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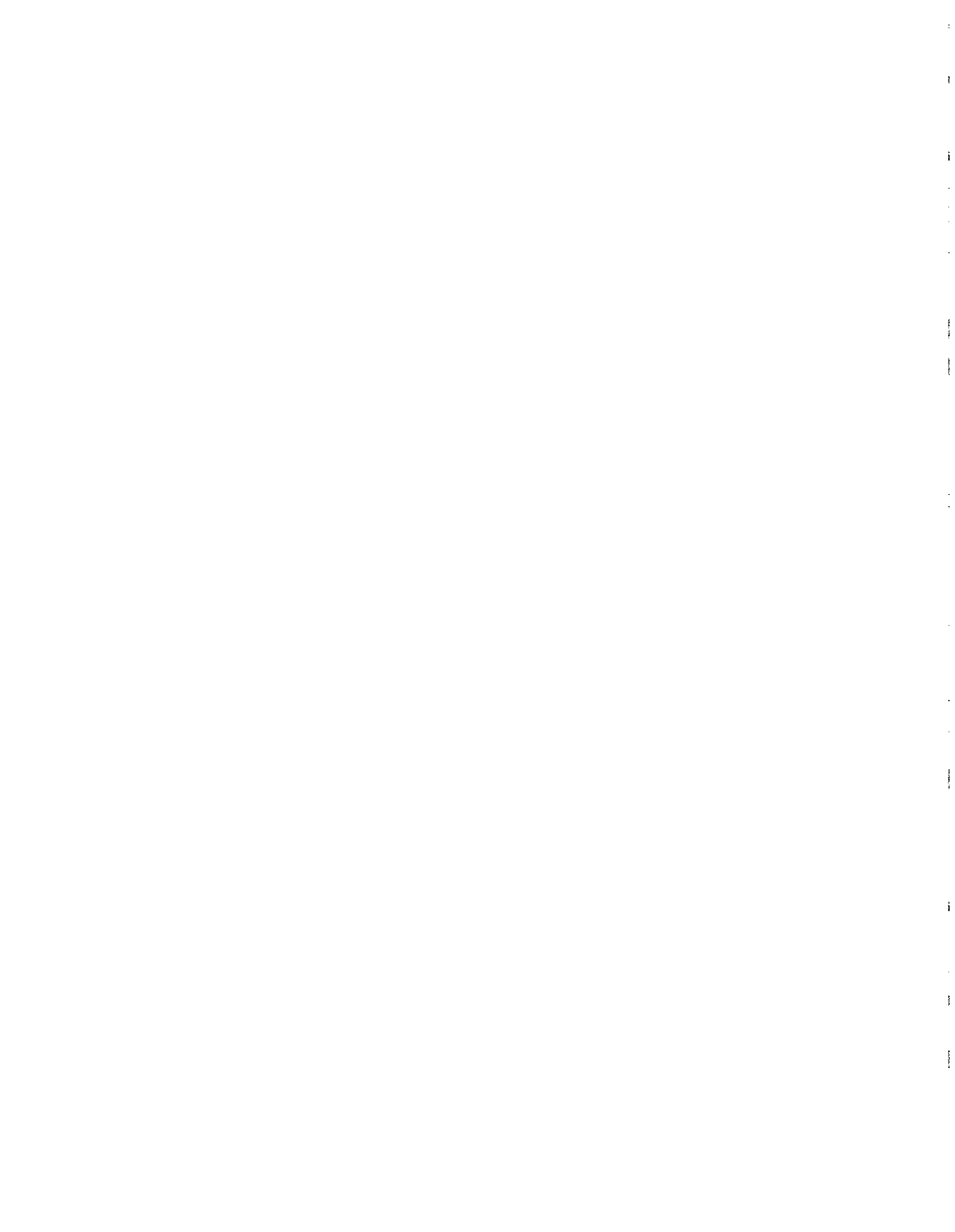
TECHNICAL SUMMARY
FINANCIAL MANAGEMENT PROFILE
OF THE
HEALTH CARE FINANCING ADMINISTRATION

PREPARED BY
THE STAFF OF THE
U.S. GENERAL ACCOUNTING OFFICE

029743

GAO/AFMD-84-15-6
AUGUST 10,1984



Foreword

The Health Care Financing Administration is an organizational component of the Department of Health and Human Services. In fiscal 1982 it received approximately $91 billion in budget authority. The Health Care Financing Administration is primarily responsible for the Medicare program and federal participation in the Medicaid program. These two programs help eligible participants pay for the cost of health care services. These programs are administered through agents such as Medicare contractors and state Medicaid agencies.

This technical summary is one of eleven volumes of detailed information that supports the overall Financial Management Profile for the Department of Health and Human Services (AFMD-84-15, April 9, 1984). The technical summaries provide detailed information on the major organization components of the Department of Health and Human Services (the Department), their financial management systems, and major internal control strengths and weaknesses in these systems.

The financial management profile of the Department and the eleven technical summaries were prepared by GAO as a pilot test of a new audit approach--called Controls and Risk Evaluation (CARE)--for (1) identifying and describing the financial managment systems used by an agency and (2) assessing and ranking the internal control strengths and weaknesses of the systems. This analysis is based on reviews of available systems documentation, discussions with agency personnel, and reviews of prior GAO and Inspector General reports. Tests were not performed on actual information processed by and recorded in the systems, therefore, conclusions cannot be reached about whether the systems' internal controls were actually operating as designed.

The information in this technical summary is intended for use in:

--planning future tests and evaluations of the accounting and financial management systems at the Health Care Financing Administration;

--monitoring the Administration's efforts to implement the Federal Managers' Financial Integrity Act of 1982, and

--supporting and enhancing the understanding and application of the CARE-based methodology by designers, operators, and evaluators of agency accounting and financial management systems.

This profile provides a description of the financial management structure of the Health Care Financing Administration. Five automated systems and one manual system form the financial management structure. These systems are used to (1) control appropriate funds and other resources, (2) authorize the use of

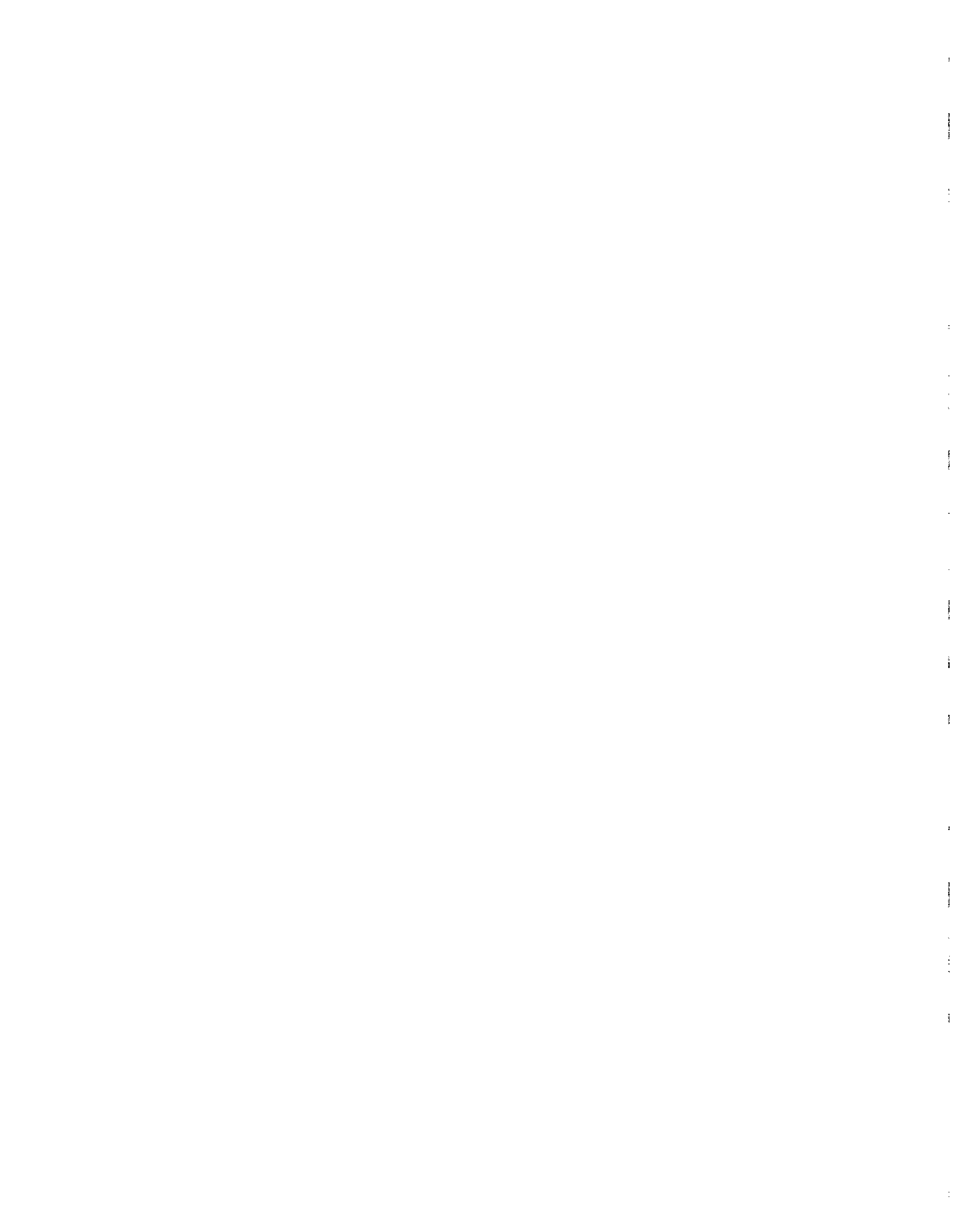
funds and other resources, and (3) capture, record, process, and summarize financial information related to the execution of budget authority. The summary also provides a detailed analysis of the six systems and identifies specific internal control strengths and weaknesses for each system.

During the course of GAO's survey agency officials were briefed. The summary was provided to cognizant agency officials for their review and comment and their comments were considered and appropriate changes made.

The assistance and cooperation of agency management enhanced the successful completion of the work. The results of the survey will be used by GAO as the basis for planning future reviews of the Health Care Financing Administration's financial management systems to ascertain if they conform to the Comptroller General's principles and standards for federal agencies. The summary is being provided to the Adminstration to assist it in its continuing efforts to improve financial management.

Contents

	Page
Health Care Financing Administration--its responsibilities, activities and financial management structure	1
Responsibilities and organizational structure of the Health Care Financing Administration and ADP resources used	3
Budget development and control for HCFA's Spending Authority	5
Accountability for two trust funds that support medicare benefit payments	9
Controls over HCFA's spending authority and administrative costs associated with program management	10
Systems and controls over the propriety of medicare and medicaid benefit payments	28
HCFA monitoring of third party contractor operations needs improvements	29
Current system and program evaluation	30
APPENDIX	
I Objective, scope, and methodology	32
II Health Care Financing Administration financial management systems internal control strengths and weaknesses	36
III Financial management systems flowchart	51



HEALTH CARE FINANCING ADMINISTRATION -- ITS RESPONSIBILITIES, ACTIVITIES, AND FINANCIAL MANAGEMENT STRUCTURE

The Health Care Financing Administration (HCFA) administers two federal health insurance programs: the Medicare and Medicaid programs. Medicare covers hospital, physician, and other medical services for persons age 65 and over who are eligible for Social Security old-age and disability benefits. Medicaid covers medical services provided to eligible low income individuals and families. For fiscal 1982, HCFA received about $91 billion in spending authority and employed about 5,200 individuals.

Funding for the Medicare and Medicaid programs comes from two sources: two trust funds and appropriated funds. The Treasury Department maintains the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust funds to support benefit payments under the Medicare program. Benefit payments under the Medicaid program are supported by funds appropriated annually by Congress.

Day-to-day operations of the Medicare and Medicaid programs--authorizing and disbursing benefit payments--are not run by HCFA but are run by third party contractors to HCFA. Day-to-day Medicare program operations are handled by about 120 health insurance carriers under contracts with HCFA, and day-to-day Medicaid operations are handled by numerous state, county, and local welfare departments and offices. Under both programs HCFA is chiefly responsible for providing third party contractors with federal funds to make benefit payments and monitor contractor operations.

Based upon our review and analysis of available documentation and through discussions with agency financial systems and ADP officials, we determined that HCFA's financial management structure is comprised of five automated and one manual system. These systems, taken together, obligate and control HCFA's spending authority, advance funds to third party contractors, make payments for administrative expenses, control assets and liabilities, and make a special class of benefit payments. These systems also produce required internal and external financial reports.

In assessing the internal control strengths and weaknesses in HCFA's financial management structure we determined that:

--Estimates of future benefit payments for the Medicaid program that are included in the President's budget request sent to the Congress are developed by the States rather than by HCFA.

--Congress can directly control only about 18 percent of HCFA's spending authority through the annual appropriation process.

--Accountability for the two trust funds that support benefit payments under the Medicare program is divided between

Department of Health and Human Services, Internal Revenue Service, and Treasury Department.

--Controls appeared to be adequate to ensure that HCFA's spending authority is not breached and that the financial results of program and administrative operations are accurately and completely recorded and reported.

--Controls over disbursements for administrative costs (like supplies, rent, utilities and official travel) appeared to be adequate to ensure that disbursements were properly authorized and computed and completely and accurately recorded in HCFA's general ledger accounts.

--Controls over authorizing, computing, and disbursing benefit payments under the Medicare and Medicaid benefit payments--which comprised about 82 percent of HCFA's requested fiscal 1982 budget authority--resided in systems designed, implemented, and operated by third party contractors and not in any systems directly operated by HCFA.

--HCFA's monitoring of third party contractor operations need improvement to provide adequate assurance over the propriety of benefit payments made by contractors under the Medicare and Medicaid programs.

HCFA has four projects underway to improve its accounting and financial management systems and enhance its ADP resources. These projects cover:

--Automation of the HCFA Cash Management System.

--Automation of the HCFA Medicaid Budget and Expenditure System.

--Transfer from HCFA to third party contractors responsibility for processing special classes of Medicare benefit payments.

--Development of long-range ADP upgrade plans for HCFA.

These projects are in various stages of completion. Two efforts are near completion while two other efforts are just in the preliminary stages. A determination as to whether these initiatives will improve HCFA's accounting and financial management was not part of our survey scope and objectives.

Appendix I discusses the objectives, scope and methodology used in applying the Controls and Risk Evaluation approach to identify the financial management structure of the Health Care Financing Administration. Appendix II lists the internal control strengths and weaknesses we identified in the financial management systems and appendix III shows the interrelationship of these systems.

RESPONSIBILITIES AND ORGANIZATIONAL STRUCTURE OF THE HEALTH CARE FINANCING ADMINISTRATION AND ADP RESOURCES USED

The Health Care Financing Administration (HCFA) is responsible for managing the two major federal health care insurance programs: the Medicare and Medicaid programs. Both programs help eligible participants pay for the cost of health care services.

The Medicare program covers hospital, physician, and other medical services for persons aged 65 and over, disabled persons entitled to social security benefits, and most persons with end-stage renal disease. The Medicare program is comprised of two parts: the Hospital Insurance (HI) and Supplemental Medical Insurance (SMI) programs. HI program pays for inpatient hospital and skilled nursing facility care. The SMI program pays for physicians and physician ordered services and supplies, outpatient hospital services, rural health clinic visits, and home health visits.

The Medicaid program provides medical care for certain low income individuals and families and those groups or categories of people who are eligible to receive benefit payments under one of the existing welfare programs established under the Social Security Act. These programs include the Supplemental Security Income, Black Lung, and Aid to Families with Dependent Children programs.

Responsibility for managing and operating the Medicare and Medicaid programs is divided between HCFA, private health insurance carriers, and state, county, and local welfare departments and agencies. Under the Medicare program, HCFA is responsible for (1) contracting with private health insurance carriers to manage and run day-to-day program operations which include accepting applications for benefit payments and authorizing, computing, and disbursing individual benefit payments and (2) providing the contractor with advances of federal cash to make the benefit payments. Under the Medicaid program, HCFA again is responsible for (1) entering into agreements with state, county, and local welfare departments and agencies to manage and run day-to-day program operations which include accepting applications for benefits, determining applicants' eligibility for benefits, and authorizing, computing, and disbursing individual benefit payments and (2) providing the welfare departments and agencies with federal cash to cover the federal share of program costs. Under both the Medicare and Medicaid programs, HCFA is responsible for monitoring contractor operations to ensure the propriety of benefit payments made.

In addition to the previously discussed responsibilities, HCFA directly makes certain classes of benefit payments. For these classes of benefits, HCFA accepts the application for benefit payments, determines the applicants' eligibility for benefits, and authorizes, computes, and disburses individual benefit payments.

To discharge its responsibilities HCFA is organized functionally under the direction of an Administrator and four Associate Administrators whose responsibilities are as follows:

--Policy: legislative planning and policy analysis and research and demonstration activities.

--Operations: central and regional office program operations, management of contracts to administer Medicare, evaluation of Medicare contractors and state Medicaid agencies, and quality control and penalty programs.

--External Affairs: liaison with health practitioners, institutional providers of health services, and academic institutions and HCFA public and intergovernmental affairs activities.

--Management and Support Services: financial, personnel, and contracts management, reimbursement to Medicare service providers dealing directly with HCFA, maintenance of the centralized automated data processing and telecommunications facility, and administration of an actuarial program.

The Social Security Administration provides about 85 percent of the computer resources needed by HCFA's automated systems. These automated systems include the financial systems discussed in this technical summary as well as other automated management information systems operated by HCFA to capture, record, process, and report a wide variety of statistical information related to the operations of the Medicare and Medicaid programs.

In addition to the computer resources provided by the Social Security Administration, HCFA operates its own central computer facility. The computer equipment in HCFA's central facility includes:

--An IBM 4341 Group 1 system that supports several management information systems for research, Medicare and Medicaid program statistical analyses, and administrative support applications.

--A Hewlett-Pachard 3000 systems to support HCFA's HART system (general ledger and financial reporting system) and HCFA's budget development system.

--An IBM 7331 system to support HCFA's Claims Processing System for Medicare health care providers that elect to deal directly with HCFA instead of third party contractors.

In addition, each of HCFA's 10 regional offices has a Datapoint 6600 minicomputer. These minicomputers support software development and a number of administrative and program management systems internal to the regional offices and provide data to HCFA systems operated in its central computer facility.

BUDGET DEVELOPMENT AND CONTROL FOR HCFA's SPENDING AUTHORITY

For fiscal 1982 HCFA requested about $91 billion in spending authority to cover Medicare and Medicaid benefit payments and general program management. This section discusses HCFA's budget development processes and the degree of control Congress can exercise over HCFA's spending authority through the annual appropriation process.

HCFA's Budget Development Processes

HCFA's annual budget request is comprised of three major parts: grants to states for Medicaid, payments to health care trust funds for Medicare, and program management costs. The budget development systems for Medicare and Medicaid are manual systems. The budget development system for program management cost is combination manual and automated system.

HCFA's budget development timeframe spans approximately eight months, and the process begins about 23 months before the start of the fiscal year for which the budget request is being prepared.For example, HCFA began planning for the fiscal year 1984 budget request in November 1981 and submitted its budget request to the HHS Office of the Secretary in July 1982. The processes to develop the three HCFA budget requests are discussed below.

HCFA's Division of Budget under the Associate Administrator for Management and Support Services had overall responsibility for preparing the three budget requests. Specific responsibilities for developing the budget requests were as follows:

--Grants to States for MEDICAID--HCFA's Bureau of Program Operations.

--Payments to Health Care Trust Funds (MEDICARE)-- HCFA's Bureau of Data Management and Strategy.

--Program Management Budget--HCFA's Division of Budget.

The Division of Budget consolidated the three budgets into one submission that is sent to the Office of the Secretary.

Grants to States for Medicaid

The grants to States for Medicaid fiscal 1984 budget request was based on estimated payments that would be made to States for payments to health care providers under the Medicaid program. Quarterly, States estimate the amount of Medicaid payments to be made during the subsequent year and send these estimates to HCFA's Bureau of Program Operations.

The Bureau of Program Operations maintains a current estimate of the subsequent year's Medicaid payments based on the estimates received from the States. This estimate is modified each quarter. Consequently, the fiscal 1984 budget request submitted to the Office of the Secretary for grant payments to States was based on estimates made during the quarters ended November 1981 through July 1982 more than 15 months before the start of fiscal 1984. When the grants to States for Medicaid budget request was submitted to OMB it was updated based on the November 1982 payment estimate prepared by the States.

The Bureau of Program Operations adjusts estimates made by the States for changes in regulations or laws that were not available to the States when they prepared their estimates. The Bureau of Program Operations sent its fiscal 1984 request to the HCFA Division of Budget for review, modification, and transmission to the HHS Office of the Secretary.

Payments to health care trust funds (Medicard)

The payments to health care trust funds (Medicare) budget request was based on actuarial projections. Specifically, actuaries in the Bureau of Data Management and Strategy used historical payment data, inflation rates, and other factors--like population trends, program utilization trends, and proposed changes in Medicare legislation--and actuarial projections to estimate the amount of Medicare payments to be made during fiscal 1984. These estimates were made and were based on information available from November 1981 through July 1982. The annual Medicare payment estimates for fiscal 1984 were sent to the Division of Budget for review, modification, and transmission to the HHS Office of the Secretary.

Program management budget request

HCFA's program management budget request was composed of six segments:

--Professional Standards Review Organizations which provide for reviews of health care services provided under Medicaid to determine whether services provided are medically necessary and whether they were provided at the lowest practicable cost.

--Research, Development and Evaluation Projects which are designed to identify ways to improve the delivery, quality, and financing methods of health care services.

--Medicare Contractors which provides the funds to pay contractors for performing the claims processing and payment function.

--State Certification Activities which provides the funds to pay States to survey and certify Medicare health care providers.

--End Stage Renal Disease Network which provides the funds needed to coordinate and support the delivery of kidney dialysis and transplant services.

--Administrative Costs which includes the funds needed for staff salaries, travel, and other administrative costs - like rent, utilities, printing and publications - needed to administer health care financing programs.

The Division of Budget is responsible for preparing the program management budget. It prepares the administrative cost segment of the program management budget and receives budget data for the other five segments from the following HCFA components:

--The Health Standards and Quality Bureau prepares the (1) Professional Standards Review Programs, (2) State Certification Activities, and (3) End Stage Renal Disease budget requests.

--The Research, Development and Evaluation Project prepares its own budget request.

--The Bureau of Program Operations prepares the Medicare Contractor budget request.

The budget development system for the program management budget is eventually a manual process. The budget development process for the administrative cost segment, however, is supported by an automated system--HCFA's automated Budget Information System. This system is made up of two major subsystems: the Control Table Subsystem and the Allotment/Allowance Reporting Subsystem. The Budget System is run on computer equipment located in HHS's Washington Computer Center. Information is entered into and retrieved from the system by computer terminal and printers connected to the computer terminals.

The Control Table Subsystem records and reports HCFA's initial budget request and subsequent changes made by the Office of the Secretary, Office of Management and Budget, and House and Senate appropriations subcommittees. HCFA's long-range plans for the control table subsystem provide for automating routine tasks, currently done manually, for acquiring, recording, and manipulating the information needed to support HCFA's budget request. When fully developed and implemented, the control table subsystem will assist budget analysts to compute different budget requests based on different assumptions on levels of effort in the various HCFA programs. These levels of effort would be based on varying assumed levels of program activity that could be authorized by the Congress.

The Allotment Allowance and Reporting Subsystem accepts, stores, and reports the spending authority finally granted HCFA for program management by the Congress and all subsequent changes thereto - that is, supplementary appropriations - and produces official notifications to HCFA organizational components of their

spending authority. The system helps ensure that the spending authority provided to HCFA's organization components does not exceed the total spending authority provided HCFA by the Congress.

Congressional Control Over HCFA's Spending Authority

Congress can only directly control HCFA's program management budget request through the appropriation process. This part of HCFA's budget request is a proposed spending level that Congress can approve, disapprove or modify. Congress cannot directly control HCFA's grants to states for Medicaid and payments to health care trust funds - Medicare budget requests - through the appropriation process. These two parts of HCFA's budget request are estimates of anticipated expenditures rather than proposed spending levels that Congress can approve, disapprove, or modify during the appropriation process.

HCFA's budget request for fiscal 1982 totalled about $91 billion. Of this amount, $75 billion represented anticipated expenditures for Medicare and Medicaid benefit payments which was about 82 percent of HCFA's total requested spending authority for fiscal 1982. Since the $75 billion represented estimates of anticipated expenditures for Medicare and Medicaid benefit payments for fiscal 1982 rather than a proposed spending level, Congress could control only about 18 percent of HCFA's fiscal 1982 spending authority through the annual appropriation process.

HCFA's annual budget request for Medicare and Medicaid benefit payments do not present HCFA's proposed spending ceilings for these programs. Instead, it presents an estimate of anticipated expenditures under these programs.

Actual spending levels for both the Medicare and Medicaid programs are determined by the number of people who continue to meet eligibility criteria and who apply for and receive benefits based on eligibility and payment computation criteria set in the laws that created the Medicare and Medicaid programs. Congress can control the amount of individual benefit payments by changing the eligibility and payment computation criteria in the legislation that established the programs, but it cannot control the total amount of benefit payments made in a year. This total is determined by the number of people who apply for and receive benefits.

Congress will appropriate funds for Medicare and Medicaid benefit payments based on the estimates of anticipated benefit payments included in HCFA's budget request. If the appropriation, however, falls short of actual obligations and expenditures for Medicare and Medicaid benefit payments, Congress will adjust the following year's appropriations for these programs to cover any shortfall in the prior year's appropriation.

ACCOUNTABILITY FOR TWO TRUST FUNDS THAT SUPPORT MEDICARE BENEFIT PAYMENTS

Two trust funds are maintained by the Treasury Department to support benefit payments under Medicare's Hospital Insurance and Supplemental Medicaid Insurance programs. These two trust funds are the Federal Hospital Insurance and Federal Supplemental Medical Insurance trust funds. These funds are primarily supported by employee and employer payroll taxes under the Fedeal Insurance Contribution Act (FICA) and Self Employment Contribution Act (SECA).

Responsibility for maintaining accounting records and accountability for the two trust funds that supported the estimated $57 billion in Medicare benefit payments in the President's fiscal 1982 budget request is divided between three federal agencies: the Treasury Department, the Internal Revenue Service, and the Department of Health and Human Services. To obtain an overview of total trust fund operations--that is, receipts, disbursements and fund balances--work would have to be done at all three agencies. The Department of Health and Human Services--HCFA--controls and accounts for total benefit payment disbursements from the two trust funds. Individual benefit payment disbursements are controlled and accounted for by third party contractors that run day-to-day program operation for HCFA.

The Internal Revenue Service collects, controls, and accounts for receipts to the two trust funds. Receipts come primarily from Federal Insurance Contribution Act (FICA) and Self Employment Contribution Act (SECA) payroll taxes, contributions by states, contributions by covered individuals, federal interbudgetary transfers, and Federal general tax revenues. The largest source of income to the trust funds comes from FICA and SECA taxes. These taxes are collected by the Internal Revenue Service and are reported to the Treasury Department. States make their contributions through the Social Security Administration. Federal interbudgetary transfers are reported to the Treasury Department by the federal agencies initiating the transfers. Contributions from federal general tax revenues are collected and recorded by the Treasury Department.

The Treasury Department, as fiduciary, maintains general ledger accounts for the two trust funds that support benefit payments to individuals covered by the Medicare program. Trust fund general ledger accounts which are based on receipts reported to it by the Internal Revenue Service and the Social Security Administration and disbursements reported to it by the Department of Health and Human Services. Specifically, at the beginning of each tax year, Treasury estimates how much money (Federal Insurance Contributions Act (FICA) and Self Employment Contributions Act (SECA) tax collections) the trust funds will receive during the year and records these estimates in the trust fund general ledger accounts. Each tax quarter, the Department prepares a trust fund letter and sends it to Treasury that certifies the FICA and SECA

tax receipts recorded by the Social Security Administration in individuals' accounts in its Earning Record System and the data needed to redistribute FICA and SECA tax receipts among the trust funds. Entries in the Earning Records System are based on information reported to the Internal Revenue Service by employers. Treasury, based on the letter received from the Social Security Administration, compares actual receipts with its estimates and adjusts the trust fund general ledger accounts as appropriate. During each month, the Department provides estimates to Treasury of cash required to meet daily trust fund benefit and administrative payments, and, at month end, reports actual disbursements made.

CONTROLS OVER HCFA's SPENDING AUTHORITY AND ADMINISTRATIVE COSTS ASSOCIATED WITH PROGRAM MANAGEMENT

HCFA's accounting and financial management responsibilies include:

--Accounting for and controlling its annual spending authority for Medicare, Medicaid, and program management.

--Accounting for and controlling cash advances to Medicare and Medicaid third party contractors to support benefit payments made by contractors under the two programs.

--Authorizing, computing, making, accounting for, and controlling payments related to HCFA's administrative expenses.

--Authorizing, computing, making, accounting for, and controlling certain special classes of medical insurance benefit payments.

--Accounting for and controlling supplies and personal property.

--Maintaining a general ledger accounting system for recording summary financial information on the execution of its budget authority and for producing internal and external financial reports on the financial results of program and administrative operations to include financial reports on Medicare disbursements required by the Treasury Department to maintain its trust fund accounts.

HCFA uses five automated systems and one manual system to discharge its financial management responsibilities. A brief description of each system follows.

--HCFA Accounting, Reporting, and Tracking (HART) System is HFCA's general ledger and financial reporting system. It accounts for and controls HFCA's spending authority, produces required internal and external reports on the financial results of program and administrative operations,

and authorizes, computes, makes, accounts for, and controls payments related to HCFA's administrative expenses.[1]

--Letter of Credit System is designed to authorize, account for and control letters of credit and resulting cash advances to third party contractors that make individual benefit payments under the Medicare program.

--HCFA's Cash Management System records cash disbursements made to third party contractors by the Treasury Department under the Medicare program and includes controls to help ensure that contractors do not exceed budget limitations for administrative costs.

--HCFA's Claims Processing System accepts applications for, authorizes, computes, and makes benefit payments to health care providers under the Medicare program that elect to deal directly with the federal government rather than third party contractors. For fiscal year 1982 Medicare benefit payments made directly by HCFA accounted for about $750 million out of Medicare benefit payments which totalled about $57 billion.

--Medicaid Budget and Expenditure System accounts for and controls spending authority granted to states for the Medicaid program and establishes letters of credit for states with the Treasury Department to provide states with the funds needed to support Medicaid benefit payments.

--HCFA's Property Control System orders, accounts for, and controls its stock of printed forms and publications. A manual system is used by HCFA to account for and control its investment in personal property.

HCFA Accounting, Reporting, and Tracking (HART) System

The HCFA Accounting, Reporting, and Tracking (HART) System is HCFA's main financial management system. It (1) maintains general ledger accounts, (2) produces all required internal and external reports on the financial results of program and administrative operations, (3) administratively controls HCFA's annual spending authority, and (4) authorizes, computes, makes, accounts for, and controls payments related to HCFA's administrative expenses. HART was implemented during fiscal 1982. It cost about $590,000 to design and develop, and its annual operating costs are estimated to total about $150,000.

HART is run on a dedicated Hewlett-Packard 3000 - Series III minicomputer. All information is entered into the system by

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1/HCFA's payroll disbursements are authorized, made, accounted for and controlled through the Department of Health and Human Service's Central personnel/payroll system. This system is discussed in a separate Technical Summary.

computer terminal and is stored on a single database. HART is designed to use the IMAGE 3000 Database Management System.

HART is comprised of the following six modules:

--Universal Transaction Module

All information entered into the HART system is first processed by the Universal Transaction Module. This module, based on the transaction code entered on the computer terminal, asks/prompts the terminal operator for needed information. This module edits all transaction information entered by computer terminal. Only completely validated information is accepted for further computer processing. The Universal Transaction Module maintains a masterfile of all transaction information accepted for further processing by the Centralized Accounting Module.

--The Centralized Accounting Module

The Centralized Accounting Module uses the information in the transaction masterfile created by the Universal Transaction Module to update HART's accounting database. This database consists of the following segments:

--General Ledger Accounts

--Allotment detailed Accounts

--Allowance Detailed Accounts

--Common Accounting Number (CAN) Summary

--Common Accountng Number (CAN) Object Class

--Class Crossreference

--Accounting Key Index

--Document Number Index

--Transaction History File

--System Codes Index

--Reporting Module

The Reporting Module is designed to (1) produce responses to requests for information by computer terminal, (2) produce 65 routine hardcopy reports, (3) send information to other HHS computer systems by telecommunications lines, and (4) produce magnetic tape copies of information maintained in HART's database. The source of information reported-out

by the Reporting Module is the information in the database maintained by the Centralized Accounting Module.

--Table Maintenance Module

The Table Maintenance Module updates information in (1) the edit tables used by the Universal Transaction Module to validate transaction information and (2) the index files used by The Centralized Accounting Module.

--Accounting and System Control Module

The Accounting and System Control Module verifies the accuracy of processing accomplished by the Centralized Accounting Module. This module, quite simply, adds the dollar value of transactions processed during a 24 hour period to the dollar balance in the various accounts in the database at the beginning of the 24 hour period and compares these totals to the balances in the various accounts in the database at the end of the 24 hour period. All discrepencies are reported-out for follow-up and correction.

--Archiving and Retrieval Module

This module periodically copies all information in the HART database onto magnetic tape.

A brief discussion of system inputs, processing, and outputs of the HART system and internal control strengths and weaknesses in the HART system follows.

System inputs

HART receives information from the various operating units in HCFA on hardcopy documents. It also receives information from other automated systems in HHS and HCFA by either magnetic tape or via telecommunications lines.

The HCFA central accounting office receives hardcopy documents from other HCFA operating units for transactions which include:

--Administrative costs like travel expenses, rent, utilities, and procurements of supplies and personal property.

--Summary information on benefit payments made under the Medicare and Medicaid programs.

--Collections of accounts receivable.

--Letter of credit advances under the Medicaid program.

The HART system receives the following information from other HCFA and HHS automated systems:

--Central Personnel/Payroll System (HHS) reports to HART bi-weekly payroll disbursements and costs for HCFA employees.

--Regional Accounting System (HHS) reports to HART transactions accomplished by HHS regional offices that relate to HCFA's program and administrative responsibilities.

--Letter of Credit System (HCFA) reports to HART cash advances to Medicare contractors and disbursements made by Medicare contractors.

System Processing

Hard copy documents received in HCFA's central accounting office are entered into the HART system by computer terminal by staff in the central accounting office. The transactions entered by computer terminal are merged with transactions received by HART from other HHS and HCFA automated systems. The merged transactions are processed by HART's six modules as previously discussed.

System Outputs

The HART system is designed to produce four classes of outputs:

--Responses to inquiries for information entered by computer terminal.

--Standard hardcopy reports.

--Machine media files for other HHS systems.

--Magnetic tape copies of information contained in HART's database.

This section will briefly discuss the hardcopy reports and machine media files produced by HART. The responses to inquiries entered by computer terminal and magnetic tape copies of information in HART's database will not be discussed because computer terminal inquires cover a wide range of non-standard, ad hoc requests for information which could not be fully discussed and because the magnetic tape copies of the HART database are simply used for archival recordkeeping purposes and to backup the database.

The HART system is designed to routinely produce 65 hardcopy reports to provide (1) managers with summary information on the financial results of program and administrative operations and (2) a hardcopy audit trail of the results of transaction processing. Examples of these reports are the:

--Report of Transactions by User

--Selected General Ledger Report

--Summary of Daily Activity Report

--Allotment/Allowance Report

--General Ledger Trail Balance

--Minor Object Class by Common Account Number with Allowance and Appropriation Report.

--Object Class by allowance and Appropriation Report

--Status of funds by Appropriation Report

--Status of Funds by Allowance Report

--Major Object Class by Appropriation Report

The HART system is also designed to routinely produce the following information for use by other HHS automated systems: [2]

--Departmental Federal Assistance Financing System (DFAFS) HART provides DFAFS with the obligational authority to make Medicare and Medicaid cash advances to third party contractors to support benefit payments.

--Financial Assistance Reporting System HART provides the Federal Assistance Reporting System with summary information on obligations for domestic assistance programs.

--Central Registry System HART provides the Central Registry System with detailed information on Medicare and Medicaid third party contractors that receive grants and contracts.

Internal Control Strengths And Weaknesses

The internal controls in the HART system appear generally adequate to ensure that the financial results of program and administrative operations are completely and accurately recorded and reported, HCFA's spending authority is not breached, and disbursements for administrative expenses are proper. The primary internal control strengths of the HART system are that

--it is balanced daily,

--all transactions are written to magnetic disc and printed out on hard copy to provide an audit trail,

--the printouts go to a Reports and Control Branch in the Division of Accounting for review before being distributed to the technicians and other users of the output,

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[2]These systems are operated and maintained by the Office of the Secretary - Department of Health and Human Services. These systems are discussed in detail in a separate technical summary.

--passwords and terminal identification numbers are stored with transaction information, and

--all computer terminals are hardwired to the system and are disconnected at night.

HCFA appears to have adequate separation of duties within the HART sytem by use of features in the IMAGE 300 database management system and by the division of duties within its Division of Accounting.

Our survey disclosed certain internal control weaknesses in the HART system. The system has not been fully documented in accordance with Federal Information Processing Standards (FIPS) Publication 38, Guidelines for Documentation of Computer Programs and Automated Data Systems, National Bureau of Standards. HCFA officials stated that this was a deliberate decision by management to accept such risk in order to get the system on-line in a timely manner. HCFA officials stated that they now have documented the HART system's program specifications and the user's guide manual. They also stated that HCFA will shortly provide the HART system to the Maritime Administration, and, in exchange, the Maritime Administration has agreed to document the system in conformance with FIPS Publication 38.

We also noted that, only one person at HCFA knows the HART system. This individual created, designed, tested, and implemented the system. The Director, Division of Accounting, did not express concern over this situation because HCFA has maintained its relationship with the contractor that developed HART. In addition, the Director stated that because of the existing and planned HART system documentation effort cited above, coupled with increased staff familiarity with various aspects of the HART system, that one person is becoming less critical to the system's operation.

Our survey also disclosed that HCFA does not have a formal back-up computer in the event the system goes down. According to the Director of Accounting, the HART could be inoperative for a month without seriously impacting upon the agency's operations. It was further stated that HCFA could use the design contractor's equipment if needed. In addition, HCFA is working with the National Park Service to reach a back-up agreement. At present however, there remains no formal written agreement for back-up service.

Letter Of Credit System

The Letter of Credit System records, accounts for, and controls cash advances made to Medicare third party contractors to support individual benefit payments made to health care providers on behalf of Medicare program beneficiaries. Most Medicare third party contractors receive cash advances on the checks-paid letter-of-credit basis. This means that federal funds are transferred to the third party contractors at the time that checks issued by the contractors to health care providers are presented to the contractors' banks for payment.

The Letter of Credit System is designed to maintain detailed records on letters-of-credit issued to Medicare third party contractors that support summary accounts maintained by the HART system. Specifically, the Letter of Credit System records, accounts for, and controls:

--Letters-of-Credit issued to Medicare third party contractors.

--Payments made by third party contractors to health care providers on behalf of Medicare beneficiaries.

--Purposes for which payments were made.

--Adjustments to payments previously recorded.

A brief discussion of system inputs, processes, outputs, and internal control strengths and weaknesses follows.

System inputs

The Letter of Credit System receives the following hard copy documents as inputs:

--Letters of Credit: These are formal authorizations sent by HCFA to third party contractors and to the Treasury Department showing the dollar amount of money available to a contractor for a specified time period.

--Payment Voucher on Letter-of-Credit: This form is used by the contractors to draw funds against a letter-of-credit.

--Payment Voucher on Letter of Credit Transmittal: This form is used by contractors to inform HCFA whether funds drawn on a payment voucher be applied to:

---Hospital Insurance Benefits,

---Supplemental Medical Insurance Benefits,

---Reimbursement for costs to administer the payment of Medicare benefits,

---End Stage Renal Disease (ESRD) costs,

---Rural Health Clinic (RHC) costs, or

---Contract Administrative costs.

Letters of credit are received from HCFA's Bureau of Program Operations by the Division of Accounting for input to the Letter of Credit System. The payment voucher on letter of credit is received by the Division of Accounting directly from the Treasury Department. The payment voucher on letter of credit transmittal is

prepared by HCFA's Cash Management System and is subsequently entered into the Letter of Credit System.

System Processing

The three hardcopy documents are processed by HCFA's Division of Accounting. Division staff enter the transaction information on the documents into the Letter of Credit System by computer terminal. Transaction information is edited for reasonableness and completeness as it is entered into the Letter of Credit System by computer terminal. Transaction information that does not pass edits is rejected from further processing.

Transaction information that passes computer edits is posted to the Letter of Credit System's database. This database includes the following information:

--Current status of a Letter of Credit:

--effective date,

--amendment number,

--amount authorized, and

--time period applicable.

--Detailed data on disbursements by Letter of Credit:

--amount of Hospital Insurance disbursements for a particular drawdown of a cash advance.

--amount of Supplemental Medical Insurance disbursements for a particular drawdown of a cash advance.

--total administrative costs on a payment voucher,

--total administrative, ESRD, and RHC costs by fiscal year on a specific payment voucher, and

--total contract costs by fiscal year on a payment voucher.

--Monthly total of disbursements by Letter of Credit

--total Hospital Insurance benefits,

--total Supplemental Medical Insurance benefits,

--total administrative costs for all fiscal years, and administrative costs for each fiscal year.

System Outputs

The Letter of Credit System produces a series of hardcopy reports and sends information via telecommunications lines to the HART system.

The main hardcopy report produced is the "Matched and Unmatched Disbursements by Appropriation". The system sends the HART system all disbursements that have been matched with appropriations.

Internal Control Strengths and Weaknesses

The computer edits of transaction information in the Letter of Credit System appeared generally adequate to ensure that the information entered into and processed by the system is valid.

HCFA Cash Management System

HCFA's Cash Management System is a manual process. It is used to:

--Record Medicare contractors' drawdowns of cash advances against letters-of-credit established for them by HCFA with the Treasury Department.

--Prepare the Payment Voucher on the Letter-of-Credit Transmittal which is an input to HCFA's Letter of Credit System.

--Track and control Medicare contractors' administrative costs to help ensure contractors do not exceed spending authority limitations for administrative costs.

A brief description of system inputs, processing, outputs, and internal control strengths and weaknesses follows.

System Inputs

The HCFA Cash Management System receives the following inputs on hardcopy documents:

--HCFA's Bureau of Program operations provides the Cash Management System with the following documents for each Medicare contractor:

---The Quarterly Budget Distribution which sets forth the spending allowance for administrative costs.

---The Notice of Budget approval which sets forth the approved spending allowance for administrative costs.

---The Final Administrative Cost Proposal submitted by Medicare contractors to the Bureau of Program Operations requesting spending allowances for administrative costs.

---The closing agreement between HCFA and each Medicare contractor which sets spending ceilings for administrative costs.

---The Letter of Credit which sets forth each Medicare contractor's cash drawndown ceilings.

--Medicare contractors provide the Cash Management System with the following documents:

---Monthly Payment Vouchers on Letter of Credit Transmittal which lists (1) cash drawdowns, (2) Hospital Insurance benefit costs, (3) Supplemental Medical Insurance costs, and (4) administrative costs.

---Monthly Intermediary Financial Report which provides detailed information on (1) cash drawdowns, (2) cash disbursements (3) numbers of records processed, (4) adjustments to reimbursements, and (5) bank balances.

---Monthly Report on Bank Processing Charges which reports the bank charges incurred by Medicare contractors to process cash receipt and disbursement transactions relating to the Medicare program.

System Processing

Based on the input documents received, the HCFA Cash Management System maintains the following manual control sheets;

--HCFA Contractor Letter of Credit record which is used to track letter of credit amounts granted to each Medicare Contractor and each contractor's cash drawdowns. This record is maintained based on letters-of-credit and the Monthly Payment Voucher on Letter-of-Credit Transmittal.

--HCFA Intermediary Control of Administrative Funds Report which is used to track each Medicare contractor's administrative costs. This report is maintained based on the (1) Quarterly Budget Distribution, (2) Notice of Budget approval, (3) Final Administrative Cost Proposal, (4) Closing agreement, (5) Letter-of-Credit (6) Monthly Payment Vouchers on Letter-of-Credit Transmittal, and (7) Monthly Intermediary Financial Report.

--Letter-of-Credit Spread Sheet which is used to summarize all financial transactions on each letter-of-credit. This spread sheet is maintained based on the (1) Quarterly Budget Distribution, (2) Notice of Budget Approval, (3) Final administrative cost proposal, (4) Closing agreement, (5) Letter-of-Credit, (6) Monthly Payment Vouchers on Letter-of-Credit Transmittal (7) Monthly Intermediary Financial report, and (8) Monthly Report on Bank Processing Charges.

If the HCFA's Cash Management System's processing results shows that a Medicare contractor has program costs and expenditures that appear reasonable, additional funds will be approved. In these cases, HCFA's Bureau of Program Operations will increase the contractor's letter of credit spending ceiling.

System Outputs

The HCFA'S Cash Management System produces the nine hardcopy reports based on the information in the (1) HCFA Contractor Letter-of-Credit Record, (2) HCFA Intermediary/control of Administrative Funds report, and (3) Letter-of-Credit Spread Sheet. The nine reports produced are the:

--Monthly Contractor Financial Report Spread Sheet.

--Monthly Bills Payment Records Processed Report.

--Classification of Benefit Funds Report.

--Periodic Interim Progress Payments Reports.

--Monthly Report of PSRO Payments.

--Monthly Intermediary Financial Reports.

--Quarterly Intermediary Financial Reports.

--Quarterly National Summary Contractor Financial Report.

These reports are used by HCFA's Bureau of Program Operations to monitor the financial operations of Medicare contractors and to prepare hardcopy input to the HART system.

In addition to the nine hardcopy reports, HCFA's Cash Management System forwards the Monthly Payment Vouchers on Letter-of-Credit Transmittals received from Medicare contractors to HCFA's Letter-of-Credit System for processing.

Internal Control Strengths and Weaknesses

The HCFA Cash Management System is a complex, manual process that requires (1) a large amount of transcription of information from hardcopy documents submitted by Medicare contractors (3 monthly reports from about 120 contractors) to manually maintained summary records and (2) a high level of individual judgement by HCFA personnel that process and review contractor reports as to the reasonableness of contractor reported costs. Further, the effectiveness of the results of HCFA Cash Management System processing depends directly on the completeness and accuracy of the information reported to HCFA by Medicare contractors.

In order for us to form an opinion--given the characteristics of the system--as to the propriety of the processing results of the HCFA Cash Management System, we would have to have evaluated a statistical sample of contractor supplied reports and the related results of processing by the HCFA Cash Management System. The level of detailed review of transaction information was beyond the scope of our survey, and, as a result, we cannot form an opinion as

to the effectiveness of internal controls in the HCFA Cash Management System.

HCFA's Claims Processing System

For certain health care providers, HCFA accepts, processes, and pays bills from health care providers for medical services rendered to Medicare program beneficiaries. Title XVIII of the Social Security Act as amended, which covers the Medicare program, stipulates that health care providers under the Medicare program have the right to submit claims directly to the federal government (HCFA) instead of dealing with a third party contractor to HCFA -- a health insurance carrier. The act also permits the third party contractors to HCFA to refuse to serve certain health care providers. HCFA's Office of Direct Reimbursement (ODR) processes bills from health care providers that elect to directly deal with the federal government or that third party contractors have refused to deal with.

The majority of health care provider bills are processed by third party contractors to HCFA and only a small portion of claims are processed by HCFA's ODR. For example in fiscal 1982, third party contractors processed and paid bills from physicians totalling more than $36 billion while HCFA's ODR processed and paid bills from health care providers totalling about $700 million.

The health care providers that dealt directly will HCFA's ODR included:

--415 home health agencies.

--377 federal hospitals.

--229 non-federal hospitals

-- 93 skilled nursing facilities.

In addition to the above listed health care providers, HCFA's ODR processed bills received from 13 special health care demonstration projects like the HOSPICE demonstration project which involves special health care services provided to terminally ill patients enabling them to continue life with minimal disruption in routine activity.

HCFA's ODR uses the automated HCFA Claims Processing System to process and pay invoices received directly from health care providers. A brief discription of system inputs, processes, outputs, and internal control strengths and weaknesses follows.

System Inputs

The HCFA Claims Processing System receives patient admission and medical care billing information. This information, depending on the health care provider, can be received in hardcopy documents,

via computer-to-computer telecommunications, or by magnetic tape files. The information received by the HCFA Claims Processing System, whether it is received in hardcopy, via computer-to-computer telecommunications, or by magnetic tape, is the same as the following HCFA forms:

--Inpatient Hospital and Skilled Nursing Admission and Billing Form (HCFA Form 1453).

--Provider Billing for Medical and Other Health Services (HCFA Form 1483)

--Home Health Agency Report and Billing Form (HCFA Form 1487)

--Provider Billing for Patient Service by Physicians (HCFA Form 1554)

--Claims from Federal Providers (Veterans Hospitals, and U.S. Public Health Services Facilities, for example) (HCFA Form 1980)

--New York State Inpatient Hospital Service Form (NYS OBF-1 as a replacement for HCFA Form 1453).

The above listed forms are supported by additional informatin on attachments that fully describe the medical services provided: for example, level and kind of care, treatment plans, and referrals for specialized medical services. This additional information is needed to allow an effective review of the appropriateness of the health care provided.

In addition to the input information discussed above, the HCFA Claims Processing System uses the masterfile maintained by HCFA's Master Health Insurance System. This masterfile maintains the current list of all individuals eligible to receive Medicare benefit payments.

System Processing

The processing of the HCFA Claims Processing System is comprised of two major parts: admissions processing and bill processing. The following paragraphs briefly discuss both processing parts.

Admissions processing is done on a daily basis. This processing involves entering the admission information for applicants for Medicare benefits into the HCFA Claims Processing System. The system will compare the admission information for each applicant for Medicare benefits against the masterfile of eligible Medicare beneficiaries maintained by HCFA's Master Health Insurance System. If the applicant is found on the masterfile of eligible Medicare beneficiaries, the admission information will be posted to the HCFA Claims Processing System's Utilization Masterfile or the Part A Admissions Records Masterfile and a notice of acceptance of the admission will be sent to the health care provider. If, on the

other hand, the applicant as not found on the masterfile of eligible Medicare beneficiaries, the admission information will be rejected from further processing, and the health care provider will be sent a notice of the rejection of the admission information.

Billing processing is done on a weekly basis. The processing involves entering billing information into the HCFA Claims Processing System. Billing information is processed through five computer edit programs:

--Receipt and Control Edit Program - This edit program verifies that each bill received is for a proper claim by, for example, comparing a bill against validated admissions records on the Utilization Masterfile and the Part A Admissions Records Masterfile which are updated during the admissions part of the claims system's processing.

--Consistency Edit Program - This edit program compares the information in a bill record against other computer masterfiles maintained by the HCFA Claims Processing System to verify, for example, the validity of the insurance number in the bill or the reasonableness of the timeframes for the billed health care service.

--Medical Screens and Utilization Edit Program - This edit program compares information in a bill record against other computer masterfiles maintained by the HCFA Claims Processing System to verify the appropriateness of the health care service provided. For example, this edit program compares the patients illness and treatment provided to a table of standard treatments for different major illnesses and it determines, by interrogating another computer table, whether inpatient hospital care was required for the patient's illness and treatment provided.

--Part B Entitlement Edit Program - This edit program verifies whether a Medicare beneficiary for whom a bill is submitted is covered for physician's services.

--Part B Duplicate Check Edit Program - This edit program compares information in a bill record against a computer masterfile of previously paid bills to determine whether the bill record covers health care services previously paid for.

Bills that do not pass any of the computer edits are rejected from further computer processing and are sent to ODR claims examiners for investigation and resolution. The health care provider that submitted a rejected bill receives a rejection notice that includes an explanation of the reasons for rejection. All bills that are received--both those that pass and do not pass edits--are recorded on the Control Record of all Bills and Transmittal Records (HRMTC).

Bills that pass all edits are next processed through the HCFA Claims Processing System payment operation program. This program

computes the payment amount and updates a series of computer masterfiles which (1) provide a detailed record of all claims processed and amounts paid and (2) provide some of the information needed by the five edit programs to check the validity of bills received for processing and payment. The major computer masterfiles maintained by the payment operation program are the:

--Control Record of all Bills and Transmittal Records (HRMTC)

--Part B--Physicians Services--Bills that have been processed and paid (HRBMAST)

--Part A--Hospital Inpatient Services--Payment Record (HRBPSM)

--Part B--Physicians Services-Payment Record (HRPBSM)

--Paid Bill Masterfile (HRBBPR)

--Provider profile database which includes complete information on reimbursement rates, accounting information, billing information, and mailing addresses for each health care provider that deals directly with HCFA ODR.

System Outputs

The HCFA Claims Processing System produces both magnetic tape and hardcopy report outputs. The magnetic tape files produced for payment amounts for processed bills which are sent to the Treasury Department for the preparation of checks which are sent to the health care providers. The hardcopy reports produced by the system include:

--Financial summaries of payment amounts which summarize individual payments included in magnetic tape files sent to the Treasury Department.

--Notice of Hospital admissions.

--Bill payment notices sent to Health Care Providers.

--Listings of Payments Made to Health Care Providers.

--Detailed Listings of Bills Submitted by Health Care Providers.

The hardcopy reports produced by the HCFA Claims Processing System are designed to provide a hardcopy audit trail of bills that are processed and paid and to provide the information needed by HCFA ODA managers and staff to monitor, manage and control the processing and payment of bills received from health care providers. The financial Summaries of Payment amounts support entries into HCFA's HART system.

Organization Control Over The Bill Payment Process

HCFA's ODR includes three major divisions whose staff monitor, and control the payment of bills submitted by health care providers. The Division of Provider Reimbursement (DPR) reviews health care provider accounting systems, establishes and adjusts payment rates, and settles cost reports. The Division of Claims Processing (DCP) designs and operates the claims processing system. The Technical Support Staff (TSS) conducts health care provider reimbursement appeals, negotiates and awards audit contracts, and authorizes payment vouchers (magnetic tape files) sent to the Treasury Department.

Internal Control Strengths and Weaknesses

Based upon our survey of the HCFA Claims Processing System, we did not observe any obvious major system internal control weaknesses.

Medicaid Budget and Expenditure System

HCFA's Medicaid Budget and Expenditure System is a manual system. It has two purposes: (1) to estimate Medicaid program costs for HCFA's annual budget requests and (2) provide states with grants and periodic cash advances to make Medicaid benefit payments. The following paragraphs briefly describe the inputs, processes, outputs, and internal control strengths and weaknesses of the Medicaid Budget and Expenditure System.

System inputs

The Medicaid Budget and Expenditure System uses two inputs: States Quarterly Estimate of Medicaid Cash Requirements (HCFA Form 25) and States Quarterly Medicaid Actual Expenditures Report (HCFA Form 64). States prepare two copies of the HCFA Form 25. One copy is sent directly to HCFA's Bureau of Program Operations, and the other copy is sent to the HCFA regional office responsible for monitoring the state's Medicaid expenditures. The regional offices review the HCFA Forms 25, annotate any recommended adjustments to the state figures on the forms, and forward the annotated forms to HCFA's Bureau of Program Operations. States send the HCFA Forms 64 directly to HCFA's Bureau of Program Operations.

System processes

Upon receipt of the HCFA form 25 from the states and recommended regional office adjustments, the Bureau of Program Operations reviews the state submitted HCFA Forms 25 for mathematical accuracy and verifies that all required information has been entered onto the forms by the states. Based on the validated HCFA Forms 25, the Bureau of Program Operations prepares summaries of cash requirements for the Medicaid program. Medicaid

cash summaries are prepared quarterly. In preparing the cash summaries for the Medicaid program, the Bureau of Program Operations does not consider the adjustments recommended by the regional offices.

Based on the Medicaid cash requirements summaries prepared from the HCFA form 25 submitted by the states, HCFA's Bureau of Program Operations prepares the annual Medicaid budget request which is included in the President's budget request which is sent to the Congress. After the annual Medicaid budget request is prepared and submitted, the Bureau of Program Operations updates this request each quarter based on the state submitted HCFA form 25.

After the Medicaid budget request has been either prepared or updated, the Bureau of Program Operations issues a grant to each state to support Medicaid benefit payments for the upcoming quarter. The grants are prepared based on the:

--States Quarterly Estimate of Medicaid Cash Requirements (HCFA Form 25).

--States Quarterly Medicaid Actual Expenditures Report (HCFA Form 64).

--HCFA regional office recommended adjustments to state HCFA Forms 25.

System Outputs

The outputs of the Medicaid Budget and Expenditure System are:

--Quarterly budget requests for the Medicaid Program.

--Quarterly grants to the states to support Medicaid benefit payments.

--Quarterly Medicaid States of Funds Report.

The quarterly budget requests for the Medicaid program are sent to HCFA's Office of Management and Budget and the Department of Health and Human Services Assistant Secretary for Management and Budget. The quarterly grants to states are sent to the respective states and to the Departmental Federal Assistance Financing System, operated by the Department of Health and Human Services' Office of the Secretary, to establish letters of credit for the states so they can draw cash advances to pay Medical benefit payments. The Quarterly Medicaid Status of Funds Reports, which list budget

authority, training costs, and program benefit payments by state, is sent to the HART system to update HCFA's general ledger accounts.

System Internal Control Strengths and Weaknesses

Since the operations of the Medicaid Budget and Expenditures System relies totally on the states to supply needed budget and expenditure information and simply arithmetically summarizes states' supplied financial information, we noted no obvious internal control weaknesses in the system.

HCFA's Property Control Systems

HCFA maintains an automated warehouse inventory system to control its stock and ordering of forms and publications. During fiscal year 1982 the system controlled publication issues valued at about $846,000. Inventory on hand at the close of fiscal year 1982 was valued at $1,228,000.

HCFA controls its other property, such as desks, chairs, and other equipment, through a totally manual process. The acquisition cost of HCFA assets valued over $300 was estimated at $7.1 million on September 30, 1982. HCFA inventories assets valued over $300 every year and all assets are inventoried every three years.

In addition, HCFA maintains title to and controls an inventory of assets located at various contractor and grantee locations. The latest reported acquisition cost of these assets was about $3.3 million.

Due to survey time constraints, we did not review HCFA's Property Control Systems.

SYSTEMS AND CONTROLS OVER THE PROPRIETY OF MEDICARE AND MEDICAID BENEFIT PAYMENTS

The Medicare and Medicaid programs accounted for an estimated $75 billion in benefit payments for fiscal 1982. HCFA's financial management systems for these programs do not include any processing procedures and controls to ensure that benefit payments are computed and paid in accordance with legislated eligibility and payment computation criteria. These procedures are supposed to be included in disbursement systems operated by third parties (private contractors, states, and local governments).

Third party disbursement systems are to include the processing and control procedures to (1) draw advances of federal cash, (2) accept applications or program benefits, (3) determine applicants' eligibility for benefits, (4) authorize and compute individual benefit payment amounts, (5) issue benefit payment checks, (6) determine program administrative costs, and (7) report the financial results of program and administrative operations and the

financial status of the programs to HCFA. There are about 120 private contractors for the Medicare program and hundreds of state and local government public welfare agencies and offices under the Medicaid programs.

HCFA's financial management systems for the Medicare and Medicaid programs, as discussed in the preceding section of this technical summary, cover:

--Accounting for and controlling, in summary totals, its overall spending authority for the Medicare and Medicaid programs.

--Providing spending authority and federal cash advances to third party contractors that authorize, compute, and disburse individual Medicare and Medicaid benefit payments.

--Maintaining general ledger accounts for recording summary financial information on third party contractor execution of the Medicare and Medicaid programs.

--Produce summary financial reports on the financial results of Medicare and Medicaid program operation. In discharging its accounting and financial management responsibilities for the Medicare and Medicaid programs, HCFA depends totally on the financial information supplied by third party contractors.

As a result, controls over authorizing, computing, and disbursing benefit payments under the Medicare and Medicaid programs resided in systems designed, implemented, and operated by third party contractors and not in any systems directly operated by HCFA.

HCFA MONITORING OF THIRD PARTY CONTRACTOR OPERATIONS NEEDS IMPROVEMENT

HCFA attempts to control day-to-day program financial operations at third party contractors through several monitoring programs of benefit payments made. For example, the Department monitors the operations of Medicare contractors through its Contractor Performance and Evaluation Program. It monitors the propriety of Medicaid payments through its State Assessment Programs. Both monitoring programs involve selecting samples of benefit payments made by third parties and making redeterminations of benefit payments made. Both programs also involve maintaining automated records on the results of the redeterminations of the samples of benefit payments made by third parties.

In addition to the monitoring programs, HCFA conducts periodic audits of third party system operations. These audits include (1) quality assurance reviews of benefit payments, (2) Departmental Inspector General audits of administrative expenses claimed by

third parties, and (3) Departmental desk reviews of expenditure reports filed with the Department:

--Quality assurance reviews involve desk reviews by Departmental personnel of samples of quality control audits of benefit payments done by the third parties or by private accounting firms.

--The Departmental Inspector General audits only involve administrative expenses and are done generally on a 3-year cycle basis. Rarely, will a third party be audited on an annual basis.

--Departmental desk reviews of samples of expenditure reports to try and identify any unreasonably high expenditure items.

GAO had studied the Department's monitoring programs of day-to-day third party financial operations and has questioned the effectiveness of these programs in controlling the propriety of benefit payments made. For example, a GAO survey completed in July 1983 of the Medicare Contractor Inspection and Evaluation Program disclosed serious design flaws and procedural weaknesses which impaired the program's ability to ensure the propriety of Medicare benefit payments. Other GAO studies have questioned the effectiveness of the HCFA's periodic audits of third party operations to ensure the propriety of benefit payments made.

CURRENT SYSTEM AND PROGRAM INITIATIVES

HCFA has four projects underway to improve its accounting and financial management systems and enhance its ADP resources. These projects cover:

--Automation of HCFA's Cash Management System - This system is currently a manual process to record Medicare contractors' drawdowns of cash advances, prepare inputs to HCFA's automated Letter of Credit System, and track and control Medicare contractor adminstrative costs.

--Automation of HCFA's Medicaid Budget and Expenditure System- This system is currently a manual process to develop annual budget requests for the Medicaid program, provide spending authority to states to make Medicaid benefit payments, and provide states with cash advances to support Medicaid benefit payments.

--Transfer from HCFA to third party contractors the responsibility to authorize, make, account for, and control special classes of Medicare benefit payments currently being processed by HCFA through its Claims Processing System.

--Development of Long Range ADP Upgrade Plans for HCFA - In fiscal 1982 HCFA initiated its "Project to Redesign Information Systems Management" (PRISM). PRISM resulted in

the issuance in August 1982 of an information requirements statement. This statement sets out HCFA's mission, functions, information processing requirements, and proposals and issues that may impact on these requirements in the foreseeable future. In fiscal 1983 HCFA will select a contractor to continue the PRISM effort. The contractor, will be engaged in fiscal 1984 to develop a concept paper to support a major system acquisition program. During fiscal years 1984-1989, HCFA plans to engage in a series of computer hardware and software enhancement projects based on the PRISM concept paper.

These projects are in various stages of completion. Two efforts are near completion while two other efforts are just in the preliminary stages. A determination as to whether these initiatives will actually improve HCFA's accounting and financial management will have to be made after the projects have been implemented and are operating.

OBJECTIVES, SCOPE, AND METHODOLOGY

This survey viewed the Health Care Financing Administration as a financial entity and focused on identifying its financial management structure, related systems, and internal control strengths and weaknesses in the structure. The survey applied GAO's newly developed Controls and Risk Evaluation (CARE) audit approach.

SURVEY OBJECTIVES

Our survey objectives were to (1) document all manual and automated systems at the Health Care Financing Administration that process financial transactions from the time they are authorized through final reporting of these transactions in internal and external reports, (2) identify the relationships between these systems, that is, the flow of information among different systems, and (3) identify and document internal control strengths and weaknesses in the systems.

SURVEY SCOPE

This survey viewed the Health Care Financing Administration as a single financial entity. Therefore, we identified and surveyed the financial management systems in the various organizational components of the Administration. Survey work was performed at the Headquarters, Health Care Financing Administration, Baltimore, Maryland.

We documented the financial management systems in operation and identified, based on available system documentation and through discussions with agency accounting, ADP systems, and program officials, and review of prior GAO, Inspector General and special system study group reports, the internal control strengths and weaknesses in these systems. We did not perform any tests of system operations or actual financial information and transactions. The following sections present the definitions of a financial management system, internal control, and an agency system of internal control used in this survey.

DEFINITION OF A FINANCIAL MANAGEMENT SYSTEM

In consonance with GAO's Policy and Procedures Manual for Guidance for Federal Agencies (Title 2 through 8), we defined a financial management system for this survey, as the manual and/or automated systems that capture, report, summarize, and/or report financial and related quantitative information related to the:

--Authorization of the use of resources.

--Management of liabilities.

--Disbursement of funds.

--Control of assets.

--Control of appropriated funds.

--Development and issuance of reports on the financial status of assets, liabilities, and appropriated funds and the financial results of program and administrative operations.

In an April 18, 1983, letter to the heads of departments and agencies, the Comptroller General announced changes in GAO's procedures for approving agency accounting systems. In this letter, the Comptroller General reiterated the definition of an accounting system in GAO's Policy and Procedures Manual for Guidance of Federal Agencies.

DEFINITION OF INTERNAL CONTROLS

On June 16, 1983, the Comptroller General issued the Standards for Internal Controls in the federal government to be followed by agencies in establishing and maintaining systems of internal controls. The standards define systems of internal controls as

> "The plan of organization and methods and procedures adopted by management to ensure that resource use is consistent with laws, regulations, and policies; that resources are safeguarded against waste, loss, and misuse; and that reliable data are obtained, maintained, and fairly disclosed in reports."

Processing procedures are those manual and/or automated procedures that govern capturing, recording, processing, summarizing, and reporting of financial and related quantitative information. Internal control procedures and independent procedures provide evidence that processing procedures have, in fact, been followed.

DEFINITION OF AN AGENCY'S SYSTEM OF INTERNAL CONTROL

Most agencies operate several financial management systems that process different types of financial transactions and provide information to each other. The individual financial management systems--taken together--form the agency's overall financial accounting, control, and reporting system. For example, most agencies have a general/ledger/administrative control of funds system, and subsidiary systems that, for example, process transactons relating to the personnel/payroll actions, personal property, disbursements, receipts, loans, accounts receivable, and accounts payable. These systems--taken together--are the agency's overall financial accounting, control, and reporting system.

The financial management systems that make up an agency's overall financial accounting, control, and reporting system include both processing procedures and independent internal control procedures, as defined in the preceding two sections. For this survey, we defined an agency's system of internal control as all the internal control procedures--taken together--that are included in all financial management systems that comprise the overall financial accounting, control, and reporting system.

HEALTH CARE FINANCING ADMINISTRATION FINANCIAL MANAGEMENT SYSTEMS INCLUDED IN OUR SURVEY

Based on the foregoing definitions, we included in our survey all manual and automated systems at the Health Care Financing Administration that:

--Maintain general ledger accounts and produce financial are reports.

--Control appropriated funds.

--Determine eligibility for, and authorize the making of payments to vendors.

--Authorize acquisition of resources.

--Record and account for assets and liabilities.

SURVEY METHODOLOGY

Our survey work followed the requirements of GAO's newly developed Controls and Risk Evaluation (CARE) survey approach. Accordingly, our survey included identification and documentation of the Administration's:

--Organization structure and major organizational components and the mission of each component.

--Accounting and related financial management systems, as previously discussed, and the interrelationships between the systems.

--Internal control strengths and weaknesses in the Administration's systems based on the internal control strengths and weaknesses identified during the survey.

In consonance with the CARE survey approach our work entailed identification and documentation of the operations and related internal control strengths and weaknesses of the Administration's

financial management system based on (1) available agency system documentation, (2) discussions with cognizant agency accounting, program, and ADP systems officials, and (3) previously issued GAO, Inspector General, and special study group reports. Our survey was made in accordance with our current "Standards for Audit of Governmental Organizations, Programs, Activities, and Functions": except that no tests were performed of system operations or of information processed by and recorded in these systems.

HEALTH CARE FINANCING ADMINISTRATION (HCFA)
PROCUREMENT CYCLE CONTROL OBJECTIVES

CYCLE CONTROL OBJECTIVES	CONTROLS IN PLACE	CONTROL WEAKNESSES
AUTHORIZATION		
1. Vendors should be authorized in accordance with laws, regulations and management's policy.	1. HCFA's Division of General Service (DGS) is responsible for purchasing standard type materials and supplies for the agency. DGS makes approximately 99 percent of its purchases from the Federal Supply Schedules (FSS). The General Service Administration must approve DGS purchases made off the schedule. HCFA's Division of Procurement Service (DPS) is responsible for purchasing service contract and automatic data processing (ADP) equipment for the agency. DPS follows the Federal Procurement Regulations for purchasing the above items.	
2. The types, estimated quantities, and prices and terms of goods and services needed should be authorized in accordance with laws, regulations and management's policy.	2. HCFA bureaus submit their material purchase requisitions to DGS, along with all appropriate certifications (e.g., management approval, justification, funds available, etc.). DGS determines whether the requisition can be filled with inhouse resources or the requisition must be filled from the FSS. HCFA bureaus requesting ADP equipment and/or service contracts submit their requisitions to DPS, along with all appropraite certifications. DPS announces the requirements in the Commerce Business Daily if a contract is to be awarded; the Federal Register if a grant is to be awarded.	
3. Adjustments should be authorized in accordance with	3. HCFA's Receiving Department receives all materials purchased and, upon delivery,	

APPENDIX II

CYCLE CONTROL OBJECTIVES	CONTROLS IN PLACE	CONTROL WEAKNESSES
laws, regulations and management's policy.	the department forwards two copies of the receiving report to DGS. DGS, in turn, forwards one copy of the receiving report to accounting. Invoices are forwarded directly to accounting. Accounting assures itself that HCFA received what it had purchased by requesting the user to complete a standard pro forma sheet. Because DPS basically procures service contracts, HCFA has little need to formalize the receipt of goods. Individual project officers attest to the quality and the performance of service contracts by approving payment invoices.	
4. Procurement cycle processing procedures should be established and maintained in accordance with laws, regulations, and management's policy.	4. See cycle control objective 1.	
ECONOMY, EFFICIENCY AND EFFECTIVENESS		
5. Procurement cycle operations should be in accordance with laws, regulations, and management's policy and plans.	5. DGS's annual procurement plan is basically a gross dollar budget based on stock on hand, past purchase experience, projected growth, planned consolidations, administrative and program changes, etc. The plan is updated on a quarterly basis and prior period planned and actual results are contrasted. DPS's annual procurement	

APPENDIX II

CYCLE CONTROL OBJECTIVES	CONTROLS IN PLACE	CONTROL WEAKNESSES
	plan is updated almost on a daily basis due to changing bureau service requirementbs. Howver, DPS does contrast on a quarterly basis prior period planned and actual results.	
6. Procurements should be achieved in an economical and efficient manner.	6. This particular cycle control was not included in our survey.	
7. Procurement procedures used should be economical and efficient.	7. This particular cycle control was not included in our survey.	
TRANSACTION PROCESSING		
8. Only those request of vendors for goods or services that meet management's criteria should be approved.	8. See cycle control objectives 1 and 2.	
9. Only requested goods and services should be accepted.	9. See cycle control objective 3.	
10. Goods and services accepted should be accurately and promptly reported.	10. See cycle control objective 3.	
11. Amounts due to vendors for goods and services accepted, and the accounting distributions of such amounts, should be computed and recognized as liabilities promptly.	11. See cycle control objectives 2 and 3.	
12. Amounts due to vendors should be accurately and promptly classified, summarized, and reported.	12. See cycle control objectives 3 and 5.	

APPENDIX II

CYCLE CONTROL OBJECTIVES	CONTROLS IN PLACE	CONTROL WEAKNESSES
13. Purchasing adjustments should be accurately and promptly classified, summarized, and reported.	13. See cycle control objectives 3 and 5.	
14. Liabilities incurred and payments received should be applied to the proper accounts.	14. This particular cycle control was not included in our survey.	
CLASSIFICATION		
15. Journal entries for amounts due to vendors and related adjustments should be prepared each accounting period.	15. This particular cycle control was not included in our survey.	
16. Purchasing journal entries should summarize and classify economic activities in accordance with management's plan.	16. This particular cycle control was not included in our survey.	
SUBSTANTIATION AND EVALUATION		
17. Recorded balances of accounts payable, and related transaction activity, should be periodically substantiated and evaluated.	17. This particular cycle control was not included in our survey.	

CYCLE CONTROL OBJECTIVES	CONTROLS IN PLACE	CONTROL WEAKNESSES
PHYSICAL SAFEGUARDS		
18. Access to purchasing, receiving and disbursement records; critical forms; processing areas; and processing procedures should be permitted only in accordance with management's criteria.	18. This particular cycle control was not included in our survey.	

APPENDIX II

HEALTH CARE FINANCING ADMINISTRATION (HCFA)
OTHER DISBURSEMENT CYCLE CONTROL OBJECTIVES

CYCLE CONTROL OBJECTIVES	CONTROLS IN PLACE	CONTROL WEAKNESSES
AUTHORIZATION		
1. Disbursements should be authorized in accordance with laws, regulations and management's policy.	1. Disbursements are not processed without a corresponding obligation document (e.g., contract, purchase order). Procurements are made from vendors on the Federal Supply Schedule (FSS) or contractors receiving awards based on Federal Procurement Regulations. See controls in place on Procurement and Asset and Liability Management Cycles. For other type of disbursements (e.g., travel orders and vouchers) the documents must be approved by someone on an authorized list of signatures for branches and offices.	
2. Adjustments to disbursements and account distributions should be authorized in accordance with laws, regulations and management's policy.	2. Accounting rarely processes any adjustments to disbursements. Adjustments would require the same procedures and signatory approvals as initial disbursements.	
3. Disbursement processing procedures should be established and maintained in accordance with laws, regulations and management policy.	3. Accounting has written standard operating procedures for paying vendor invoices under the Prompt Payment Act. Three documents are essential to process a vendor payment: (1) vendor invoice; (2) obligation document; (3) verification of receipt of goods or service.	

APPENDIX II

CYCLE CONTROL OBJECTIVES	CONTROLS IN PLACE	CONTROL WEAKNESSES
ECONOMY, EFFICIENCY AND EFFECTIVENESS		
4. Disbursement cycle results should be in accordance with laws, regulations and management's policy and plans. 5. Disbursements should be made in an economical and efficient manner. 6. Disbursement processing procedures used to create, recognize and report events and related transactions should be economical and efficient.	4,5,6 There have been no recent GAO or Inspector General audits of the results of the disbursement cycle. The actual costs of processing disbursements would be difficult to determine because of other duties performed by technicians, etc. HCFA has never really analyzed these costs. Disbursements were made a functional module (thus, automated) of HCFA's automated accounting system in October 1983. Any analysis would only be applicable for a short period of time. Accounting processes about 2,300 payment vouchers per quarter.	
TRANSACTION PROCESSING		
7. Only those requests for disbursements that meet management's policy should be approved.	7. Obligation and disbursing documents must be signed by an individual from HCFA's authorized signature list. periodic updates to the list are made by the bureaus and offices and accounting requests annual verification of the list.	7. No recent internal audit.
8. Disbursements should be accurately and promptly reported.	8. HCFA's automated accounting system produces a selected transaction (in this case cash accounts) report each month, This report is reconciled to a Statement of Transactions monthly report, which summarized the total disbursements sent to Treasury. The	

APPENDIX II

CYCLE CONTROL OBJECTIVES	CONTROLS IN PLACE	CONTROL WEAKNESSES
	Statement of Transactions report is the basis for Treasury sending HCFA a Statement of Differences, which HCFA must reconcile.	
9. Amounts due to vendors for goods and services accepted, and the accounting distributions of such amounts, shoud be computed and recognized as liabilities promptly.	9. See control objective number 8.	
10. Each disbursement of cash should be based upon a recognized liability, be accurately prepared and be appropriately authorized.	10. See control objective number 3. HCFA has no check writing capability.	
11. Disbursements should be accurately and promptly classified, summarized and reported.	11. The Accounting Operations Branch processes payments and makes accounting entries for disbursements. The Reports and Control Branch prepares payment vouchers to Treasury from the processed payment. Further detail was beyond the scope of this survey.	
12. Cash disbursements and related adjustments should be accurately and promptly classified, summarized and reported.	12. See control objective number 11.	
13. Liabilities incurred, cash disbursements and related	13. See control objective number 3.	

APPENDIX II

APPENDIX II

CYCLE CONTROL OBJECTIVES	CONTROLS IN PLACE	CONTROL WEAKNESSES
adjustments should be accurately applied to the proper vendor accounts.		
CLASSIFICATION		
14. Transactions for amounts due vendors, cash disbursements and related adjustments should be prepared each period.	14. HCFA's chart of accounts is the standard DHHS chart of accounts.	
15. Disbursements should be summarized and classified in accordance with managemnt's plan.	15. See control objectives 8 and 14.	
SUBSTANTIATION AND EVALUATION		
16. Recorded balances of disbursements, and related transaction activity, should be periodically substantiated and evaluated.	16. See control objective number 8. A review of techniques used to evaluate recorded balances was beyond the scope of this survey.	
PHYSICAL SAFEGUARDS		
17. Access to disbursement records, critical forms, processing areas and processing procedures should be permitted only in accordance with management's policy.	17. A review of safeguards was beyond the scope of this survey	

APPENDIX II

HEALTH CARE FINANCING ADMINISTRATION (HCFA)
ASSET AND LIABILITY MANAGEMENT CYCLE
CONTROL OBJECTIVES

CYCLE CONTROL OBJECTIVES	CONTROLS IN PLACE	CONTROL WEAKNESSES
AUTHORIZATION		
1. Sources of assets and liabilities should be authorized in accordance with laws, regulations and management's policy.	1. HCFA's Division of General Services (DGS) is responsible for purchasing standard type materials and supplies for the agency. DGS makes approximately 99 percent of its purchases from the Federal Supply Schedule (FSS). The General Services Administration must approve DGS purchases made off the schedule. HCFA's Division of Procurement Services (DPS) is repsonsible for purchasing service contract and automated data processing (ADP) equipment for the agency. DPS follows the Federal Procurement Regulations for purchasing the above items.	
2. The amounts, timing and conditions of transactions should be authorized in accordance with laws, regulations and management's policy.	2. HCFA bureaus submit their purchase reqisitions to DGS, along with all appropriate certifications (e.g., management approval, justification, funds available, etc.). DGS determines whether the requisition can be filled with inhouse resources or the requisition must be filled from the FSS. DPS announces the requirements in the Commerce Business Daily if a contract is to be awarded; the Federal Register if a grant is to awarded.	

CYCLE CONTROL OBJECTIVES	CONTROLS IN PLACE	CONTROL WEAKNESSES
3. The amounts, timing, and conditions of expenditures of funds should be authorized in accordance with laws, regulations and management's policy.	3. HCFA's Receiving Department receives all materials purchased and, upon delivery, the department forwards two copies of the receiving report to DGS. DGS, in turn, forwards one copy of the receiving report to accounting. Bills/invoices are forwarded directly to accounting. Accounting assures itself that HCFA has received what it has purchased by requesting the material user to complete a standard pro forma sheet. Because DPS basically procures service contracts, HCFA has little need to formalize the receipt of such services. Individual project officers attest to the quality and the performance of service contracts by approving payment vouchers.	
4. Adjustments to asset and liability accounts and account distributions should be authorized in accordance with management's policy.	4. See cycle control objective 3.	
5. Asset and liability management procedures should be established and maintained in accordance with management's policy.	5. See cycle control objectives 1, 2, and 3.	

APPENDIX II

CYCLE CONTROL OBJECTIVES	CONTROLS IN PLACE	CONTROL WEAKNESSES
EFFICIENCY AND EFFECTIVENESS		
6. Asset and liability management cycle results should be in accordance with laws, regulations and management's policy and plans.	6. DGS's annual procurment plan is basically a gross dollar budget based on stock on hand, past purchase experience, projected growth, planned consolidations, administrative and program changes, etc. The The plan is updated on a quarterly basis and prior period planned and actual results are contrasted. DPS's annual procurement plan is updated almost on a daily basis due to changing bureau service requirements. However, DPS does contrast on a quarterly basis prior period planned and actual results.	
7. Asset and liability cycle results should be achieved in an economical and efficient manner.	7. This particular cycle control was not included in our survey.	
8. Processing procedures used to create, recognize and report events and related transactions should be economical and efficient.	8. This particular cycle control was not included in our survey.	
TRANSACTION PROCESSING		
9. Only those requests to buy or sell assets that meet laws, regulations and management's policy should be approved.	9. See cycle control objectives 1 and 2. Also, DGS follows Federal Property Management regulations for disposal, inventory, and safeguards of assets. Excess assets are first offered to	

APPENDIX II

CYCLE CONTROLS OBJECTIVES	CONTROLS IN PLACE	CONTROL WEAKNESSES
	GSA. If GSA does not determine that the asset should be sent to another Federal, State, or local agency, it will instruct DGS to offer the assets at public sale. Public notice is made of the proposed sale and goods are sold to the highest sealed bid.	
10. Assets and liabilities acquired should be accurately and promptly reported.	10. See cycle control objectives 3 and 9.	
11. Retirements or dispositions of assets to outsiders should be accurately and promptly reported.	11. See cycle control objective 9.	
12. Amounts due from or to purchasers and creditors, and the accounting distribution of those amounts, should be computed accurately and promptly recognized as assets or liabilities.	12. See cycle control objectives 3 and 9.	

APPENDIX II

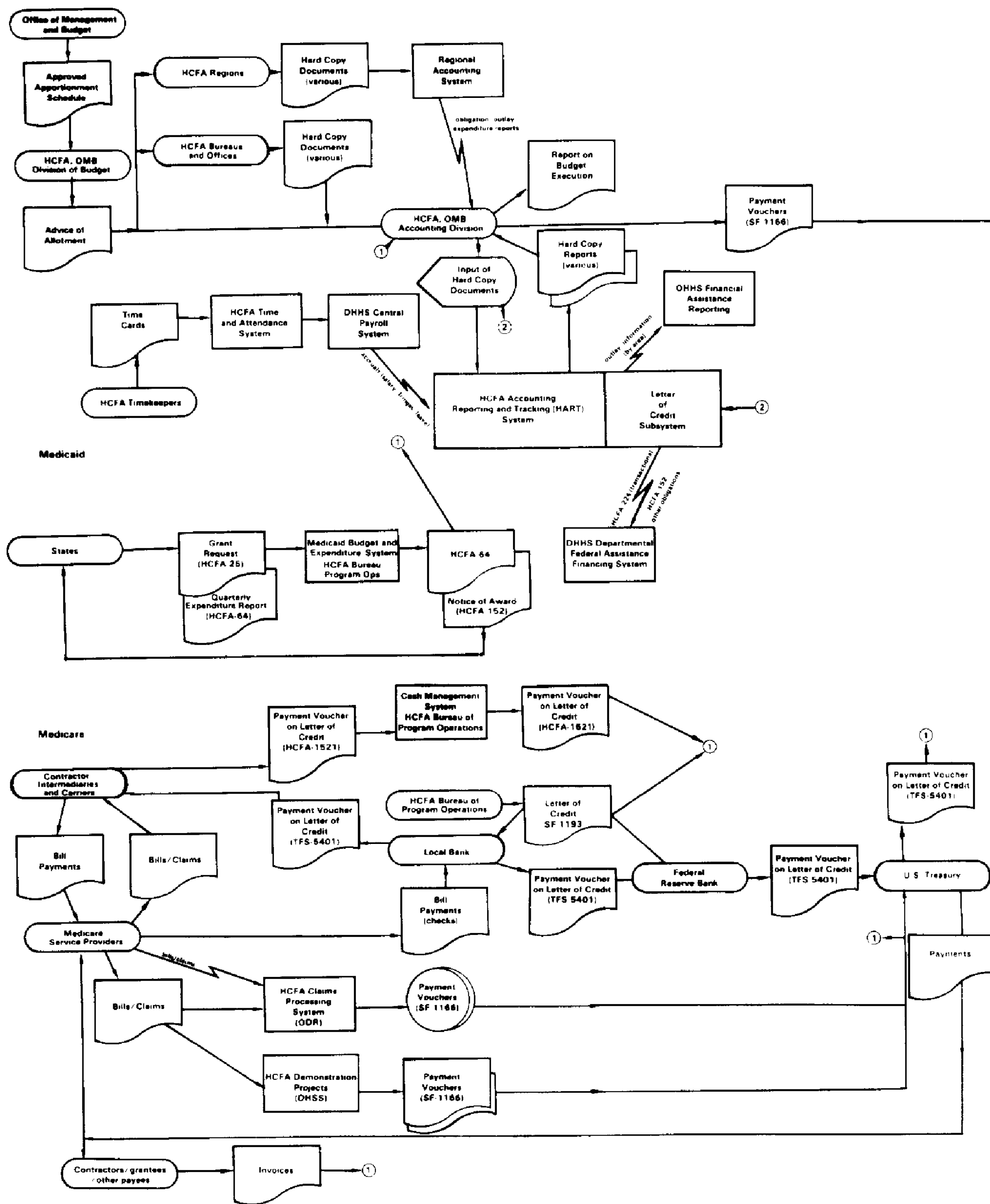
CYCLE CONTROL OBJECTIVES	CONTROLS IN PLACE	CONTROL WEAKNESSES
13. Changes in value should, where required by generally accepted governmental accounting principles, be computed accurately and recognized promptly.	13. See cycle control objectives 3 and9.	
CLASSIFICATION		
14. Amounts due to creditors, and related adjustments, should be accurately and promptly classified, summarized and reported.	14. See cycle control objectives 3, 6, and 9.	
15. Purchases and sales of assets, changes in liabilities and related adjustments should be accurately applied to the proper subsidary accounts.	15. See cycle control objectives 3, 6, and 9.	
16. Journal entries for assets and laibilities acquired and retired, and related adjustments, should be prepared and posted each accounting period.	16. This particular cycle control was not included in our survey.	
17. Journal entries should summarize and classify economic activities in accordance with management's plan.	17. This particular cycle control was not included in our survey.	

APPENDIX II

APPENDIX II

CYCLE CONTROL OBJECTIVES	CONTROLS IN PLACE	CONTROL WEAKNESSES
SUBSTANTIATION AND EVALUATION		
18. Recorded balances of asset and liability accounts, and related transaction activity, should be periodically substantiated and evaluated.	18. This particular cycle control was not included in our survey.	
PHYSICAL SAFEGUARDS		
19. Physical security safeguards should be maintained where assets are stored and transactions processed.	19. This particular cycle control was not included in our survey.	

HCFA ACCOUNTING STRUCTURE



Other HCFA Financial Management Information Automated Systems

Office of Management and Budget

Personnel Ceiling Control System
Budget System
Manpower Management System
Warehouse Inventory

Bureau of Support Services

Position Tracking System
Medical Data Communications Utility
Cost Report Data Collection and Processing

Health Standards and Quality Bureau

Medicare Medicaid Automated Certification
Professional Review PSRO Mgmt Info System

Office of Research and Demonstrations

Monitoring Grants and Contracts for R & D
National Medical Care Utilization and Exp Survey
Medicaid Cost Analysis
Medicaid Tape to Tape Data from States
American Hospital Association Survey & Panel Tapes

Bureau of Data Management and Strategy

Average Adjusted Per Capita Cost
Medicare Provider Analysis and Review Reports
Total Cost PerCase Limits Under Section 223
Routine PerDiem Limits
End Stage Renal Disease
Patient Origin and Destination Studies
HMO and Group Practice Prepayment Plan Statistics
Physician Services Study
Last Year of Life Statistics
Buy In Statistics
Extramural Contractual Support
BDMS Data Documentation and Standardization
Publication Mailing List and Labels

Bureau of Program Operations

Beneficiary Overpayment Control & Mgmt Info
Physician and Suppliers Overpayment Report
Provider Overpayment and Report
Medicaid Overpayment Report System
Medicare Entitlement System
Prepayment Plan for Group Practices Dealing Through Carrier
Health Insurance Claim Request for Medicare Payment
Provider Billings for Patient Services by Physicians
Request for Medicare Payment of Ambulance Services
Home Health Agency Report and Billing
Intermediary Processing of Outpatient Admission and Billing Forms
Intermediary Processing of Inpatient Admission and Billing Forms
Eligibility and Utilization Status (Medicare)
Part A Medicare Utilization System

Bureau of Program Operations

Part B Medicare Utilization System
Medicare Premium Collection System
Medicare Medicaid Profile System
Carrier Systems Testing Project
Analysis of State Medicaid Data
Contractor Administrative Cost Information System
Part A Operations Statistical Data
Part B Workload Report
Travel and Training Budget Control

Bureau of Quality Control

Provider Cost Reimbursement Status
Medicaid Quality Control System
Hospital Cost Report Evaluation Program (CREP
Part B Quality Assurance
High Probability Leads
Medicare Medicaid Fraud and Abuse Workload System
Integrated Data Network
Medicaid Claims Processing Quality Control System