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

JUN 9 1999

CIN: A-04-99-03012

Mr. Curtis W. Lord
President and CEO
First Coast Service Options, Inc.
532 Riverside Avenue
Jacksonville, Florida 32202

Dear Mr. Lord:

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 the Health Care Financing Administration's Fiscal Year 1998 Financial Statements at First Coast Service Options, Inc.* Also, we forwarded a copy of this report to the action official named below for his/her review and any action deemed necessary.

The Department of Health and Human Services 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-04-99-03012 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

BBA	Balanced Budget Act of 1997
FCSO	First Coast Service Options, Inc.
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CIN	Common Identification Number
DMERC	Durable Medical Equipment Regional Carrier
E&Y	Ernst & Young
EDP	Electronic Data Processing
ESRD	End Stage Renal Disease
FCSO	First Coast Service Options, Inc
FI	Fiscal Intermediary
FY	Fiscal Year
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Health and Human Services
HI	Hospital Insurance
IG	Inspector General
MCM	Medicare Carriers Manual
OAS	Office of Audit Services
OIG	Office of Inspector General
OMB	Office of Management and Budget
PPS	Prospective Payment System
PRO	Peer Review Organization
RHHI	Regional Home Health Intermediary
SMI	Supplementary Medical Insurance
SNF	Skilled Nursing Facility

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EXECUTIVE SUMMARY

BACKGROUND

The Health Care Financing Administration (HCFA), an agency of the U.S. 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), carriers, durable medical equipment regional carriers (DMERC), regional home health intermediaries (RHHI), and peer review organizations (PRO). First Coast Service Options, Inc. (FCSO) serves as both the FI and carrier for the State of Florida.

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 financial statements to the U.S. Office of Management and Budget (OMB). These financial statements should 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 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 (BBA) 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 the statements' 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 U.S. Code of Federal Regulations (42 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.

Our audit procedures have been designed exclusively for Medicare claims-based fee-for-service benefit payments expenses. A separate audit approach for non-claims-based benefit payments was also developed for use by independent auditors under contract with the Office of Inspector General (OIG). The audit is to be performed in accordance with generally accepted government auditing standards.

SUMMARY OF FINDINGS

We selected a stratified random sample of 50 beneficiaries for whom FCSO had adjudicated 818 claims during the first quarter of FY 1998 -- our audit period. The FCSO paid $393,777 for these claims. With the assistance of FCSO and PRO medical review personnel, we identified overpayments totaling $10,105 for these claims. The overpayments occurred for various reasons, including insufficient documentation, incorrect coding of procedures, and lack of medical necessity. Complete listings of the errors with the reasons for the errors are provided in Appendices A and B to this report.

Independent auditors under contract with the OIG identified reportable conditions with respect to electronic data processing controls and non-claims activities. These reports have been presented to FCSO (see Appendices C and D).

Recommendations

We recommend that FCSO:

- initiate recovery of the overpayments and periodically provide us with the status of recovery actions; and address the recommendations made by the independent auditors and provide us a copy of FCSO's responses with respect to EDP controls and non-claims activities.

Comments by BCBSFL

In their written response to our draft report, FCSO officials agreed with the overpayments identified in the report and have recovered 94% of those identified. They also stated that once they receive the format from HCFA for reporting the overpayments, they will begin reporting the recoveries. In addition, they stated they have, where appropriate, undertaken corrective actions on the recommendations/findings the independent auditors included in their draft reports regarding the EDP controls and non-claims activities.

INTRODUCTION

The objective of our review at FCSO was to test a sample of claims FCSO 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 is 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 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, carriers, DMERCs, RHHIs, 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 eligibles enroll in the SMI program.

The SMI program covers physician services as well as certain non-physician services including: clinical laboratory tests; durable medical equipment (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 allowed Part B services. The beneficiary is responsible for the remaining 20 percent as well as an annual deductible.

In FY 1998, FCSO as both FI and carrier, reported $8.452 billion in total funds expended on the HCFA Form 1522s for Medicare Part A and Part B. Of that amount, FCSO reported $2.072 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 financial statements to the U.S. OMB. These statements should 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 BBA, 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
- Reducing update factors for the Prospective Payment System (PPS)
- Modifying the Graduate Medical Education policies by providing incentives to decrease the number of medical residents
- Reducing payment levels for private plans
- Introducing new plans Medicare beneficiaries may choose from instead of the traditional system, including:

    - medical savings accounts;
    - provider sponsored organizations;
    - unrestricted fee-for-service; and
    - a reduction in the variations of payments to plans in different parts of the country.

The BBA 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 the statements' 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 U.S. CFR (42 CFR). Specifically, we were to perform substantive tests on claims FCSO 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 performed our review from July 1998 to February 1999 at the FCSO offices in Jacksonville, Florida and the OIG offices in: Jacksonville, Florida; Birmingham, Alabama; Atlanta, Georgia;

Boston, Massachusetts; Baltimore, Maryland; and various provider offices in central and southern Florida. We provided FCSO officials copies of our draft report for their review on April 29, 1999 and invited them to comment on the report contents. The relevant comments are summarized after each finding and the comments are appended in their entirety to this report as Appendix E.

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 U.S. 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 FCSO, have complied with applicable laws and regulations.

In addition to our work, independent public accounting firms (Ernst & Young [E&Y] and Clifton Gunderson L.L.C.) contracted with HHS, OIG to review various matters collateral to our audit, including electronic data processing (EDP) controls and non-claims activities. The results of these reviews were reported separately to FCSO.

We relied on substantive tests of FCSO's adjudicated claims to determine the propriety of Medicare benefit payments expenses FCSO 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 FCSO was one of the quarters selected.

Our substantive testing universe consisted of $2,021,610,994 FCSO paid during the first quarter of FY 1998 for 13,801,809 claims for services provided to 1,998,189 beneficiaries. For the same period, FCSO reported a greater amount ($2,071,976,674) 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 $50,365,681 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. Other independent auditors under contract with OIG audited these non-claims activities.

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

The FCSO adjudicated 818 claims for the 50 beneficiaries. The 818 claims consisted of 108 FI claims and 710 carrier claims for which FCSO paid a total of $393,777 ($294,510 for FI claims and $99,267 for carrier claims).

After we identified the claims for the beneficiaries in the sample, we determined whether the claims were: (1) for covered services furnished by eligible providers to eligible beneficiaries; (2) reimbursed by FCSO in accordance with Medicare laws and regulations, and (3) medically necessary, accurately coded and documented in beneficiary medical records. To accomplish these objectives, we performed audit steps to verify:

- the FCSO included all payments in the monthly HCFA Form 1522 under the caption "Total Funds Expended This Month" for each month in the quarter;
- the providers and beneficiaries were Medicare eligible;
- Medicare was the correct primary/secondary payer;
- any coinsurance and deductible amounts were correct;
- the FCSO paid only once for a service (i.e., did not pay for duplicate claims); and
- the FCSO paid the correct amount to the providers and beneficiaries.

We obtained assistance from FCSO and Florida Medical Quality Assurance, Inc., (the Florida 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 - PPS;
- Hospital Inpatient - Non-PPS;
- SNF Inpatient;
- End Stage Renal Disease (ESRD);
- Hospital and SNF Outpatient;
- Ambulatory Surgery; and
- Part B Services Paid by Carriers, such as:
  - Physician Services;
  - Clinical Laboratories; and
  - Ambulance Services.

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 $10,105 in the sample of $393,777 of Medicare benefit payments. Other independent auditors under contract with OIG identified controls that FCSO needs to improve relative to certain controls and non-claim transactions.

SUBSTANTIVE TESTING RESULTS

With the assistance of FCSO and the Florida PRO, we identified overpayments totaling $10,105 ($7,637 in FI payments and $2,468 in carrier payments). We did not identify any 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 for 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, admissions, services furnished, diagnoses, treatments 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.

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 than that which was billed 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.

Recommendations

We recommend that FCSO initiate recovery of the overpayments and periodically provide us with the status of recovery actions.

RESPONSE BY FCSO OFFICIALS

The FCSO officials, in their written response to our draft report, agreed with the overpayments identified in the report and have recovered 94% of those identified. They also stated that once they receive the format from HCFA for reporting the overpayments, they will begin reporting the recoveries.

RESULTS OF WORK PERFORMED BY OTHERS

Ernst &Young and Clifton Gunderson L.L.C. contracted with OIG to review EDP controls and non-claims activities at FCSO. They issued a total of five reports containing findings and recommendations to management.

Four reports were issued to FCSO in August and September, 1998 addressing different aspects of the EDP review for FY 1998. They were: (1) Application Controls Review of the Common Working File; (2) Follow-Up EDP Controls Assessment (general controls); (3) Follow-Up Application Controls Review of the FSS; and (4) Application Development and Program Change Control at FSS Maintainer.

A fifth report was issued in January 1999 with findings covering non-claims activities. Generally, FCSO agreed with the findings in all the reports.

Recommendation

We recommend that FCSO address the recommendations made by the independent auditors and provide us a copy of FCSO's responses with respect to EDP controls and non-claims activities.

RESPONSE BY FCSO OFFICIALS

The FCSO officials, in their written response to our draft report, stated they have, where appropriate, undertaken corrective actions on the recommendations/findings the independent auditors included in their draft reports regarding the EDP controls and non-claims activities.

AUDIT OF HCFA'S FINANCIAL STATEMENTS
FOR FISCAL YEAR 1998
AT BLUE CROSS AND BLUE SHIELD OF FLORIDA
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 $7,625.98 by $223,922.38 resulted in a 3.41% error. These percentages are for informational purposes only regarding the claims in the sample. They cannot be used to derive any conclusions regarding Blue Cross Blue Shield of Florida's paid claims universe by type of claim.

TYPE OF CLAIM	DOLLARS REVIEWED	DOLLAR ERRORS IDENTIFIED	PERCENT OF ERRORS
Hospital Inpatient-PPS	$223,922.38	$ 7,625.98	3.41%
Hospital Inpatient-Non-PPS	$13,995.83	$ -0-	0.00%
SNF Inpatient	$41,789.84	$ -0-	0.00%
ESRD	$6,353.88	$-0-	0.00%
Hospital, SNF Outpatient	$6,597.77	$ 11.46	.17%
Ambulatory Surgery	$1,849.80	$ -0-	0.00%
SUBTOTAL	$294,509.50	$ 7,637.44	2.59%
Part B	$99,267.44	$2,467.76	2.49%
TOTAL	$393,776.94	$10,105.20	2.57%

AUDIT OF HCFA'S FINANCIAL STATEMENTS
FOR FISCAL YEAR 1998
AT BLUE CROSS AND BLUE SHIELD OF FLORIDA
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 3 by 29 resulted in a 10.34% error. These percentages are for informational purposes only regarding the claims in the sample. They cannot be used to derive any conclusions regarding Blue Cross Blue Shield of Florida's paid claims universe by type of claim.

TYPE OF CLAIM	CLAIMS REVIEWED	CLAIM ERRORS IDENTIFIED	PERCENT OF ERRORS
Hospital Inpatient-PPS	29	3	10.34%
Hospital Inpatient-Non-PPS	4	0	0.00%
SNF Inpatient	7	1	14.29%
ESRD	8	0	0.00%
Hospital, SNF Outpatient	56	1	1.79%
Ambulatory Surgery	4	1	25.00%
SUBTOTAL	108	6	5.56%
Part B	710	51	7.18%
TOTAL	818	57	6.97%

AUDIT OF HCFA'S FINANCIAL STATEMENTS
FOR FISCAL YEAR 1998
AT FIRST COAST SERVICE OPTIONS, INC.
JACKSONVILLE, FLORIDA

FISCAL INTERMEDIARY CLAIMS (BY LINE ITEM) WITH IDENTIFIED ERRORS

NO. OF CLAIMS	ICN	AMOUNT QUESTIONED	NO. OF SERVICES QUESTIONED	ERROR CODE	ERROR DESCRIPTION
1	19726801983005	$16.32	1.0	35	NON-COVERED SERVICE
2	19728211234304	$0.00	1.0	35	NON-COVERED SERVICE
2	19728211234304	$0.00	1.0	35	NON-COVERED SERVICE
3	19729002000705	$0.00	1.0	31	INCORRECTLY CODED
4	19730202472005	$11.46	1.0	16	NO DOCUMENTATION
5	19733503657805	$2,680.01	1.0	31	INCORRECTLY CODED
6	19733505380205	$4,929.65	1.0	25	MEDICALLY UNNECESSARY
TOTAL		$7,637.44	7.0		

AUDIT OF HCFA'S FINANCIAL STATEMENTS
FOR FISCAL YEAR 1998
AT FIRST COAST SERVICE OPTIONS, INC.
JACKSONVILLE, FLORIDA

CARRIER CLAIMS (BY LINE ITEM) WITH IDENTIFIED ERRORS

	ICN	AMOUNT QUESTIONED	NO OF SERVICES QUESTIONED	ERROR CODE	ERROR DESCRIPTION
1	4072865211900	$8.75	1.0	31	INCORRECTLY CODED
2	4272962531200	$44.47	1.0	31	INCORRECTLY CODED
3	5072592047200	$27.49	1.0	31	INCORRECTLY CODED
4	5072656972500	$42.20	1.0	31	INCORRECTLY CODED
5	5072748344200	$15.13	1.0	31	INCORRECTLY CODED
6	5072818042600	$7.21	1.0	25	MEDICALLY UNNECESSARY
7	5072836865900	$42.20	1.0	31	INCORRECTLY CODED
8	5072886333900	$0.00	1.0	90	OTHER ERRORS
9	5072906071300	$51.47	1.0	31	INCORRECTLY CODED
10	5072961436500	$28.50	1.0	21	INSUFFICIENT DOCUMENTATION
11	5073027012100	$28.03	1.0	16	NO DOCUMENTATION
11	5073027012100	$27.84	1.0	31	INCORRECTLY CODED
12	5073046351000	$22.78	1.0	21	INSUFFICIENT DOCUMENTATION
12	5073046351000	$110.07	1.0	31	INCORRECTLY CODED
13	5073087633000	$193.65	1.0	31	INCORRECTLY CODED
14	5073116263900	$15.34	1.0	31	INCORRECTLY CODED
15	5073151664300	$9.21	1.0	25	MEDICALLY UNNECESSARY
15	5073151664300	$9.21	1.0	25	MEDICALLY UNNECESSARY
15	5073151664300	$9.21	1.0	25	MEDICALLY UNNECESSARY
16	5073183872600	$40.68	1.0	31	INCORRECTLY CODED
17	5073227131900	$12.36	1.0	31	INCORRECTLY CODED
17	5073227131900	$7.34	1.0	60	UNBUNDLING
18	5073227952200	$15.34	1.0	31	INCORRECTLY CODED
19	5073298007400	$15.34	1.0	31	INCORRECTLY CODED
20	5073373915000	$15.13	1.0	31	INCORRECTLY CODED
20	5073373915000	$15.13	1.0	31	INCORRECTLY CODED
20	5073373915000	$15.13	1.0	31	INCORRECTLY CODED
21	5073498721900	$28.66	1.0	16	NO DOCUMENTATION
22	5073505346100	$15.34	1.0	31	INCORRECTLY CODED
23	5073507684700	$33.22	1.0	31	INCORRECTLY CODED
24	5073537265400	$26.86	1.0	31	INCORRECTLY CODED
25	5172541030200	$137.80	1.0	16	NO DOCUMENTATION
26	5172812240600	$3.59	1.0	21	INSUFFICIENT DOCUMENTATION
27	5172826394400	$185.84	1.0	41	SERVICES NOT RENDERED
28	5172961236000	$161.64	3.0	16	NO DOCUMENTATION
28	5172961236000	$30.26	2.0	31	INCORRECTLY CODED
29	5172961236100	$83.92	1.0	31	INCORRECTLY CODED
30	5173040322000	$40.10	1.0	90	OTHER ERRORS
31	5173107086600	$61.77	1.0	31	INCORRECTLY CODED
32	5173156584600	$26.70	1.0	31	INCORRECTLY CODED
33	5173363632400	$15.34	1.0	31	INCORRECTLY CODED
34	5173366173400	$59.07	1.0	16	NO DOCUMENTATION
34	5173366173400	$59.07	1.0	16	NO DOCUMENTAITON
35	5173453713500	$75.58	1.0	41	SERVICES NOT RENDERED
36	5173490423100	$53.88	1.0	16	NO DOCUMENTATION
36	5173490423100	$30.35	1.0	31	INCORRECTLY CODED
37	5173533611800	$81.82	2.0	21	INSUFFICIENT DOCUMENTATION
38	5272740497400	$40.88	1.0	31	INCORRECTLY CODED
39	5272974422000	$14.47	1.0	25	MEDICALLY UNNECESSARY
39	5272974422000	$14.47	1.0	25	MEDICALLY UNNECESSARY
40	5273001894400	$59.07	1.0	16	NO DOCUMENTATION
41	5273021021900	$12.36	1.0	31	INCORRECTLY CODED
42	5273022343600	$42.65	1.0	16	NO DOCUMENTATION
43	5273080681200	$12.36	1.0	31	INCORRECTLY CODED
43	5273080681200	$12.36	1.0	31	INCORRECTLY CODED
43	5273080681200	$12.36	1.0	31	INCORRECTLY CODED
44	5273080683600	$26.39	1.0	21	INSUFFICIENT DOCUMENTATION
45	5273110963500	$12.36	1.0	31	INCORRECTLY CODED
46	5273141715400	$26.86	1.0	31	INCORRECTLY CODED
47	5273152353400	$15.34	1.0	31	INCORRECTLY CODED
48	5273222495000	$12.36	1.0	31	INCORRECTLY CODED
49	5273224631400	$36.92	1.0	31	INCORRECTLY CODED
50	5273234000000	$42.65	1.0	16	NO DOCUMENTATION
51	5273251546200	$53.88	1.0	16	NO DOCUMENTATION
		$2,467.76	68.0		

January 28, 1999

Ms. Patricia A. Williams
Vice President
Government Programs Operations A/B
Blue Cross Blue Shield of Florida, Inc.
532 Riverside Avenue
Jacksonville, Florida 32202

Dear Ms. Williams,

The independent public accounting firm of Ernst & 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 (BCBS) of Florida, Inc. The reviews and the times conducted are as follows:

- CWF application controls review, August 10-21, 1998. BCBS of Florida is one of several CWF host sites. The E&Y team audited the application controls of CWF as implemented at a production CWF host site.

- Follow-up general controls review at the claims processing data center, August 10-14, 1998. BCBS of Florida had a SAS70 during fiscal year 1997. The E&Y team conducted a follow-up on the status of prior year EDP controls issues.

- Follow-up of the Florida Shared System (FSS) application controls review, August 10-21, 1998. The FSS application controls were reviewed at Health Care Services Corporation and at BCBS Florida during FY 1997. The follow-up review will only be conducted at BCBS of Florida.

- FSS application development and program change controls review, August 17-21, 1998. The BCBS of Florida is the systems maintainer or developer of the FSS.

We have enclosed our final reports which incorporate the findings and recommendations resulting from E&Y's review and BCBS of Florida's formal management responses.

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 reviews without the excellent cooperation extended by your staff.

Ms. Patricia A. Williams - Page 2

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
Director, Audit Operations &
Financial Statement Activities

Enclosures

cc: Lamar James, Audit Coordinator
Rick Davis, Corporate Financial Analyst

United States Department of Health and Human Services
Management Letter Comments

Application Controls Review
of the Common Working File
at
Blue Cross Blue Shield of Florida

August 1998

Final Report

Ernst & Young (E&Y) LLP has completed their application controls review of the Common Working File (CWF) at Blue Cross Blue Shield of Florida (BCBSF), located in Jacksonville, Florida. This review was intended to evaluate the CWF application controls at BCBSF 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 for the year ended September 30, 1998.

E&Y performed their review from August 10, 1998 - August 21, 1998. Their procedures included interviews with key BCBSF 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.

Application control areas tested and related findings are listed below:

A. General Controls Specific to the CWF

CWF-E-98-01 Inappropriate Individuals Have Access to CWF Data and Programs

CWF-E-98-02 CWF Programmers Have Alter Access to CWF Production Data

CWF-E-98-03 No Assurance that CWF Host Sites Beneficiary Database is Concurrent with HCFA Master Beneficiary Database (This issue was dropped.)

CWF-E-98-04 No Assurance that Confidentiality of Data is Maintained over Advantis Network. (This issue was dropped.)

B. Input Controls

No exceptions noted

C. Processing Controls

No exceptions noted

D. Output Controls

No exceptions noted

A. General Controls

CWF-E-98-01. Inappropriate Individuals Have Access to CWF Data and Programs

Condition
Inappropriate individuals have access to CWF data. Specifically, four transferred/terminated employees have 'alter' access to CWF production data and programs. Additionally, 47 Production and Change Control personnel and 39 Technical Services personnel have 'alter' access to CWF production data and programs.

Cause
CWF management does not regularly review the list of individuals with access to CWF data and programs. Additionally, BCBSF management indicated that a limited number of Technical Services personnel need access to CWF data for DASD management purposes.

Criteria
The United States Office of Management and Budget (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, to processors, facilities, or peripherals) or type of access (read, write, execute, delete) to the minimum necessary to perform the user's assigned job.

Effect
Inappropriate individuals with 'alter' access to CWF data and programs could perform unauthorized updates to CWF beneficiary and claims data.

Recommendation
The access authorities of all transferred/terminated employees and all Computer Security Administration personnel should be removed. Additionally, CWF management should further limit the number of Technical Services personnel and Production and Change Control personnel with access to CWF data and programs. Furthermore, CWF management should periodically review the list of individuals with access to CWF production data and programs.

Management's Response

CWF management is working with Computer Security Administration personnel to limit the number of Technical Service personnel and Production Support personnel that have access to CWF data and programs. All Change Control personnel access to CWF has been terminated, and the number of Technical Service and Production Support personnel will be reduced by 01/31/99. The reports that will be used to limit Technical Service and Production Support personnel access to CWF will be reviewed bi-monthly by CWF management to determine individual access.

CWF-E-98-02. CWF Programmers Have Alter Access to CWF Production Data

Condition
CWF programmers have 'alter' access to CWF production data. This access is necessary because Blue Cross Blue Shield of Texas, the CWF beta site and host site requests other CWF host sites to periodically make changes to CWF data. Although such access may be justified and necessary at times, this activity should be monitored and approved by CWF management.

Cause
Blue Cross Blue Shield of Texas has contracted with HCFA to correct the CWF databases at the CWF host sites. However, Blue Cross Blue Shield of Texas does not have the capability to make all necessary changes to the CWF data (i.e. unblocking a beneficiary record, correcting pointers, and modifying a beneficiaries date of death). When these changes are needed, Blue Cross Blue Shield of Texas notifies the particular host site and instructs them to make the necessary change.

Criteria
OMB Circular A-130 states that controls such as separation of duties, least privilege and individual accountability be implemented as appropriate. Production application programmers should not have 'alter' access to production data. Production claims data are created by users (providers, fiscal intermediaries, carriers, etc.). These users should be the only individuals with the ability to change the data.

Effect
CWF programmers may perform unauthorized changes to beneficiary and claims data that would not be detected by management.

Recommendation
CWF management should monitor access to CWF data to ensure that only authorized changes are made. This could be accomplished by periodically reviewing an automated audit trail that identifies which data was altered, when the data was modified, and the user who changed the data.

Management's Response

CWF personnel is developing a SAS application which will interrogate System SMF data to create an audit trail that identifies data that was altered, date data was altered and the user who changed data. The report has an estimated completion date of February 28, 1999. CWF management will review the audit trail report periodically.

CWF-E-98-03 No Assurance that CWF Host Sites Beneficiary Database is Concurrent with HCFA Master Beneficiary Database (This issue was deleted.)

CWF-E-98-04	No Assurance that Confidentiality of Data is Maintained over Advantis Network. (This issue was deleted.)

United States Department of Health & Human Services
Management Letter Comments

Follow-Up EDP Controls Assessment
at
Blue Cross Blue Shield of Florida

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 Florida (BCBCF), located in Jacksonville, Florida. This review was intended to evaluate the information system controls at BCBSF 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 10, 1998 - August 14, 1998. Their procedures included interviews with key BCBSF 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:

A. Entity-Wide Security Program
No exception noted

B. Access Control

FLB-E-98-01.	Lack of Compliance to Data and Resource Classification Policy
FLB-E-98-02.	User IDs Not Revoked in a Timely Manner
FLB-E-98-03.	No Review of Remote Dial-in-Access
FLB-E-98-04.	Inadequate Review of Security Violation Reports
FLB-E-98-05.	RACF 'SPECIAL' and 'AUDITOR' Attributes Granted to Computer Security Administrators
FLB-E-98-06.	Inadequate Controls Over the RACF RVARY Password
FLB-E-98-07.	Powerful RACF Attributes Granted to Inappropriate Individuals

C. Segregation of Duties
No exception noted

D. System Software
No exception noted

E. Service Continuity
No exception noted

B. Access Control

FLB-E-98-01. Lack of Compliance to Data and Resource Classification Policy

Condition
Data owners have not classified resources in accordance with BCBSF policy. BCBSF policy states that resource owners should classify data and resources as either public, proprietary, or confidential.

Cause
The corporate policy requiring data and resources to be classified according to criticality was not communicated to the Medicare data owners. Additionally, Computer Security Administration was not aware of the corporate resource classification policy.

Criteria
BCBSF corporate policy requires that data be classified according to its sensitivity and criticality.

Effect
Lack of classification may result in inadequate or incorrect protection over critical data and resources. This could lead to disclosure of sensitive information or the loss of data integrity.

Recommendation
Data owners should comply with BCBSF policy and classify their data and resources as either public, proprietary, or confidential. Additionally, Computer Security Administration should work with data owners to ensure that all data and resources are adequately protected.

Management's Response

BCBSF already protects all Medicare related data files at a confidential level throughout our operations. No changes to the access control lists (ACL's) for each data set or transaction are required since they are secured at a confidential level with ACL's tying access to the various Medicare job functions. BCBSF will designate the Medicare data as confidential through either the Stewardship system or other means. This designation will be completed by March 31, 1999.

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

Condition
BCBSF's termination process does not ensure that user IDs of terminated employees are revoked in a timely manner. The powerful user ID of an intern in the Computer Security Administration department remained active for two weeks the intern left the organization. Additionally, from our sample of ten terminated employees, four employee user IDs remained active on the system.

Cause
The BCBSF Human Resources department does not notify Computer Security Administration of terminations on a timely basis. Additionally, security coordinators, who are responsible for adding and deleting users IDs, are not removing the IDs of terminated employees in a timely manner.

Criteria
The United States Office of Management and Budget (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, to processors, facilities, or peripherals) or type of access (read, write, execute, delete) to the minimum necessary to perform their assigned job. Additionally, the National Institute of Standards and Technology's (NIST's) Generally Accepted Principles and Practices for Securing Information Technology Systems state that when employees leave an organization voluntarily or involuntarily system access should be immediately terminated.

Effect
Terminated employees may retain access to BCBSF systems for an extended period of time. This access could be used to make unauthorized changes to critical BCBSF programs and data.

Recommendation
The Human Resources department should immediately notify Computer Security Administration when employees are terminated. This will ensure that access of terminated employee is deleted or removed in a timely manner.

Management's Response

Computer Security Administration (CSA) automatically receives employee termination information from BCBSF's Human Resource system on a nightly basis and User IDs are immediately revoked. Unfortunately, employee terminations are not always reported to Human Resources promptly by departmental managers/supervisors and therefore do not get fed electronically to CSA immediately at termination.

FLB-E-98-02. (Continued)

CSA will work with FCSO and BCBSF Human Resources on raising the level of awareness with management on the importance of notifying CSA of terminations and completing the HR forms that feed the HR system/process. An awareness memo or other communications will be developed by April 30, 1999.

As a secondary measure, CSA will pursue establishing an additional feed of information from our building security system (badge system) since badges are normally turned in at the time of termination. This should give us another mechanism for identifying terminated employees and automatically revoking their User IDs in a timely manner. If the interface to the badge system is feasible, target completion date will be December 31, 1999.

FLB-E-98-03. No Review of Remote Dial-in Access

Condition
Remote dial-in access is not reviewed by BCBSF personnel.

Cause
Computer Security Administration does not have enough personnel to conduct reviews of users who dial-in to the BCBSF network.

Criteria
OMB Circular A-130 states that security responsibilities should be assigned to individuals knowledgeable in the information technology used in the system and in providing security for such technology. These individuals tasked with the information security responsibility must maintain an adequate level of security through establishing adequate security measures and reviewing security violations. NIST's Generally Accepted Principles and Practices for Securing Information Technology Systems state that audit trails and security violations should be periodically reviewed.

Effect
The activity of users attempting to gain unauthorized remote access to BCBSF systems will not be detected. In addition, security violations of authorized remote users will not be addressed.

Recommendation
Security Administration should monitor the activity of individuals attempting to gain remote access to the BCBSF network. This will further strengthen overall access security at BCBSF.

Management's Response

BCBSF's Computer Security Administration department implemented violation monitoring procedures for Remote Dial-in Access in October, 1998. Dial-in access is monitored for violations on a daily basis. BCBSF considers this recommendation closed.

FLB-E-98-04. Inadequate Review of Security Violation Reports

Condition
Computer Security Administration does not adequately review security violation reports and investigate all suspicious activity. Additionally, BCBSF security coordinators do not always review security violations of individuals in their areas.

Cause
BCBSF has instituted a decentralized security administration approach whereby security coordinators are required to review security violation reports. Computer Security Administration has relied on the security coordinators to review the security violation reports on a regular basis. However, security coordinators' are unable to consistently conduct the security reviews.

Criteria
OMB Circular A-130 states that security responsibilities should be assigned to individuals knowledgeable in the information technology used in the system and in providing security for such technology. These individuals tasked with the information security responsibility must maintain an adequate level of security through establishing adequate security measures and reviewing security violations. NIST's Generally Accepted Principles and Practices for Securing Information Technology Systems state that audit trails and security violations should be periodically reviewed.

Effect
Unauthorized and inappropriate activities may not be detected and addressed within a reasonable time frame.

Recommendation
Area security coordinators should review security reports on a regular basis.

Management's Response

BCBSF's Computer Security Administration (CSA) department redesigned the security violation monitoring process in response to the lack of monitoring by "Security Coordinators." CSA now generates a written notice for data set or transaction violations that exceed our threshold. The written notice is sent to the employee and a written explanation and approval by their management is required. CSA follows up if the signed notice is not returned within 30 days.

CSA also performs monitoring of excessive password violations. Phone calls are initiated to each employee who exceeds our threshold for password violations to verify that the activity was caused by that employee and not someone else attempting to gain access with that User ID. As a second level of review, Security Coordinators are now expected to only monitor and follow-up on password

FLB-E-98-04. (Continued)

violations since they are responsible for the User IDs in their area and may have been involved with password resets. CSA is developing procedures to ensure that Security Coordinators are reviewing the password violation reports on a regular basis.

FLB-E-98-05. RACF 'SPECIAL' and 'AUDITOR' Attributes Granted to Computer Security Administrators

Condition
Computer Security Administrators have been assigned both the RACF 'SPECIAL' and 'AUDITOR' attributes. Individuals with 'SPECIAL' attribute or privilege can create users, groups and update global security options. The person with 'AUDITOR' attribute can modify the logging mechanism within the security system. Separation of these two RACF attributes provides better internal controls.

Cause
Computer Security Administration has assigned the RACF 'AUDITOR' attribute to their user IDs in order to have the auditing capability.

Criteria
NIST's Generally Accepted Principles and Practices for Securing Information Technology Systems state that organizations should strive for separation of duties between security personnel who administer the access control function and those who administer the audit trail. Furthermore, OMB Circular No. A-130 states that rules of the system shall be based on the needs of the various users of the system and that such rules shall clearly delineate responsibilities and expected behavior of all individuals with access to the system.

Effect
Computer Security Administrators with access to all systems resources may perform inappropriate activities and deactivate system logging to conceal the act.

Recommendation
The 'AUDITOR' attribute should be removed from Computer Security Administrators who do not require this privilege. Furthermore, the activities of the Computer Security Administrators who retain the 'AUDITOR' attribute should be independently monitored by security management or Internal Audit.

Management's Response

Computer Security Administration (CSA) has assigned the 'Auditor' attribute to 7 of the 12 CSA staff. CSA uses the 'Auditor' attribute to initiate detailed logging for problem identification and research purposes related to specific systems. Therefore, CSA needs the ability to change logging features rapidly in a problem situation.

Monitoring the use of the 'Auditor' attribute will not be easy to implement in our organization. The Director of CSA is the only position within CSA with the proper independence, but must devote his

FLB-E-98-05. (continued)

time to higher level issues. CSA will evaluate the issue to determine if a monitoring mechanism can be developed that will meet the objective of the recommendation, while being an efficient use of the Director's time. If an efficient method can be developed, it will be implemented by June, 1999.

FLB-E-98-06. Inadequate Controls Over RACF RVARY Password

Condition
The RACF RVARY password is stored in an online library. The RACF RVARY command requires a password which gives the user issuing the command the capability to switch RACF databases and deactivate RACF security. Unauthorized users may access the RVARY password and circumvent established security. Additionally, security management does not monitor the use of the RVARY command.

Cause
Computer Security Administration has stored the RACF RVARY password in a library which contains instructions and procedures for issuing the powerful RVARY command. This is one of many online security administration procedures that security management has developed.

Criteria
OMB Circular No. A130 specifies that appropriate technical security must be implemented using cost-effective security products and techniques within the system. Additionally, NIST's Generally Accepted Principles and Practices for Securing Information Technology Systems states that organizations should base access control policy on the principle of least privilege, which states that users should be granted access only to the resources they need to perform their official function.

Effect
Having the RVARY password in an online library increases the risk that unauthorized users will be able to execute this powerful command. Furthermore, without adequate monitoring, unauthorized execution of the RVARY command may not be detected.

Recommendation
Management should remove the RVARY password from the online library. This password should be stored in a secure location that is accessible only by appropriate BCBSF Computer Security Administration personnel. Additionally, all uses of the RVARY command should be reviewed by Computer Security Administration.

Management's Response

The RVARY password is stored in a data set that is only accessible by Computer Security Administration (CSA) staff. Therefore BCBSF feels there is no exposure for unauthorized use of the password. Additionally, the use of the RVARY command can only be executed by User IDs in the Computer Security group, or from the system Master Console, which further reduces this exposure. CSA is on call 24 X 7, therefore it is important that the password be available for emergency purposes. Storing the password in a locked cabinet would not meet our needs and could

FLB-E-98-06. (continued)

add at least 2 hours of downtime to any production problem that required use of the RVARY. BCBSF plans no action on this recommendation.

FLB-E-98-07. Powerful RACF Attributes Granted to Inappropriate Individuals

Condition
Powerful RACF attributes have been granted to inappropriate individuals. The secretary in Computer Security Administration has been granted the 'SPECIAL' attribute to perform limited data correction functions. Additionally, Technical Services personnel had been granted the 'SPECIAL' attribute. However, this attribute was removed during our fieldwork.

Cause
The secretary performs limited functions in RACF due to a lack of human resources. Additionally, Computer Security Administration inadvertently granted the 'SPECIAL' attribute to a group which included Technical Services personnel.

Criteria
OMB Circular No. A-130 specifies that appropriate technical security must be implemented using cost-effective security products and techniques within the system. It also specifies that rules of the system shall be based on the needs of the various users of the system and that such rules shall clearly delineate responsibilities and expected behavior of all individuals with access to the system. OMB Circular No. A-130 also suggests implementing the practice of least privilege. Least privilege is the practice of restricting access or type of access to the minimum necessary to enable the user to perform his or her job.

Effect
The RACF 'SPECIAL' attribute gives users highly powerful access authorities within the system. There is an increased risk of unauthorized activity when inappropriate individuals have been granted this attribute.

Recommendation
Computer Security Administration should remove the 'SPECIAL' attribute from the user ID of the secretary.

Management's Response

BCBSF disagrees with the recommendation. As a normal part of her job functions, the departmental secretary performs legitimate RACF maintenance that is clerical in nature. This includes correcting employee names, correcting SS#'s, performing simple revokes/deletes, etc. In order to do these job functions, the secretary must have the 'Special' attribute. BCBSF plans no action on this recommendation.

United States Department of Health & Human Services
Management Letter Comments

Follow-up Application Controls Review
of the
Florida Shared System (FSS)

September 1998

Final Report

Ernst & Young (E&Y) LLP has completed their follow-up application controls reviews of the Florida Shared System (FSS). The reviews were performed at Blue Cross and Blue Shield of Florida and at Blue Cross and Blue Shield of South Carolina. These reviews were intended to evaluate the FSS application controls which is a component of the overall EDP controls assessment for fiscal year 1998. The EDP controls assessment is a part of the Department of Health and Human Services Office of Inspector General's (HHS OIG) financial statement audit of HCFA for the year ended September 30, 1998.

E&Y performed the FSS application controls reviews from August 10, 1998 - August 21, 1998. Their 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 General Accounting Office (GAO) staff.

The findings are listed below:

General Controls Specific to FSS

FSS-E-97-01. Local Modification of FSS Source Programs
FSS-E-97-02. Library to Override Original FSS Programs
FSS-E-98-03. No BCBSF Application Priority Listing
FSS-E-98-04. Inadequate Standard Operating Procedures for Claims Adjudication
FSS-E-98-05. Inappropriate Access Authorities Within the FSS
FSS-E-98-06. Inadequate Separation of Duties Within the FSS Operator Control File
FSS-E-98-07. FSS Claims That Bypass CWF Processing
(This issue was dropped)
FSS-E-98-08. FSS Edits Can Be Deactivated or Bypassed
FSS-E-98-09. Potential Duplicate Claims Found in FSS Paid Claims Files
FSS-E-98-10. Inadequate Separation of Duties Within the FSS Operator Control File
(Covered in a separate memorandum to be sent separately from this report.)
FSS-E-98-11 No Time Stamp on FSS Edits
(Covered in a separate memorandum to be sent separately from this report.)

FSS-E-97-01. Local Modification of FSS Source Programs

Condition
The FSS is the Part A shared system that is developed and maintained by the Florida Shared System (FSS the system maintainer), a business unit within Blue Cross Blue Shield of Florida. The FSS system is installed and operated at the data centers of selected fiscal intermediaries. All development and changes to the programs are performed by the FSS maintainer upon approval by the fiscal intermediaries. The Program Assistance Request (PAR) process is used to request a change to the system. However, during our review of the application as implemented at Blue Cross Blue Shield Florida (BCBSF) and Blue Cross Blue Shield South Carolina (BCBSSC), we noted that in addition to the PAR process, programmers perform local changes to FSS programs. Program changes performed locally are not subjected to the same documentation, authorization, testing, quality assurance, and other requirements present in the standard PAR process.

Cause
Primarily, the source code is available to all data centers running the FSS system. Since inception, the FSS maintainer has provided the source code to all of its customers as agreed upon in their service contract. When BCBSF and BCBSSC needs are not addressed by the standard PAR process, the necessary local changes are made by copying the original FSS source, modifying this copied source code, recompiling the modified source and storing the resulting load module in a separate library. Thus, whenever the affected program is called by the system, the load module with the locally modified programs will be executed.

Criteria
The HCFA has instructed all FSS users to follow the PAR process whenever a change is warranted. The user should complete the PAR form and submit the PAR to FSS through INFOMAN. Then the FSS maintainer, along with HCFA, should analyze and evaluate the change request for operational and technical validity. Once the PAR is approved, it needs to be assigned to FSS developers for code changes and development. The completed PAR should be combined with other finished program changes and subsequently scheduled for release and distribution to fiscal intermediaries. Additionally, HCFA recently issued a policy restricting local changes to "emergency basis" only. Fiscal intermediaries may conduct local changes only if abends or failures occur and Medicare claims processing is hindered.

Effect
The capability of the users to copy, modify and recompile any of the FSS source program represents a significant risk to the integrity of the FSS application. User data centers are able to make "improper" local changes and alter any of the critical routines of the FSS without management & FSS authorization.

FSS-E-97-01. (continued)

Recommendation

We recommend that HCFA continue to work with the FSS users and develop a policy which provides for the integrity of the core FSS programs. HCFA should identify the FSS modules, routines, and programs that are critical to the claim processing and financial functions of the application. All critical aspects of the FSS application should be controlled by the FSS maintainer and any modification should be processed through the standardized PAR process. Non-critical FSS programs involved with report formats, printing configurations and other similar requirements may be modified locally by the various users. However, HCFA should coordinate with the users to develop standard and uniform local change processes that include proper documentation, user management approval, quality assurance and proper migration procedures.

Management's Response

First Coast Service Options, Inc. (FCSO) Production Systems utilizes the PAR process to effect necessary changes to the FSS distributed software. Any FCSO Production Systems Local Code changes that affect claims processing or Financial processing are forwarded to FSS via the PAR process. FCSO Production Systems Local Code changes to FSS Source Programs are primarily Shared Processor Customer requests. Most of these changes support Coordination of Benefits (COB), and cross-over changes requested by the Shared Processor Customers, and are documented via the SAR process. All changes that affect Claims Processing and Financial cycles are submitted to FSS via the PAR process. All FSS Release Implementation processes, including local code modifications, are migrated into the production environment utilizing the ENDEVOR Change Management process in effect at the Blue Cross Blue Shield of Florida Data Center. This process requires appropriate management approvals, and ensures that proper migration procedures are accomplished utilizing secured ENDEVOR production libraries process and data center administered methodologies.

While there are several processes in place already regarding control of programs and several other activities in process, we believe specific responses regarding the E & Y recommendations need to be directed to HCFA.

FSS-E-97-02. Library to Override Original FSS Programs

Condition
We noted that BCBSF has developed and implemented an override library to ensure that locally changed programs are called and executed before the standard FSS programs provided by the FSS maintainer. We found that BCBSF has placed the original FSS programs in SYS2.NDV.PRO2.OLOADMDA. We noted that locally modified FSS programs are stored in SYS2.NDV.PRO2.OLOADMDA.CBL. Whenever the system calls for a specific FSS load module, executables residing in the SYS2.NDV.PRO2.OLOADMDA.CBL are run. If the program is not found in the SYS2.NDV.PRO2.OLOADMDA.CBL library, then the system searches the SYS2.NDV.PRO2.OLOADMDA library for the specific FSS executable program. In effect, BCBSF's locally modified programs always override the original FSS programs provided by the FSS maintainer.

Similarly, we noted that BCBSF has developed and implemented an override library to ensure that Blue Cross Blue Shield of South Carolina's (BCBSSC's) locally changed programs are concatenated before the standard FSS programs provided by the FSS maintainer. We found that BCBSF has placed the original FSS programs in SYS2.NDV.PRO2.OLOADSCM and SYS2.NDV.PRO2.OLOADSCA. We noted that locally modified FSS programs are stored in SYS2.NDV.PRO2.OLOADSCM.CBL and SYS2.NDV.PRO2.OLOADSCA.CBL . Whenever the system calls for a specific FSS load module, executables residing in the SYS2.NDV.PRO2.OLOADSCM.CBL and SYS2.NDV.PRO2.OLOADSCA.CBL libraries are run. If the program is not found in the SYS2.NDV.PRO2.OLOADSCM.CBL and SYS2.NDV.PRO2.OLOADSCA.CBL libraries, then the system searches the SYS2.NDV.PRO2.OLOADSCM and SYS2.NDV.PRO2.OLOADSCA libraries for the specific FSS executable program.

Cause
BCBSF developed libraries to ensure that the original FSS programs remain unaltered. However, BCBSF also uses the SYS2.NDV.PRO2.OLOADMDA.CBL, SYS2.NDV.PRO2.OLOADSCM.CBL and SYS2.NDV.PRO2.OLOADSCA.CBL libraries to house all local changes made to the FSS for BCBSF and BCBSSC. BCBSF makes changes locally for necessary program fixes that are not approved through the PAR process.

Criteria
HCFA uses a shared system maintainer in order to ensure that all program changes are uniformly implemented at all fiscal intermediary locations. These fiscal intermediaries should not be implementing their own set of programs to replace the FSS programs provided by the maintainer. The FSS program changes provided by the maintainer have gone through extensive testing and quality assurance processes.

FSS-E-97-02. (continued)

Effect
The FSS applications running at BCBSF and other fiscal intermediaries using override libraries may process claims differently than the FSS application developed and released by the maintainer. The overriding of libraries may result in inconsistent claims processing and even improper paying of Medicare claims. This would lead to loss of Medicare funds.

Recommendation
We recommend that all changes to the FSS application be made by the maintainer via the standard 'PAR' process. This would ensure that all program changes are implemented at all intermediary locations and these changes are adequately approved and tested. The local override libraries should be removed or deactivated when feasible.

Management's Response

First Coast Service Options, Inc. (FCSO) Production Systems utilizes the PAR process to effect necessary changes to the FSS distributed software. However, the use of a "Local Code Only" library provides the ability to support Shared Processor customer requests, while protecting the integrity of FSS delivered programs. This methodology enables compilation and execution of in-house written Report Programs, and in-house modified FSS Core programs, based on customers specifications for COB (Coordination of Benefits), and cross-over requirements, into "Local Code Only" libraries. All FSS distributed Core and Financial programs reside intact, and unmodified, in separate Production FSS distribution libraries

FSS-E-98-03. FSS Edits Can Be Deactivated or Bypassed

Condition
The Florida Shared System contains numerous edits and audits. By design, the FSS allows the intermediaries to control most of the edits in the application, including mandatory HCFA edits. Examples of edits that can be turned on/off by the intermediary include:

Duplicate claim edits - The duplicate claim edit includes both exact and suspected duplicates. Without this edit, all 100 percent duplicate claims and suspected duplicate claims will not be rejected and/or suspended by the system.

- Consistency edits - These edits check for validity based on type of claim, procedures consistent with location, and HCPC codes.

- Administrative edits - These are HCFA supplied modules used to check HCPC and Revenue code information against each other. These edits read the claim record, revenue code file, and HCPC code file for edit errors involving erroneous HCPC/Revenue code file data.

While intermediaries can deactivate nearly all of the edits, they cannot alter some basic format, medical policy, and payment edits. Additionally, the design of the FSS allows claims examiners to bypass some of the edits, including all of the duplicate edits.

Prior to July 1998, BCBSF had an established procedure for turning off FSS edits. When a claims examiner determined that a claim was getting suspended in error, they would route the claim to a special location within the FSS called 'SMTURN'. After claims were received in 'SMTURN', a member of the System Liason Group would review the claims in 'SMTURN' and determine whether each individual claim was suspended in error. This process ensured that more than one individual would review a claim before that claim bypassed an FSS edit. If the determination was made that the claim was suspended in error, the System Liason person would deactivate the particular FSS edit causing the problem and the claim would pass through to continue normal processing. This deactivation was performed after regular working hours to ensure that only the affected claims would be processed while the edit was deactivated. After the claims passed through, the edit was immediately turned back on. Authorization was given by a Director at BCBSF for the System Liason Group to deactivate these edits only when there was a justified need. However, specific documented authorizations and/or justifications were not maintained by individuals in the System Liason Group each time an edit was deactivated.

In July 1998, BCBSF instituted a new procedure for bypassing FSS duplicate edits. Functionality was added to the FSS which allowed claims examiners to bypass FSS edits instead of turning these edits on/off. When a Claims Examiner determines that a claim is getting suspended in error, he or

FSS-E-98-03. (continued)

upon management approval and in situations where it is found that the edit is not properly functioning, and is therefore prohibiting the timely and accurate processing of claims.

The intermediary will validate that procedures are in fact in place to maintain documented justification of all deactivations of FSS edits. This validation will be completed by the end of February, 1999.

FSS-E-98-04 Potential Duplicate Claims Found in FSS Paid Claims Files

Condition
Six potential duplicate claims were found in the FSS paid claims files. These claims were paid by Aetna and were not processed by the Florida Shared System. The claims were included in the FSS paid claims history files when FSS became the Part A shared system. Due to the fact that a history does not exist for these claims, we were unable to verify whether these claims were in fact exact duplicates.

Cause
These potential duplicate claims were processed and paid by another Part A claims processing system. That system might have provided fiscal intermediaries the capability to pay duplicate claims.

Criteria
The Medicare Intermediary Manual states that Intermediaries and their subcontractors 'must safeguard Medicare records and operations against disaster, disruption, unauthorized disclosure, error, theft and fraud.'

Effect
There is a possibility that exact duplicate claims may have been paid by Aetna prior to the system conversion to FSS. If this was the case, then the amount of money that have been paid in error will have to be recovered by BCBSF.

Recommendation
We recommend that BCBSF conduct research to verify whether the six claims were indeed exact duplicates. If it is determined that duplicate claims were paid, appropriate actions should be taken in order to recover the improper payment of Medicare funds.

Management's Response

We have validated that the six claims were processed by this intermediary in the Part A Processing System that was in effect prior to the Fiscal Intermediary Shared System (FISS). Our review revealed that four of the claims are duplicates. The remaining two claims were actually canceled from our files. We will process cancellations for the four claims by the end of January, 1999.

FSS-E-98-05. FSS Claims That Bypass CWF Processing

Condition
Of the approximately 7.5 million claims processed over the past 18 months, we have identified approximately 10,000 Part A claims that have bypassed CWF processing at BCBSF. We noted that BCBSF claims examiners have the capability to bypass CWF when adjudicating a Part A claim. This is accomplished by setting the 'tape-to-tape' flag within the FSS application to 'Y' for each Medicare claim record. This 'tape-to-tape' flag feature within the FSS application is used in unique cases where the transmission of Medicare claim from the FSS to the CWF is not necessary because of valid or legitimate reasons. However, BCBSF management does not review all claims that bypass this critical CWF processing. Additionally, there are no documented justifications/authorizations for all paid claims that bypassed the CWF validation and payment authorization process. BCBSF indicated that of the 10,000 claims identified, approximately 3,000 claims were reject or history only claims and approximately 3,500 claims had actually posted in the CWF before the 'tape-to-tape' flag was set. However, BCBSF could not provide documented authorizations for the approximately 3,500 paid claims that bypassed CWF processing.

Cause
The FSS is a user friendly application that was designed to efficiently facilitate the processing of Medicare Part A claims. The system has features that provide processing flexibility for the users. One of these features is the 'tape-to-tape' option or functionality. This option was also included in the design of the FSS to enhance the overall flexibility of the system. However, this feature can also be abused to intentionally bypass CWF validation.

Criteria
HCFA's Medicare Intermediary Manual Part 3 section 3800 requires Part A and B claims to be processed by CWF prior to payment. Therefore, all paid claims must have been approved by the CWF for payment.

Effect
Bypassing the CWF will result in potential payment to an unqualified or ineligible person because the valid beneficiaries who are entitled to Medicare benefits are included in the CWF beneficiary database. Thus, since BCBSF is allowing FSS claims to bypass CWF checking, BCBSF management does not have assurance that only entitled beneficiaries are receiving Medicare payment.

Recommendation
BCBSF management should review all claims that are coded to bypass CWF processing. For cases where there is a legitimate reason to bypass CWF, the individuals coding the 'tape-to-tape' flag should document the justification or basis for the bypass decision. Management should implement a periodic review process to ensure that bypass decisions are appropriate.

FSS-E-98-05. (continued)

Management's Response

We agree that this control standard was not at the level of performance that it should have been and improvement efforts have been initiated. However, we believe this issue deals primarily with a need to strengthen controls and that, given our research to date, there is very limited financial impact to the Medicare Program.

The FSS system was developed to provide maximum flexibility to individual contractors in processing Medicare Part A claims. As a user of the FSS system, we believe this system flexibility should continue because there are legitimate reasons why a contractor may pay a claim and not send it to CWF, e.g. Medicaid buy-ins, CWF/FSS processing problems, intermediary's history only claims, automatic adjustments, adjustments for lab services where no co-insurance or deductible is impacted. Contractors using the standard systems must take responsibility to ensure that adequate management controls are in place to provide reasonable assurance that edits are managed effectively.

We recognize the importance of solid management controls and have implemented procedures which directly address the CWF bypass control issue that was identified in this audit. Specifically, the following CWF processing enhancements have been made:

- A revised SOP was developed which clarifies that claims can bypass CWF only with appropriate approval and documentation.
- Claims examiners have been provided education concerning the SOP and the importance of following the documented process.
- A management report was produced that allows for prompt monitoring and corrective actions, as necessary.
- Internal Audt has developed a plan to audit BCBSF's claims processing edit procedures in FY 1999.

Additionally, we are committed to documenting and, where appropriate, correcting the claims that bypassed CWF as evidenced by these steps:

- Compared the CWF bypassed claims file to the south sector CWF host file.
- Created a report which identifies claims on the CWF file and those not on CWF (information was formatted to expedite analyses and recommendations).
- Conduct a claim by claim review of those claims not on the CWF file to determine rationale and payment implications, if any, by January 31, 1999.
- Prepare a final report to HCFA outlining the impact on benefit payments and our corrective action on those impacted claims by February 28, 1999.

FSS-E-98-06. Inadequate Standard Operating Procedures for Claims Adjudication

Condition
Standard Operating Procedures do not exist for the adjudication of FSS claims.

Cause
The FSS maintainer has not developed online operating procedures for all types of FSS claims adjudication. Furthermore, BCBSF has not developed operating procedures to guide their claims examiners in adjudicating all types of FSS claims.

Criteria
Similar Part A claims should be adjudicated in a consistent manner. HCFA's Systems Security guidelines mandate that the system should have audit routines to assure detection or prevention of questionable situations involving the programs themselves or the updated records.

Effect
Claims examiners may not adjudicate similar claims in a consistent manner. This would lead to the inconsistent payment of Part A claims.

Recommendation
We recommend that Standard Operating Procedures be developed for the adjudication of complex FSS edits. This would help to ensure that claims examiners work similar claims in a consistent manner.

Management's Response

We agree that Standard Operating Procedures must be in place for the consistent processing of edits. The intermediary has such Standard Operating Procedures in place and these are contained in the Reason Code Narratives Files.

The intermediary will take steps to validate that such Standard Operating Procedures are in fact in place for the adjudication of the complex FSS edits, and are maintained on the Reason Code Narrative Files.

This validation will be completed by the end of April, 1999. If the existing Standard Operating Procedures for these complex edits are determined to be insufficient, the intermediary will then initiate action by the end of May, 1999, to modify the Standard Operating Procedures appropriately.

FSS-E-98-07 The FSS Disaster Recovery Plan Does Not Address Daily Claim File Backups (This issue was dropped.)

FSS-E-98-08. No BCBSF Application Priority Listing

Condition
There is no BCBSF application priority listing in the existing disaster recovery plan. Such a listing should indicate or specify the order in which applications are to be restored in the event of a disaster.

Cause
BCBSF management has not identified the need for an application priority listing. Management indicated that all BCBSF applications will be restored in the event of a disaster.

Criteria
OMB Circular A-130 states that an organization's disaster recovery plan should assure that there is an ability to recover and provide service sufficient to meet minimal needs of system users. The disaster recovery plan should include an application priority listing. Such a listing will be vital in the restoration of critical business functions in a recovery.

Effect
Without an application priority listing, mission critical applications might not be restored in a timely manner. Thus, critical business functions might be delayed when attempting to resume operations after a disaster.

Recommendation
Management should develop an application priority listing based on the criticality of individual applications. This list should then be included in the BCBSF Disaster Recovery Plan.

Management's Response

On the Recovery side we will be recovering all lines of business starting with the critical functions identified in the Business Impact Analysis from Risk Management. Medicare A and B has been identified as one of the six top critical functions to recover first.

For Medicare A processing for Florida and the Shared Processors, Production Systems will coordinate with the customers to identify applications that could be defined as non-executable during a disaster situation. These applications are expected to be reports that could be delayed until normal production processing is resumed. An approach for identification of applications will be an agenda topic at the next Florida Shared Processing User Group meeting scheduled for February 22-23, 1999 and the list will be finalized by May 31, 1999.

FSS-E-98-09. Inappropriate Access Authorities Within the FSS

Condition
Inappropriate individuals had access to the BCBSF FSS Operator Control File. Specifically, one employee had 'update' access to this file and four individuals had 'read' access. These individuals no longer require this access based upon their current job responsibilities. Additionally, a member of the training department had the access authority to enter claims into the production system.

We also noted that inappropriate BCBSSC individuals had update access to FSS functions. Specifically, one individual with the functions "Claim & Reason Code" was deleted, two individuals with the function " Reason Code" were deleted, one individual with the functions "Claim, Reason Code, & Provider" was deleted, and two individuals with the function "Provider" were deleted. All of these individuals had either terminated, transferred, or had a change in job responsibilities.

Cause
FSS access authorities are not updated to reflect current conditions. FSS access capabilities are not adjusted when employees change job responsibilities. Additionally, there has been no periodic review of all FSS user access authorities.

Criteria
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, to processors, facilities, or peripherals) or type of access (read, write, execute, delete) to the minimum necessary to perform their assigned job.

Effect
Users assigned privileges that are either inconsistent with or excessive for a user's job responsibilities may result in abuse of those at privileges and unauthorized access.

Recommendation
BCBSF and BCBSSC management agreed to this finding and promptly removed the access authorities of these individuals. Additionally, we recommend that Management regularly review the access authorities of all FSS users.

Management's Response

As indicated, we agree with this recommendation, and will continue to regularly review the access authorities of all FSS users.

FSS-E-98-10 Inadequate Separation of Duties Within the FSS Operator Control File
(Transferred to a separate memo.)

FSS-E-98-11. No Time Stamp on FSS Edits
(Transferred to separate memo.)

United States Department of Health & Human Services
Management Letter Comments

Application Development and Program Change Control
at
FSS Maintainer - Blue Cross Blue Shield of Florida

August 1998

Final Report

Ernst & Young (E&Y) LLP has completed their application development and program change controls review at the Florida Shared Systems (FSS) Maintainer at Blue Cross Blue Shield of Florida (BCBCF), located in Jacksonville, Florida. This review was intended to evaluate the information system controls at BCBSF 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 for the year ended September 30, 1998.

E&Y performed their review from August 10, 1998 - August 14, 1998. Their procedures included interviews with key BCBSF 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:

A. Application Development and Program Change Controls
No exception noted

United States Department of Health & Human Services
Management Letter Comments

Application Development and Program Change Control
at
FSS Maintainer - Blue Cross Blue Shield of Florida

August 1998

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

A. Application Development and Program Change Controls

No exception noted

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of Inspector General
Washington, D.C. 20201

February 11, 1999

Ms. Patricia A. Williams
Vice President
Government Programs Operations A/B
Blue Cross Blue Shield of Florida, Inc.
532 Riverside Avenue
Jacksonville, Florida 32202

Dear Ms. Williams,

The independent public accounting firm of Ernst & Young (E&Y) LLP under contract with the Department of Health and Human Services Office of Inspector General completed its electronic data processing reviews at Blue Cross Blue Shield (BCBS) of Florida, Inc. and the final report was mailed to you on January 28, 1999. Two recommendations made by E&Y were included in a memorandum sent to Lamar James and Brenda Francisco of your office during early January 1999. We have received management's responses to these two separate items.

This letter acknowledges receipt of BCBS of Florida's management responses and completes the reporting process. We are listing the two items below with the responses.

FSS-E-98-10 Inadequate Separation of Duties Within the FSS Operator Control File

CONTROL ISSUE:
There is inadequate separation of duties within the Florida FSS Operator Control File. We noted seven individuals with the ability to both enter claims and turn off edits. These individuals are responsible for maintaining the FSS edits. However, they are also called upon to adjudicate claims on an infrequent basis to support claims operations and provide training to the claims examiners.

RECOMMENDATION:
We recommend that management review the access authorities of individuals who have been assigned incompatible functions within the FSS. If management decides that this functionality is necessary, a compensating control should be implemented.

MANAGEMENT'S RESPONSE:
We agree with this recommendation. Management will review the access authorities of individuals who have been assigned capabilities for both maintenance of the FSS edit file and adjudication of claims. This review will be completed by March 31, 1999. If management decides that this functionality is necessary, appropriate additional controls will be developed and implemented as necessary.

FSS-E-98-11 No Time Stamp on FSS Edits

CONTROL ISSUE:
The FSS audit trail which captures events such as activation/deactivation of FSS edits does not detail the exact time an edit was turned off and how many claims were processed while edits were deactivated.

RECOMMENDATION:
We recommend that the Florida Shared System maintainer incorporate a more detailed time stamp into the audit trail of critical Florida Shared System edits. The audit trail should detail the exact time the edit was turned off, who turned the edit off, and how many claims were processed while the edit was deactivated.

MANAGEMENT'S RESPONSE:
Recommendations regarding changes to the FISS need to be addressed to the HCFA FISS Project Officer for a response.

These reviews are a critical part of the Health Care Financing Administration's financial statement audit for the year ending September 30, 1998 and we appreciate the cooperation your staff has provided. If you have any questions, 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

cc: Lamar James, Audit Coordinator
Rick Davis, Corporate Financial Analyst
Brenda Francisco, Acting Vice President, Finance

January 4, 1999

Ms. Brenda Franciso
Government Programs - Finance & Controls
Blue Cross Blue Shield of Florida
18 Tower - 532 Riverside Avenue
Jacksonville, Florida 32202-4918

Re: HCFA Fiscal Year 1998 Financial Statements Audit

Dear Ms. Franciso:

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 Blue Cross Blue Shield of Florida and are submitting our findings. These findings and your response to the findings have been discussed at the exit conference on November 5, 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 Mia Leswing or me at (202) 327-6000 if you have any questions.

Sincerely,

Ernst & Young, LLP

Salim Mawani, 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
Ms. Marybeth Jason
Ms. Sara Smalley
Health Care Financing Administration
C3-09-27, Central Building
7500 Security Boulevard
Baltimore, MD 21244-1850

Ms. Wilma Cooper
Atlanta Regional Office
Region IV
101 Marietta Tower, Suite 701
Atlanta, Georgia 30303-8909

The Status of Findings for Florida BC/BS as of December 28, 1998

Number	Description	Status
FLB-F-98-01	ALL PIP and Pass-through payments were not reviewed by a supervisor.	Removed
FLB-F-98-02	Cost report acceptability check list could not be located.	Removed
FLB-F-98-03	Receipts were not posted to the accounts receivable subsidiary ledger on a timely basis.	Removed
FLB-F-98-04	Account receivable MSP & Non-MSP amounts reported on the Part B Form(s)750/751 to HCFA are not properly supported by subsidiary records.	Final
FLB-F-98-05	Account receivable MSP amounts reported on the Part A, and Part B of A Form(s)750/751 to HCFA is not properly supported by subsidiary records.	Final
FLB-F-98-06	No independent dual entry Medicare General Ledger.	Final

The Status of Findings for Florida BC/BS as of December 28, 1998

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FLB-F-98-04	Account receivable MSP & Non-MSP amounts reported on the Part B Form(s)750/751 to HCFA are not properly supported by subsidiary records.	Final
FLB-F-98-05	Account receivable MSP amounts reported on the Part A, and Part B of A Form(s)750/751 to HCFA is not properly supported by subsidiary records.	Final
FLB-F-98-06	No independent dual entry Medicare General Ledger.	Final

FLB-F-98-01

HCFA
FY 98 Financial Statement Audit
Contractor Visit - BCBS of Florida
Non-Claims Disbursements
September 30, 1998

DELETED

Subject:	All PIP and Pass-thru payments are not reviewed by a supervisor
Condition:	Our sample of 30 non-claim disbursements included 6 Pass-thru and 6 PIP payments. During our testing, we did not note any documentary evidence of supervisory review on any of the selected Pass-thru and PIP payments.
Cause:	The contractor does not have a policy to perform Supervisory review for ALL PIP and Pass-thru calculations.
Criteria:	GAO standards for internal controls require supervisors to timely review and approve the assigned work of their staff.
Effect:	By not performing these reviews, there is an increased likelihood that provider interim payments may be misstated.
Response:	Per Sheri Souers - Reimbursement Supervisor, a supervisor performs a review only when the calculated amount appears to be unreasonable.

FLB-F-98-02

HCFA
FY 98 Financial Statement Audit
Contractor Visit - Blue Cross Blue Shield of Florida
Cost Report Settlements
September 30, 1998

DELETED

Subject: Cost report acceptability check list could not be located.

Condition: During the review of the System Tracking for Audit and Reimbursement (STAR) for information, that pertained to one provider, we noted that the contractor could not provide an acceptability checklist to support the receipt and post mark dates reflect in STAR.

Cause: See Contractor's Response.

Criteria: Office of Management and Budget (OMB) Circular A-123 specific controls standard states that, the documentation for transactions, management controls, and other significant events must be clear and readily available for examination.

Effect: Without adequate documentation in the files, we are unable to verify the cost report information included in the STAR.

Response: Per Saul Schmeltzer, Supervisor of Internal Quality Control, the Acceptability Checklist for the provider could not be located. In addition, due to this provider's involvement in a fraud case for 1995, the 1996 cost report was requested immediately from the provider, and may not have gone through the normal acceptability process.

FLB-F-98-03

HCFA
FY 98 Financial Statement Audit
Contractor Visit - Blue Cross Blue Shield of Florida
Cash Receipts
September 30, 1998

DELETED

Subject: Receipt was not posted to the A/R subsidiary ledger on a timely basis.

Condition: During our testing of cash receipts for the first quarter, we noted that seven of the thirty samples were not posted to the A/R subsidiary ledger until the second quarter. The seven receipts pertain to claims overpaid to providers in Part B.

Cause: Per Bobbi Black, Supervisor of the Receipts Unit of the Finance Services Department, the receipts were entered in the system as open cash receipts on 12/23/97, but due to the holidays, the A/R was not resolved until 1/5/98.

Criteria: Office of Management and Budget (OMB) Circular A-123 states that transactions should be promptly recorded, properly classified, and accounted for in order to prepare timely accounts and reliable financial and other reports.

Effect: Could result to an overstated A/R in the HCFA 750/751 report.

Response: Contractor agrees

FLB-F-97-04

HCFA
FY 98 Financial Statement Audit
Contractor Visit - Blue Cross Blue Shield of Florida
Accounts Receivable Balances
September 30, 1998

Subject: Account receivable MSP & Non-MSP amounts reported on the Part B Form(s)750/751 to HCFA are not properly supported by subsidiary records.

Condition: The contractor could not support the following MSP & Non-MSP amounts.

A/R Type	Component	Amount		HCFA 751 Line Item	
Non-MSP	Physician/Supplier	$ 3,298,511	Principal	5a	Part B
Non-MSP	Physician/Supplier	1,294,661	Interest	5a	Part B
Non-MSP	Beneficiary	1,697	Principal	5a	Part B
Subtotal		$ 4,594,469			
MSP	MSP	$ 2,988	Principal	5a	Part B
MSP	MSP	35,055	Interest	5a	Part B
Subtotal		$ 38,043			
Total		$ 4,632,512			

Cause: The contractor has not developed a tracking report/system to accumulate all transactions that support Non-MSP line 5a amounts on the HCFA Form 751. The GTE subsidiary ledger report used to support line 5a is not capturing all adjustments recorded by the contractor, however the GTE ending balance report is capturing all current year activity. When each GTE 751 line item report is footed, an adjustment of $4,632,512 is added to line 5a in order to agree the footed amount to the GTE 751 ending balance report.

Criteria: Balances reported to HCFA should be supported with detail subsidiary ledgers.

Effect: Inadequate subsidiary ledgers/records may result in potentially unsupported financial statement amounts.

Response: There is a workgroup that is continually performing in-depth analyses on the reports that are generated by GTE for CFO reporting. On a quarterly basis, a detailed review of each line of the GTE H751 report is conducted to validate the Accounts Receivable data.

The review consists of sampling of items on each line to ensure they are reported appropriately. The detail for each line is also scanned for unusual items. After any unusual items are investigated, the appropriate manual adjustment and/or system correction is submitted. The manual adjustments remain in place until the identified system changes and/or enhancements are implemented by GTE or internal management. Additional issues may arise from the quality audits and daily activities of the Financial Services area. Staff is continually educated to monitor activities as to how they impact CFO. During FY1998, the workgroup performed a special review of the system specifications for the H751 GTE report to ensure all activity was being reported.

The workgroup has worked over the last year to reduce the unsupported amount from $39,212,186 in FY1997 to the current amount of $4,632,512. This is a reduction of $34,579,674 or 88%. The workgroup will continue to research the unsupported amounts in FY1999 and coordinate resolution of GTE changes or process enhancements.

FLB-F-97-06

HCFA
FY 98 Financial Statement Audit
Contractor Visit - Blue Cross Blue Shield of Florida
Accounts Receivable Balances
September 30, 1998

Subject: Account receivable MSP amounts reported on the Part A, and Part B of A Form(s)750/751 to HCFA is not properly supported by subsidiary records.

Condition: The contractor could not support the following MSP amounts.

A/R Type	Component	Amount		HCFA 751 Line Item	
MSP	MSP	$ 2,713,481	Principal	1	Part A
MSP	MSP	1,083,278	Interest	1	Part A
Subtotal		$ 3,796,759			
MSP	MSP	$ (2,713,481)	Principal	5a	Part A
MSP	MSP	(1,083,278)	Interest	5a	Part A
Subtotal		$ (3,796,759)			
Total		$0			

A/R Type	Component	Amount		HCFA 751 Line Item	
MSP	MSP	$ 180,772	Principal	1	Part B of A
MSP	MSP	284,471	Interest	1	Part B of A
Subtotal		$ 465,242			
MSP	MSP	$ (180,772)	Principal	5a	Part B of A
MSP	MSP	(284,471)	Interest	5a	Part B of A
Subtotal		$ (465,242)			
Total		$0			

The contractor developed a MSP Dbase system report during the 3rd Quarter FY 98 to identify adjustments to line 1 (Opening Balance) that are reported on the HCFA Form 751. However, the contractor's report can not identify those adjustments to Line 1 (Opening Balance) that occurred from October 1, 1997 through the end of the 2nd Quarter 1998. Due to this system/program error, the contractor reclassed unsupported amounts from line 5a to line 1 on the HCFA Form 751.

Criteria: Balances reported to HCFA should be supported with detail subsidiary ledgers.

Effect: Inadequate subsidiary ledgers/records may result in potentially unsupported financial statement amounts.

Response: Contractor agrees with the finding, however, states that several manual processes are in place that will alleviate this condition for future periods.

In 5/98, HCFA performed a review of the CFO reports and processes. At the end of their review, the fluctuation in the beginning balance on the DBASE reports was documented in their report. BCBS of Florida responded that as of 5/98 reports are being generated from the DBASE system that document the cases that cause the shift in the beginning balance, but a portion of the fluctuation is due to cases that changed prior to creation of the explanatory DBASE reports in 5/98. BCBS OF FLORIDA continued manual efforts to

identify the cases that caused the shift in the beginning balance, but due to the volume of cases, especially in the IRS Data Match area, we were not able to identify all cases.

Subsequent to HCFA's review, we produced the 9/98 report to track the transactions that caused the MSP beginning balance to change; however, the report did not have all the data needed to identify the transactions that caused the change. We have enhanced the reports for the 12/98 CFO report. Copies of the reports run through 12/3/98 were reviewed with E & Y during their audit. The reports now have the needed data to allow the transactions to be identified and applied to the appropriate lines (i.e., collections, new receivables, transfers). In FY1999, this will not be an issue because all shifts in the beginning balance from the 9/98 ending balance will be identified on the DBASE reports.

FLB-F-97-06

HCFA
FY 98 Financial Statement Audit
Contractor Visit - Blue Cross Blue Shield of Florida
General Ledger
September 30, 1998

Subject:	No independent dual entry Medicare General Ledger.
Condition:	The contractor does not maintain an independent dual entry general ledger accounting system for Medicare operations. It is our understanding that HCFA is developing a standard general ledger, which will be provided to contractors for claim processing systems.
Cause:	See Condition
Criteria:	The OMB Bulletin 94-01 requires that financial statements be the culmination of a systematic accounting process. The statements shall result from an accounting system that is an integral part of a total financial management system, containing sufficient structure, effective internal controls, and reliable data.
Effect:	All aspects of a transaction, while in process, may not be clearly accounted for and documented.
Response:	Contractor agrees with the finding, however, states that manual processes are in place to record and document transactions.

The Status of Findings for Florida BC/BS as of December 28, 1998

Number	Description	Status
FLB-F-98-01	ALL PIP and Pass-through payments were not reviewed by a supervisor.	Removed
FLB-F-98-02	Cost report acceptability check list could not be located.	Removed
FLB-F-98-03	Receipts were not posted to the accounts receivable subsidiary ledger on a timely basis.	Removed
FLB-F-98-04	Account receivable MSP & Non-MSP amounts reported on the Part B Form(s)750/751 to HCFA are not properly supported by subsidiary records.	Final
FLB-F-98-05	Account receivable MSP amounts reported on the Part A, and Part B of A Form(s)750/751 to HCFA is not properly supported by subsidiary records.	Final
FLB-F-98-06	No independent dual entry Medicare General Ledger.	Final

FI.B-9-98-01

HCFA
FY 98 Financial Statement Audit
Contractor Visit - BCBS of Florida
Non-Claims Disbursements
September 30, 1998

DELETED

Subject:	All PIP and Pass-thru payments are not reviewed by a supervisor
Condition:	Our sample of 30 non-claim disbursements included 6 Pass-thru and 6 PIP payments. During our testing, we did not note any documentary evidence of supervisory review on any of the selected Pass-thru and PIP payments.
Cause:	The contractor does not have a policy to perform Supervisory review for ALL PIP and Pass-thru calculations.
Criteria:	GAO standards for internal controls require supervisors to timely review and approve the assigned work of their staff.
Effect:	By not performing these reviews, there is an increased likelihood that provider interim payments may be misstated.
Response:	Per Sheri Souers - Reimbursement Supervisor, a supervisor performs a review only when the calculated amount appears to be unreasonable.

FY-B-V-98-02

HCFA
FY 98 Financial Statement Audit
Contractor Visit - Blue Cross Blue Shield of Florida
Cost Report Settlements
September 30, 1998

DELETED

Subject: Cost report acceptability check list could not be located.

Condition: During the review of the System Tracking for Audit and Reimbursement (STAR) for information that pertained to one provider, we noted that the contractor could not provide an acceptability checklist to support the receipt and post mark dates reflect in STAR.

Cause: See Contractor's Response.

Criteria: Office of Management and Budget (OMB) Circular A-123 specific controls standard states that the documentation for transactions, management controls, and other significant events must be clear and readily available for examination.

Effect: Without adequate documentation in the files, we are unable to verify the cost report information included in the STAR.

Response: Per Saul Schmelzer, Supervisor of Internal Quality Control, the Acceptability Checklist for the provider could not be located. In addition, due to this provider's involvement in a fraud case for 1995, the 1996 cost report was requested immediately from the provider, and may not have gone through the normal acceptability process.

FY.B-F-98-03

HCFA
FY 98 Financial Statement Audit
Contractor Visit - Blue Cross Blue Shield of Florida
Cash Receipts
September 30, 1998

DELETED

Subject: Receipt was not posted to the A/R subsidiary ledger on a timely basis.

Condition: During our testing of cash receipts for the first quarter, we noted that seven of the thirty samples were not posted to the A/R subsidiary ledger until the second quarter. The seven receipts pertain to claims overpaid to providers in Part B.

Cause: Per Bobbi Black, Supervisor of the Receipts Unit of the Finance Services Department, the receipts were entered in the system as open cash receipts on 12/23/97, but due to the holidays, the A/R was not resolved until 1/5/98.

Criteria: Office of Management and Budget (OMB) Circular A-123 states that transactions should be promptly recorded, properly classified, and accounted for in order to prepare timely accounts and reliable financial and other reports.

Effect: Could result to an overstated A/R in the HCFA 750/751 report.

Response: Contractor agrees

FI-98-97-04

HCFA
FY 98 Financial Statement Audit
Contractor Visit - Blue Cross Blue Shield of Florida
Accounts Receivable Balances
September 30, 1998

Subject: Account receivable MSP & Non-MSP amounts reported on the Part B Form(s)750/751 to HCFA are not properly supported by subsidiary records.

Condition: The contractor could not support the following MSP & Non-MSP amounts.

A/R Type	Component	Amount		HCFA 751 Line Item	
Non-MSP	Physician/Supplier	$ 3,288,111	Principal	5a	Part B
Non-MSP	Physician/Supplier	1,284,801	Interest	5a	Part B
Non-MSP	Beneficiary	1,887	Principal	5a	Part B
Subtotal		$ 4,584,499			
MSP	MSP	$ 2,988	Principal	5a	Part B
MSP	MSP	36,064	Interest	5a	Part B
Subtotal		$ 39,053			
Total		$ 4,632,512			

Cause: The contractor has not developed a tracking report/system to accumulate all transactions that support Non-MSP line 5a amounts on the HCFA Form 751. The GTE subsidiary ledger report used to support line 5a is not capturing all adjustments recorded by the contractor, however the GTE ending balance report is capturing all current year activity. When each GTE 751 line item report is footed, an adjustment of $4,632,512 is added to line 5a in order to agree the footed amount to the GTE 751 ending balance report.

Criteria: Balances reported to HCFA should be supported with detail subsidiary ledgers.

Effect: Inadequate subsidiary ledgers/records may result in potentially unsupported financial statement amounts.

Response: There is a workgroup that is continually performing in-depth analyses on the reports that are generated by GTE for CFO reporting. On a quarterly basis, a detailed review of each line of the GTE H751 report is conducted to validate the Accounts Receivable data.

The review consists of sampling of items on each line to ensure they are reported appropriately. The detail for each line is also scanned for unusual items. After any unusual items are investigated, the appropriate manual adjustment and/or system correction is submitted. The manual adjustments remain in place until the identified system changes and/or enhancements are implemented by GTE or internal management. Additional issues may arise from the quality audits and daily activities of the Financial Services area. Staff is continually educated to monitor activities as to how they impact CFO. During FY1998, the workgroup performed a special review of the system specifications for the H751 GTE report to ensure all activity was being reported.

The workgroup has worked over the last year to reduce the unsupported amount from $39,212,186 in FY1997 to the current amount of $4,632,512. This is a reduction of $34,579,674 or 88%. The workgroup will continue to research the unsupported amounts in FY1999 and coordinate resolution of GTE changes or process enhancements.

FLR-V-97-05

HCFA
FY 98 Financial Statement Audit
Contractor Visit - Blue Cross Blue Shield of Florida
Accounts Receivable Balances
September 30, 1998

Subject: Account receivable MSP amounts reported on the Part A and Part B of A Form(s)750/751 to HCFA is not properly supported by subsidiary records.

Condition: The contractor could not support the following MSP amounts.

A/R Type	Component	Amount		HCFA 751 Line Item	
MSP	MSP	$ 2,713,481	Principal	1	Part A
MSP	MSP	1,083,278	Interest	1	Part A
Subtotal		$ 3,796,759			
MSP	MSP	$ (2,713,481)	Principal	5a	Part A
MSP	MSP	(1,083,278)	Interest	5a	Part A
Subtotal		$ (3,796,759)			
Total		$0			

A/R Type	Component	Amount		HCFA 751 Line Item	
MSP	MSP	$ 160,772	Principal	1	Part B of A
MSP	MSP	284,471	Interest	1	Part B of A
Subtotal		$ 445,242			
MSP	MSP	$ (160,772)	Principal	5a	Part B of A
MSP	MSP	(284,471)	Interest	5a	Part B of A
Subtotal		$ (445,242)			
Total		$0			

The contractor developed a MSP Dbase system report during the 3rd Quarter FY 98 to identify adjustments to line 1 (Opening Balance) that are reported on the HCFA Form 751. However, the contractor's report can not identify those adjustments to Line 1 (Opening Balance) that occurred from October 1, 1997 through the end of the 2nd Quarter 1998. Due to this system/program error, the contractor reclassed unsupported amounts from line 5a to line 1 on the HCFA Form 751.

Criteria: Balances reported to HCFA should be supported with detail subsidiary ledgers.

Effect: Inadequate subsidiary ledgers/records may result in potentially unsupported financial statement amounts.

Response: Contractor agrees with the finding, however, states that several manual processes are in place that will alleviate this condition for future periods.

In 5/98, HCFA performed a review of the CFO reports and processes. At the end of their review, the fluctuation in the beginning balance on the DBASE reports was documented in their report. BCBS of Florida responded that as of 5/98 reports are being generated from the DBASE system that document the cases that cause the shift in the beginning balance, but a portion of the fluctuation is due to cases that changed prior to creation of the explanatory DBASE reports in 5/98. BCBS OF FLORIDA continued manual efforts to

identify the cases that caused the shift in the beginning balance, but due to the volume of cases, especially in the IRS Data Match area, we were not able to identify all cases.

Subsequent to HCTA's review, we produced the 9/98 report to track the transactions that caused the MSP beginning balance to change; however, the report did not have all the data needed to identify the transactions that caused the change. We have enhanced the reports for the 12/98 CFO report. Copies of the reports run through 12/31/98 were reviewed with E & Y during their audit. The reports now have the needed data to allow the transactions to be identified and applied to the appropriate lines (i.e., collections, new receivables, transfers). In FY1999, this will not be an issue because all shifts in the beginning balance from the 9/98 ending balance will be identified on the DMIASE reports.

FLB-1-97-06

HCFA
FY 98 Financial Statement Audit
Contractor Visit - Blue Cross Blue Shield of Florida
General Ledger
September 30, 1998

Subject	No independent dual entry Medicare General Ledger.
Condition.	The contractor does not maintain an independent dual entry general ledger accounting system for Medicare operations. It is our understanding that HCFA is developing a standard general ledger, which will be provided to contractors for claim processing systems.
Cause:	See Condition
Criteria:	The OMB Bulletin 94-01 requires that financial statements be the culmination of a systematic accounting process. The statements shall result from an accounting system that is an integral part of a total financial management system, containing sufficient structure, effective internal controls, and reliable data.
Effect.	All aspects of a transaction, while in process, may not be clearly accounted for and documented.
Response:	Contractor agrees with the finding, however, states that manual processes are in place to record and document transactions.

FLB-F-97-04

HCFA
FY 98 Financial Statement Audit
Contractor Visit - Blue Cross Blue Shield of Florida
Accounts Receivable Balances
September 30, 1998

Subject: Account receivable MSP & Non-MSP amounts reported on the Part B Form(s)750/751 to HCFA are not properly supported by subsidiary records.

Condition: The contractor could not support the following MSP & Non-MSP amounts.

A/R Type	Component	Amount		HCFA 751 Line Item	
Non-MSP	Physician/Supplier	$ 3,288,111	Principal	5a	Part B
Non-MSP	Physician/Supplier	1,294,681	Interest	5a	Part B
Non-MSP	Beneficiary	1,697	Principal	5a	Part B
Subtotal		$ 4,584,489			
MSP	MSP	$ 2,969	Principal	5a	Part B
MSP	MSP	36,085	Interest	5a	Part B
Subtotal		$ 39,043			
Total		$ 4,632,512			

Cause: The contractor has not developed a tracking report/system to accumulate all transactions that support Non-MSP line 5a amounts on the HCFA Form 751. The GTE subsidiary ledger report used to support line 5a is not capturing all adjustments recorded by the contractor, however the GTE ending balance report is capturing all current year activity. When each GTE 751 line item report is footed, an adjustment of $4,632,512 is added to line 5a in order to agree the footed amount to the GTE 751 ending balance report.

Criteria: Balances reported to HCFA should be supported with detail subsidiary ledgers.

Effect: Inadequate subsidiary ledgers/records may result in potentially unsupported financial statement amounts.

FLB-F-97-06

HCFA
FY 98 Financial Statement Audit
Contractor Visit - Blue Cross Blue Shield of Florida
General Ledger
September 30, 1998

Subject:	No independent dual entry Medicare General Ledger.
Condition:	The contractor does not maintain an independent dual entry general ledger accounting system for Medicare operations. It is our understanding that HCFA is developing a standard general ledger, which will be provided to contractors for claim processing systems.
Cause:	See Condition
Criteria:	The OMB Bulletin 94-01 requires that financial statements be the culmination of a systematic accounting process. The statements shall result from an accounting system that is an integral part of a total financial management system, containing sufficient structure, effective internal controls, and reliable data.
Effect:	All aspects of a transaction, while in process, may not be clearly accounted for and documented.
Response:	See Condition

FLB-F-97-05

HCFA
FY 98 Financial Statement Audit
Contractor Visit - Blue Cross Blue Shield of Florida
Accounts Receivable Balances
September 30, 1998

Subject: Account receivable MSP amounts reported on the Part A, and Part B of A Form(s)750/751 to HCFA is not properly supported by subsidiary records.

Condition: The contractor could not support the following MSP amounts.

A/R Type	Component	Amount		HCFA 751 Line Item	
MSP	MSP	$ 2,713,481	Principal	1	Part A
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MSP	MSP	$ (2,713,481)	Principal	5a	Part A
MSP	MSP	(1,083,278)	Interest	5a	Part A
Subtotal		$ (3,796,759)			
Total		$0			

A/R Type	Component	Amount		HCFA 751 Line Item	
MSP	MSP	$ 180,772	Principal	1	Part B of A
MSP	MSP	284,471	Interest	1	Part B of A
Subtotal		$ 465,242			
MSP	MSP	$ (180,772)	Principal	5a	Part B of A
MSP	MSP	(284,471)	Interest	5a	Part B of A
Subtotal		$ (465,242)			
Total		$0			

The contractor developed a MSP Dbase system report during the 3rd Quarter FY 98 to identify adjustments to line 1 (Opening Balance) that are reported on the HCFA Form 751. However, the contractor's report can not identify those adjustments to Line 1 (Opening Balance) that occurred from October 1, 1997 through the end of the 2nd Quarter 1998. Due to this system/program error, the contractor reclassed unsupported amounts from line 5a to line 1 on the HCFA Form 751.

Criteria: Balances reported to HCFA should be supported with detail subsidiary ledgers.

Effect: Inadequate subsidiary ledgers/records may result in potentially unsupported financial statement amounts.

FIRST COAST
SERVICE OPTIONS, INC.

CURTIS W. LORD
PRESIDENT
CHIEF EXECUTIVE OFFICER

May 28, 1999

RECEIVED
JUN 03 1999
Office of Audit Svcs.

Mr. Charles J. Curtis
Regional Inspector General
Office of Inspector General-Office of Audit Services
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909

CIN: A-04-99-03012

Dear Mr. Curtis:

This is in response to your letter of April 29, 1999 regarding the draft report entitled, *Assist Audit of HCFA's FY 1998 Financial Statements at First Coast Service Options, Inc. (FCSO).*

FCSO has made a concerted effort to improve the quality of claims processing and safeguarding against inappropriate Medicare Trust Fund expenditures. To achieve such a goal requires a dedicated organization composed of vital components (such as provider registration, claims, medical review, data analysis, fraud and abuse, beneficiary/provider outreach and debt collection) all working in unison to ensure a sound Medicare benefit management strategy is in place.

We have strived to improve our performance year after year by using the recommendations and performance improvement plans resulting from past CFO Audit findings and Contractor Performance Evaluation reviews. This is evidenced, in part, by our reduced claims payment error rate, which is 2.6% according to the 1998 CFO Audit--considerably improved over 1997's 10%. We are developing processes to monitor this error rate on an ongoing basis, through a simulation of the audit process to identify and aggressively attack the causes for the errors. This will provide an additional data source for the identification of program safeguard issues.

In your draft report you outlined two recommendations which we have addressed as follows:

Report Recommendation:

We recommend that FCSO initiate recovery of the overpayments and periodically provide us with the status of recovery actions.

Comments:

We agree with the overpayments identified in the report. Thanks to the close working relationships our respective staffs have had on this project, the results and recommendations associated with the claims review are nearly complete. To date, we have recovered 94% of the dollar overpayments identified. Once we receive the reporting format from HCFA, we will begin the ongoing reporting process.

Report Recommendation:

We recommend that FCSO address the recommendations made by the independent auditors and provide us a copy of FCSO's responses with respect to EDP controls and non-claims activities.

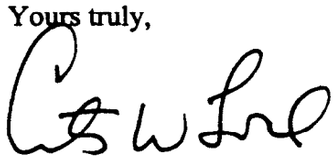
Ernst and Young LLP conducted several reviews and subsequently released the following reports (see your Appendices C and D):

- *Application Controls Review of the Common Working File at Blue Cross Blue Shield of Florida*, dated August 1998
- *Follow-Up EDP Controls Assessment at Blue Cross Blue Shield of Florida*, dated August 1998
- *Follow-up Application Controls Review of the Florida Shared System (FSS)*, dated September 1998
- *Application Development and Program Change Control at FSS Maintainer - Blue Cross Blue Shield of Florida*, dated August 1998
- *HCFA Fiscal Year 1998 Financial Statements Audit*, dated January 1999

Within each report E&Y outlined their recommendations/findings and also included our responses, and where appropriate, corrective actions we have undertaken. Our responses were included in the draft report you sent to us, therefore we did not think it necessary to repeat them in this letter.

We appreciate the opportunity to review and provide our comments prior to the report becoming final. If you have any questions, please contact Mike Davis at 904-791-8795.

Yours truly,



Curtis W. Lord