



May 20, 2010

**TO:** Yvette Roubideaux, M.D., M.P.H.  
Director  
Indian Health Service

**FROM:** /Joseph E. Vengrin/  
Deputy Inspector General for Audit Services

**SUBJECT:** Audit of the Indian Health Service Fiscal Year 2005 Cost Statement for the Navajo Area Office (A-07-08-02721)

The attached final report provides the results of our audit of the Indian Health Service cost statement for fiscal year 2005 for the Navajo area office.

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

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at [George.Reeb@oig.hhs.gov](mailto:George.Reeb@oig.hhs.gov). Please refer to report number A-07-08-02721 in all correspondence.

Attachment

cc:  
Marilyn Tavenner  
Acting Administrator and Chief Operating Officer  
Centers for Medicare & Medicaid Services

Department of Health & Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**AUDIT OF THE INDIAN HEALTH  
SERVICE FISCAL YEAR 2005  
COST STATEMENT FOR THE  
NAVAJO AREA OFFICE**



Daniel R. Levinson  
Inspector General

May 2010  
A-07-08-02721

# ***Office of Inspector General***

<http://oig.hhs.gov>

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## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

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

## EXECUTIVE SUMMARY

### BACKGROUND

The Indian Health Service (IHS), an agency in the U.S. Department of Health & Human Services, delivers clinical and preventive health services to American Indians and Alaska Natives. IHS provides care in more than 600 health care facilities, including hospitals and outpatient clinics. An IHS facility can be operated by IHS, an Indian tribe, or a tribal organization. IHS Headquarters (Headquarters) has overall responsibility for IHS programs, and 12 area offices located throughout the United States ensure that individual areas' health care needs are met.

Section 1880 of the Social Security Act (the Act) authorizes Medicare reimbursement to IHS hospitals and skilled nursing facilities. Section 1911 of the Act authorizes Medicaid reimbursement to all IHS providers for covered services. IHS providers use all-inclusive reimbursement rates to bill for certain Medicare and Medicaid services provided in IHS and tribal facilities. IHS develops these rates annually using financial and patient data from IHS and certain tribal hospitals. The financial data are obtained from the hospitals' Medicare cost reports, and the patient data are obtained from IHS's patient workload systems.

An IHS contractor prepares separate Medicare cost statements for Headquarters and most of the area offices. (IHS cost statements use obligations rather than costs because, according to IHS officials, IHS's accounting system was not designed to accumulate costs.) The Headquarters and area-office cost statements identify the portion of obligations from Headquarters and the area offices that is allowable under Medicare and allocable to IHS providers. Allowable Headquarters obligations are allocated to each area office. These obligations, combined with the area offices' own obligations, are then allocated among all IHS providers. Medicare cost statements are subject to the provisions of 42 CFR part 413 and the Medicare *Provider Reimbursement Manual*, parts I and II, which establish standards for, among other things, the allowability and allocability of costs.

IHS included approximately \$105.2 million of obligations in its fiscal year (FY) 2005 cost statement for the Navajo area office. Our audit covered approximately \$29.1 million of obligations that IHS reported in the cost statement as allocable to IHS providers.

### OBJECTIVE

Our objective was to determine whether selected obligations reported in the FY 2005 cost statement for the Navajo area office were allowable under Medicare requirements.

### SUMMARY OF FINDINGS

Of the \$29,065,369 in obligations that was reported in the FY 2005 cost statement for the Navajo area office and that we reviewed, \$2,534,597 was unallowable: \$2,523,122 for duplicate supply costs and \$11,475 for overstated depreciation costs. The cost statement also included \$4,763,573

for unsupported salaries, fringe benefits, and related obligations on which we could not express an opinion.

For the \$2,534,597 in unallowable costs:

- Contrary to Federal requirements, IHS overstated supply costs by \$2,523,122 in the FY 2005 cost statement. Specifically, IHS reported duplicated costs caused by an error in the cost statement calculations. This error occurred because IHS did not have adequate oversight of the cost statement creation process. IHS did not perform a detailed review of obligations; rather, it performed a comparative analysis from 1 year to the next, focusing on variances in obligations.
- Contrary to Federal requirements, IHS overstated equipment depreciation by \$11,475 in the FY 2005 cost statement. Specifically, IHS erroneously reported depreciation for some items that were already fully depreciated. IHS did not have adequate policies and procedures to determine when items were fully depreciated.

In addition, and contrary to Federal requirements, IHS did not properly support its allocation of \$4,763,573 for salaries, fringe benefits, and related obligations in the FY 2005 cost statement. IHS used unverifiable estimates to allocate obligations related to employees who worked on multiple activities. IHS did not have policies and procedures to ensure that its estimates were supported with cost information that was current, accurate, and in sufficient detail. Because IHS had no verifiable support for its estimates, we were unable to express an opinion on the \$4,763,573. The remaining \$21,767,199 of the \$29,065,369 in obligations that we reviewed was allowable.

## **RECOMMENDATIONS**

We recommend that IHS:

- adjust its next cost statement for the Navajo area office for \$2,534,597 of unallowable costs (\$2,523,122 of duplicate supply costs and \$11,475 of unallowable depreciation) that were reported in the FY 2005 cost statement;
- review the Navajo area office's cost statements before and after FY 2005 and adjust its next cost statement for duplicated costs caused by contractor errors in the cost statement calculations and for unallowable depreciation that was reported;
- strengthen its policies and procedures to ensure that depreciation is not reported for items that are fully depreciated;
- work with the Centers for Medicare & Medicaid Services to determine how much of the \$4,763,573 for salaries, fringe benefits, and related obligations reported in the Navajo area office's FY 2005 cost statement was allowable and adjust its next cost statement for obligations that are determined to be unallowable; and

- develop and implement policies and procedures to ensure that estimates used to allocate obligations in cost statements are supported with cost information that is current, accurate, and in sufficient detail.

## **AUDITEE COMMENTS**

In written comments on our draft report, IHS concurred with all of our recommendations but expressed concern about the feasibility of providing sufficient records before FY 2005. IHS also described corrective actions it planned to implement. IHS's written comments appear in their entirety as the Appendix.

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# INTRODUCTION

## BACKGROUND

### Indian Health Service

The Indian Health Service (IHS), an agency in the U.S. Department of Health & Human Services, delivers clinical and preventive health services to American Indians and Alaska Natives. IHS provides care in more than 600 health care facilities, including hospitals and outpatient clinics. An IHS facility can be operated by IHS, an Indian tribe, or a tribal organization.

IHS Headquarters (Headquarters) has overall responsibility for IHS programs. Twelve area offices located throughout the United States carry out the IHS mission by overseeing and administering programs that are designed to address individual areas' specific health care needs. Each area office provides regional support services to health care providers (e.g., hospitals, outpatient clinics, and community health centers) within its jurisdiction.

One of the 12 area offices is the Navajo area office in Window Rock, Arizona. This area office oversees the delivery of health care to approximately 239,000 Native Americans throughout the Navajo designated geographical area.

### Medicare and Medicaid Reimbursement

IHS health care facilities receive Federal reimbursement for certain Medicare and Medicaid services. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the Medicare and Medicaid programs. The Indian Health Care Improvement Act (IHCIA) of 1976 (P.L. No. 94-437) added section 1880 of the Social Security Act (the Act) to authorize reimbursement to IHS hospitals and skilled nursing facilities for services provided to Medicare-eligible individuals. Further, section 432 of the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program<sup>1</sup>] Benefits Improvement and Protection Act of 2000 (P.L. No. 106-554) and section 630 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. No. 108-173) amended section 1880 of the Act to authorize payments for Medicare Part B services provided in certain IHS hospitals. The IHCIA also added section 1911 of the Act to authorize Medicaid reimbursement to all IHS providers for covered services.

IHS providers use all-inclusive reimbursement rates to bill for certain Medicare and Medicaid services provided in IHS and tribal facilities. IHS develops these rates annually using financial and patient data from IHS and certain tribal hospitals. The financial data are obtained from the hospitals' Medicare cost reports, and the patient data are obtained from IHS's patient workload systems.

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<sup>1</sup> The program was renamed the Children's Health Insurance Program as of February 4, 2009.

IHS calculates one set of reimbursement rates for the lower 48 States and one set of rates for Alaska:<sup>2</sup>

- Medicare outpatient per-visit rate,
- Medicare Part B inpatient ancillary per diem rate,
- inpatient hospital per diem rate (excluding physician/practitioner services), and
- outpatient per-visit rate (excluding Medicare).<sup>3</sup>

### **Cost Statements for Headquarters and Area Offices**

IHS contracts with Eighteen Nineteen Group, Inc. (Eighteen Nineteen), to prepare separate cost statements for Headquarters and 10 of the 12 area offices, including the Navajo area office.<sup>4</sup> IHS cost statements use obligations rather than costs because, according to IHS officials, IHS's accounting system was not designed to accumulate costs. CMS and IHS agreed that IHS could use obligations instead of costs when preparing its cost statements.

The Headquarters and area-office cost statements identify the portion of obligations from Headquarters and the area offices that is allowable under Medicare and allocable to IHS providers. Allowable Headquarters obligations are allocated to the 12 area offices. These obligations, combined with the area offices' own obligations, are then allocated among all IHS providers. Headquarters and area office obligations that are allocated to IHS hospitals are included in each hospital's cost report. Errors in these cost reports can affect the calculation of the all-inclusive reimbursement rates described above.

Medicare cost statements are subject to the provisions of 42 CFR part 413 and the Medicare *Provider Reimbursement Manual* (the Manual), parts I and II, which establish standards for, among other things, the allowability and allocability of costs.

IHS included approximately \$105.2 million of obligations in its FY 2005 cost statement for the Navajo area office.

We reviewed the FY 2005 cost statement for the Navajo area office, the subject of this audit. Separate reports will address the FY 2005 cost statements for Headquarters (A-09-07-00054), the Phoenix area office (A-09-07-00086), and the Oklahoma City area office (A-06-07-00080).

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<sup>2</sup> The all-inclusive reimbursement rates developed by IHS using the fiscal year (FY) 2005 Medicare cost reports were finalized and used for reimbursement purposes in FY 2007.

<sup>3</sup> The inpatient hospital per diem and the outpatient per-visit rates are the encounter rates applicable to Medicaid services.

<sup>4</sup> Cost statements are not prepared for the California and Portland area offices because the areas for which they are responsible do not have any IHS hospitals.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether selected obligations reported in the FY 2005 cost statement for the Navajo area office were allowable under Medicare requirements.

### **Scope**

IHS included approximately \$105.2 million of obligations in its FY 2005 cost statement for the Navajo area office. Our audit covered approximately \$29.1 million of obligations that IHS reported in the cost statement as allocable to IHS providers in the Navajo area and to other areas.

We did not perform a detailed review of IHS's internal controls. We limited our review to obtaining an understanding of IHS's (including the Navajo area office's) and Eighteen Nineteen's policies and procedures related to the accounting, accumulation, and reporting of obligations. We performed our fieldwork at the Navajo area office in Window Rock, Arizona.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed the explanatory notes for the cost statement;
- reviewed IHS's reclassifications and adjustments of obligations, including salaries, fringe benefits, and related obligations;
- reviewed a judgmental sample of obligations, including depreciation, supplies, and training;
- reviewed the method that IHS used to allocate the Navajo area office's obligations to IHS providers in the Navajo area and to other areas; and
- interviewed Navajo area office and Eighteen Nineteen 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 objective.

## **FINDINGS AND RECOMMENDATIONS**

Of the \$29,065,369 in obligations that was reported in the FY 2005 cost statement for the Navajo area office and that we reviewed, \$2,534,597 was unallowable: \$2,523,122 for duplicate supply costs and \$11,475 for overstated depreciation costs. The cost statement also included \$4,763,573 for unsupported salaries, fringe benefits, and related obligations on which we could not express an opinion. The remaining \$21,767,199 of the \$29,065,369 in obligations that we reviewed was allowable.

### **DUPLICATE COSTS ADDED TO THE AREA OFFICE COST STATEMENT**

Federal requirements (the Manual, part I, § 2304) state: “Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to beneficiaries.”

IHS overstated supply costs by \$2,523,122 in the FY 2005 cost statement because it reported duplicated costs caused by an error in the cost statement calculations. In an adjustment to the cost statement, Eighteen Nineteen added costs that had already been included in the Navajo area obligations.

The Navajo area office includes in its cost statement obligations incurred by the Gallup Regional Supply Service Center (Supply Center) for providing supplies, typically drugs, to IHS and tribal service units.<sup>5</sup> Although the Supply Center is located within the Navajo area, the service units it supplies are located both within and outside that area. Through the allocation of the Navajo area office’s obligations in its cost statement, the total obligations incurred in operating the Supply Center are also allocated among all service units that receive supplies, including those outside the Navajo area. When a service unit within the Navajo area purchases supplies, the related obligations appear in the Navajo area obligations used to create the area office cost statement. However, because service units outside of the Navajo area operate on a different accounting system, their obligations relating to supplies received from the Supply Center do not appear in the Navajo area obligations used to create the cost statement. To properly identify these obligations, the Navajo area office’s standard cost statement procedures called for Eighteen Nineteen to add to the cost statement, through an adjustment, those obligations incurred on behalf of service units outside the Navajo area. Without such an adjustment, the total obligations incurred in operating the Supply Center could not be accurately allocated to the appropriate service units.

While calculating the adjustment, Eighteen Nineteen inadvertently listed the Winslow service unit (Winslow) as a non-Navajo area service unit and included Winslow’s supply obligations in the adjustment. Because Winslow is a service unit within the IHS Navajo area, its obligations for supplies were already included in the Navajo area obligations. During our fieldwork, Eighteen Nineteen notified us of this error in the adjustment, which affected several years’ cost statements, and made necessary corrections in all relevant documentation.

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<sup>5</sup> The term “service unit” applies to any location, such as a hospital, clinic, or doctor’s office, where medical services are performed.

This error occurred because IHS did not adequately oversee the cost statement creation process. IHS did not perform a detailed review of obligations; rather, it performed a comparative analysis from 1 year to the next, focusing on variances in obligations.

## **OVERSTATED DEPRECIATION**

Federal regulations (42 CFR § 413.20) require that “providers maintain sufficient financial records and statistical data for proper determination of costs” and that cost statements be submitted “on an annual basis with reporting periods based on the provider’s accounting year.” CMS reiterated these requirements in the Manual. The Manual, part I, section 2304, states that cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services provided to beneficiaries. In addition, part II, section 102, states: “For cost reporting purposes, Medicare requires submission of annual reports covering a 12-month period of operations based upon the provider’s accounting year.”

Federal regulations (42 CFR § 413.134(a)) also state that depreciation on equipment used in the provision of patient care is an allowable cost. Among other requirements, the depreciation must be based on the historical cost of the asset and prorated over the estimated useful life of the asset. Further, 42 CFR § 413.144(b) states that if an asset has become fully depreciated under Medicare, further depreciation is not appropriate or allowable, even though the asset may continue in use.

The Manual, part I, section 116, paragraph A, states that regardless of the method of depreciation being used, an asset should not be depreciated below its salvage value.<sup>6</sup>

Contrary to Federal requirements, IHS reported \$11,475 for depreciation on some equipment items that were fully depreciated. Consequently, the items were depreciated below their salvage value.<sup>7</sup> Rather than calculating a partial year’s depreciation for items that were purchased during the year, IHS calculated a full year’s depreciation in the first and last years of the items’ useful lives without regard to when the items were purchased. IHS reported the additional depreciation because it did not have adequate policies and procedures to determine when items were fully depreciated.

## **ALLOCATIONS BASED ON UNVERIFIABLE ESTIMATES**

Federal regulations state that the cost principles were developed to ensure that costs are reported according to actual use of services. The regulations (42 CFR § 413.5(a)) state: “[T]he share of the total institutional cost that is borne by the [Medicare] program is related to the care furnished beneficiaries so that no part of their cost would need to be borne by other patients. Conversely, costs attributable to other patients of the institution are not to be borne by the program.”

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<sup>6</sup> Salvage value is the estimated amount expected to be realized upon the sale or other disposition of the depreciable asset when it is no longer useful to the provider.

<sup>7</sup> IHS sets the salvage value for its equipment at zero.

Federal regulations (42 CFR § 413.5(b)) also explain that one objective of the principles of reimbursement is “[t]hat there be a division of the allowable costs between the beneficiaries of this program [Medicare] and the other patients of the provider that takes account of the actual use of services by the beneficiaries of this program and that is fair to each provider individually.”

CMS reiterated this principle in section 2200.1 of part I of the Manual: “Principle of Cost Apportionment—Total allowable costs of a provider are apportioned between [Medicare] program beneficiaries and other patients so that the share borne by the program is based upon actual services received by program beneficiaries.”

Furthermore, Federal regulations (42 CFR § 413.24(a)) state: “Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors.” In addition, 42 CFR § 413.24(c) states: “The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.”

The Manual, part I, section 2304, states that cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services provided to beneficiaries.

Contrary to Federal regulations and the Manual, IHS did not properly support its allocation of \$4,763,573 for salaries, fringe benefits, and related obligations reported in the FY 2005 cost statement. Specifically, IHS used unverifiable estimates to allocate obligations related to employees who worked on multiple activities:

- IHS reported \$3,214,623 for Diabetes Program employees who provided administrative support for the prevention and treatment of diabetes throughout the Navajo area, including patient-related clinical oversight. The Diabetes Program director estimated that her staff spent 60 percent of its time on Medicare-reimbursable activities. We could not verify the estimates using the documentation that IHS provided.
- IHS reported \$1,548,950 for Office of Environmental Health and Engineering employees who performed patient-related occupational health and safety activities. The director of the Office of Environmental Health and Engineering estimated that his staff spent 60 percent of its time on Medicare-reimbursable activities. We could not verify the estimates using the documentation that IHS provided.

These deficiencies occurred because IHS did not have policies and procedures to ensure that its estimates were supported with cost information that was current, accurate, and in sufficient detail. Because IHS had no verifiable support for its estimates, we were unable to express an opinion on the \$4,763,573.

## **RECOMMENDATIONS**

We recommend that IHS:

- adjust its next cost statement for the Navajo area office for \$2,534,597 of unallowable costs (\$2,523,122 of duplicate supply costs and \$11,475 of unallowable depreciation) that were reported in the FY 2005 cost statement;
- review the Navajo area office's cost statements before and after FY 2005 and adjust its next cost statement for duplicated costs caused by contractor errors in the cost statement calculations and for unallowable depreciation that was reported;
- strengthen its policies and procedures to ensure that depreciation is not reported for items that are fully depreciated;
- work with CMS to determine how much of the \$4,763,573 for salaries, fringe benefits, and related obligations reported in the Navajo area office's FY 2005 cost statement was allowable and adjust its next cost statement for obligations that are determined to be unallowable; and
- develop and implement policies and procedures to ensure that estimates used to allocate obligations in cost statements are supported with cost information that is current, accurate, and in sufficient detail.

## **AUDITEE COMMENTS**

In written comments on our draft report, IHS concurred with all of our recommendations but expressed concern about the feasibility of providing sufficient records before FY 2005. IHS also described corrective actions it planned to implement. IHS's written comments appear in their entirety as the Appendix.

# **APPENDIX**

## APPENDIX: AUDITEE COMMENTS



DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Public Health Service

Indian Health Service  
Rockville MD 20852

MAR 9 0 2010

TO: Inspector General

FROM: Director

SUBJECT: Response to Office of Inspector General Draft Report "Audit of the Indian Health Service Fiscal Year 2005 Cost Statement for the Navajo Area Office (A-07-08-02721)," issued November 27, 2009

The Indian Health Service (IHS) reviewed the Department of Health and Human Service's Office of Inspector General (OIG) draft report "Audit of the IHS Fiscal Year (FY) 2005 Cost Statement for the Navajo Area Office (A-07-08-02721)." The following responses to each recommendation include any corrective actions that have been implemented.

*OIG Recommendation: "Indian Health Service adjust its next cost statement for the Navajo Area Office for \$2,534,597 of unallowable costs (\$2,523,122 of duplicate supply costs and \$11,475 of unallowable depreciation) that were reported in the FY 2005 cost statement."*

IHS Response: Concur. The details in the audit report appear to support the findings, and the recommendation appears reasonable. We agree IHS should adjust as recommended in its next Medicare cost statement for the Navajo Area Office.

*OIG Recommendation: "The IHS review the Navajo Area Office's cost statements before and after FY 2005 and adjust its next cost statement for duplicated costs caused by contractor errors in the cost statement calculations and for unallowable depreciation that was reported."*

IHS Response: Concur. The recommendation appears reasonable, although it is unclear which Navajo Area Office Medicare cost statements issued prior to FY 2005 should be reviewed. In addition, we note that given records management requirements, and the systems in place prior to FY 2005, it may not be feasible for the Area Office to provide records sufficient to support a review of Medicare cost statements issued prior to FY 2005.

We agree that IHS should review the Navajo Area Office's Medicare cost statements issued after FY 2005 and adjust its next Medicare cost statement for any identified duplicated costs caused by contractor errors in the cost statement calculations and for any identified unallowable depreciation, if such adjustments were not already made after the FY 2005 Medicare cost statement.

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*OIG Recommendation: "The IHS strengthen its policies and procedures to ensure that depreciation is not reported for items that are fully depreciated."*

IHS Response: Concur. The details in the audit report support the findings, and the recommendation appears reasonable. We agree IHS should adjust, as recommended, in its next Medicare cost statement for the Navajo Area Office.

*OIG Recommendation: "The IHS work with the Centers for Medicare and Medicaid Services to determine how much of the \$4,763,573 for salaries, fringe benefits, and related obligations reported in the Navajo Area Office's FY 2005 cost statement was allowable and adjust its next cost statement for obligations that are determined to be unallowable."*

IHS Response: Concur. Although FY 2005 Medicare cost statement work papers might not provide documentation of allowable costs, IHS's position based on interviews with staff is that the costs claimed are reasonable. However, the IHS contractor will require, on all future Medicare cost report statements, signed time estimates by appropriate staff to indicate all allowable and non-allowable cost allocations. These procedures will ensure availability of sufficient cost detail and will help ensure cost report accuracy.

*OIG Recommendation: "Develop and implement policies and procedures to ensure that estimates used to allocate obligations in cost statements are supported with cost information that is current, accurate, and in sufficient detail."*

IHS Response: Concur. The IHS contractor receives an official financial report/accounting data from the HHS Unified Financial Management System. This information from the facility, along with specific changes that would have affected cost during the year, is used to prepare cost reports in accordance with Medicare cost principles and regulations using a "Method E" format.

The IHS headquarters certifies the data for cost reports and each hospital signs off on the final cost report submitted to Centers for Medicare and Medicaid Services and/or the Medicare fiscal intermediary. These procedures provide sufficient detail and will help ensure cost report accuracy.

If you have any questions concerning IHS's response to OIG's report (A-07-08-02721), please contact Mr. Carl Harper, Director of the Office of Resource Access and Partnerships, at (301) 443-3216.



Yvette Roubideaux, M.D., M.P.H.