



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office Of Inspector General
Office Of Audit Services

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278
May 7, 2002

Common Identification Number: A-02-01-01022

Mr. William Foley
Vice President, Medicare Operations
Empire Medicare Services
2651 Strang Boulevard
Yorktown Heights, NY 10598

Dear Mr. Foley:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' (OAS) report entitled "Review of Fiscal Year 2001 Financial Statement Activity at Empire Medicare Services." A copy of this report will be forwarded to the action official noted below for his/her review and any action deemed necessary.

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

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, OAS reports issued to the Department's grantees and contractors are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to Common Identification Number A-02-01-01022 in all correspondence relating to this report. Any questions or further comments on any aspect of the report are welcome. Please address them to Elliot Hirshon, Audit Manager, at (212) 264-1281.

Sincerely yours,

Timothy J. Horgan
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:
Mr. Joseph Tilghman, Acting Regional Administrator, CMS

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF FISCAL YEAR 2001
FINANCIAL STATEMENT ACTIVITY AT
EMPIRE MEDICARE SERVICES.**



**JANET REHNQUIST
INSPECTOR GENERAL**

**MAY 2002
A-02-01-01022**

Office Of Inspector General Notices

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Final determination on these matters will be made by authorized officials of the HHS divisions.



Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF FISCAL YEAR 2001
FINANCIAL STATEMENT ACTIVITY AT
EMPIRE MEDICARE SERVICES.**



**JANET REHNQUIST
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Office of Inspector General

<http://oig.hhs.gov/>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

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The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

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The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.



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May 7, 2002

Common Identification Number: A-02-01-01022

Mr. William Foley
Vice President, Medicare Operations
Empire Medicare Services
2651 Strang Blvd.
Yorktown Heights, New York 10598

Dear Mr. Foley,

This report provides you with the results of our "REVIEW OF FISCAL YEAR 2001 FINANCIAL STATEMENT ACTIVITY AT EMPIRE MEDICARE SERVICES". Our review was required by the Chief Financial Officers (CFO) Act of 1990, as amended.

The objectives of this aspect of the review were to [1] assess the accounting controls related to the reconciliation of paid claims and the financial activity reports, [2] verify the accuracy of financial activity that contributed to the preparation of the fiscal year (FY) 2001 combined financial statements for the Centers for Medicare & Medicaid Services (CMS)¹, and [3] determine the status of findings resulting from the 1998 and 1999 CFO audits. A separate report (Common Identification # A-02-01-01026) will be issued on the claims processing and medical review phases of the review. Our audit period was from January 1, 2001 through June 30, 2001.

We found that the accounting controls were generally adequate and that the reconciliation was substantially accurate, supportable and complete. We found, however, that accounting controls over certain financial activities need to be strengthened in order to prevent misstatements of the CMS financial statements. Specifically, we recommend enhancements to Empire Medicare Services' (EMS) procedures in the following areas:

- ▶ *Outstanding Items on the Bank Reconciliation;*
- ▶ *Reporting of Do Not Forward (DNF) Checks, and*
- ▶ *Timely Review of the Financial Reports.*

¹ Formerly known as the Health Care Financing Administration, or HCFA.

We also noted that one of the four weaknesses in the shared claims processing systems, which were previously identified during the 1998 and 1999 CFO audits, have been fully resolved, but that three of these issues are still under consideration by the CMS. We, therefore, recommend that EMS continue its efforts to accomplish enhancements to the Fiscal Intermediary (FI) and Carrier shared claims processing systems with respect to:

Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Fund Classification under the Fiscal Intermediary Shared System (FISS);

- ▶ *VOIDS and Stop Payment Totals* under the Multiple Carrier System (MCS) and;
- ▶ *Non-Claim Transactions* reported under FISS.

EMS concurred with the recommendations and noted that corrective actions have already been taken with respect to the reported findings. EMS also noted that it intends to continue to pursue the recommended enhancements to the shared systems. The full text of EMS's response is attached as an Appendix to this report.

INTRODUCTION

Background

Medicare was established under Title XVIII of the Social Security Act by the Social Security Amendments of 1965. At the Federal level, Medicare is administered by CMS. To accomplish its mission, CMS contracts with fiscal intermediaries (FIs) and carriers to process Medicare claims submitted by health care providers. The CMS instructions to FIs and carriers are included in the Medicare Intermediary Manual (MIM) and the Medicare Carriers Manual (MCM), respectively.

Under contract with CMS, EMS acts as a Medicare FI and carrier and processes claims for providers located in New York State, New Jersey, Connecticut, Massachusetts, and Delaware. As such, EMS is responsible for pricing covered medical items and services, making claims payments, guarding against the unnecessary use of medical services, and reporting financial activity to CMS. EMS uses three different shared systems to process its claims: FISS, MCS and the Viable Information Processing System (VIPS) Medicare System, or VMS.

With respect to reporting financial activity to CMS, Medicare contractors (FIs and carriers) prepare CMS Forms 1521 (Contractor Draws on Letter of Credit) and 1522 (Monthly Contractor Financial Report) each month to reconcile Medicare's benefit payments per the contractor's bank to CMS and contractor records.

The CMS 1521 summarizes the vouchers the bank submits to the Federal Reserve to request transfers of funds to the contractor's bank account. The amounts drawn down by the bank for

benefit payments are reported on the CMS 1521 as “*Funds Drawn this Month*” and these disbursements are also included on the CMS 1522.

The CMS 1522 reports all “Paid Claim” and “Non-Claim Transactions” for the month to CMS. The “Non-Claim Transactions” represent items such as cost report settlements, suspense/release payments, periodic interim payments, and cash collections. The net “Paid Claim” and “Non-Claim Transactions” in a given month account for the “*Total Funds Expended*” on the CMS 1522. The “*Total Funds Expended*” also represents the sum of all checks drawn and electronic funds transfer (EFT) payments issued during the calendar month, less voided checks and overpayment recoveries.

The EMS submits to CMS, on a monthly basis, a separate FI and carrier CMS 1521 and 1522. During the six month audit period (January to June 2001), the FI and carrier reported “*Total Funds Expended*” of \$8,556,761,829 and “*Funds Drawn*” of \$8,801,465,000.

Objectives, Scope and Methodology

The objectives of this review were to [1] assess the accounting controls related to the reconciliation of paid claims and the financial activity reports, [2] verify the accuracy of financial activity that contributed to the preparation of the fiscal year (FY) 2001 combined financial statements for the Centers for Medicare & Medicaid Services, and [3] determine the status of findings resulting from the 1998 and 1999 CFO audits.

The Office of Audit Services reviewed, and has reported separately on, EMS’s entity-wide security program planning and management and access controls. The independent accounting firm of Clifton Gunderson, LLC reviewed, and will report separately on EMS’s “Non-Claim Transactions”. Our review of accounting controls was primarily limited to matters concerning the recording and reporting of information on the CMS 1521 and CMS 1522.

For the six-month audit period, we verified the reconciliation of monthly CMS 1521 and CMS 1522 reports to EMS’s paid claims tapes, bank statements, journals, and systems reports for both the FI and carrier. We also inquired about the reporting of activity for DNF checks and reviewed accounting procedures related to EMS’s reconciliation and financial activity reports. Audit fieldwork was performed between March and July 2001 at EMS’s office in Syracuse, New York.

This audit was conducted in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

We found that the accounting controls were generally adequate and that the reconciliation performed by EMS was substantially accurate, supportable and complete. However, we found that accounting controls over certain financial activities need to be strengthened in order to prevent misstatements of the CMS financial statements. We also noted that one of the four

weaknesses in the shared claims processing systems, which were previously identified during the 1998 and 1999 CFO audits, have been fully resolved, but that three of these issues are still under consideration by the CMS.

ACCOUNTING CONTROLS AND FINANCIAL ACTIVITY

For the six-month audit period, we verified the reconciliation of monthly CMS 1521 and CMS 1522 reports to EMS's paid claims tapes, bank statements, journals, and systems reports for both the FI and carrier. We also reviewed accounting procedures related to EMS's reconciliation and financial activity reports. We found that the accounting controls were generally adequate and that the reconciliation performed by EMS was substantially accurate, supportable and complete. As noted below, however, the accounting controls over financial activities need to be strengthened in three areas.

Outstanding Items on the Bank Reconciliation – Although no problems were observed with respect to outstanding items at the time of the 1999 CFO audit, the 1998 CFO audit at EMS had disclosed problems with regard to the cancellation of stale dated checks and the resolution of encoding errors for both the FI and carrier operations.

As was the case for the 1999 audit, the present audit detected no problems with respect to the cancellation of stale dated checks. We noted, however, that there were many outstanding items related to encoding errors and other errors on the bank reconciliations for both the New York and New Jersey carriers, some dating as far back as June 1999. The EMS officials explained that staffing issues delayed the resolution of these outstanding items with their bank. EMS subsequently informed us that they have successfully resolved most of the New York outstanding items, reducing the total from \$212,138 as of June 2001 to \$11,683 by November 2001. In addition, EMS indicated that they hope to complete the identification and resolution of \$173,220 in June 2001 outstanding items on the New Jersey reconciliation during the February 2002 reporting period.

Reporting of Do Not Forward Checks – The DNF initiative established procedures to be followed by carriers effective July 1, 2000 once the post office returns a check to the carrier. The CMS instructions require the contractor to void the returned check and to prevent any further payments to the provider until a new address can be confirmed. At the start of our audit period, however, we noted that EMS's New York carrier was not properly reporting DNF financial activity for payments withheld from providers.

To account for the New York carrier's financial activity, EMS must accumulate information from several different VMS reports. In performing this analysis and collation of data, EMS separated the DNF activity from other Medicare expenses in order to assure that the DNF items would be excluded from the funds drawn and the Total Funds Expended on the CMS 1521 and CMS 1522. We noted, however, that EMS's Statement of Financial Position (CMS 750 Report) was not reporting a DNF liability for payments withheld by its New York carrier.

Based on our discussions about these matters, EMS posted an entry in March 2001 to capture \$1,100,793.50 in Medicare expenses and liabilities for DNF activity on the CMS 750. At that time, too, EMS revised its procedures to ensure that payments withheld by its New York carrier under the DNF initiative will be included in the CMS 750.

Finally, EMS officials explained that for the New Jersey carrier, MCS generates data about withheld DNF payments for preparation of the financial reports. The EMS officials also indicated that DNF withheld checks were reported as both expenses and liabilities for the New Jersey carrier.

Timely Review of the Financial Reports - We also noted two instances of errors which affected the accuracy of the CMS 1522 reports. Specifically, we noted that for its FI and for its New York carrier, EMS properly excluded stale dated checks from the outstanding items on the CMS 1522. Starting in April 2000, however, the stale dated checks for the New Jersey carrier were not deducted from the outstanding items reported on the CMS 1522. Once we brought this matter to their attention, EMS accounted for these stale dated checks and properly reported the outstanding items for its New Jersey carrier on the CMS 1522 report for March 2001 and throughout the remaining months of the audit period.

EMS also incorrectly reported the \$3,477,722 Health Professional Shortage Area (HPSA) payment for the quarter ended March 31, 2001 in the CMS 1522 for both March 2001 and April 2001 because of a clerical error in collating the data for the CMS 1522. In response to our inquiries about this matter, EMS adjusted the subsequent month's HPSA activity to properly reflect actual payments made.

Recommendations

We recommend that EMS improve their reconciliation and financial reporting procedures to assure that:

- ❑ all outstanding encoding errors and other errors per their bank reconciliations are documented and resolved;
- ❑ DNF transactions are properly reported on its financial reports, and
- ❑ timely review of the financial reports and/or other appropriate measures will minimize the likelihood of clerical errors.

STATUS OF PRIOR FINDINGS REGARDING PROPOSED ENHANCMENTS TO THE SHARED SYSTEMS

As a result of the 1998 and 1999 CFO audits, we recommended that EMS suggest improvements to the shared systems in four areas:

- ❑ the proper classification of Part A (HI) and Part B (SMI) expenditures through FISS;
- ❑ the reporting of Voids and Stop Payments under MCS;
- ❑ the addition of a Non-Claims Report to FISS, and
- ❑ the reporting of the number of claims processed under VMS.

As part of our fieldwork, we inquired about the current status of each of these matters.

HI and SMI Fund Classification - As previously mentioned in the discussion of our review of 1998 and 1999 CFO activity at EMS (CINs: A-02-98-01023 and A-02-99-01034), the FISS does not have the capability to properly allocate five types of transactions (miscellaneous deposits, refunds, stale-dated checks, additional benefits, and accounts receivable and withholding) between the HI and SMI trust funds. Based on this finding, EMS requested a system enhancement on March 3, 1999 under Problems Assistance Request (PAR) #NY1532; however CMS responded that this PAR did not fall into the category of “essential” and, could not be addressed at that time. The EMS officials informed us that CMS is still considering the request for a system enhancement, but in the meantime, has asked EMS not to adopt interim measures to correct the allocation problem. The EMS currently addresses this pending item on their quarterly CFO Corrective Action Plan to the CMS Regional Office.

Section 1412.1 of the MIM provides instructions for reporting the total funds expended and drawn for HI and SMI benefits on the CMS 1522. For the current six-month audit period, we found that the five types of transactions that cannot be properly classified by FISS totaled \$(3,722,438) and were incorrectly reported on the CMS 1522 as impacting only the HI funds expended. The reallocation of “*Total Funds Expended*” by OIG auditors indicated that the HI funds drawn were overstated, and the SMI funds drawn were understated, by \$6,898,780 on the CMS-1521.

MCS Voids and Stop Payments Totals - As previously mentioned in the discussion of our review of 1999 CFO activity at EMS (CIN: A-02-99-01034), the MCS “*Issue and Voids Tape Statistical Report*” supports the amount of issued checks that are transmitted to the contractor’s bank and the total voids and stop payment orders reported on the CMS 1522. However, on the last day of each month under review during the 1999 CFO audit, the summary report and the supporting detail reports had different totals. At that time, EMS determined that the difference was caused by a system deficiency and referred the matter to the MCS user group. Change Request Form (CRF) #3392, which was issued on December 10, 1999, to request a program correction, is still pending.

Until the program correction is made, EMS has developed interim alternate balancing procedures. We have determined that the interim procedures accurately capture the MCS voids and stop payments and reconcile to the summary reports and supporting detail reports on the last day of the month.

Non-Claims Transactions - As previously mentioned in the discussion of our review of 1999 CFO activity at EMS (CIN: A-02-99-01034), the FISS cannot generate a report to automatically

list and number the numerous “Non-Claim Transactions” (e.g., cost report settlements). To accommodate the OIG’s need to identify the universe of “Non-Claim Transactions” and select a random sample for substantive testing, EMS created a program and report to list and number the “Non-Claim Transactions”. At our suggestion, EMS prepared PAR #NY1546 on January 27, 2000 to request that this report be added to the standard FISS software. This item is still pending.

VMS Claims Count – The reports on the 1998 and 1999 CFO audits noted that a count of the number of claims processed could not be generated by VMS. At our suggestion, EMS requested a system enhancement (Change Maintenance Request Form #EM8019) which was accepted by the VMS User Group. EMS officials have informed us that this system enhancement was made on November 29, 2000.

Recommendations

We recommend that EMS continue to monitor the status of its suggested enhancements to the FISS and MCS programs.

OTHER MATTERS

During our review of the accuracy of the cash balances on the CMS 1522, we noted an excessive transfer of approximately \$70 million into the Part B bank account which EMS’s bank subsequently transferred out of the account on the next business day. The EMS identified the situation during their daily reconciliation and contacted the bank for an explanation. The bank responded that the excess funding was the result of a human error on their part and that an adjustment had been made a day later at which time the monies were returned to the Medicare program trust fund. There was, however, no written notice by the bank alerting EMS of the transfer error prior to the EMS inquiry. We, therefore, discussed with EMS the fact that prior OAS audits raised concerns about contractors’ monitoring of banking activity to assure that funds are not drawn from the Medicare trust fund earlier, or in amounts greater, than needed. Noting that EMS promptly investigated this particular banking error, we nevertheless suggested that EMS carefully review their own procedures to assure that they are adequate to the task of detecting any instances of excess or early transfers on a timely basis.

CONCLUSION

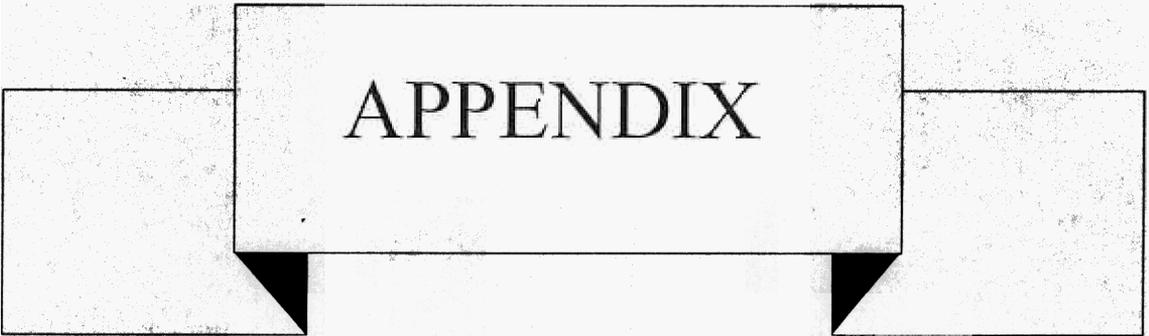
We found that the accounting controls were generally adequate and that the reconciliation performed by EMS was substantially accurate, supportable and complete. However, we found that accounting controls over certain financial activities need to be strengthened in order to prevent misstatements of the CMS financial statements. We also encourage EMS to continue to monitor the status of its suggested enhancements to the FISS and MCS programs.

Empire Medicare Service's Comments

EMS, in its response dated April 29, 2002, concurred with the recommendations and noted that corrective actions have already been taken with respect to the reported findings. EMS also noted that it intends to continue to pursue the recommended enhancements to the shared systems. The full text of EMS's response is attached as an Appendix to this report.

Office of Audit Services' Response

We are pleased to note that EMS has initiated corrective actions and reviews of its procedures to address the recommendations.

A decorative graphic for the word 'APPENDIX'. It features a central white rectangular box with a black border, containing the word 'APPENDIX' in a black serif font. This central box is set against a larger, light gray background with a fine, grainy texture. The gray background has a white rectangular area on the left and right sides, which are partially obscured by the central white box. The bottom corners of the central white box are cut off at a 45-degree angle, revealing a solid black background.

APPENDIX



MEDICARE
Part A Intermediary
Part B Carrier

April 29, 2002

Mr. Timothy J. Horgan
Regional Inspector General for Audit Services
Office of Audit Services
Office of Inspector General
Department of Health and Human Services
26 Federal Plaza, Room 3900A
New York, New York 10278

Ref: Common Identification Number A-02-01-01022

Dear Mr. Horgan:

We have reviewed the draft report "Review of Fiscal Year 2001 Financial Statement Activity at Empire Medicare Services" pertaining to the reconciliation of paid claims and the financial activity reports, CMS 1521/1522. Attached are Empire's comments. We have addressed all the findings and recommendations made in the report. All findings have been resolved.

Thank you for the opportunity to comment.

If you have any questions or require additional information, please contact me at 315-442-4650.

Sincerely,


Lloyd S. Kasow
Medicare Coordination

CC: William E. Foley
Stuart Wright

Attachment

EMPIRE MEDICARE SERVICES
A CMS Contracted Agent
www.empiremedicare.com

EMPIRE MEDICARE SERVICES
COMMENTS TO DRAFT REPORT
REVIEW OF FISCAL YEAR 2001 FINANCIAL STATEMENT ACTIVITY AT
EMPIRE MEDICARE SERVICES

(Common Identification Number A-02-01-01022)

CMS 1521/1522 Reconciliation Phase

FINDINGS AND RECOMMENDATIONS

- **Outstanding Items on the Bank Reconciliation**

Outstanding reconciling items on the New York and New Jersey bank reconciliations have been researched and resolved in March 2002. Reconciling items on the bank reconciliations are now being researched and cleared on a timely basis.

- **Reporting of Do Not Forward Checks**

An entry was recorded to correct the DNF liability in March 2001. Procedures were revised in March 2001 to ensure that DNF activity is properly reported as a liability for Part B New York on the Statement of Financial Position (CMS 750 report).

- **Timely Review of the Financial Reports**

Stale dated checks were corrected on the Monthly Contractor Financial Report (CMS 1522) for Part B New Jersey. Procedures were developed in March 2001 to properly account for stale dated checks on the CMS 1522.

The incorrect reporting of Health Professional Shortage Area (HPSA) payments was corrected in June 2001. Procedures have been reviewed with department staff. Additional emphasis has been added to the requirement for timely review of supporting detail to minimize the likelihood of clerical errors.

STATUS OF PRIOR FINDINGS REGARDING PROPOSED ENHANCEMENTS TO THE SHARED SYSTEMS

We will continue to monitor and pursue resolution of proposed enhancements to the shared systems.

OTHER MATTERS

Existing procedures resulted in prompt identification and resolution of the funding error by the Bank. Procedures for monitoring daily bank funding have been reviewed to ensure that they are adequate.