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DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

DEC 8 2004

TO: The Secretary
Through: DS ________
COS ______
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FROM: Daniel R. Levinson
Acting Inspector General

SUBJECT: Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2004 (A-17-04-00001)

PURPOSE

Our purpose is to provide you with the independent auditors' reports on the Department of Health and Human Services (HHS) fiscal year (FY) 2004 financial statements, internal controls, and compliance with laws and regulations. The Chief Financial Officers Act of 1990 (Public Law 101-576), as amended, requires the Office of Inspector General (OIG) or an independent external auditor, as determined by OIG, to audit the HHS financial statements in accordance with applicable standards.

We contracted with the independent certified public accounting (CPA) firm of Ernst & Young, LLP (EY), to audit the FY 2004 HHS financial statements. We also contracted with the CPA firm of PricewaterhouseCoopers, LLP, to perform the financial statement audit of the Centers for Medicare & Medicaid Services (CMS). EY's opinion expressed on the FY 2004 HHS financial statements makes reference to the work performed by PricewaterhouseCoopers. The contracts required that the audits be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in the "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.

INFORMATION TEXT

Audit Results

Based on the work performed by both audit firms, EY reported that the FY 2004 HHS consolidated/combined financial statements were fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America. The report on internal controls noted two continuing internal control weaknesses that, as in past years, were considered to be material weaknesses under

standards established by the American Institute of Certified Public Accountants and OMB Bulletin 01-02:

- *Financial Systems and Processes*—As in prior years, HHS continued to have serious internal control weaknesses in its financial management systems. While the auditors observed some progress in preparing financial statements, the lack of an integrated financial management system(s) and weaknesses in internal controls made it difficult for HHS to prepare timely and reliable financial statements. Substantial manual processes, significant adjustments to reported balances, and numerous accounting entries recorded outside HHS's general ledger system were necessary. In addition, deficiencies were noted in the oversight of managed care organizations and financial data provided by the States for the Medicaid program.

- *Medicare Information Systems Controls*—To administer the Medicare program and to process and account for Medicare expenditures, CMS relies on extensive information systems operations at its central office and Medicare contractor sites. Although improvement since the FY 2003 audit was noted, numerous general and application control weaknesses were identified in areas such as entity-wide security programs and access and change controls.

As discussed in the report on compliance with laws and regulations, weaknesses in HHS's financial systems and processes and in Medicare information systems controls also represented departures from certain Federal requirements.

Evaluation and Monitoring of Audit Performance

In accordance with the requirements of OMB Bulletin 01-02, we reviewed the audit of the HHS financial statements by:

- evaluating the independence, objectivity, and qualifications of the auditors and specialists;

- reviewing the approach and planning of the audits;

- attending key meetings with auditors and HHS officials;

- monitoring the progress of the audits;

- examining audit documentation related to the review of internal controls over financial reporting;

- reviewing the auditors' reports; and

- reviewing the HHS Management Discussion and Analysis, Financial Statements and Footnotes, and Supplementary Information.

EY is responsible for the attached reports dated December 8, 2004, and the conclusions expressed in the reports. Our review, as differentiated from an audit in accordance with U.S. generally accepted government auditing standards, was not intended to enable us to express, and accordingly we do not express, an opinion on HHS's financial statements, the effectiveness of internal controls, whether HHS's financial management systems substantially complied with the Federal Financial Management Improvement Act, or compliance with laws and regulations. However, our monitoring review, as limited to the procedures listed above, disclosed no instances in which EY did not comply, in all material respects, with generally accepted government auditing standards.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Joseph E. Vengrin, Deputy Inspector General for Audit Services, at (202) 619-3155 or through e-mail at Joseph.Vengrin@oig.hhs.gov. Please refer to report number A-17-04-00001 in all correspondence.

Attachment

cc:
Kerry N. Weems
Principal Deputy Assistant Secretary for Budget, Technology and Finance

George H. Strader
Deputy Assistant Secretary, Finance

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Report of Independent Auditors

To the Inspector General of the
Department of Health and Human Services, and
the Secretary of the Department of Health and Human Services

We have audited the accompanying consolidated balance sheet of the Department of Health and Human Services (HHS), as of September 30, 2004, and the related consolidated statements of net costs, changes in net position and financing and the combined statement of budgetary resources for the fiscal year then ended. These financial statements are the responsibility of the HHS' management. Our responsibility is to express an opinion on these financial statements based on our audit. With the exception of the Health Programs (principally Medicaid) included therein, we did not audit the financial statements of the Centers for Medicare & Medicaid Services (CMS), an operating division of HHS, as of and for the year ended September 30, 2004. Those statements and financial information were audited by other auditors (the "CMS auditors") whose report thereon has been furnished to us, and our opinion expressed herein, insofar as it relates to the amounts included for the CMS, excluding the Health Programs aggregating combined assets of $336.9 million and the combined net cost of $269.7 million, is based solely on the report of the CMS auditors. The consolidated and combined financial statements of HHS as of September 30, 2003, and for the year then ended, were audited by other auditors whose report dated November 14, 2003, expressed an unqualified opinion on those statements before the restatement adjustments described in Note 1, which, insofar as they relate to CMS, were audited by the CMS auditors in connection with the audit of the CMS.

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*. These standards and requirements require that we plan and perform the audit 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 significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit and the report of other auditors provide a reasonable basis for our opinion.

In our opinion, based on our audit and the report of other auditors, the financial statements referred to above present fairly, in all material respects, the financial position of the HHS as of September 30, 2004, and its net costs, changes in net position, budgetary resources, and reconciliation of net costs to budgetary obligations for the year then ended, in conformity with accounting principles generally accepted in the United States.

Our audit was conducted for the purpose of expressing an opinion on the basic financial statements taken as a whole. The information presented in the Management Discussion and Analysis, required supplementary stewardship information, required supplementary information, and the supplemental and other accompanying information is not a required part of the HHS' financial statements, but is considered supplementary information required by OMB Bulletin 01-09, *Form and Content of Agency Financial Statements*. The supplemental and other accompanying information has not been subjected to the auditing procedures applied by us and the other auditors in the audit of the financial statements, and accordingly, we express no opinion on it. For the remaining information, we and the other auditors have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the supplementary information. However, we did not audit the information and express no opinion on it. We were unable to assess control risk relevant to HHS' intra-governmental transactions and balances, as required by OMB Bulletin 01-02, because reconciliations were not performed with certain Federal trading partners as required by OMB Bulletin 01-09.

In accordance with *Government Auditing Standards*, we have also issued our reports dated December 6, 2004, on our consideration of the HHS' internal control over financial reporting and on our tests of its compliance with certain provisions of laws and regulations and other matters. The purpose of those reports is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* and should considered in assessing the results of our audit.

December 6, 2004

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Report on Internal Control

To the Inspector General of the
Department of Health and Human Services, and
the Secretary of the Department of Health and Human Services

We have audited the financial statements of the Department of Health and Human Services (HHS) as of September 30, 2004, and have issued our report thereon dated December 6, 2004. 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 No. 01-02, *Audit Requirements for Federal Financial Statements*. With the exception of the Health Programs (principally Medicaid) included therein, we did not audit the financial statements of the Centers for Medicare & Medicaid Services (CMS), as of and for the year ended September 30, 2004. Those statements and financial information which is included in HHS' financial statements, were audited by other auditors whose report thereon has been furnished to us, and the comments reflected herein, insofar as it relates to the information included for the CMS, excluding the Health Programs, are based solely on the report of other auditors.

In planning and performing our audit, we considered the HHS' internal control over financial reporting by obtaining an understanding of the agency's internal control, determined whether internal control had been placed in operation, assessed control risk, and performed 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 No. 01-02. We did not test all internal controls relevant to operational objectives as broadly defined by the Federal Managers' Financial Integrity Act of 1982 (FMFIA), such as those controls relevant to ensuring efficient operations. The objective of our audit was not to provide assurance on internal control. Consequently, we do not provide an opinion on internal control.

Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control over financial reporting that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses as defined below. Under standards issued by the American Institute of Certified Public Accountants, reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control that, in our judgment, could adversely affect the HHS' ability to initiate, record, process, summarize, and report financial data consistent with the assertions by management in the financial statements. Material weaknesses are reportable conditions in which the design or operation of one or more of the specific internal control components does not reduce to a relatively low level the risk that misstatements caused by errors or fraud 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

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employees in the normal course of performing their assigned functions. Because of inherent limitations in internal control, misstatements, losses, or noncompliance may nevertheless occur and not be detected. We noted the following matters involving the internal control and its operation that we consider to be reportable conditions. We consider the first two matters noted—Financial Systems and Processes, and Medicare Information Systems Control,—to be material weaknesses.

MATERIAL WEAKNESSES

Financial Systems and Processes (Repeat Condition)

OMB Circular A-127 requires that financial statements be the culmination of a systematic accounting process. The statements are to result from an accounting system that is an integral part of a total financial management system containing sufficient structure, effective internal control, and reliable data. In our view, the Department continues to have serious internal control weaknesses in its financial systems and processes for producing financial statements. These weaknesses caused delays in meeting milestones created to facilitate accelerated reporting and resulted in unexplained differences in reconciliations and account analyses. Within the context of the approximately $650 billion in departmental outlays, the ultimate resolution of such amounts is not material to the financial statements taken as a whole. However, these matters are indicative of serious systemic issues that must be resolved. These long standing issues, including system and process limitations and expertise needed in meeting evolving financial reporting requirements simultaneously with implementing new systems, will require a sustained commitment and qualified support team to resolve in preparation for FY 2005 and future years. As detailed below, these weaknesses concerned financial management systems, financial statement preparation, and financial analyses and reporting.

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 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 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, including the Administration for Children and Families (ACF), rely on the Program Support Center's Division of Financial Operations (DFO) for these services.

While we and other auditors observed some progress in preparing financial statements, the lack of an integrated financial management system(s) and weaknesses in internal controls made it difficult to prepare timely and reliable financial statements. The Department expects the systems used by certain operating divisions to be significantly enhanced by the end of FY 2007. Ultimately the decision to replace the existing systems is expected to provide improved financial information for better decision-making, potential cost savings, and a means to meet Federal accounting and budgetary reporting requirements. However, system implementations frequently create data conversion and other issues which can lead to difficulties in processing transactions appropriately and preparing accurate reports, and constitute a risk over the next several years. In the interim, substantial "work-arounds," cumbersome reconciliation and consolidation processes, and significant adjustments to reconcile subsidiary records to reported balances have been necessary under the existing systems. The following matters illustrate the challenges presented by departmental systems.

Centers for Medicare and Medicaid Services - CMS is the largest of the Department's operating divisions, with approximately $268 billion and $180 billion in combined net FY 2004 budget outlays for Medicare and the Health Programs, respectively. Over the past year, other auditors reported that the CMS has made significant progress in addressing the financial systems, analyses and oversight weaknesses noted during FY 2003. However significant weaknesses regarding the CMS' financial systems, analyses and oversight persist.

CMS' financial management systems are not compliant with the FFMIA. FFMIA requires agencies to implement and maintain financial management systems that comply with Federal financial management systems requirements as defined by the Joint Financial Management Improvement Program (JFMIP). More specifically, FFMIA requires Federal agencies to have an integrated financial management system that provides effective and efficient interrelationships between software, hardware, personnel, procedures, controls, and data contained within the systems. The lack of an integrated financial management system continues to impair the CMS and Medicare contractors' abilities to efficiently and effectively support and analyze accounts receivable and other financial reports.

For example, Medicare contractors currently rely on a combination of claims processing systems, personal computer based software applications and other ad hoc systems to tabulate, summarize and prepare information presented to the CMS on the 750 – Statement of Financial Position Reports and the 751 – Status of Accounts Receivable Reports. These reports are the primary basis for the accounts receivable amounts reported within the financial statements. Because the CMS, and the CMS contractors, do not have a JFMIP compliant financial management system, the preparation of the 750/751 reports, and the review and monitoring of individual accounts receivable, are dependent on labor intensive manual processes that are subject to an increased risk of inconsistent, incomplete or inaccurate information being submitted to the CMS. Likewise the reporting mechanism used by the CMS contractors to reconcile and report funds expended, the 1522 – Monthly Contractor Financial Report, are heavily dependent on inefficient, labor intensive, manual processes, that are also subject to an increased risk of inconsistent, incomplete or inaccurate information being submitted to the CMS.

The lack of integration in financial reporting is clearly demonstrated through the results of the SAS 70 reviews performed at Medicare Contractors during the current FY. These reports noted a total of 23 auditor qualifications related to financial reporting control objectives at seven of the fourteen contractors where reviews were completed. This indicates a potential problem in relying upon the data as reported without completion of significant review by the regional and central office. This prevents the timely use and reliance of this information by both operations and financial reporting personnel. For example, the contractors are unable to report all information required for the completion of quarterly financial statements in accordance with OMB timelines and provides only minimal information at year-end which supports the completion of financial statements but does provide enough data for oversight and management of the contractors' activities.

National Institutes of Health - In FY 2004, NIH had net budget outlays of approximately $25.7 billion. Because the legacy NIH Central Accounting System was not designed for financial reporting purposes and did not comply to the U.S. Standard General Ledger at the transaction level, NIH launched the Oracle General Ledger portion of the New Business System (NBS). Although the Oracle General Ledger became the official accounting system of record during the second quarter of FY 2004, we noted certain issues related to NBS that did not fully comply with the FFMIA:

- Certain parts of the statement preparation process continue to be manually intensive, time consuming, and prone to error. NIH continues to download data from the NBS general ledger (nVision) and use spreadsheets to process adjusting entries and prepare financial statements.

- The NBS does not provide for tracking manual or non-routine entries. As a result, adjustments and corrections cannot be readily identified.

- Discrepancies totaling $27.5 million were noted between NBS general ledger (nVision) and Data Warehouse because no reconciliation was performed at the point of conversion. We were informed that the discrepancies were corrected by year-end.

- The NBS system as implemented does not automatically liquidate travel advances. Upon identification of this issue, a manual process was established to review the transactions and post the applicable adjusting entries.

- During our testing we noted that transaction codes for direct, reimbursable and sponsored travel required manual intervention to assign an identifier, either Direct or Reimbursable, to the transaction within the NBS system. This identifier assigns the required budgetary accounts to the transaction.

Entities Supported by the Program Support Center - In FY 2004, the operating divisions serviced by the Program Support Center had net budget outlays of approximately $62.4 billion. The Program Support Center's DFO CORE accounting system, which supports the activities of these operating divisions, did not facilitate the preparation of timely financial statements. The necessary data had to be downloaded from CORE, with numerous adjusting entries processed throughout the year before compiling the statements. For example, in FY 2004, approximately 1,550 nonstandard accounting entries with an absolute value of almost $30 billion were recorded in CORE to compensate for noncompliance with the U.S. Standard General Ledger, to correct for misstatements, to record reclassifications, and to correct reported balances. These amounts are significantly less than FY 2003 where 2,300 nonstandard entries were recorded totaling approximately $41 billion.

The FY 2004 closeout severely taxed the Program Support Center's resources and highlighted the need to devote resources to reconciling and analyzing accounts, researching and correcting errors in underlying subsidiary records, and performing rigorous closing processes on an interim basis.

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 $5.5 billion in FY 2004. Because the central financial system did not have the capability to generate financial statements, the trial balance and financial statements had to be created offline by summarizing appropriate data. This process was manually intensive, used excessive resources, and increased the chance of error. Additionally, for FY 2004, CDC was required to record 2,143 nonstandard accounting entries with an absolute value of $86 billion, of which approximately $73 billion related to the clean up of the current system to prepare for the new Unified Financial Management System (UFMS) conversion. The central financial system has not been programmed to record these types of transactions using U.S. Standard General Ledger transaction codes.

Food and Drug Administration - The FDA operated with a combined net budget outlays of about $1.4 billion in FY 2004. Because the financial management systems are not fully integrated, FDA's ability to fully support financial balances in a timely fashion is impacted by the need for manual analysis to ensure balances are correct. Additionally, we noted that for FY 2004, FDA was required to record approximately 1,300 nonstandard accounting entries with an absolute value of $4.5 billion to adjust budgetary and proprietary accounts.

Financial Statement Preparation

Accelerating the timeliness of financial reporting, pending implementation of modern accounting systems that are compliant with the JFMIP and fully support the financial reporting process, provided challenges for us and for the Department. Accordingly, procedures need to be reassessed and modified to prepare accurate and complete financial statements in a more timely manner. The following represents issues identified during the financial statement preparation process:

- The Department and CMS lack a coordinated process among cross-functional teams of finance, program management, and legal personnel to monitor business activities to identify situations where accounting evaluation or decision-making may be necessary. For example, no structured process exists to communicate potential loss contingencies to legal or accounting personnel. Further, upon identification of potential loss contingencies, no rational, structured process exists to ensure timely resolution of accounting questions by the appropriate personnel. During the FY 2004 audit, other auditors noted an instance in which a material liability was not identified or disclosed by CMS on a timely basis. Furthermore, CMS did not consult with the HHS Office of General Counsel on this loss contingency; therefore, this matter was not included in the interim legal letter dated August 15, 2004. In addition, executive management personnel did not inform the CMS Office of Financial Management (OFM) of the ongoing analysis surrounding this loss contingency which prevented the issue from being properly assessed and accounted for on a timely basis.

- Other auditors reported that CMS lacks a comprehensive process for identifying and evaluating written employee complaints which could contain information alleging improper acts or other matters causing legal, operational or financial risk to the agency. There are numerous ways in which complaints are received by the agency as whole. These methods include, but are not limited to, calls to the HHS OIG hotline, e-mails sent directly to members of the executive management team, letters sent directly to supervisory personnel and/or executive management, and correspondence sent directly to the HHS OIG. CMS has not developed formal policies and procedures regarding actions to be taken when such correspondence or verbal notification is received.

- On a consolidated basis we identified unexplained adjustments totaling an absolute value of over $1 billion in the calculation of the Statement of Budgetary Resources and the Statement of Financing.

- The accounting and reporting process for the Strategic National Stockpile (SNS) is fragmented and disconnected. For FY 2004, five separate parties (i.e., Department of Homeland Security [DHS], CDC, Office of the Secretary [OS], Department of Veterans Affairs [VA] and SNS personnel) were involved in some aspect of the SNS accounting process. For example, the amounts provided by CDC for the SNS inventory balance as of the transfer date and the fiscal year-end was approximately $924 million and $960.8 million, respectively. The SNS inventory transfer from DHS disclosed in the footnotes to the financial statements, as well as the year-end balance on the OS records was $868 million. Sufficient supporting documentation to substantiate the SNS inventory balance and the $626 million in budget authority transferred from the DHS during FY 2004 was not provided. For example, we were unable to obtain the DHS Determination Order-Attachment C, Property, which is intended to contain the final amount of the inventory transfer balance.

- To prepare financial statements, more than 300 entries with an absolute value of over $182 billion were recorded outside the general ledger system. Many of these accounting entries were made to record year-end accruals, adjust between governmental and nongovernmental accounts, record expenditures not posted to the general ledger prior to the month-end close, adjust proprietary to budgetary accounts, and post reconciliation adjustments. A majority of the entries could have been eliminated by more timely analyses and reconciliations, as well as improved estimation methodologies.

- As previously mentioned, the Department compiles its financial statements through a multi-step process using a combination of manual and automated procedures. These processes increase the risk that errors may occur in the Department's financial statements. During our review of the interim and year-end financial statements at the operating division level, we noted various errors in supporting spreadsheet calculations used to produce the financial statements. While the errors noted were not material to the Department-level financial statements taken as a whole, they serve to illustrate that errors are more likely to occur in an environment that necessitates a time-consuming, manually intensive financial statement preparation process.

- Because significant weaknesses exist in the Department's financial management systems, management must compensate for the weaknesses by implementing and strengthening additional controls. Management has taken additional steps to compensate for system weaknesses, but further efforts, including the rigorous review of interim and year-end financial statements are still needed. Although the Department has a process whereby certain personnel are assigned to review each operating division's financial statements and follow-up on discrepancies or anomalies, errors such as those described in this report were noted by us and brought to management's attention, an indication that the Department's financial statement preparation, review, and approval processes require additional strengthening.

- For FY 2003 and prior years, approximately 150,000 entries totaling $19.7 trillion remained in the detail supporting the general ledger. Most of these entries were posted to ensure agreement between the subsidiary ledgers and the general ledgers, to record budgetary entries, and to record depreciation for capitalized property maintained by the operating divisions. Maintaining supporting subsidiary ledgers would greatly facilitate the financial reporting process.

- Contrary to HHS policy, complete, periodic reconciliations of appropriated capital used and budgetary accounts were not performed until year-end. As a result, approximately 400 miscellaneous adjustments with an absolute value of $8.8 billion were recorded to various net position accounts. Additionally, unsupported entries were recorded to the beginning-of-period unobligated balances to ensure that the trial balance agreed with the FY 2004 audited ending unobligated balances. Other unexplained differences existed in preparing budgetary reporting and other financial schedules.

- Other auditors reported that CMS' current financial reporting process lacks the framework needed to effectively and efficiently implement changes to their financial statements. Procedures do not exist to ensure that changes/updates to CMS' accounting and financial reporting policies are properly evaluated by supervisory personnel and approved in writing. Furthermore, CMS does not have sufficient policies and procedures in place to ensure that changes/updates to the financial statements conform to generally accepted accounting principles. For example, CMS did not complete a formal process when undertaking the restatement of the FY 2003 Statement of Budgetary Resources. This was evidenced by the fact that a written approved "white paper" had not been completed prior to the completion of the accounting journal entries. Further, the accounting journal entries associated with the FY 2003 SBR restatement were incomplete.

- Other auditors reported that the control processes currently in place to ensure the accuracy of CMS' financial statements are not working as intended by management as noted through a review of CMS' financial report which contained errors such as: the opening obligation balance on the SBR for FY 2004 did not tie to the FY 2003 restated ending obligation balance: the benefits due and payable for the Managed Care program was not obligated as required by A-11 and outlined in the agency whitepaper on the restatement of the SBR; contractor cash balances reflected on the financial statements did not agree to the balance per contractor 750 reports; discrepancies between the 1522 and 750 reports filed by the Medicare contractor were not investigated; and adjusting entries related to the HI and SMI trust funds were not complete which totaled more than $100 million.

Financial Analysis and Oversight

The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* states that internal control activities help ensure that management's directives are carried out. The control activities should be effective and efficient in accomplishing the organization's control objectives. Examples of control activities include: top level reviews, reviews by management at the functional or activity level, segregation of duties, proper execution of transactions and events, accurate and timely recording of transactions and events, and appropriate documentation of transactions and internal control.

Because weaknesses exist in the financial management systems, management must compensate for the weaknesses by implementing and strengthening additional controls to ensure that errors and irregularities are detected in a timely manner. Our review of internal control disclosed a series of weaknesses that impact HHS' ability to report accurate financial information. During FY 2004, we found that certain processes were not adequately performed to ensure differences were properly identified, researched and resolved in a timely manner and that account balances were complete and accurate. The following represents specific areas we noted that need enhanced periodic reconciliation and analysis procedures:

Managed Care Organization Oversight - Other auditors noted improvement in the implementation of formal policies and procedures and documentation to support the processing, approval and acceptance of applications for managed care organizations applying to join the managed care program. CMS is in the process of issuing final rules implementing the Medicare Advantage program which replaces the Medicare+Choice managed care program. As such, CMS plans to provide extensive technical assistance and training to plans, providers and internal staff which should lead to improved monitoring of the managed care program. However, other auditors noted matters that indicate inadequate monitoring of managed care organizations by both the central office and regional offices as a result of the following:

- The management system used by central office to monitor the execution and status of managed care organization reviews performed by the regional office is not being updated on a timely basis. Other auditors noted instances where the management system had not been updated to reflect changes in the monitoring review dates. We noted two terminated plans that where scheduled for review. We also found evidence of duplicate plan identification numbers in the system.

- As discussed last year, CMS was unable to provide to the other auditors sufficient documentation to evidence the on-going monitoring of managed care organizations by the regional offices in accordance with the CMS policies and procedures. As a result of this year's audit procedures, we continued to identify inconsistencies regarding the documentation that was available for review. The documentation maintained by the regional offices to support the execution of monitoring reviews performed at managed care organizations is inconsistent and in some instances incomplete due to the lack of established documentation policies for regional office reviews.

- There are no tailored policies and procedures for monitoring reviews related to demonstration projects. These are specialized health care programs/services established to address the needs of specific beneficiary populations. The current process for monitoring reviews of demonstration projects performed by the regional offices mirror the standard procedures used for existing non-demonstration project managed care organizations. However, such an approach does not contemplate or address the unique requirements or complexities that each demonstration project may possess.

- Other auditors noted instances of inadequate policies, documentation and supervisory review related to the authorization and payment process for managed care organizations:

    - Division of Enrollment and Payment Operations (DEPO) has no established procedures to reconcile payments that are authorized to the actual payment made by the Treasury.

- DEPO does not maintain a log of anomalies or errors resulting from their review of payments.

- The current methodology employed to analyze payment information is based on a simple fluctuation analysis of month-to-month payments. This simplistic model does consider additional variables which may indicate potential payment issues.

- Inconsistent execution of the documentation policy related to payment adjustments was noted.

- Instances occurred in which documentation to support payment adjustments was not available.

- **Medicaid Regional Office Oversight -** In September 2000, the Center for Medicaid State Operations (CMSO) issued financial review guides to assist the Regional Office (RO) analysts in examining budget and expenditure reports as well as to standardize the review procedures performed between analysts and regions. These review guides encompass all areas of the review process but allow each region and analyst the flexibility of determining what areas need to be addressed based on the activity of the Region as well as available resources. These guides also set forth guidance on work paper standards and supervisory review. During FY 2004, we visited two regional offices to assess the RO oversight function and found that certain procedures were not being performed to ensure financial data provided by the states is reliable, accurate, and complete. CMS management identified the most significant cause as inadequate resources, multiple oversight activities assigned to financial analysts, and inadequate travel funds.

  - <u>Documentation and Scope of Reviews</u> – Within the CMS RO, each analyst uses the CMS Financial Review guides as the procedures required to assess each states' budget requests, quarterly expenditure reports, and other state activities related to SCHIP and Medicaid funding. We noted in the two regions visited that the RO did not fully document what steps were performed and the reasons for steps not performed. Additionally, we noted limited supporting documentation in the files to support the prepared financial review guide. For example, for four states, there was either no supporting documentation maintained or insufficient documentation maintained in the working papers to support the analysts' conclusions. Finally, the working papers supporting the assessment did not bear evidence that they were properly reviewed by a supervisor to ensure consistency of reviews within the state and among regional offices.

- Monitoring of State Submissions - Analysis of changes in quarterly budget submissions is a major consideration in the RO's decision to award a grant. Although recommended, during our visit to the regional offices, we noted that analysts did not adequately perform trend analyses on Medical Assistance Payments (MAP), Administration (ADM), and SCHIP payments. For certain states, no evidence of trend analysis was available. For other states, where trending was available, balances selected for review were based on dollar amounts and judgments; however, the scope of the items selected for review was not documented in the work papers nor was there evidence of which amounts were investigated. In many cases, explanations for variances were not readily available, or were not sufficient to assist a reviewer in verifying that CMS gathered appropriate evidence to support the execution of its oversight responsibilities over the Health Programs.

- Oversight of Medicaid State Information Technology - Although CMS assesses the information technology environment for Medicare intermediaries, it currently does not systematically assess or monitor the internal control supporting state-based information systems used in processing Medicaid and SCHIP benefits. However, significant funding of such systems has been provided by CMS. CMS relies on state auditors and nongovernmental auditors executing audits pursuant to the Single Audit Act to determine whether control environments related to Medicaid state-based systems are effective. The depth of these reviews is typically far less extensive than the specialized reviews that CMS undertakes of its Medicare intermediaries. The OIG has also performed several more extensive assessments at various states and has found significant matters related to access controls and other internal control issues. Processes are not in place to ensure that adequate inspections are performed on a periodic basis, or that the results of such inspection activities are made available to, analyzed and followed up on by CMS in executing its oversight function.

Beginning in FY 2005, CMS has taken steps to increase RO personnel by hiring more than 100 analysts to work in the states to ensure compliance with Medicaid requirements. These analysts are currently undergoing extensive training to ensure adequate knowledge of CMS policies and procedures.

- **Entitlement Benefits Due and Payable -** Medicaid entitlement benefits due and payable (IBNR), totaling approximately $18 billion at September 30, 2004, represent the cost of services provided by states but not paid at the end of the FY. CMS bases its estimate of IBNR receivables and payables on historical trends of expenditures and prior year payables identified on surveys obtained from the States. CMS validates their estimate by considering current year program changes, performing analytical procedures, and evaluating significant differences. For SCHIP, CMS has not implemented procedures to

accrue an estimate for SCHIP IBNR payables and receivables at year-end. However, a large portion of SCHIP expenditures is reimbursed on a fee-for-service basis, indicating the need for an IBNR accrual. Currently, CMS has not been able to develop a method of accessing claims level data submitted by the states and maintained internally to estimate IBNR amounts and relies upon summary information submitted by the States. Although we believe this methodology produced a reasonable IBNR estimate for Medicaid and is the best available estimate in the circumstances, we believe that the process is time consuming, error prone due to the various states' inconsistencies and interpretations of how to calculate the amount due from CMS, and heavily dependent upon information provided by the states.

Given the significance of the IBNR estimate, and the possibility that accessing claims level data as part of a process to estimate the liability will aid CMS in its management of the program and in developing trends, we suggest that the Office of the Actuary be engaged to refine the estimate in accordance with actuarial standards of practice, in a process analogous to that used to calculate the IBNR for Medicare. In the interim, if CMS continues to utilize historical trending as a basis for the IBNR, further training of state personnel preparing the survey may be necessary to ensure consistency in calculating the amount payable to the state, and more explicit recognition should be made by CMS in assessing trends in the programs and the propriety of utilizing the current trending and averaging approach, which may imperfectly capture fundamental changes in the programs or how the states are administering their programs.

- **Department/Operating Division Periodic Analysis and Reconciliation -** During FY 2004, we found that certain processes were not adequately performed to ensure differences were properly identified, researched and resolved in a timely manner and that account balances were complete and accurate. The following represents specific areas we noted that need enhanced periodic reconciliation and analysis procedures:

  - Grants Management - We identified over 25,000 grants that are eligible for close out. These should be actively reviewed for close out in the Payment Management System and the Operating Divisions' grant subsidiary systems. Many of these grants have been eligible for close out for several years. Additionally, we noted that improvement is needed in the Single Audit follow-up process including more timely responses to audit reports, resolution and corrective actions.

  - Fund Balance with Treasury **-** On a monthly basis, the HHS is responsible for reconciling approximately 500 Treasury appropriation symbols. As of September 30, 2004, the general ledger and Treasury's records differed by an approximate absolute value of $290 million. Management could not explain the variance. At the PSC, four separate monthly reports are prepared that reconcile the general ledger with Treasury's records. One of the reports generated to compare detailed transactions in the general ledger with Treasury's records has lost its usefulness due to old and invalid items that remained in the general ledger. For example, the September 30,

2004 report identified an absolute value of approximately $5.56 billion of differences in transactions dating back as early as 1990. Management indicated that due to staffing limitations, the PSC primarily focused on the larger, more recent differences.

- FACTS II - The September 30, 2004 trial balance of accounts used to prepare the financial statements differed from that used for the submission of FACTS II by over $11 billion for the nine operating divisions with completed reconciliations. For three operating divisions, no reconciliations were provided. As of the end of fieldwork, the differences had not been fully identified to us, but management represented that they consisted principally of year-end accruals.

- UFMS Capitalization - We were unable to fully substantiate the methodology and capitalized costs related to the Unified Financial Management System (UFMS) that is currently being implemented throughout HHS. As of September 30, 2004, approximately $84 million have been obligated for UFMS between FY 2001 and 2004. To date, HHS has accrued approximately $66.7 million, but has only capitalized $9.6 million despite the purchase of the software platform during FY 2002.

- Improper Payment Information Act - The Improper Payment Information Act requires agencies to review annually all programs and activities they administer and identify those which may be susceptible to significant erroneous payments. HHS has informed us that it coordinated its implementation of the Improper Payment Information Act of 2002 (IPIA) with the OMB, and it is management's understanding that the progress made in FY 2004 and plans put in place to develop estimates of improper payments and mitigate their causes are substantially consistent with the intent of OMB regulations implementing the IPIA. While an improper payment rate estimate has been prepared for the largest HHS program, Medicare, methodologies for estimating improper payments for other HHS programs are under development, and therefore were not reported in the FY 2004 Performance and Accountability Report. For example, although both Medicaid and SCHIP have been identified as programs which are susceptible to improper payments, CMS has not completed its implementation of a process to estimate improper payments. For FY 2004, 12 states volunteered to participate in the pilot project for Medicaid, which did not allow for determination of a national estimate. CMS is not expected to report a national estimate for Medicaid or SCHIP until FY 2006.

- Payroll - As further described in the reportable condition "Internal Controls Over Payroll Need Enhancements" we noted a number of errors and internal control deficiencies in the processing of payroll related transactions. Particularly in the context of the overall deficiencies in HHS reporting processes these payroll related matters are indicative of deficiencies in the overall internal control structure within HHS.

- Availability of supporting documentation for accounting events - As further described in the reportable condition "Omissions and Delays in Obtaining Documentation Impacts the Audit Process" we noted a number of instances in which documentation to support accounting transactions was not readily provided. In some cases, we were unable to obtain such documentation. The lack of readily accessible documentation impedes the audit process, and calls into question whether such contemporaneous documentation is prepared and appropriately reviewed and approved as transactions are executed. In light of the deficiencies in key review processes, the inability to adequately support the audit process and maintain documentation to demonstrate that controls intended to prevent errors are functioning as intended subjects HHS to additional risks which are only partially mitigated by compensating controls.

Recommendations

Pending installation of the new systems under development, routinely meeting accelerated reporting deadlines without heroic efforts will require a change in processes. We recommend that the HHS:

- Ensure that the CMS, NIH, and the PSC implement corrective actions, pending full operation of HIGLAS, the NIH NBS, and the UFMS, 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.

- Other auditors recommended that CMS should establish appropriate policies, procedures and protocol to address situations or transactions that require cross-functional involvement in determining accounting-related estimates. The financial management function should serve as the primary coordinator to facilitate the input and involvement of the other cross-functional units whose involvement and input are required to formulate accounting estimates and the related financial statement disclosures. Further, where review and approval is required by parties outside of CMS, for example, HHS Department-Level management, OMB or others, the CMS financial management function should coordinate the process of attaining such review and approval. In addition, CMS should develop and implement policies and procedures to track all incoming correspondence related to employee grievances and concerns. In particular, CMS should establish a process by which CMS, HHS Department-Level management and the HHS OIG share information regarding correspondence that contains matters potentially causing legal, operational or financial risk to the agency.

- Ensure that the operating divisions allocate adequate resources to perform required account reconciliations and analyses monthly.

- Oversee CMS' corrective actions to provide a mechanism for central and regional office monitoring of state activities and enforcement of compliance established with CMS financial management 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.

- Ensure as required by OMB Bulletin 01-09, *Form and Content of Agency Financial Statements*, the preparation of future years' interim financial statements supported by reconciliations and account analyses to ensure such reporting is accurate for decision-making.

- In order to help strengthen the estimating process and promote consistency between CMS' programs, develop a methodology to collect the necessary data to estimate a Medicaid IBNR amount similar to the methodology used for Medicare. For SCHIP, we recommend that CMS identify a methodology for estimating an IBNR for SCHIP related expenditures.

- Continue the implementation of the pilot project to estimate improper payments for both the Medicaid and SCHIP- related payments.

- Ensure that the management system is updated on a timely basis to provide information for adequate management oversight to be executed.

- Ensure that established policies address standard documentation and retention requirement that each CMS regional office is required to follow in the execution of the monitoring reviews of the managed care organizations.

- Establish policies that require the CMS regional office in the performance of monitoring of demonstration projects to create tailored procedures that contemplate and address the unique requirements or risks of each demonstration project.

- For managed care, perform more extensive data and payment information analysis to identify potential errors, unusual variances or inappropriate payment trends. Using information such as: 1) Demographic makeup of the plans population as compared to the coverage areas population, and 2) Enrollment fluctuations as compared to other plans and enrollment in the overall Medicare program.

- Ensure that DEPO perform a timely reconciliation of authorized payments made by Treasury and establish a log to document anomalies and errors that are identified and resolved as part of the authorization process in order to further support decisions made as part of the authorization process.

- Other auditors recommended that CMS should develop formal written processes to evaluate and approve changes in accounting and financial reporting policies. This would include a process for preparing a "white paper" to support any significant changes/updates to the financial statements. This paper should include references to the applicable guidance that supports the changes/updates and CMS' conclusion. The white papers should be approved by the Chief Financial Officer. During FY 2004, we noted an increase in attrition within the OFM, which had a negative impact on the preparation of the annual financial report. To ensure that CMS' financial report is completed in an accurate and timely manner, personnel with financial statement and reporting backgrounds need to be added to the OFM staff in addition to completing a re-design of the process as noted below. Additionally, CMS should re-design the current procedures used to prepare their financial reports. This process should include the use of a cross-functional team representing all components that are responsible for information which is included in the annual financial report. This cross-functional team should be led by OFM to ensure that all information is accurate and supported by areas appropriate supporting documentation. This team should be responsible for the reviews of the financial reports to ensure internal consistency and accuracy. The following should be considered in this re-design:

  - Analytical procedures should be completed to ensure logical relationships between various financial statement amounts. Variances from expected results should be thoroughly researched and resolved.

  - Establish standard methodologies and formats for completing supporting schedules and reports across all programs. To ensure the accuracy and completeness of work performed, supervisory reviews need to be critical as opposed to cursory.

  - A "cold" review should be conducted by someone that has not worked on the financial statements to ensure that amounts within the MD&A, financial statements and performance measures are internally consistent.

Medicare Information Systems Controls (Repeat Condition)

Background and Scope of Review

The CMS relies on extensive information systems operations at its central office and Medicare contractor sites to administer the Medicare program and to process and account for Medicare expenditures. Internal controls over these operations are essential to ensure the integrity, confidentiality and reliability of the Medicare data and to reduce the risk of errors, fraud and other illegal acts.

Internal control testing covered both general and application controls. General controls involve organizational security plans, referred to as entity-wide security plans, access controls (physical and logical), application development and program change controls, segregation of duties, operating systems software for servers and mainframe platforms, and service continuity plans and testing. General controls provide the foundation to ensure the integrity of application systems, and combined with application level controls, are essential to ensure proper processing of transactions and integrity of stored data. Application controls include controls over input, processing of data, and output of data from CMS application systems.

The audit included general controls reviews at 16 sites: the CMS central office and 15 Medicare contractors. The CMS auditors reviewed application controls at the CMS central office for several systems integral to Medicare financial information. They also reviewed application controls at four of the Medicare contractors which included the Fiscal Intermediary Standard System (FISS), the Viable Processing System (VIPS), the Viable Medicare System (VMS), the Multi Carrier System (MCS) and the Common Working File (CWF) System. The CMS audit also relied on the work and findings of the SAS 70 reviews for the 14 Medicare contractors audited.

Further, the CMS auditors conducted vulnerability reviews of network controls at all 16 sites audited. The vulnerability reviews included both external and internal penetration testing in 15 of the sites, and network vulnerability assessments in all 16 sites, including reviews of security configurations of network servers.

Numerous general and application control findings were identified which is consistent with that found in prior years. The actual numeric count of findings was decreased this year versus FY 2003; however, this was primarily the result of combining similar findings. Our vulnerability testing noted numerous security settings/controls that required enhancement. The majority of weaknesses were noted at the Medicare contractors, rather than the CMS central office. CMS security over Medicare electronic data processing reflected improvement over our FY 2003 audit, but strengthened controls are still needed. The CMS auditors procedures disclosed no evidence of actual system compromise of security; however, they consider the cumulative effect of the weaknesses noted to comprise a material weakness.

Entity-Wide Security Program (EWSP) - These programs provide the foundation for the security culture and awareness of the organization. A sound EWSP is the cornerstone to ensure effective security controls throughout the organization. The CMS auditors noted several contractor locations for which an emphasis on a robust and true entity-wide security program was not in existence. In these locations, security was treated as a directive, rather than a cultural norm that guides daily activities. As a result, numerous weaknesses were noted in the areas of access and systems software controls. An overriding factor in the pervasiveness of poor security controls was that these sites did not have programs to:

- Consistently identify weaknesses in their systems;
- Assess the risks posed by these weaknesses;
- Undertake specific actions to reduce risks to acceptable levels; and,
- Perform periodic reviews of controls to ensure their continued effectiveness.

Such auditors noted again that many of the sites had continued to designate security administration duties to personnel who did not possess the proper background and education to perform their job requirements, and who did not receive specific security training required to perform their security responsibilities during the current year. Further, they noted instances where security administration duties were improperly segregated from the duties of application programming. Finally, they noted some contractor sites for which an overall EWSP was not in place.

Security controls cannot be effective without a robust, detailed EWSP that is fully sponsored and practiced by the senior management of the contractor sites. Robust plans require proper training, understanding and involvement by security personnel with the proper background and education to ensure the implementation of the program. Robust plans also require ongoing risk assessment, clear identification of controls to mitigate risks and ongoing testing to ensure the effectiveness of the controls used to mitigate risks.

Logical and Physical Access Controls – Access controls ensure that critical system assets are physically protected from unauthorized access and that logical controls provide assurance that only authorized personnel may access data and programs maintained on systems. The audit noted findings regarding physical and logical access during our controls testing. Further vulnerability testing noted a large number of security settings/controls that required enhancement. External penetration testing was successful at several sites, primarily due to poor security settings resulting from the lack of sufficient security configuration standards for the network computers tested. The CMS auditors attribute the lack of sufficient security controls to the lack of a robust entity-wide security program, as noted in the EWSP section above. A robust EWSP would consistently identify weaknesses, assess the risks posed by these weaknesses, undertake specific actions to reduce risks to acceptable levels, and require the performance of periodic reviews of controls to ensure their continued effectiveness. Such controls would include annual internal and external penetration reviews, and periodic reviews of security control settings on platforms throughout the contractor sites' networks.

Testing of access controls at contractor sites also noted that the CMS auditors were able to bypass security controls without prior knowledge of the systems tested and that numerous security weaknesses existed that would allow internal users to easily access sensitive systems, programs and data without proper authorization. The review did not disclose any exploitation of critical systems tested; however, clear potential existed.

The lack of specific guidance for computer security configuration settings and effective entity-wide security programs, including ongoing review and testing of security controls, and an EWSP administered by personnel with proper knowledge and experience, prevents contractors from providing adequate security controls that would ensure that only properly authorized personnel access sensitive CMS data and programs.

Application Security, Development and Program Change Control – Application security, development and program change controls provide assurance that programs are developed with standards that ensure their effectiveness, efficiency, accuracy, security and maintenance and that only authorized and properly tested programs are implemented for production use. The CMS auditors noted again that contractor processing sites have the ability to turn on and off front end edits in the APASS, FISS, MCS, and VMS systems without consistent procedures to ensure that edits are only turned off when required and that all such activity is properly controlled and reviewed. This represents an important area of concern because the ability to negate system edits may degrade the ability to ensure that only proper data is introduced into these systems and ultimately, the CWF and the National Claims History (NCH) System. They also noted again that application changes are being implemented without complete testing and that application change control procedures were not followed at several sites, including the CMS central office. CMS has implemented changes in its testing procedures to address the issue at the Medicare contractors. Finally, they noted again sites at which application programmers had the ability to directly update production source code for applications thereby bypassing application change controls. This potential exists in the FISS system, but CMS has developed and implemented compensating controls to address this vulnerability.

Systems Software – Systems software is a set of computer programs designated to operate and control the processing activities for all applications processed on a specific computer, including network servers, mainframe systems and personal computers. Controls over access to, and use of, such software are especially critical. The CMS auditors noted numerous findings during their general controls testing for systems software system settings and controls for network servers that required enhancement.

- **Changes to Systems Software –** The audit noted that systems software change procedures and/or controls were not in place or consistently followed at many of the sites tested. Failure to control systems software changes can seriously impact the security and effectiveness of data and operations because systems software provides the foundation to operate all of the computers used.

- **Access to Systems Software Programs and Files –** The audit noted numerous instances of poor password and system software controls that could allow unauthorized access to systems software programs and files. Findings were noted regarding systems software on mainframe, Windows, UNIX, firewall and router servers. The lack of security configuration standards at some sites contributed to the weaknesses noted and the ability of our external penetration teams to penetrate several sites tested; however, the biggest contributor to this issue was the lack of ongoing testing to ensure the effectiveness of security settings within contractor networks. Ongoing testing includes internal and external penetration tests and tests to ensure the propriety of security configuration settings on platforms used by contractors, including mainframe, Windows, UNIX, firewall, and router server security configuration settings.

Overall Conclusion - During FY 2004, improvements were noted at a number of sites the CMS auditors visited, a reflection of increased management attention and interest. CMS made progress by continuing their reviews of contractors, including penetration tests and reviews of configuration settings on servers. CMS has also continued its programs to review the contractors through SAS 70 audits, an extensive contractor self-assessment program (the CAST) and reporting process and greater central oversight by contractor management. Additionally, CMS has requested and received updated system security plans and risk assessments from its contractors and has a certification and accreditation program initiative featuring system vulnerability assessments. However, the number of findings documented during our audit indicates that improvements are still needed.

CMS also launched a program to evaluate the security levels of all contractors regarding their compliance with the Federal Information Security Management Act (FISMA) under the requirements of the Medical Modernization Act for Medicare. This evaluation program includes all eight key areas of FISMA: periodic risk assessments, policies and procedures to reduce risk, systems security plans, security awareness training, periodic testing and evaluation of the effectiveness of IT security policies and procedures, remedial activities, processes and reporting for deficiencies, incident detection, reporting and response, and continuity of operations for IT systems. These evaluations will serve CMS greatly in better understanding the current state of security operations at all contractors.

Efforts to address the findings noted in our review are challenged by budgetary constraints and the decentralized nature of Medicare operations and the complexity of fee-for-service processing. According to CMS officials, the CMS modernization program represents a long-term solution to simplify the application software code and change controls needed for more robust security. CMS is also in the process of its contractor reform initiative, including data center consolidation, which should reduce the number of contractors and data centers.

Recommendations

The CMS auditors recommend that the CMS continue to strengthen controls over Medicare electronic data processing. Specifically, CMS management should:

- Provide additional guidance to the contractors regarding the requirements to formally assess and reduce risk on an ongoing basis by specifically identifying and matching controls to mitigate risks and by specifically requiring ongoing and consistent tests of mitigating controls to ensure their continued effectiveness. Compliance with CMS Acceptable Risk Safeguards will provide a foundation for improvement.

- Develop formal and consistent policies and procedures to control the processes used to turn off edits in systems and to assess the impact of processing during periods when edits are negated. The control process should include identification of who in the organization is authorized to make edit changes and the potential impact on claims processing errors.

- Develop and implement procedures to continuously monitor and track compliance with the security configuration models for all platforms maintained within the CMS central office, the CMS contractor sites and the maintainer sites.

REPORTABLE CONDITIONS

Internal Controls Over Payroll Need Enhancements (New Condition)

The HHS payroll process encompasses a series of procedures performed by various divisions throughout the world. HHS' Human Resource Service (HRS) is responsible for managing and processing payroll for all HHS employees. In conjunction with its operating divisions, HRS processed payroll in FY 2004 for over 60,000 employees, including more than 10,000 Commission Corp officers and retirees totaling approximately $5.6 billion in payroll-related and retiree disbursements. The payroll and retiree processes utilize four automated systems to record, account and process payroll, as follows:

- The Enterprise Human Resources and Payroll System (EHRP) is a web-based, workflow enabled human capital management system providing electronic initiation and processing of personnel actions, and human capital management tools. This system replaced most of the functionality of the Improved Management of Personnel Administration through Computer Technology (IMPACT) system.

- The IMPACT system runs on mini-computers and includes pay adjustments and Time and Attendance (T&A) corrections that are manually entered.

- The T&A Systems are exception-based timekeeping systems that supports the tracking and reporting of hours worked and leave taken for HHS employees.

- The Accounting for Pay System (AFPS) is a HHS-wide system that provides information necessary to account for disbursements, obligations, and accruals for personnel costs.

- The Civilian Payroll System (CPS) is an HHS-wide system where civilian payroll is actually computed. The three sources of data input are EHRP, T&A Data files, and the IMPACT system.

Our review of payroll processes identified significant weaknesses that could result in misstatement of payroll-account balances and the Commission Corp liability, improper payments, release of sensitive data, and reduced controls over safeguarding of assets. While the budgetary process, the budget to actual reviews, and such key detect controls as employee complaints and application of headcount ceilings aid in ensuring that errors which would be material in relation to the financial statements as a whole is reduced, our detail testing suggests that HHS payroll and retiree disbursement processes is ineffective in meeting the objectives set out in the HHS Departmental Accounting and Payroll manuals. The following discusses specific issues identified during our procedures:

- The Independent Service Auditors' Report for the HRS and the Information Technology Service Center identified certain controls related to the EWSP, logical and physical access, segregation of duties, authorization, and completeness that were not operating effectively.

- We noted significant delays in processing personnel actions into the EHRP system - in some cases, personnel actions took up to a year to be approved and processed. For example, we noted one instance where an employee was due a within-grade step increase on September 21, 2003, but the action was not processed into EHRP until November 14, 2003. Once identified, management dated the transaction September 21, 2003. Management indicated that in many cases these actions are delayed because personnel and the approving officers were located in separate locations.

- Of an aggregate 337 individuals select for testing, we noted that approximately 4% were incorrectly paid amounts ranging from a $22,000 underpayment to a $1,244 overpayment during the periods when they were determined to have had their disbursement improperly calculated. Additionally, in other procedures, issues were identified that suggested certain individuals were not being paid appropriate amounts.

- We noted 12 instances where individuals were provided temporary Social Security Numbers (SSN) until such time where the government issued the official SSN. Certain personnel actions took up to 18 months to complete (i.e., including the time between the temporary assignment of the SSN and when the permanent SSN was input) at which

point HHS dated the effective date of the transaction back to the initial start date to reflect the employees' correct information. Our testing did not encompass whether such individuals had appropriate documentation to work in the United States at the date.

- We noted 121 instances among our 337 items selected where the annual leave or sick leave balances on the timecard from the T&A System did not agree with the Earning and Leave Statements from the payroll system.

- We were not provided certain documentation - over 60 separate documents - to substantiate certain benefit designations or why certain events occurred because an adequate employee history was not available.

Additionally, of the 5,577 employees identified as having their salaries administratively determined or designated as part of the senior executive service, we noted 283 employees who exceeded the base pay threshold for the highest paid senior executive service personnel. Departmental policy permits such salaries subject to certain requirements. Our review of documentation supporting a sample of such employees' appointments identified the following matters for follow-up:

- For one of 37 individuals selected, we noted that educational background was provided but the formal proof of the appointment was unavailable.

- For one of 37 individuals selected, we noted that the appointment letter lacked appropriate approval signatures.

- For one of 37 individuals, there was not supporting documentation for the qualification or the appointment approval.

Additionally, during our review of Public Financial Disclosure Forms for a sample of SES employees, we noted that:

- For one of 21 items selected, the form had not been reviewed for two consecutive years,

- For five of 21 items selected, the review did not have evidence of the Director of the Ethics Office review, and

- For six of 21 items selected, no date stamp was visible to confirm timely completion.

Recommendations

In order for HHS to meet the JFMIP Human Resources and Payroll Systems Requirements, we recommend that HHS ensure all human resources and payroll systems provide, at a minimum, the following:

- Complete, accurate, and prompt payment of pay and calculation of deductions.
- Complete, accurate, and prompt generation and maintenance of human resources and payroll records and transactions.
- Timely access to complete and accurate information, without extraneous material, to those internal and external to the agency who require the information.
- Timely and proper interaction of human resources and payroll systems with core financial systems.
- Adequate internal controls to ensure that human resources and payroll systems are secured and operating effectively, as intended.

Additionally, we recommend that further training be provided to HRS and Operating division personnel to ensure appropriate knowledge of HHS policies regarding:

- Documentation that is required to support and track personnel actions and changes to the employee's Official Personnel file.
- The need for timely update of personnel files once the Standard Form 50—Notification of Personnel action is approved.
- Levels of review required to identify recordkeeping and systemic inaccuracies in a timely fashion.
- Required procedures to ensure the payroll and financial systems are properly reconciled.
- Formalized communication structure to ensure critical information is provided to all personnel affected in the payroll process.

Departmental Information Systems Controls (Repeat Condition)

As was the case at CMS, many of the business processes that generate information for the Department's financial statements are supported by information systems. Adequate internal controls over these systems are essential to the integrity, confidentiality, and reliability of critical data while reducing the risk of errors, fraud, and other illegal acts. As part of our assessment of internal controls, we have conducted general control reviews for systems that are relevant to the financial reporting process. General controls involve the EWSP, access controls (physical and

logical), application development and program change controls, segregation of duties, operating systems software, and service continuity. General controls impact the integrity of all applications operating within a single data processing facility and are critical to ensuring the reliability, confidentiality, and availability of financial information.

While HHS has made significant progress in strengthening controls over its systems, our procedures continued to identify general controls issues in both the design and the operations of key controls. We noted weaknesses in the following review areas:

- Entity-wide security program,
- Access controls (physical and logical),
- Application development and program change controls,
- Systems software, and
- Service continuity.

Because of the pervasive nature of general controls, the cumulative effect of these weaknesses represent significant deficiencies in the overall design and operation of internal controls. Detailed descriptions of control weaknesses may be found in SAS 70 reports and the management letters issued on each system review. The following discusses the summary result by review area.

Entity-Wide Security Programs - These programs 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. EWSP afford management the opportunity to provide appropriate direction and oversight of the design, development, and operation of critical systems controls. Inadequacies in these programs can result in inadequate access controls and software change controls affecting mission-critical, systems-based operations. Our procedures identified the following issues:

- Security Plans - Security plans for some of the systems have not been updated, finalized, approved, and communicated.
- Certification & Accreditation - Required certification and accreditation statements for some of the major financial applications and general support systems have not been completed and risk assessments have not been performed.

- Security Training - Relevant security and security awareness training was not provided to all employees and contractors.

- Incident Response Capabilities - The incident response capabilities for some of the systems are limited due to the lack of clearly defined policies and procedures and the inadequate monitoring and assessment of critical events.

Access Controls (physical and logical) - Access controls ensure that critical systems assets are physically safeguarded and that logical access to sensitive application, system utilities, and data is granted only when authorized and appropriate. Access controls over operating systems, network components, and communications software are also closely related. These controls help 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. Our procedures identified the following issues:

- Access Authorizations - For some of the systems, the approval of access requests was not or inadequately documented.

- Access Revalidations - For some of the systems, the periodic revalidation of user accounts is either not performed or inadequately documented.

- Password Controls - The password controls applied to some of the systems do not provide an adequate level of authentication 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 systems software helps coordinate the input, processing, output, and data storage associated with all of the applications that are processed on a specific system. Some systems software is designed to change data and programs without leaving an audit trail. Overall, problems in managing routine changes to systems software to ensure an appropriate implementation and related configuration controls were identified. Our procedures identified the following issues:

- Configuration Controls - Systems settings for selected databases and operating systems are not optimized to provide a secure computing environment.

- Patch Management - The controls over timely and consistent application of system patches are not effective for all of the systems.

Application Software Development and Change Controls - A well defined and effectively controlled development and change management process should be in place to ensure that only authorized, tested, approved, and documented new programs or changes to existing programs are applied to the production environment. Additionally, the process facilitates that new or changed

programs meet the requirements with regards to security and controls; such as providing for programmed integrity controls, audit trails, logging capabilities, etc. Our procedures identified the following issues:

- Change Controls - For some applications, there is no formal and consistently applied change control process.

Service Continuity - Disaster recovery and business continuity plans provide a means for re-establishing both the automated and manual processes under a variety of scenarios ranging from short-term system failures to disastrous, large scale events that impairs the functioning of mission-critical processes. A critical part of service continuity is the periodic testing of the disaster recovery and business continuity plans to validate their effectiveness. Besides building redundancies on the systems side, it is critical that relevant data is stored at an off-site location to enable a timely recovery of critical information. Our procedures identified the following issues:

- Disaster Recovery Plans - The contingency plans for some of the systems are either not defined, incomplete, or outdated.

- Disaster Recovery Test - Some of the contingency plans are not tested periodically to validate the effectiveness of the contingency provisions.

Recommendations

HHS continues to rely on information systems to support its business processes. With the advances of technology this reliance will most likely increase over time. To provide a secure computing environment for critical applications throughout all the operating divisions, HHS should continue to develop, implement, and monitor cost-effective controls to include:

- Maintenance of updated security plans to provide security and controls commensurate with the risk associated with any given system.

- Completion of certification and accreditation activities, including the corresponding risk assessments, to limit the residual risk to an acceptable level.

- Training of all employees and contractors on security awareness and responsibilities to effectively communicate security policies and expectations.

- Strengthening of incident response capabilities through formalized policies and procedures and relevant tools and technologies to increase the likelihood that security relevant events are detected, isolated, and properly treated.

- Maintenance of access approval records to provide for accountability.

- Revalidation of access rights on a periodic basis to limit systems access on a need-to-have basis.

- Strengthening technical password controls to provide an effective mechanism for user authentication.

- Optimizing technical system settings to strengthen security and integrity controls of databases and operating systems.

- Development of an effective patch management process for all critical systems to reduce systems vulnerabilities to a minimum.

- Maintaining effective program change controls processes for all applications to limit the risk of unauthorized changes to the production systems.

- Development and maintenance of disaster recovery plans to enable a timely recover of systems, data, and processes in the event of a disruption.

- Testing of disaster recovery plans to ensure the effectiveness of recovery provisions.

Omissions and Delays in Obtaining Documentation Impacts the Audit Process (New Condition)

OMB Circular No. A-123, *Management Accountability and Control*, and the GAO's, *Standards for Internal Control in the Federal Government*, require agencies to maintain documentation for transactions, management controls, and other significant events that is clear and readily available for examination. During our testing, we found that HHS did not maintain or have readily available sufficient documentation to support transactions included in its financial statements. For example:

- Although the initial milestone dates for completing the PAR was October 22, 2004, we continued to receive significant changes through November 15, 2004. For example, the Department had not ensured that the net position FY 2003 ending balance agreed to the net position FY 2004 beginning balance until November 13, 2004.

- As of December 3, 2004, the Department continued to reconcile differences between amounts reported in the footnotes and amounts within the President's Budget.

- Although HHS was provided memos written by the auditors depicting the significant accounting processes, management was unable to certify the accuracy of such processes until as late as five months after the memos were initially provided.

- On May 14, 2004 we requested certain documentation to support a sample of grant expenditures disbursed during FY 2004. Certain documentation to support grant activity was not made available until the end of October - over five months after the original request.

- Although documentation to support certain payroll transactions were requested on June 14, 2004, documentation was still be provided as late as October 28, 2004 - almost four months after the original request.

- On June 22, 2004, we requested certain documentation to support a sample of Medicaid and State Children's Health Insurance Program grant advances and expenditures. Certain documentation to support this activity was not made available by CMS until early October.

- HHS was unable to provide certain subsidiary listings to support its inventory included on its financial statements.

- We did not receive one or more documents requested from management for 114 of 519 items selected during our tests of internal control.

- For seven programs within HHS, we did not receive risk assessments to support management's process to comply with the Improper Payments Information Act of 2002.

- HHS was unable to provide all documentation requested for 27 of 81 items selected to support additions, disposals, and transfers of personal property.

Based on our observations and discussions with management, we noted that the complexity and the decentralized nature of HHS, limited reviews of documentation files, and miscommunications and limited understandings of the audit process caused many documents to be either delayed or missing to support its September 30, 2004, financial statements.

Recommendations

We recommend that HHS management:

- Provide training to personnel involved in the audit process in order to communicate the types of documentation needed to support financial transactions,

- Establish or revise policies and procedures addressing documentation of transactions that are consistent with GAO's internal control standards. The policies should enable HHS to provide sufficient documentation in a timely fashion to support its financial statements.

- Implement a strategy to perform periodic reviews of files to ensure the appropriate documentation is maintained in accordance with HHS policies.

OTHER MATTERS

Integration of Performance Reporting With Financial Reporting

As reported in FY 2003, the Department manages hundreds of programs under its 12 operating divisions and uses hundreds of performance measures to direct program activities and assess progress and achievement. Due to the complexity and volume of the measures, the Department faces significant challenges in meeting the consolidated performance reporting requirements of the Government Performance and Results Act of 1993 and OMB Circular A-11. In FY 2004, OMB provided the following specific guidance to HHS on how to best meet the consolidated performance reporting requirements: (1) HHS will present a significant set of measures representing HHS' key priorities for FY 2004 in the Management Discussion and Analysis of the FY 2004 "Performance and Accountability Report" (PAR) with reference to the individual operating divisions plans, (2) FY 2006 Congressional Justifications by operating division will integrate the budget information with performance information in order to provide a comprehensive picture of HHS' performance along with its programs' effectiveness, (3) The OPDIV performance reports submitted in February 2005 must cover all the performance measures in the FY 2004 OPDIV performance plans submitted by HHS and may be combined with the FY 2006 Congressional Justification; and (4) The Secretary will certify the reliability and completeness of the performance data in November as well as for the Congressional submission in February.

Working with OMB, the Department has taken initial steps toward integrating performance reporting requirements in its FY 2005 Annual Performance Plan. However, additional effort should be focused on presenting a clearer linkage of the discussion of performance by major goals in the HHS strategic and performance plans to the operating divisions' statements of net cost. Furthermore, the Department should reassess the consistency and data availability of the indicators reported as significant in the MD&A and section II of the PAR, as well as the annual performance and strategic plans submitted to OMB. For example, HHS spotlighted eight measures as significant in the MD&A as compared to the 18 measures from the prior year. In FY 2004, HHS also reported the eight measures spotlighted in the MD&A and another 21 measures in section II of the PAR. During our review, we noted eight of the 29 indicators were not included in the FY 2004 and FY 2005 HHS Annual Performance Plans. In addition, 17 of the indicators were not included in the FY 2004 - 2009 HHS Strategic Plan. We also noted inconsistencies in the goals that the measures supported between that in the MD&A and section II of the PAR, and the HHS Annual Performance Plan and Strategic Plan. Furthermore, 19 indicators did not have actual performance results for FY 2004 and four had no actual results for FY 2003.

Although there appears to be a robust review process of the performance information for the budget process, we noted certain deficiencies in the review process of the performance information reported in the PAR including inconsistencies within the MD&A and Section II, as well as inadequate or lack of supporting documentation. Currently, although the Department develops the performance information included in the MD&A, the Department does not receive nor does it review the documentation supporting the information reported. The supporting documentation was maintained at the Operating Division level. In FY 2004, the Secretary limited his assertion of the reliability and completeness of the performance data in performance information in the PAR by stating "except as noted in the OPDIV performance plans." As previously noted, the OPDIV plans will not be submitted until February 2005, therefore we cannot assess the magnitude of this limitation.

HHS should continue to work with OMB on consolidated performance reporting requirements and should ensure that for future PAR reporting HHS identifies a process for producing the most appropriate measures; those which are reflective of the Department's strategic goals and initiatives. In addition, HHS should implement corrective action to assist in addressing the limitations regarding the reliability and completeness of the performance data.

Intragovernmental Transactions

Under OMB Bulletin 0l-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.

Beginning in FY 1996, CMS accrued expenses for Medicaid benefits incurred but not reported. As of September 30, 2004, these accrued expenses exceeded the available unexpended Medicaid appropriations by $3.6 billion. CMS' Office of General Counsel determined that the indefinite authority provision of the Medicaid appropriations allowed the entire accrued expense to be reported as a funded liability. In FY 2003, while Department of the Treasury officials agreed that there was a legal basis for recording the accrued benefit liability, they did not agree to recognize the accounting entry on their records.

A somewhat similar problem occurred in the Supplementary Medical Insurance Program, where section 1844 of the Social Security Act authorizes funds to be appropriated to match Medicare beneficiary premiums. The appropriated amount is an estimate calculated annually by CMS. This year's funding estimate was insufficient to match beneficiaries' premiums by $5.6 billion. HHS discussed these issues with OMB officials, who agreed that the longstanding accounting for these issues should continue for FY 2004. Until such time when these matters are resolved, differences between records of the operating divisions and the Department of Treasury will remain.

* * * * *

It is our understanding that management agrees with the facts as presented.

In addition, we considered HHS' internal control over Required Supplementary Stewardship Information by obtaining an understanding of the agency's internal control, determined whether internal control had been placed in operation, assessed control risk, and performed tests of controls as required by OMB Bulletin No. 01-02 and not to provide assurance on internal control.

In addition, with respect to internal control related to performance measures reported in the Management's Discussion and Analysis, we obtained an understanding of the design of internal control relating to the existence and completeness assertions and determined whether they have been placed in operation, as required by OMB Bulletin No. 01-02. Our procedures were not designed to provide assurance on internal control over reported performance measures, and, accordingly, we do not provide an opinion on such controls.

We noted other matters involving internal control over financial reporting, which we have reported to management in a separate letter dated December 6, 2004.

This report is intended solely for the information and use of the management and Office of Inspector General of the Department of Health and Human Services, OMB, and Congress, and is not intended to be and should not be used by anyone other than these specified parties.

December 6, 2004
Washington, DC

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Report on Compliance with Laws and Regulations

To the Inspector General of the
Department of Health and Human Services, and
the Secretary of Department of Health and Human Services

We have audited the financial statements of the Department of Health and Human Services (HHS) as of September 30, 2004 and have issued our report, dated December 6, 2004, 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*. With the exception of the Health Programs (principally Medicaid) included therein, we did not audit the financial statements of the Centers for Medicare & Medicaid Services (CMS), as of and for the year ended September 30, 2004. Those statements and financial information which is included in HHS' financial statements, were audited by other auditors whose report thereon has been furnished to us, and the comments reflected herein, insofar as it relates to the information included for the CMS, excluding the Health Programs, are based solely on the report of other auditors.

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

We were unable to fully test consolidated performance reporting requirements of the Government Performance and Results Act (Public Law 103-62), OMB Circular A-11, and OMB Bulletin 01-09. By letter dated July 20, 2004, OMB said that for FY 2004 performance reporting, HHS should present a significant set of measures that HHS management has identified as representing HHS' key priorities for FY 2004 in the Management Discussion and Analysis with reference to individual operating division plans. Since the issuance of the operating divisions' plans will be subsequent to the completion of our fieldwork, we were unable to fully assess compliance with the Government Performance and Results Act, OMB Circular A-11, and OMB Bulletin 01-09 as they relate to consolidated performance reporting requirements.

HHS has coordinated its implementation of the Improper Payment Information Act of 2002 (IPIA) with the OMB, and it is management's understanding that the progress made in FY 2004 and plans put in place to develop estimates of improper payments and mitigate their causes are substantially consistent with the intent of OMB regulations implementing the IPIA. While an improper payment rate estimate has been prepared for the largest HHS program, Medicare, nationwide estimates of Health Programs improper payments and rates for several other significant HHS programs are under development, but were not reported in the FY 2004 Performance and Accountability Report. Accordingly, HHS has potentially not fully complied with the IPIA requirements.

Other than the matters discussed above, the results of our tests of compliance with laws and regulations exclusive of FFMIA disclosed no instances of noncompliance that are 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 & 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.

  - At most operating divisions, suitable systems were not in place to adequately support sufficient reconciliations and analyses of significant fluctuations in account balances. In addition, some systems were not designed to apply the U.S. Standard General Ledger at the transaction level.

- General and application controls over Medicare financial management systems, as well as systems of certain other operating divisions, were significant departures from requirements specified in OMB Circulars A-127, *Financial Management Systems*, and A-130, *Management of Federal Information Resources*.

- The Independent Service Auditors' Report for the Human Resource Service identified certain controls related to the Entity-wide Security program, logical and physical access, segregation of duties, authorization and completeness that were not operating effectively.

* * * * *

The Report on Internal Control and our separate management letter includes information related to the financial management systems that were found not to comply with the requirements, relevant facts pertaining to the noncompliance, and our recommendations related to the specific issues presented. It is our understanding that management agrees with the facts as presented, and that relevant comments from the HHS' management responsible for addressing the noncompliance are provided as an attachment to this report. Additionally, the HHS is updating its corrective action plan to address FFMIA and other financial management issues.

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

This report is intended solely for the information and use of the management and the Office of Inspector General of the Department of Health and Human Services, OMB, and Congress, and is not intended to be and should not be used by anyone other than these specified parties.

Ernst + Young LLP

December 6, 2004
Washington D.C.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

DEC 6 2004

Mr. Daniel R. Levinson
Acting Inspector General
U. S. Department of Health and Human Services
330 Independence Avenue, S.W., Room 5250
Washington, D.C. 20201

Dear Mr. Levinson:

This letter responds to the opinion submitted by the Office of Inspector General on the Department of Health and Human Services' fiscal year 2004 audited financial statements. We concur with your findings and recommendations.

We are pleased that, once again, your report reflects an unqualified, or "clean," audit opinion for the Department. Through our joint efforts, we are able to achieve our sixth clean consecutive opinion for the departmental financial statement audit.

We also acknowledge that we continue to have 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). We are well on our way to implementing this new system. UFMS will be implemented in accordance with the approval implementation plan allowing HHS to comply with the requirements for the Federal Financial Management Improvement Act by the end of fiscal year 2006. We plan to fully implement the UFMS Department-wide by 2007.

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

Sincerely,

Kerry Weems
Principal Deputy Assistant Secretary
for Budget, Technology and Finance
and Acting Chief Financial Officer