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STATE BOARD OF ACCOUNTS
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REVIEW REPORT

OF

FAMILY AND SOCIAL SERVICES ADMINISTRATION

STATE OF INDIANA

March 1, 2004 to February 28, 2006

FILED

09/13/2006

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AGENCY OFFICIALS

Office	Official	Term
Secretary, Family and Social Services Administration	Cheryl Sullivan	10-20-03 to 12-17-04
	Venita Moore	12-18-04 to 01-09-05
	E. Mitchell Roob, Jr.	01-10-05 to 01-11-09

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STATE BOARD OF ACCOUNTS
302 WEST WASHINGTON STREET
ROOM E418
INDIANAPOLIS, INDIANA 46204-2765

Telephone: (317) 232-2513
Fax: (317) 232-4711
Web Site: www.in.gov/sboa

INDEPENDENT ACCOUNTANT'S REPORT

TO: THE OFFICIALS OF THE FAMILY AND SOCIAL SERVICES ADMINISTRATION

We have reviewed the receipts, disbursements, and assets of the Family and Social Services Administration for the period of March 1, 2004 to February 28, 2006. The Family and Social Services Administration's management is responsible for the receipts, disbursements, and assets.

Our review was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. A review is substantially less in scope than an examination, the objective of which is the expression of an opinion on the receipts, disbursements, and assets. Accordingly, we do not express such an opinion.

Financial transactions of this office are included in the scope of our audits of the State of Indiana as reflected in the Indiana Comprehensive Annual Financial Reports.

Based on our review, nothing came to our attention that caused us to believe that the receipts, disbursements, and assets of the Family and Social Services Administration are not in all material respects in conformity with the criteria set forth in the Accounting and Uniform Compliance Guidelines Manual for State Agencies, and applicable laws and regulations, except as stated in the review comments.

STATE BOARD OF ACCOUNTS

July 19, 2006

STATEWIDE SINGLE AUDIT

In conjunction with our review of Indiana's Family and Social Services Administration, we also tested compliance with federal regulations and grant agreements. Findings relating to the federal programs administered by the department are included in the Indiana Statewide Single Audits.

INCONSISTENT PROCEDURES

Family and Social Services Administration (FSSA) is made up of three divisions which were formerly independent agencies. We stated in our nine prior reports (most recently B21357 and B24295) that the three divisions' policies and procedures in accounting activity were inconsistent and incompatible within the present structure. We noted during prior audits that progress had been made through the implementation of standardized processes, communication through manuals and memos, etc. However, there are still various accounting software systems in use. Due to the size and diversity of FSSA's accounting operation, the lack of a standardized system reduces management's control over the accounting operation and the ability to quickly and consistently correct deficiencies and weaknesses when identified.

An agency's accounting responsibilities must include an effective accounting system. (Accounting and Uniform Compliance Guidelines Manual for State Agencies, Chapter 1)

COUNTY OFFICES OF FAMILY AND CHILDREN - ACCOUNTING OPERATIONS

As stated in our seven prior reports (most recently B21357 and B24295), we observed that the county offices of Family and Children were not consistent in the manner in which they implemented their accounting operations. Some appear to be more accurate and efficient than others. Through further inquiry we found that there is not an operations manual for these offices, though periodic memos are sent.

Subsequent to our review period, we noted that a manual had been developed and distributed for the counties' use. Also, evidence was provided that basic training had begun.

An agency must have internal controls that provide reasonable assurance for the effectiveness and efficiency of operations. (Accounting and Uniform Compliance Guidelines Manual for State Agencies, Chapter 1) Formal procedures in writing help to facilitate this goal.

COUNTY OFFICES OF FAMILY AND CHILDREN - CONTRACTS AND PROCUREMENT

As stated in our prior reports (B21357 and B24295), we found that it was common practice at the county offices of Family and Children not to utilize contracts when appropriate or to follow the State procurement process.

Each agency, department, institution or office should have internal controls in effect which provide reasonable assurance regarding the reliability of financial information and records. . . . Among other things . . . safeguarding controls over cash . . . are part of an internal control system. (Accounting and Uniform Compliance Guidelines Manual for State Agencies, Chapter 1)

CHILD CARE DEVELOPMENT FUND (CCDF) – INTAKE AGENTS

As stated in our prior report (B24295), FSSA has contracted with intake agents to perform recipient eligibility determination for the CCDF program. Payment for this service is a flat monthly fee of $18 per active case file.

FSSA's Bureau of Childhood Development (BCD) staff (program monitors) conducts annual on-site monitoring of the intake agents. While on site, the monitors select a sample of eligibility records for review. The monitors verify whether the sampled files contain complete and accurate documentation of the CCDF applicant's eligibility.

Through inquiry we found that FSSA does not have a process in place to recoup the unallowable costs to providers that were found as a result of the aforementioned testing. FSSA does collect from the intake agent an $18 per month penalty for each file that remains deficient. However, this leaves the State with the potential liability to the Federal Government for any unallowable costs paid to providers that exceed the penalty. We also found that there is no process in place to expand testing for additional unallowable costs when there are indicators that this could be a significant issue with a particular intake agent. It is planned that FSSA's Audit Division will use the program monitors findings as part of their risk assessment when determining which intake agents will receive on-site visits. However, as this has not occurred during our review period, it is unclear how this will impact monitoring for additional potential unallowable costs.

Each agency, department, institution or office should have internal controls in effect which provide reasonable assurance regarding the reliability of financial information and records, effectiveness and efficiency of operations, proper execution of management's objectives, and compliance with laws and regulations. Among other things, segregation of duties, safeguarding controls over cash and all other assets and all forms of information processing are part of an internal control system. (Accounting and Uniform Compliance Guidelines Manual for State Agencies, Chapter 1)

MONITORING

Overview of Prior Finding

State agencies have accounting responsibilities which include maintaining a control environment and maintaining control procedures. (Accounting and Uniform Compliance Guidelines Manual for State Agencies, Chapter 1) Monitoring is an important method which helps to ensure that these responsibilities are met. Additionally, many federal grants require program monitoring by the administrative recipient.

As stated in our seven prior reports (most recently B21357 and B24295), we noted several serious deficiencies in FSSA's monitoring system. It should be remembered that monitoring is not just a control to help ensure compliance with laws, regulations, and contracts, but also a control to help evaluate the validity of claims to the State, to help prevent fraud, and to help increase the effectiveness and efficiency of programs. In order to do this, monitoring must be not only a review of what has occurred at the end of a contract but what is occurring while the contract is ongoing.

As noted in the prior report, it is evident that these issues are being considered and considerable progress has been made in addressing these issues, especially in regard to the Audit Services area. However, the deficiency noted in Item C in prior reports remains to a significant degree.

Prior Finding Item C (Agency-Wide Monitoring Weakness)

C. The agency does not have a monitoring policy for contracted process servers.

Current Status Item C

We found this item to be still unresolved.

DEVELOPMENTAL DISABILITIES CONTROLS

Overview

The Bureau of Developmental Disabilities Services (BDDS) is a part of the Division of Disability, Aging, and Rehabilitative Services (DDARS) within FSSA. BDDS is responsible for the planning and administration of services in community based, residential alternatives for those who meet the criteria of developmentally disabled. The major goal of the Bureau is to support independent living in the least restrictive setting possible for the recipient. To fulfill its goal a variety of services are offered through approved providers. These services include residential habilitation, community habilitation, personal assistance, sheltered employment, and behavior intervention. In addition, funding for living expenses such as rent and utilities may also be awarded. The major funding sources are Medicaid (which consists of various Medicaid Waiver programs), Title XX, and State appropriations. In our prior reports B19502, B21357, and B24295, we found control weaknesses in the validation of claims paid and in the assurance process of the appropriateness and necessity of services.

The deficiencies noted in the prior reports do remain to a significant degree.

Claims Payments

Background

The claims payment system used by FSSA to pay the service provider depends on the funding source for the service provided. Regardless of the system used, the service providers are to maintain sufficient documentation to support the claims that are presented to the State for payment of services. FSSA does not request this documentation at the time of payment for validation. Instead, FSSA relies on monitoring controls. Monitoring controls vary according to funding source as described below:

Medicaid Waiver Funding as Stated in Original Finding

Medicaid Waiver is Medicaid funding that is available to a Medicaid eligible individual who would be institutionalized without special services. There are various waiver programs that have specific allowable services, depending on the goal of that waiver program. FSSA determines if a recipient is eligible for a waiver program. An Individualized Support Plan (ISP) is then developed which details the specific services that the recipient is allowed to receive within the waiver program. The only claims that the provider should present to FSSA are those based on the specific services identified in the ISP.

FSSA utilizes a contractor, EDS, to process Medicaid claims, including Medicaid Waiver. We found that EDS does monitor to determine if a recipient is eligible for the waiver program being billed and if a provider is eligible to receive a particular type of waiver program payment, but EDS does not monitor to determine if a specific service is allowed for a particular recipient.

All Medicaid payments are subject to review through a monitoring process that is conducted by a contractor, Health Care Excel. However, due to the volume of Medicaid payments and the method of selection, the probability of a Medicaid Waiver payment being selected is very low.

Status as Documented in Prior Report

Beginning November 1, 2002, the policy is for EDS to pay for a service only if the State has authorized the service prior to delivery.

Current Status

We found no change.

Title XX as Stated in Original Finding

Title XX funding is to provide for services that are identified as community day services. The recipient has been approved as meeting the criteria for developmentally disabled. The recipient may or may not be Medicaid eligible, but if Medicaid eligible the recipient is not considered to be at risk of institutionalization if services are not received. The recipient may or may not have a plan that stipulates which of these types of services are needed. A plan would be available only for those recipients who are also receiving State funding for residential services or Medicaid Waiver funding. Funding is not budgeted according to the recipient but is paid out to the provider as claimed. Some services have a limit on the number of units allowed per recipient, but this is tracked by the provider.

Current Status

We found no change.

State Funding as Stated in Original Finding

State funding is provided for services that are identified as community residential services. The recipient may or may not be Medicaid eligible, but if Medicaid eligible the recipient is not considered to be at risk of institutionalization if services are not received. When a recipient is determined eligible and a plan of services developed, a line item budget (Individual Community Living Budget or ICLB) is established. The provider claims for these services are paid through FSSA's Financial Management. Financial Management monitors claim payments to verify that the amounts claimed are identified in the ICLB and the amounts requested are not over the monthly amounts budgeted.

Status as Documented in Prior Report

Surveys that included monitoring for appropriate services were implemented. Exceptions found during the surveys require corrective action.

Current Status

We found no change.

Claims Payment Summary as Stated in Original Finding

We found that the monitoring for the validation of claims is limited at best. Financial Management's monitoring of residential services claims does provide timely indicators that a specific service is allowable and that the claim does not exceed the budgeted amount. However, except for the monitoring provided by Audit Services, there is no tracing to supporting documentation which would help give assurance that the claim is appropriate and reasonable. EDS's process is even more limited in that the specific service allowed for a recipient is not identified. There is no substantial verification of the validity of day service claims at the time of process.

Medicaid Waiver, residential service, and day service providers are subject to on-site review by FSSA's Audit Services. When a provider is selected, Audit Services does review for allowable costs and sufficient supporting documentation. However, as provider selection is a risk based approach, not all providers will have an on-site review. In addition, Audit Services reviews transactions after the close of the contract period. While this may be used as one part of a system of assurance of the validity of claims, it is not a timely method and does not guarantee that all providers will be adequately reviewed.

Status as Documented in Prior Report

Medicaid waiver policy now does not allow for payment without verification that FSSA has approved a specific service for a recipient before delivery. Residential and day service payments did not have significant changes during the audit period. However FSSA provided documentation to support that planning for monitoring changes did occur. Also, evidence was provided that additional monitoring processes had been implemented for residential services.

FSSA contracted with EDS to perform on-site reviews of Medicaid Waiver providers starting in January 2002. All waiver providers will have on-site reviews. These reviews will expand from the review of DD Waivers to incorporate other types of waivers. These reviews include the examination of supporting documentation. Initially, these reviews have found significant occurrences of documentation that does not support services billed and documentation errors (scratch outs, white out/alterations, etc.). The first phase of this review process is intended to be educational and to give providers an opportunity to make corrections and changes to their processes. Residential service providers and day service providers may be the same providers as selected by EDS for waiver reviews, but these claims are not included in the population examined. It is policy for results of these reviews to be shared with Audit Services.

It is now policy for the Bureau of Quality Improvement Services to coordinate reviews with EDS.

Current Status

We found no change.

Appropriate and Necessary Services as Stated in Original Finding

To help assure that the services that a recipient receives are appropriate and reasonable, FSSA requires that the recipient have a plan and a budget for the services required by the plan. Each recipient has a team that develops the plan. Two key members of the team are the service coordinator and the case manager.

The service coordinator is a State employee located at a BDDS district office. The coordinator determines eligibility, approves the individual community living budget, has placement authority and works with the recipient to plan, coordinate, and access appropriate services.

The case manager is an advocate for the recipient. The case manager assists the recipient in obtaining the needed services and help plan, monitor, and evaluate the recipient's services on an on-going basis. FSSA also relies heavily on the case manager to monitor that the recipient is actually receiving the services required and that the services are appropriate. Case management services may be provided by Area Agencies on Aging (AAA), local service providers, or independent case managers. Though some case management services may initially be provided by a State employee through the BDDS district office, in general case managers are not State employees.

We found that there was no quality assurance reviews of the services performed by either service coordinators or case managers. We also found that there is a potential for conflict of interest when the case manager is employed by the same entity that also provides other types of services to recipients.

We found that not all recipients have a plan or a case manager. While the service coordinator may take on more responsibilities in these circumstances, we did not find compensating controls that would provide assurance that the recipient was receiving appropriate and reasonable services.

Subsequent to our report period ending June 30, 2001, we found that the newly developed Bureau of Quality Improvement Services (BQIS) (started in late 2000) had developed a provider and case management standard annual survey as well as other surveying techniques. In addition, the case managers are to fill out a case management ninety day checklist that is easily accessible by both BQIS and BDDS through a data base and subject to periodic reviews.

Status as Documented in Prior Report

As stated above, surveys were developed and checklists subject to periodic review were implemented. Both of these allow for monitoring by FSSA of case managers and providers. In addition, if an entity employs case managers and also provides other services to recipients, that entity is required to submit a plan demonstrating how they will assure that there is no conflict of interest. However, FSSA does not have a specific process in place to verify the implementation of this plan. There was no change in status for the control weaknesses found for those recipients without a case manager.

Current Status

We found no change.

Providers with Fiduciary Responsibilities to Recipients as Stated in Original Finding

At times the service provider may have fiduciary responsibilities directly to the recipient (i.e., the provider is payee for the recipient's benefits or the provider is responsible for the receipt and deposit of recipient's living expenses from the State). FSSA requires that the provider keep accounting records to support transactions made by the provider on behalf of the recipient and that these records be identifiable to the recipient. We found the monitoring of this by FSSA to be very limited.

Status as Documented in Prior Report

The BQIS have included in their survey an inquiry concerning recipients' perceived satisfaction of how their money was handled and whether there was documentation. However, the surveyors did not have training or guidelines as to what would be appropriate and what resulting steps to take. BQIS is now working on a detailed financial review worksheet that is to be filled out by the case manager and incorporated with the ninety day checklist.

Current Status

We found no change.

Overview Status as Documented in Prior Report

There are significant control weaknesses over developmental disabilities. Claims are not validated on a timely basis and audit checks before payment of Medicaid Waivers and day service are inadequate. Also, day service is not adequately controlled to ensure that services provided are appropriate and necessary. There are not sufficient controls in place to address the conflict of interest of service providers when case management is one of those services. There is no quality assurance in place to help ensure that service coordinators are consistent across the State. Finally, FSSA's oversight of the service providers' fulfillment of fiduciary responsibilities to recipients is limited. Activities subsequent to our review period indicate that the Agency is aware of some of these weaknesses and is taking steps to strengthen controls.

There are still significant control weaknesses over developmental disabilities. However, there has also been significant progress with the implementation of the new payment policy for Medicaid Waivers as well as increased monitoring tools through surveys.

Each agency, department, institution or office should have internal controls in effect which provide reasonable assurance regarding the reliability of financial information and records, effectiveness and efficiency of operations, proper execution of management's objectives, and compliance with laws and regulations. Among other things, segregation of duties, safeguarding controls over cash and all other assets and all forms of information processing are part of an internal control system. (Accounting and Uniform Compliance Guidelines Manual for State Agencies, Chapter 1)

Current Status

We found no change.

HOSPITAL CARE FOR THE INDIGENT (HCI) - PHYSICIAN AND TRANSPORTATION CLAIMS

During our review of FSSA, we found that of the more than $50M in Hospital Care for the Indigent (HCI) property tax levies annually collected by counties and remitted to the State, $3M is reserved under IC 12-16-7.5-4.5(b) for payment of physician and transportation (P&T) claims for emergency medical care provided to uninsured persons. All other HCI revenues are transferred to the State's Indigent Care Trust Fund and leveraged for federal Medicaid funding for payment to hospitals.

We found a comprehensive lack of controls over payment of P&T claims under the HCI program. Control weaknesses included:

- Lack of oversight of income eligibility determinations. Caseworkers at the local Offices of Family and Children (OFCs) review income documentation and determine eligibility for the HCI program. However, FSSA does not verify whether the local OFCs maintain records of the documentation reviewed. No audits are performed by the central office staff of local HCI eligibility determinations.

- Lack of independent income verifications. For most programs managed by local OFCs, caseworkers enter income data into the Indiana Client Eligibility System (ICES). In turn, this data is automatically verified against a variety of independent sources, such as Department of Workforce Development (DWD) and Department of Revenue (DOR) records. However, income data for HCI applicants is not captured in a database. Instead, caseworkers enter limited information, includeing eligibility, into a separate database known as the HCI database. Even if income were entered into the HCI database, file transfers are not utilized to routinely compare this data to other databases.

- Lack of identity verifications. Because HCI data is not verified against independent sources, validation checks are not automatically performed or updated for social security numbers.

- Lack of signature verification. If an applicant meets the income eligibility criteria, the local OFC issues a Certificate of Action (COA) and forwards it to FSSA—Financial Management for medical review. However, Financial Management does not enforce policies prohibiting submission of photocopied signatures or use of signature stamps by OFC directors. In addition, signatures are not verified against lists of current directors or copies of signatures.

- Insufficient claim verification. Although medically trained staff review the medical conditions described on the COAs, claims are not reviewed for consistency with the conditions described. Clerical staff who lack medical training process claims. If the service dates on a claim match the service dates on an approved COA, the services described and corresponding medical billing codes are approved without further review.

- Manual calculation of claims. To calculate the payment amount for a P&T claim, a clerical assistant manually looks up various medical procedure codes in a reference table, adds the corresponding amounts on an adding machine tape, and enters the amount in the HCI database. The tape is not saved to facilitate review.

- Lack of medical license verifications. P&T claims data is not cross-checked against Health Profession Bureau (HPB) data to verify that all billing physicians are properly licensed.

- Limited, manual screening for Medicaid duplicates. If an applicant's income is sufficiently low, caseworkers may initiate a Medicaid enrollment process at the same time as an application for HCI assistance. If the Medicaid enrollment is approved, a medical provider may retroactively bill Medicaid for claims also submitted against an approved COA for HCI assistance. HCI payment data is not verified electronically on a periodic basis against Medicaid payment data. Instead, on an ad hoc basis a clerical assistant periodically checks a batch of open COAs by manually entering social security numbers into the query screen of the Medicaid payment database.

- Lack of provider audits. Audits of HCI provider records are not performed to verify consistency with submitted claims.

- Lack of data analysis. HCI data is not analyzed for unusual billing patterns or anomalies.

- Insufficient data collection to support data analysis. As discussed in the current finding, "Hospital Care for the Indigent—Demographic Data" service codes are not captured in the HCI database. This limits the type of data analysis performed. For example, if a provider shows unusual patterns of medical service indicating possible manipulation of claims, this could not be detected.

Each agency, department, institution or office has the responsibility to maintain a control environment and maintain control procedures. An agency's control environment consists of the overall attitude, awareness and actions of management. This would include establishing and monitoring polices for developing control procedures. Examples of control procedures include: proper authorization of transactions and activities; independent checks on performance; adequate documents and records; and adequate safeguards over access and use of assets. (Accounting and Uniform Compliance Guidelines Manual for State Agencies, Chapter 1)

HOSPITAL CARE FOR THE INDIGENT (HCI) - HOSPITAL CLAIMS

During our review of FSSA, we found that of the more than $50M in Hospital Care for the Indigent (HCI) property tax levies annually collected by counties and remitted to the State, all revenues above and beyond $3M are transferred to the State's Indigent Care Trust Fund to be used as the state match portion of supplemental Medicaid payments to hospitals under Indiana Code 12-15-15-9 and Indiana Code 12-15-15-9.5.

These supplemental payments are intended to help cover hospital deficits incurred from serving vulnerable populations, such as Medicaid recipients and the uninsured. Hospitals which incur significant costs related to serving the uninsured may also be eligible for disproportionate share (DSH) payments under Medicaid. However, total DSH payments are subject to various caps, including:

1. An absolute dollar limit on statewide payments.

2. A hospital-specific limit equal to the hospital's Medicaid and uninsured shortfalls. (The difference between the cost of serving Medicaid recipients and any Medicaid reimbursement received is known as the "Medicaid shortfall." The difference between serving uninsured patients and any payments received is known as the "uninsured shortfall.")

Supplemental Medicaid payments, on the other hand, are subject to the following volume-based limits:

1. A statewide limit based on total Medicaid claims priced at Medicare rates.

2. A funding limit based on available state match.

Maximizing supplemental payments across the combined Medicaid/uninsured shortfall allows DSH funding to be stretched further by the State across the remaining uninsured shortfall. Because of the sequence in which various supplemental payments are applied, HCI payments are primarily applied to the Medicaid shortfall.

HCI tax levies continued to vary from county to county based on historic utilization rates for the county-funded program times a growth multiplier. In its 2003 decision *Government Finance v. Griffin and Lake County (784 N.E. 2d 448)*, the Supreme Court of Indiana stated: "we are hard pressed to see the constitutional evil in a program . . . that sets the rate of local contribution so that it varies in harmony with expenses for indigent health care in the local area." In doing so, the court affirmed that "uniform and equal rate of property tax assessment and taxation" mandated by Article 10, Section 1 of the Indiana State Constitution can be achieved through the consistent application of laws to different local circumstances, yielding different local levies.

Partly in response to the constitutional concerns raised in *Government Finance v. Griffin and Lake County*, the Indiana State Legislature amended the HCI statute to ensure that HCI payments would be more closely tied to current program utilization rates. As of State Fiscal Year (SFY) 04, hospitals began submitting claims for indigent care provided to the uninsured in the same manner as physician and transportation (P&T) providers. However, direct payment was not made by FSSA to hospitals for services to the uninsured. Instead, hospital HCI claims were used to allocate supplemental Medicaid payments applied to the Medicaid shortfall. This shortfall is separately documented in audited cost reports submitted by hospitals to the Medicaid actuary, Myers & Stauffer.

The same pervasive lack of controls applies to HCI claims submitted by hospitals as described in our current finding "Hospital Care for the Indigent—Physician and Transportation Providers," with the following differences:

1. Less reliance on manual procedures for claims pricing. Hospital claims are priced by the Medicaid claims payment contractor, EDS, using computer software.

2. Greater risks for conflicts of interest. Under recently enacted Indiana Code 12-16-2.5-6.5, FSSA may rely on information submitted by hospitals to determine eligibility. Applicant interviews are optional. If the agency chooses to require an interview, it must allow the interview to be conducted by phone with the person or the person's representative. Indiana Code 12-16-2.5-6.5 also allows the agency to contract with hospitals to perform eligibility determinations on site. Allowing hospitals to control eligibility data or determinations without counterbalancing controls to independently verify this data creates potential conflicts of interest.

However, the potential impact of the lack of controls is different for hospital claims than P&T claims. If a hospital submits a false or duplicate claim for services to the uninsured, payment may still be made against genuinely incurred Medicaid costs verified by the hospital's cost report. What is affected is not so much the integrity of payment verification as the integrity of the allocation process.

This speaks to the constitutional issue originally raised in *Government Finance v. Griffin and Lake County.* If there are no functional controls in place over the claims verification process, then there is no consistent standard by which to apply the law. However, the lack of controls is not the only challenge to developing a consistent standard for hospital claims. Throughout SFY04, hospitals and local Offices of Family and Children reported significant logistical difficulties in obtaining compliance from the uninsured in documenting income after services had been provided. Claims volume fell below revenue collected to fund a Medicaid-related expense. The relationship of this claim volume to the Medicaid costs intended to be funded has yet to be analyzed. It is possible that even if consistent controls were in place and populations behaved consistently across counties that uninsured costs would provide an inconsistent county-to-county benchmark of Medicaid costs.

Article 10, Section 1 of the Indiana State Constitution states "The General Assembly shall provide, by law, for a uniform and equal rate of property assessment and taxation."

HOSPITAL CARE FOR THE INDIGENT (HCI) - DEMOGRAPHIC DATA

During our review of FSSA, we found that statutory requirements for data collection are not being met.

The following data is currently entered into the Hospital Care for the Indigent (HCI) database:

1. Applicant data. Name, Social Security number, date of birth, gender, marital status, street address, city, state, zip code.

2. Certificate of Action (COA) data. Admission date, discharge date, hospital (if applicable), application date (local OFC), receipt date (central office), application status, decision date (approval/denial), denial reason (if applicable).

3. Claim data. Date received (central office), service date, vendor employer identification number (EIN), amount billed, amount allowed.

The following data is not captured by the HCI database:

1. Income data. Employment, household income.

2. Medical data. Reason for care, diagnosis, types of services provided, costs of services provided.

3. Additional demographic data. County of residence, welfare/SSI status, race, household status.

Indiana Code 12-16-10.5-4 states:

"(a) The division shall adopt rules under IC 4-22-2 necessary to establish a statewide collection system of data concerning the hospital care for the indigent program.

(b) The following data must be collected:

(1) Patient demographics.

(2) Types of services provided by hospitals.

(3) Costs of particular types of services provided by hospitals."

No new rule regarding data collection was promulgated subsequent to the adoption of Indiana Code 12-16-10.5-4 in 2002. However, 470 IAC 11.1-2-3(a), last updated in 2001, states:

"Each county office of family and children shall submit to the division of family and children within sixty (60) days following disposition of patient's application for eligibility . . . information concerning the patient, which shall include, but not be limited to, the following:

(1) Name.

(2) County and state of residence.

(3) Welfare/SSI status.

(4) Age.

(5) Race.

(6) Sex.

(7) Household status.

(8) Employment.

(9) Household income.

(10) Reason for care.

(11) Diagnosis.

(12) Status of application."

HOSPITAL CARE FOR THE INDIGENT (HCI) - RECONCILIATIONS TO AUDITOR OF STATE

During our review of FSSA, we found that neither FSSA nor the Auditor of State (AOS) have systems in place to reconcile the amounts deposited into State HCI fund/centers with county HCI collections.

Upwards of 95% of HCI revenue is derived from the HCI property tax. The remainder is supplied by an allocation of financial institution, motor vehicle and commercial vehicle excise tax revenues. Per Indiana code 12-16-14-2, HCI property taxes are to be collected as other property taxes are collected. Per Indiana Code 12-16-14-6, the HCI portion of property and excise tax collections is to be deposited into the county's HCI fund/center and transferred to the State HCI fund/center on a monthly basis.

Counties report property tax collections on settlement sheets submitted to the AOS. In a typical year, HCI property tax collections would peak in June and December following the May and November payment deadlines. Property tax collections typically average about 98% of the original levy. Total HCI revenues (combined property and excise tax) typically average close to 105% of the property tax levy.

However, since reassessment property tax collections have been very atypical. In some counties, collections have been delayed for over a year. FSSA cannot rely on ratio analysis to confirm that deposit levels in HCI revenue accounts are reasonable.

The AOS tracks revenues received against settlements reported using Excel spreadsheets. We found that FSSA and AOS had not attempted to coordinate their reconciliation efforts. Tracing deposits on the AOS system back to the settlement sheets via the Excel spreadsheets currently in use would require a laborious process of manual review to determine which settlement year a given deposit is being credited against.

We inspected FSSA's tracking sheet and discovered significant anomalies: nine counties with a 2-year average for SFY04/SFY05 of less than 60% of the expected levy, and seven counties with a 2-year average of above 120%. In the absence of a functional reconciliation procedure, FSSA assumed that the correct counties had been credited with the correct amounts in the subsidiary ledgers (object codes) maintained by the State for the HCI fund/center.

Each agency, department, institution or office should have internal control in effect which provide reasonable assurance regarding the reliability of financial information and records. (Accounting and Uniform Compliance Guidelines Manual for State Agencies, Chapter 1)

HOSPITAL CARE FOR THE INDIGENT (HCI) - HIPAA COMPLIANCE

During our review of FSSA, we found that protected health information is not properly secured according to the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

We observed boxes of unsecured HCI records stacked within 50 feet of a freight elevator. This area is easily accessible by unauthorized users.

Each agency, department, institution or office is responsible for compliance with applicable statutes, regulations . . . and federal requirements. (Accounting and Uniform Compliance Guidelines Manual for State Agencies, Chapter 1)

HOSPITAL CARE FOR THE INDIGENT (HCI) - INDEPENDENT CONTRACTORS

During our review of FSSA, we found that the medical review staff for the HCI program consists of three retired nurses retained as independent contractors. Upon interviewing two of the nurses, we discovered that neither performed work for other clients; both worked on site in designated locations using materials furnished by the agency; that one of the nurses consistently worked over 40 hours per week; and each was paid an hourly rate without bearing the opportunity or risk of additional profit or loss. In addition, upon becoming employed in July 2005, one of the nurses was trained by the other nurse, who had been retained in her current capacity for over a decade.

The nurses' workload consisted primarily of performing desk reviews of Certificates of Action (COA) submitted by local Office of Family and Children (OFCs). The agency relies on their medical training to evaluate whether the medical conditions described in the COAs meet the emergency criteria of the HCI program, as articulated by internal policy. The nurses are assisted by several clerical workers retained on a long-term basis from a temporary agency. The clerical workers open and sort mail, route COA submissions to reviewers, collect approved COAs from reviewers for entry into the HCI database.

In classifying the nurses as independent contractors, the agency relied heavily on the fact that they are granted the option of working flexible, part-time hours. However, flexible work schedules are common in the contemporary workplace.

The agency also relied heavily on an affidavit provided by the nurses' supervisor asserting that no incidental training or instruction is provided to the nurses. Although specialized training is a prerequisite to performing the job, this can also be true of an employee. However, incidental training would be necessary to acquaint new staff with the review criteria for the HCI program. The affidavit also stated "no one is hired by the agency to assist the nurses." In essence the agency is relying on the legal form of an affidavit to obscure the substance of the facts, which could easily be uncovered during audit by the Internal Revenue Service (IRS). This opens the State of Indiana to the risk of financial penalties, including the assessment of back taxes, by the IRS.

According to IRS Publication 15-A, Employers Supplemental Tax Guide states "If you have an employer-employee relationship, it makes no difference how it is labeled. The substance of the relationship, not the label, governs the worker's status." The publication includes a detailed list of criteria for determining whether or not an individual qualifies for independent contractor status. We found that the nurses did not meet several key criteria, including whether the individual performs similar work for other clients, bears the risk of profit or loss, supplies their own tools, obtains their own training, and controls the location and method of performing their work. We found that other criteria the nurses did meet (sets own working hours and is not reimbursed travel expenses) were specifically described as less determinative by the IRS. These minor criteria were listed in the affidavit, but the major ones were not.

Each agency, department, institution or office is responsible for compliance with applicable statutes, regulations . . . and federal requirements. (Accounting and Uniform Compliance Guidelines Manual for State Agencies, Chapter 1)

CONTRACT REQUIREMENTS - UNALLOWABLE EXPENDITURES

During our review of FSSA, we found that FSSA was billed and paid for FSSA contractors to attend a seminar. The contracts did not allow for reimbursement to attend seminars. Thus, FSSA paid for services to contractors which were not in accordance with the contract. The total paid to the contractors for the seminar was $3,336.

Each agency, department, institution or office is responsible for compliance with applicable statutes, regulations, contract provisions, state policies, and federal requirements. (Accounting and Uniform Compliance Guidelines Manual for State Agencies, Chapter 1)

CONTRACT APPROVALS

During our review of FSSA, we found that FSSA made payments to vendors under contracts for professional services. These contracts were in effect prior to approval by the proper officials. Internal controls are weakened when a contract is put into effect before proper approval. In previous Office of Management and Budget Circular A-133 audits, FSSA had a federal finding in their audit reports for each State Fiscal Year from 1997 to 2002 whereby contracts were in effect prior to approval by the proper officials.

Indiana Code 4-13-2-14.1 and 14.2 require that a contract to which a state agency is a party must be properly approved and in writing.

INTERNAL CONTROLS - INSTITUTIONS

During our review, we found that Recreation Funds at FSSA's Muscatatuck Developmental Disability Facility (MDDF) were spent on unallowable items, such as steaks for MDDF employees. In addition, payments were made for items which were covered by state appropriations, such as patient haircuts. FSSA central office had not issued a policy on the use of Recreation Funds in State Institutions, as required by statute. The unallowable items are specifically detailed in the results of a special audit of the MDDF performed by State Board of Accounts which will be issued in a separate audit report.

Indiana Code 4-24-6-6 states in part:

"(b) These funds shall be used, at the discretion of the superintendent or warden subject to the approval of the chief administrative officer of the department, division, or state agency having administrative control and supervision over the institution, for the direct benefit of persons who are inmates or patients in such institutions, and shall not be used for any purposes which are covered by state appropriations.

(c) The funds shall be expended for purposes in accordance with the policies of the department, division, or state agency having administrative control over such institution."

INACTIVE FUND/CENTER

During our review of FSSA, we found that fund center 6000/120800 had no activity for over two years.

If a fund/center has been inactive for a period of two or more years, the agency should contact the State Budget Agency as to the continued need for any inactive funds on hand. If the fund/center contains federal funds, the grantor must be contacted regarding a balance owed. When a fund/center is no longer necessary, the agency's Budget Analyst should be contacted concerning elimination of the remaining balance. (Accounting and Uniform Compliance Guidelines Manual for State Agencies, Chapter 2)

CASH MANAGEMENT LATE DRAWS

During our review of FSSA, we found several federal draws that did not follow the check clearance pattern templates as prescribed under the Cash Management Improvement Act. These draws were drawn late and as a result the State lost interest on the draws.

Each agency, department, institution or office should have internal controls in effect which provide reasonable assurance regarding the reliability of financial information and records, effectiveness and efficiency of operations, proper execution of managements' objectives, and compliance with laws and regulations. (Accounting and Uniform Compliance Guidelines Manual for State Agencies, Chapter 1)

FAMILY AND SOCIAL SERVICES ADMINISTRATION
EXIT CONFERENCE

The contents of this report were discussed on August 2, 2006, with Anne W. Murphy, FSSA Chief of Staff; and Sidney P. Norton, FSSA Chief Financial Officer. The official response has been made a part of this report and may be found on pages 20 through 30.

The contents of this report were discussed on August 28, 2006, with Venita Moore, former FSSA Secretary.

"People helping people help themselves"

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

Indiana Family and Social Services Administration
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

E. Mitchell Roob Jr., Secretary

August 17, 2006

Bruce Hartman
State Examiner
Indiana State Board of Accounts
302 West Washington Street, Room E418
Indianapolis, Indiana 46204

Thank you for the opportunity to respond to the State Board of Accounts State Compliance Audit of the Family and Social Services Administration. We appreciate the review and recommendations. Attached please find the FSSA response to the audit findings.

Sincerely,

Sidney Norton
Chief Financial Officer
Indiana Family and Social Services Administration

INCONSISTENT PROCEDURES

Contact Person:	David Nelson
Title of Contact:	Director of Finance
Phone:	(317) 232-7088

Corrective Action Plan – August 2006:

FSSA has centralized accounting and payables functions to enhance consistent procedures. In addition, FSSA has begun implementing PeopleSoft Financials. This system will enable FSSA to have one source for all financial information. However the Auditor of State (AOS) is currently not using PeopleSoft. Until the AOS begins using PeopleSoft on July 1, 2007, FSSA must use manual processes and work-arounds including utilizing various financial software systems to be in compliance with AOS requirements. FSSA continues to assess consolidating software and systems currently in use within the agency.

COUNTY OFFICES OF FAMILY AND CHILDREN—ACCOUNTING OPERATIONS

Contact Person:	Mary Edmonds
Title of Contact:	Deputy Director of Administrative Services, DCS
Phone Number:	(317) 232-4758

Corrective Action Plan – August 2006:

The Department of Child Services is currently developing standard procedures for local office internal controls. These procedures will be implemented in each of the ninety-two (92) local offices. Implementation will include documentation of procedures and policies; resource manual; internal review team; statewide training; an on-going audit team; and a statewide accounting system. The internal review teams will at each local office review the current process; recommend appropriate re-organization of office; assist with implementation of recommendations; and assist with training.

A request has been made for three (3) Accountant 1 positions to staff the Internal Review Team. This team will be supervised by the Deputy Director of Administrative Services and/or the Controller.

Currently, a group made up of representatives from DCS Executive Staff, DCS Budget, DCS Legal, State Board of Accounts, FSSA Audit, FSSA Procurement, FSSA Financial Management, Local Office Directors, and Local Office Accounting staff, are meeting to determine what the appropriate policies and procedures should be and determine an appropriate timeline for implementation.

COUNTY OFFICES OF FAMILY AND CHILDREN – CONTRACTS AND PROCUREMENT

Contact Person:	Celia Leaird
Title of Contact:	Manager of Prevention Services
Phone Number:	(317) 232-4497

Corrective Action Plan – August 2006

The Department of Child Services (DCS) has developed a contracting process to be used by Local offices. Because of the volume of contracts at the local level and the lack of infrastructure to support that volume in the central office, Interim Guidelines have been established with the Department of Administration. These have been shared with local offices. The Department of Child Services has further developed a process by which local offices may not enter a contract for services a the local level without the approval of the Regional Services Council (an oversight group composed of officials other than DCS staff as well as some DCS staff).

DCS proposes to address corrective action by developing a process for internal review of the DCS local office contracting process. In order to accomplish this task it would be most helpful if the State Board of Accounts would notify DCS when there is a finding that there is a local office that is operating outside the contracting guidelines.
Further, it should be noted that DCS, by Memorandum of Understanding, depends upon the FSSA contracting system. This system is under internal review in order to develop procedures by which the overall contracting process can be more responsive to the contracting needs of DCS. DCS will strongly recommend that this new process be capable of incorporating the local office contracts into its final product.

As previously indicated, this process cannot be concluded in a one year period. Every year, however, there is progress made in attaining the goal of managing local office contracts as part of the state contracting system.

CHILD CARE DEVELOPMENT FUND (CCDF)—INTAKE AGENTS

Contact Person:	Jim Robertson
Title of Contact:	Director, Division of Family Resources (DFR)
Phone Number:	(317) 233-1925

Corrective Action Plan – August 2006:

As noted in FSSA/CCDF response report to SBOA in December 2004, and again in April 2005, accountability language for all FFY 2006 CCDF Intake Agent contracts was implemented effective 10-1-05. The language is specific to errors made in the eligibility determination process, and the escalating consequences for continual deficiencies in this area, up to and including repayment of direct services dollars and termination of the Intake Agent Contract. FSSA Audit is included on all Intake Agency monitoring reports

where ineligible clients are found, and uses these reports to determine potential for further audit review.

It should be noted that because all intake agents are monitored at least once a year, Audit Service's risk assessment considers the intake agents to be a low risk program. However, Audit Services does receive all intake monitoring reports, completes the associated appeals and does consider any extraordinary findings for further audit assignment.

MONITORING

Contact Person:	Debra Currey
Title of Contract:	Director, FSSA Audit Services
Phone Number:	(317) 232-6859

Corrective Action Plan – August 2006:

Prior Finding Item C (Agency-Wide Monitoring Weakness) (Process Servers)

Three initiatives are underway to resolve this finding.

1) KPMG has completed an extensive review and is finalizing a report that outlines FSSA's current auditing and monitoring activities and analyzes it for weaknesses and restructuring of resources. One of the recommendations in that report is that all contracts for auditing or monitoring services be directed through the Office of Audit Services. This coordination will help ensure better coverage of all program areas and all significant contracts.
2) Audit Services has become more involved in the Medicaid contracts for auditing and monitoring and is also involved in developing an RFP to have an MMIS audit completed on the largest claims processor contractor, EDS.
3) Audit Services recently purchased and has had a portion of their staff trained on a data mining software called Audit Command Language (ACL). In addition, a Database Administrator was added to Audit Service's staff. ACL is currently being used to do some continuous monitoring of EDS, CMS, ACS, Covansys, and ICES.

DEVELOPMENTAL DISABILITIES CONTROLS

Contact Person:	John Parks
Title of Contact:	Director, Business Operations, BDDS
Phone Number:	(317) 234-1527

Corrective Action Plan – August 2006:
Claims Payment:
Medicaid Waiver Funding as Stated in Original Finding

- A new system of managing delivery of services to consumers was implemented on November 1, 2005. This system replaced most individual service billings (in

quarter hour increments) with three budgeted groups of services: residential habilitation and supports services (RHSA), day services (DSRV) and behavioral support services (BMGT/BMG1). The annual assessment, spearheaded by the case manager, forms the basis for the development of the ISP, the CCB and the annual budget, controlled through a daily budget rate. The number of individual billing transactions per year has dropped from a rate of 82 million to 5 million, while significantly increasing both the accuracy rate and the cash flow to the providers.

Title XX as Stated in Original Finding

Status for Report Period

The Bureau of Developmental Disabilities Services plans has put in place a system to approve services for each recipient and billing will be based on that approval. This is similar to the process used for the Individual Community Living Budget (ICLB) for State Funding of residential services. This allows for the verification of the validity of day service (Title XX) claims at the time of processing. In order to accomplish the verification of billing against the proper funding source, each provider sends an electronic submission of a report indicating by client the services being billed on the claim. This was put in place on July 1, 2003.

It should also be noted that Title XX funding source was terminated on April 1, 2002. The term continued, but the funding source dried up on that date. The new process for State-line reimbursement plans (effective July 1, 2006) has finally eliminated the term, substituting the more appropriate term, "employment supports."

In 2006, the Bureau of Developmental Disabilities Services is in the process of implementing individual Cost Comparison Budget control procedures similar to those used for waiver recipients. Individual-based billings will be submitted to CMS through the state funded data system in a similar format to that used for waiver recipients. Audit and pre-approval control process are the responsibility of BDDS.

State Funding as Stated in Original Finding

Status for Report Period

This is a correction to what was stated in the previous response. The previous response stated that Financial Management ensures that we are not paying for more services than were approved. However, this is not the case. Each person has an ICLB, which establishes a specific dollar amount of services that are approved, and the provider can only bill up to that point. A claim of more than the approved amount will get kicked out automatically by the system prior to the claim being submitted to CMS for payment.

In 2006, the Bureau of Developmental Disabilities Services is in the process of implementing individual Cost Comparison Budget control procedures similar to those used for waiver recipients. Individual-based billings will be submitted to CMS through

the state funded data system (DART) in a similar methodology to that used for waiver recipients. Audit and pre-approval control process are the responsibility of BDDS. Target date for implementation of this new system is July 1, 2006.

Appropriate and Necessary Services as Stated in the Original Finding

Status for Report Period

Effective September 1, 2006, a single case management entity, IPMG, will train and oversee the case managers for all developmentally disabled consumers on waivers. This assures the independence between case manager and provider, and reinforces the importance of the quality control role that the case manager should exercise.

HOSPITAL CARE FOR THE INDIGENT (HCI)—PHYSICIAN AND TRANSPORTATION CLAIMS

Contact Persons:	Rich Adams/Carl McPherson
Titles of Contacts:	Deputy Director, DFR/Program Accountant
Phone Numbers:	(317) 232-1148/(317) 232-7087

Corrective Action Plan – August 2006:

LACK OF OVERSIGHT OF INCOME ELIGIBILITY DETERMINATIONS

Due to the anticipated privatization of this function, local office workers will no longer determine eligibility for HCI. Our budget request to add Quality Control staff to audit determinations is pending.

LACK OF INDEPENDENT INCOME VERIFICATIONS

We anticipate the future vendor will automate the HCI eligibility process and interface with other State Data bases, including DWD and DOR.

LACK OF IDENTITY VERIFICATIONS

This area will be discussed with the private vendor. Since negotiations are currently underway, we are not able to view all aspects of their eligibility solutions, including HCI.

LACK OF SIGNATURE VERIFICATION
DFR vendor will approve all financially Certificate of Action (COA) electronically and sent to the state for medical approval with secure electronic signature early 2007.

INSUFFICIENT CLAIM VERIFICATION
Since there is a medical staff review and claim approval, it is cost effective to the state to use clerical staff to data process and file processed HCI claims. Having an additional higher level review is not deemed to add enough benefit to justify the cost.

MANUAL CALCULATION OF CLAIMS
This has been corrected by attaching all adding machine tapes to the form 1500.

LACK OF MEDICAL LICENSE VERIFICATIONS
Verification of the physician license in the State is verified by the hospital that allows the physician hospital privileges. All of these services are performed at Indiana hospitals.

LIMITED, MANUAL SCREENING FOR MEDICAID DUPLICATES
HCI data base checks for Medicaid duplicate payments before processed for payment.

LACK OF PROVIDER AUDITS
Currently there is discussion with FSSA/Audit to hire medical auditor(s) to audit HCI provider records.
LACK OF DATA ANALYSIS
Currently there is discussion with programmer to analyze data for unusual billing patterns or anomalies.

INSUFFICIENT DATA COLLECTED TO SUPPORT DATA ANALYSIS.
Currently there is discussion with programmer to capture service codes to show unusual patterns of medical services.

HOSPITAL CARE FOR THE INDIGENT (HCI)—HOSPITAL CLAIMS

Contact Persons:	Rich Adams/Carl McPherson
Titles of Contacts:	Deputy Director, DFR/Program Accountant
Phone Numbers:	(317) 232-1148/(317) 232-7087

Corrective Action Plan – August 2006:

LESS RELIANCE ON MANUAL PROCEDURES FOR CLAIMS PRICING
Currently there is discussion to automate this procedure; however, cost may be inhibitive.

GREATER RISKS FOR CONFLICTS OF INTEREST
This area will be discussed with the private vendor. Since negotiations are currently underway, we are not able to view all aspects of their eligibility solutions, including HCI.

HOSPITAL CARE FOR THE INDIGENT (HCI)—DEMOGRAPHIC DATA

Contact Persons:	Rich Adams/Carl McPherson
Titles of Contacts:	Deputy Director, DFR/Program Accountant
Phone Numbers:	(317) 232-1148/(317) 232-7087

Corrective Action Plan – August 2006:

The following data is not captured by the HCI database
1. Income date

This will be done by the DFR vendor early 2007

2. Medical data

This is in the planning stage with a programmer to secure this data.

3. additional demographic data

We are collecting county of residence, welfare/SSI status, race, household status.

HOSPITAL CARE FOR THE INDIGENT (HCI)—RECONCILIATIONS TO AUDITOR OF STATE

Contact Persons:	Rich Adams/Carl McPherson
Titles of Contacts:	Deputy Director, DFR/Program Accountant
Phone Numbers:	(317) 232-1148/(317) 232-7087

Corrective Action Plan – August 2006:

FSSA reported revenue matches while the Auditor of State (AOS) reported fund transferred into the State HCI fund. FSSA believes it is the responsibility of the Department of Local Government to ensure that HCI tax levy funds are collected and deposited into the proper HCI county fund.

HOSPITAL CARE FOR THE INDIGENT (HCI)—HIPAA COMPLIANCE

Contact Persons:	Rich Adams/Carl McPherson
Titles of Contacts:	Deputy Director, DFR/Program Accountant
Phone Numbers:	(317) 232-1148/(317) 232-7087

Corrective Action Plan – August 2006:

Plans and an IR have been submitted to IDOA through Andy Turner to secure the area to meet HIPAA compliance.

HOSPITAL CARE FOR THE INDIGENT (HCI)—INDEPENDENT CONTRACTORS

Contact Persons:	Rich Adams/Carl McPherson
Titles of Contacts:	Deputy Director, DFR/Program Accountant
Phone Numbers:	(317) 232-1148/(317) 232-7087

Corrective Action Plan – August 2006:

An analysis has been completed that it is a benefit to the state to hire independent contractors rather than state employees.

FSSA believes we meet the IRS 15A employers supplemental tax guide. While Contractor do not generally perform similar work for other clients because they dedicate so many hours to our projects, they could if they chose to. In addition, the contractor, bears the risk of profit and loss, supplies their own tools, and pays for their own training. The State supplies the telephone and computer but we consider this to be for our

convenience and to less reimbursement type expenses.

CONTRACT REQUIREMENTS—UNALLOWABLE EXPENDITURES

Contact Person:	Douglas Herrington
Title of Contact:	Director, Claims Management
Phone Number:	(317) 234-1488

Corrective Action Plan – August 2006:

Financial Bulletin #5: Expenditure Authorization and Payment Accountability, Originated October 1, 2003 and revised June 1, 2005, establishes "procedures for authorized personnel to request and approve the expenditure of funds on behalf of programs administrated by FSSA and its various divisions and FSSA departments through individual work units." In this specific case, DTS was the responsible department for authorizing payment for this contract. The payment in question was signed and approved by a DTS representative whereby Claims Management then made the payment based on this approval. Established procedures within Financial Bulletin #5 will remain the same and keeps the responsibility of monitoring vendor performance and compliance with contractual terms within the responsible department. The maintaining of verification and documentation of expenses related to a specific contract are required of the vendor. Additional documentation and reporting may be required by the responsible department as needed to confirm vendor performance and compliance.

Contract Approvals

Contact Persons:	G. Douglas Seidman/Douglas Herrington
Title of Contacts:	Chief Counsel for Contract Administration & Director, Claims Management
Phone Numbers:	(317) 232-1684/(317) 234-1488

Corrective response and action plan:

Response: This finding says FSSA has allowed contracts to go into effect before those contracts have been fully approved as required by IC 4-13-2-14.1 and 14.2. This is interpreted that FSSA engages in the improper practice of allowing work under a contract to begin prior to that contract having been reduced to writing and approved by all necessary parties and that this practice is improper even if a Contractor is made fully aware of the risks and voluntarily agrees to start work.

Contractors are advised that should the approval of the contract be delayed, so will their payment be delayed. And, in the unlikely situation that their contract cannot be approved at all, that they will not be compensated at all for work performed. FSSA closely follows the requirement that, except in situations permitted under IC 4-13-2-14.2(b), no claims are paid unless and until a contract has been fully executed and approved.

It should be noted that the contracts in question were not paid prior to full execution of the contracts. The KPMG contract was signed by the Attorney General on 3/30/05 and

the first payment was made 4/27/05. The Crowe Chizek contract was signed by the Attorney General on 2/25/05 and the first payment was made on 4/21/05.

Therefore, the finding, as described above, is accurate. FSSA has, by necessity, engaged in this practice with willing Contractors for many years, however, we recognize and agree that it is not a best practice.

Corrective action plan: We are currently using a multi-disciplinary team to develop and implement a streamlined contracting process that we expect to improve the contract process so all will be fully drafted, negotiated and approved before work begins. The target date for the implementation of the greatly streamlined and more efficient contracting system is October 1, 2006.

Until that new contracting process can be fully implemented and operated for a sufficient time period to allow its more efficient processes to put us at the point of being able to have all contracts in writing and fully approved prior to the start of performance, we have no choice but to rely on the goodwill of Contractors willing to begin work at risk. To not do so would cause the vital work that FSSA performs for this State's most vulnerable citizens to be unacceptably delayed.

INTERNAL CONTROLS—INSTITUTIONS

An exit conference for the special audit performed by the State Board of Accounts on Mascatatuck was conducted 8/9/06. A response to those findings, and therefore, this finding will be expounded upon and published with that report.

INACTIVE FUND/CENTER

Contact Person:	David Nelson
Title of Contact:	Director of Finance
Phone:	(317) 232-7088

Corrective Action Plan – August 2006:

Approximately $15,000 was donated by an estate to fund the Dr. Nathon Salon Library fund center for the purpose of purchasing resources for programs related to aging. There are no federal funds in this fund center. The Indiana Division of Aging is reviewing possible uses of the remaining funds.

CASH MANAGEMENT LATE DRAWS

Contact Person:	David Nelson
Title of Contact:	Director of Finance
Phone:	(317) 232-7088

Corrective Action Plan – August 2006:

The check clearance pattern has been updated in the Federal Expenditure Tracking System (FETS) to ensure that draws are in compliance with the Cash Management Improvement Act (CMIA). As part of the implementation of PeopleSoft Financials the process of identifying and drawing federal funds is being reviewed to insure the State does not lose interest unnecessarily and complies with the CMIA.