Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

IN SELECTED STATES, 67 OF 100 HEALTH CENTERS DID NOT USE THEIR HRSA ACCESS INCREASES IN MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES GRANT FUNDING IN ACCORDANCE WITH FEDERAL REQUIREMENTS

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Office of Inspector General

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

Report in Brief
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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

In Selected States, 67 of 100 Health Centers Did Not Use Their HRSA Access Increases in Mental Health and Substance Abuse Services Grant Funding in Accordance With Federal Requirements

Why OIG Did This Audit

In 2017, HHS declared the opioid epidemic in the United States a public health emergency. As part of its efforts to combat the opioid crisis, the Health Resources and Services Administration (HRSA) awarded $200.5 million in Access Increases in Mental Health and Substance Abuse Services (AIMS) grants to health centers nationwide. OIG audited AIMS grant funds awarded to health centers as part of our oversight of the integrity and proper stewardship of Federal funds used to combat the opioid crisis.

Our objective was to determine whether health centers in selected States used their AIMS grant funding in accordance with Federal requirements and grant terms.

How OIG Did This Audit

Our audit covered AIMS grant funds totaling $112.9 million awarded to 665 health centers in the 30 States with the highest opioid overdose death rates in calendar year (CY) 2016. Depending on a health center's budget period, these funds could be spent during the period September 1, 2017, through May 31, 2019. We reviewed a statistical sample of 100 health centers from the 30 States to determine whether the health centers: (1) met AIMS grant requirements for mental health and substance use disorder (SUD) service expansion and (2) claimed allowable costs.

What OIG Found

Most health centers in the 30 States did not use their AIMS grant funding in accordance with Federal requirements and grant terms. Sixty-seven of the 100 health centers in our sample did not meet mental health and SUD service expansion requirements (30), claimed unallowable costs (34), and did not properly allocate salaries and other expenditures to their AIMS grants (34). These deficiencies occurred because health centers faced issues with hiring qualified staff, and their financial management systems did not ensure that only allowable, allocable, and documented costs were charged to their AIMS grants. In addition, HRSA did not effectively monitor health centers' progress toward meeting service expansion requirements and did not ensure that health centers spent their AIMS grant funds in accordance with grant requirements.

On the basis of our sample results, we estimated that 454 of 665 health centers did not use their AIMS grant funding in accordance with Federal requirements and grant terms. We also estimated that 125 health centers did not increase the total number of mental health and SUD services patients from CY 2017 to CY 2018, and that 99 health centers did not hire new staff or increase hours of existing staff within 120 days of their AIMS grant award. As a result, patients may not have received the needed mental health or SUD services. In addition, we estimated that the health centers charged unallowable costs totaling nearly $6 million and improperly allocated costs totaling $10.9 million to their AIMS grants that could have been spent on AIMS-related purposes.

What OIG Recommends and HRSA Comments

We made a series of recommendations to HRSA, including that it improve its monitoring of how health centers meet targets for future grant funding opportunities and charge expenditures to their HRSA grants. We also recommend that HRSA require the health centers to refund unallowable and improperly allocated costs to the Federal Government.

HRSA concurred with our recommendation that it improve its monitoring, partially concurred with our other recommendations, and described actions that it has taken or plans to take to address them. We maintain that our findings and recommendations are valid.

The full report can be found at https://oig.hhs.gov/oas/reports/region2/21902001.asp.

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INTRODUCTION

WHY WE DID THIS AUDIT

In 2017, the Department of Health and Human Services (HHS) declared the opioid epidemic in the United States a public health emergency. The misuse of and addiction to opioids—including prescription pain relievers, heroin, and synthetic opioids such as fentanyl—is a serious national crisis that affects public health as well as social and economic welfare. In 2018 alone, there were more than 46,000 opioid-related overdose deaths in the United States. As part of its efforts to combat the opioid crisis, the Health Resources and Services Administration (HRSA) awarded $200.5 million in Access Increases in Mental Health and Substance Abuse Services (AIMS) grants to health centers nationwide.[1, 2] The Office of Inspector General (OIG) audited AIMS grant funds awarded to health centers as part of our oversight on the integrity and proper stewardship of Federal funds used to combat the opioid crisis.[3]

OBJECTIVE

Our objective was to determine whether health centers in selected States used their AIMS grant funding in accordance with Federal requirements and grant terms.

BACKGROUND

The Health Center Program

The Health Center Program, authorized under section 330 of the Public Health Service Act (42 U.S.C. § 254b), provides primary health care services to medically underserved communities and vulnerable populations with limited access to health care through planning and operating grants to health centers. Health centers focus on integrating care for their patients across a full range of services, including medical, dental, mental health, substance use disorder (SUD)[4] and vision services. Within the HHS, HRSA administers the Health Center Program.

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[1] We note that the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*, no longer uses the term "substance abuse" and "substance dependence." Rather, it refers to "substance use disorders."

[2] Health centers are community-based public and private nonprofit health care organizations that deliver care to the Nation's most vulnerable individuals and families. Health centers that were receiving grant funding under section 330 of the Public Health Service Act (42 U.S.C. § 254b) were eligible for AIMS supplemental grant funding.

[3] *HRSA's Monitoring Did Not Always Ensure Health Centers' Compliance With Federal Requirements for HRSA's Access Increases In Mental Health and Substance Abuse Services Supplemental Grant Funding* (A-02-18-02010) July 21, 2020.

[4] According to the Substance Abuse and Mental Health Services Administration, individuals with alcohol or illicit drug dependence or abuse are defined as having SUD.

Access Increases in Mental Health and Substance Abuse Services Grants

In September 2017, HRSA awarded $200.5 million in AIMS supplemental grant funding to 1,178 health centers nationwide. The grants were intended to expand access to mental health and SUD services focusing on the treatment, prevention, and awareness of opioid use disorder for health centers already funded under HRSA's Health Center Program. Health centers were awarded the AIMS supplemental funds to increase personnel, strengthen health information technology (IT), and provide training to support the expansion of mental health and SUD services. Specifically, health centers received up to $85,200 in ongoing funds to support the expansion of services related to mental health and SUD services and up to $90,501 in one-time funds for health IT and training investments, for total awards up to $175,701.[5]

As a condition of receiving grant funding, health centers were required to claim reimbursement for allowable costs in accordance with grant terms and report progress toward achieving the expected outcomes in report submissions to HRSA.[6] See Appendix B for details on the Federal requirements related to the AIMS grants.

HOW WE CONDUCTED THIS AUDIT

Our audit covered AIMS grant funds totaling $112.9 million awarded during fiscal year (FY) 2017 to 665 health centers in the 30 States with the highest opioid overdose death rates in calendar year (CY) 2016.[7] Depending on a health center's budget period, these funds could be spent during the period September 1, 2017, through May 31, 2019.[8] Of the 665 health centers in the 30 States, we reviewed a statistical sample of 100 health centers.[9] For each selected health center, we reviewed documentation to determine whether the health center: (1) met AIMS

[5] In addition to AIMS grants, the health centers received operational and other supplemental grants.

[6] Health centers are required to submit annual Uniform Data System (UDS) reports, annual Federal Financial Reports (FFRs), and Budget Period Progress Reports (BPRs). The 2018 UDS reports were due to HRSA on February 15, 2019, and data were to be finalized in August 2019, according to HRSA. Health centers were required to provide narrative progress updates about achieving expected outcomes of their AIMS funding in their BPRs. Deadlines for health centers to submit their FYs 2018 through 2020 BPRs ranged from August 2017 through April 2020 and were based on their budget period start dates.

[7] Appendix C contains a list of the 30 States, which includes the District of Columbia. We obtained the States' opioid overdose death rate data from Centers for Disease Control and Prevention and National Institute on Drug Abuse websites.

[8] Health centers could use their AIMS grant funds during the budget period when funds were awarded and the subsequent 12-month budget period by submitting a carryover request to HRSA. Health centers' budget periods start between January and June. Therefore, as an example, AIMS grant funds awarded to a health center whose budget period began in June 2018 could be used through May 2019.

[9] We used a multistage sampling method in which we first selected a sample of 10 States from the 30 States. We then randomly selected 10 health centers from each of the 10 selected States. Therefore, our sample of 100 health centers was selected from the sampling frame of 665 health centers in the 30 States.

grant requirements for mental health and SUD service expansion and (2) claimed allowable costs.

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

Appendix A contains the details of our audit scope and methodology, Appendix D contains our statistical sampling methodology, Appendix E contains our sample results and estimates, and Appendix F contains a summary of deficiencies for each health center.

FINDINGS

Most health centers in the 30 States did not use their AIMS grant funding in accordance with Federal requirements and grant terms. Of the 100 health centers in our sample, 33 complied with Federal and grant requirements, but the remaining 67 did not. Of these health centers, 30 did not meet mental health and SUD service expansion requirements, 34 claimed unallowable costs, and 34 did not properly allocate salaries and other expenditures to their AIMS grants.[10]

These deficiencies occurred because health centers faced issues with hiring and recruiting qualified staff to support mental health and SUD service expansion, and their financial management systems did not ensure that only allowable, allocable, and documented costs were charged to their AIMS grants. In addition, HRSA did not effectively monitor health centers' progress toward meeting service expansion requirements and did not ensure that health centers spent AIMS grant funds in accordance with grant requirements. HRSA's monitoring of Health Center Program grant funds is crucial because AIMS ongoing funding has become part of health centers' operational grant awards, and HRSA has awarded additional grant funds to health centers to combat the opioid crisis.[11]

On the basis of our sample results, we estimated that, of the 665 health centers in the 30 States, 454 health centers did not use their AIMS grant funding in accordance with Federal requirements and grant terms. We also estimated that 125 health centers did not increase the total number of mental health and SUD services patients from CY 2017 to CY 2018, and 99 health centers did not hire new staff or increase hours of existing staff within 120 days of their AIMS grant award. As a result, patients may not have received needed mental health or SUD services. In addition, we estimated that of the $112.9 million of AIMS grant funds covered in

[10] The total exceeds 67 because 25 health centers had 2 deficiencies and 3 health centers had 3 deficiencies.

[11] In September 2018, HRSA awarded $352 million in new funding to expand access to mental health and SUD services at health centers across the nation. In addition, HRSA has awarded $46 million to rural organizations as part of a new Rural Communities Opioid Response initiative.

our audit, $5,990,823 was claimed for unallowable costs and $10,930,229 was improperly allocated. These funds could have been spent for AIMS-related purposes.

HEALTH CENTERS DID NOT MEET MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICE EXPANSION REQUIREMENTS

Health centers were required to use AIMS grant funding to increase the number of existing or new patients accessing mental health and SUD services by December 31, 2018, and to increase personnel and expand access to mental health and SUD services within 120 days of their AIMS award.[12]

Thirty health centers in our sample did not meet mental health and SUD service expansion requirements.[13] Specifically, 21 health centers documented no increases in the total number of patients seeking mental health and SUD services from CYs 2017 to 2018.[14] In addition, 15 health centers did not hire new staff or contractors or increase the hours of existing staff or contractors that supported mental health and SUD service expansion within 120 days of their AIMS award.[15, 16]

[12] AIMS Notice of Funding Opportunity (HRSA-17-118).

[13] For three additional health centers, we could not determine whether they had increases in mental health and SUD services patients from CYs 2017 to 2018 because the centers did not provide actual patient data.

[14] We also noted that there were 52 health centers that did not meet their projected increases in the number of patients seeking mental health or SUD services by December 31, 2018, as stated in their AIMS grant applications. In its Notice of Grant Award to AIMS grantees, HRSA stated that health centers were expected to serve the number of new and existing patients projected on their Patient Impact Forms submitted as part of their applications for AIMS funding. HRSA stated that the grantees would document the achievement of their projections through their UDS reports and BPRs. To calculate patient increases, we used unduplicated mental health and SUD services patient data obtained from the health centers (e.g., data from their electronic health records systems) during our site visits. We did not use patient counts reported on UDS reports because we did not assess the reliability of the data.

[15] These health centers hired new staff or contractors or increased the hours of existing staff to work on their AIMS projects between 179 and 540 days (median of 291 days) after they received their AIMS grant award.

[16] The total number of health centers with deficiencies exceeds 30 because 6 health centers had more than 1 deficiency.

Health centers stated that they did not meet expansion requirements because they faced barriers in conducting outreach to patients needing mental health and SUD services due to issues in hiring and recruiting qualified staff to support mental health and SUD service expansion.[17] (See Figure.)

Figure: Examples of Health Centers' Issues in Hiring and Recruiting Qualified Staff

- Lack of qualified professionals available in local community.
- Limited number of job applicants due to certain employment requirements (e.g., drug testing).
- Salaries not competitive with other health care facilities.
- Existing staff not willing to obtain required education or clinical experience to obtain certain certifications (e.g., licensed clinical social worker).

In addition, HRSA did not effectively monitor health centers' progress toward meeting service expansion requirements. As part of its monitoring of health centers, HRSA required health centers to document achievement of their patient projections and the addition of new staff or expansion of existing staff hours through Uniform Data System (UDS) reports and Budget Period Progress Reports (BPRs). Additionally, HRSA conducts operational site visits to health centers once every 3 years to assess and verify compliance with Health Center Program requirements. However, HRSA generally reviewed UDS reports and BPRs after centers' budget periods had ended, and its site visits focused on how centers used all of their Health Center Program funding—not just AIMS funding. Therefore, HRSA did not identify issues that health centers had with engaging patients and hiring staff as the issues occurred and did not provide timely technical assistance and other guidance to correct the issues.

HEALTH CENTERS CLAIMED UNALLOWABLE COSTS

To be allowable under Federal awards, costs must be necessary and reasonable for the performance of the Federal award and be allocable. Costs must conform to any limitations or exclusions set forth in the Federal awards as to types or amount of cost items.[18] The financial management system of each grantee must provide accurate, current, and complete disclosure of the financial results of each Federal award or program. The grantee's records must identify the source and application of funds for federally funded activities and be supported by source

[17] The U.S. Government Accountability Office issued a report in January 2020 (GAO-20-260) that included a statement that, even in States with broad coverage of SUD services, the supply of SUD providers, such as physicians, may be limited, and Medicaid beneficiaries could also have trouble finding a provider who accepts Medicaid payment. In addition, a 2018 Surgeon General's "Spotlight on Opioids" report on addiction treatment discussed health care workforce shortages. Specifically, the report states, "The existing health care workforce is already understaffed and often lacks the necessary training and education to address SUDs."

[18] 45 CFR §§ 75.403(a) and (b).

documentation.[19] Grantees may charge to the Federal award only allowable costs incurred during the period of performance.[20]

AIMS funding may not be used to support costs incurred prior to award date or to supplant existing funding sources.[21] AIMS funding may not be used to increase salaries for existing providers or for construction or minor alterations and renovations. Health centers were required to request prior approval from HRSA if some or all the additional one-time funding was to be used for equipment purchases exceeding $5,000.[22]

Of the $16,899,692 in AIMS grant funds awarded to the 100 health centers in our sample, we found that 34 health centers claimed unallowable costs totaling $773,114 for their AIMS-funded ongoing and one-time activities.[23] Specifically:

- Twenty health centers incurred costs, totaling $340,352, prior to or after the AIMS grant budget period.[24] Examples included computers purchased 8 months prior to the AIMS grant award and salaries charged 4 months after the AIMS carryover budget period.

- Twelve health centers did not maintain records that documented how they spent a portion of their AIMS funding or were unable to provide invoices or other supporting documentation for costs totaling $362,644. For example, one health center drew down its entire AIMS grant award ($175,700) for "cash-flow" purposes. However, the health center provided supporting documentation for only $56,714 in AIMS-related expenditures and did not provide documentation to support how it spent the remaining $118,986 in AIMS grant funds.[25]

- Eight health centers expended their AIMS grant funds for costs, totaling $70,118, that were not eligible for reimbursement. Examples included personnel costs associated

[19] 45 CFR §§ 75.302(b)(2) and (3).

[20] 45 CFR § 75.309(a).

[21] AIMS Notice of Funding Opportunity (HRSA-17-118).

[22] AIMS Frequently Asked Questions (HRSA-17-118) and Grant Specific Terms in Notice of Award.

[23] The total number of health centers with deficiencies exceeds 34 because 6 health centers had more than 1 deficiency.

[24] HRSA required grantees to submit a request for prior approval to carry over grant funds to a subsequent budget period if they did not spend their entire AIMS award during the budget period that the award was received (Grant Specific Terms in the Notice of Award). For this review, we considered the AIMS grant budget period to be from September 1, 2017 (when the grant was awarded), through the end of the following 12-month budget period (carryover budget period), even if the health center did not submit a request to carry over funds (also see footnote 8).

[25] We disallowed only those expenditures for which the health center did not provide supporting documentation.

with a security guard[26] and a care coordinator who did not support mental health and SUD services, salary increases for existing employees whose AIMS-related work hours were not increased, purchase of dental equipment exceeding $5,000 without prior approval from HRSA and not related to the grant, and construction costs.

These deficiencies occurred because health centers' financial management systems did not ensure that only allowable and documented costs were charged to their AIMS grants. In addition, HRSA required health centers to report all Health Center Program expenditures (including AIMS grant expenditures) in aggregate on their annual Federal Financial Reports (FFRs). However, HRSA relied on health centers to maintain internal records to separately track and account for expenditures for each HRSA grant award, including AIMS grants.

HEALTH CENTERS DID NOT PROPERLY ALLOCATE SALARIES AND OTHER EXPENDITURES TO THEIR GRANTS

Charges to Federal awards for salaries and wages must be based on records that accurately reflect the work performed. These records must support the distribution of the employee's salary or wages among specific activities or cost objectives if the employee works on more than one Federal award or both a Federal award and a non-Federal award. The grantee's system of internal controls should include processes to review after-the-fact interim charges made to a Federal award based on budget estimates. All necessary adjustments must be made so that the final amount charged to the Federal award is accurate, allowable, and properly allocated.[27] A cost is allocable to a particular Federal award if the goods or services involved are chargeable or assignable to that Federal award in accordance with relative benefits received.[28]

Of the $16,899,692 in AIMS grant funds awarded to the 100 health centers in our sample, we found that 34 health centers did not properly allocate salaries or other expenditures, totaling $1,722,271, to their AIMS grants. Specifically:

- Thirty-one health centers allocated salaries and fringe benefits costs, totaling $1,607,943, based on budget estimates that may not have accurately reflected the work performed. The health centers did not have internal control systems that included processes to review after-the-fact interim charges and make necessary adjustments to ensure amounts charged to the award were accurate for each employee who worked on

[26] HRSA guidance listed the personnel positions eligible for AIMS funding, including psychiatrist, licensed clinical psychologist, licensed clinical social worker, other mental health staff, other licensed mental health provider, substance abuse provider, case manager, patient/community education specialist (health educator), and community health worker (AIMS Notice of Funding Opportunity (HRSA-17-118)).

[27] 45 CFR § 75.430(i)(1).

[28] This standard is met if the cost: (1) is incurred specifically for the Federal award, (2) benefits both the Federal award and other work of the non-Federal entity and can be distributed in proportions that may be approximated using reasonable methods, and (3) is necessary to the overall operation of the non-Federal entity and is assignable in part to the Federal award (45 CFR § 75.405(a)).

Federal awards. Therefore, we could not determine what portion of salaries and fringe benefits costs claimed by these health centers for staff who worked less than 100 percent on AIMS grant-funded activities should have been charged to the grant.

- Three health centers did not properly allocate costs, totaling $114,328, to their AIMS grants. Specifically, the health centers charged the entire amount of certain costs to their AIMS grants that were related to the overall operation of the health centers, including costs related to an accounting software program, consultant costs for billing support, and health center association membership dues. We could not determine what portion of these costs should have been allocated to the centers' AIMS grants.

These deficiencies occurred because health centers' financial management systems did not ensure that costs were properly allocated to their AIMS grants. In addition, HRSA required health centers to report all Health Center Program expenditures (including AIMS grant expenditures) in aggregate on their annual FFRs. However, HRSA relied on health centers to maintain internal records to separately track and account for expenditures for each HRSA grant award, including AIMS grants.

RECOMMENDATIONS

We recommend that the Health Resources and Services Administration:

- improve its procedures for monitoring how health centers meet targets for future HRSA grant funding opportunities;

- require the 34 health centers in our sample identified as having claimed unallowable AIMS grant costs to refund $773,114 to the Federal Government and work with the other health centers in our sampling frame to identify additional unallowable costs, which we estimate to be $5,217,709;[29]

- require the 34 health centers in our sample identified as having improperly allocated AIMS grant costs to refund $1,722,271 to the Federal Government or work with the health centers to determine what portion of these costs is allocable to their AIMS grants, and work with other health centers in our sampling frame to determine what portion of an estimated $9,207,958 in improperly allocated grant costs is allocable;[30] and

[29] Total estimated unallowable AIMS grant costs ($5,990,823) less amount identified in the sample ($773,114).

[30] Total estimated improperly allocated grant costs ($10,930,229) less amount identified in the sample ($1,722,271).

- improve its monitoring of grant expenditures, including requiring health centers to develop and maintain financial management systems that ensure only allowable, allocable, and documented costs are charged to their HRSA grants.

HEALTH RESOURCES AND SERVICES ADMINISTRATION COMMENTS

In written comments on our draft report, HRSA concurred with our first recommendation, partially concurred with our remaining recommendations, and described actions that it has taken or plans to take to address them. HRSA also stated that our audit provided valuable feedback to further reinforce its practices related to the use of AIMS funding, in accordance with Federal requirements and grant terms, and to inform areas where it can improve its oversight over the implementation and use of supplemental funding.

Regarding our first recommendation, HRSA stated that it monitored health centers using both the 2018 UDS reports and BPRs to assess health centers' progress toward implementation of their AIMS funding, which was consistent with the AIMS Notice of Funding Opportunity and terms of award. HRSA stated that, based on its assessment of the 2018 UDS data for all AIMS awardees, it identified 322 health centers that did not increase the number of mental health and SUD services patients and requested that these health centers provide information on their progress.[31] HRSA also stated that there were significant differences between how it and OIG assessed health centers' compliance with AIMS grant funding requirements, and that OIG's methodology was not an equivalent substitute for how HRSA assessed health centers.

Regarding our second and third recommendations, HRSA stated that it will work with the health centers identified in the draft report as having charged unallowable costs and/or improperly allocated costs to their AIMS grants to determine the amounts to be refunded to the Federal Government. HRSA stated that it will also conduct a risk assessment of the other health centers in our sampling frame to determine any additional unallowable and improperly allocated costs.

Regarding our fourth recommendation, HRSA stated that it monitored AIMS expenditures in conjunction with all health center expenditures through annual reviews of FFRs and Single Audits[32] submitted by health centers. HRSA indicated that it resolved Single Audit findings for 36 of the sampled AIMS grant recipients during FYs 2018, 2019, and 2020. HRSA stated that it has been providing fiscal technical assistance to the health centers and performing financial management reviews to assess health centers' policies and procedures and financial management systems. It also stated that it has provided fiscal technical assistance to six of the sampled AIMS grant recipients since 2018 and performed financial management reviews of

[31] HRSA stated that it reviewed narratives submitted by the health centers to determine appropriate follow-up actions (e.g., technical assistance) and that, in June 2020, it took action to partially or fully discontinue ongoing AIMS funding for 37 health centers.

[32] Most non-Federal grantees are required to have Single Audits. These audits are conducted by independent auditors, are conducted in accordance with generally accepted government auditing standards, and generally accepted auditing standards.

seven of the sampled AIMS grant recipients. Finally, HRSA stated that it is developing a system to award future supplemental funds through separate document numbers to make it easier for both health centers and HRSA to account for and track drawdowns of supplemental funds.

HRSA also provided separate technical comments on our draft report, which we addressed as appropriate. HRSA's comments, excluding its technical comments, are included as Appendix G.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing HRSA's comments, we maintain that our findings and recommendations are valid and acknowledge HRSA's efforts to improve its oversight over the implementation and use of supplemental funding. Regarding HRSA's comments concerning OIG's methodology for assessing health centers' performance toward meeting AIMS grant funding requirements, we used mental health and SUD services patient data obtained from the sampled health centers rather than the patient data reported on the UDS reports because not all 2018 UDS reports were available during our fieldwork. Although the 2018 UDS reports were due in February 2019, HRSA took months to finalize these reports and did not provide them to us until October 2019—8 months after we initiated this audit. In addition, we could not reconcile the patient counts obtained from the health centers to the patient counts reported on UDS reports.[33]

[33] To ensure that the patient data were comparable (i.e., for the same length of a period) and generated from the source data used to compile the UDS reports (e.g., health centers' electronic health records systems), we obtained from the health centers mental health and SUD services patient lists for CYs 2017 and 2018. We combined the patient lists for each year to get health centers' unduplicated mental health and SUD services patient counts. We then compared unduplicated patient counts for each year to determine whether the associated health center had increases in the total number of patients seeking mental health and SUD services from CYs 2017 to 2018. We reviewed only patient counts that were related to the objective and scope of our review (i.e., the number of unduplicated patients accessing mental health and SUD services). We did not review demographic or statistical data reported on health centers' UDS reports.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered AIMS grant funds totaling $112,893,351 awarded during FY 2017 to 665 health centers in the 30 States with the highest opioid overdose death rates in CY 2016. Depending on a health center's budget period, these funds could be spent during the period September 1, 2017, through May 31, 2019. Of the 665 health centers in the 30 States, we reviewed a statistical sample of 100 health centers.

We limited our review of HRSA's and the sampled health centers' internal controls to those applicable to our objective. We did not assess the overall internal control structure of HRSA or the health centers.

We established reasonable assurance of the authenticity and accuracy of AIMS grant funding data provided by HRSA from its Electronic Handbook system by reconciling the data to AIMS grant award notices for 10 judgmentally selected health centers (separate from the sampled health centers selected for review) and by reviewing the AIMS grant award notices for the health centers in our sample. However, we did not assess the completeness of the file.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- met with HRSA officials to gain an understanding of AIMS funding requirements and HRSA's oversight activities;
- obtained from HRSA a list of health centers that received AIMS grants during FY 2017;
- identified 30 States that had the highest opioid overdose death rates in CY 2016;
- selected a stratified multistage statistical sample of 100 health centers from a sampling frame of AIMS grant funds totaling $112,893,351 ($56,414,882 ongoing funding and $56,478,469 one-time funding) awarded to 665 health centers in 30 States during FY 2017 (see Appendix D);
- for each of the 100 sampled health centers, reviewed its AIMS funding application, grant award notice, financial and performance reports, accounting, personnel, and other records to determine whether it:

- had an increase in the total number of mental health and SUD services patients in CY 2018 as compared to CY 2017 and met its mental health and SUD services patient projections by December 31, 2018;

- added new or increased hours of existing personnel who supported mental health and SUD service expansion within 120 days of its AIMS grant award, and added new mental health and SUD services or expanded existing services in scope within 120 days of its award; and

- claimed allowable costs for AIMS ongoing and one-time funding;

- estimated the number of health centers that did not use their AIMS grant funding in accordance with Federal requirements and grant terms in the 30 States and the amount of AIMS grant funding associated with the noncompliance (see Appendix E); and

- discussed the results of our audit with HRSA officials.

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

APPENDIX B: FEDERAL REQUIREMENTS FOR ACCESS INCREASES IN MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES GRANTS

To be allowable under Federal awards, costs must be necessary and reasonable for the performance of the Federal award and be allocable (45 CFR § 75.403(a)). Costs must conform to any limitations or exclusions set forth in the Federal awards as to types or amount of cost items (45 CFR § 75.403(b)).

The financial management system of each grantee must provide accurate, current, and complete disclosure of the financial results of each Federal award or program (45 CFR § 75.302(b)(2)). The grantee's records must identify the source and application of funds for federally funded activities and be supported by source documentation (45 CFR § 75.302(b)(3)). The grantee must comply with Federal statutes, regulations, and the terms and conditions of the Federal awards (45 CFR § 75.303(b)).

Grantees may charge to the Federal award only allowable costs incurred during the period of performance and any costs incurred prior to award that were authorized by the Federal awarding agency (45 CFR § 75.309(a)).

Budget estimates (i.e., estimates determined before the services are performed) alone do not qualify as support for charges to Federal awards (45 CFR § 75.430(i)(1)(viii)).

Charges to Federal awards for salaries and wages must be based on records that accurately reflect the work performed. These records must support the distribution of the employee's salary or wages among specific activities or cost objectives if the employee works on more than one Federal award or both a Federal award and a non-Federal award. The grantee's system of internal controls should include processes to review after-the-fact interim charges made to a Federal award based on budget estimates. All necessary adjustments must be made so that the final amount charged to the Federal award is accurate, allowable, and properly allocated (45 CFR § 75.430(i)(1)).

A cost is allocable to a particular Federal award if the goods or services involved are chargeable or assignable to that Federal award in accordance with relative benefits received. This standard is met if the cost: (1) is incurred specifically for the Federal award, (2) benefits both the Federal award and other work of the non-Federal entity and can be distributed in proportions that may be approximated using reasonable methods, and (3) is necessary to the overall operation of the non-Federal entity and is assignable in part to the Federal award (45 CFR § 75.405(a)). If a cost benefits two or more projects or activities in proportions that can be determined without undue effort or cost, the cost must be allocated to the projects based on the proportional benefit. If a cost benefits two or more projects or activities in proportions that cannot be determined because of the interrelationship of the work involved, then the costs may be allocated or transferred to benefited projects on any reasonable documented basis (45 CFR § 75.405(d)).

In the AIMS Notice of Funding Opportunity (HRSA-17-118), HRSA stated that health centers were required to increase personnel and expand access to mental health and SUD services within 120 days of their AIMS award, and to increase the number of existing and/or new patients accessing mental health or SUD services by December 31, 2018. In addition, HRSA stated that AIMS funding may not be used to support costs incurred prior to award or supplant exiting funding resources. Further, HRSA stated that expanded or new direct hire staff and contractors must be in one or more of the following personnel positions: psychiatrist, licensed clinical psychologist, licensed clinical social worker, other mental health staff, other licensed mental health provider, substance abuse provider, case manager, patient/community education specialist (health educator), or community health worker.

In its Frequently Asked Questions document, HRSA clarified that AIMS funding may not be used to increase salaries for existing providers.

The AIMS Notice of Award stated that health centers: (1) may not use the awarded AIMS funding for construction or minor alterations and renovations, (2) are required to request prior approval from HRSA if some or all the additional one-time funding will be used to purchase unit(s) of equipment exceeding $5,000, and (3) must submit a Prior Approval Request to carry over a portion of their awarded AIMS funds to the subsequent budget period if they did not spend the entire AIMS award during the FY 2017 budget period.

APPENDIX C: LIST OF THE 30 STATES WITH THE HIGHEST OPIOID OVERDOSE DEATH RATES IN CALENDAR YEAR 2016

	State	CY 2016 Opioid Overdose Deaths per 100,000 Population (Death Rate)	Number of Health Centers	Total AIMS Award
1	West Virginia	43.4	22	$3,683,255
2	New Hampshire	35.8	10	1,755,512
3	Ohio	32.9	43	7,438,746
4	District of Columbia	30.0	7	1,204,142
5	Maryland	29.7	15	2,419,828
6	Massachusetts	29.7	38	6,446,826
7	Rhode Island	26.7	8	1,405,600
8	Maine	25.2	16	2,685,342
9	Connecticut	24.5	16	2,666,359
10	Kentucky	23.6	20	3,225,505
11	Pennsylvania	18.5	32	5,340,828
12	Michigan	18.5	37	6,341,900
13	Vermont	18.4	10	1,750,113
14	Tennessee	18.1	21	3,532,201
15	New Mexico	17.5	17	2,871,807
16	Delaware	16.9	3	527,100
17	Utah	16.4	11	1,777,689
18	New Jersey	16.0	20	3,513,581
19	Missouri	15.9	24	3,970,840
20	Wisconsin	15.8	14	2,340,338
21	North Carolina	15.4	36	6,137,127
22	Illinois	15.3	42	7,252,595
23	New York	15.1	62	10,579,295
24	Florida	14.4	38	6,574,979
25	Virginia	13.5	19	3,163,585
26	Nevada	13.3	5	860,940
27	South Carolina	13.1	21	3,594,841
28	Indiana	12.6	21	3,598,104
29	Alaska	12.5	23	3,891,019
30	Oklahoma	11.6	14	2,343,354
	Total		**665**	**$112,893,351**

APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our target for this audit was health centers located within the States with the highest opioid overdose death rates in CY 2016 that received AIMS grant funding during FY 2017. We limited our audit to the 30 States with the highest opioid overdose death rates in 2016.

The sampling frame consisted of an Excel spreadsheet that contained AIMS grant funds totaling $112,893,351 awarded to 665 health centers in the 30 States during FY 2017. We used the AIMS grant funding data provided by HRSA from its Electronic Handbook system.

SAMPLE UNIT

The primary sample unit was a State. The secondary sample unit was a health center.

SAMPLE DESIGN AND SAMPLE SIZE

We selected the two States with the highest opioid overdose death rates in CY 2016, West Virginia and New Hampshire. We selected 8 of the remaining 28 States using the Rao, Hartley, and Cochran (RHC) sample selection method.[34] Given this approach, the chance of selecting any given State was approximately proportional to the number of health centers in the State that received AIMS grant funding during FY 2017. We then randomly selected 10 health centers from each of these 10 States (Table 1).

[34] For details on RHC sampling, please refer to section 9A.11 of William G. Cochran, *Sampling Techniques*: 3rd ed., Wiley, New York, 1977.

Table 1: Stratified Multistage Sample Design and Sample Size for Secondary Units

	State	Number of Frame Units (Health Centers)	Total AIMS Grant Funding	Sample Size
1	West Virginia	22	$3,683,255	10
2	New Hampshire	10	1,755,512	10
3	Alaska	23	3,891,019	10
4	Connecticut	16	2,666,359	10
5	Florida	38	6,574,979	10
6	Indiana	21	3,598,104	10
7	Massachusetts	38	6,446,826	10
8	Michigan	37	6,341,900	10
9	New Jersey	20	3,513,581	10
10	Pennsylvania	32	5,340,828	10
	Total	**257**	**$43,812,363**	**100**

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE UNITS

We selected West Virginia and New Hampshire. We used RHC sample selection[35] to select 8 of the remaining 28 States. Because New Hampshire only had 10 health centers, we selected all health centers in the State for review. To select the secondary sample units from the remaining States, we consecutively numbered the health centers for each State. Using the 10 random numbers generated for each State, we selected the corresponding frame items.

[35] See section 9A.11 of William G. Cochran, *Sampling Techniques*: 3rd ed., Wiley, New York, 1977.

ESTIMATION METHODOLOGY

We used the OIG/OAS attribute and variable appraisal programs to calculate the following estimates for the 30 States by combining the estimates calculated from West Virginia and New Hampshire and the estimates from the 8 States:[36]

- number of health centers that did not use their AIMS grant funding in accordance with Federal requirements and grant terms,

- number of health centers that did not increase the total number of mental health and SUD services patients from CYs 2017 to 2018,

- number of health centers that did not hire new staff or increase hours of existing staff that supported mental health and SUD service expansion within 120 days of award, and

- total amount of AIMS grant funding associated with the noncompliance.

[36] We used the OAS stratified appraisal modules to obtain estimates for West Virginia and New Hampshire and the RHC appraisal modules to obtain estimates for the remaining eight States. We then combined these results using the stratified multistage appraisal modules to create the estimates for all 30 States (see Appendix E).

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Details and Results for Health Centers That Did Not Use Their AIMS Grant Funding in Accordance With Federal Requirements and Meet Mental Health and Substance Use Disorder Service Expansion Requirements

Health Centers in Frame	Sample Size	Number of Health Centers That Did Not Use Their AIMS Grant Funding in Accordance With Federal Requirements and Grant Terms	Number of Health Centers That Did Not Increase the Total Number of Patients Seeking Mental Health and SUD Services From CYs 2017 to 2018	Number of Health Centers That Did Not Hire Personnel or Increase the Hours of Existing Personnel That Supported Mental Health and SUD Service Expansion Within 120 Days
665	100	67	21	15

Table 3: Estimated Number of Health Centers That Did Not Use Their AIMS Grant Funding in Accordance With Federal Requirements and Meet Mental Health and Substance Use Disorder Service Expansion Requirements
(Limits Calculated at the 90-Percent Confidence Level)

	Lower Limit	Point Estimate	Upper Limit
Number of Health Centers That Did Not Use Their AIMS Grant Funding in Accordance With Federal Requirements and Grant Terms	401	454	507
Number of Health Centers That Did Not Increase the Total Number of Patients Seeking Mental Health and SUD Services From CY 2017 to 2018	85	125	165
Number of Health Centers That Did Not Hire Personnel or Increase the Hours of Existing Personnel That Supported Mental Health and SUD Service Expansion Within 120 Days	59	99	140

Table 4: Sample Details and Results for Health Centers That Claimed Unallowable Costs

Health Centers in Frame	Total Value of Frame	Sample Size	Total Value of Sample	Number of Health Centers with Unallowable Costs	Value of Unallowable Costs in Sample
665	$112,893,351	100	$16,899,692	34	$773,114

Table 5: Estimated Value of Unallowable Costs
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$5,990,823
Lower limit	4,030,473
Upper limit	7,951,172

Table 6: Sample Details and Results for Health Centers That Did Not Properly Allocate Salaries and Other Expenditures to AIMS Grant

Health Centers in Frame	Total Value of Frame	Sample Size	Total Value of Sample	Number of Health Centers That Did Not Properly Allocate Expenditures	Value of Potentially Unallowable Costs in Sample
665	$112,893,351	100	$16,899,692	34	$1,722,271

Table 7: Estimated Value of Potentially Unallowable Costs
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$10,930,229
Lower limit	7,198,465
Upper limit	14,661,993

APPENDIX F: SUMMARY OF DEFICIENCIES BY HEALTH CENTER

State and Health Center	Did Not Meet Mental Health and SUD Service Expansion Requirements	Claimed Unallowable Costs	Did Not Properly Allocate Expenditures
AK-1	X	X	
AK-2			X
AK-3		X	X
AK-4	X	X	
AK-5			
AK-6		X	
AK-7		X	
AK-8	X	X	
AK-9			X
AK-10	X		
CT-1		X	X
CT-2			
CT-3			X
CT-4			
CT-5	X		
CT-6			X
CT-7			
CT-8	X		
CT-9			
CT-10			
FL-1	X	X	
FL-2			
FL-3			
FL-4		X	
FL-5		X	X
FL-6			
FL-7		X	X
FL-8			X
FL-9	X	X	
FL-10			
IN-1			
IN-2			
IN-3	X		

State and Health Center	Did Not Meet Mental Health and SUD Service Expansion Requirements	Claimed Unallowable Costs	Did Not Properly Allocate Expenditures
IN-4			
IN-5		X	
IN-6		X	X
IN-7	X		
IN-8	X	X	
IN-9		X	
IN-10		X	X
MA-1	X		X
MA-2			X
MA-3	X	X	X
MA-4			X
MA-5			
MA-6		X	
MA-7			X
MA-8			
MA-9			X
MA-10		X	X
MI-1			
MI-2			
MI-3			
MI-4		X	
MI-5	X		
MI-6	X	X	
MI-7		X	X
MI-8		X	X
MI-9			
MI-10			
NH-1			
NH-2	X		
NH-3			
NH-4			X
NH-5			X
NH-6	X	X	
NH-7			
NH-8			

State and Health Center	Did Not Meet Mental Health and SUD Service Expansion Requirements	Claimed Unallowable Costs	Did Not Properly Allocate Expenditures
NH-9			X
NH-10			X
NJ-1	X	X	X
NJ-2			
NJ-3	X	X	
NJ-4	X	X	
NJ-5		X	
NJ-6	X		
NJ-7	X		
NJ-8			
NJ-9		X	
NJ-10			X
PA-1	X		
PA-2	X		X
PA-3			X
PA-4	X	X	
PA-5	X		
PA-6			
PA-7			
PA-8	X		
PA-9			X
PA-10		X	X
WV-1			
WV-2	X	X	X
WV-3		X	X
WV-4			
WV-5	X		X
WV-6			X
WV-7			
WV-8			
WV-9	X		
WV-10			
Total	**30**	**34**	**34**

APPENDIX G: HEALTH RESOURCES AND SERVICES ADMINISTRATION COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Resources and Services Administration

Rockville, MD 20857

TO: Christi A. Grimm
Principal Deputy Inspector General

FROM: Administrator

DATE: September 16, 2020

SUBJECT: Office of Inspector General Draft Report titled, "In Selected States, 67 of 100 Health Centers Did Not Use Their Health Resources and Services Administration Access Increases in Mental Health and Substance Abuse Services Grant Funding in Accordance With Federal Requirements, A-02-19-02001"

Attached is the Health Resources and Services Administration's (HRSA) response to the Office of Inspector General draft report titled, "In Selected States, 67 of 100 Health Centers Did Not Use Their HRSA Access Increases in Mental Health and Substance Abuse Services Grant Funding in Accordance With Federal Requirements, A-02-19-02001." If you have any questions, please contact Sandy Seaton in HRSA's Office of Federal Assistance Management at (301) 443-2432.

Thomas J. Engels

Health Resources and Services Administration's Comments on the OIG Draft Report – "In Selected States, 67 of 100 Health Centers Did Not Use Their HRSA Access Increases in Mental Health and Substance Abuse Services Grant Funding in Accordance With Federal Requirements, A-02-19-02001"

GENERAL COMMENTS

The Office of Inspector General's (OIG) study provided valuable feedback to further reinforce the Health Resources and Services Administration's (HRSA) practices related to the use of Access Increases in Mental Health and Substance Abuse Services (AIMS) funding, in accordance with federal requirements and grant terms, and to inform areas where HRSA can improve its oversight over the implementation and use of supplemental funding.

Overall, HRSA investments in health centers' integration and expansion of substance use disorder (SUD) and mental health (MH) services into primary-care settings have transformed the model of primary-care delivery and have created access to essential services for the nation's most vulnerable populations. From 2016 to 2019, HRSA investments in SUD-MH service expansion have resulted in:

- A 44 percent increase in the number of health-center patients receiving MH services (from 1,788,577 to 2,581,706);
- A 44 percent increase in the number of MH visits at health centers (from 8,508,031 to 12,236,568);
- A 47 percent increase in the number of MH providers at health centers (from 9,191 to 13,542);
- A 93 percent increase in the number of health-center patients receiving Screening, Brief Intervention, and Referral to Treatment services (from 717,677 to 1,381,408);
- A 317 percent increase in the number of providers with DATA 2000 waivers to treat opioid-use disorder (OUD) (from 1,700 to 7,095); and
- A 266 percent increase in the number of health-center patients receiving medication-assisted treatment for OUD (from 39,075 to more than 142,919).

The fiscal year (FY) 2017 AIMS supplemental funding was the first HRSA investment made available to all HRSA-funded health centers focused on the treatment, prevention, and awareness of opioid abuse. HRSA's oversight of AIMS supplemental awards, conducted as a complement to its extensive and robust oversight of health centers' overall Health Center Program grant award, aligned with the AIMS Notice of Funding Opportunity (NOFO) and the terms of the award. HRSA used annual Uniform Data System (UDS) reports and Budget Period Progress Reports (BPRs) to assess progress toward implementation of AIMS funding, and this assessment informed decisions regarding continuation of AIMS funding.

HRSA is committed to continuous improvement of its oversight of supplemental funding and appreciates this opportunity to further inform those improvements.

Beginning in FY 2018, HRSA implemented several changes in its assessment and support of health-center progress in implementing SUD-MH funding, including:

1) Developing electronic systems to collect interim progress reports to support more timely monitoring of implementation of SUD-MH funding. Specifically, HRSA implemented tri-annual reporting for FY 2018 Expanding Access to Quality Substance Use Disorder and Mental Health Services (SUD-MH) awards and for FY 2019 Integrated Behavioral Health Services (IBHS) awards.

2) Investing in additional technical-assistance resources to support health centers' success in implementing funding. Specifically, in 2019 HRSA established the Center of Excellence for Behavioral Health Technical Assistance, a centralized training and technical-assistance center to support HRSA-funded grant recipients to integrate substance use and mental health services in primary-care settings and to support training and education of the workforce—including all health centers who received AIMS, SUD-MH, or IBHS funding.

HRSA's response to the OIG draft recommendations are as follows:

OIG RECOMMENDATION

OIG recommends that HRSA improve its procedures for monitoring how health centers meet targets for future HRSA grant funding opportunities.

HRSA RESPONSE

HRSA concurs with the OIG's recommendation, but notes that there were significant differences in the way that HRSA and the OIG assessed health-center compliance with the requirements of the AIMS funding. HRSA monitored AIMS grants consistent with the NOFO and terms of award, using both the 2018 UDS reports and BPRs to assess health-center progress toward implementation of the AIMS funding. The OIG's use of individual electronic health record (EHR) systems data rather than UDS data in health-center audits is not consistent with how HRSA assessed AIMS performance, and is not an equivalent substitute for UDS data in assessing progress towards the implementation of HRSA's supplemental AIMS funding.

HRSA requires health centers to regularly compile and report UDS data, rather than EHR data, which it then uses for various program oversight purposes. EHRs vary in how they capture data that is later reported in the UDS. HRSA's UDS Manual provides specific reporting guidance and measure definitions to ensure consistent data reporting across health centers and across EHR systems. Health centers must apply UDS reporting criteria to their raw EHR data before submitting data to the UDS. Thus, EHR data is not interchangeable with UDS data.

The OIG noted that it did not use patient counts reported in UDS because it did not assess the reliability of the UDS data. The purpose of the UDS is to provide a core set of data, including patient demographics, services provided, clinical processes and health outcomes, patients' use of services, and costs and revenues, which are used to quantify the national impact of the Health Center Program and to support HRSA decision making around the overall performance of health centers. As such, HRSA has heavily invested in ensuring the reliability and validity of UDS data. HRSA provides a UDS Manual and technical assistance to health centers prior to the submission of the UDS data. HRSA also has a rigorous UDS data-validation process that includes over 3,000 edit checks incorporated in the Electronic Handbooks to ensure the accuracy of the data

submissions, as well as one-on-one technical reviews and outlier analyses performed by UDS expert reviewers. None of these resources applies directly to EHR data.

Once the BPRs and UDS data necessary to assess AIMS progress were available, HRSA completed an assessment of the 2018 UDS data for all 1,178 health centers that received AIMS funding and identified a total of 322 health centers that did not increase the number of SUD and/or MH patients. HRSA required these 322 health centers to provide narratives in a formal Request for Information (RFI) to describe progress that may not have been fully explained by their 2018 UDS data or BPR submissions. HRSA reviewed these narratives to determine appropriate follow-up actions, which included identifying health centers to receive technical assistance, requesting a revised work plan, and/or partially or fully discontinuing future-year AIMS funding, as appropriate. Based on its analysis, HRSA found that 37 of the 1,178 health centers, or approximately 3 percent of the total AIMS awardees, were unable to demonstrate sufficient progress to merit continuing their AIMS awards. HRSA took action to partially or fully discontinue ongoing AIMS funding for these 37 health centers in June 2020. Of the 100 health centers reviewed by the OIG, HRSA identified 3 of these health centers as not having met their AIMS target and ultimately took action to partially or fully discontinue their funding.

Of the 30 health centers that were identified by the OIG as not having sufficient increases in MH and SUD users, HRSA's assessment of the 2018 UDS and BPRs indicated that 13 of these health centers did demonstrate sufficient increases in MH and SUD users. The remaining 17 health centers were identified through HRSA's monitoring process, described above, as not demonstrating sufficient increases in MH and SUD users, and those health centers submitted narratives in response to the RFI from HRSA. Upon review of the additional context provided by the 17 health centers, only one of these health centers was not able to demonstrate sufficient progress to warrant maintaining the original funding level, and thus HRSA funding was partially discontinued (i.e., ongoing funding was reduced but not discontinued entirely). These numbers are notably less than the OIG's estimates in the report.

OIG RECOMMENDATION

OIG recommends that HRSA require the 34 health centers in our sample identified as having claimed unallowable AIMS grant costs to refund $773,114 to the Federal Government and work with the other health centers in our sampling frame to identify additional unallowable costs, which we estimate to be $5,217,709.

HRSA RESPONSE

HRSA partially concurs with the OIG's recommendation. HRSA will work with the 34 health centers to determine the amount of unallowable costs charged to their grants and require that such amounts be refunded to the Federal Government. HRSA will also conduct a risk assessment of the other health centers in OIG's sampling frame and work with the identified health centers to determine any additional unallowable costs.

OIG RECOMMENDATION

OIG recommends that HRSA require the 34 health centers in our sample identified as having improperly allocated AIMS grant costs to refund $1,722,271 to the Federal Government or work with the health centers to determine what portion of these costs is allocable to their AIMS grants, and work with other health centers in our sampling frame to determine what portion of an estimated $9,207,958 in improperly allocated grant costs is allocable.

HRSA RESPONSE

HRSA partially concurs with the OIG's recommendation. HRSA will work with the 34 health centers to determine the amount of improperly allocated costs charged to their grants and require that such amounts be refunded to the Federal Government. HRSA will also conduct a risk assessment of the other health centers in OIG's sampling frame and work with the identified health centers to determine any additional improperly allocated costs charged to their grants.

OIG RECOMMENDATION

OIG recommends that HRSA improve its monitoring of grant expenditures, including requiring health centers to develop and maintain financial management systems that ensure only allowable, allocable, and documented costs are charged to their HRSA grants.

HRSA RESPONSE

HRSA partially concurs with the OIG's recommendation. HRSA is committed to ensuring that all grant recipients, including health centers, charge only allowable, allocable, and documented costs to their HRSA grants. All HRSA grant recipients are required to have financial management systems (FMS) that adequately safeguard all assets and assure that grant funds are used solely for authorized purposes and are supported by source documentation as specified at 45 CFR §75.302. The requirement to comply with 45 CFR part 75 is cited on all notices of award (NoA) received by health centers, including the AIMS NoAs.

The NoAs also provided additional AIMS expenditure guidance in a grant specific term that stated that any rebudgeting of AIMS costs needed to align with the intent of the AIMS funding and had to be in compliance with 45 CFR part 75 as follows:

> You may rebudget FY 2017 AIMS funding without prior approval, as long as the proposed use of AIMS funding aligns with the intent of the AIMS supplemental funding opportunity and complies with requirements in the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards available at http://www.ecfr.gov/cgibin/textidx?node=pt45.1.75.

HRSA's Office of Federal Assistance Management (OFAM) monitors the business and financial management matters related to these awards. In accordance with 45 CFR part 75 and the HHS Grants Policy Administrative Manual requirements for pre-award risk assessments, HRSA OFAM conducted financial assessments (FA) of AIMS applicants recommended for funding to ensure their ability to use and manage federal funds.

HRSA's grants-management staff also meet with HRSA's program staff, including those who oversee the Health Center Program, prior to funding any high-risk applicant to discuss financial

and programmatic risks identified through the FAs and operational site vists and to determine risk-mitigation strategies to be applied commensurate with the nature and level of risk. These staff also meet on a quarterly basis to monitor the status of all high-risk recipients. The percentage of health centers that are identified as high risk has averaged approximately 2.5 percent per year. Risk-mitigation strategies such as restricting draw down of funds without HRSA prior approval and requiring additional financial reporting, were applied, in alignment with HRSA's risk-mitigation policies and procedures (P&Ps), to AIMS grant recipients who had been identified through the FAs as having elevated risk levels.

AIMS grant expenditures were monitored in conjunction with all health-center expenditures through annual reviews of Federal Financial Reports and Single Audits submitted by health centers. If there were Single Audit findings, HRSA conducted audit resolutions of each finding and followed up with the grant recipient to ensure that the grant recipient adequestely addressed the fiscal findings through the development and implementation of corrective action plans and refunded the Federal Government for any unallowable costs. HRSA resolved Single Audit findings for 36 of the sampled AIMS grant recipients during FYs 2018, 2019, and 2020.

HRSA also continuously evaluates and identifies opportunities to improve monitoring of grant expenditures and has implemented more robust standardized procedures to assess grant-recipient financial management capacity, mitigate risk, and provide financial-management technical assistance since the period under review by the OIG. HRSA will continue to explore additional methods to assist health centers in developing and maintaining FMS that ensure only allowable, allocable, and documented costs are charged to their HRSA grants.

Based on lessons learned from the recent OIG AIMS audit and the development of oversight activities for subsequent funding opportunities, HRSA utilized separate activity codes and document numbers for the recent one-time COVID-19 awards to health centers. In addition, HRSA is developing a system to award future supplemental funds through separate document numbers to make it easier for both health centers' and HRSA to account for and track drawdowns of supplemental funds and better ensure that only allowable, allocable, and documented costs are charged to these supplemental grants.

Additionally, HRSA has recently developed a progress-reporting framework that specifically assesses progress on the uses of supplemental funding for activities consistent with the scope of activities permissible through the award and consistent with the activities identified in the awardee's application submission.

Since 2017, HRSA has been providing on-site fiscal technical assistance (FTA) of health centers' P&P and FMS, and virtually since March 2020 due to COVID-19. The FTA was targeted to grant recipients assessed at high or moderate risk and/or that had delinquent Single Audits. HRSA provided FTA to 6 of the sampled AIMS grant recipients since 2018, 5 based on their high or moderate risk and 1 due to its delinquent Single Audit. Six more of the sampled AIMS grant recipients are on HRSA's schedule to be provided FTA virtually during 2020.

Since 2017, HRSA also began performing Financial Management Reviews (FMRs) to assess the P&P and FMS of grant recipients that are under the threshold for Single Audit coverage.

Targeted FMRs may also be performed for grant recipients that are experiencing financial challenges. HRSA has performed FMRs of seven of the sampled AIMS grant recipients. Subsequent to awarding AIMS funding, HRSA has also provided a wide range of technical assistance resources that were accessible to all HRSA grant recipients. These resources focused on best practices for managing HRSA grant funds and preventing unallowable costs. For example, starting in May 2018, HRSA sponsored annual Healthy Grants Workshops, which were offered at HRSA headquarters and regionally. These workshops included a number of sessions on financial management requirements and best practices. The sessions and other resource materials were subsequently available for download on HRSA's "Manage Your Grant" website at https://www.hrsa.gov/ grants/manage-your-grant/training/workshops. Additionally, a page of the "Manage Your Grant" website contains specific information for grant recipients on financial management including legislative mandates, policy bulletins, financial management requirements, and materials from HRSA's quarterly grants management calls at https://www.hrsa.gov/grants/manage-your-grant/ financial-management.