DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

Report Number: A-05-04-00081 September 15, 2006

Ms. Jeanne M. LaBrecque
Director, Office of Health Policy and Medicaid
Indiana Family and Social Services Administration
402 West Washington Street, Room W382
Indianapolis, Indiana 46204-2739

Dear Ms. LaBrecque:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Administrative Costs for Community Mental Health Centers in Indiana." A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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Please refer to report number A-05-04-00081 in all correspondence.

Sincerely,

Paul Swanson

Paul Swanson
Regional Inspector General
For Audit Services

Enclosures

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Regional Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF ADMINISTRATIVE COSTS FOR COMMUNITY MENTAL HEALTH CENTERS IN INDIANA

Daniel R. Levinson
Inspector General

SEPTEMBER 2006
A-05-04-00081

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Title XIX of the Social Security Act (the Act) established the Medicaid program to pay for the medical assistance costs of certain individuals and families with limited incomes and resources. Section 1905(a)(13) of the Act allows optional Medicaid coverage of "rehabilitative services," generally defined as medical or remedial services recommended by physicians or other licensed practitioners for the maximum reduction of physical or mental disability and to restore an individual to their highest functional level. Indiana elected to include this optional Medicaid coverage under a State program referred to as the Medicaid Rehabilitation Option (MRO).

Under the MRO program, community providers, including community mental health centers, provide mental health services and are separately reimbursed for Medicaid services and administrative costs. The administrative costs are funded under a unique provider arrangement whereby the non-Federal share consists of "certified expenditures" of public funds that are incurred by the providers without an associated direct payment of State funds. This funding arrangement, referred to as the Indiana Mental Health Funds Recovery Program (Recovery Program), pays the providers the calculated Federal share of the certified expenditures.

In accordance with Section 1903(a)(7) of the Act, Federal reimbursement is permitted for administrative costs necessary to properly and efficiently administer State Medicaid plans. The Federal Government generally reimburses the States at a matching rate of 50 percent. Administrative costs incurred in support of the State plan are subject to the cost principles contained in the Office of Management and Budget (OMB) Circular A-87.

Indiana Administrative Cost Reimbursement

The Indiana Family and Social Services Administration (State agency) uses a series of steps to calculate the Federal share of certified expenditures. A quarterly statewide time study establishes the amount of time expended by provider staff to perform Medicaid administrative activities and is used to allocate provider administrative costs to various activity groups within its claim. The allocated costs are reduced by applying provider Medicaid eligibility rates and applicable Federal reimbursement rates to the costs in these Medicaid eligible activity groups. Provider claims are consolidated into one claim for Federal reimbursement, which in fiscal year (FY) 2003 amounted to about $21 million. At the request of CMS, we reviewed the Recovery Program administrative claiming process associated with the State agency's Medicaid Rehabilitation Option.

OBJECTIVE

The objective was to determine whether Medicaid administrative costs incurred by community providers were claimed and paid in accordance with applicable State and Federal regulations.

SUMMARY OF FINDINGS

Based on our assessment of State agency claims oversight procedures and reviews at selected community mental health centers, Federal reimbursement for the Medicaid Recovery Program was overstated by $328,151. Our review of State agency oversight procedures disclosed $223,244 in unrecovered net overpayments identified by contracted auditors. This amount is offset by $44,590 of underclaimed costs due to contractor claims processing errors. Our review at three selected community mental health centers disclosed net overpayments of $149,497 for costs that were improperly claimed during FY 2003 due to flawed cost allocations, claiming errors, unallowable costs and an incomplete sampling universe. The State agency had not recovered most of the audit-identified overpayments because it mistakenly believed a two-year Federal payment and overpayment recovery limit had lapsed. In regard to overpayments identified at the three individually audited centers, provider oversight procedures were not adequate to ensure that claims were accurate and allowable.

We also noted that documentation supporting FY 2003 enhanced claims for administrative activities needing skilled medical expertise was insufficient. Because documentation requirements existing during the audit period were met, we are only recommending enhanced contract audit procedures to ensure that providers meet the State agency's improved documentation requirements in the future.

RECOMMENDATIONS

We recommend that the State agency:

- refund $223,244 to the Federal Government for net administrative cost overpayments made to various providers for periods prior to January 1, 2003 as identified during external audits,

- refund $104,907 to the Federal Government for additional net administrative cost overpayments identified during our audit,

- improve the accuracy of administrative cost reimbursement procedures by reconciling data between the providers and the claims processing contractor,

- require external auditors to review time study documentation and activity logs and notes to ensure that claimed administrative costs are properly supported by the providers, and

- emphasize that the providers develop internal review systems to ensure that claimed cost data is accurate and allowable.

STATE'S COMMENTS

Indiana agreed to repay the net Federal overpayments identified during State contracted provider audits covering periods prior to January 1, 2003 and has modified its procedures to refund all audit adjustments that identify Federal overpayments regardless of the time elapsed. Indiana also

agreed to refund $104,907 for additional net administrative cost overpayments that were identified during our audit and has implemented improvements to help eliminate future errors. In addition, the State agreed with our other procedural recommendations and has made further changes to improve the claiming process.

The State's comments are summarized in the report and are presented in their entirety as an appendix.

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INTRODUCTION

BACKGROUND

Title XIX of the Social Security Act (the Act) established the Medicaid Program to pay for the medical assistance costs of certain individuals and families with limited incomes and resources. Section 1905(a)(13) of the Act allows optional Medicaid coverage of "rehabilitative services," generally defined as medical or remedial services recommended by physicians or other licensed practitioners for the maximum reduction of physical or mental disability and to restore an individual to their highest functional level. Each State administers its Medicaid program in accordance with a State plan approved by the Centers for Medicare & Medicaid Services (CMS). Although a State has flexibility in designing its State plan and operating its Medicaid program, it must comply with broad Federal requirements.

In Indiana, the Indiana Family and Social Services Administration (the State agency) administers the Medicaid program and elected to include optional Medicaid coverage for "rehabilitative services" under its Medicaid Rehabilitation Option (MRO) program. Under the MRO program, community providers, including community mental health centers, provide mental health services and are separately reimbursed for Medicaid services and administrative costs. The administrative costs for these activities are funded under a unique provider arrangement whereby the non-Federal share consists of "certified expenditures" of public funds that are incurred by the providers without an associated direct matching payment of State funds. This funding arrangement, referred to as the Indiana Mental Health Funds Recovery Program (Recovery Program), results in direct Federal reimbursement for the calculated Federal share of the certified expenditures.

Section 1903(a)(7) of the Act permits reimbursement for the costs of Medicaid administrative activities necessary for the proper and efficient administration of the State plan. The Federal Government generally reimburses States for administrative costs at a matching rate of 50 percent. Administrative costs incurred in support of the State plan are subject to the cost principles contained in the Office of Management and Budget (OMB) Circular A-87.

Indiana Administrative Cost Reimbursement

Effective on October 1, 1999, CMS approved a State Plan Amendment (SPA) granting the State agency's Division of Mental Health and Addiction (Mental Health) responsibility for the operational oversight of Medicaid administrative cost reimbursement under the Recovery Program. Mental Health also has the authority to enter into contractual agreements with external entities to furnish services including claims processing and payment, time study sampling, technical support, and administrative cost audits of providers. In 2004, Mental Health issued State policies for administrative cost reimbursement in its "Indiana Mental Health Funds Recovery Program Manual." The manual provides detailed claiming instructions for participating providers.

To determine provider reimbursement for the Recovery Program, Mental Health uses a series of steps to calculate the Federal share of certified expenditures. A quarterly statewide time study

establishes the amount of time expended by provider staff to perform Medicaid administrative activities. The time study is the foundation for the Recovery Program administrative claim and proportionally allocates each provider's administrative costs to various activity groups within its claim. Some Medicaid eligible activity groups are subject to a proportional reduction based on the provider's Medicaid eligibility rate, while other activities, such as Medicaid outreach, are not subject to this reduction. Finally, the reported costs associated with each activity group are subject to Medicaid Federal share reimbursement at rates of zero, 50, or 75 percent. Activities requiring the use of skilled medical expertise that are performed by skilled professional medical personnel (SPMP) are eligible for the enhanced 75 percent reimbursement rate. Other allowable Medicaid activities are reimbursed at 50 percent, while ineligible activities are not reimbursed. Ultimately, the Federal reimbursement becomes a portion, usually between about five and ten percent, of the provider's overall administrative costs.

As a part of the claiming methodology, each participating provider is responsible for certifying that i) reported costs are accurate, eligible, and unrelated to other Federal funding and ii) sufficient State and local dollars were expended to support the claim. The claimed amounts for all Recovery Program providers are consolidated into one claim for Federal reimbursement. For Federal fiscal year (FY) 2003, 41 community mental health center providers received Federal reimbursement of about $21 million.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective was to determine whether Medicaid administrative costs incurred by community providers were claimed and paid in accordance with applicable State and Federal regulations.

Scope

At the request of CMS, we evaluated the State agency's current oversight procedures for provider claims under its Medicaid Recovery Program and selected 3 of the 41 community mental health centers for on-site reviews of administrative cost reimbursements for FY 2003 (Center A, Center B, and Center C). For FY 2003, the three centers received about $4.8 million of the $21 million in Federal reimbursement received by the 41 centers.

We limited our review of internal controls to understanding the State agency's and contractor's policies and procedures for claiming administrative costs incurred by the providers. Specifically, we reviewed the general policies and procedures that (1) the providers followed in reporting administrative costs and (2) the State agency used to calculate the providers' claims for Federal reimbursement. Except as reported, we did not evaluate the overall effectiveness of controls at the State agency or contractor levels. We did not evaluate internal controls at the community mental health centers. In addition, we did not evaluate procedures used to support the certification of public expenditures or the distribution of provider reimbursement.

We performed fieldwork at the offices of the State agency and at two community mental health centers in Indianapolis, Indiana and at one in Terre Haute, Indiana.

Methodology

To accomplish our audit objective, we evaluated current administrative oversight and claiming methods and procedures at both the State agency and contractor levels. In addition, we reconciled FY 2003 documentation, retained by the State agency to support the reimbursed Federal share for each participating provider, to the CMS-64 quarterly Medicaid expense report. At the selected community mental health centers, we reviewed FY 2003 claim calculations and verified the appropriateness of the claimed costs and cost allocations.

At the State agency and contractor levels, we:

- obtained an understanding of the State agency's approved methodology for administrative cost reimbursement and verified that Federal and State requirements were met,

- evaluated the extent of State agency and contractor oversight, including Recovery Program monitoring achieved through provider audits performed under contract between Mental Health and an external firm,

- held discussions with State agency and contractor officials to identify Recovery Program controls,

- reconciled Federally reimbursed amounts from the CMS-64 to summary supporting claim documentation retained at the State agency and contractor levels for each provider, and

- reviewed supporting documentation for 31 selected statewide time study participants who charged time at the enhanced 75 percent SPMP claim rate.

At the three Providers, we:

- verified the accuracy of the administrative cost claim calculation,

- reconciled claimed costs to supporting accounting and financial records, and

- verified that selected costs were allowable and appropriately allocated and classified.

We performed the audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Based on our assessment of State agency claims oversight procedures and reviews at selected community mental health centers, Federal reimbursement for the Medicaid Recovery Program was overstated by $328,151. Our review of State agency oversight procedures disclosed $223,244 in unrecovered net overpayments identified by contracted auditors. This amount is offset by $44,590 of underclaimed costs due to contractor claims processing errors. Our review at three selected community mental health centers disclosed net overpayments of $149,497 for costs that were improperly claimed during FY 2003 due to flawed cost allocations, claiming errors, unallowable costs and an incomplete sampling universe. The State agency had not recovered most of the audit-identified overpayments because it mistakenly believed a two-year Federal payment and overpayment recovery limit had lapsed. In regard to overpayments identified at the three individually audited centers, provider oversight procedures were not adequate to ensure that claims were accurate and allowable.

In addition, documentation evaluated during our State agency oversight review disclosed that supporting FY 2003 documentation for 31 selected time study participants was insufficient to confirm the need for skilled medical expertise to perform some SPMP activities that were claimed at 75 percent. Because documentation requirements existing during the audit period were met, we are only recommending enhanced review procedures to ensure that providers maintain the improved documentation requirements adopted by the State agency in FY 2004.

STATE AGENCY OVERSIGHT

Our review of State agency oversight procedures disclosed net overpayments of $223,244 identified through external provider audits and $44,590 in underclaimed costs due to claims processing errors.

Unrecovered Audit Findings

The State agency had not recovered $223,244 in prior audit findings at various providers. Citing a two-year Federal claim-filing limit, the State agency disagreed that it should recover $202,340 of net provider overpayments that were claimed prior to January 1, 2003 and identified for audit adjustment by external auditors under contract with Mental Health. The State agency agreed that net overpayments of $20,904 identified through the same audit process for periods falling within the two-year Federal claim filing requirements should be recovered.

Federal regulations (45 CFR § 95.7) state, " . . . we will pay a State . . . only if the State files a claim . . . within 2 years after the calendar quarter in which the State agency made the expenditure." The State agency concluded that it was inappropriate to recover overpayments, or to repay underpayments, for audit findings relating to administrative cost claims that were beyond an allowable two-year claiming period. It cited Federal regulations (45 CFR § 95.7), which state " . . . we will pay a State . . . only if the State files a claim . . . within 2 years after the calendar quarter in which the State agency made the expenditure." The State agency seemed unaware that an additional Federal regulation (45 CFR § 95.19) stated that the two-year restriction does not apply to claims resulting from audit exceptions. The State agency can

recover the overpayments and should repay the Federal Government for its share of the net overpayments identified by prior audits.

Claims Processing Errors

The State agency underclaimed $44,590 as a result of reporting errors by the contractor hired to process claims. The contractor's use of a Medicaid eligibility rate of 23.03 percent for a provider, instead of the provider's correct rate of 33.60 percent, resulted in an underclaim of $29,426. In addition, another center correctly submitted indirect cost amounts for the quarter ended December 31, 2002 that were incorrectly processed by the contractor and resulted in underclaimed costs of $15,164.

The SPA, Attachment 4.16A, page 1i, section C., 3., states, " . . . DMH [Division of Mental Health] shall . . . demonstrate that adequate quality assurance controls are in place . . . ."

In the identified instances, the contractor attributed the probable cause of the errors to reliance on temporary employees for inputting claims data during the effected quarters. Quality assurance controls were inadequate.

CLAIMING BY SELECTED PROVIDERS

The selected centers received net overpayments totaling $149,497 due to flawed cost allocations, claiming errors, unallowable costs, and an incomplete sampling universe as described below.

Flawed Cost Allocations

Center C overclaimed $81,131 due to flawed cost allocations between the center and an affiliated hospital and also over-allocated the center's administrative costs to part-time employees.

The center was overpaid $81,131 because hospital overhead costs that were not allocable to the center, including non-reimbursable inpatient, cafeteria, nursing overhead, and Medicare reimbursed intern and resident costs were inappropriately allocated into the center's indirect cost pool as Medicaid reimbursable administrative costs.

Center C's existing cost allocation procedures also improperly allocated direct administrative costs to the personnel performing direct Medicaid administrative activities. Although the effect of this error could not be quantified, the allocation method incorrectly recognized all involved employees as full-time regardless of whether they held full or part-time employment status. The result was an over-allocation of the center's costs to part-time employees. The allocation occurred during all of FY 2003 but was corrected beginning April 1, 2004.

OMB Circular A-87 states," . . . A cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received." In the identified instances, the hospital's costs were either not allocable to the center, or the center's costs were allowable but had been allocated in a way that was disproportionate to the benefits received by the Medicaid program.

Claiming Errors

We identified net overpayments of $56,919 at two centers (Center B and Center C) resulting from duplicated costs, calculation and claim submission errors, and incorrectly reported Federal revenue offsets. Overclaims and underclaims by the two centers are, as follows:

Center B underclaimed net administrative costs by $55,960 for direct purchased services of $57,382 that were mistakenly omitted from the claim, overstated building-related costs of $2,863 that should not have been claimed, and overstated Federal revenue offsets of $1,441 caused by a transposition error and resulting in an underclaim.

Center C overclaimed $112,879 for duplicated contract personnel costs of $75,919, understated Federal revenue offsets against direct costs resulting in an overclaim of $30,301, duplicated education, training and mileage costs and overstated rent of $3,680, and overstated direct costs of $2,979 due to the center's failure to update a prior quarterly calculation.

The State agency's approved methodology states, "The accuracy of the financial expenditure information that is submitted by the participating MCP [Managed Care Provider] is certified at the MCP level." The submitted certified data was not accurate in the identified instances.

Unallowable Costs

The three centers claimed $9,014 in unallowable direct and indirect costs for employee entertainment, political lobbying, personal use of company cars, and unallowable client-related expenses.

Center A claimed costs of $1,475 for unallowable movie tickets, parties, and gift certificates that benefited employees. OMB Circular A-87 states, "Costs of entertainment, including amusement, diversion, and social activities . . . are unallowable." The identified amounts fell within these specifically defined categories of unallowable costs.

Center B claimed unallowable political lobbying costs of $674 that were included as itemized portions of organizational dues and $313 for personal use of company vehicles by employees. The center's cost allocation methodology specifically excluded allocation of these types of costs to the Medicaid cost pool. OMB Circular A-87 also specifically identifies these types of expenditures as being unallowable.

Center C claimed $6,552 for unallowable client-related expenses consisting of groceries, room and board, payment of a client's utility bill, and a direct payment to a client for the purchase of clothing. The identified costs were not "necessary . . . for the proper and efficient administration of the State plan" pursuant to section 1903(a)(7) of the Act.

Incomplete Sampling Universe

Center A claimed $2,433 of costs incurred for two physicians who were accidentally omitted from the time study roster. OMB Circular A-87 states, "The sampling universe must include all of the employees whose salaries and wages are to be allocated based on sample results . . . ." The identified costs were directly attributable to the identified individuals who were incorrectly excluded from the sampling universe.

INSUFFICIENT TIME STUDY DOCUMENTATION

As a part of our review of State agency oversight, the enhanced SPMP 75 percent Federal Medicaid reimbursement rate was evaluated by selecting 31 SPMP time study participants statewide. The reviewed documentation was generally insufficient to confirm the need for skilled professional medical expertise to perform the claimed administrative activities. The 75 percent enhanced Federal funding rate is available for administrative activities requiring skilled professional medical expertise.

For 16 of the 31 time studies, the State agency provided no documentation beyond a time study form. Although the State agency provided Participant Activity Logs as additional supporting documentation for the remaining 15 selected time studies, the documentation was insufficient to confirm the need for skilled medical expertise during some charged SPMP time periods in 14 of these cases. Fire destroyed eight requested time studies that were, therefore, unavailable for review. The State agency provided other documentation to summarize and support the results of the destroyed time studies. This documentation was accepted in lieu of the actual time study for the eight participants.

Federal regulations (42 CFR § 432.50) state . . . "(c) *Application of rates* . . . (2) Rates of FFP in excess of 50 percent apply only to those portions of the individual's working time that are spent carrying out duties in the specified areas for which the higher rate is authorized." Additional guidance in the approved Indiana program methodology states, "The requirement of the use of SPMP [skilled professional medical personnel] skills . . . is accounted for and documented in the time study results."

Although Federal and State requirements did not address the level of supporting documentation required during FY 2003, subsequent Mental Health policy specifically requires the retention of supporting documentation in addition to the time study form. The Recovery Program Manual, issued during 2004, stipulates, "The Participant Activity Log (PAL) needs to be completed in conjunction with the time study as supportive documentation in case of an audit." The manual also states that additional notes should be maintained as needed.

Although the enhanced rate reimbursement differential was estimated at about $1.3 million for FY 2003, the lack of clearly defined documentation requirements during this period precluded recommendations other than procedural improvement to the SPMP documentation review process. Future provider audits should verify the implementation of the State agency's improved documentation requirements.

RECOMMENDATIONS

We recommend that the State agency:

- refund $223,244 to the Federal Government for net administrative cost overpayments made to various providers for periods prior to January 1, 2003 as identified during external audits,

- refund $104,907 to the Federal Government for additional net administrative cost overpayments identified during our audit,

- improve the accuracy of administrative cost reimbursement procedures by reconciling data between the providers and the claims processing contractor,

- require external auditors to review time study documentation and activity logs and notes to ensure that claimed administrative costs are properly supported by the providers, and

- emphasize that the providers develop internal review systems to ensure that claimed cost data is accurate and allowable.

STATE'S COMMENTS

Indiana agreed to repay the net Federal overpayment identified during State contracted provider audits covering periods prior to January 1, 2003 and has modified its procedures to refund all audit adjustments that identify Federal overpayments regardless of the time elapsed. Indiana further agreed to refund $104,907 for additional net administrative cost overpayments that were identified during our audit and has made changes to help eliminate future errors.

Indiana also agreed with our procedural recommendations and stated that it has implemented revisions to improve the claim filing process. Specifically, it indicated that:

- contractor level claims processing procedures were enhanced to generally improve the accuracy of the claim submission process,

- beginning with the SFY 2007 audit cycle, the scope of Indiana's provider audits were expanded to include the review of time study documentation and activity logs and notes to verify that claimed costs are supported, and

- provider training and reporting requirements were modified to improve claiming accuracy through better provider understandings of the Recovery Program and the application of OMB Circular A-87.

The State's written comments are presented in their entirety as an appendix.

APPENDIX

INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION

"People helping people help themselves"

Mitchell E. Daniels, Jr., Governor
State of Indiana

Office of Medicaid Policy and Planning
MS 07, 402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

August 22, 2006

Paul Swanson
Regional Inspector General
Office of Audit Services
Department of Health and Human Services
233 North Michigan Avenue, Suite 1360
Chicago, Illinois 60601

Re: Draft Report A-05-04-00081

Dear Mr. Swanson:

We are writing in response to the draft Office of Inspector General (OIG) report entitled "Review of Administrative Costs for Community Mental Health Centers in Indiana". The audit covered federal fiscal year 2003 and state contractor audit findings for periods prior to January 1, 2003. The OIG recommendations and our responses are noted below.

OIG Audit recommendation: "refund $223,244 to the Federal Government for net administrative cost overpayments to various providers for periods prior to January 1, 2003 as identified during external audits."

The Office of Medicaid Policy and Planning (OMPP) did not initially refund the net audit adjustments since we believed we were operating in accordance with CMS guidelines in our oversight and administration of the program. Originally we understood the two year filing limit precluded OMPP from making a net adjustment, which consisted of both decreasing and increasing adjustments. We acknowledge a federal net over claim covering the period from 1999 through December 31, 2002 and will work with the claims processing contractor to review and assist in determining the specific refund amount due from them and the participating agencies. We will review all claims to assure that audit findings have not been already addressed via adjustments to subsequent claims. The State will make a reconciling adjustment in the next quarterly claim for the Mental Health Funds Recovery Program.

We made the appropriate modifications in our practices as of the first quarter of 2004 and now collect and refund to CMS all negative audit adjustments (i.e. those resulting in a federal over

claim) regardless of time elapsed. Positive adjustments are restricted to the two-year limit, pursuant to federal regulations.

OIG audit recommendation: "refund $104,907 to the Federal Government for additional new administrative cost overpayments identified during our audit."

We agree with OIG's recommendations and will make the refund on the next quarterly CMS-64 report. Our corrective action measures are discussed below.

Effective January 2005 the claims processing contractor instituted controls including two layers of Quality Control review to avoid processing errors similar to those cited in the OIG audit report. Examples of identified processing errors include the following: the contractor's use of an incorrect Medicaid Eligibility Rate and including incorrect direct costs for providers in developing the administrative claim. The first layer of quality control review occurs at the level of a subcontracted entity hired by the claims processing contractor. The second is an internal review process conducted at the claims processing contractor.

Center C acknowledges the over claim of $81,131 (in unallowable hospital overhead costs) and notes that it ceased including these costs in its cost reports as of April 2003. Both Center C and the claims processing contractor now monitor quarterly submissions to assure continuing adherence to the OIG findings that are based on OMB Circular A-87 guidelines.

The OIG audit identified $56,919 in net overpayments at Centers B and C. These errors largely involved either center-based concerns (e.g. duplicated contract personnel costs) or interpretative issues in the application of OMB Circular A-87 guidelines for building related costs. Both Centers B and C agree with the findings of the OIG audit and appropriate adjustments will be made in future claims.

The OIG audit identified $9,014 in unallowable costs at Centers A, B and C. (Issues with Center A involved claimed costs of $1,475 in movie tickets, parties and gift certificates that benefited employees. Center B was found to have claimed a total of $987 in unallowed lobbying costs and the personal use of company vehicle by employee. Center C was found to have $6,552 in unallowed client-related expenses for groceries, room and board, payments of utility bills, etc.) Centers A, B, and C are in agreement with the findings of the OIG audit and will cooperate in making appropriate adjustments. Additionally, Centers A, B, and C will make necessary changes to assure these costs will no longer be claimed. The claims processing contractor will incorporate the OIG audit findings into the internal procedures the centers follow when preparing the quarterly claims.

OIG audit recommendation: "improving accuracy of administrative cost reimbursement procedures by reconciling data between providers and the claims processing contractor."

The OIG audit report indicated "Center A claimed $2,433 of costs incurred for two physicians who were accidentally omitted from the time study roster." The referenced physicians were

accurately reported on Center A's cost report but not reflected in the personnel roster it submitted prior to the drawing of the random sample for the time study. Our review notes that this error occurred in only two quarters and was corrected prior to the time of the OIG audit. The claims processing contractor and their subcontracted auditor both audit the "headcount" or staff count information submitted by each provider on a quarterly basis in an effort to avoid a repetition of this error.

In cooperation with its claims processing contractor, the State has made several adjustments to the internal procedures to improve the overall accuracy of submitted claims. These include the assignment of a dedicated auditor from the claims processing contractor's subcontracted entity, Maximus, Inc., to review each cost report as submitted quarterly by participating agencies against program wide and agency specific benchmarking. Any deviations from expected values are discussed directly with the agency and reconciled prior to the calculation of the claim. The submitted cost report is specifically screened for adherence to OMB Circular A-87 allocation guidelines and accuracy of federal offset calculations. Consultation is available to all participating agencies around any questions related to cost eligibility. Each participating agency now receives all detail of adjustments made as a result of this review process. The claims processing contractor maintains a single, integrated database that tracks and documents all such cost adjustments.

OIG audit recommendation: "the State require external auditors to review time study documentation and activity logs and notes to ensure that claimed administrative costs are properly supported by the providers."

The OIG audit findings noted that some centers were not completing the Participant Activity Log (PAL) as required by The Indiana Mental Health Funds Recovery Program Manual. The (PAL) is expected to be completed as supportive documentation in the event of an audit. Since June 2004 the time study training, to which each time study participant is exposed, has been modified to include materials which emphasize the importance of accuracy in completing both the time study coding sheet and the PAL. Additionally, the training includes specific information for the participants to be as detailed as possible in documenting activities claimed at the SPMP (skilled professional medical personnel) rate. Both the Manual and the time study training instruct the participant to complete the PAL simultaneously with the time study coding sheet and to submit the completed PAL along with the code sheet to their agency liaison. The participating provider is responsible for maintaining the PAL in an accessible location organized by both time study participant and the quarter in which they are sampled.

The claims processing contractor now employs a bonded document storage facility to avoid exposure of the submitted time study coding sheets to loss by fire or other disaster. Additionally, since the audit period, the claims processing contractor has initiated the use of electronic copies of the time study coding sheets which are maintained with HIPAA compliant back-up.

Beginning with the SFY 2007 audit cycle, the scope of audit for the State contracted independent program auditor includes sampling of the adequacy of the Personal Activity Log documentation

in support of the selected time code. These audits cover all participating agencies on a biannual cycle. The claims processing contractor provides the independent auditor with electronic copies of the submitted time study coding sheets for comparison with the on-site Personal Activity Logs.

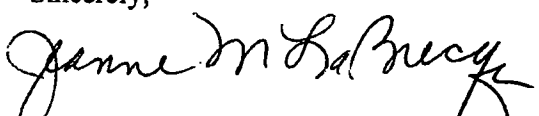
OIG audit recommendation: "emphasize that the providers develop internal review systems to ensure that claimed cost data is accurate and allowable"

Since the inception of this program in 1999, the State has had the goal of accurately and appropriately administering the Mental Health Funds Recovery Program. As a means of accomplishing this, the State and the claims processing contractor have instituted many changes intended to improve the participating providers' understanding of the Program as well as their application of the OMB Circular A-87. We believe that the improved time study training and the development of quarterly benchmarking reports allows each provider to continuously monitor their claiming history and claiming activity.

As noted previously we propose to make the required repayments and intend to do so as a single, combined adjustment to be submitted in conjunction with a regular quarterly claim for this administrative claiming program.

We are hopeful that you find this to be a sufficient response to the OIG audit report. Please contact Bridget McLaughlin at 317-232-4328 should you have any questions or require additional information.

Sincerely,



Jeanne M. LaBrecque
Director of Health Policy and Medicaid

JML:bem