August 10, 2010

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

FROM: /George M. Reeb/
Acting Deputy Inspector General for Audit Services

SUBJECT: Audit of the Indian Health Service Fiscal Year 2005 Cost Statement for the Oklahoma City Area Office (A-06-07-00080)

The attached final report provides the results of our review of the Indian Health Service cost statement for fiscal year 2005 for the Oklahoma City 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.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Robert A. Vito, Acting Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Robert.Vito@oig.hhs.gov. We look forward to receiving your final management decision within 6 months. Please refer to report number A-06-07-00080 in all correspondence.

Attachment

cc:
Donald Berwick, M.D.
Administrator
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 OKLAHOMA CITY AREA OFFICE

Daniel R. Levinson
Inspector General

August 2010
A-06-07-00080

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.

IHS contracts with Eighteen Nineteen Group, Inc. (Eighteen Nineteen), to prepare 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 $130.5 million of obligations in its fiscal year (FY) 2005 cost statement for the Oklahoma City area office. Our audit covered approximately $14.7 million of obligations that IHS reported in the cost statement as allocable to IHS providers.

OBJECTIVE

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

SUMMARY OF FINDINGS

Of the $14,700,364 in obligations that was reported in the FY 2005 cost statement for the Oklahoma City area office that we reviewed, $14,010,472 was allowable. The remaining $689,892 in obligations that we reviewed consisted of $260,000 in unallowable obligations and

$429,892 in obligations that we have set aside: $285,889 in salaries and fringe benefits for two employees that was not properly allocated and $144,003 in unsupported depreciation costs.

Contrary to Federal requirements, IHS overstated its FY 2005 cost statement by $260,000 because it reported duplicate obligations of the National Supply Service Center (which manages the purchase and distribution of drugs and other medical supplies in all 12 IHS areas). This error occurred because IHS did not adequately oversee Eighteen Nineteen's cost statement preparation, specifically by not reviewing accounting entries made during the process.

For the $429,892 in obligations on which we express no opinion:

- Contrary to Federal requirements, IHS did not properly allocate two employees' salaries and fringe benefits. One employee estimated he spent time working on issues related to four area offices. The cost statement for one of the area offices was finalized before an adjustment could be made to add his salary and fringe benefits to that cost statement. Therefore, those costs remained on the Oklahoma City area office's cost statement. A portion of the second employee's salary and fringe benefits, also based on estimates, should have been allocated to a health facility where he provided direct services. Because IHS did not have verifiable support for the amount of time the employees worked at the other locations, we were unable to determine what portion of the $285,889 in salary and fringe benefits should have been included in the cost statement. IHS did not have policies and procedures to ensure that salaries and fringe benefits of employees working in other locations were allocated in a timely manner to the facilities based on information that was current, accurate, and in sufficient detail.

- Contrary to Federal requirements, IHS calculated depreciation using a depreciation schedule that did not include acquisition dates or accumulated depreciation amounts for 513 of 857 equipment items. As a result, we could not determine what portion of the $144,003 in depreciation costs claimed was allowable. IHS did not have adequate policies and procedures to ensure that depreciation was adequately supported by its accounting records.

The remaining $14,010,472 of the $14,700,364 in obligations that we reviewed was allowable.

RECOMMENDATIONS

We recommend that IHS:

- adjust its next cost statement for the Oklahoma City area office to correct the $260,000 of unallowable costs that was reported in the FY 2005 cost statement;

- improve its oversight of Eighteen Nineteen's cost statement preparation by reviewing accounting entries made during the process;

- work with the Centers for Medicare & Medicaid Services (CMS) to determine how much of the $285,889 in salaries and fringe benefits reported in the Oklahoma City area

office's FY 2005 cost statement was allocable and adjust its next cost statement for obligations determined to be unallocable;

- develop and implement policies and procedures to ensure that obligations are allocated in a timely manner to each area or facility receiving the benefit of the services provided and that such obligations are supported with cost information that is current, accurate, and in sufficient detail;

- work with CMS to determine how much of the $144,003 of depreciation costs reported in the Oklahoma City area office's FY 2005 cost statement was allowable and adjust its next cost statement for depreciation determined to be unallowable;

- review the Oklahoma City area office's cost statements after FY 2005 and adjust its next cost statement for unallowable depreciation costs that were reported; and

- develop and implement policies and procedures to ensure that depreciation records contain the necessary information to properly support depreciation costs.

INDIAN HEALTH SERVICE COMMENTS

In written comments on our draft report, IHS concurred with all of our findings and described corrective actions it has implemented or plans to implement.

Regarding the recommendation to work with CMS on the allocable salary amount, IHS indicated that after it filed the FY 2005 cost statement, it began preparing signed time estimates to support the allocation of employee/contractor salaries. IHS believes that this subsequent information supports the amounts allocated to the FY 2005 cost statement and that further discussion with CMS is not necessary. IHS also indicated that a review of depreciation costs before FY 2005 was not cost-justified. IHS's comments appear in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

We continue to recommend that IHS work with CMS to resolve the $285,889 for unsupported salaries and fringe benefits reported in the FY 2005 cost statement. After considering IHS's comments that performing reviews of depreciation costs before FY 2005 was not cost-justified, we changed the recommendation in the final report.

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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 twelve area offices is the Oklahoma City, Oklahoma, area office. This area office oversees the delivery of health care to more than 300,000 American Indians in Oklahoma, Kansas, and a portion of Texas. This area also includes the National Supply Service Center (NSSC). NSSC manages the purchase and distribution of drugs and other medical supplies to health care facilities in all 12 IHS areas.

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[1]] 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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[1] 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:[2]

- 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).[3]

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 Oklahoma City area office.[4] 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 $130.5 million of obligations in its FY 2005 cost statement for the Oklahoma City area office.

We reviewed the FY 2005 cost statement for the Oklahoma City area office, the subject of this audit. Separate reports will address the FY 2005 cost statements for Headquarters

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[2] 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.

[3] The inpatient hospital per diem and the outpatient per-visit rates are the encounter rates applicable to Medicaid services.

[4] 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.

(A-09-07-00054), the Phoenix area office (A-09-07-00086), and the Navajo area office (A-07-08-02721).

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

IHS included approximately $130.5 million of obligations in its FY 2005 cost statement for the Oklahoma City area office. Our audit covered approximately $14.7 million of obligations that IHS reported in the cost statement as allocable to IHS providers in the Oklahoma City 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 Oklahoma City 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 Oklahoma City area office in Oklahoma City, Oklahoma.

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 travel;
- reviewed the method that IHS used to allocate the Oklahoma City area office's obligations to IHS providers in the Oklahoma City area and to other areas; and
- interviewed officials from the Oklahoma City area office and Eighteen Nineteen.

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 $14,700,364 in obligations that was reported in the FY 2005 cost statement for the Oklahoma City area office that we reviewed, $14,010,472 was allowable. The remaining $689,892 in obligations that we reviewed consisted of $260,000 in unallowable obligations and $429,892 in obligations that we have set aside: $285,889 in salaries and fringe benefits that were not properly allocated and $144,003 in unsupported depreciation costs.

DUPLICATE OBLIGATIONS ADDED TO THE AREA OFFICE COST STATEMENT

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."

Federal requirements (the Manual, part I, section 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 its FY 2005 cost statement by $260,000 because it reported duplicate NSSC obligations. This error occurred because IHS did not adequately oversee Eighteen Nineteen's cost statement preparation. Specifically, it did not review accounting entries made during preparation of the cost statement.

ALLOCATION OF SALARIES AND FRINGE BENEFITS

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."

Federal regulations (42 CFR § 413.5(b)(3)) 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 allocate $285,889 for two employees' salaries and fringe benefits that were reported in the Oklahoma City area office cost statement. Specifically:

- IHS reported salary and fringe benefits for an employee in the Equal Employment Opportunity department who estimated he spent time working on issues related to four area offices as follows: 50 percent for the Navajo area office, 30 percent for the Oklahoma City area office, 15 percent for the Albuquerque area office, and 5 percent for the Nashville area office. The employee did not have verifiable records to support these estimates. Additionally the cost statement for the Navajo area office was finalized before an adjustment could be made to add his salary and fringe benefits to that cost statement. Therefore, the Navajo portion of this employee's salary and benefits remained on the Oklahoma City area office's cost statement. Because IHS did not have verifiable support for the amount of time this employee worked at other locations, we were unable to determine what portion of the $113,951 in total salary and fringe benefits for the employee should be included in the cost statement.

- IHS reported salary and fringe benefits for an employee in the Division of Dental Services who provided direct services at a health facility. IHS did not allocate part of the employee's salary and fringe benefit costs to the health facility. The employee estimated he worked 14 days at the facility but stated that the dates might not have been all-inclusive or exact. Because IHS did not have verifiable support for the amount of time this employee worked at the facility, we were unable to determine what portion of the $171,938 in salary and fringe benefits should have been included in the cost statement.

IHS did not have policies and procedures to ensure that salaries and fringe benefits of employees working in other locations were allocated in a timely manner to the facilities based on information that was current, accurate, and in sufficient detail.

DEPRECIATION NOT SUPPORTED

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.

The Manual, part 1, section 104.9, states that depreciation must be adequately supported by the provider's accounting records and that the depreciation records must include the assets' historical costs, dates of acquisition, estimated useful lives, accumulated depreciation, and other information.

The depreciation schedule IHS used to calculate depreciation was incomplete. Specifically, the schedule did not contain the acquisition dates or accumulated depreciation amounts for 513 of the 857 equipment items. Without data showing the acquisition dates of equipment or the amount of depreciation previously claimed, we could not determine whether the items were depreciated correctly. As a result, we could not determine what portion of the $144,003 in depreciation costs claimed for these 513 items was allowable. This deficiency occurred because IHS did not have adequate policies and procedures to ensure that depreciation was adequately supported by its accounting records.

RECOMMENDATIONS

We recommend that IHS:

- adjust its next cost statement for the Oklahoma City area office to correct the $260,000 of unallowable costs that was reported in the FY 2005 cost statement;

- improve its oversight of Eighteen Nineteen's cost statement preparation by reviewing accounting entries made during the process;

- work with CMS to determine how much of the $285,889 in salaries and fringe benefits reported in the Oklahoma City area office's FY 2005 cost statement was allocable and adjust its next cost statement for obligations determined to be unallocable;

- develop and implement policies and procedures to ensure that obligations are allocated in a timely manner to each area or facility receiving the benefit of the services provided and that such obligations are supported with cost information that is current, accurate, and in sufficient detail;

- work with CMS to determine how much of the $144,003 of depreciation costs reported in the Oklahoma City area office's FY 2005 cost statement was allowable and adjust its next cost statement for depreciation determined to be unallowable;

- review the Oklahoma City area office's cost statements after FY 2005 and adjust its next cost statement for unallowable depreciation costs that were reported; and

- develop and implement policies and procedures to ensure that depreciation records contain the necessary information to properly support depreciation costs.

INDIAN HEALTH SERVICE COMMENTS

In written comments on our draft report, IHS concurred with all of our findings and described corrective actions it has implemented or plans to implement.

Regarding the recommendation to work with CMS on the allocable salary amount, IHS indicated that after it filed the FY 2005 cost statement, it began preparing signed time estimates to support the allocation of employee/contractor salaries. IHS believes that this subsequent information supports the amounts allocated to the FY 2005 cost statement and that further discussion with CMS is not necessary.

IHS also indicated that a review of depreciation costs before FY 2005 was not cost-justified because it represented less than 1 percent of the total area office costs. IHS's comments appear in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

We continue to recommend that IHS work with CMS to resolve the $285,889 for unsupported salaries and fringe benefits reported in the FY 2005 cost statement. After considering IHS's comments that performing reviews of depreciation costs before FY 2005 was not cost-justified, we changed the recommendation in the final report.

APPENDIX

APPENDIX: INDIAN HEALTH SERVICE COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

JUN 18 2010

Indian Health Service
Rockvile MD 20852

TO: Inspector General

FROM: Director

SUBJECT: Response to the Office of Inspector General's "Audit of the Indian Health Service Fiscal Year 2005 Cost Statement for the Oklahoma City Area Office (A-06-07-00080)"

The purpose of this memorandum is to respond to your May 7, 2010, memorandum transmitting the Office of Inspector General (OIG) draft report providing the results of the OIG "Audit of the Indian Health Service Fiscal Year 2005 Cost Statement for the Oklahoma City Area Office (A-06-07-00080)." I appreciate the opportunity to address your recommendations.

OIG Recommendations:

(1) Adjust next cost statement for the Oklahoma City area office to correct the $260,000 of unallowable costs that was reported in the FY 2005 cost statement.

IHS Response:
We agree. The IHS will include a correction for the $260,000 Supply Center error when it submits the FY 2010 Medicare cost statement for the Oklahoma City Area Office.

(2) Improve oversight of Eighteen Nineteen's cost statement preparation by reviewing accounting entries made during the process.

IHS Response:
We will improve oversight of the Oklahoma City Area Office cost statement preparation. The IHS sends copies of cost statements to each site preparing them and reviews the cost statements with Area personnel during subsequent site visits. These reviews can reveal methodology or typographical errors. During meetings throughout the year with Area financial staff, we will emphasize the importance of such reviews.

We do wish to note, however, that due to the complexity of the cost allocation process, in which allowable IHS headquarters obligations are allocated to the Area offices, it is not feasible for IHS personnel to review each entry made by the Medicare contractor hired to supply cost statement expertise. The IHS has requested that the Medicare contractor perform additional review of accounting workpaper formulas to decrease the incidence of typographical-type errors.

(3) Work with CMS to determine how much of the $285,889 in salaries and fringe benefits reported in the Oklahoma City Area Office's FY 2005 cost statement was allocable and adjust its next cost statement for obligations determined to be unallocable.

IHS Response:
We agree. Since the Oklahoma City Area Office FY 2005 cost statement was filed, IHS cost statement work papers and back-up data include signed time estimates to support allocation of employee/contractor salaries. The subsequent cost statement work papers and back-up data support the amounts allocated on the FY 2005 report as reasonable, and as result, further discussion with CMS does not appear to be necessary.

(4) Develop and implement policies and procedures to ensure that obligations are allocated in a timely manner to each area or facility receiving the benefit of the services provided and to ensure that such obligations are supported with cost information that is current, accurate, and in sufficient detail.

IHS Response:
We agree. Since the Oklahoma City Area Office FY 2005 cost statement was filed, the home office cost statements have been filed timely using improved methods to ensure proper allocation costs to Area office and facility cost statements.

(5) Work with CMS to determine how much of the $144,003 of depreciation costs reported in the Oklahoma City area office's FY 2005 cost statement was allowable and adjust its next cost statement for depreciation determined to be unallowable.

IHS Response:
We agree. In FY 2007, the IHS reviewed the calculation of equipment depreciation using schedules that included all data elements necessary for tracking depreciation expense, and made corrections for FY 2005 and FY 2006 on the FY 2007 Oklahoma City Area Office cost statement. In view of the improved process and adjustments made, further discussion with CMS does not appear necessary.

(6) Review the Oklahoma City area office's cost statements before and after FY 2005 and adjust its next cost statement for unallowable depreciation costs that were reported.

IHS Response:
We agree. With the FY 2007 Oklahoma City Area Office cost statement, the IHS has already corrected the FY 2005 error as well as the FY 2006 depreciation amount. Based on the total amount of errors corrected on FY 2007 workpaper 6-4-3 ($161,809 and $142,874 for FY 2005 and FY 2006 respectively), a review of depreciation for periods prior to FY 2005 does not appear to be cost-justified. We note that the amount in error for FY 2005 is only 0.13 percent of the $123,344,411 Area Office total costs, of which only a portion is allocated to allowable costs.

(7) Develop and implement policies and procedures to ensure that depreciation records contain the necessary information to properly support depreciation costs.

IHS Response:
We agree. Since the Oklahoma City Area Office FY 2005 cost statement was filed, the IHS has improved the process for calculating depreciation expenses. This process now includes creating and maintaining schedules that include all of the data elements necessary for tracking depreciation expense.

Thank you for the opportunity to provide comments on OIG draft report "Audit of the Indian Health Service Fiscal Year 2005 Cost Statement for the Oklahoma City Area Office" (A-06-07-00080). If you have any questions concerning this response, please contact Mr. Michael D. Weahkee, Director of the Management Policy and Internal Control Staff, in the Office of Management Services, IHS, at (301) 443-2650.

Yvette Roubideaux

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