The auditor should not consider the Supplement to be “safe harbor” for identifying audit procedures to apply in a particular engagement, but the auditor should be prepared to justify departures from the suggested procedures. The auditor can consider the supplement a “safe harbor” for identification of compliance requirements to be tested if the auditor performs reasonable procedures to ensure that the requirements in the Supplement are current.

The grantor agency may elect to review audit working papers to determine that audit tests are adequate. Auditors may request documentation of monitoring visits by the State Agencies.

I. PROGRAM OBJECTIVES

The Preventive Health and Health Services Block Grant (PHHSBG), funded by the CDC, is used to support clinical services, preventive screening, laboratory support, outbreak control, workforce training, public education, data surveillance, and program evaluation targeting such health
problems as cardiovascular disease, cancer, diabetes, emergency medical services, injury and violence prevention, infectious disease, environmental health, community fluoridation, and sex offenses. Because of the variance in the allowable uses of the funds, no two states allocate their Block Grant resources in the same way, and no two states provide similar amounts of funding to the same program or activities. A strong emphasis is placed on adolescents, communities with little or poor health care services, and disadvantaged populations.

II. PROGRAM PROCEDURES

The Division of Public Health (DPH) uses PHHSBG funds to support a variety of community-based statewide initiatives to address these issues including programs administered through local health departments and their community partners. Community based programs in every county in the state promote policy and environmental changes that support increased physical activity, healthy eating, prevention of tobacco use, diabetes management and injury prevention. The funds are also used to support Oral Health, the North Carolina Stroke Care Collaborative, Rape Crisis and Victim Services and HIV/STD Prevention Activities.

The Healthy Communities Program through Physical Activity and Nutrition provides funding for county and district health departments to develop and implement community-based initiatives to create policies and environments that support increased physical activity, promote healthy eating, reduce obesity, prevent the use of tobacco, support diabetes self-management and prevent injuries. The long-term goal of the program is to increase the number of North Carolina communities with established community health promotion programs that address Healthy People 2020 objectives related to physical activity, healthy eating, tobacco use, diabetes management and injury prevention.

The NC Oral Health Program’s goal is to eliminate disparities in oral health by using best practices to: (1) reduce oral diseases through prevention, education, and health promotion; (2) ensure that evidence-based systems are implemented to monitor the public's oral health; (3) ensure access to dental care; and (4) provide professional education.

The goal of the State Laboratory is to continue to provide water fluoridation testing to ensure the proper levels of fluoride in the drinking water.

The goal of the Rape Crisis/Victims Services Program is to provide assistance and services to victims of rape and sexual assault. Services include crisis response including counseling and hotlines, victim assistance and community education programs on rape prevention. These services help to mitigate the long-term effects of sexual assault which include psychological trauma, suicidal thoughts, and gynecological complications.

The goal of the North Carolina Stroke Care Collaborative (NCSCC) is to close the gaps in care received by stroke patients by continuing a registry that monitors the quality of acute stroke care in NC and to assist hospitals in developing quality improvement initiatives.

The goal of the HIV/STD Prevention Program is to reduce the rates of transmissions of HIV and Sexually Transmitted Diseases (STDs), particularly among at-risk groups including African-Americans, intravenous drug users, and men who have sex with men.

The goal of the State Center for Health Statistics is to continue to provide data and surveillance on the morbidity and mortality rates for all of the programs funded for this grant.

III. COMPLIANCE REQUIREMENTS

A. ACTIVITIES ALLOWED OR UNALLOWED
PHHSBG dollars are used to support existing programs, implement new programs, and respond to unexpected emergencies. The PHHSBG contributes to the following activities:

- Developing performance standards for local boards of health to establish consistent rules for governing the practice and performance of local health departments.
- Supporting the creation of intervention strategies to improve individual lifestyle behaviors regarding nutrition, physical activity, diabetes, and cardiovascular disease.
- Providing support for communities to develop and review health assessments.
- Supporting the review and evaluation of Behavioral Risk Factor Surveillance System data within states to monitor health status and develop health media campaigns to increase awareness for healthier living.
- Providing support to Governor’s councils on Physical Fitness and Sports campaigns and health events.
- Implementing walking trails and walking programs.
- Establishing data and surveillance systems to monitor health status and track the leading health indicators.
- Providing child safety seats and inspections at check sites for proper installation.
- Providing bicycle helmets.
- Training emergency medical service providers.
- Providing funding support for screening services to people for hypertension, cholesterol, diabetes, cancers, and infectious diseases for underserved and uninsured populations.
- Fluoridating of community water systems.

B. ALLOWABLE COSTS/COST PRINCIPLES

The North Carolina Department of Health and Human Services has adopted federal OMB Circular A-87 as its standard for determining allowable costs. Any subrecipients of PHHSBG funds, herein to be called “Grantees”, funded under the PHHSBG are responsible for ensuring that all costs included in this proposal to establish billing or final indirect cost rates are allowable in accordance with the requirements of the Federal award(s) to which they apply and 2 CPR Part 225, Cost Principles for State, Local, and Indian Tribal Governments (OMB Circular A-87). The recipient also has a responsibility to ensure sub-recipients expend funds in compliance with federal laws and regulations. Furthermore, it is the responsibility of the recipient to ensure rent is a legitimate direct cost line item which the recipient has supported in current and/or prior projects and these same costs have been treated as indirect costs that have not been claimed as direct costs. If rent is claimed as direct cost, the recipient must provide a narrative justification which describes their prescribed policy to include the effective date to the assigned Grants Management Specialist.

C. CASH MANAGEMENT

Non-State Grantees submit monthly Contract Expenditure Reports (CERs) due no later than 10 days after the end of the month for which they are submitted. Even if no funds have been expended, these monthly requests are mandatory (in such case all entries will be zeroes). Monthly payment shall be made based on actual expenditures in accordance with the approved budget on file with both parties. If the contractor needs to make any changes to the contracted budget, the contractor must submit a written budget redirection request to the
IVPB and obtain approval for the change. The budget redirection request and written approval shall be filed by the contractor with the executed contract.

If the Grantee does not submit reports, CERs, or other requested materials on time, they will be reminded in writing of the specific requirements of their contract and offered assistance. If they continue to be delinquent, they will be notified in writing that CERs will no longer be processed for payment until their performance comes into compliance with their contract.

The Division will have no obligation for payments based on expenditure reports submitted later than 30 days after termination or expiration of the contract period.

D. DAVIS-BACON ACT

N/A

E. ELIGIBILITY

The PHHSBG funds all 50 states, 2 American Indian tribes, 8 U.S. territories and the District of Columbia to address their own public health needs and challenges with innovative and community driven methods. PHHSBG Grantees must use Healthy People 2020 objectives to address the unique health needs and funding gaps in their communities.

F. EQUIPMENT AND REAL PROPERTY MANAGEMENT

To the greatest extent practicable, all equipment and products purchased with CDC funds should be American-made. CDC defines equipment as tangible non-expendable personal property (including exempt property) charged directly to an award having a useful life of more than one year AND an acquisition cost of $5,000 or more per unit. However, consistent with recipient policy, a lower threshold may be established. The grantee may use its own property management standards and procedures provided it observes provisions of the following sections in the Office of Management and Budget (OMB) Circular A-110 and 45 CFR Part 92:

i. Office of Management and Budget (OMB) Circular A-110, Sections 31 through 37 provides the uniform administrative requirements for grants and agreements with institutions of higher education, hospitals, and other non-profit organizations. For additional information, please review the following website: http://www.whitehouse.gov/omb/circulars/a110/a110.html

ii. 45 CFR Parts 92.31 and 92.32 provides the uniform administrative requirements for grants and cooperative agreements to state, local and tribal governments. For additional information, please review the following website listed: http://www.access.gpo.gov/nara/cfr/waisidx_03/45cfr92_03.html.

Purchase of necessary equipment is allowed by grantees: Requests greater than $500 require pre-approval. Requests for computer purchases also require pre-approval. Equipment purchased with funds belongs to DPH which may choose to reclaim it upon termination or completion of contract if the equipment will no longer be used in PHHSBG programs. DPH may offer an agency the option to purchase the equipment.

G. MATCHING, LEVEL OF EFFORT, EARMARKING

DPH agrees to maintain expenditures for such activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying to receive payments.
H. PERIOD OF AVAILABILITY OF FEDERAL FUNDS

The project period for the PHHSBG is October 1, 2013 – September 1, 2014. Throughout the project period, the CDC’s commitment to continuation of awards will be conditioned on the availability of funds, evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the federal government.

I. PROCUREMENT AND SUSPENSION AND DEBARMENT

Each non-State entities receiving federal pass through funds signs, as part of their contract, a “Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion.”

J. PROGRAM INCOME

Any program income generated by the DPH will be used in accordance with the additional cost alternative specified under the Cooperative Agreement. The disposition of program income must have written prior approval from the CDC’s Grants Management Officer. Additional Costs Alternative – Used for costs that are in addition to the allowable costs of the project for any purpose that further the objectives of the legislation under which the cooperative agreement was made. General program income subject to this alternative shall be reported on the FFR, as appropriate. For Local Health Department Grantees, fees for services provided to the public from this funding are allowed, subject to the following requirements:

Statutory Authority: 15A NCAC 16A.0508: Local health departments are authorized to impose fees for services provided through the use of Healthy Communities funds per the Consolidated Agreement. Revenue generation from these fees must be used for the programs. The local health department can obtain schedule of fees imposed by the local health department. Procedures adjusting charges for income, resources, and family size and evaluate for adequacy must be set up. Selected fees charged are not to be imposed for services provided to persons unable to pay.

Statutory Authority: 15A NCAC 16A.0508: Local health departments must report fee collection proceeds to the program and fee collection proceeds may be expended by the local health department upon prior approval of the program. Fee collection proceeds may be used to reduce the program portion of the Agreement amount or to expand services according to a plan approved by the program. The amount of fees collected for services will be available by the local health department. Prior program approval should be obtained to expend fee collection proceeds.

K. REAL PROPERTY ACQUISITION AND RELOCATION ASSISTANCE

N/A

L. REPORTING

The performance report year activities are due to the CDC and Prevention on February 1st of each year. The report is to be submitted through the Block Grant Management Information System.

Statutory Authority: 15A NCAC 16A.0506: Local health departments must prepare activity reports as referenced in the Agreement Addendum.

Statutory Authority: 15 A NCAC 16A.0506: Local health departments are required to submit Expenditure Report, DHHS 2949 (Rev. 3/98) on a schedule set out in the consolidated Agreement between the parties.
M. SUBRECIPIENT MONITORING

Grantees are expected to show reasonable progress towards implementing strategies. The contractors are required to incorporate into their work the feedback/technical assistance received from DPH. Performance will be measured through a variety of means, including written reports; desk reviews of all documents received including monthly expenditure reports; telephone calls, and face-to-face interactions at the site visits. Grantees will be required to report on the planning, implementation, and evaluation of their activities, and other individualized needs.

On an annual basis the Healthy Communities Program assesses programmatic risk through a program review for all local health departments receiving Healthy Communities funds. Data is collected from active projects and used in program evaluation. The Office of Local Health Services is responsible for assessing fiscal risk status for local health departments.

N. SPECIAL TESTS AND PROVISIONS

1. BUDGET AMENDMENTS

**Compliance Requirement** – The grantee may amend the budget during the contract year with prior approval from DPH. However, the grantee may not exceed the total monetary limit as shown on and approved in the Contract Agreement.

**Audit Objective** – To determine that the budget approved by the State and the budget used by the Grantee are identical. To determine that line item expenditures reported on the Request for Reimbursement to the State have not exceeded approved line item budgeted amounts.

**Suggested Audit Procedures** – Compare, by line item, the Grantee program expenses with the final budget as approved by DPH. There should be verification that the reported expenditures are allowable and supported by sufficient documentation.

2. INDIRECT COST

**Compliance Requirement** – If budgeted, the Grantee may include indirect cost in PHHSBG. Indirect cost rates negotiated by the Grantee with the federal Department of Health and Human Services regional controller or other similar federal agency may be used to compute allowable indirect cost. Expenditures included, as indirect cost may not be duplicated elsewhere in the budget. A copy of the Negotiated Agreement must be included with the contract.

**Audit Objective** – The amount of indirect cost being charged to DPH may not exceed 10% of total project cost.

**Suggested Audit Procedures** – The indirect cost plan supporting the indirect cost reported to DPH should be reviewed to determine that cost included in the plan is allowable and equitably allocated. Any discrepancies should be disclosed in the audit as “questioned costs.”

3. CONFLICT OF INTEREST AND CERTIFICATION REGARDING NO OVERDUE TAXES

**Compliance Requirement** – All non-State entities (except those entities subject to the audit and other reporting requirements of the Local Government Commission) that receive, use or expend State funds (including federal funds passed through the N. C. Department of Health and Human Services) are subject to the financial reporting
requirements of G. S. 143C-6-23 for fiscal years beginning on or after July 1, 2007. These requirements include the submission of a Notarized Conflict of Interest Policy (see G. S. 143C-6-23(b)) and a written statement (if applicable) that the entity does not have any overdue tax debts as defined by G. S. 105-243.1 at the federal, State or local level (see G. S. 143C-6-23(c)). All non-State entities that provide State funding to a non-State entity (except any non-State entity subject to the audit and other reporting requirements of the Local Government Commission) must hold the sub grantees accountable for the legal and appropriate expenditure of those State grant funds.

**Consolidated Agreement System** – The DHHS Division of Public Health is made up of six major sections: Administrative, Local and Community Support, Chronic Disease and Injury Prevention, Epidemiology, Oral Health, Women’s and Children’s Health, and Legal and Regulatory Affairs. The Division utilizes a single written agreement to manage all funds, that is, State, federal or private grant funds, that the Division allocates to local health departments across the State. This document, as amended, is called the **Consolidated Agreement**.

The Agreement sets forth the more general requirements of the funding relationship between the state and local public health agencies. The respective requirements are detailed under the headings: Responsibilities of the Department (Local Public Health Unit); Funding Stipulations; Fiscal Control; Responsibilities of the State; and Compliance. More specific information related to program activity is set out in a document called the **Agreement Addenda** which detail outcome objectives (which may or may not be negotiable at the beginning of each fiscal year) that each health department must achieve in exchange for the funding. A third part of the system is the **Budgetary Authorization** which is sent annually from each of the Sections or Branches of the Division to all health departments being allocated funds from specific sources, i.e., State appropriations or other federal grant funds for specific activities. This Estimate indicates the amount of the allocated funds and their respective sources. Each health department should be able to provide an auditor with a copy of the Consolidated Agreement for the particular year being audited, as well as copies of the Budgetary Authorization and any revisions, Agreement Addenda, expenditure reports and any activity reports for each source of money received. If the health department cannot provide these documents, they may contact the DPH Budget Office for assistance.

**Suggested Audit Procedures** – The auditor should review Section B. FUNDING STIPULATIONS of the Consolidated Agreement before beginning an audit. The fourteen items of this Section describe much of the detailed information the auditor may be seeking during a review of these programs.