



Memorandum

Date . JUL 30 1992

From Richard P. Kusserow
Inspector General *For Bryan Mitchell*

Subject Review of the Health Care Financing Administration's Implementation of the
Federal Managers' Financial Integrity Act for Fiscal Year 1991

To (A-I 4-91-03413)

William Toby
Acting Administrator
Health Care Financing Administration

Attached is a copy of our final management advisory report on the results of our review of the Health Care Financing Administration's (HCFA) implementation of the Federal Managers' Financial Integrity Act (FMFIA) for Fiscal Year (FY) 1991.

We evaluated HCFA's implementation of the FMFIA program for FY 1991 by examining HCFA's documentation maintained on internal control, corrective action, and Section 4 reviews conducted in FY 1991, documentation maintained on corrective action plans, and the current 5-year management control plan.

As a result of our review, nothing came to our attention that would cause us to believe that HCFA was not in general compliance with FMFIA. Although HCFA has made significant efforts in developing its FMFIA program, we identified areas which warrant management's attention.

Specifically, we believe that HCFA should: (1) review all financial management systems that provide data to the accounting system in accordance with Section 4, (2) consider reclassifying the risk assessments of internal control areas that are pending material weaknesses and high risk areas, and (3) enhance the testing used to evaluate the Medicare contractors' internal control activities. In response to our draft report, HCFA agreed with the majority of our recommendations.

Page 2 - William Toby

Two of these areas are of primary concern to HCFA. With the passing of the Chief Financial Officers Act of 1990, annual preparation and audit of financial statements are scheduled to begin in FY 1992. To ensure the accuracy of the financial data included on its statements, HCFA needs to provide reasonable assurance that information processed by its financial management systems is reliable and properly safeguarded. This can only be accomplished if detailed Section 4 systems control reviews of HCFA's financial management structure are performed. Additionally, the Medicare contractors must receive adequate coverage under the FMFIA program. The HCFA needs to have reasonable assurance that all major internal control systems at the contractors are adequate, especially the claims processing controls that control approximately \$110 billion of benefit payments.

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

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF THE HEALTH CARE
FINANCING ADMINISTRATION'S
IMPLEMENTATION OF THE FEDERAL
MANAGERS' FINANCIAL INTEGRITY ACT
FOR FISCAL YEAR 1991**



**Richard P. Kusserow
INSPECTOR GENERAL**

A-14-91-03413



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Federal Managers' Financial Integrity Act for Fiscal Year 1991

To (A-I 4-91-03413)

William Toby
Acting Administrator
Health Care Financing Administration

This final management advisory report (MAR) provides our observations on the Health Care Financing Administration's (HCFA) implementation of the Federal Managers' Financial Integrity Act (FMFIA) program. Our results are based on a review of HCFA's documentation maintained on internal control, corrective action, and Section 4 reviews conducted in Fiscal Year (FY) 1991, documentation maintained on corrective action plans, and the current 5-year management control plan (MCP).

As a result of our review, nothing came to our attention that would cause us to believe that HCFA was not in general compliance with FMFIA. Although HCFA has made significant efforts in developing its FMFIA program, we identified areas which warrant management's attention.

We evaluated 8 of the 21 internal control reviews (ICR) performed by HCFA in FY 1991. With respect to these reviews, nothing came to our attention that caused us to believe that the ICRs were not adequately performed. Of these reviews, approximately two-thirds were performed on administrative areas.

We also evaluated HCFA's Section 4 review of its new accounting system, the Financial Accounting Control System (FACS). Nothing came to our attention that would cause us to believe that this Section 4 review by HCFA was not performed in compliance with FMFIA and departmental guidance. The FACS was the only financial management system on which a Section 4

review was performed. We believe that HCFA should review all financial management systems that provide data to the FACS in accordance with Section 4.

The HCFA has updated its **5-year** MCP (FY 1992 through FY 1996) which identifies 83 internal control areas (ICA) of which about two-thirds relate to administrative areas. The plan assesses a risk factor for each area from low to high risk, identifies the type of area as either administrative or programmatic, and identifies the ICR which will be performed in each year. We found that certain inconsistencies exist in identifying risk under the plan, prioritizing reviews according to their risk factor, and in performing reviews to measure compliance. For example, two pending material weaknesses are classified in the plan only as moderate risks. Also, of the 17 reviews scheduled for FY 1992, 14 reviews are classified as low risks.

We believe HCFA should evaluate its **ICAs** according to risk and consider the impact of the 15 material weaknesses and high risk areas. We also believe that HCFA should consider more reviews on programmatic areas since they account for approximately \$168 billion of HCFA's \$170 billion in expenditures. Additionally, the tests used to measure compliance, especially in the area of contractor claims processing, should be enhanced.

In response to our draft report, HCFA agreed with the majority of our recommendations. The HCFA's comments are included in Appendix III.

BACKGROUND

The FMFIA (Public Law 97-255) requires Federal agency heads to set up a process for the evaluation and improvement of their internal administrative and accounting systems. The Office of Management and Budget (OMB) Circular A-123 prescribes policies and standards for executive departments and agencies in setting up, maintaining, testing, improving, and reporting on internal controls in their program and administrative activities.

The OMB Circular A-127 provides the policies and procedures for executive departments to implement Section 4 of the FMFIA in developing, operating, testing, and reporting on financial management systems. The guidelines for evaluating financial management systems prescribe that systems reviews be either limited or detailed evaluations. Detailed evaluations, which are

performed once every 3 years, include a thorough examination of the financial management and accounting systems. Department policy specifies that systems being replaced or combined with other systems within the next 2 FYs need not be subjected to a detailed evaluation. However, all systems not receiving detailed evaluations during any year must receive a limited review annually. Reviewers may structure limited reviews into a desk review using a questionnaire, checklist, or similar methodology.

SCOPE

The purpose of our review was to evaluate the implementation of HCFA's FY 1991 FMFIA program. We reviewed the documentation maintained on ICRs, corrective action reviews (CAR), Section 4 reviews, corrective action plans, and the current 5-year MCP. Field work was accomplished in Baltimore, Maryland from May 1991 to December 1991. The objectives of our review were to:

- o evaluate selected ICRs performed by HCFA,
- o determine the adequacy of HCFA's Section 4 review guides and evaluate the documentation supporting HCFA's review of FACS,
- o evaluate HCFA's efforts to identify internal control areas and their assessment of inherent risks,
- o review the process HCFA follows in identifying material weaknesses, and
- o review HCFA's progress in correcting material weaknesses.

RESULTS OF REVIEW

INTERNAL CONTROL REVIEWS COMPLETED IN FISCAL YEAR 1991

The HCFA scheduled and completed 21 ICRs during FY 1991, including 2 corrective action reviews. The completed

ICRs related to 13 administrative areas and 8 programmatic functions. The following table summarizes HCFA's ICRs for FY 1991.

<u>1991 Internal Control Reviews</u>		
	<u>ICRs Scheduled</u>	<u>ICRs Completed</u>
First Quarter	6	2
Second Quarter	8	1
Third Quarter	5	12
Fourth Quarter	<u>0</u>	<u>6</u>
Total	<u>19</u>	<u>21*</u>

* This total includes two corrective action reviews completed.

The HCFA identified, for the first time, a material internal control weakness during the review of one of its administrative function areas--Freedom of Information Act (FOIA). The ICR of the FOIA found that HCFA has a statutory requirement for a 10-day turnaround for requests. However, the HCFA determined that follow-ups are not made timely and there is a 12-month backlog.

Assessment of ICRs

We reviewed the files maintained on eight ICRs in FY 1991. The ICRs, judgmentally selected, included five regional administrative personnel management reviews and three HCFA central office programmatic reviews. The programmatic reviews included two new ICAs and one that has existed since HCFA's major segmentation in 1987, but had never been reviewed. The new ICAs are located in the Office of Research and Demonstrations and the Medicaid Bureau.

We found that, based on our review, nothing came to our attention that caused us to believe that the ICRs were not adequately performed.

Regional Personnel Management Reviews

During FY 1991, we reported that HCFA's 10 regional offices violated numerous time and attendance recording and reporting internal controls.¹ Although the individual control violations were not material, collectively they reflected a problem that needed to be addressed. Overall, we found that supervisors were not carrying out their responsibilities to enforce basic time and attendance control procedures.

The HCFA included in its FY 1991 MCP individual personnel management reviews for 7 of the 10 regional offices. The remaining three are to be completed in FY 1992.

Based on our review of HCFA's regional ICR reports, we determined that all internal control weaknesses we identified were addressed by HCFA. The HCFA reported that all deficiencies have been corrected or are in the process of being corrected. We believe that corrective actions have been established, and that if implemented properly, will correct all deficiencies noted.

HCFA Central Office ICRs

In prior years, we noted problems with HCFA's performance of ICRs and, in particular, documentation of workpapers and justification of what event cycles were to be reviewed. As a result of these comments, HCFA placed stronger emphasis on these areas.

We reviewed the files maintained on three ICRs conducted by HCFA's central office during FY 1991. We determined that except for the issues noted below, nothing came to our attention that caused us to believe that the ICRs were not adequately performed. Workpapers were found to contain adequate documentation and sufficient data was included in the files to determine that the ICA managers adequately justified which event cycles presented the greatest risk.

¹Review of Time and Attendance Recording and Reporting Practices in Health Care Financing Administration Regional Offices, CIN: A-01 -91-02513, May 1991.

Our review of the Office of the Attorney Advisor determined that there was a lack of documentation of the ICR, specifically the general control environment. For example, we determined that results of testing of the general control environment was based on the personal knowledge of the individual performing the review rather than through documented interviews with individuals responsible for the ICA.

SECTION 4 REVIEWS

Section 4 of the FMFIA requires departments to evaluate all financial management systems. The guidelines require a detailed evaluation and testing of the systems, including testing to disclose whether valid transactions are processed properly. The FYs 1990 and 1991 were transition years for Section 4 FMFIA reviews in the Department of Health and Human Services (HHS) because of the number of new core accounting systems being implemented and tested. Therefore, HHS relaxed its policy and provided that Section 4 requirements not completed by the June 30, 1990 cutoff were to be completed in FY 1991.

Based on the results of our review, nothing came to our attention that would cause us to believe that HCFA was not in compliance with the Section 4 requirements of FMFIA. The following sections cover HCFA's review of its accounting system, our assessment of the review, and the need for additional reviews.

HCFA's Detailed Review of Its Accounting System

A detailed evaluation of HCFA's new accounting system, the FACS, started during FY 1990 and was completed in FY 1991. The HCFA's evaluation consisted of reconciling historical information converted from HCFA's prior accounting system to FACS, verifying the processing of current year data in the FACS operational functions, and examining all subsystems. The FACS core system will become the system of record effective with the closeout of FY 1991 data.

During FYs 1990 and 1991, HCFA's Division of Accounting tested the new system to ensure that it met OMB, General Accounting Office (GAO), and HHS standards. The HCFA used an audit program, developed by HHS with

assistance from both HCFA and the Office of Inspector General (OIG), to review the 10 application areas and 4 subsystems of the FACS. Several different types of tests were used to examine the new system, including transaction, edit, parallel, and stress tests.

Transaction tests were conducted to examine the flow of data from the original document, into the data base, and then through the entire system. As each transaction was processed, the resulting effect upon the data base was examined and documented. Edit tests were performed to determine whether the FACS would only process accurate information. For example, in reviewing the edits for the letter of credit (LOC) subsystem, individual letter of credit numbers were entered into the system. Both valid and invalid numbers were entered to determine that the invalid LOC numbers were rejected by the system. Parallel tests were also performed monthly to compare the prior accounting system results with those of the FACS. In addition, stress tests were performed on an on-going basis to measure the speed and accuracy of the FACS.

Assessment of HCFA's Accounting System Review

The objectives of our evaluation of the FACS were to determine whether HCFA performed sufficient testing with some assurance that the FACS met GAO, OMB, and HHS standards. Specifically, our objectives included determining the adequacy of (1) the various tests that HCFA performed, (2) the documentation of the test results, (3) the audit trail, (4) the corrective actions taken when deficiencies were located, and (5) the results of any follow-up.

We reviewed HCFA's compliance with HHS guidelines in conducting its review and documenting the tests performed and the results that occurred. We used the Social Security Administration (SSA) financial management system review handbook as a guide. Our review consisted of interviewing key officials and reviewing test files. Our review showed HCFA provided adequate documentation to substantiate its Section 4 results.

We determined that HCFA used the departmental audit program and questionnaire for the applicable sections of the FACS testing. We also determined that HCFA documented the results of parallel tests and all edit tests by including a copy of the computer screens in the workpapers and testing booklets.

The documentation of parallel testing results consisted of computerized printouts comparing both the FACS and the prior accounting system. Included in the testing package were deficiencies and the corrective actions taken to ensure resolution of the problem areas. Documentation also included results of follow-up of corrective actions taken.

We determined that each section of the accounts receivable subsystem had its own documentation book containing a summary conclusion on the adequacy of the programs and the test results. The test results documentation identified that the individual functions were tested by taking a preliminary picture of the relevant data, then entering a transaction and examining the before and after effects to prove the data base was being properly updated.

Additional Section 4 Reviews Are Needed

The evaluation of FACS represents the first detailed Section 4 review that HCFA performed under the **FMFIA** requirements. However, other systems such as the Common Working File (CWF), Prepayment Group Health Plan Automated Payment Plan System, and the Provider Overpayment Reporting System, have not been reviewed in accordance with Section 4 requirements. We recommend that HCFA perform additional Section 4 reviews of all financial management systems that provide information to the FACS system.

We identified about 65 systems that support HCFA's financial management structure. Approximately, nine of these systems are directly related to accumulating and controlling financial data. All nine systems are fully automated and taken together, obligate and control **HCFA's** spending authority, advance funds to third party contractors, and control assets and liabilities. These systems include the FACS, CWF, Prepayment Group Health

Plan Automated Payment Plan System, Provider Overpayment Reporting System, Facility Management System, and Physician and Supplier Overpayment Reporting System.

With the enactment of the Chief Financial Officers (CFO) Act of 1990, the annual preparation and audit of financial statements covering trust funds and revolving funds is scheduled to begin in FY 1992. To ensure the accuracy of the financial data included on its statements, HCFA needs to provide reasonable assurance that information processed by its automated information systems is reliable and properly safeguarded. This can only be accomplished if detailed systems control reviews of HCFA's financial management structure are performed.

CORRECTIVE ACTION REVIEWS

The HCFA is required by departmental policy to start CARs within 1 year after material

weaknesses have been corrected. Additionally, the Department can request that the OIG perform a CAR. The purpose of the CAR is to verify and test that corrective actions are in place and provide a reasonable assurance that weaknesses will not reoccur. During FY 1991, the HCFA completed two CARs that were started in FY 1990. We also completed a CAR of Medicare payment safeguards. Following is a brief summary of the material weaknesses and the CARs, our assessment of the CARs, and the results of our CAR.

Summary of Material Weaknesses and CARs

In a report dated February 24, 1989², we determined that HCFA failed to enforce existing standards for recertification of a State facility that had been decertified. While the facility was still technically decertified, the facility received Federal payments. The HCFA's corrective actions included providing guidance and instructions to the regional offices clarifying the requirements for recertification. In addition, computerized controls were implemented to detect payment requests from facilities not currently certified.

²Improvements Needed in Federal Oversight of Facilities for the Retarded,
CIN: A-07-88-001 05, February 1989.

The HCFA's CAR included a follow-up memorandum to the regional offices to ensure that all offices were aware of the regional office manual sections pertaining to processing State agency certifications and terminating Medicaid eligibility.

The HCFA reported a material weakness in FY 1989 that better controls are needed to ensure that proper certification and reporting is done by Peer Review Organizations (PRO). The concern was that **PROs** may be falsely certifying and reporting to HCFA medical review cases where reviews had not been performed, resulting in a substantial loss to the Government. The HCFA's corrective actions included requiring **PROs** to prepare individual records and to maintain an audit trail for each completed review. The HCFA's CAR included on-site evaluations of the **PROs** operations and validation of the data reported.

Assessment of HCFA's CARs

Our review of HCFA's **CARs** consisted of reviewing available documentation to verify HCFA's test results and to determine if sufficient documentation existed to conclude that the procedures implemented corrected the deficiencies.

We verified that: (1) HCFA central office sent memorandums to the regional offices ensuring that all offices were aware of new instructions regarding State agency certifications and (2) written documentation was available that identified the new computerized control. We also verified that the results of HCFA's on-site **CARs** of the **PROs** operations were in the files.

We have some concerns with the documentation in the review files. We found that supporting documentation that should have been readily available was not included in the case files. It was only after numerous discussions with HCFA personnel that the requested documentation was produced and we were satisfied that the **CARs** had been conducted. In our opinion, each review file should "stand alone" and have **sufficient** documentation that would allow an independent person unfamiliar with the subject matter to be able to render an opinion on whether the deficiencies have or have not been corrected.

Review of Payment Safeguard Activities

At the request of the HHS Council on Management Oversight, we conducted a CAR of the Medicare payment safeguard program material weakness/high risk area. In a November 1991 memorandum to the Council, we reported that HCFA maintained safeguard funding levels as stated in their corrective action plan. However, we found indications that these funding levels were not adequate to maintain consistent staffing and workload activity in the safeguard areas of Medicare secondary payer (MSP) and medical review and utilization review. We noted instances where contractual workload goals were reduced or eliminated by HCFA due to inadequate funding in some safeguard areas. The staff and workload reductions in safeguard activities typify the adverse effect of the FY 1990 and FY 1991 funding levels.

We are concerned that the objectives of the payment safeguards activities to control against fraud, waste, and abuse are not being met. This could adversely impact on the integrity of the Medicare program and result in a significant program weakness. Based on the funding level and the expansion of the Medicare program, we found that the payment safeguard objectives of preventing, detecting, and recovering overpayments may have been compromised. Further, as evidenced by the \$1.1 billion MSP backlog, we believe that the safeguard weaknesses disclosed in this review could continue to hamper the Medicare program.

MANAGEMENT CONTROL PLAN SEGMENTATION

Segmentation is the process of dividing an

organization into assessable units in a way that all areas with inherent risk are identified and included in the MCP. In accordance with OMB Circular A-123, the HCFA updated its MCP for the next 5 years (FYs 1992 through 1996). The MCP assesses a risk factor for each area from low to high risk, identifies the type of area as either administrative or programmatic, and identifies the ICR which will be performed in each year. The HCFA had segmented its operations into 83 ICAs. Programmatic functions represent 39 percent of the total ICAs, while administrative functions represent 61 percent of the total. For FY 1991, programmatic costs accounted for about \$168 billion, while administrative costs only totaled about \$2 billion.

Assessment of Internal Control Areas
Need To Be Balanced Between Functions and Risks

We believe that for FY 1992, HCFA has placed too much emphasis on reviewing low risk administrative personnel management **ICAs**. We recognize the importance of these reviews, in particular the time and attendance cycle, but believe that only a limited number should be performed each year. For FY 1992, 14 out of 17 scheduled **ICRs** represent low risk personnel management areas.

We believe, that for FY 1992, HCFA should balance their **ICRs** between programmatic and administrative areas, while considering the level of risk rating.

Risk Assessments
Need Adjusting

For the total 83 **ICAs** identified in the current MCP, 62 are classified as low risk ratings or no ratings, 19 are classified as moderate, and only 2 are currently classified high risks. The two **ICAs** classified high risk are pending material weaknesses--MSP and procurement and purchasing. Additionally, there are two other pending material weaknesses that are classified as moderate risk. This demonstrates a misclassification of ICA risk. For example, the contract administration ICA currently has a moderate risk rating but it is a pending material weakness. **The** financial management--Medicaid ICA currently has a moderate risk rating but it is a pending high risk area.

The HCFA does not classify all material internal control weaknesses as high risk **ICAs**. The HCFA believes that **CARs** are performed immediately after material weaknesses have been corrected and high risk ratings are irrelevant for scheduling purposes and not needed for pending material weaknesses.

Our assessment of **HCFA's** classification is that all pending material weaknesses and high risk areas should be identified as high risk **ICAs**. The purpose of the vulnerability assessment is to rank the overall susceptibility of an ICA to loss due to fraud, waste, abuse, or mismanagement.

We recommend that the Department develop guidance concerning classifying risk assessments of **ICAs** in which material weaknesses and high risk areas

have been identified. However, until this is accomplished, the HCFA should consider reclassifying its risk assessments of **ICAs** for pending material weaknesses and high risk areas to a high risk rating.

Contractors' Operations Need Adequate
Coverage Under The FMFIA Program

It has always been our opinion that the Medicare contractors should be included in the FMFIA program. In prior reports on HCFA's FMFIA program, we have recommended, as early as 1984, that HCFA extend the OMB Circular A-123 (Internal Control Systems) requirements to include the Medicare contractors in the FMFIA program. In the past, HCFA has considered two options to implement our recommendation. The first option, to have the Medicare contractors perform **ICRs** of their own operation, was abandoned because the estimated cost was prohibitive. The second option was to modify existing Medicare contractors' monitoring programs. The monitoring programs would include additional steps to determine if Medicare contractors have established a system of internal accounting and administrative controls and if these controls meet the requirements of the FMFIA.

In FY 1989, HCFA conducted an ICR of Medicare claims processing to determine if adequate internal controls existed and were functioning. The HCFA concluded that existing controls were working **and no** problems were disclosed as a result of the testing. From our analysis of this ICR, we believe that HCFA conducted inadequate testing to reach this conclusion. It appears that HCFA did not actually test internal controls at the contractors. The tests consisted of reviewing manuals, interviewing HCFA regional office personnel, and reviewing Contractor Performance Evaluation Program (CPEP) reports and Carrier Quality Assurance Program **results**.

The HCFA has taken recent initiatives to assure that Medicare contractors have adequate internal control systems. In **HCFA's** MCP for the next **5-year** cycle (**FYs** 1992 through **1996**), there are **ICAs** for both Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B) claims processing. The previous MCP did not have an ICA for Part A claims processing. Additionally, the HCFA issued a memorandum, dated July 1, 1991, to all Medicare intermediaries and carriers that requested comments on an approach to evaluate intermediary and carrier internal controls. The

memorandum focused contractor's attention to the FMFIA requirements that internal control systems be established and in place, and functioning as intended.

With the requirements of the CFO Act, we feel even stronger that contractors must receive adequate coverage under the FMFIA program. To ensure the accuracy of the data included on its financial statements, HCFA needs to have reasonable assurance that all major contractor internal control systems are adequate, especially the claims processing controls that control approximately \$110 billion of benefit payments. We recommend that HCFA develop an ICR methodology that actually tests the contractors' claims processing internal controls.

Certain Internal Controls Over
Contractors Appear Inadequate

The GAO has previously reported that HCFA had an inadequate internal control mechanism over some areas at contractors. These inadequate control mechanisms included the CPEP and the Carrier Quality Assurance Program.

The GAO reported³ that HCFA's controls over Medicare and Medicaid benefit payments were inadequate. The GAO concluded that while HCFA's monitoring programs, including the CPEP, assessed contractors implementation of many requirements designed to detect fraud, waste, and abuse, they did not include: (1) identification of internal control objectives, (2) evaluations of whether control techniques are adequate for meeting the objective, and (3) adequate testing. The GAO concluded that the HCFA's monitoring efforts, which were limited to reviews of unverified data submitted by the Medicare contractors was a material internal control weakness.

In another report? the GAO reached the same conclusion and in particular expressed concerns about the CPEP. The GAO reported that because many

³Internal Controls: Second-Year Implementation of the Financial Integrity Act in HHS, GAO/HRD-86-9, November 8, 1985.

⁴Existing Contract Authority Can Provide for Effective Program Administration, GAO/HRD-86-48, April 22, 1986.

of the CPEP standards used data provided by the contractor, the accuracy of the CPEP evaluation depends upon the accuracy of the contractor provided data. The GAO said that it is possible for contractors to manipulate the data because of inadequate HCFA controls and that use of the contractor supplied data could involve risks. However, the GAO determined that the CPEP gives HCFA a good basis for assessing the performance of Medicare contractors and a means of identifying poor performers.

The GAO also reported⁵ that the CPEP evaluation of carrier fraud and abuse detection efforts was inadequate for the carriers reviewed. The GAO stated that during HCFA's evaluations, it should more closely examine investigations of beneficiary complaints.

Although improvements have augmented the monitoring of the contractors, we believe that the problems reported by GAO still exist and demonstrate that problems still persist in HCFA's monitoring of the Medicare contractors.

CORRECTIVE ACTIONS TAKEN ON PREVIOUS IDENTIFIED MATERIAL WEAKNESSES

An integral part of the FMFIA program is the follow-up of corrective actions on

previously reported material weaknesses. The HHS' FY 1990 report identified 10 material weaknesses that pertained to HCFA. Two of the 10 material weaknesses were identified as high risk areas. A third high risk area was identified, however, not as a material weakness. The following chart briefly summarizes the status of each material weakness and high risk area and which organization identified it (see Appendix I for details).

⁵Medicare: Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse, GAO/HRD-92-1, October 2, 1991.

<u>Status of FY 1990</u> <u>Material Weaknesses</u>		
<u>Material Weakness/ High Risk Area</u>	<u>Who Identified</u>	<u>Pending</u>
Medicare Program Data	HHS, OMB	Yes
Medicare Secondary Payer	OIG	Yes
Medicare Payment Safeguards	HHS	Yes
Cost Allocation System	OIG	Yes
Medicaid Less-Than-Effective Drugs	OIG & HCFA	Yes
Procurement Process	HCFA	Yes
Procurement Independence	OIG	Yes
Medically Unnecessary Services	OIG	Yes
Duplicate Payments Made under the Periodic Interim Payment System	OIG & HCFA	No
Improper Payments Made for Nonphysician Services	OIG	No
Medicaid Inpatient Psychiatric Benefits for Children	OIG	No

Corrective Action Plans Completion
Dates Need to Be More Realistic

We compared the targeted completion dates for each material weakness and high risk area included in the FY 1990 FMFIA report to the status included in the current corrective action plans. We found that of the 11 material weaknesses and high risk areas included in the Department's FY 1990 FMFIA report, only 5 met HCFA's targeted completion dates. We found that the correction of three material weaknesses was delayed for reasons that HCFA could not control, such as rejected legislative proposals and additional Privacy Act and Paper Reduction Act requirements.

We also found that the correction of three other material weaknesses was delayed for reasons that appeared to be within HCFA's control. For example, the cost allocation system material weakness (HCFA-90-03) had an original targeted correction date of FY 1991, but it was changed to FY 1992. According to HCFA, the delay was due to implementing the new system before the instructions were finalized. However, we believe that the delay was within HCFA's control and the reason does not justify the delay.

We believe that HCFA should be more realistic in projecting the original and current completion dates. There appears to be some inconsistency in how HCFA is projecting its targeted completion dates for pending material weaknesses. We also believe that HCFA needs to evaluate more closely why target completion dates are not being met.

The HCFA could benefit from additional OIG monitoring of corrective actions. However, the HCFA's current policy does not allow us access to records until all corrective actions have been implemented and the **CARs** completed. We believe that if HCFA provided us earlier access to records, the timeliness and accuracy of the corrective action process could be improved.

**MATERIAL WEAKNESSES/HIGH RISK
AREAS IDENTIFIED AND EARLY ALERTS**

In FY 1991, a total of nine potential material weaknesses were identified. However, the HCFA is

planning to report only seven of the nine as material weaknesses. The HCFA is reporting one material weakness as being identified and corrected in FY 1991. The HCFA clarified issues on one material weakness and the OIG, Office of Evaluation and Inspections (**OEI**) agreed to drop it. In addition, the HCFA disagreed with the findings in a recent OIG report that identified a material weakness in the Medicaid program. Two early alerts were also identified during the year. The following is a brief description of the FY 1991 identified issues (see Appendix II for additional details).

MATERIAL WEAKNESSES/HIGH RISK AREAS

Medicaid Program Data (HCFA-91-01 -HR)

The OMB and HHS identified this high risk area. This was not identified as a material weakness. We agree that it appears to be a high risk area.

Flawed Data Adds Millions to Teaching
Hospital Payments (HCFA-91-05, GAO/IMTEC-91-31)

The GAO identified this material weakness. The HCFA agreed that a material weakness exists.

Nationwide Review of Separately Billable Drug and Blood
Services Under the Medicare End Stage Renal Disease Program
(HCFA-91-02, A-01 -90-00502)

We identified this material weakness. The HCFA agreed that a material weakness exists.

Office of Public Affairs Freedom of Information Act (HCFA-91-03)

The HCFA identified this material weakness. We agree that it appears to be a material weakness.

Grants Management (HCFA-91-01)

The HCFA and Assistant Secretary for Management and Budget (ASMB) identified this material weakness. We agree that it appears to be a material weakness.

Brooks Amendment Applied to Contractors (HCFA-91-06)

The HCFA stated that it identified this material weakness based on an Office of General Counsel (OGC) opinion stating that contractors are covered under the Brooks Act. However, the OGC opinion was sought due to an OIG draft report on HCFA's implementation of the Project to Redesign Information Systems Management (PRISM). We agree that this is a material weakness.

Medicare Hospital Patient Transfers Improperly Reported And Paid As Hospital Discharges (A-06-89-00021)

The HCFA identified this material weakness. We reported the problem in a final MAR dated March 18, 1991.

States' Compliance with Federal Regulations Limiting Payments for Selected Multiple Source Drugs Under the Medicaid Program (A-03-90-00201)

We identified this material weakness in a final report dated September 24, 1991. In responding to the report, the HCFA disagreed that a material weakness exists. The OIG and HCFA agreed that a resolution meeting is needed to resolve this issue.

Carrier Maintenance of Medicare Provider Numbers (OEI-06-89-00870).
Carrier Assignment of Medicare Provider Numbers (OEI-06-89-00871)

The OIG, OEI identified a material weakness regarding provider numbers in two reports--one a final and one a draft. The HCFA disagreed that a material weakness existed. After HCFA corrected some of the problems, the OEI agreed to report the material weakness corrected in a final report planned to be issued in the near future.

EARLY ALERTS

Manipulation of Procedure Codes by Physicians to Maximize Medicare and Medicaid Reimbursements (A-03-91 -00019)

We identified a potential material weakness in a final MAR issued on August 30, 1991. We are awaiting HCFA's comments.

Carrier Payments for Unnecessary Surgical Dressing Kits (EAR OI-HQ-91-001)

The OIG, Office of Investigations (OI) issued an **early** alert on June 5, 1991.

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

As a result of our review, nothing came to our attention that would cause us to believe that HCFA was not in general compliance with FMFIA. Although HCFA has made significant efforts in developing its FMFIA program, we identified areas which warrant management's attention.

We reviewed the files maintained on 8 of the 21 **ICRs** performed by HCFA and found the **ICRs** to be in general compliance with FMFIA. However, one ICR lacked adequate documentation in the general control environment.

We also evaluated HCFA's Section 4 review of its new accounting system. Nothing came to our attention that would cause us to believe that this Section 4 review performed by HCFA was not in compliance with FMFIA and departmental guidance. However, other financial management systems, such as the CWF, Prepayment Group Health Plan Automated Payment Plan System, and Provider Overpayment Reporting System, have not been reviewed in accordance with Section 4 requirements.

As a result of our CAR of payment safeguard activities, we found that HCFA maintained funding levels as stated in their corrective action plan. However, we found that based on the funding level and the expansion of the Medicare program, payment safeguard objectives of preventing, detecting, and recovering overpayments may have been compromised.

While HCFA has updated its MCP, we found that certain inconsistencies exist in identifying risk under the plan, prioritizing reviews according to their risk factor, and in performing procedures to measure compliance. We believe HCFA should evaluate its **ICAs** according to risk and consider the impact of the 15 material weaknesses and high risk areas. We also believe that HCFA should consider more reviews on programmatic areas since they account for approximately \$168 billion of **HCFA's** \$170 billion in expenditures. Additionally, the tests used to measure compliance, especially in the area of contractor claims processing, should be enhanced.

RECOMMENDATIONS

We recommend, therefore, that HCFA take the following actions:

1. Review all financial management systems that provide information to the FACS in accordance with Section 4.

HCFA's Comments

The HCFA agreed with this recommendation to review all financial management systems that provide data to the accounting system in accordance with Section 4. The HCFA stated that they do not anticipate having staff resources available to expand Section 4 reviews in the immediate future. However, they expect to have an active program underway in FY 1993 to conduct reviews of selected financial feeder systems. The HCFA believes that the number of systems that we identified is questionable, since not all appear to be financial management systems. For the remainder of FY 1992, HCFA plans to: (1) identify financial management systems throughout HCFA that meet the requirements for Section 4 reviews, (2) prioritize those systems and develop a review plan, and (3) develop a generic review methodology for evaluating financial management systems.

OIG's Response

We identified 65 systems that support HCFA's financial management structure. We also noted that approximately nine of these systems are directly related to accumulating and controlling financial data. We agree with HCFA that these reviews are highly labor intensive. However, to ensure the accuracy of financial data included on its general ledger, HCFA needs to provide reasonable assurance that information processed by all financial management systems is reliable and properly safeguarded. We believe this can only be accomplished if system control reviews are performed in accordance with Section 4, on all financial management systems.

2. Consider reclassifying its risk assessment of **ICAs** that are pending material weaknesses and high risk areas to a high risk rating.

HCFA's Comments

The HCFA agreed with the intent of this recommendation. However, they believed there are some circumstances where a moderate rating is more appropriate. For example, **ICAs** that might initially be considered high-risk because of their inherent risk might have their rating reduced, after it has been determined that all controls are in place and working as intended.

The HCFA endorses our recommendation that HHS develop and provide guidance on identifying risk of **ICAs** when material weaknesses and high-risk areas are involved.

OIG's Response

We believe that all **ICAs** in which pending material weaknesses and high risk areas have been identified should be classified as high risk until the material weaknesses are corrected. Classifying pending material weaknesses and high risk areas with a moderate risk rating demonstrates a misclassification of ICA risk. The purpose of the vulnerability assessment is to rank the overall susceptibility of an ICA to loss due to fraud, waste, abuse, or mismanagement.

3. Enhance the tests used to evaluate the contractors' claims processing internal controls.

HCFA's Comments

The HCFA agreed with our recommendation that the tests used to measure compliance, especially in the area of contractor claims processing, should be enhanced. A task force, comprised of representatives from the contractor community as well as representatives from HCFA central and regional offices, has been established to develop a comprehensive approach to the evaluation of fiscal intermediary and carrier internal controls. A draft paper has been completed which outlines HCFA's expectations and requirements for internal controls.

During the last task force meeting, which was held on February 3, 1992, event cycles and control objectives common to all contractors were identified. In addition, contractors agreed to provide the task force with a list of management reports, relating to the corresponding event cycle.

OIG's Response

We commend HCFA on their latest efforts to bring about more effective controls in monitoring the Medicare contractors' internal control activities. We believe this will greatly enhance HCFA's FMFIA program.

OTHER MATTERS

In addition to the comments made on our recommendations, HCFA provided the following technical comments on other areas in our report that they believe warranted our attention.

HCFA Central Office Internal Control Reviews

HCFA's Comments

The HCFA does not agree with our analysis of the Office of the Attorney Advisor ICR. According to HCFA, the documentation of the general control environment was adequate. The HCFA also stated that because the office is comprised of only four people, any issue relating to the general control environment would be evident.

The HCFA stated that a meeting held with the Attorney Advisor, the reviewer for her staff, representatives from OIG, and the senior analyst from HCFA's internal control staff, had confirmed that tests were performed through actual interviews with managers.

OIG's Response

We believed that the documentation provided by the Office of the Attorney Advisor was inadequate to allow an independent person to determine that controls were in place and testing had been performed. The individual who

performed the review confirmed to us, prior to the joint HCFA and OIG meeting, that personal knowledge was the basis for the documentation supplied.

Assessment of HCFA's Corrective Action Reviews

HCFA's Comments

The HCFA disagreed with our statement that documentation for the PRO CAR was not readily available for review. The HCFA stated that information maintained in files other than those examined, does not indicate that such information was unavailable. The information was available upon request by individuals with proper identification.

OIG's Response

During our review of the PRO CAR performed by HCFA, it was difficult to determine what corrective action was taken and whether the implementation resulted in correction of the deficiency. Upon initial request, the supporting documentation was unavailable and only after several follow-up requests from various HCFA personnel was adequate documentation supplied. **The** supporting documentation for a CAR should be readily available and maintained by the Management and Analysis Branch or the component performing the review. The purpose of a CAR is to verify and test that the corrective action will prevent the weakness from reoccurring. The documentation should be sufficient to allow an independent person unfamiliar with the subject matter to be able to render an opinion on whether the deficiencies have or have not been corrected.

Management Control Plan Segmentation

HCFA's Comments

The HCFA believes that all of their programmatic functions and mandatory administrative areas that HHS has set forth, are included in their existing ICAs. The HCFA has established a Personnel Management ICA for each major bureau and office. In essence, they are identical except for their

locations. If these 26 Personnel Management **ICAs** are counted as 1 as opposed to 26, the ratio between programmatic **ICAs** and administrative **ICAs** is considerably altered.

The HCFA stated that the emphasis on reviewing low-risk administrative personnel management **ICAs** was largely due to the requirements of completing a **5-year MCP (FYs 1988-1992)**, which call for **ICAs** with a **low-risk** rating to be performed in the last 2 years of the plan.

The HCFA brought to our attention the departmentwide material weakness in time and attendance, which is addressed by these **ICAs**, and believes that HCFA would be remiss if they did not conduct these reviews.

OIG's Response

We recognize the importance of these administrative personnel management reviews. However, given the associated costs, programmatic functions accounted for about \$168 billion, whereas administrative costs totaled only about \$2 billion. We believe HCFA should balance their **ICRs** between programmatic and administrative areas in a more proportional manner.

APPENDICES

**STATUS OF PREVIOUSLY IDENTIFIED
MATERIAL WEAKNESSES/HIGH RISK AREAS
AND WHICH OFFICE IDENTIFIED THEM--
OIG, GAO, HCFA**

In FY 1990, 10 material weaknesses that were included in the Department's FMFIA report to the President pertained to the HCFA. Two of the material weaknesses were identified as high risk areas. In addition, a third high risk area was identified, however, not as a material weakness.

HIGH RISK AREAS

Medicare Proaram Data (HCFA-90-01-HR)

This high risk area is not a material weakness under the FMFIA. However, the OMB and HHS identified a need for more accurate and timely programmatic and financial data to aid in managing the Medicare program budget. This requires the development and implementation of properly integrated financial and program data systems to record actual program costs on a timely basis. Data must be reflected for each major benefit and administrative function of Medicare. Additionally, financial statements must be prepared by HCFA for the Medicare program and audited by the HHS Inspector General.

Corrective Action (Pending)

On September 18, 1991, a teleconference was held between the HCFA, ASMB, and OMB to discuss declassifying Medicare program data as a high risk area. Based on the information and reports that HCFA provided, the OMB, as of September 30, 1991, had not reached a decision on whether to declassify this high risk area in FY 1991.

Corrective actions included the development of the CWF. As of January 1991, all the Medicare contractors are using CWF to process claims. To obtain program and financial data from CWF, HCFA developed a new data base management system for use as a data collection repository. The data derived from this and the Intermediary **Benefit Payment Report, HCFA-456**, is used to generate a monthly Medicare Benefit Payment Report. This report

contains information on the Medicare Part A and **Part B** payments for the current month and FY to date.

In April 1991, the OMB redefined the high risk area to be "Financial Systems Inadequate to Predict Medicare and Medicaid Costs." An HHS, OMB task force was named to review continuing and **largely** unanticipated increases in Medicaid. Medicaid Program Data is now considered a separate high risk area.

Medicare Secondary Payer (MSP)
(A-09-89-00100) (HCFA-89-01)

Reviews by the OIG conducted since 1986 have reaffirmed HCFA's awareness that billions of dollars have been spent on claims that should have been paid by another, primary insurer. The OMB identified MSP as a high risk area in FY 1989.

Accurate and timely information on primary payers is needed to reduce annual Medicare overpayments estimated at over \$1 billion. The absence of adequate internal controls to assure the collection of timely and accurate information on the primary insurers of Medicare beneficiaries is a **FMFIA** material weakness.

Corrective Action (Pending)

A teleconference was held on September 18, 1991 between the HCFA, ASMB, and OMB to discuss the status of MSP as a high risk area. However, all parties determined that it would be inadvisable to close this high risk/material weakness area prior to the establishment of more effective systems for preventing inappropriate primary payments by Medicare. The OMB is concerned about HCFA's approach towards correcting this high risk area/material weakness. The HCFA stated that its strategy is to submit legislation to "catch overpayments at the front end" while utilizing "data matches" to identify the backlog and institute recovery actions. The HCFA projected an FY 1992 completion of both the high risk area and the material weakness.

Over the last several years, HCFA has actively pursued several initiatives, including legislative proposals and the filing of suits against noncomplying insurers, to improve the MSP program. Its corrective action plan has been revised numerous times.

The HCFA's current corrective action plan includes the data match activity, recovery activity, prepayment activity, and legislative actions. The initial data matches between the SSA, Internal Revenue Service, and HCFA for the period between 1987 and 1989 **have been** completed. In addition, the revised Medicare claim form was implemented in September 1991. Planned actions for the next 12 months include matching data received from the data match against Medicare payments to identify potential mistaken primary payments. In addition, recovery action will be initiated as appropriate by Medicare contractors and the CWF will be updated.

Medicare Payment Safeguards (HCFA-89-02)

The lack of adequate Medicare payment safeguards was identified as a material weakness and reported as a high risk area in the Department's FY 1989 FMFIA report. Payment safeguards are activities that are conducted by the Medicare contractors to preserve the Medicare trust funds. These include MSP activities, medical review and utilization review, and provider audits. Payment safeguard activities are cost-effective and a productive ___ means of identifying areas of potential waste and abuse.

Contractors are required to commit staff and other resources to these activities to the extent of budgeted funding. Inadequate and/or fluctuating program funding for payment safeguards prevents the contractors from maintaining adequate well-trained and seasoned staff to perform the payment safeguard functions in accordance with program guidelines. As a result of the contractors' inability to adequately staff these management control activities, the Medicare program is vulnerable to an increase in incorrect benefit payments.

Corrective Action (Pending)

The HCFA's strategy to correct the payment safeguards problem was to request the redirection of funds from catastrophic health insurance to

payment safeguards in FY 1990, and to request adequate funding in future years to maintain consistent levels of payment safeguard activities.

The HCFA has completed the corrective action steps for FY 1990 through FY 1992 by requesting adequate funding levels to maintain payment safeguard activities consistent with prior years. The HCFA, therefore, recommended that payment safeguards be closed out as a high risk/material weakness. The Chairman, Council on Management Oversight, requested that the OIG audit this area to ensure effective corrective actions.

In a November 1991 memorandum to the Chairman, Council on Management Oversight, we reported that HCFA met the funding goals established in its corrective action plan. However, we are concerned that the objectives of payment safeguards activities to control against fraud, waste, and abuse are not being met. We concluded that this could adversely impact on the integrity of the Medicare program and result in a significant program weakness.

As a result of a November 14, 1991 meeting between HCFA, OIG, and the Chairman, Council on Management Oversight, the HCFA agreed not to drop payment safeguard as a material weakness/high risk area.

MATERIAL WEAKNESSES IDENTIFIED IN FY 1990

Review of the Health Care Financing Administration's Cost Allocation System for Fiscal Year 1988 (A-14-89-02036) (HCFA-90-03)

In July 1990, we reported that HCFA's cost allocation system (CAS) was not in conformance with the principles and standards established by the Comptroller General and that this deficiency constituted a material weakness under FMFIA. We recommended that HCFA establish a CAS that more equitably allocated administrative costs and conform to the requirements established by the Comptroller General.

The HCFA agreed to redesign its CAS and expects it to be in place no later than the end of FY 1992. The ASMB agreed to provide guidance to HCFA on the CAS.

Corrective Action (Pending)

The HCFA planned activities included developing new methods of allocating costs, issuing procedures, and training components to ensure full compliance with the cost allocation process. The CAS is now in the testing phase. The implementation of the new method started in **February 1991**, entails conducting a comprehensive review of employee **activities** and categorizing employee activities as either direct or indirect.

The HCFA's revised CAS will change the current method used to calculate cost allocation percentages for administrative costs. Instead of developing percentages based on full-time equivalent usage, the new CAS will focus on what percentage of employee activity/output benefits the appropriate HCFA programs.

The HCFA's plans include revising its Administrative Issuance System for the CAS by December 1991.

**Duplicate Pavments Made by Blue Cross of Massachusetts
Under the Periodic Interim Pavment Svstem
(A - 0 1 - 9 0 - 0 0 5 0 0)**

In April 1990, we reported significant weaknesses in internal accounting and administrative controls at Blue Cross of Massachusetts resulting in approximately \$12.1 million in duplicate payments to Worcester City Hospital. The duplicate payments exceeded the \$10 million threshold and, therefore, constituted a material weakness under FMFIA. The material weakness was jointly identified by the OIG and HCFA.

Corrective Action (Completed)

All system related corrective actions for this material weakness have been completed. The implementation of a **new** claim processing system, systems security, and pertinent operating procedures **at** Blue Cross of Massachusetts, significantly reduced the intermediary's vulnerability to conditions that would allow both periodic interim payments and cash payments to be made during the same period to a given provider.

Complete financial audits of the overpayments at Worcester City Hospital and Spaulding Hospital were conducted in 1990. The Spaulding Hospital overpayment has been recovered, and HCFA is working with management at Worcester City Hospital to arrange an acceptable repayment schedule. HCFA conducted an on-site review of the new system in February 1990 and July 1990, and determined that adequate internal controls are in place to prevent future duplicate payments.

**The Department of Health and Human Services'
Enforcement of Regulations Prohibiting Medicaid
Payments for Less-Than-Effective Drugs
(A-03-89-00220) (HCFA-90-04)**

In a July 1990 MAR issued to HCFA, we reported that the internal controls inherent in HCFA's and the Food and Drug Administration's (FDA) procedures for administering the Department's less-than-effective (LTE) drug provisions were inadequate to prevent Federal overpayments totaling \$16 million in the 23 States reviewed. The reimbursements exceeded the \$10 million threshold and therefore constituted a material weakness under FMFIA. The material weakness was jointly identified by the OIG and HCFA.

Corrective Action (Pending)

The HCFA published a list of LTE drugs in the State Medicaid Manual (SMM) in September 1989 and issued an updated list in the SMM in August 1991. In July 1990, HCFA central office instructed the regional offices to remind all States of LTE drug requirements, verify that States are complying with the SMM, and perform follow-up reviews. In September 1990, letters were sent to all States reminding them of the LTE drug requirements.

On October 16, 1990, the Medicaid Bureau prepared and forwarded a memorandum of agreement (MOA) to the FDA. Under the MOA, FDA will provide HCFA with regular lists of LTE and identical, related and similar (IRS) drugs to assure that payment is not made for noncovered drugs. The FDA signed and returned the MOA in September 1991. The FDA made changes to the MOA that HCFA is evaluating before committing to them. It is HCFA's opinion that once the agreement is in place, States will have the necessary tools to effectively comply with the LTE drug requirements.

On January 22, 1991, HCFA's Administrator sent a memorandum to ASMB. The subject of the memorandum was a HCFA policy revision on the Medicaid payments of LTE drugs. The HCFA is in agreement with all the OIG recommendations. However, HCFA is also in agreement with the States' contention that it was impossible for the States to identify all IRS drugs and to halt Medicaid payments for those drugs. The HCFA's Administrator is convinced that it would be unfair to penalize the States for allowing expenditures for IRS drugs prior to HCFA providing them in September 1989 with the OIG list identifying such drugs. Under this policy, HCFA would not take disallowances of Federal Financial Participation (FFP) on State expenditures for IRS drugs made prior to the publication of the OIG list of LTE drugs in 1989. Over \$15 million in FFP was questioned in OIG audits of LTE drugs. There are about \$7 million related to LTE drugs that HCFA will continue to demand repayment. The balance of \$8 million in FFP for IRS drugs paid prior to September 1989 will not be disallowed and, where already recovered, will be refunded to the affected States in accordance with HCFA's revised policy.

In a memorandum from HCFA's Administrator to the OIG, HCFA proposed a plan to handle IRS drug disallowances for the pre-September 1989 period. The HCFA proposed to use First Data Bank's (FDB), a private firm, IRS drug list for the pre-September 1989 period to identify drugs to disallow. The HCFA also planned to drop disallowances where a drug is LTE for some, but not all indications.

In a memorandum to HCFA's Administrator, dated June 10, 1991, we stated that we did not agree that failure of FDB to identify IRS drugs should be a deciding factor in settling audit disallowances. At the very least, we recommended that HCFA thoroughly evaluate the accuracy and completeness of the FDB list before using it to mitigate audit disallowances. On July 25, 1991, HCFA informed the OIG that it would fully implement our recommendations and proceed with the disallowance process in accordance with the Departmental Appeals Board decision No. 1083 of August 10, 1989. HCFA has issued disallowances for those remaining audits that have been issued in final.

The MOA between HCFA and the FDA was revised to become an Interagency Agreement (IA). The **IA was** approved by HCFA on January 28, 1992, and by the FDA on March 12, 1992.

The Medicaid drug rebate system is being changed to require drug manufacturers to use a new table of values that indicates whether a drug has been designated LTE by the FDA. Revised specifications for this new system were released to each manufacturer on February 26, 1992. If there are any disputes about LTE status, the FDA will be responsible for settling the disputes with each manufacturer. All manufacturers were required to report to HCFA, by March 31, 1992, on the LTE status of their drugs. Effective August 15, 1992, States must use revised Drug Efficacy Study Implementation Project field values as the definitive source for determining LTE status for any drug. Later in FY 1992, HCFA will begin to review State utilization data for payment for LTE drugs. This should obviate any material weaknesses found in verifying compliance with this requirement by States.

Of the 23 States identified in the audit as having problems, HCFA has received voluntary refunds from 7, issued disallowance letters to 11, and have disallowances in process for the 5 remaining States.

HCFA's Division of Procurement Services
Procurement Process (HCFA-90-01)

In March 1990, the HCFA declared the procurement process a material weakness as a result of a review performed by the Logistics Management Institute, under contract with ASMB. The Office of Acquisition and Grants (formerly the Division of Procurement Services (DPS)) did not maintain sufficient controls on procurement activities, adhere to procurement rules and regulations, and conduct planning of procurements. The DPS lacked sufficient organizational influence, an adequate procurement tracking and management information system, and an adequate training and recruitment program.

Corrective Action (Pending)

To elevate DPS to a level equivalent to the program offices it serves, HCFA reorganized to raise the DPS from a Division to an Office. The

reorganization established the Office of Acquisition and Grants. In December 1990, DPS established additional divisions and branches with proper supervision to review, and monitor the procurement process more efficiently.

An improved management information system was established in December 1990. The system measures procurement milestones, planned and actual dates for requests for contracts, and contract administration data.

Certain action steps, including improving systems support and strengthening policy, cannot be completed until FY 1993. The final action step, obtaining adequate space for confidential negotiations, cannot be completed until HCFA moves to the single site in FY 1994.

MATERIAL WEAKNESSES IDENTIFIED IN FY 1989

Medicaid/Inpatient Psychiatric Benefits for Children (A-09-89-001 11) (HCFA-89-03)

In September 1989, we issued a final MAR that reported a discrepancy between the Social Security Act and the Medicaid regulations involving inpatient psychiatric benefits for children. While the Social Security Act limited benefits to children receiving care in psychiatric hospitals, Medicaid was paying about \$17 million a year for such care in nonhospital settings. Since the payments exceeded the \$10 million threshold, we recommended that it be reported as a material weakness in the Department's FY 1989 FMFIA report.

Corrective Action (Completed)

In order to correct the discrepancy between the statute and the regulation regarding covered places of service for the Medicaid inpatient psychiatric benefits for children, HCFA developed a statutory change to allow the Secretary of HHS to define the settings in which these services may be provided. Section 4755(a) of the Omnibus Budget Reconciliation Act (OBRA) of 1990 accomplished this by an amendment that allows the Secretary to specify the appropriate inpatient settings for the benefits. Due to the change in the law, this material weakness is considered corrected.

HCFA Needs to Strengthen its Internal Controls to Assure Procurement Independence (A-14-88-02026) (A-14-89-02039) (HCFA-89-04)

We performed two reviews on the contracting process in HCFA's Bureau of Program Operations (BPO). A final MAR concerning unauthorized contractual commitments in BPO was issued in November 1989. Our reviews showed instances where BPO officials, who did not have contracting authority, initiated contractual arrangements. Totalling \$17.5 million, these contractual arrangements were made from 1985 through 1987 as Medicare productivity investments. The unauthorized contractual commitments violated statutory/regulatory requirements and exceeded the \$10 million threshold. Accordingly, these conditions were included in the Department's FY 1989 FMFIA report.

Corrective Action (Pending)

Since January 1990, contracting specialists in the Medicare contracting area completed approximately 6,150 hours of training required for certification. Strong training initiatives are planned to continue through the end of FY 1992. Additional staff were certified at the Level II and Level III contracting positions.

The HCFA is still working on a reorganization of the current Medicare contracting function to more clearly separate contracting and programmatic responsibilities. However, BPO established formal contracting procedures that were approved by ASMB.

The HCFA plans to conduct a follow-up review of the contracting function using a consultant under contract to HHS to assess the effectiveness of the corrective actions taken. The follow-up review will be approximately 12 months after the corrective actions are completed.

MATERIAL WEAKNESSES IDENTIFIED IN 1988

Medically Unnecessary Services (A-05-87-001 38) /A-04-88-02058) (OAI-01-88-00010)

The Medicare program is paying for medically unnecessary services and supplies (e.g., durable medical equipment) that are ordered by the patient's physician and provided by a third party (e.g., laboratory or supplier). The beneficiaries and the billing providers are **generally** not in a position to know whether or not the item will be paid for by Medicare, while the ordering physician generally knows. Our reports showed that millions of dollars were being billed to Medicare for unnecessary medical equipment. Our reports include: Medicare Coverage of Seat Lift Chairs (OAI-02-88-00100), Transcutaneous Electrical Nerve Stimulators (TENS) Units (OAI-01-88-00010), and Oxygen Concentrators (A-04-88-02058). This material weakness was included in the Department's FY 1988 **FMFIA** report.

Note: Nationwide Review of Medically Necessary Oxygen Rentals (A-04-88-02058). This material weakness was identified in FY 1990. Since the issues are similar to the previously identified material weaknesses, it was included with the other reports under the Medically Unnecessary Services' material weakness.

Corrective Action (Pending)

Based on the actions taken by HCFA in revising the certification form (HCFA Form 484) and the additional restrictions mandated by the OBRA of 1990, we believe the over utilization of oxygen concentrators identified in our report will be curtailed. However, this only pertains to the oxygen concentrator material weakness.

The HCFA developed and published instructions in the Medicare Carriers Manual (MCM) to significantly tighten the conditions under which durable medical equipment may be paid for by Medicare. The MCM specifically addresses seat lift chairs and TENS units. The **HCFA** is also implementing the Unique Physician Identification Number (**UPIN**) program. The **UPIN** requirement was delayed due to the OBRA of 1990 requirement that the **UPIN** directory be published first. The directory **was** released in July and

August 1991. Starting in October 1991, HCFA began requiring ordering physicians to include a **UPIN** on all claim forms for durable medical equipment. The HCFA's current corrective action plan includes rejecting claims when the **UPIN** is not included on the form and expanding carrier post-payment review profiling to include ordered services.

The HCFA's implementation of the corrective action requiring profiling of ordered services on a post-payment basis by carriers was delayed to FY 1993 because carrier resources will instead be devoted to implementing a number of post-payment initiatives related to physician payment reform in FY 1992.

The HCFA also requested the OIG to determine whether a material weakness still existed in the unnecessary ordering of services and to help them to determine if compelling evidence existed to support a legislative proposal to hold the ordering physician responsible. The audit request was included in the OIG's FY 1991 work plan and assigned to the OIG Region VII, Office of Audit Services.

**Improper Pavments Made bv Intermediaries to
Prospective Pavment System Hospitals for
Nonphysician Services (A-01 -88-00502) (HCFA-88-01)
(A-01-90-00516)**

We issued a final report in July 1988 and a follow-up report in May 1990 that identified a material weakness regarding duplicate payments for nonphysician services. The weakness in intermediary computer edits and the lack of evaluation of these edits by HCFA constituted a material weakness that led to millions of dollars in overpayments.

Corrective Action (Completed)

The HCFA issued new procedures in FY 1990 notifying providers that adequate bill processing edits must be established to avoid duplicate billing. The HCFA revised the CPEP by adding three new test claims to monitor intermediary compliance.

In FY 1990, HCFA provided intermediaries with computer tapes identifying duplicate payments of over \$40 million. The HCFA instructed the intermediaries to recover the overpayments from the providers and to require the providers to refund monies collected from beneficiaries in error. For the period February 1, 1986 through November 30, 1987, an estimated \$37 million was identified as recoverable.

The HCFA also revised the CWF procedures to reject, on a prepayment basis, any inpatient claim in which an outpatient **claim** from the same provider had been paid. The edits will reduce greatly the possibility of these overpayments occurring in the future. We are conducting a follow-up review (A-01 -91-00511) to validate and assess the effectiveness of the corrective actions.

LIST OF POTENTIAL FY 1991 MATERIAL WEAKNESSES/HIGH RISK AREAS

Nine potential material weaknesses and high risk areas were identified in FY 1991. However, the HCFA is only reporting seven of the nine as material weaknesses and/or high risk areas. Of the total nine potential material weaknesses, the GAO identified one, HCFA identified two, the Department identified two, and the remaining four were identified by the OIG. In addition, we provided two early alert warnings of potential material weaknesses.

HIGH RISK AREAS

Medicaid Program Data (HCFA-91-01-HR)

This issue was not identified as a material weakness but was classified by OMB as a high risk area in FY 1991. A special HHS, OMB Management Review Task Force was established to review continuing and largely unanticipated increases in Medicaid spending.

The task force was charged with analyzing why Medicaid estimates have been so inaccurate, examining the deficiencies, and seeking corrective measures. The task force completed its review on the Medicaid estimating process and issued a report in July 1991.

The HCFA has numerous corrective actions scheduled to be completed during FY 1992. These corrective actions include maintaining State programming formation, revising HCFA reporting forms, and implementing recommendations stated in the task force report.

MATERIAL WEAKNESS

Grants Management (HCFA-91-01)

The ASMB's FY 1990 Grants Management Oversight Report on Noncompetition, dated June 28, 1991, identified grants management as a material weakness. This report identified that HCFA exercised inadequate

control over the grants management process and obtained research and development services through grants and cooperative agreements instead of competitive research and development contracts.

The HCFA's corrective actions include balancing the responsibility of the grants management staff and the **Office** of Research and Development, improving program file documentation, and implementing procedures to ensure compliance with HHS policies on competition and proper funding instrument. The targeted correction date is FY 1992.

Flawed Data Adds Millions to Teaching
Hospital Payments (GAO/IMTEC-91-31)

The GAO reported on June 4, 1991 that supplemental Medicare payments to teaching hospitals are based on inaccurate and unverifiable data, and causing Medicare to pay at least \$28 million more in indirect medical education costs than it should. The GAO stated that the shortcomings in the data constituted material internal control weaknesses and should be reported in HCFA's FY 1991 **FMFIA** report.

Supplemental Medicare payments are made to hospitals to offset the additional costs of their graduate medical education programs and are influenced by two data elements that hospitals report: the number of medical residents and the number of beds available for patient care.

The GAO reported that during **FYs** 1989 and 1990, Medicare overpaid teaching hospitals millions of dollars because hospitals inappropriately counted residents assigned to the Department of Defense (DOD) and Department of Veterans Affairs (VA) hospitals. In addition, HCFA's guidance for counting available beds was confusing and efforts to clarify it have not been successful. Consequently, the bed data that teaching hospitals report is not verifiable.

The HCFA agreed that a material weakness exists regarding the internal controls over resident data. The HCFA said that it is taking steps with the aid of DOD and VA to incorporate resident data for these agencies into

HCFA's computerized data base. The HCFA plan is to complete all corrective actions in FY 1992.

The HCFA disagreed that a material weakness exists concerning the unauditability of available bed data. Although the Department agreed that problems exist in auditing this data, it believes the problems exist in the law, not in the manner in which HCFA implemented it.

Nationwide Review of Separately Billable
Drug and Blood Services Under the Medicare
End Stage Renal Disease Program (A-01 -90-00502)

In a final report dated July 29, 1991, we recommended that HCFA report a material weakness. Our review showed that most of the 19 intermediaries reviewed did not have adequate internal controls to ensure that the claims for separately billable drug and blood services were paid in accordance with HCFA guidelines.

The HCFA agreed this constituted a material weakness and is taking corrective actions that it expects to complete in FY 1992. For example, HCFA is implementing a national policy regarding billing for drugs and blood services.

The HCFA uses a prospective payment method for dialysis services that covers all services related to dialysis treatment except for physicians' patient care services, blood, and certain drug and laboratory services that are separately billable. Medicare procedures set forth requirements that intermediaries are required to follow for the payment of separately billable drug and blood services.

Based on a statistical analysis, we estimated that on a nationwide basis about \$15.5 million in Medicare overpayments were made by intermediaries to independent dialysis facilities for separately billable drugs during the period December 1987 to September 1989. The overpayments occurred because most of the intermediaries did not clearly understand HCFA's criteria for the payment of separately billable drug and blood services.

Office of Public Affairs Freedom
of Information Act (FOIA)

The HCFA identified this material weakness as a result of an ICR completed on June 24, 1991. The **FOIA** has statutory requirements for a 1 O-day turnaround for requests. However, at HCFA, the **FOIA** requests are not answered within this time frame and currently there is a **12-month** backlog of requests. **The ICR** noted that current regulations and procedures are also outdated.

Although HCFA identified a material weakness, it was not clear whether the problem could be solved with the simple addition of more staff, or if the corrective actions should take a more comprehensive approach. The HCFA decided to conduct a thorough management review before developing a corrective action plan. This review is **underway** and is scheduled to be completed by December 30, 1991.

Contractor Acquisitions Under the Brooks
Act (HCFA-91-04) (A-I 4-89-02511)

In a draft MAR issued in July 1990, we alerted HCFA to the preliminary results of our review of its implementation of the PRISM. In this report, we determined that HCFA did not follow Federal Information Resources Management (IRM) requirements regarding Medicare claims processing systems and this, together with other factors, constituted a material internal control weakness.

The HCFA did not agree that a material weakness existed because it believed that the draft report did not provide evidence that limiting the scope of PRISM violated Federal IRM policy. The HCFA requested an opinion from the OGC regarding, in part, the applicability of Federal IRM policy to the Medicare claims processing systems.

On June 7, 1991, the OGC issued its opinion **concluding** that the provisions of the Brooks Act should be applied to **HCFA's** intermediary and carrier

contracts. Furthermore, the OGC stated that broader Federal IRM policies cover information collection activities even if Federal IRM acquisition policies do not.

The HCFA's strategy is to achieve full compliance with the Brooks Act through obtaining delegations of procurement authority (DPA) wherever needed. The HCFA has obtained a DPA to cover the CWF maintenance contracts and has requested a blanket DPA for all carriers and intermediary contracts, which would include CWF host activities. The HCFA plans to correct this material weakness in FY 1992.

Medicare Hospital Patient Transfers Improperly Reported And Paid As Hospital Discharges (A-06-89-00021)

The material weakness, identified by HCFA, was a result of a final MAR issued by the OIG on March 18, 1991. Our report determined that hospitals were erroneously showing discharges rather than transfers when submitting bills to Medicare. The overpayments occurred when patients were reported as discharged, though they were actually transferred to other hospitals. This resulted in payment of the full diagnostic related group rate rather than a per diem payment to the transferring hospital. The overpayments in Region VI totalled \$8.5 million. Projecting this nationwide, 168,599 potential errors representing payments over \$100 million were identified.

The HCFA reported the material weakness as identified and corrected in FY 1991. The HCFA's corrective actions are based on the development of CWF edits to identify inpatient claims with incorrect discharge destinations.

Carrier Maintenance of Medicare Provider Numbers (OEI-06-89-00870). Carrier Assignment of Medicare Provider Numbers (OEI-06-89-00871)

The OIG, OEI identified a material weakness regarding provider numbers in two reports issued in May 1991--one a final and one a draft. The OEI reported that inadequate direction by HCFA resulted in weaknesses in carrier controls to maintain the integrity of Medicare provider numbers. In a draft report, the OEI also reported that HCFA's direction and oversight of carrier

provider number assignment procedures were inadequate. The OEI believed this constituted a material internal control weakness within the meaning of the FMFIA.

Medicare regulations specify qualifications a provider must meet before being reimbursed by Medicare. Carriers assign provider numbers to qualified providers of Part B services who furnish services and supplies to Medicare beneficiaries. The numbers are used in processing claims and establishing Medicare pricing profiles.

The OEI reported that HCFA had not clearly defined the methods or extent of understanding and testing to ensure adequate knowledge about a provider before a number was assigned. The lack of direction and oversight contributes to carrier provider number assignment weaknesses and vulnerabilities. In addition, HCFA has issued no directives concerning a carrier's responsibility to ensure whether a provider is still qualified at some later date after an initial provider number is issued.

The HCFA disagreed that a material weakness existed. After HCFA clarified issues, the OEI agreed to drop the material weakness in a final report planned to be issued in the near future.

States' Compliance with Federal Regulations Limiting
Payments for Selected Multiple Source Drugs
Under the Medicaid Program (A-03-90-00201)

In a final report dated September 24, 1991, we concluded that HCFA's inability to detect or prevent overpayments to States for selected multiple source drugs constituted a material internal control weakness. On August 23, 1990, we alerted HCFA in a MAR about wide spread violations of the regulations. However, the HCFA does not agree that our findings constitute a material internal control weakness.

Under Federal regulations, States are required to limit Medicaid claims for Federal payments for selected multiple source drugs to an aggregate upper-payment limit established by HCFA. The HCFA estimated that compliance

with the regulations would save the Federal Government \$270 million during the first 5 years the regulations were in effect.

We determined that 4 of 12 States reviewed failed to comply with the Federal regulations. The four States claimed Federal drug payments that exceeded HCFA's aggregate upper-payment limit by about \$10.8 million (\$6.6 million, Federal share) during the first year (October 1987 through October 1988) that the payment limit was in effect. Projecting the results nationally, we estimated that HCFA overpaid States about \$35 million during that same year.

In commenting on our draft report, the HCFA stated that even if verified, findings in only four States cannot justify the designation of a material internal control weakness. We disagreed with HCFA's position because of the projected overpayments of \$35 million nationwide, and the fact that one-third of the States reviewed violated Federal regulations. In responding to the final report, HCFA stated that it continues to disagree that a material weakness exists.

At the Management Oversight Council meeting, held on March 23, 1992, OIG and HCFA agreed that a formal resolution meeting is needed to resolve the material weakness issue.

EARLY ALERTS

Carrier Payments for Unnecessary Surgical Dressing Kits (EAR OI-HQ-91-001)

The OIG, OI issued an early alert on June 5, 1991 to bring to HCFA's attention a potential material weakness regarding Medicare Part B coverage of surgical dressing kits. Specifically, the weakness relates to the methods by which carriers reimburse suppliers for these kits.

The MCM limits surgical dressing coverage to primary dressings (i.e., therapeutic and protective coverings) applied directly to lesions either on the skin or opening to the skin as a result of a surgical procedure performed by a physician. Items required for purposes other than a surgical lesion

(i.e., bedsores or decubitus ulcers) are generally for secondary coverings and are excluded from coverage.

The OI stated that several investigations, as well as congressional inquiries and media reports, have revealed situations that illustrate the many abuses and possible fraud in the way claims for these surgical dressing kits are being submitted and reimbursed. For example, they found that surgical dressing kits are routinely being used in the treatment of bedsores and are being reimbursed by some Medicare carriers. They also found that claims for beneficiaries are typically for one to three kits per day, totalling approximately \$1,200 to \$3,600 per month.

The OI believes these abuses could result in a material internal control weakness that could significantly impair HCFA's goal of providing cost effective health care supplies under the Medicaid and Medicare programs. They also stated that the weakness had enough merit to draw the attention of congressional oversight committees.

Manipulation of Procedure Codes By Physicians to
Maximize Medicare and Medicaid Reimbursements
(A-03-91 -00019)

In a final MAR dated August 30, 1991, we alerted HCFA to the preliminary results of our review of the manipulation of procedure codes by physicians to maximize their Medicare and Medicaid reimbursements. This "gaming" of codes results in physicians being potentially overpaid an estimated \$12.2 million in Medicare funds and nearly \$700,000 in Medicaid funds annually. Our results are limited to a single Medicare carrier, Pennsylvania Blue Shield, and a single State Medicaid agency. At this time, we cannot statistically project our Pennsylvania findings nationally. We plan to project our results, however, after completion of our expanded review to eight randomly selected State agencies. Early indications show that overpayments due to physicians "gaming" procedure codes will be highly significant, particularly in the Medicare program.



MAY 15 1992

Memorandum

Date *William Toby, Jr.*
William Toby, Jr.
From Acting Administrator

Subject OIG Draft Report: "Review of the Health Care Financing Administration's (HCFA) Implementation of the Federal Managers' Financial Integrity Act for Fiscal Year 1991" (A-14-91-03413)

To Inspector General
Office of the Secretary

We have reviewed the subject draft report which examines HCFA's implementation of the Federal Managers' Financial Integrity Act (FMFIA) program for Fiscal Year (FY) 1991. This review was based on HCFA documentation maintained, on internal control, corrective action, and Section 4 reviews in FY 1991, as well as documentation on corrective action plans and the current **5-year** management control plan.

As a result of the review, OIG concluded that HCFA was in general compliance with the FMFIA. Although HCFA has made significant efforts in strengthening and improving its FMFIA program, OIG identified additional areas which they believe still warrant management attention. OIG believes HCFA should: (1) review all financial management systems that provide data to the Financial Accounting Control System in accordance with Section 4 reviews; (2) consider reclassifying its risk assessment of Internal Control Areas; and (3) enhance the tests used to evaluate the contractors' claims processing internal controls.

We agree with the intent of the report's recommendations but have reservations regarding their implementation. Our specific comments on the report's recommendations and other technical comments are **attached** for your consideration.

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

Attachment

Page 2 of 6

Comments of the Health Care Financing Administration (HCFA)
on the OIG Draft Report: "Review of the HCFA's Implementation
of the Federal Managers' Financial Integrity Act
for Fiscal Year (FY) 1991" (A-14-91-03413)

Recommendation 1

That HCFA review all financial management systems that provide information to the Financial Accounting Control System in accordance with Section 4.

HCFA Response

We agree. However, we would like to point out that these reviews are highly labor-intensive. We do not anticipate having available staff resources to expand Section 4 reviews in the immediate future. In its recommendation, OIG stated that 65 program financial management systems should be reviewed throughout HCFA. OIG's number of systems is questionable since not all 65 systems identified appear to be financial management systems.

Nonetheless, during the remainder of FY 1992, we plan to: (1) identify financial management systems throughout HCFA that meet the requirements for Section 4 reviews, (2) prioritize those systems and develop a plan, and (3) develop a generic review methodology for evaluating financial program systems. Depending on how these efforts proceed, it may be possible to begin a program review this FY. However, we do expect to have an active program underway in FY 1993 to conduct Section 4 reviews of selected financial feeder systems.

Recommendation 2

That HCFA consider reclassifying its risk assessment of Internal Control Areas (ICA) that are pending material weaknesses and high-risk areas to a high-risk rating.

HCFA Resuonse

We agree with the intent of this recommendation. However, we believe there are some circumstances where a moderate rating is more appropriate. For example, **ICAs** that might initially be considered high-risk because of their "inherent risk" (areas such as those dealing with financial matters) might have their risk rating reduced, after it has been determined that all controls are in place and working as intended.

We endorse **OIG's** recommendation that the Department provide guidance on identifying risk of **ICAs** when material weaknesses and high-risk areas are involved.

Page 2

Recommendation 3

That HCFA enhance the tests used to evaluate the contractors' claims processing internal controls.

HCFA Resuonse

We agree. HCFA has established a task force to develop a comprehensive approach to the evaluation of fiscal intermediary and carrier internal controls. The task force includes representatives of the contractor community, as well as representatives from HCFA central and regional offices. A draft paper has been completed which defines internal controls and outlines HCFA's expectations and requirements for internal controls. This paper also contains a proposal for contractor self-assessment which will be used for their ongoing review and evaluation of the effectiveness and reliability of internal control systems.

The last meeting of the task force was held on February 3. This meeting resulted in the drafting of event cycles and control objectives common to all contractors. The contractors also agreed to provide the task force with a list of management reports, relating each report to the corresponding event cycle.

An analysis of these data coupled with the data being produced by OIG (based upon its review of several contractors) will allow HCFA to decide how to address the adequacy of claims processing internal controls of intermediaries and carriers.

Technical Comments

HCFA Central Office Internal Control Reviews (ICR). We believe the documentation for the Office of Attorney Advisor ICR mentioned on page 6 of this report is adequate, contrary to OIG's analysis. Because this office comprises only four people, any issue relating to the general control environment would be evident.

However, to allay OIG's concerns about whether personal knowledge supplanted testing in these reviews, a meeting was held with the Attorney Advisor, the reviewer for her staff, representatives from OIG, and the senior analyst from HCFA's internal control staff. The Attorney Advisor confirmed that tests were performed through actual interviews with managers.

Page 3

Assessment of HCFA's Corrective Action Reviews (CAR). HCFA disagrees with OIG's statement that documentation for the Peer Review Organization CAR was not readily available for review (page 10). Because information is maintained in files other than those OIG examined does not mean this information is unavailable. The information is available upon request by individuals with the proper identification. We believe the component should maintain separate files if this arrangement is more advantageous to their operations.

Management Control Plan (MCP) Seementation. We believe that all of our programmatic functions are included in our existing ICAs. We also have included all of the mandatory administrative areas that the Department has set forth. In addition, we have established a Personnel Management ICA for each major bureau and office (a total of 26). These Personnel Management ICAs have identical event cycles, control objectives and testing protocols. In essence, they are identical except for their organizational location. If these 26 ICAs are counted as 1 as opposed to 26, the ratio between programmatic ICAs and administrative ICAs is considerably altered. As we have previously stated, we believe that all of the program functions of HCFA staff are properly covered in our management plan.

Assessment of ICAs Needs To Be Balanced Between Functions and Risks. On page 12 of this report, OIG states that HCFA is placing too much emphasis on reviewing low-risk administrative personnel management ICAs. OIG fails to note that the seeming preponderance of these reviews in FY 1991 was largely due to the requirements of completing a 5-year MCP (FYs 1988-92), which call for ICAs with a low-risk rating to be performed in the last 2 years of the plan.

Also, there is a departmentwide material weakness in time and attendance which is addressed by these ICAs. Therefore, we believe HCFA would be remiss if we did not conduct these reviews. Additionally, this 5-year plan was adjusted in FY 1991. This adjustment resulted in the inclusion of several new ICAs with a high or moderate risk rating, escalation of the risk ratings of several ICAs for scheduling purposes, and the conduct of an ICR in an area identified by OIG as containing a potential material weakness.

Material Weaknesses/High-Risk Areas. The OIG report appears to have been completed prior to recent actions on two previously identified Medicaid audits. We suggest the final report incorporate the following updates since they have a significant effect on the status of these issues.

The Department of Health and Human Services' Enforcement of Regulations Prohibiting Medicaid Payments for Less-Than-Effective (LTE) Drugs (A-03-89-00220)-- Appendix I, Page 6.

- An initial Memorandum Of Understanding between HCFA and the Food and Drug Administration (FDA) was revised to become an Interagency Agreement (IA). The IA was approved by HCFA on January 28, and by the FDA on March 12.
- The Medicaid drug rebate system is being changed to require drug manufacturers to use a new table of values that indicates whether a drug has been designated LTE by the **FDA**. Revised specifications for this new system were released to each manufacturer on February 26. If there are any disputes about LTE status, the FDA will be responsible for settling the disputes with each manufacturer. All manufacturers were required to report to **HCFA**, by March 31, on the LTE status of their drugs. Effective August 15, States must use revised Drug Efficacy Study Implementation Project (**DESI**) INDICATOR field values as the definitive source for determining LTE status for any drug. Later in FY 1992, HCFA will begin to review State utilization data for payment for LTE drugs. This should obviate any material weaknesses found in verifying compliance with this requirement by States.
- Of the 23 States identified in the audit as having problems, we received voluntary refunds from 7, issued disallowance letters to 11, and have disallowances in process for the 5 remaining States.
- With current resources, we will only be able to do spot checks to ensure that States are in compliance. If significant problems are uncovered, in-depth reviews will be done.

State Compliance With Federal Regulations Limiting Payments for Selected
Multiple Source Drugs Under the Medicaid Program
(A-03-90-00201)-- Appendix II, Page 6.

- HCFA continues to disagree with OIG's position that HCFA's lack of oversight constitutes a material internal control weakness. This position is clearly stated in our comments to the subject final report.
- At the Management Oversight Council meeting, held on March 23, OIG and HCFA agreed that a formal resolution meeting is needed to resolve the material weakness issue. We look forward to the resolution of this issue.