- County Project Directors at Scott County and Muscatine County stated they rely on the numbers submitted by the other providers in their county and do not review supporting documentation or request it.

As a result of these conditions, we concluded the Project Directors are not currently providing control over the Grant's administration or expenditures.

RCHCs are responsible for biannual compliance reviews of all the providers within their region as well as general instruction and communication with providers regarding Grant administration. **Table 27** summarizes the regions and the number of counties each RCHC is responsible for. Because a number of the counties have more than 1 provider, the RCHCs are responsible for more biannual reviews than listed in the **Table**.

Table 27

Region	Counties	Grant Funding
1	16	$ 2,529,835.00
2	18	1,309,902.00
3	16	1,316,832.00
4	18	1,283,735.00
5	17	1,498,920.00
6	14	2,699,723.00
Total	99	$ 10,638,947.00

In addition to the responsibilities associated with compliance reviews, providers we spoke with consistently stated they are in regular contact with their RCHC and work closely with the RCHC on a routine basis.

Currently, each RCHC is responsible for completing compliance reviews within their own regions. On a logistical and familiarity basis, the current practice makes sense. However, we identified variations between the RCHCs and their tolerance for particular spending practices. For example, in Polk County, the RCHC worked with PCHD to fit material costs into a service-based MUR. The same RCHC also was referenced in a contract VNS made with the Polk County Board of Health as having approved a unique billing practice of allowing billing rates to fluctuate from month to month based on actual costs. In both cases, IDPH Central Office officials stated they were unaware of the arrangement and were not in agreement with the RCHC's decisions.

During testing at Pottawattamie County and Cerro Gordo County, we determined the RCHC assisted the county in developing its billing rates. RCHCs also permitted providers to routinely adjust their billing rates to match their actual expenditures. All billing rate adjustments must be supported by appropriate cost analysis or alternative cost reports which with supporting documentation to verify the accuracy of the rates. These cost reports should be adequate for the RCHC to ensure cost factors are appropriate for the grant.

In addition, providers we spoke with consistently stated they are in continual contact with their RCHCs and get verbal approval when changing their billing practices. By providing day-to-day assistance to the providers, the RCHCs may become part of the daily operations of the providers. While this system provides county vendors with knowledgeable assistance, it eliminates the RCHCs' ability to conduct an independent evaluation of the counties' operations.

We identified at least 4 (Scott, Muscatine, Pottawattamie and Cerro Gordo) adverse compliance reports which were not published. Rather, the RCHC would wait to issue the report until the provider became compliant with Grant requirements. Although we recognize due diligence in working with the providers to correct their deficiencies, failure to report actual findings could put IDPH at risk if it is not on record with its concerns.

In addition, more stringent reporting practices would aid in ensuring providers use due diligence in administering the Grant. We identified RCHC compliance review worksheets which document the RCHC identified repeated billing problems in SCHD. However, an adverse compliance report was never issued because extensions were allowed to give the county time to correct billing problems. Given the multiple compliance report extensions, counties may not be as diligent at correcting problems if they know no action will be taken by IDPH.

During testing, we identified concerns which were not identified by the RCHCs during compliance reviews. For example, as previously stated, Cerro Gordo indicated it had not reduced billings to the Grant by sliding fees collected in 20 years. Although the RCHC eventually identified the deficiency, there is concern the error was not identified in a more timely manner.

During discussions with RCHCs, an RCHC stated they were not trained to adequately evaluate financial records of the counties. A representative of PCHD stated the compliance review typically took an hour, which is not sufficient to adequately ensure program standards are achieved. A representative of Polk County's VNS stated the RCHC never asked for details regarding their billing rates and instead just evaluated the rates for reasonableness.

A provider we spoke with stated, and we observed, RCHCs are not consistent from region to region regarding their interpretation of allowable expenditures. In addition, we identified RCHC errors, such as when the Buena Vista County RCHC inadvertently approved a billing submission which resulted in exceeding the capacity building technology limitation.

In addition to RCHC controls, IDPH also has Central Office staff who are responsible for working with the RCHCs and the counties. Central Office staff manage documentation to ensure counties have been approved for alternative use of funds and are part of the approval process. They also maintain cumulative billing information and incentive payment documentation to ensure counties do not submit costs exceeding their allocation and they complete year-end reports in order to receive the incentive payment.

Due to the need to oversee 99 counties, the level of oversight at Central Office is limited to high level review. For example, when BVCPH submitted capacity building technology requests in excess of the $2,000.00 limitation, the error was undetected. In addition, Central Office officials do not review billing rates for reasonableness or consistency. In Polk County, VNS was using a variable rate process for billing nursing (health maintenance).

Billing rates varied from $34.71 to $274.77 per unit of service in fiscal year 2008 without scrutiny.

Recommendations

- IDPH should re-evaluate the roll of Project Directors and its reliance on oversight provided by the Project Directors. If Project Directors are included in the Grant's system of controls, their roles need to be clearly defined and IDPH needs to periodically ensure the Project Directors are fulfilling their requirements.

  For example, in accordance with the Contract Management Guide, Project Director responsibilities include ensuring provider's records contain documentation of service provided. IDPH should verify Project Directors are taking adequate steps to assure providers in their counties are maintaining adequate documentation of services rendered.

- IDPH should consider possible alternatives to current compliance review coverage with consideration to the following factors:

  a. Equitable assignment of compliance reviews to RCHCs,

  b. Necessity for independent reviewer to complete compliance reviews,

  c. RCHC ability to adequately evaluate billing support and ensure compliance with purposes of the Grant,

  d. Risks associated with specific providers and whether biannual reviews are sufficient,

  e. Potential conflict of interest of RCHCs completing compliance reviews in their own regions and

  f. Lack of consistency between regions if RCHCs and compliance reviewers are not independent of one another.

- IDPH should re-evaluate Central Office controls to ensure improper expenditures are not processed. For example, Central Office should consider tracking capacity building technology expenses.

  In addition, Central Office should consider maintaining a list of approved billing rates or developing a systematic process to verify billing rates to cost support on a test basis. These procedures would mitigate the risks associated with RCHC compliance reviews being done only once every 2 years and would assure providers are maintaining adequate support for their billings.

IDPH Changes - As a result of preliminary discussions with IDPH regarding our findings and concerns about internal controls, IDPH increased reporting requirements to include more specific details on the development of the pricing, which increases the visibility of the costs providers will submit beginning in fiscal year 2010.

In order for compliance reviews to be independent and to improve consistency of review coverage across the state, we emphasize the importance of procedures to bring independent reviewers to counties during the compliance review process, at least for 1 compliance review per region per year.

The increased details required for fiscal year 2010 on required IDPH forms necessary to receive reimbursement should improve IDPH's ability to evaluate and control costs submitted for grant reimbursement.

IDPH RESPONSE

We provided a copy of this report to IDPH officials for their review and response to the findings and recommendations. A copy of the response is included in **Appendix H**. The **Appendix** includes a reference to a comprehensive review and information provided by IDPH in February 2010. Due to the volume of the information provided in February after preliminary findings were discussed with IDPH officials, we have not included a copy of that information in this report. A copy of the information may be requested from IDPH.

While the response included in **Appendix H** does not include all the related documentation provided in February 2010, it summarizes IDPH's position regarding our findings and recommendations. We have addressed IDPH's response in the following paragraphs.

In paragraph 1), IDPH stated, in part, "the Department's enabling statute granted broad flexibility to the Department to establish 'program direction, evaluation requirements, and formula allocation procedures for each of the programs…by rule.' Iowa Code §135.11(16). This statutory authority contains no restriction that these funds be utilized solely for any one particular age group." The response also stated "'healthy aging' is a term understood in public health to include the entire lifespan of a person, and is not limited to any particular age category or stage of life."

After reviewing the information IDPH submitted in February 2010, we discussed this position with IDPH officials. As stated on pages 6 and 7, according to IDPH officials, the Department was authorized to provide services to non-elderly clients because the *Code* in effect at the time IDPH's administrative rules were established allowed for services to non-elderly clients by referring to appropriation language enacted by the General Assembly for fiscal year 1998. IDPH officials also stated populations other than the elderly were served in years prior to fiscal years 2007 and 2008 and legislators did not take issue with IDPH's continued use of Grant funds for non-elderly clients even though the appropriation language for those years specified the Grant funds were to be used to provide services to the elderly. According to IDPH officials, the current *Code* gives IDPH broad authority in establishing Grant administrative rules. As a result, the current administrative rules which allow the provision of services to a broader population are not inappropriate. IDPH officials contend the Department acted in good faith and properly used the funds for non-elderly recipients.

While we concur the prior version of the *Code* and the fiscal year 1997 appropriation language allowed services for non-elderly populations, IDPH does not have authority to divert funds from the purposes expressly described in the appropriation language in effect during our review period. IDPH staff should have revised the rules in the IAC to comply with restrictions established by the Acts of the General Assembly.

In addition, in accordance with section 4.8 of the *Code of Iowa*, "If statutes enacted at the same or different sessions of the legislature are irreconcilable, the statute latest in date of enactment by the general assembly prevails. If provisions of the same Act are irreconcilable, the provision listed last in the Act prevails."

IDPH also maintained aging is a "cradle to grave" process and begins at birth. Therefore, the Grant is flexible in providing services to a variety of clients because the appropriation language in effect in fiscal year 2008 authorizes services to promote healthy aging. Examples of services billed to the Grant which could be for non-elderly services include immunizations, health education, screenings and assessments and services for prevention of abuse and neglect. While services for non-elderly clients may be necessary, IDPH does not have authority to divert elderly wellness funds to other clients on the basis of their

"cradle to grave" aging interpretation or outdated *Code* requirements. IDPH's interpretation that aging begins at birth is not supported by Legislative appropriation language.

After we met with IDPH officials regarding our preliminary findings, the appropriation language submitted to the 2010 session of the General Assembly by IDPH representatives was modified to define healthy aging. The proposed language, which was approved by the General Assembly for fiscal year 2011, removes the title "Elderly Wellness" and replaces it with "Healthy Aging." The purpose stated in the appropriation language is:

> "To provide public health services that reduce risks and invest in promoting and protecting good health over the course of a lifetime with a priority given to older Iowans and vulnerable populations."

As a result of the new language, IDPH and county providers utilizing funds have discretion regarding the populations served as the appropriation language does not define the amount of funds which should go to elderly and does not define "older Iowans" or "vulnerable populations." However, this same level of discretion was not available to IDPH officials prior to the General Assembly's actions for fiscal year 2011.

As illustrated by **Appendix H**, IDPH officials also responded the administrative rules "were adopted by the State Board of Health and approved by the Legislature's Administrative Rules Review Committee. No concerns were raised by either body that the rules were inconsistent with the appropriation language." As stated on page 24, it is IDPH's responsibility to maintain current administrative rules. IDPH should not rely on the Administrative Rules Review Committee to analyze administrative rules for consistency with the *Code*. Also, as stated on page 14, although members of the General Assembly and the Legislature's Administrative Rules Review Committee (ARRC) reviewed the reports submitted by IDPH and the updated administrative rules, their role in review is more cursory in nature and their processes do not include in-depth analysis and comparison of administrative rules to *Code* and Iowa Acts language. Particularly in cases where the substance of the administrative rules is not significantly changed, the ARRC's role does not include significant review of historical law. IDPH is responsible for ensuring administrative rules in the IAC are current and in accordance with limitations established in the *Code* and Iowa Acts.

IDPH's response also stated "Significantly, the Department received assurances from legislators that the rules in fact conformed with their intended use of these funds." As stated on page 13, IDPH obtained a letter with signatures from 3 members of the General Assembly who are the co-chairs and the House ranking member of the Health and Human Services Budget Subcommittee which stated appropriation language was condensed under the title "Elderly Wellness," but the intent of the funds was to refer back to the 1997 Iowa Acts language. As stated on page 14, the letter also stated populations covered in the 1997 Iowa Acts language were meant to continue to receive services even when the later Iowa Acts designated persons over 55 of age or 60 years of age and older as the target population to be served. However, we are unable to determine if the remaining members of the General Assembly concurred with the support provided by the 3 members. When appropriation language designates people of a specific age as the population to be served by the funds, those populations are expected to be served by those funds.

As illustrated by **Appendix H**, in paragraph 2), IDPH stated during the period of our review 88% of the Elderly Wellness appropriations were used for Iowans over 60 years of age. In addition, local Boards of Health used LPHS State Grant funds to support public health activities for older Iowans. As stated in its response, "Hence, the overwhelming percentage of the funds at issue was utilized to support public health services provided to Iowans over the age of sixty." While IDPH is authorized to spend a portion of the LPHS State Grant funds to support public health of older Iowans, 100% of the funds from the elderly wellness

appropriations should have been spent for older Iowans in accordance with language enacted by the members of the General Assembly. In addition, we must reiterate, based on service descriptions and testing we performed for 1 county in each of the 6 regions during a limited number of months during fiscal years 2007 and 2008, at least 20% of the appropriations for elderly wellness was most likely used for non-elderly services. This is in contrast to the 12% identified by IDPH officials.

IDPH officials further stated in paragraph 3), "With respect to the remaining use of a small percentage of these funds for services to those under age sixty, the Department disputes the draft press release and report's inferences that these funds were improperly used." The Department's description of "improperly used" is correct. We specified in the news release and the report the use of the funds was not in compliance with the appropriation language found in the Acts of the General Assembly. Specifically, the news release states, in part, the language for the elderly appropriation, which funds 87% of the Grant, stated:

> "the funding in fiscal year 2007 was to be used 'for optimizing the health of persons 60 years of age and older' and funding in fiscal year 2008 was to be used 'for promotion of healthy aging and optimization of health care of older adults.' Vaudt reported fiscal year 2007 and 2008 Grant funds were used for populations other than 'persons 60 years of age or older' or 'older adults' as required by the appropriation language found in the Acts of the General Assembly."

While we concur with IDPH officials' response there is no allegation funds were used for personal or other inappropriate gain, **Finding J** includes information regarding claimed costs which are not appropriate for reimbursement from Grant funds which we identified during our review of billings at each provider's location in the 6 counties we tested. **Finding J** also includes a recommendation IDPH officials reevaluate the services approved for Grant reimbursement as described in the Contract Management Table (**Appendix F**) to ensure all approved services are consistent with the purpose of the related appropriations.

Schedule

A Review of the Local Public Health Services Grant Administered by the Iowa Department of Public Health

A Review of the Local Public Health Services Grant
Administered by the
Iowa Department of Public Health

Distribution of Grant Funds for Fiscal Years 2007 and 2008

Co. No.	County	Region	Home Care Aide (HCA)	Public Health Nursing (PHN)	Local Public Health Services (LPHS)	Incentive	Local Board of Health (LBOH)	Total
01	Adair	4	$ 30,520	12,118	5,633	1,000	1,238	50,509
02	Adams	4	22,780	9,745	4,741	1,000	1,015	39,281
03	Allamakee	2	42,321	16,102	7,160	1,000	1,619	68,202
04	Appanoose	5	47,013	18,737	6,933	1,000	1,562	75,245
05	Audubon	4	27,518	11,297	5,298	1,000	1,154	46,267
06	Benton	6	57,668	19,576	9,683	1,000	2,248	90,175
07	Black Hawk	6	295,260	88,712	34,056	1,000	8,328	427,356
08	Boone	1	63,661	20,718	9,900	1,000	2,302	97,581
09	Bremer	2	51,816	18,455	9,212	1,000	2,131	82,614
10	Buchanan	6	52,088	19,135	8,683	1,000	1,999	82,905
11	Buena Vista	3	52,460	18,015	8,521	1,000	1,958	81,954
12	Butler	2	43,533	15,848	7,309	1,000	1,656	69,346
13	Calhoun	1	37,672	14,400	6,315	1,000	1,408	60,795
14	Carroll	1	53,768	19,484	8,761	1,000	2,018	85,031
15	Cass	4	45,657	16,912	7,162	1,000	1,619	72,350
16	Cedar	6	46,274	16,149	7,993	1,000	1,827	73,243
17	Cerro Gordo	2	118,521	35,618	14,700	1,000	3,500	173,339
18	Cherokee	3	38,570	14,664	6,770	1,000	1,522	62,526
19	Chickasaw	2	38,781	14,290	6,785	1,000	1,525	62,381
20	Clarke	4	31,833	11,717	5,844	1,000	1,291	51,685
21	Clay	3	49,155	16,532	7,800	1,000	1,778	76,265
22	Clayton	6	50,110	18,542	8,110	1,000	1,856	79,618
23	Clinton	6	120,518	39,286	15,578	1,000	3,719	180,101
24	Crawford	3	46,680	17,886	7,698	1,000	1,753	75,017
25	Dallas	1	66,070	22,221	13,348	1,000	3,162	105,801
26	Davis	5	30,227	12,526	5,704	1,000	1,256	50,713
27	Decatur	4	34,837	13,518	5,739	1,000	1,264	56,358
28	Delaware	6	45,525	17,509	8,045	1,000	1,839	73,918
29	Des Moines	5	105,911	34,945	13,728	1,000	3,257	158,841
30	Dickinson	3	47,198	16,644	7,575	1,000	1,722	74,139
31	Dubuque	6	179,020	56,745	24,832	1,000	6,027	267,624
32	Emmet	2	37,511	13,620	6,294	1,000	1,403	59,828
33	Fayette	2	61,959	22,369	8,900	1,000	2,053	96,281
34	Floyd	2	53,887	18,416	7,688	1,000	1,750	82,741
35	Franklin	2	34,196	13,438	6,217	1,000	1,384	56,235
36	Fremont	4	29,237	11,824	5,578	1,000	1,224	48,863
37	Greene	1	37,214	13,487	6,137	1,000	1,364	59,202
38	Grundy	1	35,725	13,281	6,612	1,000	1,482	58,100

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Distribution of Grant Funds for Fiscal Years 2007 and 2008

Co. No.	County	Region	Home Care Aide (HCA)	Public Health Nursing (PHN)	Local Public Health Services (LPHS)	Incentive	Local Board of Health (LBOH)	Total
39	Guthrie	4	37,773	14,095	6,371	1,000	1,422	60,661
40	Hamilton	1	49,114	15,965	7,578	1,000	1,723	75,380
41	Hancock	2	35,348	13,174	6,549	1,000	1,466	57,537
42	Hardin	1	51,516	19,009	8,141	1,000	1,864	81,530
43	Harrison	4	45,573	16,664	7,395	1,000	1,677	72,309
44	Henry	5	48,132	17,735	8,503	1,000	1,954	77,324
45	Howard	2	32,608	13,050	6,034	1,000	1,338	54,030
46	Humboldt	2	33,407	12,652	6,141	1,000	1,365	54,565
47	Ida	3	28,134	11,647	5,537	1,000	1,214	47,532
48	Iowa	6	40,213	14,680	7,396	1,000	1,678	64,967
49	Jackson	6	55,175	20,003	8,494	1,000	1,951	86,623
50	Jasper	1	85,927	26,166	12,508	1,000	2,953	128,554
51	Jefferson	5	42,174	16,783	7,517	1,000	1,708	69,182
52	Johnson	6	137,465	50,740	30,020	1,000	7,321	226,546
53	Jones	6	50,026	18,211	8,476	1,000	1,947	79,660
54	Keokuk	5	38,815	14,828	6,382	1,000	1,425	62,450
55	Kossuth	2	50,320	17,967	7,750	1,000	1,766	78,803
56	Lee	5	95,744	32,840	12,707	1,000	3,003	145,294
57	Linn	6	326,757	98,651	49,170	1,000	12,098	487,676
58	Louisa	5	34,371	13,585	6,568	1,000	1,471	56,995
59	Lucas	5	33,599	13,410	5,913	1,000	1,308	55,230
60	Lyon	3	34,036	13,516	6,469	1,000	1,446	56,467
61	Madison	4	35,539	13,536	7,004	1,000	1,580	58,659
62	Mahaska	5	55,516	20,780	8,977	1,000	2,072	88,345
63	Marion	5	75,025	23,649	11,283	1,000	2,647	113,604
64	Marshall	1	92,835	31,108	13,006	1,000	3,077	141,026
65	Mills	4	39,360	13,819	7,129	1,000	1,611	62,919
66	Mitchell	2	35,927	13,329	6,258	1,000	1,394	57,908
67	Monona	3	35,957	14,359	6,055	1,000	1,343	58,714
68	Monroe	5	30,548	12,396	5,579	1,000	1,225	50,748
69	Montgomery	4	37,796	14,612	6,470	1,000	1,447	61,325
70	Muscatine	5	111,876	31,365	13,578	1,000	3,220	161,039
71	O'Brien	3	44,049	15,923	7,261	1,000	1,644	69,877
72	Osceola	3	24,648	10,374	5,339	1,000	1,165	42,526
73	Page	4	50,461	18,493	7,706	1,000	1,755	79,415
74	Palo Alto	3	34,866	13,333	6,085	1,000	1,351	56,635
75	Plymouth	3	51,765	19,090	9,574	1,000	2,221	83,650
76	Pocahontas	3	30,815	12,138	5,733	1,000	1,263	50,949
77	Polk	1	713,811	189,673	92,575	1,000	22,925	1,019,984

A Review of the Local Public Health Services Grant
Administered by the
Iowa Department of Public Health

Distribution of Grant Funds for Fiscal Years 2007 and 2008

Co. No.	County	Region	Home Care Aide (HCA)	Public Health Nursing (PHN)	Local Public Health Services (LPHS)	Incentive	Local Board of Health (LBOH)	Total
78	Pottawattamie	4	197,030	60,709	24,490	1,000	5,942	289,171
79	Poweshiek	1	49,177	17,557	8,142	1,000	1,864	77,740
80	Ringgold	4	26,810	11,057	4,975	1,000	1,074	44,916
81	Sac	3	40,662	14,782	6,413	1,000	1,432	64,289
82	Scott	6	325,369	101,468	41,331	1,000	10,143	479,311
83	Shelby	4	38,942	14,695	6,803	1,000	1,530	62,970
84	Sioux	3	59,712	21,578	11,174	1,000	2,620	96,084
85	Story	1	115,746	40,789	22,658	1,000	5,485	185,678
86	Tama	1	51,110	17,642	7,973	1,000	1,822	79,547
87	Taylor	4	38,709	12,302	5,328	1,000	1,162	58,501
88	Union	4	43,116	15,383	6,598	1,000	1,479	67,576
89	Van Buren	5	29,165	12,203	5,530	1,000	1,212	49,110
90	Wapello	5	100,602	34,464	12,232	1,000	2,884	151,182
91	Warren	1	78,330	23,799	13,329	1,000	3,158	119,616
92	Washington	5	52,698	19,013	8,582	1,000	1,974	83,267
93	Wayne	5	30,763	12,166	5,274	1,000	1,148	50,351
94	Webster	1	103,053	33,860	13,225	1,000	3,132	154,270
95	Winnebago	2	36,944	13,528	6,459	1,000	1,444	59,375
96	Winneshiek	2	48,845	18,235	8,734	1,000	2,011	78,825
97	Woodbury	3	216,803	67,177	28,329	1,000	6,899	320,208
98	Worth	2	28,932	11,194	5,554	1,000	1,218	47,898
99	Wright	2	44,771	15,551	7,076	1,000	1,596	69,994
Total			$ 6,907,004	2,326,981	1,058,482	99,000	247,480	10,638,947

A Review of the Local Public Health Services Grant
Administered by the
Iowa Department of Public Health

Staff

This review was performed by:

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Brett M. Zeller, Staff Auditor
Daniel W. Henaman, Assistant Auditor
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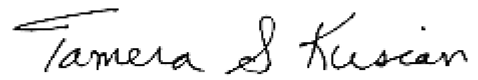

Tamera S. Kusian, CPA
Deputy Auditor of State

Appendices

A Review of the Local Public Health Services Grant
Administered by the
Iowa Department of Public Health

Copy of Example Alternative Plan

(County #)	(County Name)	Submit electronically to RC
77	POLK	NOTE: Complete all sections 1-5

Alternative Plan FY08 LPHSC

Only one activity per form

According to the Contract Management Table for FY08 Local Public Health Services Contract the following are activities which require an Alternative Plan. NOTE: The contractor may bill for activities within the entire month IDPH approves the Alternative Plan.

Section 1: ALTERNATIVE PLAN, FUNDING REQUEST, AND UNIT COST

Check the activity requested. Indicate the amount of money the authorized agency plans to use for the activity. Enter the cost per unit for the activity. Do not enter data in the striped boxes. NOTE: An approved costing methodology for the unit cost must be available for review by the Regional Community Health Consultant.

check one	Activity requested		$ requested	cost/unit		$ requested	cost/unit
☐	Communicable Disease Follow-up	HCA					
☐	Foot Care Clinics	HCA					
☐	Health Hazard Investigation	HCA					
☐	Home Care Aide (Chore)				PHN		
☐	Home Care Aide (Home Helper)				PHN		
☐	Home Care Aide (Homemaker)				PHN		
☐	Home Care Aide (Personal Care)				PHN		
☐	Immunizations	HCA					
☐	Nursing (Disease & Disability)	HCA					
☑	Nursing (Health Maintenance)	HCA	$106,000.00	TBD			
☐	Nursing (Health Promotion)	HCA					
☐	Regulatory Environmental Health	HCA					
☐	Screening and Assessment	HCA					
☐	Other (list)	HCA			PHN		
☐	Other (list)	LBOH			LPHS		

Section 2: PROVIDE RATIONALE FOR REQUESTING THE ACTIVITY.

Describe why funds are being requested for the activity using the funding source identified.

Community partners came togetherin the fall of 2006 to discuss a gap in services for children in Polk County. The Community Partners included: the Polk County Health Department, the County Attorney's Office, Polk County judges, the Department of Human Services and Visiting Nurse Services. Children being removed from their homes often have a medical need that needed to be addressed for safe transition/placement. Examples of needs include a medical diagnosis of diabetes or asthma, medication management relating to ADHD or other emotional/behavioral issue. The registered nurses from Visiting Nurse Services are present for the preremoval conference and are available to the caregiver and to the child. Services include assistance with identifying a medical home; dental home; up-to-date immunizations; education regarding medications, diagnosis, and treatment. VNS communicates frequently with the court systems and DHS to assist in the smooth transition for the child and frequently work with grandparents, schools, and other community partners to make sure that the medical needs of the children are met. Visiting Nurse Services is also collaborating with the Polk County Department of Human Services to make home visits on referrals of potential adult abuse. During these visits, the nurses provide an ir

On the FY08 End of Year Report, the contractor will report the benefit to the county on having implemented the alternative plan.

A Review of the Local Public Health Services Grant
Administered by the
Iowa Department of Public Health

Copy of Example Alternative Plan

Section 3: ASSURANCES

1) Describe how the services for which the funds are intended will continue to be provided once the funds are used for the activity requested. *Example: "How will consumers who use HCA appropriations for HCA activities be served if funds are used instead for Immunizations?"*

These funds will be utilized to fill a very necessary gap in the community. This will not impact the HCA appropriations for HCA activities as these funds have not been fully expended by the current HCA provider for the past several years.

2) Describe how other authorized agencies who currently use the funds will be impacted by this plan. Describe the input these authorized agencies had regarding the development of the Alternative Plan and the non-traditional use of these funds.

We do not believe that other agencies will be impacted by this plan. In the past few years, there have been HCA dollars not expended by the HCA provider and VNS was able to expend them.

3) Indicate the outcome measure for the activity. *(The outcome measure corresponding to each activity can be found on the FY08 application. For activities selected as "other", write an outcome measure related to the activity.)* Results of the outcome measure will be reported on the FY08 End of Year Report.

200 children and adults will be served through the Protect Children and Protect Adults Program: 100% of the targeted children will be assessed for needs including medical, dental, emotional, developmental, school transitioning, foster placement transitioning, and parent/foster placement education; 100% of the targeted children will have an identified medical home; 95% of the targeted children will have an identified dental home;100% of all targeted children and families in need of family support will be referred for services; 100% of all adults referred to the Protect Adult Program will

Section 4: CONTRACTOR APPROVAL

Local Board of Health (Contractor) approval date of Alternative Plan	Date:	
OR		
Board of Supervisors (BOS) (Contractor) approval date of Alternative Plan	Date:	9/18/2007
And Local Board of Health approval date of Alternative Plan	Date:	9/18/2007

Note: BOS/BOH had discussed & approved in June 2007

Section 5: Project Director

Project Director Name	Scott Slater
Project Director Email	sslater@co.polk.ia.us

For RCHC and IDPH Use

RCHC approval	7/1/2007	IDPH approval	[signature]	7/1/2007

3/21/07

A Review of the Local Public Health Services Grant
Administered by the
Iowa Department of Public Health

Summary of Changes to the *Code of Iowa*, Acts of the General Assembly
and the Iowa Administrative Code

During Fiscal Year	Code of Iowa	Acts of the General Assembly	Iowa Administrative Code
1997	Chapter 135.11 (15) describing the duties of the IDPH states "Administer the statewide public health nursing and homemaker-home health aid programs by approving grants of state funds to the local boards of health and the county boards of supervisors and by providing guidelines for the approval of the grants and allocation of the state funds."	Effective for fiscal year 1998: Chapter 203, Section 5, of the 1997 Iowa Acts specified: • Public Health Nursing programs – "for elderly and low income persons with the objective of preventing or reducing institutionalization." • Home care aide/chore – "with an emphasis on services to elderly and persons below the poverty level and children and adults in need of protective services with the objective of preventing or reducing inappropriate institutionalization." • Senior health program – "to senior health programs located in counties which provide funding on a matching basis for the senior health program." • Alternate plans – Notwithstanding the program allocations for the above mentioned directives, "a county may submit to the department a plan for an alternate allocation of funding which provided for assuring the delivery of existing services and the essential public health services based on an assessment of community needs, and targeted populations to be served under the alternate plan."	No administrative rules were in effective prior to 1998.
1998		Effective for fiscal year 1999: Chapter 1221 of the 1998 Iowa Acts specified, in part: IDPH " shall adopt administrative rules defining program direction, a formula used for distributing money, and program evaluation requirements for the three programs." While the Chapter did not define the 3 programs as was done in the previous year, it specified no more than 5.8% of the home care aide/chore program of was to be used for court-ordered services for children. The Chapter also stated a county may continue or submit to IDPH an alternative plan.	IDPH established Chapters 79 and 80 which incorporated the purpose of the Grant as described in the 1997 appropriation language. This language remained unchanged through 2007.

A Review of the Local Public Health Services Grant
Administered by the
Iowa Department of Public Health

Summary of Changes to the *Code of Iowa*, Acts of the General Assembly
and the Iowa Administrative Code

During Fiscal Year	Code of Iowa	Acts of the General Assembly	Iowa Administrative Code
1999	Chapter 135.11 (15) describing the duties of the IDPH states, "program direction, evaluation requirements, and formula allocation procedures for each of the programs shall be established by the department by rule, consistent with the 1997 Iowa Acts, chapter 203, section 5." As a result, the specific appropriation language of the 1997 Iowa Acts became codified.	Effective for fiscal year 2000: The General Assembly significantly changed the target population to be served by the funds. The appropriation language introduced the title "Elderly Wellness," stated funding was "for optimizing the health of persons over 55 years of age."	Beginning in 1999 and continuing through 2003, the Iowa Acts conflicted with the *Code*, which codified the 1997 Iowa Acts. The *Code* continued to reference the 1997 Iowa Acts, which specified elderly, low income, protective services and alternative plans, through 2003 even though appropriation language effective during those years limited funding to persons over 55 or 60 years of age as recipients of the services funded by the Grant. According to section 4.8 of the *Iowa Code*, the statute latest in date of enactment prevails.
2000	↓	Effective for fiscal year 2001: The appropriation language under the title "Elderly Wellness," continued to state funding was "for optimizing the health of persons over 55 years of age."	
2001 through 2004	↓	Effective for fiscal years 2002 – 2005: The appropriation language was modified to state the "Elderly Wellness" funding was "for optimizing the health of persons over 60 years of age."	
2005	The language codifying the 1997 Iowa Acts was removed from the *Code*. As a result, the Code no longer includes a reference to low income, child protective services and alternate plans. New language in the *Code* stated "program direction, evaluation requirements, and formula allocation procedures for each of the programs shall be established by the department [IDPH] by rule."	Effective for fiscal year 2006: The appropriation language continued to state the "Elderly Wellness" funding was "for optimizing the health of persons over 60 years of age.	

A Review of the Local Public Health Services Grant
Administered by the
Iowa Department of Public Health

Summary of Changes to the *Code of Iowa*, Acts of the General Assembly
and the Iowa Administrative Code

During Fiscal Year	Code of Iowa	Acts of the General Assembly	Iowa Administrative Code
IDPH representatives stated the modification was to further expand IDPH's discretion over Grant spending and the *Code* allowed IDPH to utilize Grant funds as IDPH directed and as it established through IAC rules. However, the IAC rules were not changed and still allow alternate plans and for a broader population to be served. The IAC rules were not consistent with the appropriation language contained in the Iowa Acts in effect for this time period. IDPH does not have authority to supersede the purpose for the Grant as directed in the appropriation language of the Iowa Acts.			
2006		Effective for fiscal year 2007: The appropriation language continued to state the "Elderly Wellness" funding was "for optimizing the health of persons over 60 years of age.	
2007		Effective for fiscal year 2008: The appropriate language was modified to state the purpose of the "Elderly Wellness" funds was "for promotion of healthy aging and optimization of the health of older adults."	IDPH merged Chapters 79 and 80 to form an updated Chapter 80. The content did not materially change and remained consistent with the purpose described in the 1997 Iowa Acts appropriation.

**A Review of the Local Public Health Services Grant
Administered by the
Iowa Department of Public Health**

A Review of the Local Public Health Services Grant
Administered by the
Iowa Department of Public Health

Copy of Example Monthly Utilization Report

L AL PUBLIC HEALTH SERVICES CONTRACT FY08 · ONTHLY UTILIZATION REPORT (MUR)

IOWA DEPARTMENT OF PUBLIC HEALTH, DIVISION OF HEALTH PROMOTION AND CHRONIC DISEASE PREVENTION

Month of Claim: September 2007 | County Name: 77 Polk

Prepared By: Debbie Webster | Phone: 515-286-3068

Enter only activities (as listed below) in the activity column. Enter the unit in the billing unit column. Activity and billing units are:

Community Health Needs Assessment-*hour*
Communicable Disease follow-up-*hour*
Health Hazard Investigation-*hour*
Injury Prevention & Follow-up-*hour*
Screening and Assessments-*person*
Agency Evaluation/Quality Improvement-*hour*
Local Board of Health-*hour*
Regulatory Environmental Health-*hour*
Redesign-*hour*
Research-*hour*
Case Management-*hour*

Family Support Home Visits-*visit*
Foot Care Clinics-*person*
Home Care Aide (Chore)-*hour*
Home Care Aide (Home Helper)-*hour*
Home Care Aide (Homemaker)-*hour*
Home Care Aide (Personal Care)-*hour*
Immunizations-*person*
Nursing (Disease & Disability)-*visit*
Nursing (Health Maintenance)-*visit*
Nursing (Health Promotion)-*visit*
Prevention of Abuse & Neglect-*visit*

Protective Services-*visit*
(court ordered)
Capacity Building Technology-*1unit*
(actual $ amt) Limit $2000 per county
Resources-*1 unit* (actual $ amt)
Workforce Development-*hour*
Health Education-*hour*
Community Partnerships-*hour*
Other-*requires alternative plan*

LOCAL BOARD OF HEALTH (LBOH)

LBOH Activities	Billing Units	Units Provided		Reimburse Rate		Sub-Total		Sliding Fee / Donation		Claim
Community Partnerships-Suicide Coalition	hour	30.0000	x	$53.861	=	$1,615.82	-		=	$ 1,615.82
Community Partnership	hour	30.0000	x	$25.053	=	$751.58	-		=	$ 751.58
Screenings and Assessments	person	73.0000	x	$61.388	=	$4,481.33	-		=	$ 4,481.33
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	

LBOH TOTAL $6,848.73

HOMECARE AIDE (HCA)

HCA Activities	Billing Units	Units Provided		Reimburse Rate		Sub-Total		Sliding Fee / Donation		Claim
Nursing (Health Maintenance) FSS	hour	182.2500	x	$39.583	=	$7,214.00	-		=	$7,214.00
Nursing (Health Maintenance) PAN	hour	89.5500	x	$36.393	=	$3,258.99	-		=	$3,258.99
Home Care Aide (Personal Care)	hour	1,347.7500	x	$25.000	=	$33,693.75	-	$2,815.01	=	$30,878.74
Home Care Aide (Homemaker)	hour	767.7500	x	$25.000	=	$19,193.75	-	$1,434.12	=	$17,759.63
Home Care Aide_HH (Homemaker)	hour	70.2500	x	$25.000	=	$1,756.25	-	$141.56	=	$1,614.69
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	

HCA TOTAL $60,726.05

007

A Review of the Local Public Health Services Grant
Administered by the
Iowa Department of Public Health

Copy of Example Monthly Utilization Report

L CAL PUBLIC HEALTH SERVICES CONTRACT FY08 ONTHLY UTILIZATION REPORT (MUR)

IOWA DEPARTMENT OF PUBLIC HEALTH, DIVISION OF HEALTH PROMOTION AND CHRONIC DISEASE PREVENTION

Month of Claim September 2007 County Name 77 Polk

PUBLIC HEALTH NURSING (PHN)

PHN Activities	Billing Units	Units Provided		Reimburse Rate		Sub-Total		Sliding Fee / Donation		Claim
Foot Care Clinics	person	218.0000	x	$25.350	=	$5,526.30	-	$855.00	=	$4,671.30
Nursing (Health Maintenance)	visit	318.0000	x	$91.440	=	$29,077.92	-	$102.65	=	$28,975.27
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	

PHN TOTAL $33,646.57

LOCAL PUBLIC HEALTH SERVICES (LPHS)

LPHS Activities	Billing Units	Units Provided		Reimburse Rate		Sub-Total		Sliding Fee / Donation		Claim
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	
			x	$0.000	=		-		=	

LPHS TOTAL

INCENTIVE Performance Measure-

Performance Measure		Units Provided		Reimburse Rate		Sub-Total				Claim
			x	$1,000.000	=		-		=	

TOTAL OF ALL ACTIVITIES (LBOH + HCA + PHN + LPHS)

LBOH + HCA + PHN + LPHS TOTAL $101,221.35

4/17/2007

A Review of the Local Public Health Services Grant
Administered by the
Iowa Department of Public Health

Copy of Map of IDPH Regions

Bureau of Local Public Health Services

Iowa Department of Public Health
Division of Health Promotion and Chronic Disease Prevention

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CHC = Community Health Consultant (statewide)
EO2 = Executive Officer 2
RCHC = Regional Community Health Consultant
PP2 = Program Planner 2

vised 10/27/2008

A Review of the Local Public Health Services Grant
Administered by the
Iowa Department of Public Health

Copy of Financial Assessment Worksheet

CERRO GORDO COUNTY DEPARTMNET OF PUBLIC HEALTH
Financial Data Sheet

Client Name ______________________ **Date** ______________________

In order to better serve you, the following information is requested even if Insurance, Medicare or Medicaid pays for your services. If you pay privately for your services, this information will help our agency to determine the amount you pay according to your income in a non-discriminatory manner. If you are unwilling to provide this information, the full fee will be applied.

Please provide the following information:

Household Monthly Income

Salary __________
Social Security __________
Business/property income __________
Pension/Dividend income __________
SSI/FIP __________
Interest earned __________
Cash rent for farm land __________
Other __________
Total Monthly income __________

Household Monthly Expenses

Medical insurance premium __________
Pharmacy bill __________
Medical payments __________
Medical supplies/equipment __________

Total monthly expenses __________

Total resources

For every $20,000.00 of liquid resources the fee will be increased one level on the sliding scale

Savings Account __________
Checking Account __________
Stocks/Bonds/CD __________
Farm Land (2,630/acre) __________
Total resources __________

Fee Calculation

Total Monthly Income __________
Subtract monthly expenses __________
Adjusted Monthly income __________

☐ I have been informed of the guidelines for Home Heath Care coverage by Medicare, Medicaid or Insurance and understanding that because I meet these guidelines, ______________ will pay for my services. I authorize any third party payment for my care to be paid directly to Cerro Gordo County Department of Public Health. I understand that I will be required to pay nothing ($0.00) for my services unless the third party payer requires a client participation amount. I understand that I will be fully responsibility to pay the client participation amount.

☐ I understand that I am not eligible for Medicare, Medicaid, or Insurance to pay for my services. I agree to pay $ ____________for a Nursing Visit and/or $ ______________per hour of Home Care Aide Service. I understand that other sources such as Elderbridge Agency on Aging, Grants, state or local tax funding will cover the difference between what I pay and the cost of a visit or hour of service.

I do solemnly swear that I have fully disclosed all sources of income and resources as noted above. I understand that I may be asked to verify any of the above information through receipts or income tax returns. I also understand that this will be reviewed annually or sooner if I have changes in any of the above information. I have received a copy of this document.

Signed ______________________ Signed ______________________
Signature of Client or Designee — Signature of Nurse

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A Review of the Local Public Health Services Grant
Administered by the
Iowa Department of Public Health

Copy of Fiscal Year 2008 IDPH Contract Management Table

CONTRACT MANAGEMENT TABLE FY08 LPHSC

Key Last Page of Table

CORE PUBLIC HEALTH FUNCTION: ASSESSMENT								
Essential Public Health Service	**Activity** *(Entered on MUR)*	**Description**	**Billing Unit**	**Appropriation**				
				LBOH	**HCA**	**PHN**	**LPHS**	
Monitor health status and understand health issues facing the community.	**Community Health Needs Assessment**	*Community Health Needs Assessment* includes identification of health problems and development of a health improvement plan. The health improvement plan includes identification of resources (financial and human) and identifies strategies to implement the plan which best meets the community's identified needs.	**Hour**		NOT APPLICABLE	NOT APPLICABLE		
Protect people from health problems and health hazards.	**Communicable Disease Follow-Up**	*Communicable Disease Follow-Up* includes: 1) Immunization audit -- reviewing immunization cards for all pre-school and K-12 students, as well as children enrolled in day care services to assure compliance with the immunization laws as outlined in 641 IAC Chapter 7; 2) Case identification -- locating persons with identified health risks and linking them to resources to prevent disease and disability; 3) Case finding -- data gathering regarding exposure, contact determination, and referral for follow-up treatment; 4) Treatment and follow-up -- activities related to treating the disease process as well as evaluating the results through follow-up contact with the individual; 5) Surveillance -- ongoing collection, analysis, and interpretation of health data to detect trends as well as to identify the incidence and prevalence of diseases.	**Hour**		**Requires Alternative Plan**			
	Health Hazard Investigation	*Health Hazard Investigation* includes identification of agents (chemical, biological, physical or psychosocial) which affect the health of a consumer or population. Activities to identify health hazards include: water testing, air quality measures, and lead testing.	**Hour**		**Requires Alternative Plan**			
	Injury Prevention & Follow-Up	*Injury Prevention and Follow-Up* includes screening for potential safety risks and implementing follow-up activities to prevent injuries. Activities include fall prevention, child restraint, and home safety inventory.	**Hour**					
	Screening and Assessment	*Screening and Assessment* includes providing tests for consumers who may be at risk or have asymptomatic conditions. Screening and assessment tests include hypertension, cholesterol, diabetes, cancer, scoliosis, tuberculosis, head lice, vision, hearing, mental health, fitness testing, physical assessment, worksite and school testing. The process focuses primarily on "well" populations to identify potential health problems which may include referral with follow-up contact to determine results.	**Person**		**Requires Alternative Plan**			

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CONTRACT MANAGEMENT TABLE FY08 LPHSC

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Essential Public Health Service	Activity (Entered on MUR)	Description	Billing Unit	Appropriation			
CORE PUBLIC HEALTH FUNCTION: ASSESSMENT *(continued)*							
				LBOH	HCA	PHN	LPHS
Evaluate and improve programs and interventions.	**Agency Evaluation/Quality Improvement**	*Agency Evaluation/Quality Improvement* includes the agency process of reviewing and defining the vision and mission; identifying strengths, weaknesses, opportunities and threats which affect the operations; planning of short and long-term goals; and determination of appropriateness , adequacy, effectiveness, and efficiency in delivery of public health services to the community.	**Hour**		NOT APPLICABLE		
CORE PUBLIC HEALTH FUNCTION: POLICY DEVELOPMENT							
Essential Public Health Service	**Activity** *(Entered on MUR)*	**Description**	**Billing Unit**	**Appropriation**			
				LBOH	HCA	PHN	LPHS
Develop public health policies and plans.	**Local Board of Health**	*Local Board of Health* includes review of rules, regulations, policies, contracts, and activities to assure the health of the public.	**Hour**		NOT APPLICABLE		
Enforce public health laws and regulations.	**Regulatory Environmental Health**	*Regulatory Environmental Health* includes developing, implementing, and enforcing state laws and local ordinances and rules related to water, solid waste, and nuisances.	**Hour**		**Requires Alternative Plan**		
Contribute to and apply the evidence base of public health.	**Redesign**	*Redesign* includes activities related to "Redesign of Public Health in Iowa". This includes researching, reviewing and evaluating working documents; attending committee meetings; and special meetings for education of local board of health, board of supervisors, staff and policy makers/stakeholders.	**Hour**		NOT APPLICABLE		
	Research	*Research* includes best practice guidelines identified through review of literature, evaluation of programs, and research investigations.	**Hour**		NOT APPLICABLE		
CORE PUBLIC HEALTH FUNCTION: ASSURANCE							
Essential Public Health Service	**Activity** *(Entered on MUR)*	**Description**	**Billing Unit**	**Appropriation**			
				LBOH	HCA	PHN	LPHS
Help people receive health services.	**Case Management**	*Case Management* includes the process of optimizing self-care capabilities of consumers and families in gaining access to needed medical, social, and other services.	**Hour**				

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CORE PUBLIC HEALTH FUNCTION: ASSURANCE *(continued)*							
Essential Public Health Service	**Activity** *(Entered on MUR)*	**Description**	**Billing Unit**	**Appropriation**			
				LBOH	**HCA**	**PHN**	**LPHS**
Help people receive health services. *(continued)*	**Family Support Home Visits**	*Family Support Home Visits* include services that promote the well-being of children and families. The community-based services utilize informal and formal family supports and are: 1) family driven with a true partnership with families; 2) comprehensive, flexible, and individualized to each family based on their culture, needs, values and preferences; 3) built on strengths to increase the stability of family members and the family unit. The services produce the following results: 1) Increased parent confidence and competence in their parenting abilities. 2) Safe, stable, and supportive families connected to their communities. 3) Enhanced health, growth, and development of children and families. Family Support Home Visits are ongoing programs that provide support to the family. (i.e. HOPES-HFI, Parents As Teachers (PAT), Shared Visions, Early Head Start, etc…).	**Visit**				
	Foot Care Clinics	*Foot Care Clinics* include promoting health and wellness through assessment, education, and care of the feet.	**Person**		**Requires Alternative Plan**		
	Home Care Aide (Chore)	*Home Care Aide (Chore)* includes provision of services necessary to live independently to consumers or families. The services encompass heavier cleaning tasks, including outside maintenance and chores. Services may include garbage removal, shoveling snow, changing light bulbs, putting screens on windows, covering and uncovering air conditioners, lawn care, and mowing. There is no physical contact between workers and staff.	**Hour**			**Requires Alternative Plan**	
	Home Care Aide (Home Helper)	*Home Care Aide (Home Helper)* includes the provision of essential shopping and housekeeping under the supervision of a professional to protect the environment for a self-directing consumer to preserve a safe and sanitary home.	**Hour**			**Requires Alternative Plan**	

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CORE PUBLIC HEALTH FUNCTION: ASSURANCE *(continued)*							
Essential Public Health Service	**Activity** *(Entered on MUR)*	**Description**	**Billing Unit**	**Appropriation**			
				LBOH	**HCA**	**PHN**	**LPHS**
Help people receive health services. *(continued)*	**Home Care Aide (Homemaker)**	*Home Care Aide (Homemaker)* includes the provision of services under the supervision of a professional, primarily in the homes of consumers who, due to the absence, incapacity or limitations of the usual homemaker or caregiver are experiencing stress or crisis. The services promote consumer health and a safe, stable, sanitary home environment and do not require a physician's order. Services may include cleaning a client's house, laundry, changing bed linens, planning meals (including special diets), shopping for food, cooking, helping clients get out of bed, bathe, dress, and groom, money management, childcare, respite, accompanying clients to doctors appointments or on other errands, and providing instruction and psychological support to clients.	**Hour**			**Requires Alternative Plan**	
	Home Care Aide (Personal Care)	*Home Care Aide (Personal Care)* includes health-related services under the direction of nursing and/or medical staff. The services may include observation of a client self-administering medications; checking clients' pulse rate, temperature, and respiration rate; helping with simple prescribed exercises; keeping clients' rooms neat; helping clients to move from bed, bathe, dress, and groom; changing non-sterile dressings; giving skin care and back rubs; assisting with braces and artificial limbs; or assisting clients in using medical equipment.	**Hour**			**Requires Alternative Plan**	
	Immunizations	*Immunizations* include nursing activities related to provision of vaccine preventable diseases for adults and children.	**Person**		**Requires Alternative Plan**		
	Nursing (Disease and Disability)	*Nursing (Disease and Disability)* includes nursing intervention for an acutely ill or unstable condition under a specified medical diagnosis and with a plan of care from a licensed physician.	**Visit**		**Requires Alternative Plan**		
	Nursing (Health Maintenance)	*Nursing (Health Maintenance)* includes teaching and nursing intervention that assist consumers in managing a chronic condition and maintaining and preventing a worsening of a consumer's condition through a self-care model.	**Visit**		**Requires Alternative Plan**		

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CORE PUBLIC HEALTH FUNCTION: ASSURANCE *(continued)*							
Essential Public Health Services	**Activity** *(Entered on MUR)*	**Descriptions**	**Billing Unit**	**Appropriations**			
				LBOH	**HCA**	**PHN**	**LPHS**
Help people receive health services. *(continued)*	**Nursing (Health Promotion)**	*Nursing (Health Promotion)* includes visits performed to promote continued good health and reduce risk of injury or preventable illness/ disease. The visits involve teaching or nursing intervention that emphasizes self and environmental awareness and promotes a lifestyle change that will result in optimal health and wellness.	**Visit**		**Requires Alternative Plan**		
	Prevention of Abuse & Neglect	*Prevention of Abuse & Neglect* include activities provided to a consumer (age 6 and older) who meet one or more of the following criteria: 1) Abuse or neglect has been reported to DHS and evaluated, but no court ordered services are in place, 2) DHS is in the process of investigating a report of abuse or neglect, or 3) DHS may or may not be involved with the consumer; however, the consumer is determined to be at risk of abuse or neglect by meeting at least one of the following criteria: a) Lack of parenting skills, b) Family or caregiver history of abuse or neglect, c) Unsafe environmental conditions in home, d) Consumer and/or caregiver has psychological disorder/dysfunction, e) Consumer and/or caregiver with substance abuse, f) History of self-neglect.	**Visit**				
	Protective Services *court ordered*	Protective Services include services intended to stabilize a child's or adult's residential environment and relationships with relatives, caretakers, household members and other persons in order to alleviate a situation involving abuse or neglect or to otherwise protect the child or adult from a threat of abuse or neglect. Also include services intended to prevent situations which could lead to abuse or neglect of a child or adult when a definite potential for abuse or neglect exists. These services require an order from the justice system.	**Visit**				
Maintain a competent public health workforce.	**Capacity Building Technology** *limit $2000 per county*	*Capacity building technology* includes computers, software, travel drives, tokens, facsimile machines, internet service, cellular phones, pagers used by staff of the agency.	**Actual Expense**		**NOT APPLICABLE**		
	Resources	*Resources* include textbooks, handbooks, videotapes, audiotapes, DVDs, training resources to enhance the knowledge and skill of agency staff and board of health membership.	**Actual Expense**		**NOT APPLICABLE**		
	Workforce Development	*Workforce development* includes education and training opportunities for contractor, local board of health members, and agency staff.	**Hour**		**NOT APPLICABLE**		

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CORE PUBLIC HEALTH FUNCTION: ASSURANCE *(continued)*							
Essential Public Health Service	Activity *(Entered on MUR)*	Description	Billing Unit	Appropriation			
				LBOH	HCA	PHN	LPHS
Give people information they need to make healthy choices.	**Health Education**	*Health education* includes activities which provide educational information about physical, behavioral, environmental, social, economic, and/or other issues affecting health.	**Hour**				
Engage the community to identify and solve health problems.	**Community Partnerships**	*Community partnerships* include activities which promote community participation in identifying and solving public health problems.	**Hour**				

* Source: Operational Definition from the National Association of County and City Health Officials (NACCHO)

APPROPRIATIONS KEY	
Acronym	Appropriation
LBOH	**Local Board of Health**
HCA	**Home Care Aide**
PHN	**Public Health Nursing**
LPHS	**Local Public Health Services**

ADDITIONAL ITEMS	
Term	Definition
LPHSC	**Local Public Health Services Contract**
Requires Alternative Plan	**Identifies activity in which an alternative plan is required.**
NOT APPLICABLE	**Identifies activities unavailable utilizing Home Care Aide or Public Health Nursing appropriations.**

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Copy of Example Alternative Cost Report

	A	B	C	D	E	F	G	H	I	J	K
1	Iowa Department of Public Health - Bureau of Local Public Health Services Worksheet for Alternative Costing										
2											
3	Alternative Cost Report							Fiscal Year	2005-2006		
4	Program: Foot Clinic							Date	05/12/2006		
5								Instructions			
6		Staff	Staff	Mileage	Additional	Total #		* Enter staff wage, staff fringe, any mileage cost			
7		Wage	Fringe	Cost	Cost	Units		directly related to the program and any special			
8	July							costs related directly to program on a monthly			
9	Aug							basis in columns B,C,D, or E and on monthly line 8			
10	Sept							through 19.			
11	Oct							* Column F on a monthly basis place the units of			
12	Nov							service for program activity.			
13	Dec							* Line 20 is the sum columns B,C,D, and E.			
14	Jan							* Line 21 calculates the year to date total for			
15	Feb							all expenses.			
16	March							Cost Report:			
17	April							* Place unit cost multiplier either HCFA or			
18	May	$ 202.61	$ 52.68	$ 0.89		30		percent of indirect cost in column F line 24 or			
19	June							line 28			
20	Total	$ 202.61	$ 52.68	$ 0.89	$ 132.27	30		* Column K Line 24 or line 28 are the unit cost.			
21	Cost				$ 388.45						
22											
23	Certified Agency				Cost	Cost Multiplier	MultCost	Total Cost	Divided	Total Units	Cost/Unit
24	Cost times HCFA Unit Cost Multiplier				$ 388.45		0	$ 388.45	by units	30	$ 12.95
25	divided by total units = cost per unit.										
26											
27	Non Certified Agency				Cost	Indirect %	Indir Cost	Total Cost	Divided	Total Units	Cost/Unit
28	Cost times % Indirect cost				$ 388.45	0.15	58.2675	$ 446.72	by units	30	$ 14.89
29	divided by total units equal cost per unit										
30	FY05 alternative cost report				07/01/2004						

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IDPH Response to Findings and Recommendations

Iowa Department of Public Health
Promoting and Protecting the Health of Iowans

Thomas Newton, MPP, REHS
Director

Chester J. Culver
Governor

Patty Judge
Lt. Governor

August 26, 2010

Tami Kusian, CPA
Deputy Auditor of State
LOCAL

Dear Ms. Kusian,

The purpose of this communication is to provide the Iowa Department of Public Health's (Department) response to the August 2, 2010, draft report on the Local Public Health Services State Grant (LPHS State Grant) administered by the Bureau of Local Public Health Services. This brief response follows the more comprehensive review and response by the Department in February 2010, which we incorporate in full herein.

The Department acknowledges and appreciates the review by the Office of the State Auditor and has a high regard for the audit and review process conducted by the Office over the past twenty-four months. This type of oversight is key to responsible government, and as you acknowledge the Department has implemented several recommendations your Office made during the review process to further our shared goals of accountability and transparency in the expenditure of LPHS State Grant funds.

At the same time, the Department believes LPHS State Grant funds *were* used appropriately during the time period of July 1, 2006 through June 30, 2008, as we stated in our February 2010 response. We want to highlight three factors we believe are overlooked in the draft report:

1) The draft press release and report state that the Department's administrative rules "do not comply with the appropriation language enacted by the General Assembly for the years tested." We strongly disagree with this conclusion. For the time period in question the Department's enabling statute granted broad flexibility to the Department to establish "program direction, evaluation requirements, and formula allocation procedures for each of the programs…by rule." Iowa Code § 135.11(16). This statutory authority contains no restriction that these funds be utilized solely for any one particular age group. In addition, the appropriation language provided the funding was to be used for the "promotion of healthy aging and optimization of the health of older adults." As discussed in more detail in the Department's February letter, "healthy aging" is a term understood in public health to include the entire lifespan of a person, and is not limited to any particular age category or stage of life.

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Iowa Department of Public Health

IDPH Response to Findings and Recommendations

In accord with this broad grant of authority and its historical understanding of the legislative intent for the use of these funds, the Department adopted 641 IAC Chapter 80, the administrative rules at issue. The rules were adopted by the State Board of Health and approved by the Legislature's Administrative Rules Review Committee. No concerns were raised by either body that the rules were inconsistent with the appropriation language. Significantly, the Department received assurances from legislators that the rules in fact conformed with their intended use of these funds.

2) The overall percentage of Elderly Wellness appropriations utilized for older Iowans over sixty (60) years of age was 88% during the audited period. In addition to the Elderly Wellness appropriations, the LPHS State Grant includes Community Capacity appropriations to support the delivery of public health services in Iowa's ninety-nine counties. Local Boards of Health used 46% ($1,210,198 during the time period) of these appropriations to support public health activities for older Iowans. Hence, the overwhelming percentage of the funds at issue was utilized to support public health services provided to Iowans over the age of sixty.

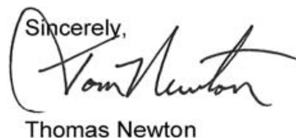
3) With respect to the remaining use of a small percentage of these funds for services to those under age sixty, the Department disputes the draft press release and report's inferences that these funds were improperly used. There is no allegation that these funds were improperly diverted or utilized by either Department staff or local boards of health for personal or other inappropriate gain. These funds were in fact used to provide important local public health services, including health education, immunizations, family support home visiting, communicable disease investigation, health hazard investigations and injury prevention activities. These activities were approved by the Department after local boards of health assured the Department elderly needs were being met and these additional public health services were a priority need in the counties.

As you know, Department staff and I met with key budget legislators representing both parties to clarify our understanding of the 1997 language and the current language in Iowa Code section 135.11 and Iowa Administrative Code 641 Chapters 79 and 80. The legislators agreed that the Department and local boards of health use of these grant funds has been consistent with legislative intent. Further, the 2010 General Assembly replaced the outdated appropriation language to more appropriately refer to these funds as "Healthy Aging" appropriations.

The Iowa Department of Public Health along with local boards of health in all ninety-nine counties is committed to promoting and protecting the public health through responsible and accountable use of public health appropriations.

Thank you for this opportunity to respond to the current draft of the auditor's review.

Sincerely,



Thomas Newton