Memorandum

Date JUN 24 1993

From Bryan B. Mitchell
Principal Deputy Inspector General

Subject Review of the Accounts Receivable Balances for the Hospital Insurance and Supplementary Medical Insurance Trust Funds at September 30, 1991 (A-01-91-00525)

To

Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of the U.S. Department of Health and Human Services, Office of Inspector General's report entitled "Review of the Accounts Receivable Balances for the Hospital Insurance and Supplementary Medical Insurance Trust Funds at September 30, 1991." We audited to determine whether Medicare accounts receivable transactions were accurately recorded and reported and to identify the sources of unreported receivables due the Medicare program.

In order to accomplish our objectives, we reviewed the systems that recorded the $1.04 billion accounts receivable balance and supporting documentation reported by the Health Care Financing Administration (HCFA) for the Hospital Insurance and Supplementary Medical Insurance Trust Funds at September 30, 1991. We also reviewed other systems and supporting documentation to identify unreported Medicare receivables. We found that these systems, maintained by HCFA and Medicare contractors, were designed as overpayment and/or delinquent payment tracking systems and were not part of a fully integrated accounts receivable system containing attributes such as full accrual accounting, aging of accounts, proper cut-off procedures, and adequate audit trails.

By not developing a full accounting and reporting system, HCFA's accounts receivable balances for the Medicare trust funds at September 30, 1991 were underreported. The HCFA estimated that there was about $1.23 billion in Medicare secondary payer overpayments which were not reported as accounts receivable balances at yearend.

The financial management systems that do not record, monitor, follow-up, and collect all accounts receivable are a major concern. As such, HCFA management does not

have all the timely and accurate financial data needed to evaluate program needs, nor does it have sufficient information to safeguard assets or fully determine the financial viability of the Medicare program. In our opinion, HCFA's current recording and reporting of accounts receivable amounts is a material nonconformance under the Federal Managers' Financial Integrity Act (FMFIA). Accordingly, we recommend that HCFA improve its financial management systems and related accounting and administrative internal controls to ensure that:

- the accounts receivable data for HCFA and its Medicare contractors are integrated and standardized to promote consistency, uniformity, and efficiency in recording and reporting of accounts receivable balances, uncollectibles, and write-offs;

- all receivables are accurately recorded in subsidiary systems on a timely basis by implementing double-entry accrual accounting and system controls, proper cut-off procedures, and adequate audit trails; and

- general ledger balances for accounts receivable include all overpayments and are reconciled with subsidiary ledgers on an ongoing basis.

We are also recommending that HCFA perform FMFIA section 4 reviews on all systems used to report accounts receivable and report the lack of financial management systems to properly record, monitor, follow-up, and collect overpayments as a material nonconformance under the FMFIA.

Officials in your office have generally concurred with our recommendations and have taken, or agreed to take, corrective action. To improve the quality of data being received from Medicare contractors, HCFA has recently developed Financial Core Requirements which requires the automation of financial functions at all Medicare contractors and a standardized reporting format for reporting accounts receivable. The HCFA also scheduled joint FMFIA section 2/4 reviews for its financial systems beginning with Fiscal Year 1993. We commend HCFA's efforts to initiate corrective action to produce timely and reliable financial statement information.

With regard to the declaration of the issue as a material nonconformance, HCFA defers comment. We believe that HCFA should report the lack of financial

management systems for accounts receivable as a material nonconformance under FMFIA until it can be demonstrated that the proposed improvements have been effectively implemented.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. 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-01-91-00525 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF THE ACCOUNTS RECEIVABLE BALANCES FOR THE HOSPITAL INSURANCE AND SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS AT SEPTEMBER 30, 1991

JUNE 1993 A-01-91-00525

SUMMARY

The objectives of our review were to determine whether Medicare accounts receivable transactions were accurately recorded and reported and to identify the sources of unreported receivables due the Medicare program. To accomplish our objectives, we reviewed supporting systems and documentation related to the accounts receivable balance of $1.04 billion, and allowance for uncollectibles of $382 million, reported by the Health Care Financing Administration (HCFA) for the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds at September 30, 1991. We also performed similar tests to identify unreported Medicare receivables.

We found that these systems, maintained by HCFA and Medicare contractors, were designed as overpayment and/or delinquent payment tracking systems, and were not part of a fully integrated accounts receivable system[1] containing attributes such as full accrual accounting, aging of accounts, proper cut-off procedures, and adequate audit trails. In our opinion, these systems do not provide the control and accountability to effectively report accounts receivable transactions and balances for the HI and SMI trust funds.

By not developing a full accounting and reporting system, HCFA's accounts receivable balances for the Medicare trust funds at September 30, 1991 were underreported. The HCFA estimated that there was about $1.23 billion in Medicare secondary payer (MSP) overpayments which were not reported as accounts receivable balances at yearend. Our review showed that the reported accounts receivable balances could be understated by:

- about $44.6 million in unreported MSP overpayments identified by random samples we took at three fiscal intermediaries (FI) and one carrier;
- an unquantifiable amount in unreported overpayments arising from FI post payment reviews, and at least $10.5 million in unreported peer review organization adjustments;
- an unrecorded and unreconciled amount of $13.1 million, or a portion thereof, in nonwithheld Medicare premiums, and misstated by $6.9 million in reported Medicare premiums recorded to the SMI trust fund instead of the HI trust fund;

[1] An integrated system encompasses a unified set of automated and manual procedures, controls, data, hardware, software, and personnel necessary to manage the agency's financial management needs.

- overpayments arising from provider credit balances. Although HCFA reported a receivable of $87 million, a recent Office of Inspector General (OIG) draft report (CIN: A-03-92-00010) identified an estimated $265.9 million in provider credit balances in Fiscal Year (FY) 1991; and

- a probable overstated allowance for uncollectible receivables. The HCFA included $87 million in provider credit balances in the allowance for uncollectibles. This amount was not determined based on an appropriate analysis of expected losses, but instead was based on the fact that the receivables were in excess of 1 year old.

We also found that reported accounts receivable balances were incorrectly stated by overpayments reported by the Provider Overpayment Reporting (POR) and Physician/Supplier Overpayment Reporting (PSOR) systems. For example, we found numerous errors at three Medicare FIs and carriers we visited. These errors included a statistically projected error rate of 30.92 percent, equating to a $2,149,550 overstatement, when a sample of outstanding PSOR system balances was traced to source documents. We also found that the POR system balance was allocated to the HI and SMI trust funds using a percentage based on benefit payments as opposed to actual results.

We believe that HCFA's lack of financial management systems that record, monitor, follow-up, and collect all sources of accounts receivable is a material nonconformance under the Federal Managers' Financial Integrity Act (FMFIA).

Based on our results, we recommend that HCFA develop and implement financial management systems and related accounting and administrative internal controls to ensure that:

- the accounts receivable data for HCFA and its Medicare contractors are integrated and standardized to promote consistency, uniformity, and efficiency in recording and reporting of accounts receivable balances, uncollectibles, and write-offs;

- all receivables are accurately recorded in subsidiary systems on a timely basis by implementing double-entry accrual accounting and system controls, proper cut-off procedures, and adequate audit trails; and

- general ledger balances for accounts receivable include all overpayments and are reconciled with subsidiary ledgers on an ongoing basis.

We also recommend that HCFA perform FMFIA section 4 financial management system reviews on all systems used to track and record receivables, and report the lack of a comprehensive accounts receivable system as a material nonconformance under the FMFIA.

In response to our draft audit report, HCFA agreed with our assessments that improvements are needed in HCFA's accounting of Medicare receivables. To improve the quality of data being received from Medicare contractors, HCFA has recently developed Financial Core Requirements which requires the automation of financial functions at all Medicare contractors and a standardized reporting format for reporting receivables. The HCFA has also scheduled joint FMFIA section 2/4 reviews for its financial systems beginning with FY 1993. We commend HCFA's efforts to initiate corrective action to produce timely and reliable financial statement information.

With regard to the declaration of the issue as a material nonconformance, HCFA defers comment. We believe that HCFA should report the lack of adequate financial management systems for accounts receivable as a material nonconformance under FMFIA until it can be demonstrated that the proposed improvements have been effectively implemented.

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INTRODUCTION

BACKGROUND

The Medicare program helps pay medical costs for about 32 million people aged 65 years and older, and about 3 million people with disabilities. The HCFA administers two Medicare trust funds. The Medicare Part A trust fund (HI) covers inpatient hospital, skilled nursing facility, home health, and hospice care services, while the Medicare Part B trust fund (SMI) covers physicians' services and a range of other noninstitutional services, such as diagnostic laboratory tests and x-rays. Expenditures for the HI and SMI trust funds for the year ended September 30, 1991 exceeded $68 and $45 billion, respectively.

The HCFA contracts with FIs and carriers to process Medicare Part A and Part B claims, respectively, and collect overpayments.

The HCFA used the Department of Treasury Standard Form (SF) 220, Report on Financial Position, to report its assets, liabilities, and equity for the Medicare trust funds at September 30, 1991. The Medicare trust funds balance as reported by HCFA for accounts receivable was $1.04 billion, and the balance for the allowance for uncollectibles was $382 million[2] (see Table I).

	(In Millions) Accounts Receivable	% of A/R Balance	Allowance Account
HI Trust Fund			
POR System	$ 670.8	85.4%	$175.2
Credit Balances	76.3	9.7%	76.3
Appeals	28.5	3.6%	28.5
HMOs/HCPPs	7.2	1.0%	6.8
OIG Disallow.	2.2	0.3%	2.2
Subtotal	$ 785.0	100.0%	$289.0
SMI Trust Fund			
POR/PSOR Systems	$ 159.9	62.7%	$ 56.3
Appeals	13.6	5.3%	13.6
Credit Balances	10.7	4.2%	10.7
Beneficiaries	9.7	3.8%	0.0
HMOs/HCPPs	7.6	3.0%	6.6
Delinquent Premiums	47.5	18.7%	0.0
OIG Disallowances	6.0	2.3%	5.8
Subtotal	$ 255.0	100.0%	$ 93.0
Total	$1,040.0		$382.0

Table I: Accounts Receivable and Allowance for Uncollectibles at September 30, 1991

The HCFA reported $785 million in HI trust fund receivables, of which the POR system accounted for $670.8 million (85.4 percent). This system records overpayments arising from cost report settlements between FIs and providers. Overpayments reported by the POR system are allocated to the HI and SMI trust funds using a percentage based on benefit payments. The HCFA also

[2] In addition, the Department of the Treasury reported about $2.8 billion of investment interest accounts receivable for the trust funds at September 30, 1991.

included HI trust fund receivables related to provider credit balances, appealed accounts receivable at contractors, health maintenance organizations (HMO)/health care prepaid plans (HCPP), and OIG audit disallowances.

The HCFA reported $255 million in SMI trust fund receivables, of which the PSOR system accounted for $159.9 million (62.7 percent). This system records overpayments arising from carriers performing utilization reviews, some MSP adjustments, and quality control reviews, as well as resolving physician or supplier inquiries. The HCFA also classified SMI trust fund receivables related to the POR system, appealed accounts receivable at contractors, provider credit balances, beneficiaries, HMOs/HCPPs, delinquent premiums, and OIG disallowances.

INTERNAL ACCOUNTING CONTROLS

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

The objective of an internal control structure is to provide management with reasonable, but not absolute, assurance that: (1) obligations and costs are in compliance with applicable laws; (2) funds, property, and other assets are safeguarded against waste, loss, and unauthorized use or misappropriation; and (3) revenues, and expenditures applicable to agency operations are properly recorded to maintain accountability and to permit the preparation of accounts and reliable financial and statistical reports.

The purpose of the auditor's assessment of internal controls is to identify and communicate reportable conditions and material weaknesses. Reportable conditions are significant deficiencies in the design or operation 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 when the internal control does not reduce, to a relatively low level, the risk that errors or irregularities in amounts material to the financial statements being audited may occur and not be detected in a timely manner by responsible employees.

Because of inherent limitations in any internal control structure, errors or irregularities may, nevertheless, occur and not be detected. Also, projection of the results of any evaluation to future periods is subject to the risk that procedures may become inadequate because of changes in conditions or that the effectiveness of the design and operation of policies and procedures may deteriorate.

COMPLIANCE WITH LAWS AND GUIDELINES

The HCFA's management is responsible for compliance with laws and guidelines applicable to HCFA programs. As part of our review of internal controls, we performed tests of HCFA's compliance with provisions of the following laws and guidelines:

- the Social Security Act, as amended;
- the FMFIA of 1982--requires agencies to report material nonconformances in agency's financial management systems to the President and the Congress. A material nonconformance is when a financial management system does not provide all information on Federal spending, collections, assets, liabilities, equity, and related budgetary transactions and balances;
- the Office of Management and Budget (OMB) Circular A-127, "*Financial Management Systems*"--requires agencies to establish and maintain a single, integrated financial management system, which may be supplemented by subsidiary systems. Financial management systems should generate data that is useful, timely, reliable and complete, comparable and consistent, and efficient and economic;
- the Joint Financial Management Improvement Program's (JFMIP) *Core Financial System Requirements* (CORE)--states that the accounts receivable function should record, bill, monitor, and collect amounts due the Government. "The accounts receivable activity must be supported by aging schedules, exception reports, and reports used to monitor due diligence efforts;" and
- the General Accounting Office (GAO) *Policy and Procedures Manual for Guidance of Federal Agencies*, Title 2 (Title 2)[3]--outlined of the accounting principles and standards for financial statement presentation, and requires the accrual basis of accounting for reporting receivables. Accordingly, receivables should be accounted for as assets from the time an event gives rise until the time they are collected, converted into other resources, or determined to be uncollectible in whole or in part.

In addition, the Chief Financial Officers (CFO) Act of 1990 subjects all trust and revolving funds, and commercial activities to its requirements. As a result, the CFO Act added emphasis on the requirements that HCFA improve its internal controls and financial management systems, and prepare, for the first time, annual audited financial statements on the Medicare trust funds beginning with the period ended September 30, 1992.

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[3] Although this report addresses FY 1991, for FY 1992, the OMB issued OMB Bulletin No. 93-02 entitled "*Form and Content of Agency Financial Statements*," dated October 22, 1992, requiring HCFA to follow the accounting principles, standards, and other requirements prescribed by the U.S. Department of Health and Human Services (HHS). The HHS *Departmental Accounting Manual* incorporates the applicable requirements of the OMB, Department of the Treasury, GAO, and JFMIP.

SCOPE

Our audit was conducted in accordance with generally accepted government auditing standards. The objectives of our review were to determine whether financial transactions were accurately recorded and reported and to identify the sources of unreported receivables due the Medicare program.

To achieve our objectives, we tested accounts receivable balances either greater than or equal to 4.5 percent of the accounts receivable balance reported by HCFA at September 30, 1991. We performed testing of the POR and PSOR systems, provider credit balances, and delinquent premiums. However, we did not perform testing on accounts receivable balances related to appeals, HMOs, HCPPs, beneficiaries, and OIG disallowances (see Table II). We also did not test the trust funds accounts receivable balances reported by the Department of the Treasury at September 30, 1991.

Account Description	(In Millions) Receivable Balance	% of Total
POR System	$ 670.8	64.5%
PSOR System	159.9	15.4%
Credit Balances	87.0	8.4%
Delinquent Premiums	47.5	4.6%
Appeals	42.1	4.0%
HMOs/HCPPs	14.8	1.4%
Beneficiaries	9.7	.9%
OIG Disallowances	8.2	.8%
Total Receivables	$1,040.0	100.0%

Table II: Accounts Receivable Balances At September 30, 1991

We also obtained an understanding of the relevant internal control policies and procedures, tested procedures, and assessed control risk. Based on our results, we concluded that it would be more efficient to evaluate the internal control environment, accounting systems, and control procedures by expanding substantive audit tests, instead of performing a detailed assessment of the internal control structure. Accordingly, we performed the following steps at HCFA's central office and at the contractors selected:

- reviewed applicable laws, GAO reports and related accounting principles and standards, OIG reports, OMB Circulars, carrier and FI manuals, and HCFA directives;
- obtained the Report on Financial Position and general ledger for the HI and SMI trust funds;
- obtained POR and PSOR systems' reports of outstanding overpayment balances at September 30, 1991;

- selected a simple random sample of 35 demand letters at each of 2 FIs from a population of 1,090 and 4,846 demand letters, and a simple random sample of 35 out of 1,847 beneficiaries at a third FI, to obtain the value of unreported receivables related to MSP cases at September 30, 1991 (see Exhibit I);

- selected a simple random sample of 100 outstanding overpayment balances from 953 outstanding overpayment balances recorded to the unverified MSP backlog report, but not recorded to the PSOR system for 1 carrier, and verified the outstanding overpayment balances to supporting demand letters (see Exhibit II);

- selected a stratified random sample of 99 outstanding overpayment balances for the 3 FIs from 286 outstanding overpayment balances reported by the POR system and verified the outstanding overpayment balances to supporting demand letters;

- selected a stratified random sample of 76 outstanding overpayment balances for the 3 carriers from 1,285 outstanding overpayment balances reported by the PSOR system and verified the outstanding overpayment balances to supporting demand letters (see Exhibit III);

- used a variable appraisal program to estimate the value of unreported balances and identified errors, and an attribute appraisal to estimate the number of errors and error rate for noted exceptions;

- selected a judgmental sample of 10 outstanding demand letters at each of 3 FIs and carriers, and verified that the outstanding overpayments had been recorded to the POR or PSOR systems, respectively; and

- reviewed management's process for evaluating and reporting on internal controls and accounting systems as required by FMFIA.

For those items tested, we found no instances of noncompliance except for the matters discussed in the Findings and Recommendations section of this report. Regarding the items not tested, nothing came to our attention to cause us to believe that the untested items would have shown results which varied from the results of the tested items.

Field work was performed from October 1991 through April 1992. Our field work was performed at judgmentally selected Medicare contractors. These contractors included Blue Cross/Blue Shield (BC/BS) of Massachusetts, BC/BS of Florida, and BC/BS of Minnesota in Regions I, IV, and V, respectively. We reviewed both the intermediary and carrier operations at each contractor. The Medicare contractors were

selected from the total 81 contractors because they represented different geographical locations and operational output. We also performed field work at HCFA central office in Baltimore, Maryland.

The draft report was issued to HCFA on September 30, 1992. The HCFA's written comments, dated March 24, 1993, are appended to this report (see Appendix) and addressed on page 28.

FINDINGS AND RECOMMENDATIONS

Recognizing the complexity and volume of claim payments, and the Medicare program's inherent vulnerability to fraud and abuse, overpayments will occur. However, we noted several matters involving the internal control structure and its operations that we consider to be reportable conditions as defined earlier.

The results of our tests of compliance with laws and guidelines indicate that, with respect to the items tested, except for compliance with GAO Title 2, FMFIA, OMB Circular A-127, and JFMIP CORE financial requirements explained in the following reportable conditions, HCFA complied, in all material respects, with the above provisions. Regarding the items not tested, nothing came to our attention to cause us to believe that the untested items would have shown results which varied from the results of the tested items.

We identified numerous systems, maintained by HCFA and Medicare contractors, that were designed as overpayment and/or delinquent payment tracking systems. These systems had not been fully developed into an accounts receivable system which would contain attributes such as full accrual accounting, aging of accounts, proper cut-off procedures, and adequate audit trails. In our opinion, HCFA's systems do not provide the control and accountability to effectively report accounts receivable transactions and balances for the HI and SMI trust funds. Due to HCFA's lack of a fully developed accounts receivable system, the $1.04 billion accounts receivable balance for the Medicare trust funds at September 30, 1991, were under reported. The HCFA estimated that there was about $1.23 billion in MSP overpayments which were not reported as accounts receivable balances at yearend.

Specifically, HCFA and its FIs and carriers should develop integrated and standardized financial management systems and related accounting and administrative internal controls to:

- ensure that general ledger balances for accounts receivable include all overpayments and are reconciled with subsidiary ledgers on an ongoing basis;

- implement double-entry accrual accounting and system controls, proper cut-off procedures, and adequate audit trails in subsidiary systems;

- report amounts due from insurance companies under the MSP program;

- report, monitor, collect, and follow-up on amounts arising from post payment reviews and peer review organization (PRO) adjustments;

- report provider credit balances that are complete, correct, timely, and valid;

- estimate a reasonable allowance for uncollectible receivables;

- identify receivables to be written-off;

- categorize and report receivables as they relate to the HI and SMI trust funds when overpayments arising from the settlement of cost reports are recorded to the POR system; and

- record receivables that are correct, timely, and supported to the POR and PSOR systems.

Based on our results, we believe that the above weaknesses in HCFA's financial management systems for accounts receivable are a material nonconformance considered reportable to the President and the Congress under the FMFIA.

UNREPORTED AMOUNTS UNDERSTATED THE ACCOUNTS RECEIVABLE BALANCES FOR THE MEDICARE TRUST FUNDS

Our review found that HCFA did not have a financial management system to adequately record, monitor, collect, follow-up, and report accounts receivable from third parties under the MSP program, and overpayments resulting from FI post payment reviews and PRO adjustments. As a result, the accounts receivable balances for the Medicare trust funds at yearend were understated in unrecorded receivables.

Based on our review, the accounts receivable balances were understated by $44.6 million in unrecorded MSP overpayments identified in our random sample at three FIs and one carrier, an unquantifiable amount of FI post payment adjustments, and at least $10.5 million in PRO adjustments. Furthermore, the HCFA estimated that unreported MSP overpayments could be as much as $1.23 billion at September 30, 1991.

UNREPORTED AMOUNTS DUE FROM THIRD PARTIES UNDER THE MSP PROGRAM

> Title II required agencies to record amounts receivable at the time an event occurs that entitles an agency to collect funds.

A primary cause of overpayments occurs when Medicare mistakenly pays as a primary insurer when payment should have been made by a responsible third party. Our analysis disclosed that receivables due from third parties under the MSP program were not reported by HCFA on the Report on Financial Position or general ledger account for the HI trust fund, and were not consistently reported for the SMI trust fund, at September 30, 1991. We believe this amount to be significant based on our random sample which identified $44.6 million in unrecorded MSP overpayments, and estimated overpayments reported by HCFA's MSP backlog reports.

HCFA'S CURRENT SYSTEM FOR REPORTING OVERPAYMENTS ARISING FROM MSP ACTIVITY

The MSP units at FIs and carriers are responsible for identifying, monitoring, recording, and collecting overpayments resulting from conditional or mistaken payments. Such payments occur when Medicare initially pays as a primary insurer and later determines that a third party should have paid as a primary payer. Conditional or mistaken payments may occur when a Medicare beneficiary is covered under: (1) a workman's compensation plan; (2) an employee group health plan (EGHP) on the basis of end stage renal disease; (3) an EGHP as a working aged; (4) a large group health plan on the basis of disability; or (5) a no-fault, auto or liability insurer.

Claims identified by FIs and carriers as possible MSP overpayments are researched, and demand letters are sent to overpaid parties when final determinations are made. The FIs and carriers are required by HCFA to follow-up on outstanding overpayments every 30 days after the date of the first request letter. Overpayments over 120 days are referred to HCFA regional offices for collection. Each of the FIs and carriers we reviewed maintained a log of outstanding MSP overpayments.

Although each FI and carrier maintained a tracking system for outstanding MSP overpayments, these amounts were not fully integrated into HCFA's financial management systems (e.g., the POR and PSOR systems). As a result, HCFA did not recognize all MSP receivables as an asset on its Report on Financial Position. This was contrary to Title 2 which required agencies to record accounts receivable at the time an event occurs that entitles an agency to collect funds.

Effective April 3, 1991, contractors were requested by HCFA to establish a system to identify and report backlogged MSP claims resulting from a lack of funding to research and follow-up on potential overpayments. Based on the information provided in the MSP backlog report, the HCFA projected $233.6 million in outstanding MSP demand letters sent to providers, and as much as $1 billion in confirmed MSP overpayments not communicated to providers.

However, our review of MSP backlog reports, for the contractors reviewed, noted inconsistencies in determining the amount of outstanding MSP overpayments at September 30, 1991. Some outstanding balances reported by the contractors did not include all MSP overpayments as of September 30, 1991, since only overpayments not being reviewed (i.e., backlogged) were reported. Other contractors used the reports to record all outstanding MSP overpayments (i.e., backlogged and/or current activity). Furthermore, a recent report published by the GAO disclosed that "HCFA's analysis of the contractors' (MSP backlog) reports showed that many contained missing or inaccurate data. For example, some contractors failed to submit completed reports or did not specify the dollar amount of identified MSP claims."[4]

As a result, the MSP backlog report is not an adequate source for reporting outstanding overpayments arising from MSP activity. To conform with OMB Circular A-127, the HCFA needs to develop a financial management system that properly records, monitors, follows-up, collects, and reports MSP overpayments.

STATISTICAL ESTIMATE OF UNREPORTED MSP AMOUNTS AT THREE FIS AND CARRIERS

To estimate unreported MSP overpayments identified by FIs, we took a random sample of 35 outstanding demand letters at yearend for 2 FIs, and 35 beneficiaries for 1 FI. Using a standard scientific estimation process, we determined the point estimate and precision for each sample, and concluded that the total accounts receivable balance at yearend for all three FIs was understated by about $42,784,249 (see Exhibit I for statistical information).

For unreported MSP overpayments identified by carriers, we noted that two of the three carriers recognized MSP overpayments as accounts receivable and recorded these amounts to the PSOR system. To determine the amount of unreported MSP overpayments for the third carrier, we took a random sample of 100 out of 953 outstanding demand letters at yearend. Using a standard scientific estimation process, we concluded that the accounts receivable balance at yearend was understated by

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[4] GAO report entitled, "*MEDICARE, Over $1 Billion Should Be Recovered From Primary Health Insurers*" (GAO/HRD-92-52), dated February 1992.

about $1,765,719 for the third carrier. The precision of the estimate at the 90 percent confidence level is +/- 19.69 percent (see Exhibit II for statistical information).

UNREPORTED AMOUNTS RESULTING FROM POST PAYMENT AND PRO ADJUSTMENTS

Our review also disclosed that HCFA did not have a financial management system to record, monitor, collect, follow-up, and report accounts receivable resulting from FI post payment and PRO adjustments. As a result, the year-end balance for accounts receivable did not adequately report all overpayments. We believe the unrecorded amounts are significant. As a result, the HCFA should develop a financial management system that ensures all outstanding overpayments are reported as accounts receivable at yearend.

POST PAYMENT ADJUSTMENTS

The FIs are responsible for conducting post payment reviews, and processing post payment adjustments (receivables) for Part A claims. However, the HCFA does not require FIs to report post payment adjustments. As a result, the FIs are not required to develop financial management systems to account for the number and amount of related overpayments.

Although we were unable to determine the effect of unrecorded post payment adjustments at yearend, we believe the amount may be significant. For example, the results of a nationwide OIG computer application identified approximately $38 million in Medicare overpayments resulting from outpatient services overlapping with inpatient stays for the period December 1987 through October 1990 (CIN: A-01-91-00511). Although the amount was identified by an outside party, and not part of an ongoing post payment review, it does indicate that post payment adjustments are material in nature and are not being reported.

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 ledgers for the HI and SMI trust funds. As a result, overpayments arising from post payment adjustments identified by FIs were not included in the accounts receivable balance at September 30, 1991.

PRO 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 denied or

partially denied claims to FIs as PRO adjustments (receivables). The FIs must abide by PRO determinations and adjust subsequent claim payments to providers to ensure Medicare is reimbursed for overpayments. The PROs are required to report their adjustments to FIs by the seventh of the month following their claims review. This could result in an adjustment being outstanding for at least 30 days. The FIs have 60 days to process all PRO adjustments from the date they are received. Based on these requirements, a PRO adjustment could conceivably be outstanding for 90 days before it is processed by an FI.

Our review noted that HCFA did not maintain a financial management system that reported the current amount of outstanding PRO adjustments. The HCFA did maintain a central database of adjustments identified by PROs, and processed by FIs. The database was capable of reporting the total dollar value for processed PRO adjustments by month. However, due to the significant time delays mentioned above (30 to 90 days), the database was not updated with current and complete settlement information made by FIs. Therefore, the HCFA's database did not produce an updated accounts receivable balance for outstanding PRO adjustments at yearend. By not maintaining a sufficient financial management system to report the accounts receivable balance for PRO adjustments, the HCFA did not include this amount in the general ledger for the HI and SMI trust funds.

To estimate the potential magnitude of the amount of unreported receivables for PRO adjustments at yearend, we obtained a Peer Review Organization File 3 report, which contains PRO adjustment information from HCFA's PRO work load database. We based our calculation on September 1991 since PROs were not required to report their adjustments to FIs until October 7, 1991. As a result, we estimated that potential overpayments arising from PRO adjustments for September 1991 could be at least $10.5 million. In accordance with the above procedures, PRO adjustments for July and August, or a portion thereof, also may have been outstanding since adjustments processed by FIs may not have been reported to HCFA's central database for PRO adjustments by yearend. The HCFA officials questioned the reliability of the information provided by the PRO adjustment database, and cautioned against its use. However, we believe this information provides an estimate of the potential impact of unreported PRO adjustments.

In summary, we believe that by not establishing an accounts receivable system to adequately record, monitor, collect, follow-up, and report all overpayments, the HCFA exposed its accounts receivable function to potential fraud, abuse, and material misstatement. Specifically, our review disclosed that:

- The HCFA's MSP backlog report is not an adequate source for reporting outstanding overpayments arising from MSP activity. The HCFA needs to

develop a financial management system that is verifiable and conforms with OMB Circular A-127.

- The accounts receivable balances for the Medicare trust funds at September 30, 1991 could be understated by unrecorded overpayments arising from the MSP program, and FI post payment and PRO adjustments.

INACCURATE AMOUNTS UNDERSTATED THE ACCOUNTS RECEIVABLE BALANCES FOR THE MEDICARE TRUST FUNDS

Our review disclosed that deficiencies in HCFA's financial management systems for reporting provider credit balances and delinquent Medicare premiums did not include accounts receivable balances at September 30, 1991 that were accurate or complete. The reporting of provider credit balances was based on voluntary information as of June 30, 1991 from a small percentage of providers serviced by the Medicare program. The amounts HCFA reported to the SMI trust fund for delinquent Medicare premiums were incorrect, incomplete, or did not reconcile with related records maintained by the Office of Personnel Management (OPM).

Title II required agencies to record amounts receivable at the time an event occurs that entitles an agency to collect funds and categorize the amounts receivable in the agency accounting records under the fund, appropriation, or receipt account where the receivable is to be deposited when collected.

Also, CORE required the receivable function to record transactions to the appropriate fund, and maintain historical information on transactions and account updates.

PROVIDER CREDIT BALANCES

Credit balances occur when Medicare providers receive more than the amount charged for covered services rendered to Medicare beneficiaries. The excessive amount reimbursed may result from overpayments made by FIs. Providers are responsible for reviewing credit balances to determine whether a refund is due the Medicare program.

The HCFA does not have a system to record and report provider credit balances, nor does it have a system which requires providers to report credit balance accounts. The provider credit balances reported by HCFA were based on voluntary information from a small percentage of providers serviced by the Medicare program as of June 30, 1991. This voluntary information was obtained as the result of a memorandum dated April 8, 1991, in which HCFA instructed its regional offices to

contact FIs and obtain voluntary information about Medicare credit balances from providers. As a result, 9,095 of approximately 27,000 providers with Medicare credit balances reported $87 million in outstanding credit balances for the HI and SMI trust funds at September 30, 1991.

Although HCFA took initial steps to establish a financial management system to report provider credit balances, we noted that reported balances were not complete, correct, or valid since they were based on voluntary information released by providers. The HCFA obtained OMB approval in May 1992 to obtain credit balance information from providers for 1 year.

To determine the reasonableness of the amount reported in provider credit balances at yearend, we referred to a March 1992 OIG report[5] which addressed this issue. The projected results of the national review estimated that providers owed the Medicare program about $265.9 million in credit balances, and the HCFA collected $66 million of the projected amount as of the report date. As a result of the $265.9 million in credit balances identified in the OIG report, the accounts receivable balance of $87 million reported by the HI and SMI trust funds at September 30, 1991 appeared to be understated.

Based on our review, the financial management system responsible for reporting provider credit balances was not able to produce an accounts receivable balance that was complete, correct, or valid. Furthermore, the HCFA allocated the $87 million in provider credit balances to the HI and SMI trust funds using the same questionable process used to allocate the accounts receivable balance reported by the POR system (see page 18).

DELINQUENT MEDICARE PREMIUMS

Uninsured aged individuals who do not meet the required wage credits under the Social Security Act may obtain HI protection by paying monthly premiums. Individuals eligible for HI may opt to enroll in the SMI program which requires that a monthly premium be paid. State welfare or human service agencies may pay HI and SMI premiums for individuals who qualify under the Medicaid and Medicare programs. Accounts receivable for delinquent Medicare premiums arise when an individual or third party fails to pay HI and SMI premiums on time.

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[5] OIG management advisory report entitled, "*Update on Findings Developed in Our National Review of Medicare Beneficiary Accounts with Credit Balances*" (A-03-92-00010), dated December 1992.

DELINQUENT MEDICARE PREMIUMS RELATED TO THE HI TRUST FUND WERE NOT ACCURATELY REPORTED

Our review disclosed that HCFA's financial management system for reporting delinquent Medicare premiums was not capable of categorizing and reporting delinquent premiums to the HI and SMI trust funds. As a result, accounts receivable balances for the Medicare trust funds were not accurately reported.

The HCFA's financial management system for delinquent Medicare premiums reported $47.5 million in accounts receivable for the SMI trust fund at September 30, 1991. However, this system was not able to ensure that amounts reported as receivables were reported to the proper trust fund. Our review disclosed that HCFA reported all delinquent Medicare premiums to the SMI trust fund, and did not consider whether these amounts applied to the HI trust fund. Upon receipt of a recovery, the HCFA associated and recorded the recovered amount to the appropriate trust fund general ledger. To determine the effect of misrecorded recoveries, we reviewed HCFA's Medicare Group Premium Collection Ledger which categorizes recoveries under Part A or Part B. As a result, the HI trust fund was understated, and the SMI trust fund was overstated by $6.9 million.

THE HCFA'S FINANCIAL MANAGEMENT SYSTEM FOR DIRECT BILLINGS OF MEDICARE PREMIUMS CANNOT ENSURE THAT ALL OUTSTANDING PREMIUMS ARE REPORTED TO THE MEDICARE TRUST FUNDS

Under certain circumstances, the HCFA directly bills individuals for premiums relating to the HI and SMI programs. Accounts receivable for direct billings occur when premiums are not paid on time. Our review disclosed that HCFA's financial management system for direct billings of Medicare premiums was not able to ensure that outstanding amounts reported to the HI and SMI trust funds included all delinquent accounts.

The effort to collect delinquent premiums may be suspended under certain circumstances. However, suspensions do not forgive the debt owed by beneficiaries. Our review disclosed that suspended premiums from direct billings were recorded to HCFA's financial management system for delinquent premiums, but were not reported in the accounts receivable balances for the HI and SMI trust funds at yearend. Furthermore, the HCFA's system to track direct billings was not programmed to accumulate and report suspended accounts.

As a result of these reporting deficiencies, we were not able to determine the accuracy of the delinquent direct billings account balance of the HI and SMI trust funds at

September 30, 1991. However, HCFA officials acknowledged that the accounts receivable balance of $37.8 million for delinquent direct billings at September 30, 1991 was understated.

UNRECONCILED ITEMS CONTINUE TO EXIST BETWEEN HCFA AND THE OFFICE OF PERSONNEL MANAGEMENT

Retired civil servants may enroll in the Medicare SMI program. To ensure the collection of SMI premiums, OPM withholds the appropriate amount from enrollees retirement checks. Accounts receivable may arise when a problem occurs in the exchange of data, or when enrollees change their status.

Each month, HCFA informs OPM of the amount of the SMI premium to be withheld from each retirement check. This procedure requires close coordination between the two financial management systems.

Our review noted unresolved reconciliation problems between HCFA's and OPM's financial management systems. A November 1990 OIG report[6] noted an unreconciled amount between HCFA's and OPM's records for 1988. The cause for the variance had not been identified. Officials at HCFA stated that the 1988 reconciliation was the last one performed, and the same problems continue to exist between the two agencies' records.

As a result, the HCFA was not confident in the accuracy of the $13.1 million in nonwithheld premiums reported by its SMI Premium Accounts, Collection, and Enrollment System. Therefore, it did not include this amount in the accounts receivable balance for the HI and SMI trust funds at September 30, 1991.

Without proper reconciliations between the HCFA's and OPM's financial management systems, the accuracy of the accounts receivable balance for retired civil servants is questionable. If the unreconciled amount of $13.1 million had been properly reconciled and reported, it could have had a material affect on the accounts receivable balance for the SMI trust fund at yearend.

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[6] OIG report entitled, "*Follow-Up Review of Medicare Part B Premium Collection Procedures for Civil Service Annuitants*" (A-03-90-00619), dated November 1990.

REPORTED ALLOWANCES FOR UNCOLLECTIBLES DID NOT COMPLY WITH REQUIRED GUIDELINES AND COULD BE OVERSTATED

To determine the allowance for uncollectible receivables at September 30, 1991, HCFA included all overpayments over 1 year old. The aging of receivables was based on overpayment determination dates. In establishing the allowance, HCFA did not consider the nature of outstanding balances, related collection activity, or type of receivable. As a result, the allowance accounts for the Medicare trust funds could be overstated at September 30, 1991.

Based on Government accounting principles, receivables over 1 year may still be collectible and should not automatically be categorized as uncollectible. However, our review disclosed that HCFA may have overstated its allowance for uncollectibles by including all receivables over 1 year even those that are under installment repayment plans or are involved in collection activity.

> Title II required agencies to record the allowances for uncollectibles based on past experience, present market conditions, and an analysis of outstanding balances.
>
> Additionally, accounts receivables that will not be collectible within 1 year of the date of the financial statements and are included in the receivable amount shall be disclosed in the footnotes to the financial statements.

We believe that to accurately record the allowance account, the HCFA should consider past experience and current market conditions, and perform an analysis of outstanding balances. For example, the HCFA included $87 million in credit balances in its accounts receivable balances and related allowance accounts for the Medicare trust funds. This resulted in a net effect of zero. Yet a recent OIG report noted that $66 million of $265.9 million in provider credit balances had been collected by FIs as of March 1992, and providers were reporting that they wanted to return Medicare credit balances reported on their records. This indicates that credit balances are collectible, and should not be automatically off-set with an allowance account merely because they have aged more than 1 year. Furthermore, HCFA included all $28.5 million in appealed HI trust fund receivables in the allowance account. Past experience of appealed cases should have been analyzed to determine a reasonable amount for the allowance.

REPORTED WRITE-OFFS DID NOT CONSIDER ALL RECEIVABLES, WERE UNSUPPORTED, AND COULD BE UNDERSTATED

The balance for accounts receivable write-offs reported by the POR and PSOR systems could not be substantiated by supporting documents, and the financial management system for write-offs did not include all categories of receivables. As a result, we could not verify $32.6 million in write-offs reported by the POR and PSOR systems, and believe that unrecorded write-offs related to other categories of receivables understated the balance for accounts receivable write-offs at September 30, 1991.

> The CORE required the accounts receivable function to identify and report selected accounts which meet predetermined criteria for write-offs, record the write-off of delinquent or uncollectible receivables, and maintain data to monitor closed accounts.

To identify and select accounts receivable for write-offs, the HCFA queried the POR and PSOR systems. The query was based on overpayment status codes for accounts with partial or no collection activity. However, the HCFA did not consider write-offs for provider credit balances, appealed accounts receivable at FIs and carriers, HMOs/HCPPs receivables, or delinquent receivables. Once established, HCFA was not able to support or reconstruct the amount written-off.

By HCFA not maintaining detailed records of the amounts written-off, and limiting write-offs to POR and PSOR systems accounts, we could not verify $32.6 million in reported write-offs at September 30, 1991, and believe the amount written-off could be understated.

HCFA'S POR AND PSOR SYSTEMS NEED IMPROVEMENT

In preparing the 1991 year-end SF 220 report, HCFA primarily relied upon the POR and PSOR systems to report its accounts receivable balance. The reported balance of $1.04 billion at September 30, 1991 included $670.8 million from the POR system, and $159.9 million from the PSOR system. Our review of account transactions and balances at the contractors visited, which composed approximately $107 million (10.3 percent) of the POR and PSOR systems balances, disclosed that the transactions and balances were not always correct, properly supported, or recorded to the proper accounting period.

Our review found that the POR system was not designed to categorize and report overpayments related to the Medicare trust funds. As a result, the amounts reported for HI and SMI were not based on actual receivables and may not be accurate.

> Title II required that accounting systems, whether automated or manual, must contain internal controls which operate to prevent, detect, and correct errors and irregularities which may occur anywhere in the chain of events from transaction authorization to issuance of reports.

Although our testing of HCFA's financial management systems was limited to the contractors visited, we believe that identified error rates were significant. These error rates indicated that accounting controls within HCFA's financial management systems needed to be improved to ensure accurate and reliable financial reporting under HCFA's POR and PSOR systems.

HCFA'S POR SYSTEM WAS NOT ABLE TO CATEGORIZE AND REPORT OVERPAYMENTS RELATING TO BOTH THE HI AND SMI TRUST FUNDS

Currently, the POR system only captures overpayments arising from cost report settlements between FIs and providers. Receivables arising from cost report settlements may include overpayments associated with the HI and SMI trust funds. However, the POR system was not able to categorize and report overpayments related to the Medicare trust funds. To recognize the portion of overpayments related to the HI and SMI trust funds, HCFA allocated the outstanding balance reported by the POR system at yearend using a percentage based on benefit payments. As a result, the amounts reported for the HI and SMI trust funds were not based on actual receivables and may not be accurate.

> Title II required that receivables shall be categorized in the agency accounting records under the fund, appropriation, or receipt account where the receivable is to be deposited when collected.
>
> The CORE required the receivable function to identify detailed receivable information and maintain activity information by account, and record transactions to the appropriate fund, maintain historical information on transactions, and account updates.

ACCOUNT BALANCES REPORTED BY THE POR SYSTEM WERE NOT ALWAYS ACCURATE

The POR system is an on-line computer tracking system that captures overpayments through direct update by FIs, HCFA central office, and regional offices. The POR system was designed to serve as a uniform method for reporting overpayment data, and as a base for compiling management information on overpayments. However, the POR system was not designed for, nor was it intended to be, a financial management system.

In addition to recovering overpayments, the FIs are also responsible for ensuring that account transactions and balances are properly recorded and supported. At the three FIs reviewed, we noted that each maintains subsidiary records to account for overpayments, collections, and interest. These records serve as the basis for data entered into HCFA's POR system.

To assess the reliability and accuracy of account transactions and balances reported to the POR system at September 30, 1991, we selected a stratified random sample of 70 outstanding balances from 257 outstanding balances reported by the POR system for 2 FIs. Thirty-five outstanding balances were selected from each FI. Twenty-nine outstanding balances at a third FI were selected since this represented 100 percent of its population of outstanding balances reported by the POR system. Selected sample items were traced to demand letters sent to providers. We also traced a judgmental sample of 31 demand letters to outstanding balances reported by the POR system at the selected Medicare FIs.

Since our stratified random sample of POR system balances did not include at least six errors per strata, we did not project the error value of the sample to the universe of POR system balances for the three FIs. However, the following identified errors and amounts did affect the accounts receivable balances reported to the POR system by the FIs visited.

- Nine errors out of 99 sample items, and a related overstatement of $486,300 were identified when a stratified random sample of outstanding balances reported by the POR system was traced to supporting documents.

- Seven errors out of 31 sample items, and a related understatement of $1,383,238 were identified when a judgmental sample of source documents was traced to the POR system.

TESTING OF POR BALANCES TO SUPPORTING DOCUMENTS IDENTIFIED VARIOUS RECORDING ERRORS

To assess the accuracy and reliability of the account balances reported to the POR system at September 30, 1991, we randomly selected 70 (35 each) of 257 balances from Massachusetts Blue Cross and Florida Blue Cross, and reviewed all 29 POR system balances at Minnesota Blue Cross. Our analysis of the 99 transactions disclosed the following 9 errors and related net overstatement of $486,300 when selected POR system balances were traced to supporting documents.

- Five errors resulted from timing differences due to recording recoveries to the incorrect accounting cycle which overstated the POR system balance by $498,138. The FIs received recoveries in September 1991 but did not record them to the POR system until October 1991.

- Two errors resulted from unrecorded recoveries which overstated the POR system balance by $10,107. One FI recorded a recovery to its internal records but not to the POR system, and the second recovery was not recorded to either system.

- A duplicate account overstated the POR system balance by $185,304. The FI mistakenly established two accounts for the same overpayment.

- A duplicate payment understated the POR system balance by $207,249. The FI posted the recovery twice to the POR system.

TESTING OF SOURCE DOCUMENTS TO THE POR SYSTEM IDENTIFIED UNRECORDED ACCOUNT BALANCES

To ensure that procedures were in place to record all transactions to the POR system, we judgmentally selected 31 source documents and traced them to the POR system. Our analysis disclosed the following seven errors and a net understatement of $1,383,238 when source documents were traced to the POR system:

- Four errors resulted from timing differences due to recording overpayments to the incorrect accounting cycle which understated the POR system balance by $1,278,741. All four overpayments were recorded to the FI's records in September 1991 but not recorded to the POR system until October 1991.

- Two errors resulted from removing referred overpayments to HCFA from the POR system. This understated the POR system balance by $59,479. The two overpayments were referred to HCFA for collection and no longer carried on the POR system.

- An unrecorded overpayment understated the POR system balance by $45,018. The overpayment was not recorded to the FI's internal records or the POR system.

ACCOUNT BALANCES REPORTED BY THE PSOR SYSTEM WERE NOT ALWAYS ACCURATE

The PSOR system is an on-line computer tracking system that captures most physician and supplier overpayments under Medicare Part B through direct update by carriers and HCFA's central office and regional offices. However, not all Part B overpayments are recorded to the PSOR system since FI's record overpayments under both Part A and Part B to the POR system.

The HCFA primarily relies on carriers to identify overpayments resulting from Medicare Part B claims. Overpayments are identified by (1) investigating general correspondence and telephone inquiries from providers and beneficiaries; (2) accounting for returned claim payments submitted as errors from providers or beneficiaries; and (3) performing internal quality control reviews, utilization reviews, and end-of-the-line quality reviews.

The PSOR system is used to track overpayments to physicians and suppliers, and is broken down into the following four reporting categories:

- physician and supplier overpayments greater than or equal to $600;

- physician overpayment amounts of $50 to $599;

- supplier overpayments of $50 to $599; and

- physician and supplier overpayments less than $50.

In accordance with HCFA policy, carriers are required to report detailed overpayment information to the PSOR system for overpayments greater than or equal to $600. Each overpayment category under $600 is reported to PSOR in the aggregate by the 25th of each month.

At the carriers reviewed, we noted that each maintained subsidiary records that accounted for overpayments, recoveries, and interest. These records served as the basis for overpayment data entered into HCFA's PSOR system.

To assess the reliability and accuracy of account transactions and balances reported to the PSOR system, we selected a stratified random sample of 70 outstanding balances from 1,279 outstanding balances reported by the PSOR system for 2 carriers. Thirty-five outstanding balances were selected from each carrier. Six outstanding balances at a third carrier were selected since this represented 100 percent of its population of outstanding balances reported by the PSOR system. Selected sample items were traced to demand letters sent to providers. We also traced a judgmental sample of 30 demand letters to outstanding balances reported by the PSOR system, and reconciled the outstanding balance for the PSOR system to the carriers' internal records. The following errors and related amounts were identified as a result of our testing at the selected carriers.

- Thirty-one errors out of 76 sample items, and a related overstatement of $74,442 when a random sample of outstanding balances reported by the PSOR system was traced to supporting documents. When we statistically projected our results, we identified an error rate of approximately 30.92 percent with a precision of +/- 11.81 percent at the 90 percent confidence level. We also estimated that the PSOR balance was overstated by about $2,149,550 with a precision of +/- 136.99 percent at the 90 percent confidence level.

- Five errors out of 30 sample items, and a related understatement of $12,873 when a judgmental sample of source documents was traced to the PSOR system.

- A $55,759 understatement in reconciling items between the PSOR system and the carriers' internal records.

TESTING OF PSOR BALANCES TO SUPPORTING DOCUMENTS IDENTIFIED VARIOUS RECORDING ERRORS

To assess the accuracy and reliability of the transactions and balances reported by the PSOR system, we randomly selected a sample of 76 out of 1,285 outstanding overpayment balances recorded to the PSOR system at September 30, 1991 for the carriers visited. Although we found the PSOR balance to be overstated by only a net $74,442 when tracing the outstanding balances to source documents, we believe that the following 31 errors out of 76 sample items to be very significant.

- Eighteen errors resulted from timing differences due to recording recoveries to the incorrect accounting cycle which overstated the PSOR balance by $70,809. These overpayments were recovered in September 1991 but not recorded to the PSOR system until October 1991.

- Five errors resulted from a lack of supporting documentation which overstated the PSOR balance by $4,931. One carrier was not able to locate supporting demand letters for all five outstanding overpayment balances.

- Two errors resulted from unrecorded recoveries which overstated the PSOR balance by $2,193. Both payments were recorded to the carrier's internal records but not to the PSOR system.

- A dummy test account not removed from one carrier's records resulted in an overstatement of $700. The dummy test account was used to test the carrier's internal overpayment system and was mistakenly recorded to the PSOR system.

- Four errors resulted from input errors which understated the PSOR balance by a net $126. The incorrect amounts were entered when the overpayments were recorded to the PSOR system.

- A contested overpayment was not recorded to the PSOR system and understated the PSOR balance by $4,065. The original overpayment covered several treatments and were all disallowed as a result of a postpayment utilization review. However, the provider had contested one of the treatments which amounted to $4,065. As a result, the HCFA verbally instructed the carrier not to record the contested amount to the PSOR system. The provider agreed in October 1991 that the charges should be disallowed.

We projected the results of our stratified random sample to a universe of 1,285 outstanding overpayment balances at September 30, 1991 for the carriers visited. The 31 errors resulted in a net overstatement of $74,442. Using a standard scientific estimation process, we determined that the PSOR balance at September 30, 1991 for the three carriers was overstated by $2,149,550. The precision at the 90 percent confidence level is +/- 136.99 percent.

Due to the variability of the sampled items, and the resultant high precision, we could not conclude on the materiality of our results. However, when we projected the 31 identified errors to our universe of 1,285 outstanding overpayment balances at September 30, 1991, we determined that there were about 398 errors. We also determined that the error rate for the universe was 30.92 percent, with a precision of +/- 11.81 percent at the 90 percent confidence level (see Exhibit III for detailed information on the statistical projection).

TESTING OF SOURCE DOCUMENTS TO THE PSOR SYSTEM IDENTIFIED UNRECORDED ACCOUNT BALANCES

To ensure that procedures were in place to record all transactions to the PSOR system, we judgmentally selected 30 demand letters and traced them to the PSOR system at the carriers visited. As a result, we identified the following five errors, which understated the PSOR balance by $12,873.

- Three errors resulted from timing differences due to recording overpayments to the incorrect accounting cycle which understated the PSOR balance by $10,761. The overpayments were recorded to the carrier's records in September 1991 but not recorded to the PSOR system until October 1991.

- Two errors resulted from unrecorded overpayments which understated the PSOR balance by $2,112. Both overpayments were recorded to the carrier's internal records but not to the PSOR system.

RECONCILIATION OF THE PSOR SYSTEM TO THE THREE CARRIERS' INTERNAL RECORDS IDENTIFIED VARIANCES AND UNRECONCILING ITEMS

We performed a reconciliation between the outstanding overpayment balances reported by the PSOR system and the three carriers' records. As a result, we identified a net understatement of $55,759 based on the following discrepancies.

- The HCFA requires carriers to report the total number and amount of overpayments under $600 by the 25th of each month. We noted that all three carriers followed this practice and did not record related transactions for two business days in September 1991 to the PSOR system. We were able to quantify the effect for the Region I carrier which amounted to an understatement of $78,935.

- We noted that the practice in the Region I carrier was to record cash receipts and adjustments in the subsequent month. By recording September 1991 activity in October 1991, the carrier created a net timing difference of $23,176 in its PSOR balance. The timing difference consisted of an overstatement of $52,173 in September cash receipts, and an understatement of $28,997 in September adjustments.

In addition to the above discrepancies, we identified unreconciled differences between the PSOR system and the carrier's records for two of the three carriers:

- When considering the above reconciling items for the Region I carrier, the difference of $407,901 between the PSOR system and the carrier's records was increased to $463,660 ($407,901 + $55,759). Although we were not able to identify the complete nature of the adjusted difference, we were able to conclude that it may be comprised of overpayment balances under $600. Overpayment balances under $600 were not recorded to the PSOR system before July 1991. A review of the carrier's records noted a multitude of such outstanding overpayments, some dating back as far as 1989.

- The Region IV carrier was not able to generate a report from its automated system that would reconcile with the PSOR balance at September 30, 1991. Officials from the carrier believed that the unreconciled difference of $6,677,581 resulted from problems within its reporting program. The officials added that the program apparently was not including all accounts receivable under Part B.

In summary, we believe that by establishing the POR and PSOR tracking systems, the HCFA has attempted to account for outstanding overpayments to providers on an ongoing basis. However, our review disclosed that:

- The HCFA's policies and procedures did not require carriers to adopt standardized accounting controls for recording overpayments.

- The HCFA's POR system was not designed to categorize and report overpayments related to the HI and SMI trust funds. As a result, the amounts reported for the HI and SMI trust funds were not based on actual receivables and may not be accurate.

- Neither system was designed to ensure that transactions were recorded to the proper accounting cycle.

- Input controls for recording accounts receivable activity to POR and PSOR systems need strengthening and did not adequately ensure that transactions were correct, complete, and valid.

- Overpayments under $600 were recorded to PSOR in the aggregate.

To ensure accurate financial reporting, these matters need to be corrected.

MATERIAL NONCONFORMANCE RELATED TO THE REPORTING OF ACCOUNTS RECEIVABLE FOR THE MEDICARE TRUST FUNDS

The OMB Circular A-127 provides guidance for determining what constitutes a material nonconformance in a financial management system that would be considered reportable to the President and the Congress under the FMFIA. Based on our review, we believe that the deficiencies identified in the recording and reporting of the accounts receivable transactions and balances for the Medicare trust funds met the following OMB criteria for material nonconformance under FMFIA.

Did The Material Nonconformance Prevent The Agency's Primary Accounting System From Achieving Central Control Over Agency Financial Transactions And Resource Balances?

Based on our review, we determined that HCFA's general ledger accounts for accounts receivable did not include all overpayment transactions and balances. The general ledger accounts did include overpayments arising from MSP cases identified by some carriers, and a portion of provider credit balances. The general ledger accounts did not include outstanding overpayments resulting from MSP, post payment reviews, and PRO adjustments identified by FIs.

As a result, the HCFA general ledger did not achieve central control over the agency's financial transactions and resource balances.

Did The Material Nonconformance In A Subsidiary Or Program System Cause Nonconformances In The Primary System Or Prevent Compliance With Title 2, As Implemented In OMB Circular A-127?

The OMB Circular A-127 and Title 2 require agency financial management systems to provide for:

- complete disclosure of the financial results of the activities of the agency;
- adequate financial information for agency management and for formulation and execution of the budget; and
- effective control over revenues, expenditures, funds, property, and other assets.

Based on our review, we concluded that HCFA's accounts receivable systems were not in compliance with the above OMB Circular A-127 and Title 2 requirements. For

example, we found that HCFA did not have a financial management system to adequately record, monitor, collect, follow-up, and report accounts receivable from third parties under the MSP program, and overpayments resulting from FI post payment reviews and PRO adjustments.

In addition, OMB Circular A-127 requires the head of each executive agency to report to the President and the Congress on whether the agency's financial management systems conform to appropriate accounting principles and standards. However, the HCFA's accounts receivable function has not been reviewed by HCFA in accordance with OMB Circular A-127 requirements.

RECOMMENDATIONS

Based on our results, we recommend that HCFA improve and implement financial management systems and related accounting and administrative internal controls to ensure that:

1. The financial management systems for the accounts receivable function for HCFA and its Medicare contractors are integrated and standardized to promote consistency, uniformity, and efficiency in recording and reporting of accounts receivable balances, uncollectibles, and write-offs.

2. All receivables are accurately recorded in subsidiary systems on a timely basis by implementing double-entry accrual accounting and system controls, proper cut-off procedures, and adequate audit trails.

3. General ledger balances for accounts receivable include all identified overpayments and are reconciled with balances reported by subsidiary ledgers on an ongoing basis.

We also recommend that HCFA perform FMFIA section 4 reviews on all systems used to report accounts receivable and report the lack of financial management systems to properly record, monitor, follow-up, and collect overpayments as a material nonconformance under the FMFIA.

HCFA COMMENTS

In response to our draft report, HCFA does not believe it would be cost effective at this time to modify its current systems as described in the above recommendations. However, it agrees with our assessment that improvements are needed in HCFA's accounting of Medicare receivables. In this respect, HCFA indicated that it has or is in the process of developing the following improvements.

- Establishing the Financial Core Requirements that require the automation of financial functions at all Medicare contractors and a standardized reporting format for Medicare receivables.

- Developing a separate MSP accounts receivable reporting system to better account for receivables due from beneficiaries, insurers, or employers.

- Redesigning the entire Medicare premium billing system to allow HCFA to identify, control, and report accounts receivable.

- Establishing a HCFA work group to address the Financial Core Requirements including the reporting of accounts receivable by PROs.

- Exploring the incorporation of financial reporting into the design of the new Medicare Transaction System.

In response to our second recommendation, HCFA has scheduled joint FMFIA section 2/4 reviews for its financial systems beginning with FY 1993. The FMFIA section 2 reviews include evaluating and reporting on internal controls in its programmatic and administrative activities. The FMFIA section 4 reviews deal with a financial management review on all systems used to track and record receivables. With regard to the declarations of this issue as a material nonconformance with FMFIA section 4, HCFA defers comment.

OIG RESPONSE

The OIG has responsibility under the CFO Act to audit the Medicare trust funds as well as to develop recommendations that could result in more beneficial data for users of financial statements. With this in mind, it is important that HCFA, OMB, and the OIG continue to work together to accomplish this goal.

As we stated in our report, we recognize the complexity of the Medicare program and the fact that most of the systems maintained by HCFA and the Medicare contractors were originally designed as tracking systems and not accounting systems. Accordingly, we commend HCFA's current action and overall commitment to

addressing the problems identified in this report so that timely and reliable financial statements can be produced in the future. However, until such time as these improvements have been fully implemented, we believe that HCFA should report the lack of a comprehensive accounts receivable system as a material nonconformance under the FMFIA.

Based on our review of HCFA's general comments, nothing came to our attention that we believe would require us to change our conclusions or recommendations. However, we would like to address HCFA's concerns regarding the use of small sample sizes which resulted in large precision intervals as shown in the Exhibits. The HCFA did not believe those intervals should have been used to support our recommendations for major changes in its current system. First of all, the sample projection was statistically valid. Furthermore, we did not use the intervals to support our recommendations but rather the number of errors found in our sample results. As noted in Exhibit III, we identified 31 errors from a sample of 76 transactions (a 40 percent error rate). The number of errors clearly support our conclusion that weaknesses exist and corrective action is warranted.

We would also like to point out that proper cut-off procedures are necessary to produce reliable financial statements. Although it may be HCFA's policy to allow Medicare contractors up to 10 days to post recoveries to the POR and PSOR systems, it results in transactions not being posted to the correct accounting period.

EXHIBITS

STATISTICAL RESULTS FOR MSP OVERPAYMENTS FISCAL INTERMEDIARIES

Our review of HCFA's accounts receivable function noted that MSP overpayments identified by FIs were not reported to HCFA's general ledger for the HI trust fund. Since HCFA's MSP backlog report was not an adequate source for reporting outstanding MSP overpayments, we elected to use simple random sampling to estimate the amount of unreported MSP overpayments at each of the FIs visited.

We selected a random sample of 35 demand letters at each of 2 FIs, and a sample of 35 beneficiaries at a third FI, to obtain the value of unreported receivables related to MSP cases at September 30, 1991. Sample items were selected by numbering the demand letters identified at each FI and randomly selecting 35 numbers using the Office of Audit Services Statistical Sampling Software. Dollar values were obtained from related demand letters for each sample item. To determine the point estimate and precision for each FI, we used the Office of Audit Services Statistical Sampling Software (see Table III).

BC	Univ. No.	Sample No.	Sample Value	Sample Average	Point Estimate	Precision +/-
MA	1,090	35	$344,225	$9,835	$10,720,140	35.07%
FL	4,846	35	207,406	5,926	28,716,846	60.93%
MN	1,847	35	63,429	1,812	3,347,263	39.57%
					$42,784,249	

Table III: Statistical Value of MSP Accounts Receivable - Intermediaries

As a result, we were able to determine that the point estimate and precision at the 90 percent confidence level for Blue Cross (BC) of Massachusetts (MA) was $10,720,140 and +/- 35.07 percent, respectively. For BC of Florida (FL), the point estimate was $28,716,846 and the precision at the 90 percent confidence level was +/- 60.93 percent. The third sample, BC of Minnesota (MN), resulted in a point estimate of $3,347,263 and a precision at the 90 percent confidence level of +/- 39.57 percent. The sum of the point estimates for all three samples equaled $42,784,249 in unreported MSP receivables.

STATISTICAL RESULTS FOR MSP OVERPAYMENTS CARRIERS

Our review of HCFA's accounts receivable function noted that MSP overpayments identified by carriers were not reported to the PSOR system and HCFA's general ledger for the SMI trust fund for one of the three carriers. However, the MSP carrier backlog report for the carrier did include a September 30, 1991 balance of outstanding MSP overpayments. Therefore, we used a simple random sample to determine the validity of the amount of MSP overpayments recorded to the MSP backlog report but not reported as a receivable for the SMI trust fund.

We selected a random sample of 100 outstanding overpayments from 953 line items reported on a supporting schedule for the MSP backlog report at September 30, 1991. The sample items were selected by numbering each line item on the supporting schedule and randomly selecting 100 numbers using the Office of Audit Services Statistical Sampling Software. Dollar values were obtained from related demand letters for each sample item. To determine the point estimate and precision for our sample, we used the Office of Audit Services Statistical Sampling Software (see Table IV).

BS	Univ. No.	Sample No.	Sample Value	Sample Average	Point Estimate	Precision +/-
MA	953	100	$185,280	$1,853	$1,765,719	19.69%

Table IV: Statistical Value of MSP Accounts Receivable - Carriers

As a result, we were able to determine a point estimate of $1,765,719 with a precision of +/- 19.69 percent at the 90 percent confidence level for Blue Shield (BS) of MA.

STATISTICAL RESULTS FOR PSOR

Our review of HCFA's accounts receivable function noted that the carriers visited recorded identified overpayments to the PSOR system. Therefore, we used a stratified random sample to assess the reliability and accuracy of account balances reported to the PSOR system.

We selected a random sample of 76 outstanding overpayment balances from the PSOR system from a universe of 1,285 outstanding overpayment balances for the 3 carriers at September 30, 1991. Sample items for each strata were selected by numbering the demand letters identified at each carrier and randomly selecting 35 numbers for 2 of the carriers, and 6 numbers for the third carrier, using the Office of Audit Services Statistical Sampling Software. Outstanding balances were traced to related demand letters for each sample item. Discrepancies were categorized as errors. To determine the effect of identified errors, we used a variable appraisal program to estimate the variance (point estimate) of the PSOR balance for each of the below carriers, and the total variance for all three carriers. The point estimate for each strata was added together to obtain the point estimate for all three carriers (see Table V).

BS	Univ. No.	Sample No.	Sample Amount	Number Errors	Error Amount	Average Error	Point Estimate	Precision +/-
MA	108	35	$ 79,526	20	$<15,574>	$ 445	$ 48,057	34.37%
FL	1,171	35	464,818	10	<62,933>	1,798	2,105,558	139.85%
MN	6	6	35,164	1	4,065	<678>	<4,065>	0.00%
	1,285	76	$579,508	31	$<74,442>	$1,673	$2,149,550	136.99%

Table V: Statistical Projection of Errors Identified in the PSOR Balance for Three Medicare Carriers at September 30, 1991

To determine the precision of the value of errors for our sample, we used the Office of Audit Services Statistical Sampling Software. As a result, we were able to determine a point estimate of $2,149,550 with a precision of +/- 136.99 percent at the 90 percent confidence level.

Due to the variability of the sampled items, and the resultant high precision, we could not conclude on the materiality of our results. However, when we projected the 31 errors to our universe of 1,285 outstanding overpayment balances at September 30, 1991, we determined that the error rate was significant.

To determine the effect of identified errors, we used an attribute appraisal program to estimate the below error rate for the population of 1,285 PSOR balances for the 3 carriers. Total errors for each strata were statistically projected to the strata's universe to determine the number of errors in the universe. The total number of errors was divided by the number of universe items within each strata to obtain the error rate. The number of errors and the universe sizes for the strata were added together to obtain the totals for all three carriers. All three strata were used to calculate the error rate for the overall universe (see Table VI).

BS	Univ. No.	Sample No.	No. of Errors	No. of Errors in Universe	Error Rate	Precision +/-
MA	108	35	20	62	57.14%	11.85%
FL	1,171	35	10	335	28.57%	12.91%
MN	6	6	1	1	16.67%	0.00%
	1,285	76	31	398	30.92%	11.81%

Table VI: Statistical Projection of Identified PSOR Errors for Three Medicare Carriers

To determine the precision of our sample, we used the Office of Audit Services Statistical Sampling Software. As a result, we were able to determine an error rate of 30.92 percent with a precision of +/- 11.81 percent at the 90 percent confidence level.

APPENDIX

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

IG	
PDIG	
DIG-AS	
DIG-EI	
DIG-OI	
AIG-MP	
OGC/IG	
EX SEC	V
DATE SENT	3/24

Memorandum

Date MAR 24 1993

From William Toby, Jr.
Acting Administrator

Subject Office of Inspector General (OIG) Draft Audit Report: "Review of the Accounts Receivable Balances for the Hospital Insurance and Supplementary Medical Insurance Trust Funds at September 30, 1991," A-01-91-00525

To Bryan B. Mitchell
Principal Deputy Inspector General

We reviewed the subject draft audit report which concerns OIG's assessment of the accuracy of the recording and reporting of Medicare accounts receivable transactions and the identification of the sources of unreported accounts receivable due the Medicare program.

We agree with OIG's assessment that improvements are needed in the Health Care Financing Administration's (HCFA) accounting of Medicare receivables. In 1990, as a result of the Chief Financial Officers (CFO) Act requirement to improve financial reporting as well as HCFA's decision to begin issuing private-sector type financial statements, we initiated a study to identify contractor reporting weaknesses and to institute improvements.

Many problems were identified concerning the accounting of Medicare receivables and payables. Most of these problems are unique to HCFA and result from our use of Medicare contractors to pay Medicare benefits, collect overpayments, and carry out other day-to-day operational responsibilities of the Medicare program. The use of outside contractors to pay benefits creates unique accounting and reporting problems. The problems we identified were shared with OIG. In fact, most of the audit report discusses problems previously identified by HCFA. Therefore, the problems discussed in the OIG report are not at issue.

The issue, as we perceive it, is to develop a realistic approach to these problems in light of our administrative challenges and constraints. While we believe that the necessary information for proper and full accounting is available at every Medicare contractor site, we do not believe that it would be advisable, or even possible during a time of declining budgetary resources to spend large sums of money to develop integrated accrual accounting systems. HCFA was not provided with funds to implement the CFO Act. Instead, we have begun to implement many improvements in Medicare accounting and reporting that will improve the quality of data being received from the Medicare contractors. For example, during 1992, HCFA developed

Financial Core Requirements requiring the automation of financial functions at all Medicare contractors and implemented a standard reporting format designed to improve the reporting of Medicare receivables. We also required that data submitted to HCFA by the contractors be certified by their financial officers. During 1993, we plan to visit contractors to review the information submitted and to verify its accuracy. Other improvements in Medicare contractor accounting and reporting of financial data are detailed in the attachment.

We recognize that these initiatives will take time and that additional work needs to be done. We believe we have established a strong foundation and that additional improvements will be forthcoming.

Also, we would like to defer a decision on the material nonconformance until we determine if these problems meet the criteria for a material nonconformance under the FMFIA. Our specific comments are attached for your consideration.

Thank you for the opportunity to review and comment on this draft audit report. Please advise us if you agree with our position on the report's recommendations at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration (HCFA) on the Office of Inspector General (OIG) Draft Audit Report: "Review of the Accounts Receivable Balances for the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds at September 30, 1991," A-01-91-00525

Recommendation 1

OIG recommends that HCFA improve and implement financial management systems and related accounting and administrative internal controls to ensure that:

- The financial management systems for the accounts receivable function for HCFA and its Medicare contractors are integrated and standardized to promote consistency, uniformity, and efficiency in recording and reporting of accounts receivable balances, uncollectibles, and writeoffs.

- All accounts receivable are accurately recorded on a timely basis by implementing double-entry accrual accounting and system controls, proper cutoff procedures, and adequate audit trails.

- General ledger balances for accounts receivable include all identified overpayments and are reconciled with balances reported by subsidiary ledgers on an ongoing basis.

HCFA Response

Although we agree that HCFA needs to obtain better data from Medicare contractors, we do not believe it would be cost effective at this time to modify HCFA's current systems as described in the recommendation.

The main thrust of the OIG report is that neither HCFA nor the Medicare contractors have fully integrated accounts receivable systems containing such attributes as full accrual accounting, aging of accounts, proper cutoff procedures, and adequate audit trails. The financial management systems that HCFA and the Medicare contractors use were designed, and have historically operated, as overpayment and/or delinquent payment tracking systems. They were not designed to be full accounting reporting systems. We have never required the Medicare contractors to report detailed accounting data. The needs of our program managers have always been for operational, administrative, and programmatic financial and statistical data.

We have recognized and accepted the need to improve our financial reporting for the Medicare program. To this end, we began enhancements nearly 2 years ago to the Provider Overpayment Reporting (POR) and Physician/Supplier Overpayment Reporting (PSOR) systems. In addition, HCFA recently completed the development and promulgation of the Financial Core Requirements, standard financial accounting and reporting criteria for all Part A and Part B systems. Implementation of the

Financial Core Requirements will ensure that HCFA is provided with current and accurate data for the preparation of financial statements. Those requirements will also enable the Medicare contractors to improve their internal accounting and financial reporting systems. Finally, HCFA will use the requirements to evaluate the degree of automation achieved by the intermediaries and carriers in their financial/accounting systems.

We believe that the Financial Core Requirements have provided HCFA with a solid base to strengthen accounting for, and control over, accounts receivables. HCFA has already scheduled the next phase of work to enhance the Financial Core Requirements. Over the next few months, a HCFA work group will be addressing the task of improving accounts receivable and payable reportings. We believe the Financial Core Requirements and their subsequent improvements will substantially improve the reliability of accounts receivable data reported by the Medicare contractors.

While the report contained no specific recommendation on Medicare secondary payer (MSP) overpayments, OIG noted that not all mistaken payments or overpayments are included in management reports such as the POR and PSOR, nor are all accounts receivable reported in the MSP backlog report. This is correct. The POR and PSOR do not track accounts receivable from beneficiaries, insurers, or employers. Further, the backlog reports do not account for current transactions. Therefore, we are developing a separate MSP accounts receivable reporting system to address these deficiencies. The instructions are currently being reviewed by contractors prior to implementation.

In addition, the report stated that HCFA's financial management system for direct billing of Medicare premiums cannot ensure that all outstanding premiums are reported to the Medicare trust funds. This is currently true. Because beneficiaries are billed in advance of the date that the premiums are actually owed, it is difficult to identify accounts receivable for Medicare premiums. For example, a person may receive a quarterly bill which may include 2 past-due months' premiums and 3 future months premiums. The only portion of this bill that is a true receivable is the amount for the 2 past-due months' premiums.

Another problem in reporting premium accounts receivable is that the current billing system is set up to bill only one-third of the beneficiaries each month. There may be a current receivable on the account of an individual not in the current month's billing cycle. Finally, the current Billing and Collection Master system cannot adequately control and bill for Medicare premiums for a prior period of coverage. This situation would apply when coverage is terminated and re-established at a later date. However, the direct billing system is able to credit the appropriate trust fund.

HCFA is in the process of redesigning the entire premium billing system. The redesign contains enhancements that allow HCFA to identify, control, and report accounts receivable. The system is scheduled to be implemented during fiscal year (FY) 1994.

Regarding unreconciled items which continue to exist between HCFA and the Office of Personnel Management (OPM), HCFA agrees that there is a discrepancy between the premium deductions made by OPM and the premium liability calculated by HCFA. For this reason, HCFA did not include a previously calculated discrepancy of $13.1 million in unreconciled premiums in its accounts receivable balance for the SMI trust fund as of September 30, 1991, since this amount at this time is not a true receivable.

The Social Security Administration, HCFA, and OPM are currently engaged in a project to resolve problems in data exchange among the agencies. When problems with data exchange have been resolved, HCFA and OPM will conduct a major reconciliation. One of the goals of the reconciliation will be to accurately determine the actual amount of the premium owed by OPM and ensure that premium discrepancies do not occur between the files of the two agencies in the future.

Another of OIG's findings was that HCFA accounts receivable balances were understated because they did not include peer review organization (PRO) adjustments. The HCFA work group responsible for the next phase of work on the Financial Core Requirements will also be addressing the reporting of accounts receivable by PROs.

We believe that the short-term actions described above will improve HCFA's accountability of Medicare receivables and should satisfy OIG's concerns. We will also explore the incorporation of financial reporting into the design of the new Medicare Transaction System (MTS). To accomplish this, we have assigned the responsibility of developing recommended approaches to financial reporting in the MTS environment to an MTS work group.

Recommendation 2

OIG also recommends that HCFA perform Federal Managers' Financial Integrity Act (FMFIA) section 4 reviews on all systems used to report accounts receivable and report the lack of financial management systems to properly record, monitor, followup, and collect overpayments as a material nonconformance under FMFIA.

HCFA Response

HCFA has scheduled joint FMFIA section 2/4 reviews for its financial systems beginning with FY 1993. In addition, as new systems for accounts receivable are introduced, we will conduct section 4 reviews on those systems. With regard to the

declaration of this issue as a material nonconformance, HCFA defers comment. We are currently analyzing this issue to determine if it meets the criteria of nonconformance under the FMFIA.

General Comments

1. Page 7 OIG bracketed the following rule: "Agencies are required to record amounts receivable at the time an event occurs that entitles an agency to collect funds (title 2)." In a claims processing environment, Federal agencies are required to give notice before they are entitled to collect funds. How does this affect the interpretation of an accounts receivable?

2. Page 13 OIG stated that the provider credit balances portion of the FY 1991 HCFA accounts receivable balances was understated and HCFA's allocation of reported credit balances was questionable. OIG also suggested that HCFA obtain Office of Management and Budget (OMB) approval to require providers to report Medicare credit balances. This approval was obtained from OMB in May 1992. Instructions issued on June 8, 1992, require separate reporting for HI and SMI credit balances. However, for purposes of the FY 1992 financial statement, these credit balances will be broken down into other accounts receivable categories, such as Medicare Secondary Payer (MSP), overpayment, medical review/utilization review, etc.

3. Page 14 OIG found that delinquent Medicare premiums related to the HI trust fund were not accurately reported. We wish to note that HCFA's direct billing system is able to identify the appropriate trust funds which should be credited only after the premium remittance has been processed. This activity is based on a hierarchy of distribution. This distribution ensures that beneficiaries in danger of being terminated due to delinquent payment have their delinquent premiums credited first. The appropriate balances due are calculated again during the next billing cycle.

   We were also concerned that several of OIG's calculations of the underreporting of accounts receivable estimates for the HI and SMI trust funds used small sample sizes which resulted in large precision intervals as seen in exhibits 1 - 3. We do not believe those intervals should have been used to support recommendations made by OIG for major changes in HCFA's current system.

4. Page 18 OIG stated that the POR system was not able to categorize and report overpayments related to the Medicare trust funds and that HCFA allocated the outstanding balance reported by the POR system at year end using a percentage

based on benefit payments. We agree that the POR system was not designed to separate HI and SMI trust fund amounts. Percentages based on benefits paid were used to allocate accounts receivable between these two trust funds in FY 1991. We believe that the percent estimates used for allocation purposes did not result in material differences between the trust funds. In addition, the POR was not used to obtain receivable information for FY 1992 financial statements.

5. Page 20 OIG assessed the accuracy and reliability of the account balances reported to the POR system and found a net overstatement of $486,300. We believe that this is not a significant finding when compared with the total overpayments of $259.5 million for the three fiscal intermediaries (FIs) reviewed, or the national total overpayments of $3.1 billion.

6. Page 20 OIG stated that five errors resulted because the FIs received recoveries in September 1991, but did not record them to the POR system until October 1991. We do not agree that these situations were errors. FIs are allowed 10 calendar days to enter overpayment data into both the POR and PSOR. This policy was instituted to reduce contractors' administrative costs.

   OIG also found two errors which resulted from unrecorded recoveries which overstated the POR system balance by $10,107. In view of the overpayment volume and dollars, we believe the two unrecorded recoveries are immaterial. In addition, OIG stated that four errors resulted from timing differences due to recording overpayments to the incorrect accounting cycle which understated the POR system balance by $1,278,741. All four overpayments were recorded to the FIs' records in September 1991, but were not recorded to the POR system until October 1991. HCFA does not consider these instances errors. As we discussed in the first paragraph of this general comment, FIs are allowed 10 calendar days to enter overpayment data into both the POR and PSOR.

7. Page 21 OIG stated that two errors resulted from removing referred overpayments to HCFA from the POR system. According to OIG, this understated the POR balance by $59,479. OIG maintains that the two overpayments were referred to HCFA for collection and were no longer carried on the POR system.

   The two referred cases were transferred from the FIs' accounts to the regional office accounts. We believe there was no understatement of accounts receivable, but a transfer from one account to another.

OIG also maintains that an unrecorded overpayment understated the POR system balance by $45,018. The overpayment was not recorded to the FI's internal records or the POR system. HCFA believes that this amount is immaterial in light of the heavy volume relating to the three FIs involved.

8. Page 23 OIG found 18 errors resulting from timing differences due to recording recoveries to the incorrect accounting cycle which overstated the PSOR balance by $70,809. As stated earlier, we do not consider this an error since HCFA policy allows FIs 10 days to enter data.

   OIG found that a contested overpayment was not recorded to the PSOR system and understated the PSOR balance by $4,065, the original overpayment amount. HCFA requires carriers to recoup any contested overpayments until the issue is resolved. Based on the limited information provided in OIG's finding, it appears that HCFA should have instructed the carrier to enter the amounts into the PSOR.

9. Page 25 The report states that overpayment balances under $600 were not recorded to the PSOR system before July 1991. OIG's review of the carrier's records noted a multitude of such outstanding overpayments, some dating back as far as 1989. HCFA has undertaken a review to determine all overpayment balances under $600 and to provide an outstanding amount for these types of accounts receivable. The accounts receivable for September 30, 1992, will include overpayments that have an aggregated amount of $600 or under.