DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date APR 26 1994

From June Gibbs Brown
Inspector General

Subject Improvements Needed in Financial Management Systems To Enhance Medicare Financial Reporting (A-14-92-03015)

To
Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, "*Improvements Needed In Financial Management Systems To Enhance Medicare Financial Reporting*." The objective of our review was to determine whether information processed through the Health Care Financing Administration's (HCFA) financial management systems supported the amounts contained in Medicare financial reports.

The HCFA's financial reporting has improved because financial information is being recorded in the general ledger using the accrual basis of accounting instead of the previous used cash basis of accounting. Improvements, however, are needed to generate more information directly from the financial management system. We believe that HCFA's financial management systems need improvement to meet the requirements of the Chief Financial Officers Act of 1990 and Office of Management and Budget requirements. The HCFA needs to develop integrated financial management systems that generate accrual financial information. The planning to integrate accounting data in HCFA's financial management system should be included in the design of the Medicare Transaction System.

We recommend that HCFA take action to ensure that (1) actual disbursement information is recorded timely by the Medicare contractors and HCFA; (2) all accounts payable are adequately recorded and reported; (3) all Medicare liabilities are recorded in the HCFA general ledger at fiscal yearend; (4) capitalized HCFA equipment in the possession of contractors is included in the general ledger; (5) assets paid from the trust funds and liabilities owed from the trust funds are properly distributed to the Medicare trust funds; (6) the value of automated data processing hardware and software is properly reported; and (7) all transactions from the entire life cycle of a transaction, including the initiation and authorization until its final classification in the summary records from which reports and statements are prepared, are promptly recorded and properly classified. Lastly, we recommend that HCFA take steps to ensure that all of the subsidiary financial management systems

that process, control, and account for Medicare financial transactions and resources, both present and planned, are designed to be an integral part of HCFA's overall financial management system.

Based on our review of HCFA's comments, there was disagreement with recommendations 1, 4, and 5. After reviewing HCFA's comments and having follow-up meetings with HCFA officials, we modified our recommendation to concur with HCFA's comments with respect to recommendation 1, but continue to disagree with HCFA's position on recommendation 4. The outstanding issues with recommendation 4 involve the recording of HCFA owned equipment in the possession of Medicare contractors. We propose that HCFA request a waiver from the Department's Assistant Secretary for Management and Budget to continue their present accounting procedure. The HCFA did not agree with recommendation 5, but they are taking corrective actions that we find acceptable.

Although HCFA concurred with recommendations 3, 7, and 8 they do not plan to fully implement them at this time. We share HCFA's concerns and plan to assist them in implementing these recommendations. The HCFA's comments and our responses are included in the *HCFA Comments And Office of Inspector General Responses* section of this report and HCFA's comments are included in their entirety as an Appendix to this report.

Please advise us, within 60 days, on actions taken or planned on our recommendations. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at (410) 966-7104. Copies of this report are being sent to other interested Department officials.

To facilitate identification, please refer to Common Identification Number A-14-92-03015 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

IMPROVEMENTS NEEDED IN FINANCIAL MANAGEMENT SYSTEMS TO ENHANCE MEDICARE FINANCIAL REPORTING

JUNE GIBBS BROWN
Inspector General

APRIL 1994
A-14-92-03015

SUMMARY

Federal agencies, including the Health Care Financing Administration (HCFA), have traditionally prepared financial reports to monitor and control the obligation and expenditure of budgetary resources. We believe that HCFA's financial management systems were designed for that reason. The focus on fund control has caused HCFA to concentrate primarily on financial management systems that control obligations rather than account for total costs and resources used. The HCFA has made improvements to its financial reporting by incorporating accrued financial data into its general ledger system. However, we believe that HCFA's financial management systems need improvement to support the preparation of financial statements and meet Office of Management and Budget (OMB) requirements.

Under 31 U.S.C. section 3512(a) and (b), each agency is responsible for establishing and maintaining adequate systems of accounting and internal control. These systems must conform to the accounting principles, standards, and internal control standards established by the OMB, Department of the Treasury (Treasury), and Comptroller General. However, with the enactment of the Chief Financial Officers (CFO) Act of 1990, the Congress called for the production of financial statements that fully disclose a Federal entity's financial position and results of operations. These statements are to provide information not just for the effective allocation of budgeted resources, but also information with which the Congress and others can assess management performance and stewardship. The OMB requires financial statements to be the result of an accounting system that is an integral part of a total financial management system containing sufficient discipline, effective internal controls, and reliable data. Under the authority of the CFO Act, OMB waived HCFA's preparation of the Medicare Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds financial statements for Fiscal Year (FY) 1991.

Our review showed that HCFA's financial management systems did not report Medicare benefit accrued disbursements when benefit checks were issued. Benefit payment data was recorded in HCFA's financial systems at the time the checks issued to providers were processed by the contractors' banks rather than when the checks were issued by the Medicare contractors. As a result, Medicare benefit payments and accounts payable data were not reported timely and may not be accurate.

In addition, until HCFA develops integrated financial management systems that generate accrual[1] data, Medicare trust funds financial reports and statements will not be as accurate or complete as necessary. Our review found: (1) all assets, which included cash and accounts receivable, accounts payable, expenses, and liabilities were not accurately recorded; and (2) assets and liabilities were not adequately allocated from the general fund to the trust funds.

We recommend that HCFA develop and implement financial management systems and related management controls to ensure that (1) Medicare contractors report actual disbursement information in conformance with requirements, (2) all accounts payable are recorded in the HCFA general ledger at fiscal yearend, (3) all Medicare liabilities are recorded in the HCFA general ledger at fiscal yearend, (4) capitalized HCFA equipment in the possession of contractors is included in the general ledger, (5) assets paid for from the trust funds and liabilities owed from the trust funds, are properly distributed to the Medicare trust funds, (6) the value of automated data processing (ADP) hardware and software is properly reported, and (7) all transactions from the entire life cycle of a transaction, including the initiation and authorization until its final classification in the summary records from which reports and statements are prepared, are promptly recorded and properly classified. Lastly, we recommend that HCFA take steps to ensure that all of the subsidiary financial management systems that process, control, and account for Medicare financial transactions and resources, both present and planned, are designed to be an integral part of HCFA's overall financial management system.

Based on our review of HCFA's comments, there was disagreement with recommendations 1, 4, and 5. After reviewing HCFA's comments and having follow-up meetings with HCFA officials, we modified our recommendation to concur with HCFA's comments with respect to recommendation 1, but continue to disagree with HCFA's position on recommendation 4. The outstanding issues with recommendation 4 involve the recording of HCFA owned equipment in the possession of Medicare contractors. We propose that HCFA request a waiver from the Department's Assistant Secretary for Management and Budget to continue their present accounting procedure. Although HCFA did not agree with recommendation 5, they are taking corrective actions that we find acceptable.

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[1] The accrual basis of accounting recognizes the significance and accountable aspects of financial transactions, events, or allocations as they occur. When the cash basis of accounting is used, revenue and related assets are recognized when the cash is received, rather than earned, and expenses are recognized when the cash payment is actually made, rather than when the obligation is incurred.

Although HCFA concurred with recommendations 3, 7, and 8 they do not plan to fully implement them at this time. We share HCFA's concerns and plan to assist them in implementing these recommendations. The HCFA's comments and our responses are included in the *HCFA Comments And Office of Inspector General Responses* section of this report and HCFA's comments are included in their entirety as an Appendix to this report.

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INTRODUCTION

BACKGROUND

The Medicare program, authorized by title XVIII of the Social Security Act, helps pay medical costs for about 32 million people aged 65 years and older, as well as, 3 million people with disabilities. The HCFA, within the Department of Health and Human Services (HHS) administers two Medicare trust funds. The Medicare Part A trust fund (HI) covers inpatient hospital, skilled nursing facility, home health, and hospice care services. The Part B trust fund (SMI) covers physician services, outpatient hospital services, durable medical equipment, and various other health services, such as laboratory tests and diagnostic x-rays.

The HCFA is comprised of a central office and 10 regional offices. In addition, HCFA employs Medicare contractors to process and pay claims for health services rendered to beneficiaries. The Medicare Part A contractors are called fiscal intermediaries (intermediaries); whereas, the Part B contractors are called carriers.

For the FY ended September 30, 1991, Medicare trust funds financial information was reported on two separate sets of Standard Form (SF) 220 series reports. The SF 220 series reports include: *Report on Financial Position* and *Report on Operations*. One set of SF 220 series reports was prepared by HCFA and the other set was prepared by the Treasury. The HCFA prepared SF 220 series reports incorporated data from its general ledger. The Treasury prepared SF 220 series reports incorporated data initiated by the Treasury and by other Government agencies that were reported to the Treasury.

Under the CFO Act, HCFA was to prepare FY 1991 financial statements on the HI and SMI trust funds. These financial statements were to be submitted to OMB by March 31, 1992. On September 21, 1991, OMB exercised its authority under the CFO Act and waived HCFA's FY 1991 financial statements requirements. The OMB Bulletin No. 91-15, however, requires that the principal financial statements should result from an accounting and budgeting system that is an integral part of its total financial management system and one that contains sufficient discipline, effective internal controls, and reliable data. The financial statements and underlying financial systems shall report on the total operation of the reporting entity and shall comply with the OMB, Treasury, and Comptroller General's principles, standards, and related requirements.

INTERNAL CONTROL STRUCTURE

The HCFA is responsible for establishing and maintaining an internal control structure in accordance with the Accounting and Budgeting Act of 1950, and the Federal Managers' Financial Integrity Act (FMFIA) of 1982. In fulfilling this responsibility, estimates, and judgments by management are required to assess the expected benefits and related costs of the required internal control structure.

The objectives of an internal control structure are to provide management with reasonable assurance that (1) obligations and costs are in compliance with applicable law; (2) funds, property, and other assets are safeguarded against waste, loss, and unauthorized use or misappropriation; and (3) assets, liabilities, revenues, and expenditures applicable to agency operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports.

The purpose of the auditor's assessment of the internal control structure is to identify and communicate reportable conditions. Reportable conditions are significant deficiencies in the design or operations of the internal control structure, which could adversely affect HCFA's ability to meet the above stated objectives. Reportable conditions are classified as a material weakness or material nonconformance when the internal control structure, including the financial management systems, do not reduce, to a relatively low level, the risk that errors or irregularities in amounts material to the financial reports and statements being audited may occur and not be detected in a timely manner by responsible officials.

SCOPE

The objective of our review was to determine whether Medicare financial reports were supported by information maintained by financial management systems that was in accordance with applicable Government accounting principles.[2] In planning and performing our review, we obtained an understanding of the relevant internal control policies, procedures, and data flow by interviewing officials and reviewing documentation; tested procedures; and assessed control risk. In order to achieve our objectives, we:

- Reviewed the appropriate reports of the Office of Inspector General (OIG) and the General Accounting Office (GAO) and HCFA's internal reports pertaining

[2] This includes the HHS *Departmental Accounting Manual*, that incorporates the GAO *Policy and Procedures Manual for Guidance of Federal Agencies*, Title 2 (Title 2), and accounting principles issued by OMB, Treasury, and the Joint Financial Management Improvement Program (JFMIP).

to the scope of our review. The latter reports were considered in planning our review, and in determining the nature, timing, and extent of our review tests.

- Reviewed applicable laws and regulations;[3] GAO,[4] OMB,[5] Treasury, and HHS related accounting principles and standards; and HCFA procedures.

- Reviewed management's process for evaluating and reporting on internal controls and accounting systems as required by the FMFIA and compared the agency's most recent FMFIA reports with reviews we conducted of the entity's internal control system.

- Reviewed management's process and financial management systems used to prepare Treasury SF 220 series reports for September 30, 1991 and reviewed HCFA's process to prepare the SF 220 series reports to ensure the reports were prepared in accordance with applicable Treasury and HHS procedures.

- Obtained an understanding of the design of the relevant policies and procedures for activities that pertain to the Part A and Part B benefit payments, Medicare accounts payable, program administrative costs allocated to the Medicare trust funds, and Medicare revenues. We performed limited tests, including observation, and inquiry of judgmentally selected control procedures for all the activities listed above. We also performed limited tests by tracing judgmentally selected transactions on selected account balances associated with the respective control category.

We performed our review in accordance with generally accepted government auditing standards. We performed our work at HCFA central office and at judgmentally selected Medicare intermediaries and carriers for the States of Massachusetts, Florida, and Minnesota.

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[3] The Social Security Act, as amended; the FMFIA of 1982; and the CFO Act of 1990.

[4] References to Title 2 are made when it supplements the HHS *Departmental Accounting Manual.*

[5] This includes OMB Bulletins on form and content of agency financial statements and OMB circulars on financial management systems and internal controls.

FINDINGS AND RECOMMENDATIONS

The task of preparing full disclosure financial reports and statements in accordance with applicable Government accounting principles has shown to be an evolving process by the various Federal agencies that have prepared financial statements for the first time. On several occasions during FYs 1991 and 1992, the OIG and HCFA staff discussed the preparation of financial statements and the changes needed in the HCFA financial management systems in order to prepare full disclosure financial statements. Although HCFA has not modified its financial management systems to record information in accordance with applicable Government accounting principles, HCFA has incorporated the following changes into its reporting of financial information:

- FY 1990 was the first year HCFA recorded amounts in its general ledger for benefit payment accounts receivable and accounts payable;
- FY 1991 showed that HCFA recorded amounts in its general ledger for additional categories of benefit payment accounts receivable and accounts payable; and
- FY 1991 was the first year HCFA recorded amounts in its general ledger for benefit payment contingent liabilities.

Although HCFA recorded these amounts, we have reported[6] and our review has shown that the reliability of this data is uncertain because it was not complete and not always based on actual amounts. The HCFA needs to develop financial management systems which record assets, liabilities, payments, and collections as they accrue.

RECORDING OF MEDICARE BENEFIT DISBURSEMENTS

Our review found that HCFA did not have adequate financial management systems to report the actual disbursement of Medicare benefits at the time the contractor issued checks to the providers. As a result, Medicare benefit payments (cash), expenses, and accounts payable information are not reported timely and may not be accurate.

[6] OIG report entitled *Review of the Accounts Receivable Balances for the Hospital Insurance and Supplementary Medical Insurance Trust Funds at September 30, 1991* (A-01-91-00525, draft dated September 1992 and final dated June 1993).

FINANCIAL MANAGEMENT SYSTEM REQUIREMENTS FOR REPORTING MEDICARE DISBURSEMENTS NOT FOLLOWED

Government accounting systems should record transactions on the accrual basis of accounting[7] and should recognize accountable aspects of financial transactions, events, or allocations as they occur. In addition, under 31 U.S.C. section 3512(a) and (b) and OMB guidance, an agency must provide complete disclosure of financial results; effective control over, and accountability for, assets; and adequate internal accounting and administrative controls that ensure that expenditures may be accounted for properly so that accounts and reliable financial reports may be prepared.

The GAO[8] requires that accounting system transactions be promptly recorded if pertinent information is to maintain its relevance and value to management in controlling operations and making decisions. This standard applies to (1) the entire process or life cycle of a transaction or event and includes the initiation and authorization, (2) all aspects of the transaction while in process, and (3) its final classification in summary records.

In addition, the JFMIP's *Core Financial System Requirements* for disbursement accounting provide that the financial management system: (1) include for each payment all relevant identification information, such as, order number, invoice number, disallowance (reason for and amount), and interest penalty amount; (2) automatically calculate totals by appropriation symbols for inclusion on the payment schedule; and (3) provide information about each payment to reflect the stage of the scheduling process that the payment has reached and the date each step was reached.

Recording Benefit Payments

When a contractor received a Medicare claim for services rendered to a beneficiary, it was subjected to several preliminary processing steps and edits. If the claim passes all edits, it was transmitted to the contractor's servicing Common Working File (CWF) host. At the CWF host, the CWF performed several final edits, and if the claim passed all the edits, payment was authorized, and it was transmitted back to the contractor. The contractor held the authorized payment for 14 days. After this required waiting period, the contractor processed the payment to the provider. A

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[7] The HHS *Departmental Accounting Manual* defines disbursements as checks issued or cash paid, net of refunds.

[8] As required by Title 2, Appendix III, Accounting System Standards.

check was issued to the provider using a subcontracted commercial bank. We noted, however, that the date the Medicare beneficiary received services was not recorded on a financial management system.

At the time the check issued to the provider cleared the commercial bank, a Treasury Financial Management Service Form 5401 (Form 5401), was completed and sent to the Federal Reserve Bank to obtain the necessary funds to pay for the Medicare checks the commercial bank received that day. The Federal Reserve Bank sent a copy of the Form 5401 to HCFA for their use in recording the disbursing entries in the HCFA general ledger.

Intermediaries also processed some Part B claims that are paid out of the SMI trust fund (these principally involve outpatient service claims filed by hospitals). When these contractors used the same commercial bank for HI and SMI trust fund banking activity, one Form 5401 was processed daily and did not identify the amounts that were applicable to the individual trust funds. The HCFA's accounting system, therefore, distributed the total disbursements to the HI and SMI trust funds based on the prior 5 months actual expenditures. Each month the contractor submitted a Contractor Draws on Letter of Credit, HCFA Form 1521 (Form 1521) that summarized the daily Form 5401s processed for the month and provided individual HI and SMI trust fund totals. Accounting entries to the general ledger were used to reverse the estimated HI and SMI trust fund disbursement transactions and record actual trust fund totals based on the Form 1521.

As illustrated, HCFA does not have financial management systems to report the actual disbursement of Medicare benefits at the time the contractor issued checks to the providers and was not receiving essential accounting disbursement information, such as:

- when the payment (check) was issued;
- the payment amount attributable to the appropriate Medicare trust fund;
- the period of time covered by the Medicare claim; and
- any differences between the amount authorized by the CWF system and the amount paid by the contractor including disallowances or interest.

Medicare Contractors Are Not Required To Report Disbursement Information

Financial management systems do not record the actual disbursement of Medicare benefits at the time the contractor issued checks to the providers because HCFA does not require the contractors to report such information. The HHS *Departmental*

Accounting Manual specifies that a disbursement occurs when a bill is paid and that the disbursement be recorded as a reduction of a liability (e.g., accounts payable) and a reduction to cash. In addition, the *Treasury Financial Manual* specifies that a recipient organization (i.e., contractor) initiate each letter of credit draw down considering when checks will be issued for payment.

When the contractor issued checks to the provider, HCFA did not recognize the disbursement. The HCFA recorded the draw down on a letter of credit by the contractors' bank as a disbursement of Federal funds. This process resulted in the recording of disbursements well after the date the Medicare claim was actually paid (by issuing a check). We believe the payments were no longer an accounts payable, as defined by the HHS *Departmental Accounting Manual*, as the service to the beneficiary was not only provided and payment was authorized, but a check was issued to the provider. As a result, reported Medicare benefit disbursements (cash), expenses, and accounts payable information was not timely and may not always be accurate.

RECORDING OF ACCOUNTS PAYABLE AMOUNTS

Our review found that HCFA did not have financial management systems that could adequately record and report Medicare accounts payable. We found that categories of accounts payable were not recorded, an estimate for beneficiary services incurred but not yet billed was not included in the reported amount, actual claim amounts were not reported for claims in process, and Medicare contractor outstanding checks and commercial bank balances were included in the accounts payable amount. As a result, we believe that the accounts payable balances for the Medicare trust funds at yearend FY 1991 are not correct and are potentially understated.

The Medicare trust funds reported a balance for public accounts payable of $4.57 billion at September 30, 1991. The majority of the accounts payable balance consisted of $2.35 billion of contractor claims in process and $2.16 billion in outstanding checks and bank balances (see Table I).

Trust Funds
(in billions)

	Total	HI	SMI
Contractor Claims In Process	$2.35	$1.37	$ .98
Outstanding Checks & Bank Balances	2.16	.95	1.21
Appealed Claims	.05	✓	.05
Demonstration Projects	.01	✓	.01
Total	$4.57	$2.32	$2.25

✓ Less than $5 million.

Source: HCFA provided documentation.

Table I: Medicare Accounts Payable Balances at September 30, 1991

ITEMS NOT REPORTED AS ACCOUNTS PAYABLE

The HHS *Departmental Accounting Manual* requires that an accounts payable for goods and services shall be recorded as a liability and reported when the services are received. Our review found that HCFA did not have a financial management system to adequately record, monitor, and report accounts payable pertaining to Peer Review Organizations' (PRO) adjustments, intermediaries' post-payment adjustments, provider cost reports, and interest charges for provider cost reports. As a result, the accounts payable balances reported for the Medicare trust funds at September 30, 1991 were potentially understated in unrecorded payables.

Peer Review Organization Adjustments

The PROs are responsible for determining whether claims submitted by providers are reasonable, appropriate, and medically necessary for the level of care provided. The PROs are contracted by HCFA to perform utilization reviews and report any required underpayment adjustments to a claim to the intermediaries. The intermediaries must abide by PRO determinations and adjust subsequent claim payments to providers to ensure Medicare properly reimburses providers for underpayments. The PROs are required to report their adjustments to intermediaries by the seventh of the following month. The intermediaries have 60 days to process all PRO adjustments from the date they are received. Based on these requirements, a PRO adjustment could be outstanding for 90 days before it is processed by an intermediary.

A prior OIG report[9] noted that HCFA had not developed a financial management system to determine the amount of outstanding PRO adjustments for any given reporting period, including the current amount of outstanding PRO adjustments. We noted that HCFA maintained a database that was capable of reporting the total dollar value for processed PRO adjustments by month. However, due to the significant time delays mentioned above, the database was not updated with current and complete settlement information made by intermediaries. Therefore, the HCFA's database did not produce an updated accounts payable balance for outstanding PRO adjustments at September 30, 1991.

Post-Payment Adjustments

The intermediaries are responsible for conducting post-payment reviews and processing post-payment adjustments for claims they process. However, the HCFA

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[9] OIG report entitled *Review of the Accounts Receivable Balances for the Hospital Insurance and Supplementary Medical Insurance Trust Funds at September 30, 1991* (A-01-91-00525, dated June 1993).

does not require intermediaries to report post-payment adjustments. As a result, the intermediaries are not required to develop financial management systems to account for the number and amount of related underpayments.

By not requiring financial management systems to report the amount outstanding in post-payment adjustments, the HCFA was not able to include this amount in its general ledger for the HI and SMI trust funds. As a result, underpayments arising from post-payment adjustments by intermediaries were not included in the accounts payable balance reported at September 30, 1991.

Provider Cost Reports

Our review noted that HCFA does not require intermediaries to report provider cost report underpayments that were not paid at fiscal yearend. The intermediaries are responsible for reviewing provider cost reports. If the review determines that the Medicare program has underpaid the provider, a payment is usually made within 30 days to reimburse the provider for the underpayment. However, when a final determination is made that an underpayment exists, but payment was not made by the end of the FY, an accounts payable should be established to recognize the liability.

Interest Charges For Provider Cost Reports

Our review noted that HCFA did not require intermediaries to report interest assessed (accrued), but not yet paid, on underpaid provider cost reports at fiscal yearend. If the review of the provider cost report shows that the Medicare program has underpaid the provider and payment is not made within 30 days from the date of the final determination, the intermediary is required to pay interest. Where the interest accrued, but was not paid at fiscal yearend, a liability (accounts payable) should be established.

Estimate For Provider Services Incurred But Not Billed

We determined that an accounts payable amount was not reported for provider services incurred but not billed in the accounts payable balance reported at September 30, 1991. However, we found that an amount was recorded as a contingent liability in the HCFA general ledger. Documentation supplied by HCFA explained that the amount was recorded as a contingent liability, instead of an accounts payable, because the uncertainty of the events used to develop the estimate and the uncertain nature of the number of Health Maintenance Organizations plan enrollees (e.g., the contract conditions not fulfilled).

The HHS *Departmental Accounting Manual* requires the accounts payable balance reported in annual financial statements to reflect an estimated amount for invoices not yet received and that amounts due for benefit payments as of the end of the period shall be recorded based on available information, provided that the payment is probable and the amount estimable. In addition, the HHS *Departmental Accounting Manual* requires Federal agencies that administer health insurance programs to follow the accounting principles and standards prescribed by the American Institute of Certified Public Accountants, Financial Accounting Standards Board, and the actuarial standards of the American Academy of Actuaries. A review of the HCFA general ledger for September 30, 1991 showed a contingent liability balance to be $8 billion for the HI trust fund and $5.05 billion for the SMI trust fund for services incurred but not billed (see Table II). As a result, the accounts payable amount reported at September 30, 1991, was understated as these amounts represent an estimate for invoices not yet received. We did not review the reasonableness of this amount.

Trust Funds
(in billions)

Services Incurred But Not Billed:	Total	HI	SMI
Hospital Services	$ 7.29	$7.29	
Physicians/Suppliers	4.15		$4.15
HMO Services	1.61	.71	.90
Totals	$13.05	$8.00	$5.05

Source: HCFA Provided Documentation

Table II: Services Incurred But Not Billed Balances Recorded In The HCFA General Ledger As A Contingent Liability At September 30, 1991

THE ACCOUNTS PAYABLE BALANCE DID NOT INCLUDE AN ACTUAL CLAIMS IN PROCESS AMOUNT

Our review found that HCFA, in lieu of reporting an actual claims in process amount, used an estimated amount to report claims in process. This estimated claims in process amount was calculated using expenditure, claims processed, claims pending, a calculated percentage of approved claims, and a calculated percentage used to allocate the results based on expenditures (see Table III). As HCFA did not have financial management systems to record and report the dollar amount of actual claims in process, the claims in process amount included in the reported accounts payable balance at September 30, 1991 was not supportable and could be misstated.

$$\frac{\$75,498,402,332^{a}}{81,660,261^{b}} \times 1,897,855^{c} \times .8897^{d} \times .877^{e} = \$1,369,089,746^{f}$$

[a] Cumulative intermediary expenditures
[b] Claims processed
[c] Claims pending
[d] Percent resulting in payment
[e] Part A weighted 6 mo. average
[f] Claims in process

Source: Formula and data taken from HCFA documentation.

Table III: Procedures Used By HCFA To Determine Contractor Claims In Process Estimate For HI Trust Fund

OUTSTANDING CHECKS AND BANK BALANCES SHOULD NOT BE INCLUDED IN THE ACCOUNTS PAYABLE

Our review found that HCFA reported in its accounts payable balance, amounts representing outstanding Medicare benefit checks and Medicare bank balances. Documentation provided by HCFA explained that these amounts represented the balance owed the Medicare contractors. These amounts were reported as an accounts payable because HCFA records cash disbursements at the time the checks clear the contractors' commercial bank, rather than when the benefit payment checks were issued.

The HHS *Departmental Accounting Manual* defines accounts payable as liabilities, amounts owed for goods and services received, and amounts received but not yet earned. As the outstanding checks and bank balances represent benefits already paid, as the check was issued, this amount should not be included in the accounts payable balance. We believe that amounts representing Medicare outstanding checks and Medicare bank balances should not be reported as accounts payable. In addition, any adjustment to an accounts payable would also affect asset accounts, such as cash balances.

RECORDING OF LIABILITIES

Our review found that HCFA did not have financial management systems that could adequately report appealed provider cost reports and claims. Accordingly, HCFA will be required to pay these cost reports and claims if the appeals are decided in the favor of the provider. These cost reports and claims meet the HHS *Departmental Accounting Manual* definition of a liability and may result in a Medicare disbursement if the appeals are decided in the favor of the provider. As a result, we believe that a liability should be established to reflect the amount of cost reports and claims that will be decided in the favor of the provider.

Our review showed that HCFA did not have a financial management system to determine the amount of provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The PRRB is a quasi-judicial independent activity that conducts hearings and renders decisions on appealed cost reports from Medicare providers under certain circumstances. The HCFA reported that the PRRB had a backlog of approximately 6,000 cases at the end of FY 1990, but did not have any information pertaining to FY 1991.

We also found that HCFA did not have a financial management system to determine the amount of intermediary claims appealed to administrative law judges (ALJ). When a provider requests an appeal of disallowed claims from an intermediary, the

appealed claims may eventually be appealed to an ALJ. Our review noted that HCFA was revising its reporting requirements to determine the amount of claims appealed to ALJs for FY 1992.

As these appealed cost reports and claims may represent a Medicare disbursement that could be estimable, a liability should be recorded in HCFA's general ledger and disclosed on Medicare financial reports and statements. As a result, we believe that HCFA should develop a financial management system to estimate and report these liabilities.

PROGRAM MANAGEMENT ACCOUNTING AND REPORTING NEEDS IMPROVEMENT

Our review found that HCFA's financial management systems for program management accounting and reporting needed improvement. As a result, the HCFA improperly reported assets, liabilities, and expenditures within each trust fund balance.

Assets And Liabilities Need To Be Reported To The Proper Trust Fund

Program management assets, liabilities, and expenses were recorded in the HCFA general ledger under the program management appropriation. The HCFA cost allocation system distributed program management expenses among the general fund and the trust funds for reporting purposes. However, HCFA did not allocate program management assets and liabilities among the general fund and the trust funds. This distribution was not performed even though the trust funds have either paid for the assets or will pay for the liabilities through the cost allocation system.

HCFA Equipment On Loan To The Contractors Needs To Be Capitalized And Depreciated

The HHS *Departmental Accounting Manual* requires that all equipment with an initial acquisition cost of $5 thousand or more and an estimated life of 2 years or greater must be capitalized and recorded to the proper trust fund.

Over the years, HCFA equipment, mostly computer and related equipment, has been in the possession of various contractors performing Medicare services.[10] Our

[10]For HCFA equipment in the possession of the PROs, the equipment was purchased with HI trust funds and should be recorded to the HI trust fund.

review noted that as of November 1991, using data from the HCFA Property Management System database, we identified about $2.4 million that met the HHS capitalization of equipment requirements. As a result, HCFA should capitalize and depreciate this equipment and record it to the proper trust fund.

ADVANCED DATA PROCESSING HARDWARE AND SOFTWARE ACCOUNTING NEEDS IMPROVEMENT

Our review showed that the HCFA general ledger recorded all ADP capitalized equipment to one general ledger account. This general ledger account accumulated the value of both ADP capitalized hardware and software. The HHS *Departmental Accounting Manual* requires ADP capitalized hardware and software to be recorded into separate general ledger accounts.

CONCLUSIONS AND RECOMMENDATIONS

We found that HCFA's financial management systems did not support the accounts receivable, accounts payable, and cash disbursement amounts recorded in the HCFA general ledger. Applicable Government accounting principles require that all transactions and other significant events are to be promptly recorded and properly classified. This standard applies to the entire life cycle of a transaction and includes the initiation and authorization, all aspects of the transaction while in process, and its final classification in the summary records. Proper classification of transactions and format of information on summary records from which reports are prepared is the agency's responsibility.

As discussed, the financial management systems that support the HCFA general ledger did not always contain the necessary controls to ensure accurate Medicare financial data and reports. We determined that due to financial management systems that inadequately process accrual data, some Medicare accounts had to be manually developed based on information extracted from several systems, while others had to be estimated because needed data were not readily available. For example:

- Amounts were allocated based on expenditure data between the HI and SMI trust funds because the financial management systems were not designed to identify the proper trust fund.

- Estimates were developed using work load and expense data in lieu of actual data because the financial management systems were not developed to provide the needed data.

- Cash disbursements were not reported using actual payment data of Medicare benefits at the time the contractor issued the checks to the providers because the HCFA does not require the contractors to provide Medicare benefit disbursement information.

We believe that HCFA financial management systems were not designed to support the development of Medicare financial reports and statements in accordance with applicable Government accounting principles. In addition, the financial management systems did not meet OMB guidelines.

The HCFA's present system of reporting disbursement information does not conform to JFMIP and HHS requirements. We recommend that HCFA develop and implement financial management systems and related accounting and administrative internal controls to ensure that:

1. The Medicare contractors report actual disbursement information in conformance with JFMIP and HHS requirements.

2. All accounts payable are reported to the HCFA general ledger at fiscal yearend. The following categories should be included:

   - outstanding PRO adjustments;
   - post-payment adjustments;
   - provider cost report underpayments;
   - interest assessed on underpaid provider cost reports;
   - amount of claims in process at the Medicare contractors; and
   - services incurred but not billed by providers.

3. All Medicare liabilities are reported to the HCFA general ledger at fiscal yearend. The following accounts should be included:

   - all provider cost reports under appeal at the PRRB; and
   - claims under appeal from an intermediary to an ALJ.

4. Capitalized HCFA equipment in the possession of contractors is included in the general ledger.

5. Assets paid for from the trust funds and liabilities owed from the trust funds under the appropriation are properly distributed to the HI and SMI trust funds.

6. The value of ADP hardware and software is properly reported.

7. All transactions from the entire life cycle of a transaction, including the initiation and authorization until its final classification in the summary records from which reports and statements are prepared, are promptly recorded and properly classified.

Lastly, we recommend that HCFA take steps to ensure that all of the subsidiary financial management systems that process, control, and account for Medicare financial transactions and resources, both present and planned, are designed to be an integral part of HCFA's overall financial management system.

HCFA COMMENTS AND OIG RESPONSES

In response to our draft report HCFA agreed that it should strive to perfect its accounting system and that improvements are needed in Medicare accounting. However, there was disagreement with recommendations 1, 4, and 5. After reviewing HCFA's comments and having follow-up meetings with HCFA officials, we modified our recommendation to concur with HCFA's comments with respect to recommendation 1, but continue to disagree with HCFA's position on recommendation 4. Although HCFA did not agree with recommendation 5, they are taking corrective actions that we find acceptable.

The HCFA indicated that it has or is in the process of implementing several improvements that address recommendations 1, 2, 3, 5, and 6. For example, HCFA implemented the Financial Core Requirements to require Medicare contractors to report accounts payable data to HCFA. The HCFA also plans to:

- footnote future financial statements to disclose that the disbursement figure does not include amounts for outstanding contractor checks and will cross-reference the footnote to the accounts payable line item;

- estimate the Medicare liability for claims under appeal from an intermediary to an ALJ and report it in the general ledger at FY end;

- allocate the trust fund amounts under the Program Management appropriation to the Medicare trust funds in future financial statements; and

- record automated data processing hardware and software to proper general ledger accounts.

The HCFA concurred with recommendations 3, 7, and 8, but they do not plan to fully implement them at this time. We share HCFA's concerns and have the following comments and suggestions on these issues.

Recommendation 3

We recommend that HCFA develop and implement financial management systems and related accounting and administrative internal controls to ensure that all Medicare liabilities, including all provider cost reports under appeal at the PRRB, are reported to the HCFA general ledger at fiscal yearend.

HCFA Comments

Given the limited resources HCFA has to implement the CFO Act, HCFA plans to focus on more material system changes, and not on producing estimates of the potential liability of cases being appealed, to implement the CFO Act. The HCFA agreed that all reasonable available data should be included in the reporting of the Medicare liability. However, HCFA does not believe that implementing this recommendation is likely to produce "reliable data" for several reasons. Among the reasons is the lack of readily available financial data on provider cost reports under appeal at the PRRB. The HCFA proposed that a footnote, rather than a line item, be placed on the financial statement for recording PRRB potential liability in the HCFA general ledger.

OIG Response

The OMB Bulletin No. 93-02 requires that claims against the Government that are in process be included as a liability line item if the amount can be reasonably estimated as a specific amount or range of amounts. If HCFA can reasonably estimate the PRRB liability, the amount should be included in the financial statements as a line item. However, if an estimate cannot be made we would concur that a footnote would be appropriate to disclose the PRRB liability in the interim. Taking into account the potential materiality of the provider cost reports under appeal at the PRRB (7,000 backlogged cases), as HCFA improves upon its financial management systems, it should assess the feasibility of including these appealed cost reports.

Recommendation 7 and 8

We recommend that HCFA develop and implement financial management systems and related accounting and administrative internal controls to ensure that all transactions from the entire life cycle of a transaction, including the initiation and authorization until its final classification in the summary records from which reports and statements are prepared, are promptly recorded and properly classified.

We also recommend that HCFA take steps to ensure that all of the subsidiary financial management systems that process, control, and account for Medicare financial transactions and resources, both present and planned, are designed to be an integral part of HCFA's overall financial management system.

HCFA Comments

The HCFA concurs with this recommendation. But given the broad and sweeping nature of this recommendation, HCFA believes further discussions are necessary between HCFA and the OIG to bring about the implementation of this recommendation. While a single system might be ideal, the nature of HCFA's programs is such that it is more cost-effective to have a series of smaller systems which can be used to provide specific internal controls and summary level data as needed. The HCFA stated that the OIG appears to envision an integrated accounting process with all source data flowing to the general ledger. The HCFA recognized that additional work is needed to ensure that Medicare contractor data reported to HCFA is accurate. To this end, HCFA is developing new accounting and reporting instructions for the medicare contractors.

OIG Response

We concur that further discussion between HCFA and the OIG is needed to bring about the implementation of this recommendation. It is not our position that all source data needs to flow to the general ledger. However, a unified set of financial management systems, including subsidiary systems, is necessary to effectively manage HCFA's financial operations and report on its financial status to the Congress and the public. Additionally, HCFA's financial management systems should be planned for and managed together, operated in an integrated fashion, and linked together electronically in an efficient and effective manner to provide agency-wide financial system support necessary to carry out HCFA's mission and support its financial management needs.

Although HCFA did not concur with recommendation 4, we have the following proposal and suggestion.

Recommendation 4

We recommend that HCFA develop and implement financial management systems and related accounting and administrative internal controls to ensure that capitalized HCFA equipment in the possession of contractors is included in the general ledger.

HCFA Comments

The HCFA did not concur with this recommendation. The HCFA's accounting procedures provide that any contractor equipment, contractually owned by HCFA, is reflected in a control account and once this equipment is returned to HCFA, is depreciated based on its fair market value.

OIG Response

We do not believe this accounting procedure follows HHS *Departmental Accounting Manual* requirements. All HCFA owned equipment, whether in the possession of a contractor or at HCFA, should be accounted for and capitalized in accordance with HHS *Departmental Accounting Manual* requirements. In order to resolve this issue, we recommend that HCFA request a waiver from the Department's Assistant Secretary for Management and Budget to continue their present accounting procedure.

APPENDIX

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

OCT 19 1993

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Improvements Needed in Financial Systems to Enhance Medicare Financial Reporting" (A-14-92-03015)

TO: Bryan B. Mitchell
Principal Deputy Inspector General

We reviewed the subject draft report concerning the method used by the Health Care Financing Administration (HCFA) to prepare Fiscal Year (FY) 1991 Medicare trust fund financial reports. Although we agree that HCFA should strive to perfect its accounting systems and that improvements are needed in Medicare accounting, we do not agree with many of the conclusions reached by OIG in this report.

HCFA recognized in 1990 that improvements would be needed in its Medicare accounting activity as it moved from a cash based to an accrual based accounting system, as required by the Chief Financial Officers Act. The year 1991 was one of transition. HCFA has made significant progress since that time.

The development and enhancement of HCFA's control and reporting systems are ongoing and evolutionary. HCFA is well into the process of implementing corrective actions for problems identified by both HCFA and OIG. In FY 1992, HCFA developed and implemented the Part A and Part B Financial Core Requirements so that the Medicare contractors would have the ability to secure accounting data from their shared systems. This year, HCFA developed new accounting and reporting instructions for Medicare contractors. These instructions address the issue of internal control procedures and require an audit trail for all financial information reported to HCFA.

Our detailed comments on the report findings and recommendations are attached for your consideration. Thank you for the opportunity to review and comment on this draft report. Please advise us if you would like to discuss our position on the report recommendations at your earliest convenience.

Attachment

IG	
PDIG	
DIG-AS	✓
DIG-EI	
DIG-OI	
AIG-MP	
OGC/IG	
EX SEC	✓
DATE SENT	10-20

Comments of the Health Care Financing Administration (HCFA)
on the Office of Inspector General (OIG) Draft Report:
Improvements Needed in Financial Systems to Enhance
Medicare Financial Reporting
(A-14-92-03015)

Recommendation 1

HCFA's present system of reporting disbursement information does not conform to Joint Financial Management Improvement Program (JFMIP) and Department of Health and Human Services (HHS) financial management requirements, and this deficiency constitutes a material nonconformance under the Federal Managers' Financial Integrity Act (FMFIA). As a result, HCFA should report this "material nonconformance" in HHS' annual FMFIA report to the President and Congress, and should begin to implement corrective actions. HCFA should ensure Medicare contractors report actual disbursement information in conformance with JFMIP and HHS requirements.

HCFA Response

We do not agree with this recommendation. HCFA's method of reporting Medicare contractor letter-of-credit disbursement amounts is in conformance with Government-wide accounting standards, procedures, and requirements, including those of JFMIP and HHS.

OIG reports that HCFA does not record a disbursement of Medicare benefits at the time a contractor issues a check to the provider. This is correct. HCFA records disbursements to contractors when the Treasury Financial Management Service (TF&MS) Form 5401 is processed by the Federal Reserve Bank. This is the proper procedure for accounting and reporting Government disbursements made through the letter-of-credit mechanism.

HCFA administers the Medicare program through contracts with fiscal intermediaries that pay Part A claims and carriers that pay Part B claims. The intermediaries and carriers are collectively referred to as Medicare contractors. Medicare contractors do not issue U.S. Treasury checks when paying Medicare claims. Rather, Medicare contractors issue individual corporate checks drawn on private commercial banks. This is a significant point that OIG has overlooked. While there is a commitment of funds when contractors write checks, funds are not outlayed by the Federal Treasury when contractor checks are issued.

Medicare contractors are funded by HCFA through the checks paid letter-of-credit mechanism. And, as OIG correctly points out, when checks issued by the Medicare contractors clear their commercial bank accounts, the TFMS-5401 is prepared and

sent to the Federal Reserve Bank to obtain the necessary funds to pay for the Medicare checks cleared by the commercial bank. The TFMS-5401 is the mechanism whereby funds are outlayed from the Medicare trust funds. This is the source document used Government-wide to recognize letter-of-credit disbursements. Therefore, funds are not outlayed from the Medicare trust funds until the TFMS-5401 is processed by the Federal Reserve Bank.

The checks paid letter-of-credit mechanism was specifically designed to delay the drawdown of Federal funds until the checks issued by the recipient organization are presented to the recipient organization's bank for payment. The benefit of this funding arrangement is to increase interest earnings to the Federal Government, e.g., Medicare trust funds, by delaying the outlay of Federal funds as long as possible.

The letter-of-credit process is discussed in chapter 6-2000 of the Treasury Fiscal Requirements Manual. As discussed in this chapter, after processing the TFMS-5401, the Federal Reserve Bank credits the reserve account of the commercial bank, and charges the account of the U.S. Treasury. This is the point at which cash is considered to be outlayed by the Federal Government. One copy of the TFMS-5401 is sent to the Department of the Treasury's Letter of Credit Section. Another copy is sent to HCFA. Chapter 6-2000 states that the program agency will use its copy to record the expenditure in its accounting system. At the end of each month, the program agency is required to report to Treasury the total of its expenditures relating to letter-of-credit transactions based on all of the TFMS-5401s it received during the month. The data are reported to Treasury on the SF-224, Statement of Transactions, which reflects all cash activity that occurred during the month. Treasury reconciles the data reported on the Letter-of-Credit SF-224 to summary totals of the TFMS-5401s processed during the month. When the summary totals determined by Treasury agree with the detail data shown on the program agency's SF-224, Treasury considers the paid month reconciled. If HCFA reported the disbursements as OIG suggests, the report on financial position (SF-220 reports) would not reconcile with Treasury reports of disbursements.

HCFA is correct in its use of the TFMS-5401 to account for Medicare outlays and is following standard Government-wide procedures. OIG is incorrect in saying that this process results in a material nonconformance. OIG's approach would actually overstate Medicare outlays by recognizing outlays before they actually occur to the Federal Government, would prevent reconciliation with the Treasury Department, and would not be in adherence with Government-wide letter-of-credit procedures.

During 1991, about 2,000 hard copy TFMS-5401s were received by HCFA each month. Since that time, HCFA became a pilot agency for Treasury's automated letter-of-credit system. Instead of receiving TFMS-5401s, HCFA now receives

disbursement data electronically each day through the Federal Reserve Bank of Richmond. Disbursement data are now received by HCFA on a same day basis eliminating the delay that had previously occurred in receiving the TFMS-5401s.

In previous discussions with OIG, OIG equated Medicare contractors with government agencies, and stated that government agencies recognize disbursements when payments are made; therefore disbursements should be recorded when Medicare contractors write checks. We do not agree. Medicare contractors are not "government agencies." They do not issue U.S. Treasury checks. Medicare contractors are private entities that issue corporate checks drawn on private commercial banks. Funds are not outlayed from the U.S. Treasury when contractor checks are issued; thus government funds are not disbursed. The General Accounting Office and the Office of Management and Budget (OMB) agree that we are recording disbursements correctly.

In response to OIG's recommendation, HCFA will indicate on future financial statements, using a footnote, that the disbursement figure does not include amounts for which contractor checks have been written and have not yet been submitted on the TFMS-5401 for disbursement from the U.S. Treasury. We will cross-reference the footnote to the accounts payable for outstanding checks line item. We would be pleased to discuss the wording of footnotes with OIG.

Recommendation 2

HCFA should develop and implement financial management systems and related accounting and administrative internal controls to ensure that all accounts payable are reported to the HCFA general ledger at fiscal year (FY) end.

HCFA Response

We agree that improvements are needed in recording of accounts payable. The Financial Core Requirements that were implemented in 1992 will require Medicare contractors to report payable data to HCFA. As OIG properly points out, HCFA was required to use estimates to determine some payables. But, we believe that the estimates used were reasonable and that any differences between estimates and actuals would be immaterial when compared to overall Medicare expenditures, which exceeded $110 billion in FY 1991. However, it should be noted that some of the payable data reported to HCFA; e.g., claims in process, by necessity, will continue to be based on estimates. Some carriers could have as many as 400,000 claims in process at any given time. There is simply no reasonable, cost-effective way to determine properly the actual value of a claim until it has been approved for payment and deductibles, coinsurance, and other adjustments have been applied.

Recommendation 3

HCFA should ensure that all Medicare liabilities are reported to the HCFA general ledger at FY end. The following accounts should be included:

- all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB); and
- claims under appeal from an intermediary to an Administrative Law Judge (ALJ).

HCFA Response

We agree that all reasonably available data should be included in the reporting of Medicare liabilities. However, implementing this recommendation is unlikely to produce "reliable data" for several reasons. A recent management control review of PRRB indicated that most of the appeals in the backlog never go to a hearing. In fact, many are never perfected. It has become common practice for providers to file an appeal on their cost report simply to ensure that the filing deadline is met.

PRRB presently has a backlog of approximately 7,000 cases. Based on data from the past 5 years, about 350 appeals will go to a hearing. Of the remaining cases, 3,790 will be settled or resolved by the provider and the intermediary; and 2,860 will be abandoned or dismissed without further action. Thus, there are approximately 4,140 of the 7,000 cases (59 percent) where there is potential liability to the Government. When a decision is rendered through hearing, the precise monetary effect is not generally determined at that time. When a resolution is reached, the provider and the intermediary identify the dollar amount. Therefore, reporting the dollar impact of all provider cost reports under appeal at the PRRB would be not only very cumbersome, but an accurate accounting of government's potential liability would be impossible.

While the PRRB can give a reasonable estimation of the amount in controversy in recent decisions before the PRRB (the last 3 years), the overall potential liability to the Government would need to be obtained from the fiscal intermediaries who resolve the vast number of cases with the providers. In FY 1992, there was a total of 98 issues in the 73 decisions rendered by the PRRB. The PRRB found for the provider in 54 of the 98 issues, but the Acting Administrator reversed, modified, or remanded 34 of the 54 issues. The PRRB found in favor of the intermediary in 44 issues, all of which were upheld by the Acting Administrator.

Given the limited resources and the need to prioritize efforts in implementing the Chief Financial Officers (CFO) Act, HCFA does not plan to focus on producing estimates of the potential liability of cases being appealed. We plan to focus on the

more material system changes necessary to implement the CFO Act. We propose that a footnote, rather than a line item, be placed on the financial statement for recording PRRB potential liability (perhaps using the percentage mentioned above) in the HCFA general ledger.

With respect to claims under appeal from an intermediary to an ALJ, the reporting procedures (recently developed and sent to the Medicare contractors) provide estimates, on a rolling month-by-month basis (reported to HCFA quarterly), of the dollar value of liabilities for these claims. These estimates will be included on the FY 1993 financial statement.

Recommendation 4

HCFA should ensure that capitalized equipment lent to contractors is included in the general ledger.

HCFA Response

We do not concur with this recommendation. HCFA has not furnished or loaned equipment to Medicare contractors. Although some equipment bought by HCFA's other contractors, such as Peer Review Organizations, is contractually owned by HCFA, this does not include equipment bought by Medicare contractors. Additionally, the dollar value of equipment loaned to the non-Medicare contractors cited by OIG is incorrect; the correct amount is $3.1 million, rather than $4.1 million.

Equipment acquired by Medicare contractors is owned by them not by HCFA. Therefore, it would not be shown on HCFA's general ledger. Medicare contractors charge HCFA for the use of their equipment as part of their administrative budget, which is charged to HCFA's Program Management appropriation. Equipment acquired by any of HCFA's contractors that is contractually owned by HCFA is reflected in a control account in the Program Management appropriation. Once this equipment is returned to HCFA, it is depreciated based on its fair market value.

Recommendation 5

HCFA should ensure that trust fund assets and liabilities accumulated under the Program Management appropriation are properly distributed to the Hospital Insurance (HI) and Supplemental Medical Insurance (SMI) trust funds.

HCFA Response

We do not concur, relative to our treatment of Program Management appropriation distribution for FY 1991. OIG's position, that assets and liabilities accumulated

under the Program Management category should be distributed to the HI and SMI trust funds in FY 1991, is inappropriate. For FY 1991, HCFA prepared the SF-220 series of reports, not formal financial statements. The SF-220 reports are prepared separately for each category of appropriation an agency maintains. Program Management is one of those categories. Therefore, assets and liabilities were properly chargeable to the Program Management appropriation and could not have been included in SF-220 reports that were prepared for the Medicare trust funds.

For FY 1993 financial statements, we plan to allocate the trust fund amounts under Program Management appropriation to the HI and SMI trust funds.

Recommendation 6

HCFA should ensure that the automated data processing hardware and software is properly reported.

HCFA Response

We concur. OIG stated that HCFA recorded all capitalized equipment to one general ledger account. We agree this was an error and made the necessary adjustments.

Recommendations 7 and 8

HCFA should ensure all transactions from the entire cycle of a transaction, including the initiation and authorization until its final classification in the summary records from which reports and statements are prepared, are promptly recorded and properly classified.

HCFA should take steps to ensure that all of the subsidiary financial management systems that process, control, and account for Medicare financial transactions and resources, both present and planned, are designed to be an integral part of HCFA's overall financial management system.

HCFA Response

We concur, but suspect that HCFA and OIG may still have some different definition of terms. Given the broad and sweeping nature of this recommendation, we believe further discussions are necessary between HCFA and OIG to bring about the implementation of this recommendation.

Since 1992, HCFA developed Financial Core Requirements requiring Medicare contractors to account for certain data elements, and implemented a standard reporting format designed to improve the reporting of Medicare data. We

met with the Medicare Contractor Financial Management Technical Advisory Group to discuss the accounting and reporting improvements that are being implemented. In 1993, we visited contractors to further facilitate the implementation process.

The basis for these efforts is an initiative to improve the quality of accounting data Medicare contractors report to HCFA. We believe we will meet the reporting requirements of the CFO Act which will allow HCFA to prepare financial statements that reasonably present the financial status of the Medicare program. Under this approach, the detail source documents would be maintained by the Medicare contractors with summary data reported to HCFA. This approach takes into account the organizational structure of the Medicare program with its use of Medicare contractors to pay benefits, collect overpayments, and carry out other day-to-day operational responsibilities of the Medicare program. In view of the current budgetary environment, we believe this is the only reasonable approach available.

It is important to point out that HCFA's accounting and budgetary system is not a single system, but a series of systems which provide data for management's use in tracking, monitoring, reporting on, and budgeting for, agency operations. While a single system might be ideal, the nature of the programs administered by HCFA is such that it is more cost-efficient to have a series of smaller systems which can be used to provide specific internal controls and tapped for summary level data as needed.

OIG, however, appears to envision an integrated accounting process with all source data flowing to the HCFA general ledger. Medicare contractors process over 700 million claims annually. Not only would the costs of implementing such a massive integrated accounting system be prohibitive, it is unclear what real benefits would accrue to HCFA even if such a system could be implemented. As long as Medicare contractors are responsible for paying Medicare benefits, maintaining the source data at the contractor sites with only summary data reported to HCFA as required is a reasonable approach. However, as we have previously stated, it is our responsibility to ensure that the data reported to HCFA are accurate, and we recognize that additional work is needed in this area.

Therefore, we have concerns about this recommendation if OIG's position is that Medicare financial transactions should be part of the HCFA accounting system. OMB has issued a revision to OMB Circular A-127, dated October 13, 1992, which states that an integrated financial system may include multiple applications with appropriate electronic interfaces, as necessary, to meet defined data and processing requirements. This directive appears to support our current approach.

HCFA is developing new accounting and reporting instructions for payment of Medicare benefits. These instructions are designed to interface the data from Medicare contractors with the Government's standard general ledger accounts in the

Division of Accounting's Financial Accounting Control System (FACS). HCFA will secure these data using the Contractor Administrative Budget-Financial Management System and provide them to the FACS.

Technical Comments

- On page 6, OIG points out that a portion of current month outlays is not identified specifically by trust fund, but is allocated between the trust funds based on estimates. We believe the estimating process is reasonable. Carriers pay only Part B claims. Accordingly, all TFMS-5401s received from carriers are charged 100 percent to Part B SMI each month. No estimates are used.

  Intermediaries pay primarily Part A claims, but a small amount of this payment, usually about 7 percent a month (for example, medical services provided by hospitals), relates to Part B. The intermediaries' Part A/Part B allocation percentage is estimated each month based on the previous 5 months' actual data. We have found the intermediaries' Part A/Part B allocation to be very consistent from month to month. When the HCFA-1521, the contractor letter-of-credit form, is received, the estimates are replaced with the actual distribution between the trust funds. The adjustment, however, is usually immaterial. For example, for the month of September 1992, over $10 billion in Medicare outlays were recorded by HCFA. The adjustment between the trust funds after the HCFA-1521 was received was only $250,000, less than 1/100 of 1 percent of total outlays. In HCFA's view, the trust fund assets and liabilities accumulated under the Program Management appropriation are properly distributed to the HI and SMI trust funds.

- At the bottom of page 6, OIG states that HCFA does not have financial management systems to report the actual disbursements of Medicare benefits at the time the Medicare contractors issued checks to providers and that "therefore HCFA could not report on any given day the amount the contractors actually paid for Medicare benefits." As discussed previously, HCFA does receive disbursement data each day through Treasury's automated letter-of-credit system. OIG is correct, however, in that HCFA does not receive daily information from the Medicare contractors. However, it is unclear why OIG believes daily information is necessary. Federal reporting requirements are monthly, quarterly, and annually. Medicare contractors are required to report disbursement and expenditure data to HCFA each month; e.g., HCFA-1521, Contractor Draws on Letter of Credit, HCFA-1522, Monthly Contractor Financial Report, and the HCFA-456, Intermediary Benefit Payment Report. These reports summarize Medicare outlays and expenditures, including checks issued, checks cleared, and outstanding checks. In addition, HCFA is currently implementing additional reports in conjunction with the Core Financial Requirements that will provide

additional Medicare financial data to HCFA. This reporting process will provide HCFA with the data needed to properly report on the status of the Medicare program.

- On pages 9 and 10, OIG lists a number of categories of payables which were not accounted for separately in 1991. This is correct. These amounts were included in the claims-in-process estimate. These categories, however, are included in the Financial Core Requirements and will be reported by the Medicare contractors to HCFA beginning with the 1993 financial statements in a combined category referred to as benefits payable.

- At the bottom of page 10, OIG points out that the actuarial estimate for provider services incurred but not billed was recorded as a contingent liability instead of an accounts payable. This is correct. This occurred because we wanted to differentiate the actuarial estimate from the claims-in-process estimate. The actuarial estimate, however, was included as an accounts payable in the 1992 financial statements.