Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ASSIST AUDIT OF HCFA'S FY 1998 FINANCIAL STATEMENTS AT PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS (PGBA)

JUNE GIBBS BROWN
Inspector General

APRIL 1999
A-04-99-03013

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
Room 3T41
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

APR 15 1999

CIN: A-04-99-03013

Ms. Ann Archibald
Vice President of Medicare Administration
Blue Cross and Blue Shield of South Carolina
Mail Code AH-100
I-20 East at Alpine Road
Columbia, South Carolina 29219-0001

Dear Ms. Archibald:

We have enclosed two copies of our report on the United States Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, *Assist Audit of HCFA's FY 1998 Financial Statements at Palmetto Government Benefits Administrators (PGBA)*. Also, we forwarded a copy of this report to the action official named below for his/her review and any action deemed necessary.

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

In accordance with the principles of the Freedom of Information Act (Public Law 90-23) OIG, OAS reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to the exemptions in the Act which the Department chooses to exercise (see 456 Code of Federal Regulations Part 5).

To facilitate identification, please refer to Common Identification Number (CIN) A-04-98-03013 in all correspondence related to this letter.

Sincerely yours,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosure

Direct Reply to HHS Action Office:

Rose Crum-Johnson, Regional Administrator
Health Care Financing Administration
U.S. Department of Health and Human Services
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303

GLOSSARY OF ACRONYMS

CFO	Chief Financial Officer
CFR	Code of Federal Regulations
DME	Durable Medical Equipment
DMERC	Durable Medical Equipment Regional Carrier
E&Y	Ernst & Young
EDP	Electronic Data Processing
FI	Fiscal Intermediary
FY	Fiscal Year
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HI	Hospital Insurance
IG	Inspector General
MCM	Medicare Carriers Manual
OIG	Office of Inspector General
OMB	Office of Management and Budget
PGBA	Palmetto Government Benefits Administrators
PRO	Peer Review Organization
RHHI	Regional Home Health Intermediaries
SMI	Supplementary Medical Insurance
SNF	Skilled Nursing Facility
US	United States
VIPS	Viable Information Processing System
VMS	VIPS Medicare System

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EXECUTIVE SUMMARY

BACKGROUND

The Health Care Financing Administration (HCFA), an agency of the United States (US) Department of Health and Human Services (HHS), has primary responsibility for administering the Medicare program. The agency carries out most Medicare operational activities through contractors that include fiscal intermediaries (FI), regional home health intermediaries (RHHI), carriers, durable medical equipment (DME) regional carriers (DMERC), and peer review organizations (PRO). Blue Cross and Blue Shield of South Carolina, doing business as Palmetto Government Benefits Administrators (PGBA) serves as both the FI and carrier for the State of South Carolina as well as the DMERC and RHHI for several States.

In Fiscal Year (FY) 1998, 39.2 million beneficiaries were enrolled in the Medicare program nationwide, and HCFA incurred $213.8 billion in Medicare benefit payments expenses for health care services.

The Chief Financial Officers (CFO) Act of 1990 requires the head of each executive agency to annually prepare and submit to the US Office of Management and Budget (OMB) financial statements that fully disclose the financial position and results of operations for all trust and revolving funds and, to the extent practical, each office, bureau, and activity of the agency which performed substantial commercial functions during the preceding FY.

The CFO Act also requires the Inspector General (IG), for each agency having an IG, to audit the financial statements in accordance with applicable generally accepted government auditing standards. The IG may select an independent external auditor to conduct the audit.

In addition, the CFO Act also requires each agency to improve its systems of financial management, accounting and internal controls to assure the issuance of reliable financial information.

The Balanced Budget Act of 1997 adds additional requirements HCFA must implement and enforce with regards to the Medicare program. These additional requirements apply to both beneficiaries, in terms of the amount of services which will be covered, and to providers, in terms of the reimbursement for services and other factors.

OBJECTIVES

Our agency's overall audit objective is to express an opinion on HCFA's FY 1998 combined financial statements and to report on their compliance with laws and regulations. An aspect of the overall work is to determine whether the Medicare fee-for-service benefit payments expenses are made in accordance with the provisions of Title XVIII and implementing regulations in Title 42 of the US Code of Federal Regulations (CFR). Specifically, we were to determine if services were:

(1) furnished by certified Medicare providers to eligible beneficiaries;
(2) reimbursed by Medicare contractors in accordance with Medicare laws and regulations; and
(3) medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records.

The audit procedures for this audit have been designed exclusively for Medicare claim-based fee-for-service benefit payments expenses. A separate audit approach for non-claim based benefit payments was also developed for use by independent auditors under contract with the OIG. We performed this audit in accordance with generally accepted government auditing standards.

SUMMARY OF FINDINGS

We selected a stratified random sample of 50 beneficiaries for whom PGBA had adjudicated 361 claims during the first quarter of FY 1998 -- our audit period. The PGBA paid $273,974 for these claims. With the assistance of PGBA and PRO medical review personnel, we identified overpayments totaling $34,852 and underpayments totaling $1,239 for these claims. The overpayments and underpayments occurred for various reasons, including insufficient documentation, incorrect coding of procedures, and lack of medical necessity. We also identified two DME payment errors which may indicate the need for PGBA to improve its claims processing edits. These DME errors are similar to DME errors identified in FY 1997. However, we realize PGBA did not have the opportunity to improve their claims processing edits since the quarter selected for review (1st) for FY 1998 had already passed before obtaining the results of the prior year's audit. A complete listing of the errors with the reasons for the errors is provided in Appendices A and B to this report.

Independent auditors under contract with the Office of Inspector General (OIG) identified reportable conditions with respect to electronic data processing (EDP) controls and non-claims activities. These reports have been presented to PGBA (see Appendix C).

Recommendations

We recommend that PGBA:

- initiate recovery of the overpayments, reimburse the underpayments, and periodically provide us with the status of recovery and reimbursement actions;
- analyze the DME errors noted and make the necessary improvements in their claims processing edits to prevent such payment errors from reoccurring; and
- address the recommendations made by the independent auditors and provide us a copy of such responses with respect to EDP controls and non-claims activities.

Comments by PGBA Officials

The PGBA officials concurred with our findings and recommendations and stated they were in the process of analyzing errors not in the DME claims and will make any improvements in DME processing edits resulting from the analysis. They also have addressed the recommendations made by the independent auditor with respect to EDP controls and non-claims activities (see Appendixes C).

INTRODUCTION

The objective of our review at PGBA our review at PGBA was to test a sample of claims PGBA adjudicated during the first quarter of FY 1998 (October 1, 1997 through December 31, 1997). This quarter was 1 of 12 contractor quarters our headquarters randomly selected nationwide for review. This audit forms a part of our agency's overall audit of HCFA's FY 1998 financial statements.

BACKGROUND

Congress established Medicare under Title XVIII of the Social Security Act by enacting the Social Security Amendments of 1965. Legislated as a complement to Social Security retirement, survivors, and disability benefits, Medicare originally covered people age 65 and over. In 1972, Congress has broadened the program to cover the disabled, those with end-stage renal disease, and certain others who elect to purchase Medicare coverage.

The HCFA, an agency of HHS, has primary responsibility for administering Medicare. This responsibility includes: formulation of policy and guidelines; contract oversight and operation; maintenance and review of utilization records; and general financing. The HCFA carries out most Medicare operational activities through contractors including FIs, RHHIs, carriers, DMERCs and PROs. In FY 1998, 39.2 million beneficiaries were enrolled in Medicare, and HCFA incurred $213.8 billion in Medicare benefit payments expenses for health care services.

Medicare is a combination of two programs - the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) programs. Each program has its own enrollment, coverage, and financing.

HI Program

The HI program, also known as Part A, is generally provided automatically to people age 65 and to most persons who are disabled for 24 months or more who are entitled to either Social Security or Railroad Retirement benefits. Most HI enrollees do not pay any enrollment premium, but some who are otherwise unqualified for Medicare may purchase HI coverage if they also elect to purchase SMI coverage.

The HI program pays participating hospitals, skilled nursing facilities (SNF), home health agencies, and hospice providers for covered services rendered to Medicare Part A enrollees. The FIs process and pay both Part A and outpatient Part B claims.

The HI program is financed primarily through employers' and employees' contributions from taxable earnings into the HI trust fund. Employers and employees each currently contribute through a mandatory payroll deduction of 1.45 percent of taxable earnings. Self-employed individuals currently contribute 2.90 percent of their taxable earnings.

SMI Program

The SMI program, also known as Part B, is optional and available to: almost all resident citizens age 65 and over; certain aliens age 65 and over -- even those not entitled to Part A based on eligibility for Social Security or Railroad Retirement benefits; and disabled beneficiaries entitled to Part A benefits. Almost all HI enrollees enroll in the SMI program.

The SMI program covers physician services as well as certain non-physician services including: clinical laboratory tests; DME (prosthetics and orthotics); flu vaccinations; drugs which cannot be self-administered (except certain anticancer drugs); most supplies; diagnostic tests; ambulance services; some therapy services; and certain other services Part A does not cover.

The SMI program is financed through monthly beneficiary premium payments (usually deducted from Social Security benefits) along with significant contributions from general revenues of the Federal Government. Carriers process and pay Part B claims.

Benefit Payments

For both Parts A and B, beneficiaries are responsible for charges not covered by the Medicare program as well as any applicable deductibles and coinsurance. For example, Medicare usually pays 80 percent of Part B services. The beneficiary is responsible for the remaining 20 percent as well as an annual deductible.

In FY 1998, PGBA, as both FI (including RHHI) and carrier (including DMERC), reported $10.974 billion in total funds expended on the HCFA Form 1522s for Medicare Part A and Part B. Of that amount, PGBA reported $3.002 billion during the first quarter. The HCFA utilizes total funds expended amounts from the HCFA Form 1522s to calculate the Medicare benefit payments expenses reported in their financial statements.

Legislative and Other Requirements

The CFO Act of 1990 requires the head of each executive agency to annually prepare and submit to the US OMB financial statements that fully disclose the financial position and results of operations for all trust and revolving funds, and to the extent practical, each office, bureau, and activity of the agency which performed substantial commercial functions during the preceding FY.

The CFO Act also requires the IG, for each agency having an IG, to audit the financial statements in accordance with applicable generally accepted government auditing standards.

The IG may select an independent external auditor to conduct the audit. In addition, the CFO Act requires each agency to improve its systems of financial management, accounting and internal controls to assure the issuance of reliable financial information.

The Balance Budget Act of 1997 signed into law in August 1997, is set to balance the budget by 2002. The changes specifically affecting Medicare are as follows:

- Creating a National Bipartisan Commission on the Future of Medicare;
- Limiting growth rates for hospital and physician payments;
- Restructuring payment methods;
- Reduction in update factors for the Prospective Payment System;
- Modification to the Graduate Medical Education policies by providing incentives to decrease the number of medical residents;
- A reduction in payment levels for private plans; and
- The introduction of new plans Medicare beneficiaries may choose from instead of the traditional system, including:

    - Medical Savings Accounts;
    - Provider Sponsored Organization;
    - Unrestricted Fee-For-Service; and
    - A reduction in the variations of payments to plans in different parts of the country

The Balanced Budget Act of 1997 also slows the growth of Medicare spending by $115 billion over 5 years.

OBJECTIVES

Our agency's overall audit objective is to express an opinion on HCFA's FY 1998 combined financial statements and to report on their compliance with laws and regulations. One aspect of our overall work is to determine whether the Medicare fee-for-service benefit payments expenses are made in accordance with the provisions of Title XVIII and implementing regulations in Title 42 of the US CFR. Specifically, we were to perform substantive tests on claims PGBA adjudicated during the first quarter of FY 1998 (October 1 through December 31, 1997) for a sample of 50 beneficiaries.

Our testing was to determine if services were:

(1) furnished by certified Medicare providers to eligible beneficiaries;
(2) reimbursed by Medicare contractors in accordance with Medicare laws and regulations; and
(3) medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records.

SCOPE AND METHODOLOGY

We conducted our audit in accordance with Government Auditing Standards issued by the Comptroller General of the United States, financial statement audit methodologies prescribed by the General Accounting Office (GAO), and OMB Bulletin 93-06, "Audit Requirements of Federal Financial Statements." These standards require that we plan and perform our audit to obtain reasonable assurance that HCFA's financial statements are free of material misstatement and that HCFA, as well as Medicare contractors such as PGBA, have complied with applicable laws and regulations. We provided PGBA a draft report for comments on March 11, 1999. We summarized PGBA's comments after each finding and the comments are appended in their entirety to this report (see Appendix C).

In addition to our work, Clifton Gunderson, LLC and Ernst & Young (E&Y) contracted with HHS, OIG to review two areas related to our audit:

(1) a review of the EDP general controls without program change and application controls of VMS [VIPS (Viable Information Processing System) Medicare System]; and

(2) certain financial amounts not related to claims. Clifton Gunderson and E&Y reported the results of these reviews separately to PGBA.

We relied on our substantive tests of PGBA's adjudicated claims to determine the propriety of Medicare benefit payments expenses PGBA reported to HCFA. To perform our substantive tests, OIG headquarters first randomly selected 12 contractor FY quarters (primary sampling unit) for review. The first quarter of FY 1998 (October 1 through December 31, 1997) for PGBA was one of the quarters selected.

Our substantive testing universe consisted of $3,162,308,113 PGBA paid during the first quarter of FY 1998 for 9,860,748 claims for services provided to 2,205,740 beneficiaries. For the same period, PGBA reported a lessor amount ($3,002,370,486) as net expenses on the HCFA Form 1522s. Net expenses reflect claims paid plus or minus costs associated with non-claims activities. In this instance, net expenses were $159,937,627 less than the amount paid for claims; that is non-claims activities (cost report settlements, overpayment collections, periodic interim payments, etc.) served to reduce total expenses. These amounts were audited by other independent auditors under contract with OIG.

We selected a stratified random sample of 50 beneficiaries (secondary sampling unit) from claim files PGBA provided containing all claims PGBA adjudicated during our audit period. Prior to selecting the sample of beneficiaries, we reconciled these files to: (1) PGBA's FI and carrier check registers; and (2) Medicare benefit expenses PGBA reported on the HCFA 1522s for the first quarter of FY 1998.

The PGBA adjudicated 361 claims for the 50 beneficiaries. The 361 claims consisted of 107 FI claims and 254 carrier claims (including DMERC) for which PGBA paid a total of $273,974 ($229,454 for FI claims and $44,520 for carrier claims).

After we identified the claims for the beneficiaries in the sample, we determined that the claims were:

(1) for covered services furnished by eligible providers to eligible beneficiaries;
(2) were reimbursed by PGBA in accordance with Medicare laws and regulations; and
(3) were medically necessary, recorded and documented in beneficiary medical records.

To accomplish these objectives, we performed audit steps to verify:

- The PGBA included all payments in the monthly HCFA Form 1522 amount for "Total Funds Expended This Month" for each month in the quarter;
- The PGBA paid the correct amount to the providers and beneficiaries;
- Any coinsurance and deductible amounts were correct;
- Medicare was the correct primary/secondary payer;
- The PGBA paid only once for a service (eliminating duplicate claims); and
- The providers and beneficiaries were Medicare eligible.

We obtained assistance from PGBA's and Carolina Medical Review's, (the South Carolina PRO) medical review personnel to review the selected claims. The medical review personnel for these organizations determined if the paid claims were for services actually provided, correctly coded, medically necessary, and supported by medical records.

We used the following Medicare claim categories to report our substantive testing results:

- Hospital Inpatient - Prospective Payment System;
- Hospital Inpatient - Non-Prospective Payment System;
- SNF Inpatient;
- Home Health;
- Hospital and SNF Outpatient;
- Hospice;
- Part B Services Paid by Carriers such as:
  - Physician Services;
  - Clinical Laboratories; and
  - Ambulance Services. And,
- DME

For the claim types listed above we performed tests to ensure compliance with the Medicare laws and regulations.

FINDINGS AND RECOMMENDATIONS

We identified overpayments of $34,852 and underpayments of $1,239 in the sample of $273,974 of Medicare benefit payments. Other independent auditors under contract with OIG identified controls that PGBA needs to improve relative to EDP controls and non-claim transactions.

SUBSTANTIVE TESTING RESULTS

With the assistance of PGBA and the South Carolina PRO, we identified overpayments totaling $34,852 and underpayments totaling $1,239. This results in a net overpayment of $33,613 ($34,237 in FI overpayments and $624 in carrier underpayments). See Appendix A for a listing of the dollar amounts of errors and number of errors by claim type. See Appendix B for a list of all the errors by claims and number of services questioned within each claim along with the reason for each error.

We relied on the following criteria to identify errors.

Federal regulations require that Medicare providers maintain medical records that contain sufficient evidence to support, as applicable, admission, services furnished, diagnoses, treatment performed and continued care for claims billed.

The Social Security Act § 1862 states that no payment under Medicare Part A and Part B can be made for items and services which: (1) are not reasonable or necessary; or (2) do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member (i.e., personal comfort items).

The Medicare Carriers Manual (MCM), Part 3, §5114 states that if the sum of the payment allowance for the separately billed tests exceeds the payment allowance for the battery that includes the tests, the carrier should make payment at the lesser amount for the battery of tests.

The MCM Part 3, §4824, states that because the Medicare fee schedule amount for surgical procedures includes all services that are part of a global surgery package, carriers should not pay more than the fee schedule amount when a bill is fragmented (unbundled).

Intermediary Letter 372 addresses the billing of professional services by a physician in a teaching setting when residents are involved. In essence, the physician billing for the services must have either performed the service or have been present and supervised the resident when the service was performed.

The MCM Part 3, § 5246.4, specifies that when a carrier determines that a less expensive level of service would have met the patient's medical needs or was actually furnished, the carrier must reimburse the provider for the less expensive level of service.

DMERC Claims Processing Edits

Like other Medicare contractors, PGBA utilizes electronic edits within their claims processing systems to identify potentially erroneous claims (e.g., duplicates, erroneous billing). During our verification of the amounts PGBA paid for DME claims, we identified two payment errors which may warrant improvement in PGBA's claims processing edits. These DME errors are similar to DME errors identified in FY 1997. However, we realize PGBA did not have the opportunity to improve their claims processing edits since the quarter selected for review (1st) for FY 1998 had already passed before obtaining the results of the prior year's audit.

The two payment errors we identified this year are as follows:

- The PGBA improperly paid $192.83 for a semi-electric hospital bed with a mattress when on a separate claim the supplier billed for a power alternating low air loss mattress. Two mattresses were billed for one bed.

- The PGBA improperly paid $31.05 for a wheelchair accessory (wheel lock assembly). The wheel lock assembly is included in the purchase price of the wheelchair which was billed on a separate claim.

Recommendations

We recommend that PGBA:

- initiate recovery of the overpayments, reimburse the underpayments, and periodically provide us with the status of recovery and reimbursement actions; and

- analyze the DME errors noted and make the necessary improvements in their claims processing edits to prevent such payment errors from reoccurring.

Comments by PGBA Officials

In their written response to our draft report, PGBA officials stated they:

- concurred that the claims we identified in our draft report involved incorrect reimbursements, agreed with the calculated amounts, had already taken some and were in the process of taking other appropriate actions to correct the reimbursements (recouping the identified overpayments and reimbursing the identified underpayments); and

- were analyzing the errors we noted in the DME claims and will make any improvements in the DME claims processing edits indicated as a result of their analysis.

OAS Response

Since the PGBA did not comment on the portion of our recommendation that dealt with periodically providing us with the status of recovery and reimbursement actions, we recommend they reconsider our recommendation and include their comments on this recommendation in their reply to the HHS action official identified in the transmittal letter to this report.

RESULTS OF WORK PERFORMED BY OTHERS

Clifton Gunderson reported to PGBA in December 1998 on their review of non-claims activities. This report contained a number of findings concerning various aspects of non-claims activities. Generally PGBA agreed with the findings.

Recommendation

We recommend that PGBA keep us informed of the progress made towards implementing the recommendation made by the private contractors.

Comments by PGBA Officials

The PGBA officials also started in their written comments that they have addressed the recommendations the independent auditors made with respect to EDP controls and non-claims activities and enclosed a copy of the independent auditors' response and resulting correspondence from them (see Appendix C).

AUDIT OF HCFA'S FINANCIAL STATEMENTS
FOR FISCAL YEAR 1998
AT PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
DOLLAR AMOUNT OF ERRORS BY TYPE OF CLAIM

The listing below shows the dollar amount of errors by type of claim. We calculated the percent of errors by dividing the Dollar Errors Identified by the Dollars Reviewed for each type of claim. For example, for Hospital Inpatient-PPS, dividing $254.61 by $42,335.84 resulted in a .60% error. These percentages are for informational purposes only regarding the claims in the sample. They cannot be used to derive any conclusions regarding Palmetto Government Benefits Administrator's paid claims universe by type of claim.

TYPE OF CLAIM	DOLLARS REVIEWED	DOLLAR ERRORS IDENTIFIED	PERCENT OF ERRORS
Hospital Inpatient-PPS	$ 42,335.84	$ 254.61	.60%
Hospital Inpatient-Non-PPS	$-0-	$ -0-	0.00%
SNF Inpatient	$13,424.38	$ -0-	0.00%
Home Health Agency	$162,232.54	$34,032.58	20.98%
Hospital, SNF Outpatient	$ 266.71	$ -0-	0.00%
Hospice	$11,194.30	$ -0-	0.00%
SUBTOTAL	$229,453.77	$34,287.19	14.94%
Part B	$ 5,621.12	$ 196.97	3.50%
DMERC	$38,899.35	$1607.08	4.13%
TOTAL	$273,974.24	$36,091.24	13.17%

AUDIT OF HCFA'S FINANCIAL STATEMENTS
FOR FISCAL YEAR 1998
AT PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
NUMBER OF CLAIMS WITH ERRORS BY TYPE OF CLAIM

The listing below shows the number of claims with errors by type of claim. We calculated the percent of errors by dividing the Claim Errors Identified by the Claims Reviewed for each type of claim. For example, for Hospital Inpatient - PPS, dividing 1 by 5 resulted in a 20.00% error. These percentages are for informational purposes only regarding the claims in the sample. They cannot be used to derive any conclusions regarding Palmetto Government Benefits Administrator's paid claims universe by type of claim.

TYPE OF CLAIM	CLAIMS REVIEWED	CLAIM ERRORS IDENTIFIED	PERCENT OF ERRORS
Hospital Inpatient-PPS	5	1	20.00%
Hospital Inpatient-Non-PPS	0	0	0.00%
SNF Inpatient	2	0	0.00%
Home Health Agency	90	49	54.44%
Hospital, SNF Outpatient	5	0	0.00%
Hospice	5	0	0.00%
SUBTOTAL	107	50	46.73%
Part B	90	7	7.78%
DMERC	164	12	7.32%
TOTAL	361	69	19.11%

AUDIT OF HCFA'S FINANCIAL STATEMENTS
FOR FISCAL YEAR 1998
AT PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
COLUMBIA, SOUTH CAROLINA

FISCAL INTERMEDIARY CLAIMS (BY LINE ITEM) WITH IDENTIFIED ERRORS

NO. OF CLAIMS	ICN	AMOUNT QUESTIONED	NO. OF SERVICES QUESTIONED	ERROR CODE	ERROR DESCRIPTION
1	19726000277005	$24.00	1.0	21	INSUFFICIENT DOCUMENTATION
1	19726000277005	2,210.40	24.0	21	INSUFFICIENT DOCUMENTATION
2	19726000279005	14.40	1.0	21	INSUFFICIENT DOCUMENTATION
2	19726000279005	2,118.30	23.0	21	INSUFFICIENT DOCUMENTATION
3	19726000643605	63.28	1.0	21	INSUFFICIENT DOCUMENTATION
3	19726000643605	392.00	4.0	25	MEDICALLY UNNECESSARY
4	19726000830205	27.54	1.0	21	INSUFFICIENT DOCUMENTATION
5	19726101126905	95.80	2.0	25	MEDICALLY UNNECESSARY
6	19726101953705	145.38	2.0	25	MEDICALLY UNNECESSARY
6	19726101953705	101.82	2.0	41	NO SERVICE RENDERED
7	19726202070105	419.48	4.0	21	INSUFFICIENT DOCUMENTATION
8	19726500866405	134.00	2.0	21	INSUFFICIENT DOCUMENTATION
8	19726500866405	67.00	1.0	41	NO SERVICE RENDERED
9	19726501325305	(4.50)	1.0	90	OTHER ERRORS
10	19726801673705	(2.40)	1.0	90	OTHER ERRORS
11	19727500330905	490.00	5.0	25	MEDICALLY UNNECESSARY
12	19727500373605	160.00	4.0	25	MEDICALLY UNNECESSARY
13	19727501324305	145.38	2.0	25	MEDICALLY UNNECESSARY
14	19727901385105	629.22	6.0	21	INSUFFICIENT DOCUMENTATION
15	19728002633305	58.22	1.0	21	INSUFFICIENT DOCUMENTATION
16	19728302687505	62.48	1.0	21	INSUFFICIENT DOCUMENTATION
17	19728303289805	59.60	1.0	25	MEDICALLY UNNECESSARY
18	19728900355105	431.10	9.0	25	MEDICALLY UNNECESSARY
19	19729000036905	289.45	5.0	25	MEDICALLY UNNECESSARY
20	19729000434705	95.76	50.0	21	INSUFFICIENT DOCUMENTATION
20	19729000434705	2,947.20	32.0	21	INSUFFICIENT DOCUMENTATION
21	19729002133905	13.68	1.0	21	INSUFFICIENT DOCUMENTATION
21	19729002133905	145.38	2.0	25	MEDICALLY UNNECESSARY
21	19729002133905	916.38	18.0	25	MEDICALLY UNNECESSARY
22	19729002522905	(1.95)	1.0	90	OTHER ERRORS
23	19729300606505	392.00	4.0	25	MEDICALLY UNNECESSARY
24	19729301984105	62.00	1.0	25	MEDICALLY UNNECESSARY
24	19729301984105	(2.25)	1.0	90	OTHER ERRORS
25	19729401191505	734.09	7.0	21	INSUFFICIENT DOCUMENTATION
25	19729401191505	90.00	1.0	31	INCORRECTLY CODED

AUDIT OF HCFA'S FINANCIAL STATEMENTS
FOR FISCAL YEAR 1998
AT PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
COLUMBIA, SOUTH CAROLINA

FISCAL INTERMEDIARY CLAIMS (BY LINE ITEM) WITH IDENTIFIED ERRORS

NO. OF CLAIMS	ICN	AMOUNT QUESTIONED	NO. OF SERVICES QUESTIONED	ERROR CODE	ERROR DESCRIPTION
26	19730000116305	201.00	3.0	21	INSUFFICIENT DOCUMENTATION
26	19730000116305	4,020.00	60.0	21	INSUFFICIENT DOCUMENTATION
26	19730000116305	201.00	3.0	25	MEDICALLY UNNECESSARY
27	19730400324105	48.55	1.0	25	MEDICALLY UNNECESSARY
28	19730402040905	254.61	1.0	35	NON-COVERED SERVICE
29	19730800532905	490.00	5.0	25	MEDICALLY UNNECESSARY
30	19730802374505	233.46	1.0	21	INSUFFICIENT DOCUMENTATION
30	19730802374505	2,483.73	27.0	21	INSUFFICIENT DOCUMENTATION
30	19730802374505	1,653.53	37.0	21	INSUFFICIENT DOCUMENTATION
30	19730802374505	275.97	3.0	25	MEDICALLY UNNECESSARY
31	19731000443805	40.00	1.0	25	MEDICALLY UNNECESSARY
32	19731401992405	(2.30)	1.0	90	OTHER ERRORS
33	19731500210205	10.34	15.0	16	NO DOCUMENTATION
33	19731500210205	644.70	7.0	21	INSUFFICIENT DOCUMENTATION
34	19731500715405	59.03	1.0	21	INSUFFICIENT DOCUMENTATION
35	19731802505905	64.08	1.0	21	INSUFFICIENT DOCUMENTATION
35	19731802505905	64.08	1.0	21	INSUFFICIENT DOCUMENTATION
36	19732200058405	289.45	5.0	25	MEDICALLY UNNECESSARY
37	19732200734405	392.00	4.0	25	MEDICALLY UNNECESSARY
38	19732300662205	670.60	14.0	25	MEDICALLY UNNECESSARY
39	19732401983005	2,759.70	30.0	21	INSUFFICIENT DOCUMENTATION
39	19732401983005	1,340.70	30.0	21	INSUFFICIENT DOCUMENTATION
40	19733601576805	183.98	2.0	21	INSUFFICIENT DOCUMENTATION
40	19733601576805	1,340.70	30.0	21	INSUFFICIENT DOCUMENTATION
41	19733700131505	125.06	2.0	21	INSUFFICIENT DOCUMENTATION
42	19733700667505	294.00	3.0	21	INSUFFICIENT DOCUMENTATION
42	19733700667505	98.00	1.0	25	MEDICALLY UNNECESSARY
43	19733902084505	395.60	5.0	25	MEDICALLY UNNECESSARY
44	19734601968305	(2.10)	1.0	90	OTHER ERRORS
45	19734601969005	434.00	7.0	21	INSUFFICIENT DOCUMENTATION
45	19734601969005	9.25	1.0	60	UNBUNDLING
45	19734601969005	(9.45)	1.0	90	OTHER ERRORS
46	19734602635905	119.20	2.0	21	INSUFFICIENT DOCUMENTATION
47	19734901850405	474.72	6.0	25	MEDICALLY UNNECESSARY
48	19735102823505	251.36	4.0	25	MEDICALLY UNNECESSARY
49	19735102858205	188.40	3.0	21	INSUFFICIENT DOCUMENTATION
50	19735300052705	616.10	10.0	21	INSUFFICIENT DOCUMENTATION
		$34,287.19	551.0		

AUDIT OF HCFA'S FINANCIAL STATEMENTS
FOR FISCAL YEAR 1998
AT PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
COLUMBIA, SOUTH CAROLINA

CARRIER CLAIMS (BY LINE ITEM) WITH IDENTIFIED ERRORS

NO. OF CLAIMS	ICN	AMOUNT QUESTIONED	NO. OF SERVICES QUESTIONED	ERROR CODE	ERROR DESCRIPTION
1	97258112942000	($9.49)	(1.00)	90	OTHER ERRORS
2	97272877255000	37.03	1.00	16	NO DOCUMENTATION
3	97272877262000	37.03	1.00	16	NO DOCUMENTATION
4	97290888528000	42.89	1.00	31	INCORRECTLY CODED
4	97290888528000	20.92	1.00	31	INCORRECTLY CODED
5	97309887959000	17.79	1.00	31	INCORRECTLY CODED
6	97314882442000	17.79	1.00	31	INCORRECTLY CODED
7	97321110942000	7.86	1.00	21	INSUFFICIENT DOCUMENTATION
7	97321110942000	6.17	1.00	21	INSUFFICIENT DOCUMENTATION
		$196.97	9.00		

AUDIT OF HCFA'S FINANCIAL STATEMENTS
FOR FISCAL YEAR 1998
AT PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
COLUMBIA, SOUTH CAROLINA

DMERC CLAIMS (BY LINE ITEM) WITH IDENTIFIED ERRORS

NO. OF CLAIMS	ICN	AMOUNT QUESTIONED	NO. OF SERVICES QUESTIONED	ERROR CODE	ERROR DESCRIPTION
1	95293814930001	$38.12	1.00	25	MEDICALLY UNNECESSARY
2	95293814932001	38.12	1.00	25	MEDICALLY UNNECESSARY
3	95324817428001	38.12	1.00	25	MEDICALLY UNNECESSARY
4	97044820968001	31.05	1.00	60	UNBUNDLING
5	97252844309000	18.88	1.00	25	MEDICALLY UNNECESSARY
5	97252844309000	6.03	1.00	25	MEDICALLY UNNECESSARY
5	97252844309000	18.87	1.00	25	MEDICALLY UNNECESSARY
5	97252844309000	(964.44)	(12.00)	90	OTHER ERRORS
6	97266828452000	67.71	9.00	31	INCORRECTLY CODED
7	97272858137000	(240.07)	(3.00)	90	OTHER ERRORS
8	97281851588000	22.40	20.00	25	MEDICALLY UNNECESSARY
9	97304814182000	38.12	1.00	25	MEDICALLY UNNECESSARY
10	97304814206000	40.35	1.00	25	MEDICALLY UNNECESSARY
11	97318846836000	22.40	20.00	25	MEDICALLY UNNECESSARY
12	97343850192000	22.40	20.00	25	MEDICALLY UNNECESSARY
		$1,607.08	93.00		

HCFA
Health Care Financing Administration

MEDICARE

Part A Intermediary
Part B Carrier
DME Regional Carrier

April 2, 1999

Charles J. Curtis, Regional Inspector General for Audit Services
US DHHS Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, SW Room 3T41
Atlanta, Georgia 30303-8909

Re: Response to Draft Report (*Assist Audit of HCFA's FY 1998 Financial Statements at Palmetto Government Benefits Administrators*)
CIN: A-04-99-03013

Dear Mr. Curtis:

Palmetto Government Benefits Administrators (PGBA) has reviewed your letter dated March 11, 1999 and the above referenced draft report which accompanied it. With respect to the findings and recommendations of this draft report:

- PGBA concurs with the finding that the claims identified in the draft report involved incorrect reimbursements, and also agrees with the calculated amounts.

- Appropriate corrective actions have already been taken or are now being taken to correct these reimbursements (recouping the identified overpayments and reimbursing the identified underpayments).

- PGBA is analyzing the errors noted in the durable medical equipment (DME) claims. PGBA will make any improvements in the DME claims processing edits indicated as a result of this analysis.

- PGBA has addressed the recommendations made by the independent auditors (Clifton Gunderson, L.L.C.) with respect to EDP controls and non-claims activities. A copy of the PGBA response and resulting correspondence from the independent auditors is enclosed.

If there are any questions, or if I may be of further assistance, please call me at (803)788-0222, ext. 38700, or Ray Bair at extension 38143.

Sincerely,

Ann Archibald

Ann Archibald
Vice President, Medicare Administration

2 Enclosures

Palmetto Government Benefits Administrators, LLC
Medicare Administration
Post Office Box 100190 • Columbia, South Carolina • 29202-3190 • FAX (803) 691-4761

A HCFA Contracted Intermediary and Carrier

cc: Carol Nicholson, HCFA CO
William R. Horton, President & COO, Government Programs, BCBSSC
Bruce W. Hughes, Jr., COO, Palmetto GBA, LLC

Washington, D.C. 20201

January 29, 1999

cc: Byrne
Dicar
for

Mr. William R. Horton
President and Chief Operating Officer
Government Programs
Blue Cross Blue Shield of South Carolina
I-20 at Alpine Road
Columbia, South Carolina 29219

Dear Mr. Horton:

The independent public accounting firm of Ernst and Young (E&Y) LLP under contract with the Department of Health and Human Services Office of Inspector General has completed its electronic data processing reviews at Blue Cross Blue Shield of South Carolina. (BCBSC). The E&Y audit team conducted a follow-up review to the 1997 general controls review without program change controls and the applications controls review of the VIPS Medicare System (VMS). The follow-up reviews were conducted from August 24 through August 28,1998.

We especially appreciate the timeliness of your response to our draft report dated December 22, 1998. We have enclosed our final report which incorporates the findings and recommendations resulting from E&Y's review. The report includes BCBSSC's formal management responses which indicates that you have already started a corrective action plan to address the findings. We have received documentation from Susan McGuirt regarding the finding in the VIPS report. As soon as E&Y completes their evaluation of the documentation, we will let you know the results.

These reviews are a critical part of the Health Care Financing Administration's financial statement audit for the year ending September 30, 1998. We have been informed by the E&Y audit team that they could not have completed their follow-up without the excellent cooperation extended by your staff.

If you have any questions or would like to let us know of your progress in improving your EDP operations, please do not hesitate to call Jerry Hammond at (410) 786-2130 or Bruce Randle at (410) 786-9232.

Sincerely,

Janet S. Kramer

Janet S. Kramer
Director, Audit Operations &
Financial Statement Activities

Enclosure
cc: Ann Archibald
Susan McGuirt

United States Department of Health & Human Services
Management Letter Comments

Follow-Up EDP Application Controls Assessment of the VIPS Medicare System (VMS)

August 1998

Final Report

Ernst & Young (E&Y) LLP has completed their follow-up application controls review of the VIPS Medicare System (VMS). This follow-up review was performed at Blue Cross Blue Shield of South Carolina located at Columbia, South Carolina. This review was intended to evaluate the VIPS application controls as part of the Department of Health and Human Services Office of Inspector General's (HHS OIG) financial statement audit of the Health Care Financing Administration (HCFA) for the year ended September 30, 1998.

E&Y procedures included interviews with key contractor personnel, observation of procedures performed, and testing of certain identified controls. The nature and scope of E&Y's procedures were reviewed with HHS OIG and GAO staff.

The findings are listed below:

General Controls Specific to FSS

No issue noted

Input Controls

No issue noted

Processing Controls

VIP-E-98-01 VMS Edits Can Be Deactivated or Bypassed

Output

No issue noted

Processing Controls

VIP-E-98-01 VIPS Edits Can Be Deactivated or Bypassed

Condition
The VIPS Medicare System contains numerous edits and audits. By design, the VIPS allows the carriers to control some of the edits in the application, including mandatory HCFA edits. Examples of edits that can be turned on/off by the carriers include consistency edits such as invalid diagnosis codes, invalid procedure codes, and invalid HCPCS codes. Additionally, authorizations are not maintained for all edit deactivations and management does not review all edit changes. Finally, the VIPS audit trail only details the last change made to an edit/audit. Therefore, a complete history of all edit modifications does not exist.

Cause
The design of the VIPS application allows the carriers to control some of the edits. This design feature gives the carriers increased flexibility in the way Medicare Part B claims are processed. Additionally, the VIPS audit trail was designed to only capture the last change made to the edits.

Criteria
Some HCFA mandated edits should not be altered, deactivated, or bypassed by the individual carriers. These edits were designed to ensure compliance with HCFA policies and Medicare laws.

Effect
Individual carriers can configure their VIPS system in a manner that may not comply with existing HCFA policies and Medicare laws. When certain edits are turned off, a carrier may process and pay claims that would not otherwise be paid. Thus, the capability to deactivate edits may result in fraud and loss of Medicare funds.

Recommendation
HCFA should determine which edits are most critical in the VIPS system. These edits should be hard coded into the application by the VIPS maintainer and the carriers should not have the ability to deactivate them. Additionally, the VIPS maintainer should enhance the audit trail to include all edit modifications. Furthermore, BCBSSC should maintain documented justification and review all deactivations of VIPS edits.

VIP-E-98-01 (continued)

Management's Response

The first portion of the finding pertained to the ability of client sites (e.g., Palmetto) to change the setting of individual edits within the VMS system. This ability is typical in large systems and generally viewed as desirable because it prevents the need for frequent programming changes. However, that decision is ultimately HCFA's, not ours. It would probably result in the need to compensate the system maintainer for additional programming and wait for software releases in order to implement changes that can be accomplished in minutes today. We believe a balance is necessary and many edits should be user controlled. Some of the extremely sensitive and critical edits are already controlled programmatically, such as the batch duplicate claims logic. If there are specific edits that E&Y feels should be removed from user control and placed under the control of hard coded programs, we would suggest that these edits be identified and presented to HCFA for review and discussion with all VMS users and VIPS to determine the full scope and impact of this change. We would defer final response to this portion of the finding to HCFA.

The second portion of the finding pertained to controls over the process for actually making changes to edits. We believe we have sound procedures and practices in place and reference the attached documentation provided to Clifton & Gunderson during the CFO audit which resulted in removal of a nearly identical preliminary finding. Therefore we are requesting that this finding be removed from the contractor level and taken to the HCFA Central Office level for consideration.

United States Department of Health &Human Services
Management Letter Comments

Follow-Up EDP Controls Assessment
at
BlueCross BlueShield of South Carolina

August 1998

Final Report

Ernst & Young (E&Y) LLP has completed their follow-up electronic data processing (EDP) general controls review at Blue Cross Blue Shield of South Carolina (BCBSSC), located in Columbia, South Carolina. This review was intended to evaluate the information systems controls at BCBSSC as part of the Department of Health and Human Services Office of Inspector General's (HHS OIG) financial statement audit of the Health Care Financing Administration (HCFA) for the year ended September 30, 1998.

E&Y performed their review from August 24, 1998 - August 28, 1998. Their procedures included interviews with key BCBSSC personnel, observation of procedures performed, and testing of certain identified controls. The nature and scope of E&Y's procedures were reviewed with HHS OIG and General Accounting Office (GAO) staff.

Sections of the *Federal Information System Controls Audit Manual* (FISCAM) tested and related findings are listed below:

SCB-E-98-01. Viewed Medicare Reports Residing in the SDSF Output Queue
SCB-E-98-02. User IDs Not Revoked in a Timely Manner
SCB-E-98-03. No RACF Tape Data Set Protection
SCB-E-98-04. No Logging of Remote Dial-in Access
SCB-E-98-05. No Policies and Procedures for Following-up Security Violations **(This issue was dropped)**
SCB-E-98-06. Key Data Security Administration Functions Performed by Systems Programmers
SCB-E-98-07. Inappropriate Individuals Have Access to System Software and Authorized Program Facility (APF) Libraries **(Covered in a separate memorandum to be sent separately from this report.)**

B. Access Control

SCB-E-98-01. Viewed Medicare Reports Residing in the SDSF Output Queue

Condition
Using a low-level TSO user ID provided by BCBSSC, we viewed Medicare reports residing in or temporarily held in the SDSF output queue. Thus, our testing confirmed that regular users with minimal access rights can view output files containing confidential Medicare data.

Cause
Access to Medicare reports residing in the SDSF output queue has not been restricted to authorized TSO users. Data Security Administration indicated that access to Medicare output in the SDSF output queue will be restricted using RACF.

Criteria
The United States Office and Management and Budget (OMB) Circular No. A-130 requires cost-effective security products and techniques be used within the system to restrict access to sensitive data. Additionally, OMB Circular No. A-130 suggests incorporating controls such as "least privilege" to appropriately control user access privileges. Least privilege is based on restricting a user's access (to data files, processors, facilities, or peripherals) or type of access (read, write, execute, or delete) to the minimum necessary to perform the user's assigned job.

Effect
Unauthorized individuals who can view Medicare reports containing beneficiary names, beneficiary numbers, addresses, date of birth, age, provider IDs, Medicare claim numbers, and other critical information may disclose such information.

Recommendation
Data Security Administration should restrict access to the mainframe output queue. The access security rules implemented within RACF should be followed within SDSF.

Management's Response

BCBSSC agrees that unauthorized viewing of sensitive data in the output queue should be restricted. Data Security Administration has been researching this issue and anticipates compliance with this audit finding by February 1999.

SCB-E-98-02. User IDs Not Revoked in a Timely Manner

Condition
User accounts of terminated and transferred employees are not always revoked in a timely manner. Specifically, the user IDs of two individuals who had been terminated for two weeks and the user ID of one individual who had been terminated for five weeks were active on the system. Additionally, several transferred employees who no longer work in Medicare Systems continue to have 'alter' and 'update' access to Medicare data.

Cause
Supervisors, who are responsible for notifying Data Security Administration of terminations/transfers, do not provide notification on a timely basis.

Criteria
BCBSSC's Corporate Policy Manual on Security Procedures states that supervisors shall notify Data Security Administration of terminations or transfers by no later than the effective termination date. Additionally, the National Institute of Standards and Technology's (NIST's) Generally Accepted Principles and Practices for Securing Information Technology Systems states that when employees leave an organization, either voluntarily or involuntarily, system access should be immediately terminated. Furthermore, OMB Circular No. A-130 suggests incorporating controls such as "least privilege" to appropriately control user access privileges. Least privilege is based on restricting a user's access (to data files, processors, facilities, or peripherals) or type of access (read, write, execute, or delete) to the minimum necessary to perform the user's assigned job.

Effect
Terminated employees may have access to BCBSSC systems for extended periods of time. This access could be exploited by the terminated employee or by "hackers" in order to perform unauthorized changes to critical BCBSSC programs and data. Additionally, transferred employees may also perform unauthorized changes to Medicare programs and data.

Recommendation
Data Security Administration should send e-mails, memos, and other correspondence to user supervisors in order to emphasize the importance of timely notification of employee terminations and transfers. Additionally, Data Security should immediately remove the access authorities of terminated/transferred employees.

SCB-E-98-02. (Continued)

Management's Response
Ernst and Young identified three (3) terminated employees who maintained CICS access beyond their effective dates of termination. In situations where supervisors neglect to inform Data Security of employee terminations, a compensating control existed whereby bi-weekly reports are produced from our payroll system. Each of these employees were reflected on this report and Data Security was in process of deleting the CICS accounts during Ernst and Young's review. A copy of this report was provided to Ernst and Young to validate that the terminated employee's were detected and in process of being deleted.

Ernst and Young also identified transferred employees who maintained 'alter' and 'update' access to Medicare data files. Since this finding, Data Security has enhanced the reporting of "access rights" to data owners. Weekly reports are now generated which provide Medicare personnel with detailed information regarding which employee's have access to their data. Medicare data owners have agreed to review this report on a routine basis and notify Data Security of any required changes in access rights. Data Security has also incorporated periodic follow-up with Medicare personnel to ensure access rights are appropriate.

Data Security agrees that timely notifications from supervisory personnel would ensure system access for terminated employees would be revoked in a timely manner. Data Security has developed a series of security awareness emails, one of which addresses supervisor responsibilities for terminated/transferred employees.

SCB-E-98-03. No RACF Tape Data Set Protection

Condition
Our review of the RACF global security options indicated that tapes at BCBSSC are not addressed by the RACF security system. We found that the tape data set protection option within the RACF SETROPTS is not activated.

Cause
Management has not elected to activate the tape security at BCBSSC.

Criteria
OMB Circular No. A-130 requires cost-effective security products and techniques be used within the system to restrict access to sensitive data. The Circular also suggests incorporating controls such as "least privilege" to appropriately control user access privileges. Least privilege is based on restricting a user's access (to data files, processors, facilities, or peripherals) or type of access (read, write, execute, or delete) to the minimum necessary to perform the user's assigned job.

Effect
Individuals may perform unauthorized changes to confidential data and programs residing on tape.

Recommendation
The tape data set protection option within RACF SETROPTS should be activated.

Management's Response

BCBSSC agrees that Tape Data Set Protection should be activated. Unfortunately, this is not an overnight fix. All tape accesses must be researched to ensure user id's have appropriate access before this feature can be activated. Data Security Administration has been researching and changing access levels for several months in preparation for activation. The anticipated activation date is March 1999.

SCB-E-98-04. No Logging of Remote Dial-in Access

Condition
Remote dial-in access to the BCBSSC network through Procomm and Packet PC is not logged. Although an access log is maintained for users connecting to the network through Secure ID, a log is not maintained for those users connecting to the system through Procomm and Packet PC. Additionally, there are no procedures for monitoring dial-in access.

Cause
BCBSSC has recently implemented Secure ID which will serve as the primary remote dial-in software. Management also indicated that Procomm will be eliminated December 1998 and all Medicare remote dial-in users will use Secure ID.

Criteria
OMB Circular No. A-130 suggests incorporating controls such as individual accountability to trace specific actions to a particular individual. Individual accountability can be accomplished by identifying and authenticating users of the system and subsequently tracing actions on the system to the user who initiated them.

Effect
The activity of individuals attempting to gain unauthorized access and the activity of those who successfully gain unauthorized access to BCBSSC systems through Procomm and Packet PC would not be identified. Therefore, fraudulent or malicious activity may not be traced to individuals engaging in such activity.

Recommendation
Management should log all successful and unsuccessful remote access attempts. Additionally, the log should be periodically reviewed to detect unauthorized activity.

Management's Response

There are two misconceptions that must be clarified. Procomm will not be eliminated December 1999. Our plan is to replace the hardware protocol converters with either SecureID or Packet/PC as the hardware fails. Second, all remote dial-in users will not be using SecureID. Medicare has several methods for dial-in access, with some being outside the control of Network Services (i.e., Advantis Dial). We have, however, migrated the Medicare Cottage Users to SecureID along with several members of Medicare's management staff.

SCB-E-98-04. (Continued)

Procomm and Packet/PC products have NO facility to monitor dial-in access activity, however, both of these products assign users to VTAM LU / CICS term ids. For the user to gain access to mainframe applications they must have a valid RACFID whose access is logged (successful and unsuccessful) via SMF and TMON.

As to SecureID logging, once the user is cleared to enter the Network, the other logging facilities are used to track the activities of this user. Currently we are reviewing enhancements to existing reports to show external access attempts.

SCB-E-98-05. No Policies and Procedures for Following-up Security Violations (This issue was dropped)

C. Segregation of Duties

SCB-E-98-06. Key Data Security Administration Functions are Performed by Systems Programmers

Condition
Key data security functions are performed by BCBSSC systems programmers. Specifically, three systems programmers, whose user IDs possess the RACF system SPECIAL, OPERATIONS, and AUDITOR attributes, are responsible for adding and deleting TSO user IDs. Consequently, systems programmers have inappropriate access to change RACF global options and issue RACF RVARY command and password.

Cause
The Data Security Administration Division at BCBSSC was created two years ago. Prior to the creation of this division, RACF was implemented and administered by systems programmers in the Information Systems Division. Since the development of Data Security Administration, security responsibilities have slowly transferred from the systems programmers to the security administrators. In effect, many of the security privileges have been retained by systems programmers.

Criteria
OMB Circular No. A-130 suggests incorporating controls such as separation of duties to divide the steps in a critical function among different individuals. Specifically, systems programmers should be responsible for the development and maintenance of programs that comprise the system software while data security administration is responsible for the development and administration of the organization's security policies.

Effect
The RACF SPECIAL attribute gives users highly powerful access authorities within the system except those dealing with the logging of security information. A user with the SPECIAL attribute can also add, modify, and delete user, group, data set, and general resource profiles, activate or deactivate the RACF global options, and assign any user attribute to other RACF users. The OPERATIONS attribute allows a user access to RACF-protected resources including data sets and general resources. The AUDITOR attribute gives a user the ability to modify as well as turn on and off system logging. Therefore, it is possible that systems programmers may deactivate system logging in order to conceal certain activities. Additionally, Data Security Administration does not have the capability to inactivate a user ID that is suspected of conducting inappropriate activities.

SCB-E-98-06. (Continued)

Recommendation
Data Security Administration should be given the RACF SPECIAL attribute as well as the responsibility for adding and deleting RACF users IDs. Additionally, the AUDITOR attribute should be removed from systems programmers. Furthermore, management should consider assigning the AUDITOR attribute to an internal auditor who will periodically monitor the activities of Data Security Administration, the systems programmers, and other privileged users.

Management's Response
Management agrees that security administration should not be performed by Technical Support. Therefore TSO ownership will be transferred to Data Security. Anticipated completion date is February 1999 (Excluding Technical Support accounts).

The AUDITOR attribute has been removed from the technical staff and has been given to an internal I/S Auditor for monitoring purposes.

SCB-E-98-07. Inappropriate Individuals Have Access to System Software and Authorized Program Facility (APF) Libraries

(Transferred to a Separate Memorandum)

The below comments relate to the above issue which was transferred to a separate memorandum

Control Issue
Inappropriate individuals have been granted alter access to system software and APF libraries. This access has been granted to four software and hardware product representatives and system engineers.

Recommendation
The 'alter' access of the four software and hardware product representatives and system engineers should be removed. Additionally, Technical management should periodically review access to system software and APF libraries.

Management's Response

The ID's in question are periodically used by IBM representatives for technical problem resolution. BCBSSC agrees that access to systems software and APF libraries should be restricted. Technical support will remove this access and periodically review access to system software and APF libraries.

Clifton Gunderson L.L.C.
Certified Public Accountants & Consultants

Golden Triangle I
7833 Walker Drive, Suite 440
Greenbelt, Maryland 20770
(301) 345-0500
(301) 345-0054 Fax
www.cliftoncpa.com

December 30, 1998

Ms. Ann Archibald, Vice President
Medicare Administration
Blue Cross and Blue Shield of South Carolina
Mail Code: AH-100
I-20 East at Alpine Road
Columbia, South Carolina 29219

Re: HCFA Fiscal Year 1998 Financial Statements Audit

Dear Ms. Archibald:

Clifton Gunderson L.L.C. and Ernst and Young were engaged by the HHS Office of Inspector General (HHS OIG) to perform certain procedures related to Medicare contractors' non-claims activity for the fiscal year (FY) 1998, in conjunction with their audit of the Health Care Financing Administration's (HCFA) FY 1998 Financial Statements.

We have completed the work related to Palmetto Government Benefit Administrators and are submitting our findings. These findings and your response to the findings have been discussed at the exit conference on November 13, 1998.

As discussed in our entrance conference, Ernst & Young will opine on HCFA's Financial Statements for FY 1998. Since the financial data reported by the Contractors is included in HCFA's Financial Statements, the findings will be evaluated individually and in aggregate, as to their impact on HCFA's Financial Statements. Additionally, Ernst & Young will issue a report on HCFA's internal control structure and report on compliance with laws and regulations.

We would like to thank you and your staff for the cooperation and assistance we received. Please do not hesitate to call Allen Perkins or me at (301) 345-0500 if you have any questions.

Sincerely,

CLIFTON GUNDERSON L.L.C.

William H. Oliver, CPA
Member

cc: Mr. Bruce Randle
Office of Inspector General
N2-25-10, North Building
7500 Security Boulevard
Baltimore, MD 21244-1850

Ms. Maria Montilla
Office of Inspector General
N2-25-26, North Building
7500 Security Boulevard
Baltimore, MD 21244-1850

Ms. Carol Nicholson
Health Care Financing Administration
C3-14-27, Central Building
7500 Security Boulevard
Baltimore, MD 21244-1850

Ms. Nancy Schmidt
Health Care Financing Administration
Program Integrity Branch
Division of Financial Management and
Program Initiatives
1301 Young Street, Room 833
Dallas, TX 75202

Ms. Marybeth Jason
Health Care Financing Administration
C3-14-27, Central Building
7500 Security Boulevard
Baltimore, MD 21244-1850

Ms. Sara Smalley
Health Care Financing Administration
C3-14-27, Central Building
7500 Security Boulevard
Baltimore, MD 21244-1850

Ms. Norma Jo Bales
HCFA/CBS/CMB
Atlanta Federal Center
61 Forsyth Street, S. W., Suite 4T20
Atlanta, GA 30303-8909

Mr. Ballard Hillman
OIG Office of Audit Services
61 Forsyth Street, S. W., Room 3T41
Atlanta, GA 30303-8909

Mr. Salim R. Mawani
Ernst & Young LLP
1225 Connecticut Avenue, N. W.
Washington, DC 20036

HCFA 98 Financial Statements Audit
Contractor Visit to Palmetto Government Benefit Administrators
– Findings –
September 30, 1998

Number:	Subject Matter:	Comments:
SCBF97-01	Review of Interim Calculations for Non-claim Disbursements and Withholdings	Response incorporated
SCBF97-02	Timely Recording of Checks Received in Subsidiary Ledgers	Response incorporated
SCBF98-01	**Finding Deleted**	**REMOVED 8/20/98**
SCBF98-02	MSP Stale Accounts Receivables	Response incorporated **ALSO A CO FINDING**
SCBF98-03	Timely Deposit of Checks Received	Response incorporated
SCBF98-04	**Finding Deleted**	**REMOVED 9/12/98**
SCBF98-05	Use of Unauthorized Identification Codes	Response incorporated
SCBF98-06	Segregation of Duties	Response incorporated
SCBF98-07	Cash Disbursements Area Cycle Memos - Segregation of Duties	Response incorporated
SCBF98-08	MSP Allowance for Doubtful Accounts	Response incorporated
SCBF98-09	M751A Part A – HI Subrogation: Unidentified New/Accrued Receivables (line2) M751B Part B – SMI Subrogation: Unidentified New/Accrued Receivables (line 2)	Response incorporated
CBF98-10	M751A Part A – HI Subrogation: Unidentified Reclassified/Adjusted Amounts (line 5a)	Response incorporated
SCBF9811	M751B – Part B: Unidentified Reclassified/Adjusted Amounts (line 5A)	Response incorporated
SCBF98-12	H751A Part A – HI Principal Provider Overpayment: Unidentified New/Accrued Receivables (line 2) H751B Part A – SMI Principal Provider Overpayment: Unidentified New/Accrued Receivables (line 2)	Response incorporated
SCBF98-13	H751B Part B – New/Accrued Receivables (line 2) – Part B & DMERC Estimated Receivables	Response incorporated
SCBF98-14	H751B Part B – MR/UR: Reclassified/Adjusted Amounts (line 5a)	Response incorporated
SCBF98-15	**Finding Referred to E & Y EDP Review Team**	**REFERRED 12/11/98**

HCFA Central Office

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Number:	SCBF97-01
Subject:	Review of Interim Calculations for Non-Claim Cash Disbursements and Withholdings
Condition:	**Results of Original Testing for Quarter 1 Activity:** The review included 30 sampled non-claims disbursements and withholding amounts in Quarter 1. These disbursements could have arisen from any possible non-claims scenario for that quarter. Each sample was examined for supervisory review, prior to inclusion in the shared system. Lack of supervisory reviews were noted in 14 of 30 non-claim items shown in the following disbursements and withholdings: • 10 Interim Calculations for PIP Payments • 2 Pass Through Bad Debts • 1 Interim Calculation for rate review for Non-PIP provider. • 1 Non-Claims Disbursement for Final Settlements Exceptions were also noted in prior year's audit and a finding made. In response to those exceptions, the Contractor has stated that they changed their policies and procedures as of September 1, 1998. **Results of Additional Testing for September 1998 Activity:** Five additional items were selected from non-claims activity that occurred in the last two weeks of September. These items were then examined for the supervisory review. Three of 5 additional items examined were created prior to September 1, 1998. As the PIP, Pass Through Payments, and Settlement Withholding were created prior to September 1, 1998 they would not have been subject to the new policies and procedures. • 2 PIP & Pass Through Payments • 1 Settlement Withholding This testing indicates that although policies and procedures may have been incorporated and in place by September 1, 1998, they did not apply to all non-claims withholdings and disbursements made in September. Withholdings and Disbursements amounts may have been created earlier in the year. Therefore, the 1998 FYE CFO report contains the majority of calculations that were not subject to review. Furthermore, we reviewed of a sample of the first PIP payment made in October 8 (for Gulf Coast Providers) and October 9 (for South Carolina Providers). There were 20 items sampled. Of these 20 items only 3 were subject to the new PGBA policy in effect September 1, 1998. Of these three all had evidence of supervisory review. The policies and procedures for supervisory reviews have been obtained and it appears that PGBA has begun the necessary corrective actions to implement supervisory reviews of all interim calculations.

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Cause:	The Contractor's previous policy was not to perform a supervisory review for all PIP calculations or tentative settlements. Senior or supervisory staff routinely reviewed only those calculations performed by inexperienced personnel. The Contractor relied upon other procedures to ensure the reviews are accurate and reliable. These include performing internal sample reviews on an annual basis and transaction letter reviews (for completeness and accuracy).
Criteria:	Supervisory review should be performed on all settlements and interim rate reviews to ensure accuracy.
Effect:	By not performing these reviews for eleven months of the year, there was an increased likelihood the individual providers' interim or lump sum payments or withholdings could have been misstated due to errors generated during the calculation. As PGBA has installed new supervisory review policies and procedures, it does not appear that this will be a problem in the future.
Contractor Response:	Additional funding was secured and supervising positions were approved on June 24, 1998. Effective September 1, 1998, all rate review functions and other reimbursement transactions will be reviewed. We ask that this area be reviewed again as part of the year-end testing.

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Number:	SCBF97-02
Subject:	Timely Recording of Receipts
Condition:	Upon testing receipts, it was determined that 5 of 30 receipts were not posted to the subsidiary ledgers in a timely manner. Exceptions noted are: • 4 MSP receivables • 1 Tentative Settlement, which accompanied the cost report submitted by the provider.
Cause:	This is a repeat finding from the prior year as it relates to MSP Liability receivables. Contractor did not have any subsidiary ledgers in prior year, but created Excel spreadsheets (in March 1998) to use in tracking MSP Liability receivables. No MSP receivables were recorded prior to this date. The more recent receivables were recorded later than usual due to the backlog of MSP receivables that had to be originally input into the Spreadsheets. Therefore it took longer than usual for all receivables to be recorded after the ledger was created. In relation to the Tentative Settlement Overpayment, it appears that the provider changed names during this time period. As the deposit was made by Best Home Care and the Receivable was in the name of United House Call Inc, it is believed that the Contractor did not properly associate the two provider names as one in the same.
Criteria:	General Accounting Office Standards for Internal Controls state that transactions should be promptly recorded, properly classified, and accounted for in order to prepare timely accounts and other reports.
Effect:	The information reflected in the system does not reflect all available data. Accounts receivable at year-end may be overstated, because the receivable numbers do not represent monies that may have been submitted by the providers and already deposited.
Contractor Response:	<u>MSP</u> Palmetto GBA has revised its departmental procedure to ensure accurate and prompt posting of any and all checks received by the Part B Medicare Secondary Payer Department. Checks are posted upon receipt into the department rather than at the time they are researched and applied. This procedure makes that timely posting of checks independent of aged inventories. This new procedure was implemented July 20, 1998 <u>Medicare Audit and Reimbursement</u> Response (45-7107, as filed overpayment) The provider had a change of ownership on 6/1/97. Because of this change of ownership, the provider filed a cost report for the period 7/1/96 – 5/31/97. When we receivec their 5/31/97 cost report, we had not received a HCFA tie in notice identifying this change of ownership. The $150 check that was sent with the cost report was deposited but the overpayment was not initially set up pending research of the change of ownership. The issue was later resolved and the overpayment was set up on FSS. However, FSS automatically started withholding future payments, collecting the amount of the overpayment. Since the check was never applied to the actual overpayment, we refunded the amount that was withheld automatically by FSS. To prevent this from happening in the future, we are now verifying that each deposited check has been applied accurately.

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Number:	**SCBF98-02 – ALSO A CENTRAL OFFICE FINDING**
Subject:	MSP Stale Accounts Receivables
Condition:	There appears to be a significant dollar amount of receivables in the greater-than-one-year category on the M751 delinquent aging report.
Cause:	Contractors are not authorized to write-off outstanding MSP receivables, per HCFA regulations. Therefore, PGBA is following HCFA policies and directives related to MSP receivables by not writing off stale account receivables.
Criteria:	HCFA requires that Contractor's maintain all outstanding receivables, regardless of age. It appears that many older receivables should be considered for write off or transferred to HCFA RO.
Effect:	Due to the significant age of many of the MSP receivables, the ultimate collectibility of a significant portion may not occur.
Contractor Response:	On August 25, 1998, Palmetto Government Benefits Administrators (Palmetto GBA) provided to Clifton Gunderson copies of HCFA's policies applicable to closing old non-data match and data match files. Palmetto GBA is in full compliance with current HCFA instructions and guidance on this issue. Per Clifton Gunderson and HCFA Central Office (CO) this finding will be removed from the contractor level and taken to the CO level where it will be addressed.

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Number:	**SCBF98-03**
Subject:	Timely Deposit of Checks Received
Condition:	Seven of 30 receipts (checks) tested were not deposited in a timely manner. Exceptions noted are: • 4 Tentative Settlement Receipts (7, 8, 8, and 8 day time lags) • 1 Overpayment Receipt (8 day time lag) • 2 Credit Balance Receipts (4 and 15 day time lag)
Cause:	Although Providers and Beneficiaries are instructed to mail all checks to Government Finance, this does not always occur. When a department other than Government Finance does receive a check it appears that the check may not be found the day mail is opened. For example it may be slipped between several pages of a cost report. If this occurs a time lag occurs between the actual date of receipt of the check and the conveyance of this check to Government Finance. Furthermore, checks may be received in locations other than South Carolina. When this occurs, checks are mailed to South Carolina so that Government Finance has control over the entire deposit population.
Criteria:	Per HCFA regulations (Medicare Intermediary & Carrier Manuals): checks that are greater than or that accumulate to greater than $1,000 are to be deposited on a daily basis.
Effect:	Accounts Receivables may be misstated.
Contractor Response:	Providers are instructed to send their checks directly to Government Finance. The majority of checks are sent to the correct department and are immediately deposited. For checks received in the Medicare Reimbursement area, we have controls in place to safeguard the check while it is in our possession. These controls include logging the check and transferring it in a lock bag. For the six checks identified that were not deposited within 24 hours of receipt, the deposit was delayed because of research being performed. We have changed our procedures to ensure that the deposit is not delayed by researching the check. All checks received Medicare Reimbursement will be sent to Government Finance promptly. While this will improve the deposit time, checks received in a department other than government finance may not be deposited within 24 hours of receipts. Additional efforts will be made to educate the providers to send their checks directly to Government Finance. Palmetto GBA is currently developing improved policies and procedures to expedite the delivery of checks (improperly delivered to Palmetto GBA units) to Government finance for deposit. The target date of implementation is by November 1998.

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Number:	**SCBF98-05**
Subject:	Use of Unauthorized Identification Codes
Condition:	Identification Codes from a previous employed person are still being used on the Provider Overpayment Report (POR) System. There are only two Identification Codes utilized in the Overpayment Area. One of the Identification Codes is for the supervisor and the other is for an old employee. In addition, employees do not have their own ID codes to log on the system. PGBA has tried several times over the year to correct this problem by working with a systems specialist.
Cause:	The system does not distinguish which employee is logging into the various screens to ensure limited access is being allowed.
Criteria:	Identification Codes for old employees should be deleted. In addition, PGBA employees should have individualized ID codes to log on the system to ensure duties are segregated.
Effect:	Without ID codes and periodically changed Identification Codes, some employees could have access to system functions and data beyond the scope of their job function.
Contractor Response:	Duties are segregated to ensure that employees do not have access to system functions and data beyond the scope of their job function. Although the overpayment staff was sharing a password to the POR to ensure the POR was updated timely, only authorized staff had access to the POR. None of these staff members have access to the Florida Shared System, the source document used for the CFO reports. In addition to the segregation of duties between those who report and those who collect overpayments, separate staff reconcile the POR to the FSS. Thus any unauthorized POR transactions would be detected in the reconciliation process. Prior to the finding, we requested and received IDs for all employees and changed the password of the former employee to prevent unauthorized access to the POR. These Ids were not operational because HCFA had not granted the Ids access to the POR and had not provided the Ids with access to dial into HCFA. The Ids now have access to the POR and we are waiting on HCFA to grant the Ids access to dial into HCFA. We have also requested that HCFA delete the ID for the former employee. Once each employee has their own separate dial in access and separate Ids, we will have the ability to more readily identify which individual may be making inappropriate entries to the POR system. However, we currently have the ability to pinpoint individuals because each overpayment staff member is assigned specific providers. We would appreciate more timely response from HCFA in granting access and Ids. However, we feel there are sufficient controls in place and that this finding should be dropped, at least as it relates to Palmetto GBA.

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Number:	**SCBF98-06**
Subject:	Segregation of Duties
Condition:	Overlapping functions are being performed within the cash receipts area. The person who makes the deposit and prepares the deposit slip also receives the checks prior to a log being prepared.
Cause:	Because of lack of segregation of duties within the department, the person making the deposit receives all checks.
Criteria:	Functions should be separated to ensure the person making the deposit does not receive the checks initially without record of receipt.
Effect:	Checks can be misplaced or stolen without a record of receipt.
Contractor Response:	We agree with this finding. We have implemented a change in procedures effective 08/25/98 so that two of the people in the area who prepare the logs will be responsible for sorting the mail between lines of business and distributing it to all those that log checks. This will prevent the person making the deposit from handling the checks prior to a record of a receipt and provide for proper segregation of duties.

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Number:	**SCBF98-07**
Subject:	Cash Disbursements Area Cycle Memo – Segregation of Duties
Condition:	Within the process of disbursing checks, manual checks are sometimes used. Generally, no more than five manual checks are either typed or manually fed through a printer. During our observation, a manual check was printed and signature stamped by the same person.
Cause:	Adequate procedures related to the segregation of duties for the custody of manual checks and the signing of manual checks are the policy of Palmetto GBA. However due to new personnel, the control procedures are not always followed. The Palmetto GBA employee with possession of the signature stamp was able to obtain manual checks to print and sign.
Criteria:	The Contractor should ensure that the employee with custody of manual checks cannot also print and sign manual checks.
Effect:	Without adequate control of the signature stamp and manual checks, unauthorized checks can be produced.
Contractor Response:	We agree with this finding. On the day of this audit, the team leader did obtain two checks from another associate. She typed them and stamped them with the signature stamp. We did have controls in place to ensure proper segregation of duties; however, this was a one time occurrence due to urgency. We will continue to ensure the proper procedures are in place and followed.

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Number:	**SCBF98-08**
Subject:	MSP Allowance for Doubtful Accounts for Part B and A
Condition:	**Medicare MSP Part B:** PGBA has recorded in the CFO report an estimated allowance that is approximately 65% of the ending balance for this component. The average collectibility of receivables for MSP part B has averaged 5% over the past four years. Thus the allowance portion does not appear to be large enough to reduce accounts receivable to the estimated net realizable value. **Medicare MSP Part A:** PGBA has recorded in the CFO report an estimated allowance that is 40% of the ending balance for this component. The average collectibility of receivables for MSP Part A HI has averaged about 9% and SMI has averaged about 5%. Thus the allowance portion does not appear to be large enough to reduce the accounts receivable to the net realizable value.
Cause:	There are no specific guidelines from HCFA as to how to calculate the allowance for doubtful accounts estimate. Therefore, the separate departments have devised their own methods as follows: **Medicare MSP Part B:** The Part B component uses the number of delinquent receivables that are greater than one year old as the allowance account. Receivables in this category make up more than half of the outstanding receivables. While this does reduce the net realizable value of the account receivable, it does not take into consideration the current portion of receivables that appear uncollectible based on historical analysis of collections. Thus, the collectibility of receivables in all aging categories is not being considered. **Medicare MSP Part A:** The Part A component uses the following method to calculate its allowance for doubtful accounts: $\text{Allowance for Doubtful Accounts} = \frac{\text{Reclassified Receivables}}{\text{Requested}} \times \text{Outstanding}$ This appears to be a reasonable theoretical approach to calculating the allowance, since there are no other guidelines. However, there is a large portion of MSP receivables greater than one year old, which is not taken into consideration by this calculation. The allowance is less than the total delinquent receivables that are greater than one year old. It is does not appear reasonable to state that an MSP case this old would be potentially recovered, due to the nature of a MSP receivable and the historical collectibility rate.
Criteria:	The allowance for doubtful accounts is estimated to reduce the gross receivable amount to a net realizable value. The method for estimating the allowance should consider the historical trend of previous cash collections on MSP receivables.

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Effect:	The allowance for doubtful accounts appears understated For MSP Part B & A
Contractor Response:	Palmetto GBA believed the calculations to be accurate based on limited HCFA instruction. Beginning with the quarter ending December 31, 1998, Palmetto GBA will estimate the uncollectible accounts using a methodology based on actual cash receipts. Palmetto GBA believes, however, that HCFA should provide clearer definitions and instructions for calculating uncollectibles, especially those related to data match cases.

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Number:	**SCBF98-09**
Subject:	M751A Part A – HI Subrogation: Unidentified New/Accrued Receivables (line2) M751B Part B – SMI Subrogation: Unidentified New/Accrued Receivables (line 2)
Condition:	New/Accrued Receivables (Line 2) is incorrect for both of these reports, due to a mathematical error. The reported amount on the M751A is $365,996.26, but the detailed amount on the spreadsheet was $405,551.92. This produced an understatement of New receivables in the amount of $39,555.66. The reported amount on the M751B is $22,732.20, but the detailed schedule on the spreadsheet is $23,058.69, which is a variance of $326.49.
Cause:	A mathematical error in the spreadsheet used to track these receivables.
Criteria:	Detailed records should accurately support all lines in the M751A. Any reconciling items should be specifically identified to the appropriate receivable.
Effect:	M751A Part A & M751B Part B: New receivables (line 2) are understated, the ending balance, however, appears reasonably supported.
Contractor Response:	As previously reported, Palmetto GBA implemented a new Excel spreadsheet for the reporting of liability financial data effective March 1998. An updated spreadsheet was implemented October 1, 1998, to enhance the report and correct minor formula and calculation errors. Palmetto GBA does not anticipate a repeat of this error.

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Number:	**SCBF98-10**
Subject:	M751A Part A – HI Subrogation: Unidentified Reclassified/Adjusted Amounts (line 5a)
Condition:	The reclassified/adjusted amount is not supported by a detailed report depicting each receivable.
Cause:	To better report financial data for the CFO report, Medicare Part B MSP Subrogation has developed a new reporting system using an excel spreadsheet. Because of obstacles inherent in implementing a new system, the ending balance from the prior year did not match the beginning balance as reported on the excel spreadsheet, after all data had been entered. To reconcile the beginning balances, an adjustment was calculated and included in line 5a of the M751A. The ending balance appears reasonable and properly supported by the new system by detailed account receivable balances. Therefore, the unidentified adjustment necessary this year will create a reliable ending balance that will carry forward to a reliable beginning balance for FYE 99. It does not appear that this unidentified variance will occur in future years.
Criteria:	Detailed records should accurately support all lines in the M751A. Any reconciling items should be specifically identified to the appropriate receivable.
Effect:	M751A Part A: Reclassified/Adjusted Amounts (line 5a) are not properly supported, the ending balance, however, appears reasonably supported.
Contractor Response:	As noted in our SCBF98-09 reply, Pt. B MSP developed a new Excel spreadsheet to track and record liability AR activity effective March 1, 1998. The initial spreadsheet was more complex and labor intensive than necessary and had some minor calculation errors. This resulted in the rewrite of the Excel spreadsheet. When converting data from the old spreadsheet to the new spreadsheet, corrected formulas resulted in some changed financial data. An adjustment was made accordingly. The adjustment figure was not documented to the applicable receivables. The ending balance is accurate and is properly supported by the new spreadsheet. This error was a direct result of the conversion and Palmetto GBA does not anticipate a reoccurrence of the error.

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Number:	**SCBF98-11**
Subject:	M751B – Part B: Unidentified Reclassified/Adjusted Amounts(line 5A)
Condition:	Per examination of the three items that makes up the M751B Part B MSP portion, an unidentified adjustment was found for each item, which is depicted as follows: **Overpayments:** Current period transactions are tracked on the "Monthly Status of Receivables Report." The ending balance is derived from the 279 reports. A variance in the ending balance for the two reports is calculated and included in Reclassified/Adjusted Amounts (line 5a). **Subrogation:** Current period transactions and the ending balance amounts are tracked on an excel spreadsheet. An unexplained variance exits and is included in Reclassified/Adjusted Amounts (line 5a). **Datamatch:** Current period transactions are tracked on the "LT, LW, LC, A0, & B0 Medicare Part B and DMERC reports." The ending balance is derived from the YP reports. A variance in the ending balance for the two reports is calculated and included in Reclassified/Adjusted Amounts (line 5a). The variance in Datamatch appears to be the most significant, as it makes up $451,680.09 of the total unexplained variance of $451,844.40 for September 1998.
Cause:	It appears that the separate reports printed for the current period transactions and the ending balance do not print similar information, relative to Overpayments and Datamatch. For Subrogation, no reason can be identified for the variance.
Criteria:	Detailed records should accurately support all lines in the M751B. Any reconciling items should be specifically identified to the appropriate receivable.
Effect:	M751B Part B: Reclassified/Adjusted Amounts (line 5a) is not properly supported, though the ending balance does appear to be properly supported by detailed records.
Contractor Response:	All reports utilized for the M751B - Pt. B MSP financial data are not generated from VMS; however, Palmetto GBA concurs that it should produce the necessary data to document line 5a. Given consideration for Y2K system activity, every effort will be made to make the necessary modifications to produce the desired detail no later than the second quarter of FY 1999. It should be noted that while researching this finding, Palmetto GBA identified that the Data Match amounts were incorrectly compiled and the September 1998 Data Match adjustment of $451,680.09 was reduced to $1,013.96. The ending balance however remained the same. Updated procedures and additional controls will be implemented by December 18, 1998, to ensure that this error does not reoccur.

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Number:	**SCBF98-12**
Subject:	H751A Part A - HI Principal Provider Overpayment: Unidentified New/Accrued Receivables (line 2) H751B Part A - SMI Principal Provider Overpayment: Unidentified New/Accrued Receivables (line 2)
Condition:	An audit trail report was obtained from the FSS system that supported the current period transactions including the following components: new balances, collections, adjusted/reclassified, waivers, and amounts written-off/transferred. When this information is combined with the beginning balances, the resulting ending balance is not correct. A spreadsheet was prepared by PGBA that contains the ending balance. This spreadsheet contains all the information from the FSS system report "Outstanding Accounts Receivable" less the Receivables that were not accepted from the Gulf Coast Region. This report contains the true ending balance for FYE 9/30/98. PGBA calculates the difference and places this amount into New/Accrued Receivables (line 2) as they strongly believe that the audit trail report did not pull into the report new receivables that were keyed into FSS after the end of the month for the prior months. (see further explanation below)
Cause:	It appears that FSS prints the audit trail report by specific definitions related to the period ending dates, not the key-entry date. For example, if a receivable was determined to be in existence for June 26 and not keyed into FSS until July 1, then the activity will not be included in the June audit trail report. When the July report is printed it will not be included because the activity does not relate to the month of July. Therefore this activity is not included in the audit trail report. It is however included in the outstanding report, if the ending balance of the receivable does exist for that period. PGBA has taken measures to identify each of these transactions that have not been included in the audit trail reports. Due to the sheer volume of the number of transactions that must be examined it is very time consuming. As of 11/10/98 the calculated receivables related to the timing difference above have been narrowed down to the following amounts: HI: $4,961,450.00 SMI: $484,227.91
Criteria:	Detailed records should accurately support all lines in the H751A. Any reconciling items should be specifically identified to the appropriate receivable.
Effect:	H751A HI: New receivables (line 2) may be misstated H751A SMI: New receivables (line 2) may be misstated Even though these line items do not contain complete support, the ending balance appears fairly stated and supported by the proper identified receivables.

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Contractor Response:	Palmetto GBA identified $16,033,342 new HI receivables and ($2,068,197.74) new SMI receivables that were not included on the audit trail report for the quarter ending September 30, 1998. We will continue to identify transactions excluded from the audit trail report. In an attempt to identify new receivables excluded from the audit trail report, we will reconcile new receivables on the audit trail report to the POR on a monthly basis. This reconciliation will be in addition to the ending balance reconciliation currently performed between the Florida Shared System (FSS) and the POR. By reconciling new receivables between the FSS audit trail report and the POR for October 1998, we identified $38,457,836 HI and $1,008,624 SMI receivables that were not included on the audit trail report. The majority of these receivables were cost report final settlements that were dated on October 31, 1998, and not keyed to the FSS until the first week of November. Also, we will submit a request to the Florida Shared System to create a new report which will capture all transactions needed for the HCFA 750/751 reports.

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Number:	**SCBF98-13**
Subject:	H751B Part B – New/Accrued Receivables (line 2): Part B & DMERC Estimated Receivables
Condition:	Medicare Part B and DMERC Non-MSP components both include an accrual for work in progress at the end of each reporting period. This accrual is added to new receivables each quarter while the prior quarter's accrual is removed from the reclassified/adjusted (line 5a) row. The estimate has been between 4% and 10% of the ending balance. This accrual is based on multiplying the average dollar per receivable by the average number of cases pending at the end of the month. Although, this appears to be a reasonable method to determine the accrual estimate, no subsequent comparison of the actual receivables resulting from the pending cases is performed. As such, it is not known how closely this estimate approximates pending receivables. Because this estimate has varied between two million and five million dollars in the four quarters for FYE 9/30/98 this could potentially misstate receivables.
Cause:	An estimate is used that has not been tested or reviewed for propriety.
Criteria:	Estimated receivables should be compared to actual to determine if the estimate is working properly.
Effect:	H751B Part B – New/Accrued Receivables (line 2) – may be misstated.
Contractor Response:	The protocol for estimating accounts receivable contained in the instructions for submitting the HCFA 750/751 reports do not state that estimated receivables should be compared to actual to determine if the estimate is working properly. The protocol states that the amounts recorded may be estimated on actual volumes and historical rates; therefore, a new estimated liability will be calculated and accrued each reporting period and the accrual for the previous period will be reversed in full. The protocol contains additional procedures for intermediary to calculate the average reimbursement rate on a representative sample of the most recent 12 months. No additional procedures are provided for calculating average reimbursement rates for carriers or DMERC's. In calculating the estimate receivables, we determine the average receivable amount by dividing the total receivable dollar amount for the current month by the total receivable cases for the current month. Since the average reimbursement amount is based on actual data, we do not feel additional validation is necessary. Also, we feel that since this is an estimate it would not be feasible to validate a number that will fluctuate from claim to claim. We request that this finding be deleted since we have computed our estimate based on actual data and in accordance with instructions.

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Number:	**SCBF98-14**
Subject:	H751B Part B – MR/UR: Reclassified/Accrued Receivables (line 5A) – Estimated Receivable
Condition:	Upon examining the support for the estimate used by PGBA for the MR/UR Post Pay for DMERC accounts receivable, a manual counting error was made. This error was carried into the calculation. PGBA recalculated the estimate after the filing of the September 30, 1998 CFO report and the determined variance is: Originally reported: $21,735.00 Recalculated amount: $18,637.79 Understated amount: ($ 3,097.21)
Cause:	The estimate is based on two manual counts of the number of VMS System entry's made in processing CMRs and FMRs. One entry is made to create the letter informing the provider that a medical review is going to take place on the claim(s) indicated. This letter requests specific information necessary to complete the review. The second letter informs the provider of the case results. The progress of these cases is tracked manually on departmental PCs. During this procedure it appears that a counting error was made for the quarter ending 9/30/98. As the counts are not reviewed by another person the error was not detected until further inquires were made. The department recognizes the elevated likelihood of errors due to the high amount of human reliance without review. They have begun to examine the possibility of using the computer system to perform these counts systematically to reduce a similar result in the future.
Criteria:	Controls should be in place to ensure that all components used in calculating estimates are correct.
Effect:	H751B Part B – MR/UR: Reclassified/Accrued Receivables (line 5A) – is overstated.
Contractor Response:	Prior to this finding the process for compiling the MR/UR Data for entry to the Quarterly CFO Estimates of Liability was, for the most part, a manual process. Each clinician conducting a CMR or FMR would track and record the data individually. At quarter end the clinicians submitted the collected data which was then manually tabulated and a report generated. The reported data was used to calculate the MR/UR Post pay Estimate. We have taken steps to minimize the human error in collecting and compiling this data. The focus of this effort is to have a single clinician responsible for the entry of tracking data into a single PC system that will systematically compile monthly and quarterly data. A new departmental desk procedure has been developed that details these new procedures. Data will be compiled and checked monthly as well as quarterly. In addition, a supervisory review of the reported data will be conducted prior to its submission for entry to the CFO calculations.

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	Corrective Action Summary: 1. Single system for data entry. 2. Single clinician responsible for compilation of the data. 3. Three levels of review, e.g.: • Individual clinician conducting the Reviews • Single clinician for data entry and tabulation • Supervisory Review prior to CFO estimate calculations 4. Revised departmental procedure detailing the above. 5. Data checked Monthly as well as Quarterly.