STATE OF WEST VIRGINIA

SPECIAL REPORT

OF

WEST VIRGINIA RURAL HEALTH EDUCATION PARTNERSHIPS

FOR THE PERIOD

JULY 1, 2005 – DECEMBER 31, 2007

OFFICE OF THE LEGISLATIVE AUDITOR
POST AUDIT DIVISION

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WEST VIRGINIA LEGISLATURE
Joint Committee on Government and Finance

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June 5, 2009

The Joint Committee on Government and Finance:

In compliance with the provisions of the West Virginia Code, Chapter 4, Article 2, as amended, we are conducting an ongoing post audit of the West Virginia Rural Health Education Partnerships program for the period July 1, 2005 through December 31, 2007. We are conducting our audit in accordance with auditing standards generally accepted in the United States.

Our fieldwork to date has disclosed certain findings which are detailed in this report; we anticipate more reports will follow. Additionally, we have included work performed by other auditors pertaining to the West Virginia Rural Health Education Partnerships program. The Higher Education Policy Commission's management has responded to the audit findings; we have included the responses following each finding.

Respectfully submitted,

Stacy L. Sneed, CPA, CICA, Director
Legislative Post Audit Division

SLS/cdo

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- At the behest of the Higher Education Policy Commission [the Commission] the CPA firm *Suttle & Stalnaker* performed and issued a report on a set of agreed-upon procedures. The Agreed-Upon Procedures report is attached to this report as supplemental item #1.

- **Note: At this time, issues noted in the Agreed-Upon Procedures report are being researched by our legal staff and an opinion is forthcoming.**

Spending Unit's Response

The Higher Education Policy Commission (HEPC) agrees with the Suttle & Stalnaker report.

See Pages 9 and 10 for Finding and HEPC's Response

Finding 1 **Bonuses Paid to Northern West Virginia Rural Health Education Center [NWVRHEC] Staff with No Fiscal Monitoring or Oversight.**

- During our audit of the West Virginia Rural Health Education Partnerships [RHEP] program we learned staff of the NWVRHEC was paid bonuses from RHEP funds totaling $20,035.00 and $15,664.00 for fiscal years 2008 and 2007, respectively.
- Documentation provided by Tri-County Health Clinic, the lead agency (or fiscal agent) for the NWVRHEC indicated 11 staff members received an annual bonus in amounts ranging from $1,000.00 to $4,200.00 in fiscal year 2008 and from $800.00 to $3,000.00 in fiscal year 2007.
- Considering the bonuses are paid near the end of the fiscal year and may not be paid if no money is left, the risk exists for the NWVRHEC to cease making some expenditures necessary to the program to ensure bonuses will be funded.

  The grant agreements require the grantee, in this case Tri-County, to spend RHEP grant funds in line with the mission and goals of the RHEP program. Additionally, the Commission is required to monitor the grant activities to "provide reasonable assurance that the Grantee uses these grant funds for intended purposes."

Auditor's Recommendation

We recommend the Higher Education Policy Commission comply with the monitoring requirements of the RHEP program grant agreements and ensure all funds are spent in line

with the mission and goals of the program as defined by West Virginia Code and the goals and scope defined within the various RHEP grant agreements.

Spending Unit's Response

The Higher Education Policy Commission has not authorized the payment of bonuses to RHEP employees.

See Pages 11 – 13 for Finding and HEPC's Response

WEST VIRGINIA RURAL HEALTH EDUCATION PARTNERSHIPS PROGRAM

INTRODUCTION

POST AUDIT AUTHORITY

This is the first report on the ongoing post audit of the West Virginia Rural Health Education Partnerships (RHEP) program. The audit is being conducted pursuant to Chapter 4, Article 2 of the West Virginia Code, which requires the Legislative Auditor to "make post audits of the revenues and expenditures of the spending units of the state government, at least once every two years, if practicable, to report any misapplication of state funds or erroneous, extravagant or unlawful expenditures by any spending unit, to ascertain facts and to make recommendations to the Legislature concerning post audit findings, the revenues and expenditures of the state and of the organization and functions of the state and its spending units."

BACKGROUND

On March 9, 1995, the West Virginia State Legislature passed S. B. 161 amending the RHI Act and providing for the official and legal integration of the Rural Health Initiative and the Kellogg Community Partnerships program. These two programs are now a statewide program consisting of 9 training consortia or networks of community based health, social, and education agencies, covering all 55 of West Virginia's counties.

This enabling legislation called for the appointment of an integrated state Advisory Panel, which reports to the Vice Chancellor for Health Sciences of the University System in the development and implementation of the restructured program. The Vice Chancellor served as the project director of the Kellogg Community Partnerships and the Rural Health Initiative and now heads the integrated program.

The 1995 legislation renamed the program "The West Virginia Rural Health Education Partnerships" and prescribed the membership and duties of the State Advisory Panel appointed by the governor, which reports to the Vice Chancellor for Health Sciences.

The mission of the West Virginia Rural Health Education Partnerships is to achieve greater retention of West Virginia trained health science graduates in underserved rural West Virginia communities by creating partnerships of community, higher education, health care providers, and governmental bodies.

WEST VIRGINIA RURAL HEALTH EDUCATION PARTNERSHIPS PROGRAM

ADMINISTRATIVE OFFICERS AND STAFF
JULY 1, 2005 TO PRESENT

Higher Education Policy Commission
Administrative Staff

Dr. Brian Noland..... Chancellor (May 2006 – Present)
Dr. Bruce Flack .....Interim Chancellor (October 2005– May 2006)
Dr. Michael Mullin.....Chancellor (July 2005 – September 2005)

Dr. Robert Walker ..... Vice Chancellor (August 2008 – Present)
Vacant .....Vice Chancellor (July 2005 – August 2008)

Rural Health Education Partnerships/Area Health Education Center
Administration Staff

Hilda Heady, MSW .....Executive Director (July 2005 – Present)

April Vestal.....Associate Director (July 2005 – Present)

WEST VIRGINIA RURAL HEALTH EDUCATION PARTNERSHIPS PROGRAM

AUDIT SCOPE

The scope of this special report on the Rural Health Education Partnerships (RHEP) program is limited to presenting the agreed-upon procedures report performed by independent auditors and reporting on grant monitoring across the RHEP program during our audit of July 1, 2005 through December 31, 2007 and up to the date of this report.

OBJECTIVES AND METHODOLOGIES

The objectives of this special report were to (1) present the report issued by independent auditors to the Post Audit Subcommittee for their consideration; and (2) to determine if the Higher Education Policy Commission (HEPC) has implemented procedures for monitoring grant agreements and RHEP expenditures to ensure compliance with the intent of the program.

In order to achieve the objectives noted above, we reviewed applicable sections of the West Virginia Code, Legislative Rules, grant agreements as well as other rules and regulations, policies and procedures, conducted interviews with RHEP staff, Higher Education Policy Commission employees and reviewed various documents related to RHEP program.

Our reports are designed to assist the Post Audit Subcommittee in exercising its legislative oversight function and to provide constructive recommendations for improving State operations. As a result, our reports generally do not address activities we reviewed that are functioning properly.

This report is intended for the information and use of the Post Audit Subcommittee, the members of the WV Legislature, management of the spending unit and others within the spending unit. However, once released by the Post Audit Subcommittee, this report is a matter of public record and its distribution is not limited.

CONCLUSIONS

We found the HEPC does not have effective procedures in place to monitor grant agreement expenditures. Line item descriptions established within the program do not explicitly allow for the payment of bonuses. Budget reports prepared do not have sufficient detail to allow effective monitoring of program expenditures. Due to these issues, we could not assure ourselves staff bonuses were in compliance with applicable sections of the West Virginia Code and other governing criteria.

EXIT CONFERENCE

We discussed this report with management of the spending unit on June 5, 2009. All findings and recommendations were reviewed and discussed. Management's response has been included in italics at the end of each finding.

WEST VIRGINIA RURAL HEALTH EDUCATION PARTNERSHIPS PROGRAM

FUND LISTING

SPECIAL REVENUE FUNDS

I. 4925 - Higher Education Policy Commission-Lottery Education

ACT 036 - RHI PROGRAM AND SITE SUPPORT-DISTRICT CONSORTIA – To support the RHEP programs regional networks, or consortia, in carrying out the missions and goals of the program as defined by Code.

WEST VIRGINIA RURAL HEALTH EDUCATION PARTNERSHIPS PROGRAM

WORK PERFORMED BY OTHER AUDITORS

Informational Item 1: At the behest of the Higher Education Policy Commission [the Commission] the CPA firm *Suttle & Stalnaker* performed and issued a report on a set of agreed-upon procedures. The Agreed-Upon Procedures report is attached to this report as supplemental item #1.

Note: At this time, issues noted in the Agreed-Upon Procedures report are being researched by our legal staff and an opinion is forthcoming.

Spending Unit's Response: *The Higher Education Policy Commission (HEPC) agrees with the Suttle & Stalnaker report.*

Background

In 2007, the HEPC hired a CPA as financial analyst in its Health Sciences office to establish better oversight of the RHEP subgrants. At that time, the agency did not have a Vice Chancellor for Health Sciences. As the financial analyst developed and implemented new budgeting and reporting policies, it became clear that there was confusion among the RHEP administrative office, the consortia boards, the lead agencies, and the Rural Health Advisory Panel as to their authority and responsibilities for the program. The HEPC therefore commissioned the Suttle and Stalnaker report to document existing practices and to identify problems areas and suggest solutions. Their report has validated our concerns, and given us a roadmap for resolving the identified issues.

Moving Forward

The HEPC is committed to making the RHEP program more effective while maintaining community involvement and financial accountability. We will draw upon the guidance of four reports to accomplish this:

- *Dr. Michael Friedland's report on West Virginia's Medical Education and Training Programs. The report recommended that, in order to meet more rigorous accreditation standards, the state medical schools should have responsibility for all medical educational programs (i.e., rural training) within their geographic areas. The HEPC would have coordination and oversight responsibility at the state level.*

- *The Suttle & Stalnaker Agreed-Upon Procedures Report, which recommended three options for addressing the financial and legal issues in administering the RHEP program, while retaining local community input and participation.*

- *The study of the state's physician workforce and the practice location of medical school graduates conducted by Dr. Donald Pathman.*

- *The anticipated final report of the Legislative Post-Audit Division on the RHEP program.*

The Vice Chancellor for Health Sciences, who was appointed in August 2008, will establish a Task Force to plan for the administrative, structural, and statutory changes that will be necessary to ensure that RHEP fulfills its mission while providing an adequate degree of accountability. The Vice Chancellor will direct the Task Force to focus on Option 3 of the Suttle & Stalnaker report – management of RHEP funding at the state level – as this would be the most cost effective option.

Under Option 3, the HEPC would have responsibility for overseeing and coordinating policy. The HEPC would allocate RHEP funding to the medical and health sciences schools, which would in turn be responsible for the administration of these funds within their geographic regions. The HEPC will ensure that the schools implement the program appropriately and maintain a process for obtaining community input. This will take advantage of the organizational infrastructure already in place at the schools for managing personnel, purchasing, and travel, and for providing oversight to any subgrantees. The policies and procedures already in place at the schools will ensure adherence to state guidelines for managing state funds.

WEST VIRGINIA RURAL HEALTH EDUCATION PARTNERSHIPS PROGRAM

FINDINGS

Finding 1 **Bonuses Paid to Northern West Virginia Rural Health Education Center [NWVRHEC] Staff with No Fiscal Monitoring or Oversight.**

Condition: During our audit of the West Virginia Rural Health Education Partnerships [RHEP] program we learned staff of the NWVRHEC was paid bonuses from RHEP funds totaling $20,035.00 and $15,664.00 for fiscal years 2008 and 2007, respectively.

Documentation provided by Tri-County Health Clinic, the lead agency (or fiscal agent) for the NWVRHEC indicated 11 staff members received an annual bonus in amounts ranging from $1,000.00 to $4,200.00 in fiscal year 2008 and from $800.00 to $3,000.00 in fiscal year 2007.
Based upon documentation provided we noted the following:

- These bonuses are paid in addition to any salary increases given to the staff during the course of their employment.

- Employees 1, 2 and 3 in the chart below do not receive regular salary from state grant funds.

Tri-County Employee/NWVRHEC Staff	FY 2008	FY 2007
Employee 1	$ 4,200.00	$ 3,000.00
Employee 2	2,400.00	2,300.00
Employee 3	2,400.00	1,800.00
Employee 4	2,400.00	1,800.00
Employee 5	1,875.00	1,700.00
Employee 6	1,560.00	1,064.00
Employee 7	1,200.00	800.00
Employee 8	1,000.00	800.00
Employee 9	1,000.00	800.00
Employee 10	1,000.00	800.00
Employee 11	1,000.00	800.00
Totals	**$20,035.00**	**$15,664.00**

Tri-County administrative staff informed us they receive word near the end of each fiscal year from the Executive Director of the NWVRHEC authorizing the bonuses and listing the amount to be paid to each employee. They went on to say the Executive Director receives approval from the NWVRHEC board for all bonuses and any raises paid to RHEP staff.

The line items RHEP grant funds are budgeted for and categorized into upon expenditure allow for staff salary payments and employee benefits. Within the parameters of these definitions, no allowances for employee bonuses are provided.

Criteria:

The West Virginia Rural Health Education Partnerships (WVRHEP) Grant (Affiliation) Agreement Between The West Virginia Higher Education Policy Commission And Tri-County Health Clinic, Inc. a representative of the Northern WV Rural Health Education Consortium, section 7.3 states in part:

"Monitoring: The Commission has a responsibility to monitor activities as necessary to provide reasonable assurance that the Grantee uses these grant funds for intended purposes; complies with laws, regulations and the provisions of contracts and grant agreements; and achieves performance goals."

The West Virginia Rural Health Education Partnerships Project Budget – Line item Definitions For Policy 2006-01 RHEP Project Budget Addendum #1 states in part:

"**Salaries** (Lines 1-id) – Compensation paid to full-time, part-time, temporary or intermittent employees with payroll deductions. Itemize each position classification and total salary amount on lines la through 'Id. Insert the number of positions that make up the total in the # cell. Attach more sheets if necessary to itemi7e classifications. Grand total of all salaries should be inserted on Line 1.

Employee Benefits (Line 2) – Employee benefits is defined as social security matching, workers' compensation, pension and retirement contributions, insurance or any other benefit *normally paid by the employer* as a direct cost of employment."

Cause:

The CFO for Tri-County informed us the clinic entrusts final authority for expenditures to the judgment of the Executive Director of the NWVRHEC and pays all expenses he approves despite Tri-County being the responsible party named in the grant agreement with the Higher Education Policy Commission [the Commission]. The grant agreements require the grantee, in this case Tri-County, to spend RHEP grant funds in line with the mission and goals of the RHEP program. Additionally, the Commission is required to monitor the grant activities to "provide reasonable assurance that the Grantee uses these grant funds for intended purposes."

Effect: Considering the bonuses are paid near the end of the fiscal year and may not be paid if no money is left, the risk exists for the NWVRHEC to cease making some expenditures necessary to the program to ensure bonuses will be funded. Additionally, as Tri-County does not assess the relevance of the expenses encumbered by the NWVRHEC to the program's mission and goals and the Commission does not adequately monitor RHEP grant agreements, we cannot assure ourselves all grant funds expended meet the guidelines set forth in West Virginia Code. The NWVRHEC received RHEP grant funds during our audit period totaling $1,671,593.00. The Commission issued $5,833,621.36 in RHEP grant funds state-wide during the same period.

Recommendation: We recommend the Higher Education Policy Commission comply with the monitoring requirements of the RHEP program grant agreements and ensure all funds are spent in line with the mission and goals of the program as defined by West Virginia Code and the goals and scope defined within the various RHEP grant agreements.

Spending Unit's Response:

The Higher Education Policy Commission has not authorized the payment of bonuses to RHEP employees.

HEPC, rather than enlarging its own administrative staff to manage the RHEP program, delegated the management to the RHEP Administrative Office in Morgantown, which approves budgets and provides program guidance. Because the RHEP employees in the field are employees of their respective lead agencies, the personnel policies of the lead agency should apply to them.

We would expect salaries paid to RHEP employees to be in line with salaries paid by the lead agency to similarly qualified people doing similar work. We were not aware until recently that bonuses were paid, and have therefore not addressed that issue specifically. However, since the lead agencies are nonprofit corporations, we believe that bonuses would not be routine, and would not be an allowable expenditure.

The HEPC has not interfered with the personnel policies of the lead agency with respect to salaries, benefits, pay raises, or leave. However, we would expect employees working with the RHEP program to receive no special treatment, and would anticipate their raises to be given within the framework of the lead agency's organization-wide salary structure.

WEST VIRGINIA RURAL HEALTH EDUCATION PARTNERSHIPS PROGRAM

SUPPLEMENTAL INFORMATION ITEM #1
ATTACHED: *SUTTLE & STALNAKER* AGREED-UPON PROCEDURES REPORT

WEST VIRGINIA
HIGHER EDUCATION POLICY COMMISSION
RHEP/AHEC ADMINISTRATION OFFICE

AGREED-UPON PROCEDURES REPORT

Suttle & Stalnaker
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT ACCOUNTANTS' REPORT
ON APPLYING AGREED-UPON PROCEDURES

West Virginia Higher Education Policy Commission
RHEP/AHEC Administration Office
Charleston, West Virginia

We have performed the procedures enumerated below, which were agreed to by the West Virginia Higher Education Policy Commission (Commission) and the RHEP/AHEC Administration Office (collectively referred to as the "specified parties") solely to assist you with respect to your analysis of the organizational structure of the West Virginia Rural health Education Partnership (RHEP) program. A flowchart of the current infrastructure prepared by the West Virginia Higher Education Policy Commission Office of Health Sciences is included in Appendix A. The sufficiency of these procedures is solely the responsibility of those parties specified in the report. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

The procedures performed are as follows:

Procedures Performed:

1. Reviewed WV Code Section 18B-16 regarding the establishment of the rural health initiative and other relevant documents provided by the specified users or other key stakeholders.

2. Reviewed and summarized the current rural health initiative structure including the flow of funds, organizational structures, grant award processes, role of the consortium, role of the lead agencies, and the role of both RHEP/AHEC Administrative Office and the Commission.

3. Conducted interviews of the key stakeholders and representatives, as identified by the specified users to discuss the current structure and issues with the current structure.

4. Reviewed a typical grant award document and budget form.

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5. Reviewed contracts between each lead agency and the consortium or other entity operating as a fiscal agent.

6. Reviewed a sample of audit reports for appropriate disclosure and reporting of the RHEP program.

Following are the results of our procedures:

Summary of Selected West Virginia Code Sections

In response to concerns that medical schools were not adequately serving the State's needs in regard to providing needed training and clinical experience in rural areas of the State, the legislature passed "The Rural Health Initiative Act of 1991" which was amended in 1995. The legislation provided for the combining of the Kellogg Community Partnerships Initiative funded by the W. K. Kellogg Foundation with the State's Rural Health Initiative.

Code Section 18B-16-4 established a rural health initiative under the auspices of the board of trustees (of the now West Virginia Higher Education Policy Commission), and under the direction and administration of the vice chancellor. (Throughout this report, any West Virginia Code references to the board of trustees will be replaced by Commission.) Among the 15 specifically stated goals are the following:

- The development of at least six primary health care education sites, defined in Section 18B-16-3 as "rural health care facilities established for the provision of education and clinical experiences." Rural health care facilities are defined as "nonprofit, free standing primary care clinics or medically underserved or health professional shortage areas and nonprofit rural hospitals with one hundred or less licensed acute beds."

- The establishment of satellite programs from the health care education sites to provide additional opportunities for students and medical residents to serve under role models in rural areas;

- The provision of training to all medical students under the direction of primary care physicians practicing in rural areas;

- The creation of medical residency rotations in hospitals and clinics in rural areas and the provision of incentives to medical residents to accept the residencies at these hospitals and clinics;

- The development of innovative programs which enhance student interest in rural health opportunities;

- The increased use of underserved areas of the state in the educational process;

- The establishment of primary health care education sites which complement existing community health care resources and which do not relocate the fundamental responsibility for health care from the community to the Commission.

Code Section 18B-16-5 specifically charges the vice chancellor with several powers and duties related to this program, including the following:

- Provide assistance to communities in planning an educational and clinical component for the health care education sites;

- Coordinate and approve the provision of faculty members, students, interns and residents at the education sites;

- Report directly to the Commission regarding the rural health initiative;

- Coordinate the rural health initiative with the allied health care education programs within the state college system;

- Prepare the budget for the rural health initiative and submit the budget to the Commission for their approval:

- Distribute the funds which were appropriated to the Commission and the secretary of the department of education and the arts, by the Legislature, for the rural health initiative.

Code Section 18B-16-6 created the West Virginia rural health advisory panel (Advisory Panel), appointed by the governor after consulting with the vice chancellor. The composition of the advisory panel includes representatives from the various stakeholders in the rural health initiative, including "one community representative from each of the *consortia* (emphasis added) of primary health care education sites." The guidance in the code regarding the function of the panel includes:

- The functions and the duties of the panel are to recommend policies and procedures to the vice chancellor related to the rural health initiative and to oversee and coordinate the implementation of those policies and procedures.

- The Advisory Panel has the power and the duty to recommend rural health care facilities to be established as primary health care education sites. Such recommendation shall be made to the vice chancellor…(and) shall include an estimation of the costs to be allocated per site from the available funds…designated for rural health initiative site support.

- The Advisory Panel shall adopt guidelines regarding the application by rural health care facilities for selection as primary health care education sites and shall approve an application form which provides the panel with sufficient information to consider the criteria set forth in…this article.

- The Advisory Panel shall provide an ongoing evaluation of the rural health initiative and shall make the reports required by the code.

- A Committee on recruitment and retention was established within the Advisory Panel whose members are appointed by the Vice Chancellor. This committee's responsibilities include working cooperatively with health care agencies and economic development agencies of the State in conjunction with the Vice Chancellor and the director of the office of community and rural health services to facilitate statewide and interagency coordination of the recruitment and retention of primary care physicians and other health related care providers to serve the State of West Virginia.

Code Section 18B-16-7 provided guidance regarding the establishment and operation of the primary health care education sites and their satellites, including the following:

- The Commission is authorized and directed to establish at least six primary health care education sites at existing rural health care facilities…;

- The advisory panel and the vice chancellor shall carefully analyze prospective sites so that the selection of the primary health care education sites and their satellites meet the ultimate goals of expanding rural health care without adversely impacting on existing health providers or facilities;

- The advisory panel and the vice chancellor shall employ an open and competitive process in selecting locations for primary health care education sites…;

- The vice chancellor shall select the primary health care education sites from the list of recommendations made by the advisory panel…;

- The Commission may enter into a contractual relationship with each primary health care education site, which shall be in accordance with such laws as may apply to publicly funded partnerships with private, nonprofit entities…

Code Section 18B-16-8 provides specific guidance regarding the process to be followed by the vice chancellor regarding how appropriations should be allocated, and how any additional financial support should be handled.

Code Section 18B-16-9 provides accountability guidance, specifying that the vice chancellor, with the assistance of the Advisory Panel, shall report in detail to the Commission on the expenditure and planned expenditure of public funds. Both the Advisory Panel and the vice chancellor are required to report at least annually to the joint legislative oversight commission on education accountability.

West Virginia Rural Health Education Partnership Structure

State Level - The West Virginia State Code summarized above provides a broad outline of the goals and structure of the Rural Health Initiative program, which is known as the West Virginia Rural Health Education Partnership (RHEP). However, the language in the Code creates some basic ambiguities regarding the specific roles of the Advisory Panel and the vice chancellor. It appears that the Advisory Panel was intended to be essentially an advisory body to assist the vice chancellor in implementing the program. However, duties such as oversight and coordination of the implementation of policies and procedures; adopting guidelines for and approving application forms; and having specific responsibilities regarding reporting on expenditures and planned expenditures appear to take on certain aspects of governance responsibilities. In some respects this overlapping of duties and responsibilities appears to have been deliberate in order to encourage collaboration and inclusion of all the significant stakeholders.

However, over the years, it appears that the Advisory Panel's advisory role has evolved to more of a governance role. This may have evolved in part due to the fact that the vice chancellor position was vacant for several years. For instance, Code section 18B-16-4 specifies the establishment of a rural health initiative under the auspices of the Commission and under the direction and administration of the vice chancellor. Code section 18B-16-6 specifies that the functions and duties of the Advisory Panel are to recommend policies and procedures to the vice chancellor related to the rural health initiative and to oversee and coordinate implementation of those policies and procedures. The Code does not specifically address the Commission's/vice chancellor's ability to accept or reject the Advisory Panel's recommendations or to adopt policies that may not have been recommended by the Advisory Panel, but that the vice chancellor believes may be necessary to properly administer the program and effectuate the provisions of the Code. If the Advisory Panel's role was intended to be primarily advisory, then the Commission/vice chancellor would be able to adopt those policies and procedures deemed appropriate taking into account the recommendation of the Advisory Panel. If the Advisory Panel was intended to be a governance body, then the Commission would not have the freedom to implement policies and procedures without the Advisory Panel's recommendation.

It would appear to be unusual and perhaps unreasonable to charge the Commission/vice chancellor with being responsible for the program, but not giving them the freedom to adopt the policies and procedures they deemed necessary to administer the program, even if those policies and procedures may not have been recommended by the Advisory Panel. It seems that the Advisory Panel's role if they disagreed with the adopted policies and procedures would be to include such disagreement in their ongoing evaluation of the rural health initiative and reports required by the Code.

This kind of ambiguity can cause inefficiencies in administering the program. If there are differing interpretations of the roles of the Advisory Panel versus the Commission/vice chancellor, a legal opinion should be obtained to clarify the roles.

RHEP/AHEC Administrative Office -The day to day operations of the statewide RHEP program are managed by the West Virginia Rural Health Education Partnership Administrative Office (RHEP/AHEC Administrative Office). This West Virginia University (WVU) office also manages several other programs, including the Area Health Education Center (AHEC) federal grant program, a program that is administered in a manner similar to the RHEP program. The executive director of the RHEP/AHEC Administrative Office reports to the vice chancellor for matters related to the RHEP program, receives governance guidance for the RHEP program from the Advisory Panel, and reports to the WVU Vice President for Health Sciences for matters related to the WVU Health Sciences Center, including the AHEC program. There is no formal contractual agreement or memorandum of understanding between the Commission, who has responsibility for the RHEP program according to the Code, and WVU to spell out the authority and responsibility of the RHEP/AHEC Administrative Office.

Primary health education site level - The basic ambiguity in the legislation also appeared to create some difficulties in implementing the program at the primary health care education site level. The composition of the West Virginia Rural Health Advisory Panel includes representatives from each of the *consortia* (emphasis added) of primary health care education sites. However, the term *consortia* is not otherwise used in the applicable code section, and other references in the code to primary health care education sites appear to refer to existing nonprofit healthcare entities.

In the current structure and administration of the program as outlined in the flow chart in Appendix A, the term *primary health care education site,* a term defined in the Code, is not commonly used. Currently there are nine consortia boards who work with a corresponding nine lead agencies. The roles of the consortia boards and the lead agencies have evolved differently in the various arrangements. Five of the consortia boards are unincorporated advisory boards to the lead agency. Four are governing boards, two of which are incorporated as 501(c)(3) nonprofit organizations. The other two governing boards are not incorporated. Some of the consortia boards have sub-consortia boards from specific areas within their service areas. The nine lead agencies are the fiscal agents for the programs. With the exception of the 2008 agreement between WVU Research Corp. (a lead agency) and the Southern Board (consortia board) no formal comprehensive memorandum of understanding has been established between the lead agencies and the consortia boards which outline the powers and responsibilities of the parties. In all cases the grant agreements are with the lead agencies. In some instances, the lead agency has one or more representatives on the corresponding consortia board. The extent to which the consortia boards act in a governing capacity varies from board to board. Funding levels for 2008 and 2009 were approximately $2.4 million.

It may be appropriate to make a distinction between the term "consortia" and "consortia boards." The single reference in the Code is in Section 18B-16-6, which defines the composition of the Advisory Panel, which is to include representatives from each of the *consortia* of primary health care education sites. Primary health education sites are defined as "rural health care facilities established for the provision of education and clinical experiences." Rural health care facilities are defined as "nonprofit, free standing primary care clinics or medically underserved or health professional shortage areas and nonprofit rural hospitals with one hundred or less licensed acute beds."

The first two stated goals of the rural health initiative listed in Code section 18B-16-4 are "(a) The development of at least six primary health care education sites; [and] (b) The establishment of satellite programs from the primary health education sites to provide additional opportunities for students and medical residents to serve under role models in rural areas." In this context it seems that the consortia may most appropriately refer to the networks of independent entities and individuals (known as preceptors) in the service area of the primary health care education site that act as the satellite programs to provide training to the students during the rural rotation at their individual work sites. As such, the consortia may include rural health clinics, rural hospitals, private physicians, dentists, pharmacies, public health departments, home service agencies, mental health centers, schools, other health care organizations and community agencies.

The consortia boards appear to be acting in the capacity of managing/coordinating activity among these consortia networks, the students, and the medical schools. They also, to varying degrees, manage the employees carrying out the RHEP program and oversee the expenditure of grant funds.

My discussions with various individuals involved in the program revealed differing ideas of what the actual structure was, and differing opinions regarding the role of the consortia boards versus the role of the lead agency. This confusion was also apparent in a nationwide 2001 study prepared by Rebecca Miller, MPH, Elisa Weiss, Ph.D. and Roz Barker, M.D. from the Center for the Advancement of Collaborative Strategies in Health, Division of Health, New York Academy of Medicine, which reported the following in regards to the West Virginia program:

- Most of the partnership [site] coordinators reported that their partnership's legal status is "an organization created by government such as a commission, public authority or council." The other type of legal status mentioned by the partnership [site] coordinators is a "non profit organization such as a 501(c)(3) or a community foundation."

The study also reported a high level of perceived synergy and effectiveness in carrying out the program. My discussions with current site coordinators and others also echoed those feelings.

West Virginia Area Health Education Centers

Although not covered by the RHI legislation, another program runs parallel to the RHEP program and is administered by the RHEP/AHEC Administrative Office. In 2001, the West Virginia University Health Sciences Center received a federal Basic/Core Health Education Center (AHEC) grant to establish a statewide health education program complementary to RHEP. The intent was to expand the state's rural programs to include graduate medical education, interdisciplinary community projects, and continuing medical education. A goal associated with the program was to develop a strategy to maximize resources and meld federal, state and local resources. West Virginia University originally established five AHECs, three of which were directly affiliated with the three state medical schools. In 2009, two of the medical schools and their respective AHEC Centers were no longer eligible for Basic/Core funding under the AHEC program, and these schools elected to not seek federal funds to support their activities and used state funds only to continue these activities. One of the medical schools may re-enter the federal AHEC program in 2010.

RHEP and AHEC share a common mission of serving the health care needs of underserved areas and populations, improving the distribution of primary care physicians, and linking health professions education with community recruitment and retention. However, while the RHEP program's rural rotations are a degree requirement, participation in the AHEC interdisciplinary team sessions is voluntary. Only the RHEP program is overseen by the West Virginia Higher Education Policy Commission. The AHEC program is overseen by West Virginia University. Community level funding is administered through grant agreements to each RHEP and AHEC site. The AHEC and RHEP consortia (boards) cover different service area and each has its own site coordinator. The only exception is the Northern consortia board, which has an integrated RHEP/AHEC board and service area. Funding levels for AHEC in 2008 were approximately $1.3 million, of which approximately $1.15 was federal funding.

Analysis

The structure of the program appears to have been a contributing factor in successfully engaging the community in the program and creating synergy among its various stakeholders. However, from the standpoint of our background in auditing numerous governmental and non profit organizations, we believe there are a number of issues.

Status of the Consortia Boards - It appears to be clear in the law that the vice chancellor has responsibility for the program under the auspices of the Commission. Also the Advisory Panel was set up with certain specific responsibilities, but primarily to act in an advisory capacity to the vice chancellor. The consortia boards, however, are not specifically authorized or established by the code; therefore we do not believe they could be considered "organizations created by government such as a commission, public authority or council." Consequently, we are unclear as to the legal standing of the consortia boards to actually be responsible for making programmatic and fiscal decisions regarding the grant funds and believe that the consortia board members may be unknowingly exposing themselves to unanticipated risks. We recommend that legal counsel be consulted if the current structure is going to be maintained.

Status of Lead Agencies - It is not clear what the law intended with regards to the structure of the primary health care education sites. We believe that the most likely interpretation of the term would refer to an existing rural health physical facility that could also provide training, including clinical experience. Under the current structure, this would essentially correspond to the lead agencies. The lead agencies are in fact the recipients of the grant agreements, however not all lead agencies are rural health care facilities. Specifically, one is a university research corporation.

Absence of clear lines of authority and responsibility - The current structure as outlined in Appendix A and described above appears to attempt to maximize community involvement and penetration though the conscious use of a model that shares responsibility for administering the program. The fact that the program is perceived by those involved in running the program to have been successful in carrying out its mission and achieving its goals is a testament to the ability of the various stakeholders to forge ways to work together for the common good. An evaluation of the programmatic success of the program was not within the scope of this report; therefore we are not in a position to comment on the actual performance and results.

At the State level there is ambiguity regarding the roles of the Advisory Panel and the Commission/vice chancellor. Also, the RHEP/AHEC Administrative Office reports in some manner to the Commission, to the Advisory Panel, and to WVU. While multiple reporting lines of authority create inefficiencies in most instances, the more significant risk is that the inefficiencies become ineffectiveness if there are significant differences in goals or styles of the various parties. Effective communication could also be affected by the distance between the Commission offices and the RHEP/AHEC Administrative Office, requiring additional effort to ensure that communication remains active and effective.

At the community level, the lead agencies that are the grant recipients take on responsibilities that generally are much more than simply writing checks at the direction of the consortia board. It is our experience that when one entity has fiscal responsibility and another entity has programmatic or governing responsibilities for the program, a number of difficulties arise since lines of authority and responsibility get blurred. It is our understanding that a number of such issues have arisen over the years, including the following.

Spending decision accountability - First and foremost is the question of the degree to which the lead agency or the consortia board will be held responsible for the spending decisions of the consortia if it were determined at a later date that funds were improperly spent. Grantors look to the named grantee for reimbursement of fund spent inappropriately. In this case, even if the consortia was determined to be responsible for inappropriate spending, since the consortia have no separate funds, the lead agency would likely be asked to pay the money back for improper expenditures.

Conversely, a lead agency might be having fiscal difficulties and cash flow problems. In this scenario, the lead agency might utilize program cash received in advance, but not yet expended for program purposes. When this type of situation occurs it is often to pay for very pressing needs such as payroll taxes. The consortia board might find that there are no funds available to meet their fiscal commitments even though they have not approved the inappropriate expenditures.

Under either scenario, we would be concerned that consortia board volunteers could end up having to defend themselves personally or be asked to personally reimburse costs of improperly spent funds, etc. We understand that the Commission has consulted with the West Virginia Board of Risk & Insurance Management, however, complete clarification of coverage cannot be determined in the absence of specific facts related to possible claims. Insurance is a complex area and individuals often believe that they have coverage but discover they may not when it is too late. Both the lead agencies and the consortia boards should review their insurance policies with knowledgeable professionals to ensure that appropriate coverage is in place. In addition, if the current structure is maintained, a comprehensive memorandum of understanding between the consortia boards and the lead agencies should be developed in conjunction with each party's legal counsel.

Personnel policies - The personnel that carry out the program are lead agency employees. As such, any liability associated with normal employment will likely be borne by the lead agency. If the policies and benefit programs followed for RHEP programs differ from those followed for other employees, the agency could be vulnerable to a variety of personnel related actions. We have been informed that most of the lead agencies and consortia boards have worked to resolve these issues, but lead agencies may want to consult with an experienced labor lawyer to ensure that related risks are appropriately mitigated.

Another personnel related issue could arise if an RHEP funded employee were assigned other responsibilities not related to the RHEP program, but an appropriate cost allocation plan is not utilized to allocate the costs.

Property and Equipment Purchases - Some of the consortia boards/lead agencies have acquired real property and/or equipment with program funds. Both federal and state grants generally include requirements that govern the acquisition and disposition of such assets when they are no longer in use by the program. The Commission has subsequently issued policies regarding the acquisition and disposition of property and equipment in order to address this issue going forward. Even though this issue has been addressed moving forward, the ultimate disposition of property and equipment previously acquired with RHEP funds remains unresolved, particularly in the case of real estate titled in a lead agency's name.

Since the RHEP program began, both federal and state grant management and accountability laws, such as West Virginia State Code Section 12-4-14 and Single Audit Act Amendments of 1996 and subsequent related guidance. However it does not appear that the RHEP structure has evolved consistent with such practices.

Recommendations regarding structure

We believe that the existing structure's lack of easy understandability and potential for issues arising from the lack of clarity regarding lines of authority and levels of responsibility have the potential to create significant issues. We recommend that the structure follow the funding responsibility. The legal organization that receives the funding should be responsible for carrying out the program in accordance with the law and the grant agreement, as applicable, and be accountable for the decisions made. This could be achieved under the following three scenarios, each of which would retain the local community input and participation.

Scenario 1 - Grants continue to be made to lead agencies - Under this scenario, the lead agencies would be recognized as the primary health education sites and responsible at the community level for carrying out the program including managing the consortia network of individual preceptors and training providers in their service area. RHEP employees would be employees of the lead agency receiving the grant and would report to management of the lead agency. The current local consortia boards could easily be continued as community advisory boards. The grant agreements could even include provisions regarding the use and composition of the community advisory boards. This should minimize potential exposure to individual consortia board members, while still providing for input into finding effective ways to carry out the program objectives, and feedback regarding the success or lack thereof of program initiatives. Repayment of disallowed costs would be the responsibility of the lead agency.

Scenario 2 - Grants be made directly to the local consortia boards - Under this scenario the current consortia boards would become fully responsible for carrying out all aspects of the program at the community level. The issue of whether the consortia boards would qualify as a primary health education site would need to be addressed, since it does not appear that they currently meet the Code definition, and the Code specifically authorizes the Commission to enter into contractual relationship with each primary health care education site. The consortia boards should formalize their individual structure as incorporated non profit entities classified under section 501(c)(3) of the Internal Revenue Code. Each consortia board would need to hire the employees necessary to carry out programmatic and administrative functions, including the procurement of appropriate facilities, and establish appropriate policies and procedures. They could also enter into a comprehensive management contract with another entity to manage the program for them. This scenario would formalize program control at the community level by the consortia boards. A drawback to this scenario is a lack of an existing infrastructure within the consortia boards. Since the current boards do not all have individuals experienced in managing formal non profit organizations, additional board members familiar and knowledgeable about non-profit governance matters and reporting would need to be recruited. Formalizing each local consortia board, including obtaining section 501(c)(3) status could take a significant amount of time. Also, the cost to set up and run an entity designed to administer a single relatively small program could exceed the benefit. Finally, absent other funding streams for these entities, there would be no funds available to repay any disallowed costs.

Scenario 3 - Manage funds directly from state level - Under this scenario, the Commission or an other State agency would be directly responsible for carrying out the program. RHEP program personnel would become employees of the Commission or other State agency, and the lead agency's administrative/fiscal function would not be needed. The Commission or other agency could still enter into contracts with the lead agencies, which would be formally designated as the primary health education sites, and the consortia networks of individual preceptors and training providers would be maintained. In the absence of a change in the Code designating an agency other then the Commission to administer the program, a comprehensive memorandum of understanding would need to be developed between the Commission and the other agency. This would reduce the local formal infrastructure needed to run the program, thus having the advantage of a potentially more streamlined decision making process. Less infrastructure should also result in cost savings. The local consortia boards could still be maintained as community advisory boards, thus minimizing exposure to individual consortia board members. A challenge in this scenario would be to retain the feeling of full community integration in the process so that it does not feel like a program run from Charleston without the active input from and co-operation with the community stakeholders.

State Level -At the State level, additional clarification is needed regarding the role of the Advisory Panel and the Commission. This could be effected by a legal opinion clarifying the duties and responsibilities of the respective parties. Similarly, the role of the RHEP/AHEC Administrative Office, which is not specified in Code, should either be clarified though a comprehensive memorandum of understanding or consideration should be given to establishing a separate RHEP administrative office depending on an evaluation of the relative costs to do so, and the impact on the programmatic synergies that may exist by having the RHEP and AHEC programs administered from the same office.

Reporting by lead agency grantees of the RHEP programs

The lack of clarity regarding the structure also created difficulties in the proper accounting and disclosure in the audited financial statements of the grantee (lead) agencies that received the grant funds. The lead agency incurs the audit; however, in most instances no footnote disclosure existed explaining the relationship with the consortia board. Depending on the interpretation of the arrangement, RHEP program funds would be considered revenue to that lead agency and grant activity would be included with revenues and expenses in the lead agency's statement of activities. However, the grant could be treated as funds held on behalf of others if it was interpreted that the consortia board was responsible for the program and the lead agency was performing solely an administrative check issuance function. In this case no revenues or expenses would be reported in the lead agency's statement of activities. Only the funds remaining on hand at the end of the year would be reported in the statement of net assets. Footnote disclosure of the arrangement should be included if the funds were material to the lead agency. Therefore requesting the lead agencies to include a supplemental schedule of the grant activity with their audited financial statements is appropriate and has in fact been the practice. However, over the years, the specific supplemental schedule reporting required for the RHEP program has varied. That format did not always include accounting for funds received in prior years that were still unspent by the program. As a result, the RHEP grant schedules did not necessarily disclose any related excess funds being retained by the lead agency, which sometimes have involved significant amounts of money, and there was a risk of losing accountability for those funds. At the end of the 2007 fiscal year, the Commission required that any unspent lead agency funds be returned to the appropriate Commission account for future allocation since the funds do not expire. Also effective with the 2008 fiscal year, a standardized supplemental financial schedule was developed that should adequately address the reporting issue going forward.

With the passage of Senate Bill 4006 (Code §12-4-14) in 2005, specific guidelines were established regarding reporting requirements for entities receiving State funds or grants. We recommend that any reporting requirements by the grantees should be consistent with the law and related legislative rule. The reporting implemented in fiscal 2008 appears to be consistent with those requirements.

Conclusion

Based on our analysis of the West Virginia Code, review of numerous documents related the RHEP program, and discussions with individuals involved in various levels and functions within the program, it appears that various parties remain confused about lines of authority and about possible exposures. We believe the adoption of one of the scenarios listed above and other recommendations will significantly alleviate the confusion, enable efficiencies to be achieved in administering the program and reduce exposures, particularly to the consortia board members and lead agencies. The recommendations included in this report are intended to address certain structural issues within the current Code language. Some of those issues could also be addressed by changes in the Code to clarify the legislature's intent, or consideration could be given to a basic rewrite which would improve clarity and help ensure that the Code is aligned with the current needs of the program.

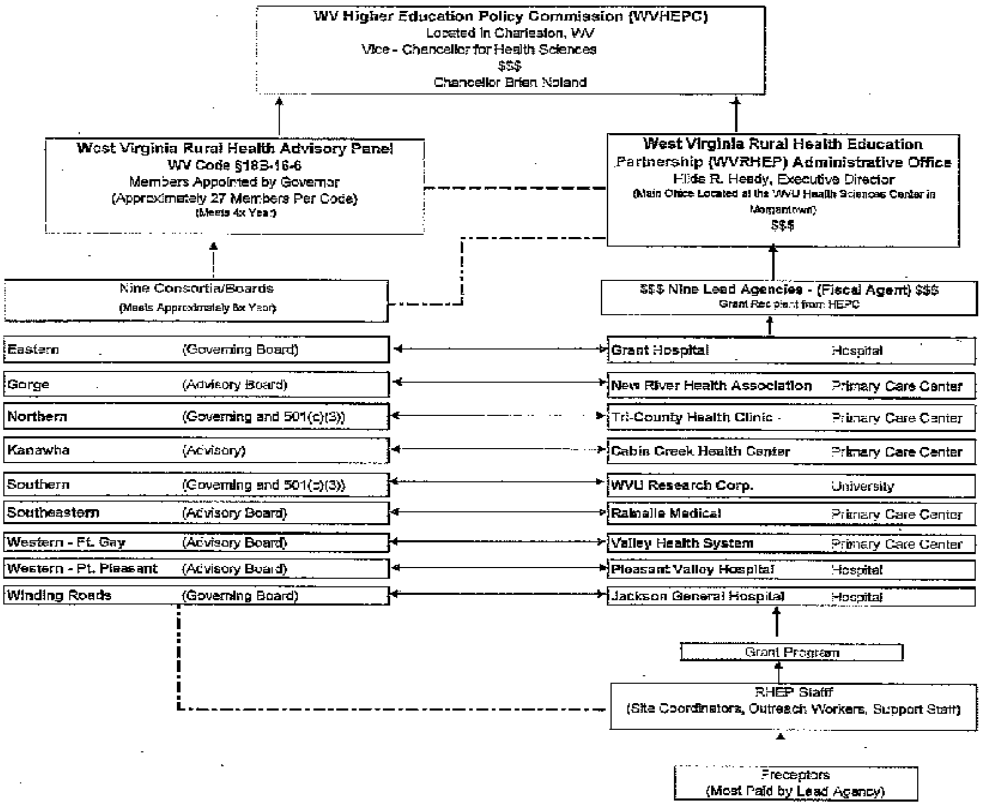
* * * * *

This report is intended solely for the information and use of the specified parties listed above and is not intended to be and should not be used by anyone other than those specified parties.

Suttle & Stalnaker, PLLC
Charleston, West Virginia
April 29, 2009

APPENDIX A

West Virginia Rural Health Education Partnership (WVRHEP)
Organization and Flowchart
As of FY 2008



Detailed Description:

WVRHEP - The WVRHEP program is a product of the Rural Health Initiative per Senate Bill 161 (Passage 03/09/95). In 1995, the Legislature directed the the State Rural Health Initiative program and the Kellogg Community Partnerships Initiative be merged into a single statewide program that became known as the West Virginia Rural Health Education Program under the direction of the Vice - Chancellor for Health Sciences.

WVHEPC - Per WV Code §18B-16-5, the Vice – Chancellor for Health Sciences is responsible for the oversight of the Rural Health Initiative including the West Virginia Rural Health Advisory Panel.

WVRHEP Administrative Office - This office is located at the Office of Rural Health in the WVU Health Sciences Center within the Vice President's Office. This office is responsible for the day to day operations of the WVRHEP program on behalf of the WVHEPC. The Office of Rural Health also houses other functions that relate to WVRHEP including the federal Area Health Education Centers Grant, the WVU Residency Placement Service, the SEARCH student and resident stipend program, and the WV Childhood Oral Health grant. This state level office has staff located in Morgantown, Charleston, and Raleigh. Hilda R. Heady reports to the Chancellor of HEPC in her role as the Executive Director of WVRHEP and reports to the Vice President for Health Sciences related to her other duties.

Consortia - Made up of Nine (9) Boards with up to twelve (12) Members per each Board. Boards may be Governing or Advisory - and two have elected to become 501(c)(3)'s. The Boards do not have direct access to funds (WVRHEP grant). The board is the oversight body that guides the community partnership and network of preceptors - including collaboratively overseeing the WVRHEP grant program with the lead agency.

Lead Agency - This is the entity that receives the WVRHEP grant from HEPC and acts in a "fiscal agent like" capacity to the Consortium. However, the lead agency is responsible for the grant funds and has direct responsibility to ensure the grant program is run appropriately. The WVRHEP staff are employees of the lead agency and most have a direct supervisor at the lead agency as well as report to their Consortium Board. None of the grant funds transfer directly to the Consortia Boards for administration.

Preceptors - Doctors or other health professionals that provide training to the student during the rural rotation at their workplace. Rural preceptors have adjunct clinical appointments at one or more of the health sciences schools. These individuals are in direct clinical practice and also provide training to the students. Most are not paid but some receive an annual honorarium for their services. Typically, they are not an employee of the lead agency.

$$$ - Administers state funds originating within WV HEPC (Fund 4925, Activity 038,037,038).

STATE OF WEST VIRGINIA

OFFICE OF THE LEGISLATIVE AUDITOR, TO WIT:

I, Stacy L. Sneed, CPA, CICA, Director of the Legislative Post Audit Division, do hereby certify that the report appended hereto was made under my direction and supervision, under the provisions of the West Virginia Code, Chapter 4, Article 2, as amended, and that the same is a true and correct copy of said report.

Given under my hand this 16th day of June 2009.

Stacy L. Sneed, CPA, CICA, Director
Legislative Post Audit Division

Copy forwarded to the Secretary of the Department of Administration to be filed as a public record. Copies forwarded to the Higher Education Policy Commission; Office of the State Treasurer; Governor; Attorney General; and State Auditor.