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Memorandum

Date *Michael Mangini*
for June Gibbs Brown
From Inspector General

Subject Review of Controls Over Electronic Billing and Payment at Selected Medicare Contractors in Region V--Considerations for the Design of the Medicare Transaction System (A-05-93-00056)

To

Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached for your review and comment is our final report entitled, "Review of Controls Over Electronic Billing and Payment at Selected Medicare Contractors in Region V--Considerations for the Design of the Medicare Transaction System." The review was performed at three Medicare contractors and at the Health Care Financing Administration's (HCFA) Region V office. Because two of the contractors handle claims for both Part A (intermediaries) and Part B (carriers) of Medicare, our review covered the operations of two carriers and three intermediaries.

Our primary objective was to identify strengths and weaknesses in internal controls over provider billings made via Electronic Media Claims (EMC) and Medicare payments made via Electronic Fund Transfers (EFT). The purpose of this analysis was to better understand what control procedures and practices may be needed for the Medicare Transaction System (MTS). The HCFA expects the MTS, the new Medicare claims processing system currently in the design phase, to be operating by the late 1990's. Our other objective was to determine whether the contractors we reviewed were meeting EMC/EFT goals set by HCFA.

Generally, we found that the contractors' internal controls over EMC/EFT transactions were adequate. Many of the existing controls were noteworthy and should be considered for inclusion in MTS. However, some inconsistencies existed between the contractors' practices and certain areas were in need of improvement. In most instances, controls could be improved by modifying existing control structures.

We also found that the reviewed contractors have performed well in meeting goals and objectives set by HCFA to encourage increased use of EMC. Similar goals, however,

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were not being used to encourage EFT participation. The HCFA should consider establishing such goals to increase the use of EFT.

This review represents our first step in understanding and evaluating EMC/EFT activity in Medicare. We believe our report provides timely, baseline information to HCFA on EMC/EFT control procedures while MTS is still in its design phase so that the best of the current controls can be considered for inclusion in the new system. Concerning current operations at the contractors, we are recommending that HCFA consider establishing requirements that would provide for uniform and consistent internal controls applicable to EMC/EFT processing. We are also recommending that HCFA consider actions to strengthen other control and safeguard measures, and to increase the use of EFT. Further recommendations may evolve as we expand on this initial review.

We will continue our review of EMC/EFT issues and will revisit the three contractors to address concerns, recently expressed by HCFA staff, regarding areas having high risk for fraud and abuse. The review will include visits to health care providers serviced by the three contractors to observe first-hand the impact of EMC/EFT on provider operations and to identify any control problems.

In Fiscal Year 1995, we plan to expand the review, using a national sample of contractors, to confirm and enhance our understanding of essential control procedures and practices in an all-electronic claims processing environment. We also plan to meet with your staff at the central and regional offices to refine our audit objectives and ensure that we address areas of greatest concern and interest to HCFA.

In response to our draft report, HCFA agreed with all of our recommendations. The HCFA's comments are included as Appendix II.

We would appreciate receiving your written comments on the report within 60 days from the date of this memorandum. Should you wish to discuss the issues raised in the report, please let me know or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 966-7104.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF CONTROLS OVER
ELECTRONIC BILLING AND PAYMENT
AT SELECTED MEDICARE CONTRACTORS IN
REGION V--CONSIDERATIONS FOR
THE DESIGN OF THE
MEDICARE TRANSACTION SYSTEM**



**JUNE GIBBS BROWN
Inspector General**

**OCTOBER 1994
A-05-93-00056**

SUMMARY

The Health Care Financing Administration (HCFA), Region V, and the contractors included in our review have made good progress in establishing electronic billing and payment functions under the Medicare program. The growing use of Electronic Media Claims (EMC) and Electronic Fund Transfers (EFT) has helped to streamline claims processing operations. Generally, EMC-related internal controls over the reviewed contractors' systems were adequate and HCFA should consider adopting many of the existing control procedures and practices in the design for the Medicare Transaction System (MTS). However, some inconsistencies exist between the practices of the contractors, and several areas are in need of improvement. We believe that HCFA should expand on instructions to contractors to ensure a base level of internal controls at all EMC processing sites. Also, HCFA should more closely monitor the contractors' compliance with existing requirements.

Our review was performed at three Region V contractors, two of which handled claims for both Parts A and B of Medicare, and at the HCFA regional office. The purpose of the review was (i) to identify EMC/EFT internal controls at the contractors and evaluate strengths and weaknesses for HCFA's consideration under the MTS and (ii) to determine if the contractors were meeting HCFA's goals for EMC/EFT activities.

The HCFA regional office's actions have led to increased EMC utilization at the contractors that we studied. Thus far, however, HCFA has placed primary emphasis on increasing EMC usage. More attention and effort now should be devoted to standardizing controls that will guard the integrity of EMC processing and using the best of what is available in designing the MTS. The Appendix I to this report summarizes the status of control practices at the three contractors we reviewed. Clearly, the majority of these practices are of great value to overall control structures. In some instances, a control procedure judged to be an excellent practice was not present at all three contractors. In others, more emphasis needed to be given to a particular function by a contractor.

To encourage the advances in EMC utilization, HCFA sets annual goals for each contractor. The contractors that we reviewed were successful in meeting these goals. Similar goals, however, were not being used to encourage contractors to increase provider participation in EFT. As HCFA moves toward establishing a complete electronic claims and payment environment through the MTS, it should place greater emphasis on increasing the use of EFT.

This is the first in a series of reviews we will make to address EMC, EFT, and MTS issues. At this time, we are recommending that HCFA consider establishing standardized requirements for EMC/EFT internal controls at Medicare contractors. Also, the HCFA

should adopt existing controls which are effective into the MTS design. Last, we are recommending that HCFA closely monitor contractors' security safeguards and encourage increased use of EFT by setting goals for the contractors. Further recommendations may be appropriate as we continue our review.

We will perform additional work at Region V contractors to focus on concerns, recently expressed by HCFA staff, regarding EMC areas with high risk for fraud and abuse. In particular, we will review the adequacy of internal controls at health care providers. If results in Region V warrant and HCFA central office is supportive, we will expand to a national review in Fiscal Year (FY) 1995. The results of our initial review are presented in this report to provide HCFA with timely information on internal control practices, unique to EMC/EFT, while the MTS is still in the design phase. Also, we hope this report will facilitate our having continuing discussions with HCFA on Medicare claims processing in a totally electronic environment.

In response to our draft report, HCFA agreed with all of our recommendations.

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INTRODUCTION

BACKGROUND

The HCFA administers both parts of the Medicare program (Part A and Part B) through contractors. Medicare Part A contractors, referred to as fiscal intermediaries, are responsible for the processing and payment of medical claims primarily for hospitals, nursing facilities, and home health agencies. Part B contractors, or carriers, handle claims for physician services, laboratory services, and medical equipment/supplies.

The Part A and Part B contractors use shared computer software systems to process the claims. Currently, each Part A contractor uses one of six different shared systems, while each Part B contractor uses one of eight other systems. The 14 systems evolved over the years to meet the changing demands of the Medicare program. These demands are now calling for a single national processing system that will handle all types of Medicare claims. The HCFA recently awarded a contract to design, develop, implement, and maintain such a system. This system, referred to as the MTS, will eventually replace the 14 shared systems. The HCFA anticipates that the MTS will be completed by December 1998.

Not only does HCFA expect greater efficiency under the MTS through standardization in claims processing, it also intends for virtually all Medicare claims to be submitted and paid electronically. For a number of years, medical providers have had the option of billing Medicare by using paper (hard copy) claims or by using EMC formats. The EMC formats include on-line electronic submissions, as well as the submission of magnetic storage media such as tapes and diskettes. An ever-increasing percentage of claims are being submitted via EMCs. The HCFA estimates that by the end of FY 1994, nationwide, about 97 percent of Part A claims and 75 percent of Part B claims will be in EMC formats. More recently, the providers could also receive their Medicare payments through EFTs at their banking institutions, rather than by check payments delivered through the mail. Electronic Remittance Advices (ERAs) are also now available, instead of the traditional "hard copy" documents.

The Medicare program benefits from the use of EMCs, EFTs, and ERAs through the elimination of a number of manual processing efforts. Providers benefit from less paperwork, more timely payments, and prompt feedback of information. Although benefits are gained, the absence of hard copy documentation requires the presence of additional controls and safeguards to ensure program integrity. Logically, the design of the MTS should include the best of these control measures.

OBJECTIVES AND METHODOLOGY

Our review was made in accordance with generally accepted government auditing standards. The objectives of the review were:

- To determine what EMC/EFT controls and safeguards were currently in place at selected Region V contractors, to identify any weaknesses in the control structures, and to determine which of the existing controls and safeguards should be considered by HCFA for inclusion in the MTS.
- To determine whether the contractors were meeting the goals and objectives for EMC processing and EFT payments as set forth by HCFA.

To accomplish our objectives, we reviewed procedures and interviewed staff at the HCFA Region V office; and we reviewed internal controls and EMC-related performance at three Region V contractors. Because our review did not include visits to medical providers, we did not observe or evaluate controls that the contractors had put in place at the provider level. Our field work was conducted during the period March through October 1993 at the contractors, and subsequent work has been conducted at HCFA central office.

Our review at the three contractors included three Part A intermediaries and two Part B carriers, as follows:

- Health Care Service Corporation, Chicago, Illinois - (Part A and B for Illinois)
- Associated Insurance Company, Indianapolis, Indiana - (Part A and B for Indiana)
- Community Mutual Insurance Company, Cincinnati, Ohio - (Part A for Ohio)

We selected the contractors judgementally and within one region to permit timely input to HCFA while the MTS is still in the design stage. Because our primary objectives were to establish a data base of existing controls specific to EMC/EFT and to make a preliminary assessment of strengths and weaknesses, we did not issue separate reports to each contractor for their review and comment. However, to ensure the quality of information collected, we discussed our observations on internal controls with appropriate staff from each contractor during the course of our review.

RESULTS OF REVIEW

CONTROL PRACTICES

Generally, each of the three contractors had adequate controls in place to help ensure the integrity of electronically transmitted data and to safeguard Medicare assets in the EMC/EFT environment. We identified a number of good practices that we believe should be considered by HCFA when designing and developing the MTS. Although we also identified certain control weaknesses at one or more of the contractors, we believe these deficiencies could be corrected by modifying or enhancing existing control structures. The HCFA needs to clarify or expand instructions to the contractors to achieve consistent, quality claims processing. The Appendix I to this report identifies each of the major EMC/EFT control areas that we reviewed, and the status of the controls at the contractors.

Our review of EMC control practices covered six areas: data collection systems, shared processing systems, monitoring and internal review, administrative controls, EFT controls, and overall security safeguards affecting EMC/EFT.

Data Collection Systems

Each of the contractors had developed unique front-end EMC data collection systems capable of accepting EMC submissions from providers on magnetic media (tape and diskette) and through direct electronic transmissions by remote terminals, personal computers, and mainframes. The contractors were accepting numerous versions of Part A and Part B EMC formats. As such, the EMCs were often required to be reformatted prior to further processing. This task will no longer be required once national standard formats are fully adopted. Although the exclusive use of the American National Standards Institute (ANSI) "837" transaction format as the standard for electronic billing may be an ultimate goal of HCFA, any phase-out of other electronic billing formats will contribute to greater efficiency of data collections under the proposed MTS.

Within the data collection systems, EMCs were also edited to ensure that the claims were accurate prior to their transfer into either the Part A or Part B shared claims processing system. Although the data collections systems were all capable of processing EMC data to required HCFA specifications, the systems were not standardized. For example, one contractor performed a duplicate claim check at the data collection level whereby each EMC claim by a provider was compared to the previous 100 EMC submissions for that provider. This edit was designed as a control to detect electronic "resubmissions."

Another contractor did not perform a duplicate check within data collections since duplicate claims editing is done by all the Part A and Part B shared claims processing systems.

The EMCs that did not meet the accuracy edits of the contractors' data collection systems were rejected by the contractors either individually or in batches. The HCFA has required a 95 percent accuracy level for EMC submissions. According to the HCFA Carrier Manual, Part B contractors are instructed to reject a tape or transmission which does not meet the 95 percent accuracy level. Addressing Part A contractors, the HCFA Intermediary Manual does not require a contractor to reject a tape or transmission, but states that the contractor **may** return the entire submission for correction.

This apparent difference in requirements makes compliance difficult, especially for a contractor under both Part A and Part B, since all EMCs are submitted in a similar manner to the contractor's data collections center. We noted that two contractors (one Part A & B and one Part A) were rejecting batches of EMCs based on the 95 percent accuracy criteria. The third contractor (Part A & B) was rejecting individual EMCs within the batches and accepting the remaining claims without regard to the overall accuracy of the batches.

We informed HCFA Region V officials about this condition. They were unaware of any problems with the way claims were being rejected, and indicated that they will make an analysis in this area. We believe that such an analysis should address the need for consistent requirements by HCFA, and uniform application of the requirements by the contractors.

Additional areas of control within the EMC data collection activities of each contractor included:

- ▶ Adequate reporting and maintenance of audit trails in order to document the disposition of individual and batch EMC receipts.
- ▶ Sufficient "log in" procedures to document the receipt of EMC tapes and other magnetic media.
- ▶ Prompt corrections of data collection systems deficiencies when detected.

To assist certain providers, HCFA requires the Part A and Part B contractors to furnish providers, upon request, low cost or free EMC software for use in submitting claims. Two of the contractors were clearly in compliance with this requirement while the third contractor was providing its "low cost" software to providers at a price of about \$300. We believe this price may be excessive in an environment where HCFA's intent is to

furnish providers with EMC software at low or no cost. The HCFA, however, needs to clarify its policy on what constitutes "low cost" software. The contractor was also marketing higher priced EMC software through its private side corporate division. Although we did not determine if this software was being sold at a profit, we believe that HCFA should determine if conflicts of interest or the potential for such conflicts exist in the marketing of proprietary EMC software and related services to providers by Medicare contractors.

Some providers rely on external vendors for EMC processing software or EMC billing services. We noted that all three contractors utilized vendor certification procedures to designate the vendors having the most efficient EMC processing capabilities.

Concerning EMC data collection controls for the integrity and accuracy of claims at the provider/biller level, all three contractors:

- ▶ Required potential EMC providers to submit to testing prior to receiving approval to transmit production EMCs.
- ▶ Provided some degree of assistance to EMC providers through training seminars and help desks.
- ▶ Controlled EMC system access through the use of passwords, user identification (I.D.) numbers, and provider I.D. numbers.
- ▶ Prevented EMC system access once a provider had unsuccessfully attempted to access the system a predetermined number of times.
- ▶ Furnished the EMC providers with the actual edits used to screen EMCs for accuracy prior to their transfer to the shared claims processing systems.

Shared Processing Systems

After successfully passing front-end edits at the data collection point, the EMCs were transferred by each of the three contractors into their respective Part A or Part B shared processing system. Claims entering these systems were immediately assigned a unique EMC identification number for control and tracking purposes. All claims (including hard copy claims and EMCs) were processed in the same manner beyond this point. The EMCs submitted to the shared processing systems by providers through remote terminal entry were subjected to a series of on-line edits at the time of data entry. These EMCs were treated identically to other incoming claims after they had successfully entered the system and received a claim identification number.

Our review of the shared systems was limited to EMC-specific controls. We did not review controls of the shared systems beyond the point where EMCs and hard copy claims were identical in format. Our analysis disclosed that:

- ▶ Two of the three contractors were adequately approving and testing all proposed claim adjudication system modifications, while one contractor had not tested its shared system "emergency" changes through its change control procedures. Two of the contractors were using actual beneficiary data in some system test applications (may compromise confidential information).
- ▶ All three contractors had sufficient on-line edit procedures within the shared systems to ensure the accuracy of EMCs submitted directly to the processing system through remote terminal entry.
- ▶ We were advised that existing deficiencies with the "PC Print" program used under one of the shared systems had not been corrected. This free software gives providers the ability to receive the "ANSI 835" electronic remittance advice over a wire, and to print the remittance advice data on a personal computer. Because of numerous problems encountered with the program, one contractor had discontinued its use.

Monitoring and Internal Review

We noted inconsistencies between the three contractors with the extent that they monitored EMC providers and performed internal reviews. One contractor had recently implemented a noteworthy practice of making on-site visits to providers to confirm that services billed using EMC media were supported by adequate records. These visits concentrated on providers whose EMCs were returned for failure to submit supporting medical records. Conversely, another contractor had discontinued its EMC provider audit procedures, diverting the efforts to medical review activities that were unrelated to EMCs.

Two of the three contractors had conducted periodic internal audits of their own EMC procedures. The third contractor had not performed this type of review. We believe that HCFA should establish a periodic internal audit requirement of EMC procedures.

Administrative Controls

We identified the following practices regarding the oversight of administrative EMC controls:

- ▶ Adequate documentation of the EMC systems functions and safeguards was retained at two of the contractors. The third contractor had only limited

documentation to explain its EMC procedures. We believe that documentation in the form of flow charts and/or narrative explanations should exist to describe these functions.

- ▶ Signed EMC agreements between the contractor and the EMC provider were kept on file at all of the contractors.
- ▶ The EMC providers were furnished adequate information concerning record retention requirements through Medicare bulletins and flyers issued by all of the contractors.

EFT Controls

The EFT is available to Part A and Part B providers as an alternate payment method to conventional check and remittance advice. The EFT consists of a fund transfer to the provider's bank, in conjunction with an electronic remittance transmitted to the provider via direct transmission or data storage media such as magnetic tape or diskette.

Our review did not disclose any significant control weaknesses at the three reviewed contractors with regard to EFT/ERA procedures. Some of the best EFT processing safeguards included:

- ▶ The EFT transactions were encrypted; that is, transformed for the purpose of making the message unintelligible to all but the intended receiver.
- ▶ Payment flags were used to highlight unusually large EFT payments for additional review.
- ▶ Security of EFT transactions was maintained between the contractors and their respective banks through use of passwords, user I.D. numbers, and/or courier tape delivery.
- ▶ Providers were required to successfully complete a test transaction prior to receiving actual EFT.
- ▶ Signed EFT agreements were retained at the contractors.
- ▶ Access to ERA data was restricted by issuing provider passwords and user I.D. numbers.

- ▶ The EFT transactions were reconciled for the number and amounts of the transactions between the contractors and their banks.
- ▶ Providers receiving EFT were monitored to ensure compliance with current HCFA requirements that EFT recipients must submit 90 percent of their claims by EMC.
- ▶ Duties were separated between personnel responsible for EFT transaction and reconciliation procedures.

Concerning areas for improvement, we noted that two of the contractors did not encrypt their EFT transactions, and two contractors did not flag unusually large EFT payments for additional review.

Overall Security Safeguards

Our analysis included a review of security-related controls and safeguards. These controls, although not specific to EMC/EFT, were critical to the electronic environment, helping to ensure adequate data protection and contractor ability to meet Medicare EMC/EFT commitments under all circumstances.

Although improvements could be made, the overall systems security at the contractors was good. We noted that each of the three contractors:

- ▶ Controlled unauthorized system access through the use of security software, passwords, and user I.D. numbers.
- ▶ Arranged for "hot site" back-up facilities to be available for the transfer of data processing activities in the event of a systems shutdown.
- ▶ Utilized off-site data storage facilities for protection of data against destruction by fire, flood, or other disasters that may affect primary locations.
- ▶ Maintained good physical security over data processing systems.
- ▶ Monitored the use of data systems and generated audit trails to document data processing system activity.
- ▶ Developed data backup procedures and used backup communication systems.

The HCFA has addressed systems security by establishing specific requirements in its Intermediary Manual for Part A contractors and in its Carrier Manual for Part B contractors. Major requirements include the development and periodic review of

contingency plans, the preparation of a Triennial Risk Analysis, and the annual assessment of minimum safeguards. We believe that HCFA should more closely monitor contractor compliance with these requirements.

While all three contractors had prepared contingency plans to ensure continued Medicare claims processing in the event of a disaster or disruption, two contractors were not conducting regularly scheduled updates to their plans, and one contractor was not testing its plan.

The Triennial Risk Analysis was designed as a systematic method for anticipating mishaps and determining the cost effectiveness of safeguards. Only two of the three contractors had prepared this analysis on a timely basis, and only one contractor had followed-up on all recommendations. One contractor had not completed the risk analysis since 1987-88. We noted that although each of the three contractors had designated a security coordinator to oversee all security functions (including the risk analysis), this position could be strengthened at two of the contractors.

The HCFA did not include a review of contractor risk analysis as part of its contractor performance evaluations. The contractors (and HCFA) therefore did not always place the needed emphasis on ensuring that the required documentation was prepared. Nonetheless, we did not find any material weaknesses in the contractors' safeguards and capabilities to deal with mishaps and disasters.

None of the contractors was assessing minimum safeguards on an annual basis, as required. One contractor reviewed minimum safeguards on a periodic basis, but not as frequently as annually. The other two contractors reviewed the safeguards only as part of the Triennial Risk Analysis.

Regarding additional security-related areas, we found that:

- ▶ One of the contractors did not require all providers to change systems passwords on a regular basis.
- ▶ The programming staff at one contractor was storing sensitive data in personal libraries. These files were not "access protected" and could be viewed by anyone having access to the system.
- ▶ Dedicated lines were generally not used by two of the contractors for data communication links. Although all three contractors controlled line access with user I.D.s and passwords, one contractor also believed that the added security of

dedicated lines when compared with non-dedicated commercial lines was an important factor for "remote terminals." This contractor also transmitted its Part B claims data on dedicated lines to its subcontractor for processing.

THE HCFA's GOALS AND OBJECTIVES

The HCFA sets annual goals for EMC submission rates for each Part A and Part B contractor. The three contractors that we surveyed were meeting their individual goals and were successfully marketing EMC to Medicare providers. Similar goals, however, were not being used for EFT/ERA. As HCFA moves toward establishing a complete electronic claims and payment environment through the MTS, it now needs to place greater emphasis on increasing EFT/ERA provider participation rates.

EMC Goals

In FY 1992, HCFA reinstituted a previous practice of setting EMC goals and establishing annual incentives within its Contractor Performance Evaluation Program (CPEP) to encourage EMC use under Medicare. The goals for individual contractors were based on targets that considered each contractor's historical EMC performance and HCFA's overall goals. The overall goals included targets by the end of FY 1994 of:

- ▶ 100 percent EMC for all inpatient, outpatient, and hospital lab claims under Part A;
- ▶ 75 percent EMC for skilled nursing facility, home health agency, and other claims under Part A; and
- ▶ 75 percent EMC for all claims under Part B.

The performance records of the three contractors showed they were successful in achieving EMC participation from providers. All three were exceeding the national average rates for EMC participation and have consistently met HCFA's established annual CPEP goals. At the time of our survey, we noted that the contractors were meeting their Part A goals of about 98 percent participation for inpatient, outpatient, and hospital laboratory claims. Likewise, the two contractors that had Part B contracts with HCFA were achieving participation rates of about 65 percent.

The contractors used various means to improve EMC services and to increase EMC participation rates including:

- ▶ Providing on-site EMC demonstrations and training to providers.

- ▶ Publishing directories of EMC vendors and billing agencies which meet the certification requirements of the respective contractors pertaining to accuracy, timeliness, claims volume, and software support.
- ▶ Implementing systems to allow providers to make on-line corrections to claims.
- ▶ Soliciting large chain organizations and provider associations to participate in EMC.
- ▶ Introducing new electronic technology and services to increase EMC usage.

One of the contractors had participated in two HCFA pilot projects for testing innovative methods for data transmission. One pilot project involved the direct electronic collection of claims through the transmission of data fields by facsimile (FAX) machine. The contractor concluded that this project should be discontinued because of technical problems encountered when creating EMC records from the FAX transmissions. The EMCs created from the transmissions were generally not 100 percent accurate, requiring manual intervention for necessary corrections. We were also informed that there was a lack of provider interest in the FAX project. The other pilot project allowed providers to submit EMCs by entering the claim data on a touch-tone telephone. Although this project was also considered by the contractor to be generally an inefficient method for data transmission, the system was recently implemented at the contractor for use by low-volume providers.

Another contractor, anticipating future HCFA requirements (and to increase its EMC rates), informed its Part A participants that it was requiring all claims to be submitted electronically. Following a protest by a non-EMC biller, the contractor was advised by HCFA to accept hard copy claims since a 100 percent requirement was not yet supported by Federal regulation.

Officials at one contractor told us that a 100 percent EMC goal for inpatient, outpatient, and hospital laboratory claims in FY 1994 was not realistic. They contended that many small providers were still reluctant to undergo technological changes. They also indicated that considerable effort is required to respond to questions and deal with transmission problems of low-volume providers. The contractor officials believed that under certain circumstances, EMC submissions from small rural providers were not cost efficient.

How to obtain 100 percent EMC participation is one of the issues that now confronts HCFA when laying the framework for the MTS. We plan to address this problem further, from the providers' perspective, when we expand our review of EMC issues.

EFT/ERA Goals

Since HCFA did not use individual goals to encourage the use of EFT/ERA, we could not measure progress at the three contractors against a set of performance standards. We did, however, review the progress under this relatively new initiative.

In December 1991, HCFA issued its "Financial Core Requirements" calling for all Medicare contractors to have the capability within their payment systems to generate Automated Clearing House payment files by October 1992. These requirements did not make contractors convert to EFT, but did encourage contractors to begin the process of implementing EFT/ERA. Contractors were required to be capable of transmitting ERAs using the national standard format "ANSI 835." Full EFT/ERA capability under both Part A and Part B was anticipated by October 1993.

The three contractors met HCFA's capability requirement for EFT/ERA. In late 1992, EFT became operational at two of the three Part A contractors. The third Part A contractor encountered problems with its bank and was required to seek bids for new banking services. In September 1993, it generated its first EFT transactions. Neither of the two Part B operations at the surveyed contractors were using EFT at the time of our review.

Two of the three Part A contractors were also using the "ANSI 835" format for ERAs to some extent, although local formats were still widely used. The other Part A contractor and the two Part B contractors used ERAs on a limited basis, and only under local formats that were preferred by the providers.

Although use of EFT should continue to increase under Part A, its widespread use under Part B will be more difficult to achieve. Of the three Part A contractors that we surveyed, one had increased its rate of EFT payments to over 50 percent, while the other two were each making less than 10 percent. EFT was not yet being used at either of the two Part B contractors. To encourage contractors to aggressively market the EFT payment option, HCFA should consider establishing EFT goals for individual Part A and Part B contractors (similar to current EMC goals), and incorporating them with other CPEP requirements.

CONCLUSIONS

Generally, we found that the three contractors had established good internal controls over electronic claim and payment functions. However, the quality of control policies and procedures was not consistent at all of the contractors reviewed, indicating a need for standardized internal controls. The HCFA needs to develop instructions for Medicare contractors that will establish a consistent level of safeguards and controls over all Medicare claims and payments which are processed electronically. On a more positive note, many of the control procedures identified in our review (see Appendix I) were excellent and these procedures, or some equivalent, should be incorporated in the MTS design.

As EMC/EFT usage increases, the paperless environment will dramatically increase the degree of reliance on internal controls. The HCFA should closely monitor electronic claims processing and electronic payments to ensure that contractors' control systems are adequate and functioning properly. Although we noted certain weaknesses at the three contractors reviewed, we believe that the weaknesses can be corrected by modifying existing control structures. Better monitoring by HCFA could have precluded some of the deficiencies--most notably, deficiencies in the area of "overall security safeguards." In this area, the contractors often did not follow HCFA's written requirements.

The HCFA and its contractors have done well in meeting goals and objectives for increasing the use of EMC. In order to attain a complete electronic claims and payment environment under MTS, we believe that HCFA now needs to address the issue of increasing the amount of EFT/ERA participation. Establishing annual EFT goals for each contractor could provide results similar to those achieved with EMC.

We are continuing our work on electronic claims and payment issues at Region V contractors to address HCFA's recently expressed concerns on areas having high risk for fraud and abuse, particularly at the provider level. In FY 1995, we plan to expand our effort to a nationwide review of internal controls related to EMC/EFT, using a statistical sample of Medicare contractors. For now, we believe this report contains information on existing control systems that may be useful to HCFA in setting goals and standards for existing contractors and in establishing internal control policies and procedures for the MTS. Accordingly, our initial recommendations are presented in the following section for HCFA's consideration.

RECOMMENDATIONS

We recommend that HCFA consider:

1. Establishing standardized, baseline requirements for internal controls applicable to EMC/EFT at Medicare contractors.

HCFA's Comments

The HCFA agreed with this recommendation and is planning to implement many of the recommended EFT and ERA control safeguards via the manual issuance process in the coming months.

2. Adopting the best of internal control policies and procedures identified in this report into the MTS design.

HCFA's Comments

The HCFA agreed with this recommendation. It will use our report as a resource in the development of MTS EMC requirements.

3. Monitoring closely the contractors' security safeguards over EMC/EFT including
(a) development of contingency plans and periodic testing of these plans,
(b) preparation of Triennial Risk Analyses and annual assessments of minimum safeguards, and (c) internal audits of EMC policies and procedures.

HCFA's Comments

The HCFA agreed with this recommendation. It will monitor contractors for the issues listed in this recommendation and note these issues in its annual reminder to the regional offices.

4. Encouraging the use of EFT by establishing goals for EFT participation. Progress could be evaluated, as EMC progress is now, during contractor performance evaluations.

HCFA's Comments

The HCFA agreed with this recommendation, indicating that it will consider establishing goals to expand the use of EFT by Medicare providers, physicians, and suppliers.

APPENDIX I

SUMMARY OF EMC/EFT CONTROLS

SUMMARY OF EMC/EFT CONTROLS

CONTROL AREA AND DESCRIPTION	GOOD PRACTICES	NEED FOR IMPROVEMENT
<i>DATA COLLECTION SYSTEMS</i>		
Data collection systems designed to accept various types of electronic media	Flexible systems accept EMC claim submission via tape, diskette, cartridge, PC, terminal, or mainframe transmission	None identified
Sufficient data collections edit procedures over EMC submission	All contractors thoroughly edited incoming EMC claims prior to their transfer into the respective Medicare Part A or B processing systems	None identified
Capability to edit both EMC batches and individual claim receipts	All data collection systems had the capability to accept or reject both individual claims or claim batches	None identified
Furnish confirmation of EMC transmission status to the submitter	All contractors furnished EMC submitters with a report to confirm the receipt of their EMC transmissions	None identified
Balance and confirm the transfer of EMC transmissions into their respective Medicare A and B processing systems	All contractors utilized a series of reports to reconcile EMC transfers from data collections into the Medicare A or B processing systems	None identified
Log the receipt of incoming EMC tapes and diskettes	All contractors used a log system to document physical receipt of EMC submission on tape or diskette	None identified
Adequate testing and approval of data collection system modifications	Modifications to the data collection systems were subject to adequate testing and management approval procedures by all contractors	None identified
Timely correction of system deficiencies when detected	Prompt resolution of data collection problems by all contractors	None identified
Furnish submitters with quality EMC software at low or no cost	Two contractors furnished EMC software at no or low cost to the providers	One contractor furnished similar software at a cost of about \$300

SUMMARY OF EMC/EFT CONTROLS

CONTROL AREA AND DESCRIPTION	GOOD PRACTICES	NEED FOR IMPROVEMENT
Utilization of vendor certification procedures	All contractors designated the best vendors using vendor certification procedures	None identified
EMC users must test prior to receiving EMC production approval	All contractors required potential EMC submitters to successfully input test claim data	None identified
Provide training and assistance to EMC submitters	All contractors provided training seminars and help desk facilities	None identified
Control over provider EMC system access	All contractors issued EMC providers with passwords, user ID, and provider ID numbers	None identified
Deny user system access after a predetermined number of aborted system entry attempts	All contractors denied system access after a predetermined number of unsuccessful access attempts	None identified
Furnish EMC submitters with front-end program edits to enhance the accuracy of EMC submission	All contractors furnished front-end edits to submitters for incorporation into their EMC software design	None identified
<i>SHARED PROCESSING SYSTEM</i>		
System access is password protected	All systems access required the user to submit a valid password	None identified
Assignment of a claim ID number unique to EMC claims	The shared systems assigned a unique claim ID number to EMC claims entering the system at each contractor	None identified
Adequate testing and approval of shared system modifications	Two contractors used change control procedures which included adequate testing and approval procedures	One contractor was unable to test emergency system modifications prior to implementation
Use of fictitious beneficiary data for system test applications	Contractors used fictitious data in some test applications to protect the confidential nature of beneficiary information	Live data was used in some test applications by two contractors which may compromise confidential beneficiary information

SUMMARY OF EMC/EFT CONTROLS

CONTROL AREA AND DESCRIPTION	GOOD PRACTICES	NEED FOR IMPROVEMENT
Sufficiency of edit procedures to validate EMC claim accuracy	All of the shared systems utilized on-line EMC claim edit procedures	None identified
Timely correction of shared system deficiencies when detected	System deficiencies were generally promptly resolved by all of the contractors	Deficiencies within the PC print programs had not been resolved within one of the shared systems
<i>MONITORING AND INTERNAL REVIEW</i>		
Periodic completion of EMC provider audits	Two contractors audited provider EMC medical documentation supporting their EMC claim submission	One contractor discontinued its performance of EMC provider audits
Periodic internal audit of the contractor EMC function	Two contractors conducted periodic internal audits of their EMC function	One contractor did not perform this type of review
<i>ADMINISTRATIVE CONTROLS</i>		
Adequate EMC system control and safeguard documentation	Two contractors had properly documented systems functions using flow chart/narrative illustration	One contractor had limited documentation explaining its EMC system functions
Retention of signed EMC agreements by the contractor	All contractors retained EMC agreements signed by both the submitter and the contractor	None identified
Furnish EMC providers with adequate information concerning medical record retention requirements	All contractors adequately informed providers about EMC requirements through Medicare bulletins/flyers	None identified
<i>EFT CONTROLS</i>		
Data encryption of EFT transactions	One contractor encrypted its EFT transactions as an additional data security measure	Two contractors did not use data encryption for EFT transactions
Provider payment flags to highlight large EFT transactions	One contractor flagged large EFT payments for additional review to ensure accuracy of payment	This procedure was not performed at other contractor locations

SUMMARY OF EMC/EFT CONTROLS

CONTROL AREA AND DESCRIPTION	GOOD PRACTICES	NEED FOR IMPROVEMENT
Security of EFT transactions between bank and contractor	Data security through password protection and/or courier tape delivery at all locations	None identified
Potential EFT users must complete a test transaction prior to obtaining EFT approval	All contractors required completion of an EFT test transaction consisting of a 0 dollar value	None identified
Use of signed EFT agreements	Signed EFT agreements were kept on file at all contractor locations	None identified
Access to EFT/ERA data is restricted	Access restriction using passwords and user ID numbers at all locations	None identified
Reconciliation of EFT transactions	All contractors utilized both manual and electronic EFT reconciliation procedures	None identified
EFT providers are monitored to ensure compliance with HCFA EMC submission requirements	All contractors monitored providers receiving EFT to ensure that EMC submission remained at 90% or higher	None identified
Adequate separation of duties for EFT transactions	All contractors separated responsibilities for preparing EFT transactions and reconciliations	None identified
<u>OVERALL SECURITY SAFEGUARDS</u>		
System access protection using passwords, user ID, and provider ID numbers	System access was adequately protected at all contractor locations	None identified
Require password changes by providers on a regular basis	Two contractors required providers to change passwords on a regular basis	One contractor did not require providers to cycle passwords
Use of backup computer facilities	All contractors had backup computer facilities available in case of an emergency	None identified

SUMMARY OF EMC/EFT CONTROLS

CONTROL AREA AND DESCRIPTION	GOOD PRACTICES	NEED FOR IMPROVEMENT
Utilize off-site data storage facilities	All contractors utilized off-site storage facilities for record storage	None Identified
Adequate safeguards over access to systems software	Use of tape libraries and management approval to ensure adequate software access restriction	Programming staff stored sensitive data in personal data processing libraries at one contractor
Preparation of a contingency plan for disaster recovery	All contractors developed a plan to continue their Medicare service in the event of a disaster	None identified
Regularly scheduled testing of contingency plans	Two contractors tested their contingency plans at least one time per year	One contractor had not tested its disaster recovery contingency plan
Regularly scheduled updates of the contingency plans	One contractor updated its plan on a regular basis	Two contractors updated their plans on a limited basis with little or no documentation to support the updates
Adequate physical security over the data processing system	All contractors used logs, property passes, and secure areas to protect equipment from unauthorized access	None identified
Adequately monitor data processing system activity	All contractors monitored data processing system activity	None identified
Use of audit trails to document data processing system activity	Contractor security software systems generated printed audit trails to document system activity	None identified
Adequate data backup procedures	All contractors backed up Medicare data for record retention and disaster recovery purposes	None identified
Availability of backup communication networks	All contractors used backup communication links to alternate data processing facilities for disaster recovery purposes	None identified

SUMMARY OF EMC/EFT CONTROLS

CONTROL AREA AND DESCRIPTION	GOOD PRACTICES	NEED FOR IMPROVEMENT
Coordination of security functions by a security coordinator	Security coordinators monitored all security functions relating to their assigned divisions	Centralized security oversight was given low priority at two contractor locations
Security software protection of the data processing system	Security software was used by all contractors to restrict access into the data processing system	None identified
Internal monitoring of the software security system	One contractor performed periodic internal audits of the security software function to ensure that it continues to meet corporate needs	None Identified
Contractor completion of a "Triennial Risk Analysis"	Two contractors completed their Risk Analysis every three years as required by HCFA	One contractor had not completed a Risk Analysis since 1987-88
Contractor follow-up on Risk Analysis recommendations	One contractor addressed the recommendations set forth in the Risk Analysis	Two contractors had not completely addressed all recommendations outlined in their most recent Risk Analysis
Perform an annual assessment of HCFA minimum safeguards	All contractors reviewed the minimum safeguards on a periodic basis	None of the contractors reviewed the HCFA minimum safeguards on an annual basis
Use of dedicated lines for communication links	One contractor used dedicated lines for communication links	Two contractors used dedicated lines only to a limited extent or not at all

APPENDIX II

HCFA'S COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

APPENDIX II
Page 1 of 3
Health Care
Financing Administration

Memorandum

Date SEP - 9 1994
From Bruce C. Vladeck Administrator *Bruce Vladeck*
Subject Office of Inspector General (OIG) Draft Report: "Review of Controls Over Electronic Billing and Payment at Selected Medicare Contractors in Region V-- Considerations for the Design of the Medicare Transaction System,"
To (A-05-93-00056)

June Gibbs Brown
Inspector General

We reviewed the subject report which identified strengths and weaknesses in internal controls over provider billings made via Electronic Media Claims and Medicare payments made via Electronic Fund Transfers.

The Health Care Financing Administration concurs with all four of the recommendations presented in the report. Additional comments are attached for your consideration.

Thank you for the opportunity to review and comment on the report. Please advise us if you would like to discuss our position on the report's recommendations at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration (HCFA) on
Office of Inspector General (OIG) Draft Report: "Review of Controls
Over Electronic Billing and Payment at Selected Medicare Contractors
in Region V--Considerations for the Design of the Medicare
Transaction System (MTS)," (A-05-93-00056)

OIG Recommendation

HCFA should consider establishing standardized, baseline requirements for internal controls applicable to Electronic Media Claims (EMC) and Electronic Fund Transfer (EFT) at Medicare contractors.

HCFA Response

We concur with this recommendation. We plan to implement many of the recommended EFT and electronic remittance advice (ERA) control safeguards via the manual issuance process in the coming months.

We strive continually to enhance the level of standardization in our baseline requirements. Most recently, we enhanced our instructions for EMC agreements between HCFA and the provider of service, the security requirements for data transmissions over wire, and EMC audit trails.

On October 1, 1995, all intermediary ERA will adhere to an American National Standard, and, by July 1, 1996, all claims and remittance advice will adhere to standards. HCFA staff is in the process of developing a standardized eligibility transaction.

OIG Recommendation

HCFA should adopt the best of internal control policies and procedures identified in this report into the MTS design.

HCFA Response

We concur with this recommendation. We will use your report as a resource in the development of MTS EMC requirements.

We established a work group to review the existing practices, procedures, and requirements for EMC. That group will produce recommendations and standards to be used in the MTS environment.

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OIG Recommendation

HCFA should monitor closely the contractors' security safeguards over EMC/EFT including (a) development of contingency plans and periodic testing of these plans, (b) preparation of Triennial Risk Analyses and annual assessments of minimum safeguards, and (c) internal audits of EMC policies and procedures.

HCFA Response

We concur with this recommendation. Contractors are currently required to maintain security safeguards over EMC/EFT. Those that do not develop and test contingency plans are out of compliance with manual instructions, as are those that do not include EMC in their Triennial Risk Analysis and annual audits of contingency plans, minimum safeguards, and administrative measures. We will note these issues in our annual reminder to the regional offices.

OIG Recommendation

HCFA should encourage the use of EFT by establishing goals for EFT participation. Progress could be evaluated, as EMC progress is now, during contractor performance evaluations.

HCFA Response

We concur with this recommendation. Although our data indicate that EFT usage is expanding rapidly, especially among Part A providers, we will consider establishing goals to expand the use of EFT by Medicare providers, physicians, and suppliers. These include:

- o HCFA's prohibition on picking up benefit checks at the contractor site by Medicare providers. All benefit payments must be sent either via EFT or hard copy checks sent via first class mail.
- o Elimination of the time and cost involved in depositing benefit checks.
- o Elimination of the possibility of lost or stolen benefit checks.
- o Better cash management forecasting.
- o Reduction of clerical costs for posting payments for those providers, physicians, and suppliers who integrate ERA into their internal accounting or practice management application.