Section IV - Independent Auditor's Report on Financial Statements and Management Response

INDEPENDENT AUDITOR REPORT

To: The Secretary of Health
and Human Services

We have audited the accompanying consolidated balance sheets of the Department of Health and Human Services (HHS) as of September 30, 2002 and 2001, and the related consolidated statements of net cost for the fiscal years (FY) then ended, as well as the consolidated statements of changes in net position and financing and the combined statement of budgetary resources for the FY ended September 30, 2002. These financial statements are the responsibility of HHS management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States; *Government Auditing Standards* issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 01-02, *Audit Requirements for Federal Financial Statements*. These standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and the significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of HHS as of September 30, 2002 and 2001, and its net costs for the years then ended, as well as the changes in net position, budgetary resources, and reconciliation of net costs to budgetary resources for the FY ended September 30, 2002, in conformity with accounting principles generally accepted in the United States.

We conducted our audits for the purpose of expressing an opinion on the financial statements referred to in the first paragraph. The information in the Overview and the Supplementary Information are not required parts of the HHS financial statements but are considered supplemental information required by OMB Bulletin 01-09, *Form and Content of Agency Financial Statements*. Such information, including trust fund projections, has not been subjected to the auditing procedures applied in the audit of the financial statements. Accordingly, we express no opinion on it.

In accordance with *Government Auditing Standards*, we have also issued our reports, dated January 17, 2003, on our consideration of HHS internal controls over financial reporting and on our tests of HHS compliance with certain provisions of laws and regulations. Those reports are an integral part of our audits; they should be read in conjunction with this report in considering the results of our audits.

Janet Rehnquist
Inspector General

January 17, 2003
A-17-02-00001

INDEPENDENT AUDITOR REPORT ON INTERNAL CONTROLS

To: The Secretary of Health
and Human Services

We have audited the financial statements of the Department of Health and Human Services (HHS) as of September 30, 2002, and have issued our report, dated January 17, 2003, on those statements. We conducted our audits in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 01-02, *Audit Requirements for Federal Financial Statements.*

In planning and performing our audits, we considered the HHS internal controls over financial reporting by obtaining an understanding of the applicable internal controls, determining whether internal controls had been placed in operation, assessing control risk, and performing tests of controls in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin 01-02. We did not test all internal controls relevant to operating objectives as broadly defined by the Federal Managers' Financial Integrity Act (31 U.S.C. § 3512), such as those controls relevant to ensuring efficient operations. The objective of our audit was not to provide assurance on internal controls; consequently, we do not provide an opinion on the internal controls.

Our consideration of internal controls over financial reporting would not necessarily disclose all matters in these controls that might be reportable conditions. Under standards issued by the American Institute of Certified Public Accountants, reportable conditions are matters coming to our attention relating to significant deficiencies in the design or operation of internal controls that, in our judgment, could adversely affect the department's ability to record, process, summarize, and report financial data consistent with management assertions in the financial

statements. Material weaknesses are reportable conditions in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Because of inherent limitations in internal controls, misstatements, losses, or noncompliance may nevertheless occur and not be detected. As discussed below, we noted certain matters involving internal controls and their operation that we consider to be reportable conditions. We consider the first two matters to be material weaknesses.

INTERNAL CONTROL WEAKNESSES

MATERIAL WEAKNESSES

Financial Systems and Processes (Repeat Condition)

Since passage of the Chief Financial Officers (CFO) Act of 1990, as amended by the Government Management Reform Act of 1994, agencies have prepared financial statements for audit by the Inspectors General. The act emphasized production of reliable financial statements; consequently, HHS worked diligently to prepare statements capable of receiving an unqualified audit opinion. With this year's audit, HHS has sustained the important achievement of an unqualified, or "clean," opinion, which we issued for the first time on the FY 1999 financial statements. A clean audit opinion, however, assures only that the financial statements are reliable and fairly presented. The opinion provides no assurance as to the effectiveness and efficiency of agency financial systems and controls.

In our view, the department continues to have serious internal control weaknesses in its financial systems and processes for producing financial statements. These weaknesses are related to financial management systems, financial analyses and reporting, and grant accounting.

Financial Management Systems Issues

The Federal Financial Management Improvement Act (FFMIA) of 1996 was intended to advance federal financial management by ensuring that financial management systems provide reliable, consistent disclosure of financial data, that they do so uniformly across the Federal Government and from year to year, and that they consistently use accounting principles generally accepted in the United States. Policies and standards for agencies to follow in developing, operating, evaluating, and reporting on financial management systems are prescribed in OMB Circular A-127, *Financial Management Systems*.

Within the department, the Centers for Medicare and Medicaid Services (CMS), the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC)/Agency for Toxic Substances and Disease Registry (ATSDR), and the Food and Drug Administration (FDA) are responsible for their respective financial management and accounting. The remaining operating divisions rely on the Program Support Center's Division of Financial Operations (DFO) for these services.

While we observed steady improvement in the process of preparing financial statements, weaknesses in system and internal controls made it difficult to prepare timely and reliable financial statements. The lack of an integrated financial management system(s) continued to impair the ability of certain operating divisions to prepare timely financial information. *We remain concerned that the department's antiquated accounting systems will present an obstacle to meeting accelerated financial reporting schedules required by OMB Bulletin 01-09.*

The department expects the systems used by CDC, FDA, NIH, and the largest CMS contractors to be significantly enhanced by the end of FY 2005. Full implementation of the CMS system is not anticipated until 2007. These systems are expected to provide improved financial information for better decisionmaking, potential cost savings, and a means to meet federal accounting and budgetary reporting requirements.

Centers for Medicare and Medicaid Services. The CMS is the department's largest operating division with about $472 billion in net FY 2002 budget outlays. To accumulate and report financial data, CMS, which operates as a decentralized organization, relies on complex systems as well as ad hoc and manually intensive reporting processes. As a result, the CMS financial

management system is not fully integrated and, as reported in prior years, is not compliant with the FFMIA.

During FY 2002, CMS engaged approximately 50 contractors to manage and administer the Medicare program. These contractors report Medicare activity on various financial reports, such as the CMS 750/751 reports, which accumulate transactions and activity throughout the year. The Medicare claim processing systems have limited system interfaces to process and prepare data for these reports. Additionally, because the claim processing systems lack general ledger capabilities, preparing the 750/751 reports is labor intensive and requires reconciliations between various systems and ad hoc spreadsheet applications.

To address its systems problems, CMS has continued to test and implement the Healthcare Integrated General Ledger Accounting System (HIGLAS) for the Medicare contractors and the CMS regional and central offices. The HIGLAS will have capabilities to incorporate Medicare contractors' financial data, including claim activity, into the CMS internal accounting system and will replace the current central office general ledger and accounting system. Once implemented and fully operational—anticipated in FY 2007—the new system is expected to strengthen Medicare financial management and enhance oversight of contractor accounting systems.

National Institutes of Health. In FY 2002, NIH had net budget outlays of approximately $20.5 billion. The NIH Central Accounting System was not designed for financial reporting purposes and does not apply the U.S. Standard General Ledger at the transaction level. For example:

- The NIH process for preparing financial statements includes downloading necessary data from its Central Accounting System and using spreadsheets to process adjusting entries and prepare financial statements. This process continues to be time consuming, has a high risk of error, and does not include procedures to ensure the completeness of the final data used to prepare financial statements.

- To compensate for noncompliance with the U.S. Standard General Ledger, NIH recorded nonstandard accounting entries totaling $3.2 billion in the Central Accounting System during the year. These entries were necessary to properly adjust account balances, including inventory, accrued leave, personal property, receipt of donations, and other revenues. In addition, NIH developed a process to record the impact of current-year day-to-day entries on budgetary and expended appropriations accounts at the yearend. This process generated about 19,000 nonstandard accounting entries with an absolute value of about $386 billion that

were not reflected in the Central Accounting System. The use of nonstandard accounting entries increases the risk of bypassing accounting controls.

In FY 2002, NIH continued the development of the NIH Business System to replace existing administrative and management systems. Predeployment activities from May through September 2002 included system testing, setup activities, and training.

Administration for Children and Families. In FY 2002, ACF had net budget outlays of approximately $45.7 billion. The Program Support Center's DFO CORE accounting system used by ACF, as well as by other operating divisions, does not facilitate the preparation of timely financial statements. The necessary data must be downloaded from CORE, then adjusting entries are processed and the statements are compiled. This process continues to be manually intensive and limits the resources available for financial analyses and related research of unusual account relationships.

Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry. The CDC/ATSDR operated with combined net budget outlays of about $4.4 billion in FY 2002. Their central accounting system does not facilitate the preparation of timely financial statements and was not configured to record certain transactions in accordance with the U.S. Standard General Ledger at the transaction level. For example:

- The financial statement preparation process continues to be manually intensive and requires numerous adjusting entries, which are recorded outside the accounting system. General ledger account data are downloaded from the accounting system into a data file, which is imported into a database. To ensure that the data have been imported properly, the database must be compared against hard copy reports.

- To compensate for noncompliance with the U.S. Standard General Ledger, CDC/ATSDR makes manual adjusting entries to correct misstatements associated with upward and downward adjustments, travel advances, appropriated capital related to reimbursable expenses, and revenue associated with four appropriated trust fund accounts.

Financial Analyses and Reporting Issues

The OMB Circular A-123, *Management Accountability and Control*, provides guidance to federal managers on improving management controls to ensure that (1) programs achieve their intended results; (2) resources are used consistent with agency missions; (3) programs and resources are protected from waste, fraud, and mismanagement; (4) laws and regulations are followed; and (5) reliable, timely information is obtained, maintained, reported, and used for decisionmaking.

During FY 2002, the HHS operating divisions improved their financial accounting and supervisory review processes, including the preparation of more timely account analyses and periodic reconciliations. However, our review disclosed numerous weaknesses in some operating divisions' ability to report accurate, timely financial information. Certain reconciliation processes were not adequately performed to ensure that differences were properly identified, researched, and resolved in a timely manner and that account balances were complete and accurate. In addition, significant analysis by department staff, as well as outside consultants, was necessary to determine proper balances months after the close of the year. Had the operating divisions followed departmental policies and conducted all required financial analyses and reconciliations throughout the year, many account anomalies would have been detected earlier. The need for enhanced, periodic reconciliation and analysis procedures was noted at CMS, NIH, ACF, and CDC/ATSDR.

Centers for Medicare and Medicaid Services. Pending implementation of HIGLAS, strong oversight of the Medicare contractors and properly trained personnel are needed to (1) reduce the risk of material misstatements in financial data and (2) ensure that periodic analyses and reconciliations are completed to detect and resolve errors and irregularities in a timely manner.

While we found improvements in internal controls, our review at selected Medicare contractors disclosed weaknesses that continue to affect CMS's ability to report accurate financial information. Misstated accounts receivable, reconciliation problems, and other weaknesses in financial analysis and oversight were noted.

During our review of accounts receivable activities at September 30, 2002, we noted that the Medicare contractors had problems similar to those disclosed in prior years. One contractor had $18.2 million of Medicare Secondary Payer receivables that were older than 180 days. However, these transactions had not been identified as currently not collectible in accordance with CMS policy. Another contractor could not provide the detailed documentation to support $26 million

in offsets of collections. As a result, we were unable to determine if amounts were properly offset against the respective accounts receivable. In addition, clerical and data input errors contributed to misstatements of $3.3 million and $1 million, respectively, at two other contractors.

We also identified continuing deficiencies in the reconciliation of the monthly 1522 financial reports, on which Medicare contractors report total Medicare funds expended. At the contractor level, "total funds expended" is the sum of all checks drawn and electronic fund transfer payments issued during the month less voided checks and overpayment recoveries. To ensure that amounts reported are accurate, supported, and properly classified, the Medicare contractors are required to reconcile the monthly financial reports with the paid claims tapes or system reports. The reconciliations constitute a key internal control procedure. We noted, however, that one contractor did not properly perform this reconciliation. Due to a computer conversion problem, total funds expended for January 2002 were understated by $4.3 million.

Although improvement has been noted in the central and regional offices' financial analysis and oversight functions, certain processes still need to be strengthened to provide reasonable assurance that material errors will be detected and corrected in a timely manner. At the CMS central office, for instance, supervisory reviews were not consistently performed and documented. Several of the following errors could have been identified with the appropriate level of supervisory review:

- Managed care payments totaling $238 million were misclassified as fee-for-service payments due to miscommunication within CMS about the creation of new general ledger codes to separately track managed care demonstration payments.

- Department of the Treasury and CMS records differed by $32 billion. The CMS did not properly close out certain budgetary accounts by recording open balances as budget authority on the statement of budgetary resources; instead, it recorded balances as appropriations temporarily not available.

- Noncurrent amounts of $2.4 million were manually input as negative, rather than positive, amounts on the contractor Medicare secondary payer accounts receivable spreadsheets. As a result, the receivable balances were misstated by $4.8 million. Additionally, $1.4 million of the allowance related to Medicare Part B was excluded.

In addition, CMS is required to match its data with data provided by the Social Security Administration and the Internal Revenue Service to identify potential accounts receivable. For FY 2002, CMS notified its contractors to redirect their resources to debt collection rather than processing Medicare secondary payer data match tapes. At September 30, 2001, accounts receivable related to the data match were estimated at $110 million. Had the data match processes been performed at the individual contractor level, additional receivables could have been recognized and collected during FY 2002. The lack of this required data match may adversely affect trust fund cash flows.

While the central and regional offices share oversight duties for Medicare contractors, the regional offices play a critical role in that they are the first point of contact with the contractors. During FY 2002, we assessed the oversight function at two regional offices and found that certain procedures were not adequately performed to ensure that contractor financial data were reliable, accurate, and complete. For example:

- The regional offices are responsible for reviewing contractors' performance in various audit and reimbursement functions reported in the System Tracking of Audit and Reimbursement. However, the protocols for these reviews did not include procedures for testing the completeness of data in the system.

- The regional offices did not consistently obtain contractors' quarterly recommendations for classifying debts as currently not collectible. The two regional offices reviewed had not received 8 of 60 contractor reports on a timely basis or could not produce documentation to support the timely submission. The regional offices indicated that tracking sheets had been developed to monitor the timely submission of contractor quarterly reports and related documentation.

National Institutes of Health. The NIH financial systems did not facilitate automatic reconciliation between general ledger accounts and subsidiary accounts. In addition to these system weaknesses, the financial analysis and reconciliation procedures in place during FY 2002 were not effective in producing reliable financial statements or in identifying errors in a timely manner.

- To prepare the FY 2002 financial statements, NIH recorded 50 entries with an absolute value of $27 billion outside the Central Accounting System. Of the $27 billion, $21 billion related to the reversal of the FY 2001 grant accrual and the establishment of the FY 2002 grant accrual and $3.4 billion represented

adjustments to correct misclassifications between intragovernmental and nongovernmental accounts.

- The NIH adjusted accounts payable based on its review of material disbursements that occurred after the yearend. Auditors determined that additional adjustments of $232 million were required to fairly state the accounts payable balance as of September 30, 2002.

- Contrary to HHS policy, periodic reconciliations for net position and other budgetary accounts were not performed throughout the year. In addition, the process used to reconcile accounts was not adequately documented for all accounts as of September 30, 2002.

- As stated in OMB Bulletin 01-09, better linkage between the budgetary information presented in financial statements and the Budget of the U.S. Government is critical to the integrity of the numbers represented in the latter document. Adjustments should be posted to the Federal Agencies' Centralized Trial-Balance System II (FACTS II) during the January window for posting corrections to the budgetary information. Adjustments not posted should be disclosed and explained in the footnotes to the financial statements.

  Since final financial statements were not completed before the November 9, 2002, FACTS II fourth quarter submission deadline, the September 30, 2002, trial balance of accounts used to prepare the financial statements differed from that submission by an absolute value of $13 billion. No adjustments were posted to FACTS II during the January window, and note 28 to the HHS financial statements did not adequately disclose or explain the difference.

Administration for Children and Families. The need for more timely financial analysis is critical to reduce the likelihood of errors in the ACF financial statements. For example:

- In FY 2002, a total of 21 journal vouchers were recorded outside the CORE system in order to prepare the ACF financial statements. The absolute value of these entries affecting amounts ultimately reflected in the financial statements was $26.1 billion. Of this amount, $20.7 billion related to the reversal of the FY 2001 grant accrual and the establishment of the FY 2002 grant accrual.

Two unusual adjustments significantly affected certain line items in the draft statements. One transaction for approximately $1.95 billion related to correcting an error in the presentation of transferred authority as a cancelled appropriation. The second transaction for approximately $2.8 billion adjusted an incorrect legal interpretation to account for a cancelled appropriation relating to the Temporary Assistance for Needy Families (TANF) program. Both transactions affected the statement of budgetary resources, while the latter transaction also affected the balance sheet and the statement of changes in net position.

- The ACF recorded a significant number of miscellaneous adjustments to various net position accounts during the year and at the yearend. The absolute value of these entries affecting amounts ultimately reflected in the financial statements was $11.2 billion. These adjustments recorded the impact of both prior-year adjusting journal entries and adjustments needed to reconcile other accounts at the yearend.

- Contrary to HHS policy, complete, periodic reconciliations of Appropriated Capital Used and Expended Authority accounts were not performed. These reconciliations could provide valuable insight into ACF's determination of the reasonableness of amounts reflected on the budgetary and net position statements.

- Since final financial statements were not completed before the November 9, 2002, FACTS II fourth quarter submission deadline, the September 30, 2002, trial balance of accounts used to prepare the financial statements differed from that submission by an absolute value of $21 billion. No adjustments were posted to FACTS II during the January window, and note 28 to the HHS financial statements did not adequately disclose or explain the difference.

Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry. We noted internal control weaknesses in the preparation, analysis, and monitoring of financial information reported in the CDC/ATSDR financial statements. These weaknesses resulted from the accelerated reporting deadline, a turnover in critical positions, and the manually intensive financial reporting processes. For example:

- In FY 2002, over 70 adjusting journal entries were recorded outside the general ledger system in order to prepare financial statements. The absolute value of these entries affecting amounts ultimately reflected in the financial statements was $1.7 billion. Many of these adjusting entries could have been eliminated by more

timely review of journal entries by supervisory staff and by performance of account analyses and reconciliations throughout the year.

- The existing process of recording accounts payable at the fiscal yearend is manually intensive and based on a review of material disbursements after the yearend. Management delays in completing an analysis and the ultimate audit of such amounts resulted in additional accruals of approximately $24.5 million as of September 30, 2002.

- Approximately $11 million of Construction in Progress was misclassified as Buildings in Service at September 30, 2002.

Grant Accounting Issues

The mission of the Program Support Center's Division of Payment Management (DPM) is to provide world-class grant payment and cash management services to HHS and other federal and nonfederal entities. Serving as a fiscal intermediary between awarding agencies and the recipients of grants and contracts, DPM currently pays out over $244 billion annually in federal grant-in-aid funds. During FY 2002, DPM's customers included a wide variety of grant recipients with over 23,400 accounts.

An independent public accounting firm concluded that the description of controls presented fairly, in all material respects, the relevant aspects of DPM's controls placed in operation as of September 30, 2002. In addition, the firm concluded that the controls, as described, were suitably designed to provide reasonable assurance that the specified control objectives would be achieved if the described controls were complied with satisfactorily and if user organizations applied the internal controls contemplated in the design of DPM's controls. Lastly, the firm concluded that the controls tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives specified were achieved during the period October 1, 2001, to September 30, 2002.

We remain concerned, however, about deficiencies in certain controls at the operating divisions. For example, periodic reconciliations and routine analyses of accounts to detect accounting anomalies were not performed on a consistent and timely basis.

National Institutes of Health. Although NIH took actions to improve grant financial management and oversight processes, certain deficiencies persisted during FY 2002. For example:

- Reconciliations of the grant advance balances between the Payment Management System and the Central Accounting System were not timely for 4 months of FY 2002. The October reconciliation was not completed until December, the November reconciliation was not completed until February, and the December and January reconciliations were not completed until March 2002. Untimely identification and resolution of reconciling items could result in a material misstatement of interim financial statements.

- In 31 of 45 grant documents reviewed, the authorization amounts in the Payment Management System and the Central Accounting System differed. Restrictions placed on the grantees had been electronically communicated to the Payment Management System, and the authorization amounts were reduced. However, because the two systems were not integrated, the full authorization amounts remained in the Central Accounting System. Some of these differences continued longer than they should have because the grant restrictions, which should be temporary, were not lifted on a timely basis. Restrictions lasted 1 year for 9 grants and 2 years for 15 grants.

- Approximately 15,283 grant documents with authorization totaling over $3.6 billion were eligible for grant closeout but had not been closed as of September 30, 2002. Most of these documents related to FY 1997 and prior appropriations. Better review and monitoring procedures would assist in a more proactive closeout process.

Administration for Children and Families. Grants comprise over 97 percent of ACF's program costs. Although improvement was noted in FY 2002, ACF continued to have difficulty in performing timely analyses of grant-related accounts.

- A complete analysis of fluctuations between FY 2002 and 2001 program costs was not available until December 2002. For example, TANF program costs increased $1.2 billion over FY 2001. The ACF ultimately concluded that the fluctuation of costs in various programs was reasonable.

- Grant transactions with an absolute value of $10 billion were misclassified between intragovernmental and nongovernmental accounts in the general ledger. Entries to correct these errors were not posted to the general ledger system; instead, the correction was made by manually adjusting the financial statements.

- Approximately 8,646 grant documents with over $35 billion in authorization were eligible for grant closeout but had not been closed as of September 30, 2002. Some of these grant documents were related to FY 1997 and prior appropriations.

Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry. The lack of formal policies and procedures, as well as an inadequate number of personnel, resulted in the untimely closeout of expired grants. In FY 2002, CDC/ATSDR did not close out any expired grants and had a backlog of expired, unclosed grants from prior years.

Recommendations

Specific recommendations to the operating divisions are contained in the individual audit reports. We also recommend that the Assistant Secretary for Budget, Technology, and Finance (ASBTF):

- ensure that CMS and NIH implement corrective actions, pending full operation of HIGLAS and the NIH Business System, respectively, to mitigate system deficiencies that impair the capability to support and report accurate financial information;

- ensure that the operating divisions (1) develop formal procedures to conduct periodic, detailed reviews and analyses of transactions within the subsidiary ledgers and (2) establish controls to identify, research, and resolve significant accounting anomalies in a timely manner;

- oversee CMS's corrective actions to provide a mechanism for central and regional office monitoring of contractors' activities and enforcement of compliance with CMS financial management procedures;

- direct the operating divisions' CFOs to work with their program office counterparts to refine procedures for analyzing and explaining unusual changes in account balances related to grant reporting;

- refine grant closeout policy for consistency between the operating divisions and the Payment Management System, and require reconciliations of authorizations, advances, and disbursements among recipient records, operating division general ledgers, and the Payment Management System;

- ensure that the operating divisions allocate adequate resources to perform required account reconciliations and analyses, including grant closeout procedures;

- direct that the operating divisions prepare quarterly reports on the status of corrective actions on recommendations identified in the individual operating division reports on internal controls; and

- ensure the preparation of interim financial statements in future years, as required by OMB Bulletin 01-09, *Form and Content of Agency Financial Statements.*

Medicare Information Systems Controls (Repeat Condition)

Our review of Medicare information systems controls continued to disclose weaknesses in general and application controls at Medicare contractors, data centers where Medicare claims are processed, maintainers of shared application system software used in claim processing, and the CMS central office. The number of identified weaknesses remained consistent with that found in previous years.

General controls affect the integrity of all applications operating in the claim processing environment—whether at an individual location or across the Medicare fee-for-service system as a whole. They include the entity-wide security program, access controls (physical and logical), application development and program change controls, segregation of duties, operating systems software, and service continuity. Application controls include input, processing, and output controls related to specific applications.

To administer the Medicare program and to process and account for Medicare expenditures, CMS relies on extensive, interdependent information systems operations at its central office and Medicare contractor sites. The central office systems maintain administrative data, such as Medicare beneficiary enrollment, eligibility, and paid claims data, and process all payments for managed care. The Medicare contractors and data centers use several "shared" systems to process and pay fee-for-service claims. All of the shared systems, which are maintained by "system maintainers," interface with the CMS Common Working File (CWF) to obtain authorization to pay claims and to coordinate Medicare Parts A and B benefits. This network

accounted for and processed more than $254.5 billion in Medicare expenditures during FY 2002. Strong internal controls over these operations are essential to ensure the integrity, confidentiality, reliability, and availability of critical data while reducing the risk of errors, fraud, and other illegal acts.

In FY 2002, CMS continued to make progress in identifying and addressing weaknesses in its automated processing systems. Although our review disclosed no exploitation of any identified vulnerability, the weaknesses noted could ultimately result in (1) unauthorized access to and disclosure of sensitive information, (2) malicious changes that could interrupt data processing or destroy data files, (3) improper Medicare payments, or (4) disruption of critical operations. No individual weakness was determined to be material; however, in the aggregate, the vulnerabilities identified constitute a material weakness.

Scope of Review

Our review covered both general and application controls and did not include management or operational controls.

We completed internal control reviews at 16 Medicare sites, including the central office. Two of the 16 sites received only 1 type of review, while the remaining 14 sites received multiple reviews. These reviews included new and updated general and application control reviews, change control reviews at system maintainers, reviews of the results of CMS-sponsored external vulnerability assessments, and reviews of the results of CMS-sponsored Statement on Auditing Standards (SAS) 70 independent auditor reviews.

To expand the scope of our reviews, we conducted new application control reviews at four Medicare contractors where we assessed those controls for five shared systems: the Fiscal Intermediary Standard System (FISS), the Arkansas Part A Standard System, the VIPS Medicare System, the Multi-Carrier System, and the CWF. We also conducted updates at three Medicare contractors and the central office for CMS-sponsored FY 2001 vulnerability assessments, new reviews of the results of CMS-sponsored FY 2002 external vulnerability assessments at three Medicare contractors, and reviews of the results of CMS-sponsored FY 2002 SAS 70 independent auditor reviews at nine Medicare contractors.

Systems Control Weaknesses

As detailed below, we identified weaknesses at the Medicare contractors in five primary types of general controls: entity-wide security programs, access controls, systems software, application software development and change controls, and service continuity. At the CMS central office, most of the important initiatives to address the findings reported in FY 2001 have been completed. However, weaknesses continued in the areas of entity-wide security plans, Medicare data file and physical data center access controls, and service continuity. In addition, we identified certain application control weaknesses at the contractors and the central office.

Entity-Wide Security Programs. These programs, the framework for establishing effective systems controls, are intended to ensure that security threats are identified, risks are assessed, control objectives are appropriately designed and formulated, relevant control techniques are developed and implemented, and managerial oversight is consistently applied to ensure the overall effectiveness of security measures. Security programs typically include formal policies on how and which sensitive duties should be separated to avoid conflicts of interest. Similarly, policies on background checks during the hiring process are usually stipulated. Inadequacies in these programs can result in inadequate access controls and software change controls affecting mission-critical, computer-based operations.

Entity-wide security plan control weaknesses were identified at the FY 2002 review sites and continued at certain sites reviewed in FY 2001. Certain contractors and the central office had not formalized all of their security plans and related programs to address federal mandates. For example, at the central office, revised data access password standards had not been fully implemented for critical systems. Also, one contractor's security plan did not contain a ranking of Medicare information according to risk. Funding provided to the contractors late in FY 2002 should facilitate the development of consistent security plans in FY 2003.

Access Controls. Access controls ensure that critical system assets are physically safeguarded and that logical access to sensitive computer programs and data is granted only when authorized and appropriate. These controls help to ensure that only authorized users and computer processes access sensitive data in an appropriate manner. Weaknesses in such controls can compromise the integrity of sensitive program data and increase the risk that such data may be inappropriately used and/or disclosed.

Access control weaknesses continue to be identified and represent a significant risk to the Medicare program. Such weaknesses involved the configuration of access control software, policies and procedures for ongoing monitoring and review of suspected access violations, the

consistency of security controls between mainframe and Internet-connected Medicare systems, and physical access to Medicare data centers.

For example, penetration testing at three Medicare contractors identified weaknesses related to dial-in access, user account and password management, Internet security, and systems software configuration. One contractor's web site made certain information available to the general public that could make it easier for unauthorized individuals to access and exploit computer networks. Another contractor did not periodically review lists of users with authorized access to sensitive data files to determine whether the users were current and appropriate. Late in FY 2002, CMS provided funding to the Medicare contractors to address gaps in access controls.

Systems Software. Systems software is a set of computer programs designed to operate and control the processing activities for a variety of applications on computer hardware and related equipment. The software helps coordinate the input, processing, output, and data storage associated with all of the applications processed on a specific system. Some systems software is designed to change data and programs without leaving an audit trail.

Our FY 2002 reviews identified problems in managing routine changes to systems software to ensure appropriate implementation and related configuration controls. For example, updates to systems software in non-mainframe environments that support Medicare claim processing were not always applied timely. Such environments also were found, in some instances, to have unnecessary system functions placed in operation, resulting in potentially unwarranted exposures subject to exploitation. These types of problems could weaken critical controls over access to sensitive Medicare data files and operating system programs.

Application Software Development and Change Controls. Often, mandated changes in Medicare fee-for-service processing are of high volume and significance. Such changes are made through scheduled releases of updated and/or enhanced application system software for claim processing and payment. Implementation of these system updates and enhancements requires the coordinated efforts of numerous contractors to achieve desired results within stringent time constraints. Due to the materiality of payments affected by these applications, controls in this area are paramount to ensure the integrity of fee-for-service processing.

The CMS resolved the prior control weakness related to the Medicare data centers' access to the FISS program source code by implementing improved monitoring controls and change management processes at the central office. However, we identified additional weaknesses at the contractors and their data centers, primarily concerning the testing of new versions of the Medicare shared systems. Of concern is whether the contractors and data centers are able to test

all changes in the updated versions within the scheduled time between the release of the changed program code and the implementation dates. The CMS agrees that continuous improvements in existing controls over this process are needed to strengthen system releases, as is an awareness at all levels of the risk inherent in the high volume and significance of the changes being mandated.

The CMS notes, however, that efforts at the Medicare contractors to address this issue are significantly hampered by the volume of changes being requested of the systems and the legacy environment in which they operate. Because of the tremendous demand on the systems from constantly changing legislation, regulations, and administrative initiatives, in conjunction with the complexity of the aging legacy code and operating environment, only long-term steps to streamline and modernize the claim process appear to offer a real solution.

Service Continuity. We found that several contractors did not have up-to-date, completed, and tested continuity plans to ensure uninterrupted processing of Medicare data. Also, the central office had not completed business continuity plans for all critical Medicare systems.

Application Controls. We identified weaknesses in the routine interchange of data among several critical applications and data sources, including data affecting Medicare beneficiary eligibility received from another federal agency, the CWF, and several critical CMS central office databases. Certain standard system edits could be bypassed without timely detection, and updates to CWF databases using information from the central office were not always timely or complete. Because of the complexity of the interfaces and the current design of Medicare applications, driven by a claim processing environment with multiple dependencies, the reliability and integrity of critical Medicare information will continue to be affected by such weaknesses.

Conclusions and Recommendations

The CMS is making concerted efforts to identify vulnerabilities and to address security issues. The agency identified additional weaknesses through vulnerability assessments and SAS 70 reviews, Medicare contractor control self-assessments, and the results of our reviews. These activities provide a baseline for improvement. Our discussions with management indicate that CMS will continue its assessment of the risks inherent in each vulnerability, assign priorities, and seek additional resources as necessary to correct known deficiencies.

The CMS external business partner systems security initiative encompasses security policies and procedures, training and awareness, systems engineering, and oversight and management to effect corrective actions. If adequately resourced and properly implemented and monitored, this initiative has potential as a framework for addressing those vulnerabilities that can be reduced or

eliminated over the shorter term. Efforts to build on that framework are proceeding but need to be enhanced, as evidenced by the control weaknesses found again this year.

In late FY 2002, CMS allocated approximately $9.7 million for short-term contractor improvements. In the area of access controls, CMS is having the contractors focus on high-priority vulnerabilities. To strengthen the contractors' entity-wide security planning, CMS is promulgating a standardized planning methodology, providing additional funding, and requiring all contractors to prepare system security plans in FY 2003.

Efforts to address these and related general control issues within budgetary constraints are hampered, however, by the decentralized nature of Medicare operations and the complexity of fee-for-service processing. According to CMS officials, the agency is actively pursuing longer term solutions through its proposed modernization program to simplify the application software code and environment, as well as its contractor reform initiative to shorten the security perimeter by reducing the number of contractors and data centers.

We recommend that ASBTF (1) ensure that CMS identifies and implements corrective actions to address the causes of Medicare systems control weaknesses within current legislative, policy, and budgetary constraints; (2) work with CMS in assessing, and finding ways to address, the shortfall in information technology resource needs; and (3) work with the administration and the Congress to promote Medicare reforms and modernization that will facilitate implementation of improved and cost-effective internal controls. Detailed recommendations are contained in the CMS financial statement audit report and the individual reports issued to the Medicare contractors and the CMS central office.

REPORTABLE CONDITION

Departmental Information Systems Controls (Repeat Condition)

The following summarizes some of the systemic information systems control weaknesses identified during FY 2002. Detailed descriptions of control weaknesses may be found in the individual operating division financial statement audit reports and SAS 70 reports.

Systems Control Weaknesses

Division of Financial Operations, Program Support Center. This year's review identified network vulnerability weaknesses as well as information systems general control weaknesses. We identified 18 network vulnerabilities, 13 of which remained unresolved from prior years (3 from FY 2000 and 10 from FY 2001). Five of these vulnerabilities were considered high risk; six, medium risk; and seven, low risk.

General control weaknesses were identified in the following areas:

- Access controls. Several access controls were not suitably designed to provide reasonable assurance that computer resources would be protected against unauthorized modification, disclosure, loss, or impairment. For instance, the password change policy was not enforced for all users, computer passwords were either easily guessed or nonexistent, access to the security administrator's functions was not restricted, inactive user accounts were not monitored or removed, and security officers were not notified when non-DFO employees were separated.

- System software. These controls should provide reasonable assurance that changes to existing system software and implementation of new system software are authorized, tested, approved, properly implemented, and documented. Weaknesses were noted in the areas of access authorizations; documentation for monitoring and using system software utilities; and documentation for identifying, selecting, installing, and modifying system software.

As a result of the above weaknesses, DFO's controls were not operating effectively to provide reasonable assurance that (1) computer resources were protected against unauthorized modification, disclosure, loss, or impairment or (2) changes to the existing system software and implementation of new system software were authorized, tested, approved, properly implemented, and documented.

Our review also found weaknesses in DFO's entity-wide security program. Such a program should be periodically updated and should include periodic risk assessments, development and implementation of effective security procedures, and monitoring of the effectiveness of those procedures. Our review of DFO's entity-wide security program disclosed weaknesses in incident response; security plan documentation, approval, and distribution; security management structure; and employee terminations. The approval and distribution of the plan is the most

critical area. Such weaknesses limited assurance that systems controls were adequate and operating effectively.

Human Resources Service, Program Support Center. Our tests of operating effectiveness noted exceptions in the following control areas:

- Access controls. Remote access sessions on the Human Resources Service-Civilian network were not password protected.
- Application development and change controls. One division did not maintain documentation to support the existence of test plans, test transactions, or approval for migrations of changes into the production environment.

Administration for Children and Families. Our review of controls over accounting systems supporting ACF's CORE accounting system, such as the Grants Administration Tracking and Evaluation System (GATES), noted that the risk assessment for the GATES grant application was outdated and that the security plan had not been certified or accredited. Additionally, ACF's ability to respond to a disruption in business operations was uncertain because its disaster recovery plan was incomplete.

Centers for Disease Control and Prevention. During FY 2002, CDC continued many information security program initiatives for its major applications and general support systems. While noteworthy, additional actions are necessary to properly secure the control environment. Specifically, we noted that CDC had not:

- fully developed an entity-wide risk management framework that included a process for periodically assessing risks, establishing mitigating controls across the organization, and continuously monitoring the effectiveness of these controls;
- fully updated and formally approved its security plans for all financial applications;
- consistently designed, configured, and reviewed logical security controls to prevent unauthorized access to networked resources and critical production data; or
- fully implemented a certification and accreditation process that included reviewing security controls, documenting application controls in its security plans, and identifying application-specific risks before accreditation.

Food and Drug Administration. The FDA has strengthened software application change controls and service continuity since last year. However, we noted the following weaknesses:

- Security program. The FDA had not prepared risk assessments for all major financial applications. Also, improvements were needed in documenting and approving detailed incident response procedures, and procedures should be developed to address compliance with security awareness training for delinquent users.

- Access controls. Although we noted continued improvement in this area, the following matters could be improved: granting and monitoring user access, adherence to the FDA-wide guidelines for remote access, database access configuration, local area network log settings, password assignment for servers, and restrictions surrounding network ports and services.

- Change management. Controls had been established; however, detailed procedures should be included in the software development and change control policies and procedures, configuration management and change controls should be established on financial platforms, and management approval for production program changes should be improved.

- Service continuity. The FDA contingency plan was not completed in accordance with the FDA-wide policy. Further, financial system backup tapes should be rotated to an offsite location on a frequent basis, and FDA should strengthen its disaster recovery planning activities and identify an alternate data processing facility.

National Institutes of Health. Our review of NIH's security program plans found that risk assessments or security program plans for two systems were lacking and that the security plan for one application was out of date. In addition, management had not identified or classified the criticality and sensitivity of these systems and applications, and contingency plans and contingency test plans were not current.

Recommendation

We recommend that ASBTF ensure that the operating divisions and service organizations address security issues, system access controls, application change controls, and service continuity plans. Specific recommendations are covered in the individual audit reports.

OTHER MATTERS

Intragovernmental Transactions

Under OMB Bulletin 01-09, *Form and Content of Agency Financial Statements*, government entities are required to reconcile intragovernmental transactions with their trading partners. Some operating divisions were not able to timely and accurately eliminate trading partner information. The department continues to work with Treasury to develop and implement workable, governmentwide procedures to meet this requirement. Until a process is operational, we expect that unresolved differences between operating divisions' records and those of their trading partners will continue.

Medicare National Error Rate

Estimated improper Medicare benefit payments made during FY 2002 totaled $13.3 billion, or about 6.3 percent of the $212.7 billion in processed fee-for-service payments reported by CMS. This error rate is the same as last year's rate—which was the lowest to date—and less than half of the 13.8 percent that we first estimated for FY 1996. However, the current error rate may not be statistically different from the estimates for FYs 1998-2000, which ranged from 6.8 to 8 percent. The decrease may be due to sampling variability; that is, selecting different claims with different dollar values and errors will inevitably produce a different estimate of improper payments.

As in past years, these improper payments could range from reimbursement for services provided but inadequately documented to inadvertent mistakes to outright fraud and abuse. The overwhelming majority (95 percent) of the improper payments were detected through medical record reviews coordinated by the OIG. When these claims were submitted for payment to Medicare contractors, they contained no visible errors. Although CMS has made substantial progress since FY 1996 in reducing improper payments in the Medicare program, continued efforts are needed.

STATUS OF PRIOR-YEAR ISSUES

During FY 2002, HHS and its operating divisions substantially completed corrective actions on two prior-year reportable conditions, as discussed below.

Medicaid Estimated Improper Payments

The CMS made significant progress by resolving its previous reportable condition related to Medicaid estimated improper payments, which we had reported since 1998. One of CMS's goals is the development and testing of a methodology to determine the Medicaid Payment Accuracy Measurement. Currently, a select number of states have volunteered to pilot the early phases of this project. As results are received and evaluated, the Payment Accuracy Measurement methodology will be expanded to the remaining states.

Management Systems Planning and Development

In FY 2001, we recommended that ASBTF work with NIH in (1) strengthening internal controls to ensure that systems planning and development efforts are properly authorized, sufficiently documented, and effectively monitored and (2) reassessing the method by which the institutes and centers transfer appropriated funds to the Service and Supply Fund to ensure a closer correlation between these advances and those funds obligated or expended by the fund.

In FY 2002, NIH took the following corrective actions:

- Instituted a policy that precluded the collection of additional contributions after June 30, 2002, to avoid the appearance of improper use of the funding procedures.
- Notified institutes and centers that new Common Account Numbers must be provided in writing.
- Directed system project managers' attention to NIH policies and procedures already in place in areas such as effective budget processing and file documentation.
- Maintained processes to ensure a correlation of (1) amounts contributed by the institutes and centers versus the obligations incurred by the Service and Supply Fund and (2) executed costs and deadlines versus original projections/budgets.

Based on our review of these actions, we believe that NIH has addressed the weaknesses identified in FY 2001.

* * * * * * *

In addition, we considered the HHS internal controls over Required Supplementary Stewardship Information by obtaining an understanding of the controls, determining whether the controls had been placed in operation, assessing control risk, and performing tests of controls as required by OMB Bulletin 01-02 and not to provide assurance on these internal controls. Accordingly, we do not provide an opinion on such controls. With respect to internal controls related to performance measures reported in section I of the *Accountability Report*, we obtained an understanding of the design of significant internal controls relating to existence and completeness assertions, as required by OMB Bulletin 01-02. Our procedures were not designed to provide assurance on internal controls over reported performance measures; accordingly, we do not provide an opinion on such controls.

This report is intended solely for the information and use of HHS management, OMB, and the Congress and is not intended to be and should not be used by anyone other than these specified parties.

Janet Rehnquist
Inspector General

January 17, 2003
A-17-02-00001

INDEPENDENT AUDITOR REPORT ON COMPLIANCE WITH LAWS AND REGULATIONS

To: The Secretary of Health and Human Services

We have audited the financial statements of the Department of Health and Human Services (HHS) as of September 30, 2002, and have issued our report, dated January 17, 2003, on those statements. We conducted our audit in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 01-02, *Audit Requirements for Federal Financial Statements*.

The management of HHS is responsible for complying with laws and regulations applicable to HHS. As part of obtaining reasonable assurance about whether the HHS financial statements are free of material misstatement, we performed tests of the department's compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts, and with certain other laws and regulations specified in OMB Bulletin 01-02, including the requirements referred to in the Federal Financial Management Improvement Act (FFMIA) of 1996. We limited our tests of compliance to these provisions and did not test compliance with all laws and regulations applicable to HHS.

The results of our tests of compliance with laws and regulations described in the preceding paragraph, exclusive of FFMIA, disclosed no instances of noncompliance required to be reported under *Government Auditing Standards* and OMB Bulletin 01-02.

Under FFMIA, we are required to report whether HHS financial management systems substantially comply with federal financial management systems requirements, applicable federal accounting standards, and the U.S. Government Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA section 803(a)

requirements. The results of our tests disclosed instances, described below, in which HHS financial management systems did not substantially comply with certain requirements.

- The financial management systems and processes used by HHS and the operating divisions made it difficult to prepare reliable and timely financial statements. The processes required the use of extensive, time-consuming manual spreadsheets and adjustments in order to report reliable financial information.

  - The Centers for Medicare and Medicaid Services did not have an integrated accounting system to capture expenditures at the Medicare contractor level, and certain aspects of the financial reporting system did not conform to the requirements specified by the Joint Financial Management Improvement Program. Extensive consultant support was needed to establish reliable accounts receivable balances.

  - At most operating divisions, suitable systems were not in place to adequately support sufficient reconciliations and analyses of significant fluctuations in account balances.

- Medicare financial management systems' general and application controls were significant departures from requirements specified in OMB Circulars A-127, *Financial Management Systems*, and A-130, *Management of Federal Information Resources*.

Our report on internal controls includes information on the financial management systems that did not comply with requirements, relevant facts pertaining to the noncompliance, and recommended remedial actions. The HHS has developed a departmentwide corrective action plan to address FFMIA and other financial management issues. Although certain milestone dates have passed, we recognize that the plan will require periodic updating to reflect changed priorities and available resources.

Providing an opinion on compliance with certain provisions of laws and regulations was not an objective of our audit; accordingly, we do not express such an opinion.

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This report is intended solely for the information and use of HHS management, OMB, and the Congress. It is not intended to be and should not be used by anyone other than these specified parties.

Janet Rehnquist
Inspector General

January 17, 2003
A-17-02-00001

Exhibit I

FISCAL YEAR 2002 CFO REPORTS ON HHS OPERATING DIVISIONS AND SERVICE ORGANIZATIONS

Nine separate financial statement audits of HHS operating divisions were conducted for FY 2002:

- Administration for Children and Families *(A-17-02-00003)*
- Centers for Disease Control and Prevention *(A-17-02-00010)*
- Food and Drug Administration *(A-17-02-00008)*
- Centers for Medicare and Medicaid Services *(A-17-02-02002)*
- Health Resources and Services Administration *(A-17-02-00005)*
- Indian Health Service *(A-17-02-00006)*
- National Institutes of Health *(A-17-02-00009)*
- Program Support Center *(A-17-02-00007)*
- Substance Abuse and Mental Health Services Administration (*A-17-02-00004*)

Four SAS 70 examinations were conducted:

- Center for Information Technology, NIH *(A-17-02-00012)*
- Central Payroll and Personnel System, Program Support Center *(A-17-02-00014)*
- Division of Financial Operations, Program Support Center *(A-17-02-00014)*
- Payment Management System, Program Support Center *(A-17-02-00013)*

Exhibit II

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

JAN 22 2003

Janet Rehnquist
Inspector General
Department of Health and Human Services
Washington, DC 20201

Dear Ms. Rehnquist:

This letter responds to the Office of Inspector General opinion on the Department of Health and Human Services' fiscal year 2002 audited financial statements. We concur with your findings and recommendations.

We are very pleased that, once again, your report reflects an unqualified, or "clean," audit opinion for the Department. Through our joint effort, we were able to achieve both a clean and timely Departmental financial statement audit.

We also acknowledge that we continue to have serious internal control weaknesses in our financial systems and processes. The Department's long-term strategic plan to resolve these weaknesses is to replace the existing accounting systems and certain other financial systems within the Department with a Unified Financial Management System (UFMS). A major sub-component of this effort is the Healthcare Integrated General Ledger Accounting System (HIGLAS), which will be used by the Centers for Medicare & Medicaid Services and Medicare contractors. We have already begun this modernization effort. Implementation of UFMS in accordance with the approved implementation plan will allow HHS to comply with the requirements of the Federal Financial Management Improvement Act by the end of fiscal year 2005. We plan to fully implement the UFMS Departmentwide by 2007.

I would like to thank your office for its continuing professionalism during the course of the audit.

Sincerely,

Janet Hale

Janet Hale
Assistant Secretary for Budget, Technology, and Finance/Chief Financial Officer

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