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December 2001

CIVIL FINES AND PENALTIES DEBT

Review of CMS' Management and Collection Processes

G A O

Accountability ★ Integrity ★ Reliability

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Abstract
On December 14, 2001, we briefed your office on our review of selected federal agencies management and collection of civil fines and penalties debt.1 As agreed with your staff, this work focused on the debt collection processes and procedures used by the Department of the Treasurys U.S. Customs Service, the Department of Interiors Office of Surface Mining, and the Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS).2 This report summarizes the information presented in our December 14, 2001, briefing related to CMS collection of civil fines and penalties debt, referred to as civil monetary penalties (CMP) debt. The briefing slides are included in appendix I. We will separately report on our work on the U.S. Customs Service and the Office of Surface Mining. As discussed with your staff, our original objectives were to determine (1) the primary reasons for the growth in CMS reported CMP debt, (2) whether CMS CMP receivables have similar financial accountability and reporting issues as its non-CMP receivables, (3) whether adequate processes exist to collect CMP debt, and (4) what roles, if any, the Office of Management and Budget (OMB) and Treasury play in overseeing and monitoring CMS collection of CMP debt.

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G A O
Accountability * Integrity * Reliability

United States General Accounting Office
Washington, D.C. 20548

December 31, 2001

The Honorable Susan M. Collins
Ranking Minority Member
Permanent Subcommittee on Investigations
Committee on Governmental Affairs
United States Senate

Dear Senator Collins:

On December 14, 2001, we briefed your office on our review of selected federal agencies' management and collection of civil fines and penalties debt.[1] As agreed with your staff, this work focused on the debt collection processes and procedures used by the Department of the Treasury's U.S. Customs Service, the Department of Interior's Office of Surface Mining, and the Department of Health and Human Service's (HHS) Centers for Medicare and Medicaid Services (CMS).[2]

This report summarizes the information presented in our December 14, 2001, briefing related to CMS' collection of civil fines and penalties debt, referred to as civil monetary penalties (CMP) debt. The briefing slides are included in appendix I. We will separately report on our work on the U.S. Customs Service and the Office of Surface Mining. As discussed with your staff, our original objectives were to determine (1) the primary reasons for the growth in CMS' reported CMP debt, (2) whether CMS' CMP receivables have similar financial accountability and reporting issues as its non-CMP receivables, (3) whether adequate processes exist to collect CMP debt, and (4) what roles, if any, the Office of Management and Budget (OMB) and Treasury play in overseeing and monitoring CMS' collection of CMP debt.

However, for the third objective, incomplete and unreliable CMP information limited the determination of the overall adequacy of the CMP debt collection policies and procedures. Instead, as agreed with your staff, we performed limited tests of CMS' debt collection policies and procedures. Specifically, we selected and reviewed all delinquent CMP

[1]This work was part of a broad review that also looked at the management and collection of criminal fines and penalties at the Department of Justice and the U.S. Courts. See *Criminal Debt: Oversight and Actions Needed to Address Deficiencies in Collection Processes* (GAO-01-664, July 16, 2001).

[2]Formerly the Health Care Financing Administration (HCFA).

debts (over 60 days delinquent per CMS records) with a recorded receivables balance as of September 30, 2000, greater than $2 million (12 debts). We also analyzed long-term care CMP assessment and settlement data for fiscal years 1999 and 2000 for all cases where the settlements were reached at three selected CMS regional offices. These regional offices accounted for 76 percent of the reported cases opened in this 2-year period.

Results in Brief

The primary reason for the growth of CMS' CMP receivables was the expansion of fraud and abuse detection activities from fiscal year 1995 through fiscal year 1997 that significantly increased fraud and abuse debts in fiscal year 1997. This is supported by CMS' accounting records, which revealed that about $255 million of the $260 million CMP receivables balance as of September 30, 2000, related to fraud and abuse debts. For the $255 million in receivables, about $172 million remained outstanding from fiscal year 1997.

Our analysis of CMS' CMP receivables data revealed similar financial accountability and reporting issues as those identified for non-CMP receivables by CMS' external financial statement auditors. We found that CMS does not have formal written policies and procedures for reconciling CMP receivables, recording CMP receivables in the general ledger, and determining the allowance for uncollectible accounts related to CMP receivables. As a result, we identified (1) unreconciled differences of tens of millions of dollars in the CMP receivables balances reported by HHS and CMS for fiscal years 1997 through 1999 and (2) an unreconciled net difference of about $22 million between the CMP receivables balance in CMS' general ledger and the detailed subsidiary systems as of September 30, 2000. We also found that certain long-term care CMP receivables were not being recorded in the general ledger, which contributed to the unreconciled difference between the general ledger and the subsidiary systems. In addition, our testing of selected CMP debts as of September 30, 2000, found that CMS incorrectly recorded certain CMP debts in the general ledger by not removing debts paid in full and misclassifying current debts as delinquent. We further found that CMS' allowance for uncollectible accounts is not calculated based on a systematic analysis of the collectibility of the outstanding receivables balance as required by Statement of Federal Financial Accounting Standards (SFFAS) No. 1, *Accounting for Selected Assets and Liabilities*.

The data reliability issue noted above limited us from determining the overall adequacy of the CMP debt collection policies and procedures.

However, our limited tests showed that debt collection policies and procedures were followed for 11 of the 12 selected delinquent debts. We could not determine whether debt collection policies and procedures were followed for one selected debt because supporting documentation was not available. In addition, in analyzing long-term care CMP cases and settlement data for fiscal years 1999 and 2000, we noted one debt collection matter in which debt collection policies and procedures can be strengthened. The matter relates to CMS often settling at amounts that exceeded the 35-percent discount threshold established by CMS management. We found that CMS reduced the assessed long-term care CMP amounts by more than 35-percent for 89 out of 215 cases settled by three selected regional offices in fiscal years 1999 and 2000, resulting in reduced potential collections of about $2.9 million. According to CMS officials, other matters can develop while a hearing is pending that can affect the settlement amount, and, as such, it may be in CMS' best interests to settle for less. However, CMS' policies and procedures do not require that specific documentation be maintained to support that such settlements were warranted. While not required, we noted that one out of the three selected regional offices was maintaining documentation to support such settlements.

OMB and Treasury are provided with information useful in performing CMP debt oversight roles. However, OMB stated that it has broad oversight responsibility in monitoring and evaluating governmentwide debt collection activities. OMB further stated that it is the specific responsibility of the agency to monitor, manage, and collect CMP debt and the responsibility of the agency's Office of Inspector General (OIG) to provide oversight through audit of the agency's debt collection activities. In addition, Treasury stated that it relies on the agencies to determine what debt should be referred to Treasury for collection action, as required by the Debt Collection Improvement Act of 1996 (DCIA). However, not all eligible CMP debts are currently being referred.

Our recommendations are designed to improve the accounting, reporting, and collection of CMP receivables. In commenting on a draft of the briefing slides, CMS agreed with all but one of our eight recommendations. CMS did not agree with our recommendation to establish and implement debt collection policies and procedures for long-term care CMP settlements in which a discount greater than 35-percent is allowed. According to CMS, flexibility is needed in the settlement process and issuing policies and procedures on settlements would add rigidity to the process. It was not our intent that a rigid process for determining

settlement amounts would be implemented. However, consistent with good management practices and the *Standards for Internal Control in the Federal Government*,[3] when exceptions to a stated management policy occur, typical control practices are to document, review, and approve such exceptions to ensure that management's objectives are being met.

Scope and Methodology

To determine the primary reasons for the growth in reported CMP debt at CMS and whether CMS' CMP receivables have similar financial accountability and reporting issues as its non-CMP receivables, we obtained and reviewed CMS' audited financial statements, HHS' accountability reports, and other financial reports that relate to CMS' CMP and non-CMP collection activities.

We also analyzed CMS' reported CMP receivables and related accounts and information for fiscal years 1997 through 2000 and compared CMS' CMP accounting records to detailed subsidiary tracking records. We did not independently verify the completeness or accuracy of the subsidiary system data or test information security controls over the systems used to compile these data.

We interviewed officials in CMS, HHS OIG, and Department of Justice's (DOJ) Executive Office for U.S. Attorneys (EOUSA) to obtain explanations for identified significant trends, similarities with non-CMP receivables, material internal control weaknesses, findings and exceptions, as well as unsupported/unreconciled amounts.

To determine whether adequate processes exist to collect CMP debt, we obtained an understanding of CMS' CMP debt collection policies and procedures that relate to CMS' long-term care, HHS OIG, and DOJ cases, as well as applicable federal laws and regulations. Because CMS could not provide complete and reliable CMP information, a random sample was not selected from CMP receivables as of September 30, 2000, and CMP receivables cases closed in fiscal years 1999 and 2000. However, as agreed with your staff, we performed limited tests of CMS' debt collection policies and procedures.

[3]GAO/AIMD-00-21.3.1, November 1999.

Specifically, we selected and reviewed all delinquent CMP debts (over 60 days delinquent per CMS records) with a recorded receivables balance as of September 30, 2000, greater than $2 million (12 debts). This represented 57 percent of the delinquent CMP debt balance and 27 percent of the total CMP debt balance per CMS records.[4] We interviewed DOJ's EOUSA officials to obtain explanations for identified findings and exceptions.

We also analyzed long-term care CMP assessment and settlement data for fiscal years 1999 and 2000 for all cases in which the settlements were reached at three selected CMS regional offices. According to CMS' Civil Monetary Penalty Tracking System, the long-term care cases opened at these regional offices represented approximately 76 percent of all long-term care CMP cases opened during this 2-year period. For identified findings and exceptions, we developed and submitted questions to CMS' regional offices. We obtained and analyzed the regional offices' written responses to our questions.

To determine what roles, if any, OMB and Treasury play in overseeing and monitoring the government's collection of civil debt, we interviewed OMB and Treasury officials.

We performed our review in Washington, DC and Atlanta, GA from March 2001 through August 2001 in accordance with U.S. generally accepted government auditing standards. Prior to our December 14, 2001, briefing to your office on the results of our work, we provided CMS, HHS OIG, DOJ's EOUSA, Treasury, and OMB with a draft of our detailed briefing slides, which contained recommendations to the Administrator of CMS, for review and comment. The comments received are discussed in the "Agency Comments and Our Evaluation" section of this report and on the "Agency Comments" slide in Appendix I or incorporated into the report as applicable. CMS' letter is reprinted in appendix II.

Background

As of September 30, 2000, HHS reported that CMS' CMP receivables totaled about $260 million. CMP debt results from deficiencies at long-term care nursing facilities or fraud and abuse and is collected by three separate groups. CMS' regional offices are responsible for the long-term care debt, and HHS OIG and DOJ are responsible for fraud and abuse debt. DOJ fraud

[4]The 12 selected debts were fraud cases managed by DOJ.

debt accounted for about 88 percent of the reported $260 million receivables balance as of September 30, 2000, while OIG fraud and abuse debt accounted for approximately 11 percent and CMS' long-term care debt accounted for about 1 percent of the reported balance.

For the long-term care debt, Sections 1819 (42 U.S.C. Sections 1395i-3) and 1919 (42 U.S.C. Section 1396r) of the Social Security Act establish requirements for surveying nursing facilities to determine whether they meet the requirements for participation in the Medicare and Medicaid programs. A survey must be conducted at each nursing facility within 15 months of the previous survey by a state survey agency. In addition, the statewide average interval between surveys must be 12 months or less. Remedies, of which CMP is one, may be used when a nursing facility is not in substantial compliance with the requirements for participation in the Medicare and Medicaid programs.

A CMP is imposed either for the number of days ($50 to $10,000 per day) or for each instance ($1,000 to $10,000 per instance) that a nursing facility is not in substantial compliance with the participation requirements. The amount depends on the severity of the deficiency. A written notice of the CMP is sent to the nursing facility. The facility has 60 days from the date of the notice to either waive its right to an administrative hearing and receive automatically a reduction of 35-percent in the CMP amount or request an administrative hearing. At any time prior to an administrative hearing, the nursing facility may enter into a settlement of the CMP amount. Once there is an administrative hearing decision or a settlement, the final CMP receivable amount is determined.

According to CMS' *State Operations Manual*, if a decision is made to settle, the settlement should not be for a better term than had the nursing facility opted for a 35-percent reduction. To track assessments and collections, CMS' regional offices use the Civil Monetary Penalty Tracking System for fiscal year 1999 and later CMP cases and spreadsheets for fiscal year 1996 through fiscal year 1998 CMP cases.[5] In addition, CMS' regional offices use the long-term care system to track CMP cases.

[5]Regulations implementing the imposition of long-term care CMP were effective July 1, 1995. The first long-term care CMP assessment was made at the beginning of fiscal year 1996.

For civil health care fraud matters, DOJ generally uses the False Claims Act, as well as common law fraud remedies, payment by mistake, unjust enrichment, and conversion to recover amounts from those who have submitted false or improper claims to the United States. Civil health care fraud matters are referred directly from federal or state investigative agencies, or result from filings by private persons known as "relators," who file suits on behalf of the federal government under the 1986 qui tam amendments to the False Claims Act. The False Claims Act (31 U.S.C. Sections 3729-3733) provides that anyone who "knowingly" submits a false claim to the government is liable for a penalty from $5,000 to $10,000 plus up to three times the amount of damages sustained by the government.

A court judgment or settlement establishes amounts due by violators. DOJ prepares a Health Care Fraud Tracking Form,[6] which is submitted to HHS OIG and CMS' Office of Financial Management, and establishes the debt in a tracking system. If the health care violator does not pay the fraud debt, DOJ's U.S. Attorney Offices (USAO) have several options to pursue collection, including contacting the debtor, securing or executing upon a judgment, filing liens or garnishments, and referring the delinquent debt to Treasury. To track assessments and collections of civil health care fraud cases, DOJ's USAOs use either the Tracking Assistance for the Legal Office Network or the Collection Litigation Automated Support System, and DOJ's Civil Division uses the Debt Collection System.

HHS OIG also pursues fraud and abuse cases. According to HHS OIG data, since 1988, about 90 percent of its CMP assessments relate to the requirements of Section 1867 of the Social Security Act (42 U.S.C. Section 1395dd). This statute specifies that a hospital's emergency department must provide an appropriate medical screening examination within the capability of the hospital's emergency department to any individual who comes to the department with a request for examination or treatment of a medical condition. In addition, if the hospital determines that the individual has an emergency medical condition, the hospital must either stabilize the medical condition or transfer the individual to another medical facility. This statute provides for a maximum penalty of $50,000 per violation. According to HHS OIG data, since 1988, approximately 10 percent of its CMP assessments relate to violations of the statutory provisions applicable to false or fraudulent claims submitted to federal

[6]In documenting a judgment or settlement, DOJ uses this form to note the judgment or settlement amount and the recipients to be paid from the collected debt.

health care programs in Section 1128A of the Social Security Act (42 U.S.C. Sections 1320a-7a). This law provides that for false, fraudulent, or otherwise improper claims, HHS may impose a penalty of not more than $10,000 for each item or service and an assessment of no more than triple the amount claimed for each item or service in lieu of damages. HHS OIG uses spreadsheets to track assessments and collections of CMP cases.[7]

CMS' Office of Financial Management is responsible for the accounting and reporting of CMP receivables in the general ledger using the Financial Accounting Control System. This office is also responsible for determining the allowance for uncollectible receivables. According to CMS, an allowance is calculated as the amount of CMP debt delinquent for 60 days or longer that is considered to be inactive and truly delinquent based on a case-by-case review of each receivable.

HHS OIG's Office of Audit Services stated that due to the immateriality of the CMP receivables balances in relation to CMS' total accounts receivable balance, CMS' external financial statement auditors have not performed any detailed audit work on CMP receivables. However, these auditors have identified various reporting, internal control, and accountability issues related to Medicare (non-CMP) receivables. These issues resulted in a qualified opinion on CMS' financial statements for fiscal year 1998 and a material weakness on non-CMP receivables during fiscal years 1998 through 2000.[8] The external financial statement auditors reported that CMS' lack of an integrated financial management system continues to impair its ability to adequately support the reported non-CMP receivables activity and balances. The external financial statement auditors also identified deficiencies in the non-CMP receivables activity, including

- incorrectly reported activity by non-CMP contractors and
- inability of non-CMP contractors to reconcile reported ending balances to the contractors' subsidiary records.

[7]According to HHS OIG, collections being received through payment plans for CMP assessments under Section 1128A of the Social Security Act are sent directly to CMS. HHS OIG does not track collections for these cases.

[8]CMS' financial statements and related auditor reports referred to in this report were issued under CMS' former name (HCFA).

The external financial statement auditors' recommendations included

- establishing an integrated financial management system for use by non-CMP contractors and CMS' central and regional offices and
- ensuring that all non-CMP contractors develop and implement control procedures to provide independent checks of the validity, accuracy, and completeness of the amounts reported to CMS, including a reconciliation with the contractors' supporting documentation, and periodic review of contractors' control procedures over reconciliations.

Increase in Fraud and Abuse Debt Is the Primary Reason for Reported Growth in CMP Debt

The primary reason for the growth of CMS' CMP receivables was the expansion of fraud and abuse detection activities from fiscal years 1995 through 1997 that significantly increased fraud and abuse debts in fiscal year 1997. This is supported by CMS' accounting records, which revealed that about $255 million of the $260 million CMP receivables balance as of September 30, 2000, related to fraud and abuse debts.[9] For the $255 million in receivables, about $172 million remained outstanding from fiscal year 1997.

In 1995, under authority to use trust fund money to develop or demonstrate improved methods for investigating and prosecuting fraud, HHS launched Project Operation Restore Trust. The project targeted fraud and abuse in three high-growth areas of the health care industry: home health agencies, nursing homes, and durable medical equipment suppliers. In addition, the passage of the Health Insurance Portability and Accountability Act (HIPAA) in 1996 expanded funding for HHS' fraud and abuse detection activities by establishing the Fraud and Abuse Control Program, a program designed to combat fraud and abuse committed in the health plans (both public and private). By January 1, 1997, HHS OIG and DOJ had jointly implemented the Fraud and Abuse Control Program, as required by HIPAA.

HHS reported, in fiscal year 1996, that Project Operation Restore Trust combined with the upgraded funding provided by HIPAA would enable HHS to more aggressively detect and prevent fraud, waste, and abuse. In addition, DOJ's EOUSA stated that DOJ's health care fraud activities were expanded in fiscal years 1996 and 1997, and with the implementation of the Health Care Fraud Tracking Forms in December 1996, DOJ began

[9]DOJ is responsible for collection activity for the majority of the fraud and abuse debt.

submitting health care fraud debts to CMS during fiscal year 1997. Prior to this time, only fraud and abuse debts submitted by HHS OIG were recorded and reported by CMS.

CMP Receivables Have Similar Financial Accountability and Reporting Issues as Non-CMP Receivables

As discussed above, no detailed audit work on CMP receivables has been performed by CMS' external financial statement auditors due to the small balance of CMS' CMP receivables in relation to CMS' total accounts receivables, which consist primarily of non-CMP Medicare receivables. For example, as of September 30, 2000, CMS' CMP receivables were reported to be about $260 million, or 3 percent, of total reported accounts receivables of approximately $8.1 billion, of which non-CMP Medicare receivables totaled more than $7.7 billion.

Our analysis of CMS' CMP receivables data revealed similar financial accountability and reporting issues as those identified for non-CMP receivables by CMS' external financial statement auditors. We found that CMS does not have formal written policies and procedures for the reconciliation of CMP receivables, recording CMP receivables in the general ledger, and determining the allowance for uncollectible accounts related to CMP receivables. As a result, we found (1) unreconciled differences between CMP receivables amounts on HHS' accountability reports and CMS' audited financial statements, (2) unreconciled differences between CMP receivables amounts in CMS' general ledger and the detailed subsidiary systems, (3) incorrect recording—not removing debts paid in full and misclassifications between delinquent and current—of CMP receivables in the general ledger, and (4) lack of an adequate collectibility analysis for uncollectible accounts relating to CMP receivables.

- CMS does not have policies and procedures requiring it to compare CMP receivables reported in its audited financial statements and HHS' accountability report. According to HHS, CMS is the only HHS component that has CMPs. Therefore, the CMP receivable amounts reported in HHS' accountability report and CMS' audited financial statements should be the same. However, our work identified that year-end CMP receivables balances for fiscal year 1997 through fiscal year 1999, differed by tens of millions of dollars between HHS' accountability report and CMS' audited financial statements.

  For example, CMS' fiscal year 1997 financial statements reported a CMP receivables balance of about $243 million; however, HHS' accountability

report for fiscal year 1997 reported approximately $191 million—a difference of about $52 million. The beginning balance for CMP receivables in HHS' fiscal year 2000 draft accountability report was adjusted by approximately $50 million to agree with CMS' accounting records. As a result of the adjustment, the fiscal year 2000 beginning balance in HHS' fiscal year 2000 accountability report differed from the ending balance in its fiscal year 1999 accountability report. After we brought this difference to HHS' attention, a statement identifying the difference was added to HHS' fiscal year 2000 accountability report's overview; however, the statement did not explain the cause of the difference.

- Similar to the accountability and reporting issues reported for non-CMP receivables by CMS' external financial statement auditors, CMS also does not have policies or procedures for reconciling CMP receivables balances in the general ledger to detailed support maintained in the subsidiary systems. As discussed above, three separate groups (CMS' long-term care, HHS OIG, and DOJ) collect CMP debt. Each group maintains at least one subsidiary system to track its CMP cases. As of September 30, 2000, the CMP receivables balance in the general ledger and the detailed subsidiary systems differed by a net of about $22 million, with the difference for each group ranging from what appears to be an understatement of about $35 million to a possible overstatement of about $29 million.

  The difference between the general ledger and the subsidiary systems for the long-term care CMP debt totaled about $17 million. The primary reason for the long-term care difference is that, beginning in fiscal year 1999, all new long-term care CMP receivables are no longer recorded in the general ledger until a collection is made. This practice is not in accordance with SFFAS No. 1, *Accounting for Selected Assets and Liabilities*, and SFFAS No. 7, *Accounting for Revenue and Other Financing Sources and Concepts for Reconciling Budgetary and Financial Accounting*. These statements require a receivable to be recognized once amounts that are due to the federal government are assessed, net of an allowance for uncollectible amounts. CMS stated that the general ledger does not include all potentially valid long-term care CMP receivables because of the unreliability of the long-term care CMP accounts receivable amounts in the Civil Monetary Penalty Tracking System. CMS stated that the long-term care CMP receivables would be reviewed for validity and recorded in the general ledger as part of the planned upgrade of the subsidiary system.

In addition, according to CMS' accounting records, of the 12 selected delinquent debts we reviewed, 2 totaling about $24 million were the responsibility of HHS OIG. However, upon further research by DOJ, these debts were actually the responsibility of DOJ and were included in DOJ's subsidiary system on September 30, 2000, as uncollected. This misclassification appears to explain a portion of the difference between the general ledger and HHS OIG's and DOJ's subsidiary systems.

- In addition to CMS' lack of policies and procedures relating to the reconciliation of CMP information, CMS stated that Division of Accounting staff responsible for the recording of information in the general ledger use notes and knowledge gained during training provided by staff previously responsible for the duties to record CMP receivables in the general ledger. However, these informal policies and procedures do not (1) contain specific guidance on recording due dates for payments being made through payment plans or recording collections against established receivables and (2) address control procedures to ensure the accurate recording of CMP receivables in the general ledger, such as review and approval of transactions by a supervisor. Our testing identified instances, in addition to the above misclassification between HHS OIG and DOJ receivables, in which CMP receivables were recorded in the general ledger incorrectly.

  For the 12 selected delinquent debts with receivable balances totaling about $70 million, 7 debts totaling approximately $32 million were recorded incorrectly in the general ledger. For four of the debts totaling about $23 million, CMS failed to remove the debts from CMP receivables even though collections of these debts were received prior to September 30, 2000. In addition, CMS incorrectly classified three of the debts totaling about $9 million as delinquent, instead of current, even though collections were being received in accordance with the due dates of the respective payment plans. Further, for the 12 selected delinquent debts, documentation supporting one of the debts with a balance of about $3 million could not be located by DOJ. The status of receivables—current, delinquent, or paid—should be properly noted since it affects the accuracy of the allowance for uncollectible accounts, which is netted against gross CMP receivables reported on HHS' and CMS' financial statements. In addition, these errors could possibly have been avoided if there was appropriate review and approval of such transactions.

- Lastly, CMS does not have formal written policies and procedures for determining its allowance for uncollectible accounts. As previously noted, CMS stated that its allowance for uncollectible accounts represents the balance of all CMP debt delinquent for 60 days or longer that is considered to be inactive and truly delinquent based on a case-by-case review of each receivable. According to SFFAS No. 1, losses due to uncollectible amounts should be measured through a systematic methodology with an analysis of both individual accounts and a group of accounts as a whole. Individual account analysis should be based on factors such as the debtor's ability to pay and the probable recovery of amounts from secondary sources. Group analysis should be performed using a method such as statistical estimation by modeling or sampling and should take into consideration such factors as historical loss experience and recent economic events. However, CMS' allowance for uncollectible accounts is not based on a systematic analysis of the collectibility of the outstanding receivables balance.

Incomplete and Unreliable CMP Data Limited the Determination of Overall Adequacy of CMP Debt Collection Policies and Procedures

CMP debt collection policies and procedures have been established by CMS for the long-term care debt and by HHS OIG and DOJ for the fraud and abuse debt. However, incomplete and unreliable CMP information limited us from determining the overall adequacy of the CMP debt collection policies and procedures. As a result and as agreed with your staff, we performed limited tests of CMS' debt collection policies and procedures. We found that debt collection policies and procedures were followed for 11 of the 12 selected delinquent debts. We could not determine whether DOJ followed its debt collection policies and procedures for the remaining selected debt because DOJ was unable to locate supporting documentation.

In analyzing long-term care CMP cases and settlement data for fiscal years 1999 and 2000, we noted one debt collection matter in which debt collection policies and procedures can be strengthened. The matter relates to CMS often settling at amounts that exceeded the 35-percent discount threshold established by management. At the three selected regional offices, we found that CMS reduced the assessed long-term care CMP amounts more than 35-percent for 89 out of 215 cases (41 percent), or about $8.4 million out of about $11.4 million (73 percent) in assessments settled in fiscal years 1999 and 2000. For the 89 cases, a 35-percent discount on approximately $8.4 million in assessments results in possible collections of about $5.5 million. However, CMS actually discounted these cases in total by about 69 percent, reducing potential collections by about

$2.9 million. According to CMS officials, other matters can develop while a hearing is pending that can affect the settlement amount, such as unavailability of witnesses and new information related to the deficiencies. In these cases, according to the officials, it may be in CMS' best interests to settle for less, given the cost of litigation and the risk of not collecting anything. However, CMS does not have debt collection policies and procedures for instances in which a discount greater than 35-percent is allowed. Of the three selected regional offices, one regional office was maintaining documentation to support that such settlements were warranted, while two regional offices were not maintaining documentation. Consistent with good management practices and the *Standards for Internal Control in the Federal Government*, when exceptions to a stated management policy occur, typical control practices are to document, review, and approve such exceptions to ensure that management's objectives are being met.

OMB's and Treasury's Roles in the Oversight and Monitoring of CMP Debt

OMB and Treasury are provided with the information useful in performing their debt oversight roles through the agencies' reporting of CMP receivables and referral of CMP debt to Treasury for collection. With respect to the reporting of CMP receivables, beginning with fiscal year 1997, CMS and HHS have annually disclosed CMP receivables information in their financial reports.[10] In accordance with requirements of DCIA and Treasury guidance, CMS reports receivables information quarterly, which includes CMP, to Treasury in the Report on Receivables Due from the Public.

However, in discussions with OMB officials, they emphasized that OMB's oversight is broad and consists of monitoring and evaluating governmentwide credit management, debt collection activities, and federal agency performance. OMB also stated that it is the specific responsibility of the agency Chief Financial Officer and program managers to manage and be accountable for the debt collection of their agency's credit portfolios in accordance with applicable federal debt statutes, regulations, and guidance. OMB further added that it is the role of each agency to specifically monitor and collect its civil penalty debt regardless of dollar magnitude and the responsibility of each agency's OIG to provide oversight through audit of the agency's debt collection activities.

[10]The information reported to OMB and Treasury needs to be considered in light of the reliability issues we identified.

Regarding referral of CMP debt to Treasury, Treasury stated that it relies on the agencies to determine what debt should be referred to Treasury for collection as required by DCIA. DCIA requires federal agencies to transfer eligible nontax debt or claims[11] over 180 days delinquent to Treasury for collection actions. DOJ stated that referral to Treasury was one type of debt collection tool used by USAOs when pursuing collection of fraud cases.[12] However, CMS is not referring long-term care CMP debt to Treasury for collection actions. CMS stated that it plans to refer eligible long-term care CMP debts to Treasury in the future and is currently researching the issue.

Conclusion

The expanded fraud and abuse detection activities and resulting growth in fraud and abuse debt is the primary reason for the increase in CMP receivables over the last several years. In addition, our work found similar financial accountability and reporting issues as those reported for non-CMP receivables and that a CMP debt collection policy and procedure can be strengthened. As long as CMP receivables continue to be considered immaterial in the judgment of CMS' external financial statement auditors, minimal audit coverage will be provided in this area. Therefore, CMS management needs to take steps to improve the accounting and reporting of CMP receivables.

Recommendations

In order to improve CMS' accounting, reporting, and collection of CMP receivables, we recommend that the Administrator of CMS establish and implement formal written accounting and reporting policies and procedures for

- comparing CMP receivables reported in CMS' audited financial statements and HHS' accountability report,
- reconciling CMP receivables between CMS' general ledger and the detailed subsidiary systems,

[11]Claims include debts owed to the United States or debts being collected by the United States on behalf of others.

[12]HHS OIG stated that, as of September 30, 2000, it did not have any eligible delinquent CMP debt for the cases in which the OIG tracks collections.

- recording of long-term care receivables in the general ledger since long-term care CMP receivables currently are not recorded in the general ledger until a collection is made, and
- ensuring the accurate recording of information into the general ledger.

We also recommend that the Administrator of CMS

- determine an approach for assessing the collectibility of outstanding amounts so that a meaningful allowance for uncollectible accounts can be reported and used for measuring debt collection performance and
- establish formal written policies and procedures to ensure that the allowance for uncollectible CMP debts is properly determined using such an approach.

We further recommend that the Administrator of CMS establish and implement formal written debt collection policies and procedures for

- handling instances in which a discount greater than 35-percent is allowed, including the documentation, review, and approval of such settlements and
- referring eligible long-term care CMP debt to Treasury as required by DCIA.

Agency Comments and Our Evaluation

A draft of the briefing slides was provided to CMS, HHS OIG, DOJ's EOUSA, OMB, and Treasury for their review and comment. CMS' letter is reprinted in appendix II. CMS, HHS OIG, DOJ's EOUSA, OMB, and Treasury also provided us with technical comments that we considered and addressed, as appropriate. The following discussion addresses these agencies' comments and our evaluation.

CMS agreed with all but one of our recommendations. CMS did not agree with our recommendation to establish and implement debt collection policies and procedures for instances in which a discount greater than 35-percent is allowed. According to CMS, flexibility is needed in the settlement process and issuing policies and procedures on settlements would add rigidity to the process. It was not our intent that a rigid process for determining settlement amounts would be implemented. However, consistent with good management practices and the *Standards for Internal Control in the Federal Government*, when exceptions to a stated management policy occur, typical control practices are to document,

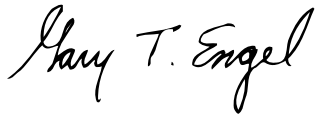
review, and approve such exceptions to ensure that management's objectives are being met.

CMS also stated that the non-CMP issues reported by CMS' external financial statement auditors have no correlation to the CMP issues discussed in the report. We disagree. Even though these are two different types of debt, the underlying financial accountability and reporting issues are similar. For example, as discussed earlier, the external financial statement auditors reported that non-CMP contractors are unable to reconcile reported ending balances to the contractors' subsidiary records. Our review also found reconciliation problems with the CMP receivables. As discussed in this report, as of September 30, 2000, the CMP receivables balance in the general ledger and the detailed subsidiary systems differed by a net of about $22 million.

We are sending copies of this report to the Chairman of the Permanent Subcommittee on Investigations, Senate Committee on Governmental Affairs, as well as the Chairman and Ranking Minority Member of the Senate Committee on Governmental Affairs. We will also provide copies to the Secretary of Health and Human Services; the Administrator, Centers for Medicare and Medicaid Services; the Attorney General; the Inspector General of the Department of Health and Human Services; the Secretary of the Treasury; and the Director, Office of Management and Budget. Copies will also be made available to others upon request.

If you have any questions about this report, please contact me at (202) 512-3406 or Steven Haughton, Assistant Director, at (202) 512-5999. Additional contributors to this assignment were Dawn Simpson, Suzanne Murphy, Rathi Bose, and Marshall Hamlett.

Sincerely yours,



Gary T. Engel
Director
Financial Management and Assurance

Briefing to the Permanent Subcommittee on Investigations, Senate Committee on Governmental Affairs

Financial Management and Assurance Team

Review of the Centers for Medicare and Medicaid Services' Management and Collection of Civil Monetary Penalties

Briefing to the Permanent Subcommittee on Investigations, Senate Committee on Governmental Affairs

December 14, 2001

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Contents

- Objectives
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2

Objectives

- In discussions with you and your staff about reported material weaknesses related to non-civil monetary penalties (non-CMP) receivables at the Centers for Medicare and Medicaid Services (CMS),[1] you also expressed concern over the growth of reported CMP debt.
- You requested that we determine
  - the primary reasons for the growth in CMS' reported CMP debt,
  - whether CMS' CMP receivables have similar financial accountability and reporting issues as its non-CMP receivables,

[1]Formerly the Health Care Financing Administration (HCFA).

3

Objectives (cont'd)

- whether adequate processes exist to collect CMP debt, and
- what roles, if any, the Office of Management and Budget (OMB) or the Department of the Treasury play in overseeing and monitoring CMS' collection of CMP debt.

4

Overview

- We found the following.
  - Increases in fraud and abuse debt was the primary reason for the reported growth in CMP debt.
  - CMS' CMP receivables have similar financial accountability and reporting issues as those identified for non-CMP receivables by its external financial statement auditors.
  - Incomplete and unreliable CMP data limited the determination of overall adequacy of CMP debt collection policies and procedures. Instead, as agreed with your staff, we performed limited tests of CMS' debt collection policies and procedures and found that one policy and procedure, relating to settling at amounts that exceed a 35-percent discount threshold, can be strengthened.

5

Overview (cont'd)

- OMB and Treasury are provided with information useful in performing CMP debt oversight roles. However, OMB stated that it has broad oversight responsibility in monitoring and evaluating governmentwide debt collection activities. OMB further stated that it is the specific responsibility of the agency to monitor, manage, and collect CMP debt and the responsibility of the agency's Office of Inspector General (OIG) to provide oversight through audit of the agency's debt collection activities. In addition, Treasury stated that it relies on the agencies to determine what debt should be referred to Treasury for collection action, as required by the Debt Collection Improvement Act of 1996 (DCIA). However, not all eligible CMP debts are currently being referred.

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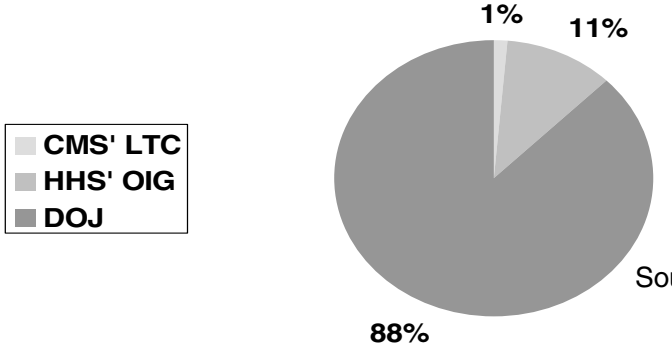
Background

- As of September 30, 2000, the Department of Health and Human Services (HHS) reported that CMS' CMP receivables totaled about $260 million. CMP debt results from deficiencies at long-term care nursing facilities (LTC) or fraud and abuse and is collected by three separate groups. CMS is responsible for the LTC debt and HHS' Office of Inspector General (OIG) and the Department of Justice (DOJ) are responsible for fraud and abuse debt.



Source: CMS Account Receivable - Aging Report as of 9/30/00

7

Background (cont'd)

- CMP receivables relate to two categories of violations: (1) LTC and (2) Fraud and Abuse.
  - LTC
    - Sections 1819 (42 U.S.C. Sections 1395i-3) and 1919 (42 U.S.C. Section 1396r) of the Social Security Act require standard surveys of nursing facilities to determine whether they meet the requirements for participation in the Medicare and Medicaid programs.
    - A survey must be conducted at each nursing facility within 15 months of the previous survey by a state survey agency. In addition, the statewide average interval between surveys must be 12 months or less.

8

Background (cont'd)

- Remedies, of which CMP is one, may be used when a nursing facility is not in substantial compliance with the requirements for participation in the Medicare and Medicaid programs.
- CMP is imposed either for the number of days ($50 to $10,000 per day) or for each instance ($1,000 to $10,000 per instance) that a nursing facility is not in substantial compliance with the participation requirements. The amount depends on the severity of the deficiency.
- A written notice of the CMP is sent to the nursing facility. The facility has 60 days from the date of the notice to either waive its right to an administrative hearing and automatically receive a reduction of 35-percent in the CMP amount or request an administrative hearing.

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Background (cont'd)

- At any time prior to an administrative hearing, the nursing facility may enter into a settlement of the CMP amount. Once there is an administrative hearing decision or a settlement, the final CMP receivable amount is determined.
- According to CMS' *State Operations Manual*, if a decision is made to settle, the settlement should not be for a better term than had the nursing facility opted for a 35-percent reduction.
- To track assessments and collections, CMS' regional offices use the Civil Monetary Penalty Tracking System (CMPTS) for FY 1999 and later CMP cases and spreadsheets for FY 1996 through FY 1998 CMP cases.[2] In addition, CMS' regional offices use the LTC system to track CMP cases.

[2]Regulations implementing the imposition of LTC CMP were effective July 1, 1995. The first LTC CMP assessment was made at the beginning of FY 1996.

10

Background (cont'd)

- Fraud and Abuse
  - DOJ
    - For civil health care fraud matters, DOJ generally uses the False Claims Act, as well as common law fraud remedies, payment by mistake, unjust enrichment, and conversion to recover amounts from those who have submitted false or improper claims to the United States.
    - Civil health care fraud matters are referred directly from federal or state investigative agencies, or result from filings by private persons known as "relators," who file suits on behalf of the federal government under the 1986 qui tam amendments to the False Claims Act.

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Background (cont'd)

- The False Claims Act (31 U.S.C. Sections 3729-3733) provides that anyone who "knowingly" submits a false claim to the government is liable for a penalty from $5,000 to $10,000 plus up to three times the amount of damages sustained by the government.

- A court judgment or settlement establishes amounts due by violators. DOJ prepares a Health Care Fraud Tracking Form,[3] which is submitted to HHS OIG and CMS' Office of Financial Management, and establishes the debt in a tracking system.

[3]In documenting a judgment or settlement, DOJ uses this form to note the judgment or settlement amount and the recipients to be paid from the collected debt.

12

Background (cont'd)

- If the health care violator does not pay the fraud debt, DOJ's U.S. Attorneys' Offices (USAO) have several options to pursue collection, such as contacting the debtor, securing or executing upon a judgment, filing liens or garnishments, and referring the delinquent debt to Treasury.
- DOJ uses one of the following systems to track assessments and collections of civil health care fraud cases.
  - USAOs use either the Tracking Assistance for the Legal Office Network or the Collection Litigation Automated Support System.
  - The Civil Division uses the Debt Collection System.

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Background (cont'd)

- HHS OIG
  - According to HHS OIG data, since 1988, about 90 percent of its CMP assessments relate to the requirements of Section 1867 of the Social Security Act (42 U.S.C. Section 1395dd). This statute specifies that a hospital's emergency department must provide an appropriate medical screening examination within the capability of the hospital's emergency department to any individual who comes to the department with a request for examination or treatment of a medical condition. In addition, if the hospital determines that the individual has an emergency medical condition, the hospital must either stabilize the medical condition or transfer the individual to another medical facility. This statute provides for a maximum penalty of $50,000 per violation.

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Background (cont'd)

- According to HHS OIG data, since 1988, approximately 10 percent of its CMP assessments relate to violations of the statutory provisions applicable to false or fraudulent claims submitted to federal health care programs in Section 1128A of the Social Security Act (42 U.S.C. Sections 1320a-7a). This law provides that for false, fraudulent, or otherwise improper claims, HHS may impose a penalty of not more than $10,000 for each item or service and an assessment of no more than triple the amount claimed for each item or service in lieu of damages.

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Background (cont'd)

- HHS OIG uses spreadsheets to track assessments and collections of CMP cases.[4]

- CMS' Office of Financial Management is responsible for the accounting and reporting of CMP receivables in the general ledger using the Financial Accounting Control System (FACS). This office is also responsible for determining the allowance for uncollectible receivables. According to CMS, an allowance is calculated as the amount of CMP debt delinquent for 60 days or longer that is considered to be inactive and truly delinquent based on a case-by-case review of each receivable.

[4]According to HHS OIG, collections being received through payment plans for CMP assessments under Section 1128A of the Social Security Act are sent directly to CMS. HHS OIG does not track collections for these cases.

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Background (cont'd)

- HHS OIG's Office of Audit Services stated that due to the immateriality of CMP receivables balances, no detailed audit work has been performed on CMP receivables by CMS' external financial statement auditors. However, these auditors have identified various reporting, internal control, and accountability issues related to Medicare (non-CMP) receivables.
  - These issues resulted in a qualified opinion on CMS' financial statements for fiscal year 1998 and a material weakness on non-CMP receivables during fiscal years 1998 through 2000.[5]
  - The external auditors reported that CMS' lack of an integrated financial management system continues to impair its ability to adequately support the reported non-CMP receivables activity and balances.

[5]CMS' financial statements and related auditor reports referred to in the slides were issued under CMS' former name (HCFA).

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Background (cont'd)

- The external auditors also identified deficiencies in non-CMP receivables activity, including the following:
  - incorrectly reported activity by non-CMP contractors and
  - inability of non-CMP contractors to reconcile reported ending balances to the contractors' subsidiary records.

- The external auditors' recommendations included (1) establishing an integrated financial management system for use by non-CMP contractors and CMS' central and regional offices and (2) ensuring that all non-CMP contractors develop and implement control procedures to provide independent checks of the validity, accuracy, and completeness of the amounts reported to CMS, including a reconciliation with the contractors' supporting documentation, and periodic review of contractors' control procedures over reconciliations.

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Scope and Methodology

- To accomplish our objectives, we:
  - Obtained and reviewed CMS' audited financial statements, HHS' accountability reports, and other financial reports that relate to CMS' CMP and non-CMP collection activities.
  - Analyzed CMS' reported CMP receivables and related accounts and information for fiscal years 1997 through 2000.
  - Compared CMS' CMP accounting records to detailed subsidiary tracking records.

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Scope and Methodology (cont'd)

- Obtained an understanding of CMS' CMP debt collection policies and procedures that relate to LTC, HHS OIG, and DOJ cases, as well as applicable federal laws and regulations.
- Did not select a random sample, due to incomplete and unreliable CMP information, from CMP receivables as of September 30, 2000, and CMP receivable cases closed in fiscal years 1999 and 2000. However, as agreed with your staff, we performed limited tests of CMS' debt collection policies and procedures, including the following.

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Scope and Methodology (cont'd)

- Selected and reviewed all delinquent CMP debts (over 60 days delinquent) with a recorded receivable balance as of September 30, 2000, greater than $2 million (12 debts), which represented 57 percent of the delinquent CMP debt balance and 27 percent of the total CMP debt balance per CMS' records.[6]

- Analyzed LTC CMP assessment and settlement data for FY 1999 and 2000 for all cases settled at three selected CMS regional offices. According to CMPTS, the LTC cases opened at these regional offices represented approximately 76 percent of all LTC CMP cases opened during this 2-year period.

[6]The 12 selected debts were fraud cases managed by DOJ.

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Scope and Methodology (cont'd)

- Interviewed officials in CMS, HHS OIG, and DOJ's Executive Office for U.S. Attorneys (EOUSA) to obtain explanations for identified significant trends, similarities with non-CMP receivables material internal control weaknesses, findings and exceptions, as well as unsupported/unreconciled amounts.
- Interviewed OMB and Treasury officials to determine what roles, if any, OMB and Treasury play in overseeing and monitoring the government's collection of civil debt.

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Scope and Methodology (cont'd)

- Did not independently verify the completeness or accuracy of the subsidiary system data or test information security controls over the systems used to compile these data.
- Provided CMS, HHS OIG, DOJ's EOUSA, OMB, and Treasury with a draft of our detailed briefing slides, which contained recommendations to the Administrator of CMS, for review and comment. The comments received are discussed on the "Agency Comments" slide or incorporated into the slides as applicable.
- Performed our review in Washington, DC and Atlanta, GA from March 2001 through August 2001 in accordance with U.S. generally accepted government auditing standards.

23

Increases in Fraud and Abuse Debt is the Primary Reason for Reported Growth in CMP Debt

- Between FY 1995 and 1997, fraud and abuse detection activities were expanded that significantly increased fraud and abuse debts in FY 1997. This was the primary reason for the growth of CMS' CMP receivables.[7]

- In 1995, under authority to use trust funds money to develop or demonstrate improved methods for investigating and prosecuting fraud, HHS launched Project Operation Restore Trust (ORT). ORT targeted fraud and abuse in three high-growth areas of the health care industry: home health agencies, nursing homes, and durable medical equipment suppliers.

[7]DOJ is responsible for collection activity for the majority of the fraud and abuse debt.

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Increases in Fraud and Abuse Debt is the Primary Reason for Reported Growth in CMP Debt (cont'd)

- In 1996, the passage of the Health Insurance Portability and Accountability Act (HIPAA) expanded funding for HHS' fraud and abuse detection activities. In FY 1996, HHS reported that ORT combined with the upgraded funding provided by HIPAA would enable HHS to more aggressively detect and prevent fraud, waste, and abuse.

- With the establishment of HIPAA, HHS OIG and DOJ jointly implemented, by January 1, 1997, the Fraud and Abuse Control Program to combat fraud and abuse committed in the health plans (both public and private).

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Increases in Fraud and Abuse Debt is the Primary Reason for Reported Growth in CMP Debt (cont'd)

- A DOJ EOUSA official stated that health care fraud activities were expanded in FY 1996 and FY 1997, and, with the implementation of the Health Care Fraud Tracking Forms in December 1996, DOJ began submitting health care fraud debts to CMS during FY 1997. Prior to this time, only fraud and abuse debts submitted by HHS OIG were recorded and reported by CMS.

- CMS' accounting records revealed that about $255 million of the $260 million CMP receivables balance as of September 30, 2000, related to fraud and abuse debts. Of the fraud and abuse debts, about $172 million remained outstanding from FY 1997.

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CMP Receivables Have Similar Financial Accountability and Reporting Issues as Non-CMP Receivables

- Our analysis of CMS' CMP receivables data revealed similar financial accountability and reporting issues as those identified for non-CMP receivables by CMS' external financial statement auditors.
- Nonetheless, using HHS' accountability reports, the following is a summary of CMS' key CMP financial information for FY 1997 through FY 2000:
  - CMS' outstanding CMP receivables increased from about $41 million, as of September 30, 1996, to about $260 million, as of September 30, 2000.

27

CMP Receivables Have Similar Financial Accountability and Reporting Issues as Non-CMP Receivables (cont'd)

- CMS annually reserved, in an allowance account, from 14 to 29 percent of the outstanding CMP receivables balance for the estimated amounts that it deemed collection was doubtful.
- There were no write-offs of CMS' CMP receivables during the 4-year period.

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CMP Receivables Have Similar Financial Accountability and Reporting Issues as Non-CMP Receivables (cont'd)

- CMS does not have policies and procedures requiring it to compare CMP receivables reported in its audited financial statements and HHS' accountability report. The following differences between such reported balances have been identified.
  - According to HHS, CMS is the only HHS component that has CMP. However, FY 1997 through FY 1999 ending balances reported for CMP receivables differed by tens of millions of dollars between HHS' accountability reports and CMS' audited financial statements.
  - FY 2000 beginning balance for CMP receivables in HHS' draft accountability report was adjusted by approximately $50 million to agree with CMS' accounting records.

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CMP Receivables Have Similar Financial Accountability and Reporting Issues as Non-CMP Receivables (cont'd)

- As a result of the adjustment, the beginning balance in HHS' FY 2000 accountability report differed from the ending balance in its FY 1999 accountability report. After we brought this difference to HHS' attention, a statement identifying the difference was added to HHS' FY 2000 accountability report's overview; however, the statement did not explain the cause of the difference.

- According to HHS OIG's Office of Audit Services, no detailed audit work on CMP receivables has been performed by CMS' external financial statement auditors due to the small balance of CMS' CMP receivables in relation to CMS' total accounts receivables, which consists primarily of non-CMP Medicare receivables.

30

CMP Receivables Have Similar Financial Accountability and Reporting Issues as Non-CMP Receivables (cont'd)

- As of September 30, 2000, CMS' reported CMP receivables were about $260 million, or 3 percent, of total reported accounts receivables of approximately $8.1 billion, of which non-CMP Medicare receivables totaled more than $7.7 billion.

- Similar to the accountability and reporting issues reported for non-CMP receivables by CMS' external financial statement auditors, CMS also does not have policies or procedures for reconciling CMP accounts receivables balances to detailed support maintained in the subsidiary systems.

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CMP Receivables Have Similar Financial Accountability and Reporting Issues as Non-CMP Receivables (cont'd)

- For FY 2000, the amounts reported in HHS' and CMS' financial reports differed significantly from the underlying subsidiary ledgers. As of September 30, 2000, CMP receivables balance in FACS and the detailed subsidiary systems differed by a net of about $22 million.

(Dollars in thousands)	FACS	Subsidiary Systems	Difference
LTC	$ 3,687	$ 21,109	($ 17,422)
HHS OIG	28,922	87	28,835
DOJ	226,443	261,393	(34,950)
Interest	1,437	0	1,437
Totals	$ 260,489	$ 282,589	($ 22,100)

Sources: FACS: CMS Account Receivable - Aging Report as of 9/30/00
Subsidiary Systems: Data files provided by CMS, HHS OIG, and DOJ

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CMP Receivables Have Similar Financial Accountability and Reporting Issues as Non-CMP Receivables (cont'd)

- Statement of Federal Financial Accounting Standards (SFFAS) No. 1, *Accounting for Selected Assets and Liabilities*, and SFFAS No. 7, *Accounting for Revenue and Other Financing Sources and Concepts for Reconciling Budgetary and Financial Accounting*, state that a receivable should be recognized once amounts that are due to the federal government are assessed, net of an allowance for uncollectible amounts.
- However, CMS stated that beginning in FY 1999, all new LTC CMP receivables are no longer recorded in FACS until a collection is made due to the unreliability of the accounts receivable amounts in CMS' subsidiary system--CMPTS. CMS stated that the LTC CMP receivables would be reviewed for validity as part of the planned upgrade of CMPTS. As a result, FACS does not include all potentially valid LTC CMP receivables. This appears to be the primary reason for the LTC difference between FACS and the subsidiary system.

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CMP Receivables Have Similar Financial Accountability and Reporting Issues as Non-CMP Receivables (cont'd)

- Of the 12 selected delinquent debts that we reviewed, 2 totaling about $24 million were the responsibility of HHS OIG according to CMS' accounting records. However, upon further research by DOJ, these debts were actually the responsibility of DOJ and were included in DOJ's subsidiary system on 9/30/00 as uncollected. This misclassification appears to explain a portion of the difference between FACS and HHS OIG's and DOJ's subsidiary systems.

- CMS does not have formal written policies and procedures for determining its allowance for uncollectible accounts. CMS stated that the allowance represents the balance of all CMP debt delinquent for 60 days or longer that is considered to be inactive and truly delinquent based on a case-by-case review of each receivable.

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CMP Receivables Have Similar Financial Accountability and Reporting Issues as Non-CMP Receivables (cont'd)

- According to SFFAS No. 1, losses due to uncollectible amounts should be measured through a systematic methodology with an analysis of both individual accounts and a group of accounts as a whole. Individual account analysis should be based on factors such as the debtor's ability to pay and the probable recovery of amounts from secondary sources. Group analysis should be performed using a method such as statistical estimation by modeling or sampling and should take into consideration such factors as historical loss experience and recent economic events.

- However, CMS' allowance for uncollectible accounts is not based on a systematic analysis of the collectibility of the outstanding receivables balance.

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CMP Receivables Have Similar Financial Accountability and Reporting Issues as Non-CMP Receivables (cont'd)

- For the 12 selected delinquent debts with receivable balances totaling about $70 million, 7 debts totaling approximately $32 million were recorded incorrectly in FACS.
  - CMS failed to remove four of the debts totaling about $23 million from CMP receivables even though collections of these debts were received prior to September 30, 2000.
  - CMS incorrectly classified three of the debts totaling about $9 million as delinquent, instead of current, even though collections were being received in accordance with the due dates of the respective payment plans.
- For the 12 selected delinquent debts, documentation supporting one of the debts with a balance of about $3 million could not be located by DOJ.

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CMP Receivables Have Similar Financial Accountability and Reporting Issues as Non-CMP Receivables (cont'd)

- CMS stated that Division of Accounting staff responsible for the recording of information in FACS use notes and knowledge gained during training provided by staff previously responsible for the duties to record CMP receivables in the general ledger. However, these informal policies and procedures do not (1) contain specific guidance on recording due dates for payments being made through payment plans or recording collections against established receivables and (2) address control procedures to ensure the accurate recording of CMP receivables in the general ledger, such as review and approval of transactions by a supervisor.

- The status of receivables—current, delinquent, or paid—should be properly noted since it affects the accuracy of the allowance for uncollectible accounts, which is netted against gross CMP receivables reported on HHS' and CMS' financial statements. In addition, these errors could possibly have been avoided if there was appropriate review and approval of such transactions.

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Incomplete and Unreliable CMP Data Limited the Determination of Overall Adequacy of CMP Debt Collection Policies and Procedures

- CMS (LTC, HHS OIG, and DOJ) has established debt collection policies and procedures. However, incomplete and unreliable CMP information limited us from determining the overall adequacy of the CMP debt collection policies and procedures. As a result and as agreed with your staff, we performed limited tests of CMS' debt collection policies and procedures and found the following.
  - For 11 of the 12 selected delinquent debts, DOJ followed its debt collection policies and procedures.
    - For four cases, DOJ had followed its procedures and had collected the debts in full.

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Incomplete and Unreliable CMP Data Limited the Determination of Overall Adequacy of CMP Debt Collection Policies and Procedures (cont'd)

- For three cases, DOJ was following its procedures for collecting the debts in accordance with the respective payment plans.
- Four cases remained delinquent, but DOJ was following its procedures for pursuing collection of unpaid debt.

- We were unable to determine whether DOJ followed its debt collection policies and procedures for one case since DOJ was unable to locate supporting documentation.

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Incomplete and Unreliable CMP Data Limited the Determination of Overall Adequacy of CMP Debt Collection Policies and Procedures (cont'd)

- For LTC CMP debt collection policies and procedures, we noted one debt collection matter in which such policies and procedures can be strengthened. The matter relates to CMS often settling at amounts that exceeded the 35-percent discount threshold.
  - At the three selected regional offices, CMS reduced the assessed LTC CMP amounts more than 35-percent for 89 out of 215 cases (41 percent), or about $8.4 million out of about $11.4 million (73 percent) in assessments settled in fiscal years 1999 and 2000.
  - For the 89 cases, a 35-percent discount on approximately $8.4 million in assessments results in possible collections of about $5.5 million. However, CMS actually discounted these cases in total by about 69 percent, reducing potential collections by $2.9 million.

40

Incomplete and Unreliable CMP Data Limited the Determination of Overall Adequacy of CMP Debt Collection Policies and Procedures (cont'd)

- According to CMS, other matters can develop while an administrative hearing is pending that can affect the settlement amount, such as unavailability of witnesses and new information related to the deficiencies. In these cases, according to CMS, it may be in CMS' best interest to settle for less, given the cost of litigation and the risk of not collecting anything.

- However, CMS does not have debt collection policies and procedures for instances in which a discount greater than 35-percent is allowed. Of the three selected regional offices, one regional office was maintaining documentation to support that such settlements were warranted, while two regional offices were not maintaining documentation. Consistent with good management practices and the *Standards for Internal Control in the Federal Government*,[8] when exceptions to a stated management policy occur, typical control practices are to document, review, and approve such exceptions to ensure that management's objectives are being met.

[8]GAO/AIMD-00-21.3.1, November 1999.

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OMB's and Treasury's Roles in the Oversight and Monitoring of CMP Debt

- Reporting of CMP Receivables[9]
  - Beginning with fiscal year 1997, CMS and HHS have annually disclosed CMP receivables information in their financial reports.
  - In accordance with requirements of DCIA and Treasury guidance, CMS reports receivables information quarterly, which includes CMP, to Treasury in the Report on Receivables Due from the Public.

[9]The information reported to OMB and Treasury needs to be considered in light of the reliability issues we identified (see slides 27-37).

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OMB's and Treasury's Roles in the Oversight and Monitoring of CMP Debt (cont'd)

- OMB and Treasury are provided with information useful in performing CMP debt oversight roles. However, in discussions with OMB officials, they emphasized that OMB's oversight is broad and consists of monitoring and evaluating governmentwide credit management, debt collection activities, and federal agency performance. OMB also stated that it is the specific responsibility of the agency Chief Financial Officer and program managers to manage and be accountable for the debt collection of their agency's credit portfolios in accordance with applicable federal debt statutes, regulations, and guidance. OMB further added that it is the role of each agency to specifically monitor and collect its civil penalty debt regardless of dollar magnitude and the responsibility of each agency's OIG to provide oversight through audit of the agency's debt collection activities.

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OMB's and Treasury's Roles in the Oversight and Monitoring of CMP Debt (cont'd)

- Referral of CMP Debt to Treasury
  - DCIA requires federal agencies to transfer eligible nontax debt or claims over 180 days delinquent to Treasury for collection action.
  - DOJ stated that referral to Treasury was one type of debt collection tool used by USAOs when pursuing collection of fraud cases.[10]
  - CMS stated that CMS is not referring LTC CMP debt to Treasury for collection actions. CMS stated that it plans to refer eligible LTC CMP debts to Treasury in the future and is currently researching the issue.

[10]HHS OIG stated that, as of September 30, 2000, it did not have any eligible delinquent CMP debt for the cases in which the OIG tracks collections.

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OMB's and Treasury's Roles in the Oversight and Monitoring of CMP Debt (cont'd)

- Treasury stated that it relies on the agencies to determine what debt should be referred to Treasury for collection action, as required by DCIA.

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Conclusion

- The expanded fraud and abuse detection activities and resulting growth in fraud and abuse debt is the primary reason for the increase in CMP receivables over the last several years. In addition, our work found similar financial accountability and reporting issues as those reported for non-CMP receivables and that a CMP debt collection policy and procedure can be strengthened. As long as CMP receivables continue to be considered immaterial in the judgment of CMS' external financial statement auditors, minimal audit coverage will be provided in this area. Therefore, CMS management needs to take steps to improve the accounting and reporting of CMP receivables.

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GAO
Accountability * Integrity * Reliability

Recommendations

- We recommend that the Administrator of CMS take the following actions.
  - Establish and implement formal written accounting and reporting policies and procedures for

    (1) comparing CMP receivables reported in CMS' audited financial statements and HHS' accountability report,
    (2) reconciling CMP receivables between CMS' general ledger and the detailed subsidiary systems,
    (3) recording of LTC receivables in FACS since LTC CMP receivables currently are not recorded in FACS until a collection is made, and
    (4) ensuring the accurate recording of information into FACS.

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Recommendations (cont'd)

- Determine an approach for assessing the collectibility of outstanding amounts so that a meaningful allowance for uncollectible accounts can be reported and used for measuring debt collection performance. In addition, establish formal written policies and procedures to ensure that the allowance for uncollectible CMP debts is properly determined using such an approach.
- Establish and implement formal written debt collection policies and procedures for
  (1) handling instances in which a discount greater than 35-percent is allowed, including the documentation, review, and approval of such settlements, and
  (2) referring eligible LTC CMP debt to Treasury as required by DCIA.

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Agency Comments

- In commenting on these briefing slides, CMS agreed with all but one of our recommendations.
- CMS did not agree with our recommendation to establish and implement debt collection policies and procedures for instances in which a discount greater than 35-percent is allowed. According to CMS, flexibility is needed in the settlement process and issuing policies and procedures on settlements would add rigidity to the process. It was not our intent that a rigid process for determining settlement amounts would be implemented. However, consistent with good management practices and the *Standards for Internal Control in the Federal Government*, when exceptions to a stated management policy occur, typical control practices are to document, review, and approve such exceptions to ensure that management's objectives are being met.

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Agency Comments (cont'd)

- CMS also stated that the non-CMP issues reported by CMS' external financial statement auditors have no correlation to the CMP issues discussed in the slides. We disagree. Even though these are two different types of debt, the underlying financial accountability and reporting issues are similar. For example, as discussed on slide 18, the external financial statement auditors reported that non-CMP contractors are unable to reconcile reported ending balances to the contractors' subsidiary records. Our review also found reconciliation problems with the CMP receivables. As discussed on slide 32, as of September 30, 2000, CMP receivables balances in FACS and the detailed subsidiary systems differed by a net of about $22 million.

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Comments From the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services

Note: GAO comments supplementing those in the report text appear at the end of this appendix.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: AUG 30 2001

TO: Gary T. Engel
Director, Financial Management and Assurance
General Accounting Office

FROM: Ruben J. King-Shaw, Jr.
Chief Operating Officer and Deputy Administrator

SUBJECT: General Accounting Office (GAO) Draft Report: *Review of the Centers for Medicare and Medicaid Services' Management and Collection of Civil Monetary Penalties*

Thank you for the opportunity to comment on your draft report prepared in response to the Congressional request to report on the Centers for Medicare & Medicaid Services' (CMS) management and collection of civil monetary penalty (CMP) receivables, and the growth of reported CMP debt. We offer the following comments:

The CMS has received two consecutive unqualified audit opinions for its fiscal years 1999 and 2000 consolidated financial statements. With each year's audit, we have achieved substantial progress in improving internal controls. While we have made some improvements in financial analysis and Medicare contractor oversight, we still have some financial management issues that hinder our ability to report accurate financial information. Our long-term plans for improving the proper recording and reporting of accounts receivable involves the implementation of an integrated general ledger accounting system. Until that system is fully implemented and operational, CMS will continue its efforts in strengthening its internal controls over the accounts receivable process by:

- testing financial management internal controls, including accounts receivable balances at Medicare contractors using Certified Public Accounting firms,
- conducting Medicare contractor performance evaluation reviews of financial management issues at Medicare contractors considered to be high risk,
- strengthening and improving analytical tools necessary to perform more expansive trend analysis of critical financial data to identify potential errors or misstatements, and
- providing training to Medicare contractors regarding the proper accounting and reporting of accounts receivable data.

The Health Care Financing Administration (HCFA) was renamed to the Centers for Medicare & Medicaid Services (CMS). We are exercising fiscal restraint by exhausting our stock of stationery.

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Also, the non-CMP issues reported by our auditors have no correlation to the CMP issues stated in your report. As you noted in the report, the Department of Justice (DOJ) and the OIG account for 99 percent or $255.3 million of CMS's CMP debts. These agencies are responsible for assessing, monitoring, and maintaining the detailed subsidiary support for these debts. While CMS has a responsibility to help reconcile the data, we are reliant on our partners to share that information and routinely update us as to the status of these debts. For example, CMS does not routinely receive notification that DOJ has closed a CMP case, therefore, the receivable remains open on CMS's general ledger. Your report does not recommend nor require DOJ to provide such information to CMS. Therefore, it will be difficult for CMS to fully resolve problems discussed in your report.

Attached are our comments on the specific recommendations in the report.

Attachments

The Centers for Medicare & Medicaid Services Comments on the General Accounting Office Draft Report, *Review of the Centers for Medicare & Medicaid Services' Management and Collection of Civil Monetary Penalties*

See comment 1.

GAO Recommendation #1

Establish and implement policies and procedures to ensure the proper recording of long-term care (LTC) receivables in The Financial Accounting Control System (FACS) since LTC civil monetary penalties (CMP) receivables currently are not recorded in FACS until a collection is made.

CMS Comment

We agree. In fact, since November 2000, a workgroup consisting of representatives from the Office of Financial Management, the Center for Medicaid and State Operations, Program Integrity Group, and the Regional Offices (ROs) have been updating policies and procedures to better track LTC receivables and collections. The redesigned tracking system will automatically post into FACS any receivable that has been validated by the RO. Meanwhile, current receivables will be validated before being transferred to the redesigned system. We expect the new system to go online in February 2002. Also, as an interim measure until the redesign effort is complete, the Centers for Medicare & Medicaid Services (CMS) is considering requiring ROs to begin reporting their CMP balances on a quarterly basis so these receivables can be recorded in FACS.

GAO Recommendation #2

Determine an approach for assessing the collectibility of outstanding amounts so that a meaningful allowance can be reported and used for measuring debt collection performance. In addition, establish policies and procedures to ensure that the allowance for uncollectible CMP debts is properly determined using such an approach.

CMS Comment

We agree. By refining our current method of classifying all inactive debts over 60 days as uncollectible and incorporating statistical measurements that can predict the likelihood of recovery of older debts, we should be able to report a more meaningful allowance in accordance with the Statement of Federal Financial Accounting Standards No. 1. In addition, when collections on debts with repayment plans are received, we will update the due date accordingly and remove the debt from delinquent status.

See comment 1.

GAO Recommendation #3

Establish and implement policies and procedures for:

1) comparing CMP receivables reported in CMS' audited financial statements and HHS' accountability report,
2) reconciling CMP receivables between CMS' general ledger and the detailed subsidiary systems, and
3) ensuring the accurate recording of information into FACS.

CMS Comment

We agree. For fiscal year (FY) 2001, we will ensure that procedures are in place to review and reconcile CMS' audited financial statements to the Department of Health and Human Services' accountability report. We will also perform regular general ledger and cash reconciliations to ensure that the data in FACS are accurate, beginning in FY 2002. While we agree that reconciliation between CMS and the subsidiary systems is necessary, the Department of Justice (DOJ) and the Office of Inspector General (OIG) maintain those subsidiary systems. To date, DOJ has not provided that level of detail to CMS. During recent conversations with DOJ they expressed concerns about providing such information to CMS. As far as OIG's information, we are working with staff to obtain this information and will perform reconciliations once that information is provided.

See comment 2.

GAO Recommendation #4

Establish and implement policies and procedures for:

1) instances in which a discount greater than 35 percent is allowed, including the documentation, review, and approval of such settlements, and
2) referring eligible CMP debt to the Department of the Treasury as required by Department Collection Improvement Act (DCIA).

See comment 3.

CMS Comment

1) Settlements. We do have policy on the 35-percent reduction in CMP for waiving a hearing. Section 7524 of the State Operations Manual indicates that if a decision is made to settle, the settlement should not be for a better term than had the facility opted for a 35-percent reduction. In other words, the facility should not be able to receive a greater reduction in CMP when it settles and does not waive the right to a hearing. Last year, we considered bringing greater consistency to the settlement process by prescribing a rather rigid process for determining settlement amounts. However, we concluded

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from regional attorneys and staff comments that there were problems that we had not anticipated, and that there is a need for flexibility rather than rigidity in the settlement process. Therefore, we do not agree that we should issue policies and procedures on settlements to be strictly followed by the regions. We believe that each case is unique and requires an individual assessment. Regional attorneys should have the discretion to handle each case individually, by evaluating the merits of that case.

2) We agree. We are in the process of referring eligible CMP debts from the FACS to the Debt Collection System for referral to Treasury as mandated under the DCIA. During FYs 2000 and 2001, CMS focused our debt referral efforts on large dollar receivables. In FY 2000, we referred over $2 billion of eligible debt and are on track for similar referral efforts for 2001. Beginning in FY 2002, CMS plans to refer all remaining eligible debts to Treasury including CMP debts.

The following are our comments on the Centers for Medicare and Medicaid Services' letter dated August 30, 2001.

GAO Comments

1. We subsequently combined recommendations 1 and 3 together under recommendation 1 in order to group related topics. CMS agreed with both recommendations.

2. Recommendation 4 was subsequently renumbered as recommendation 3 due to the combining of recommendations 1 and 3.

3. See the "Agency Comments and Our Evaluation" section.