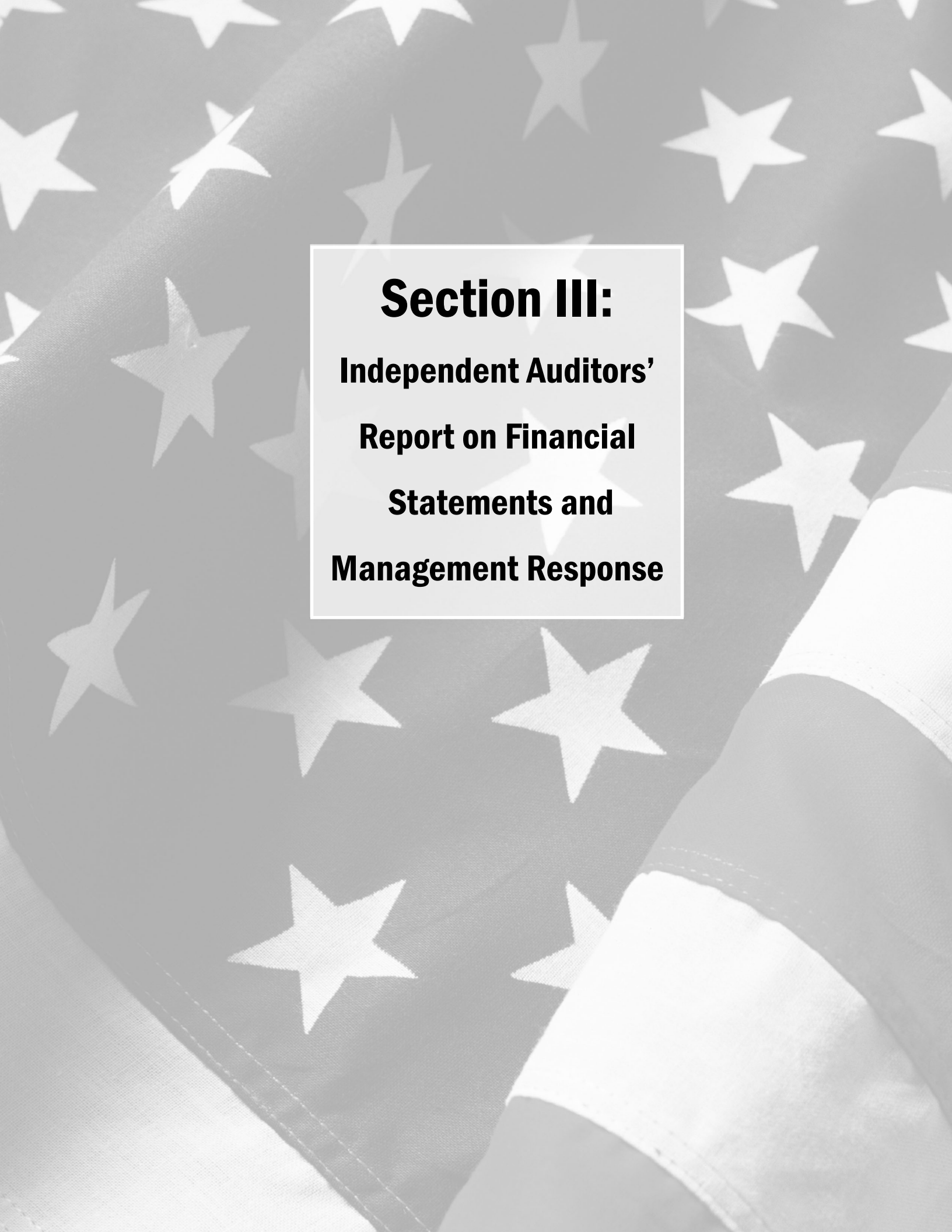

Section III:

Independent Auditors' Report on Financial Statements and Management Response

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

FEB 15 2002

To: The Secretary
Through: DS _____
COS ___
ES _____

From: Janet Rehnquist
Inspector General

Subject: Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2001 (A-17-01-00001)

PURPOSE

Our purpose is to provide you with our audit report on the Department's Consolidated/Combined Financial Statements for Fiscal Year (FY) 2001. This audit is required by the Government Management Reform Act of 1994.

The attached report reiterates problems reported at the Centers for Medicare and Medicaid Services (CMS) and highlights weaknesses noted during audits of other operating divisions' financial statements and departmental system examinations.

Following is a summary of the major issues discussed in the Departmentwide audit report.

INFORMATION TEXT

In our opinion, the Department of Health and Human Services (HHS) financial statements present fairly, in all material respects, the financial position of HHS as of September 30, 2001 and 2000, and its net costs for the years then ended, as well as the changes in net position, budgetary resources, and reconciliation of net costs to budgetary obligations for FY 2001 in conformity with accounting principles generally accepted in the United States.

Our report on internal controls notes two internal control weaknesses that we consider to be material under standards established by the American Institute of Certified Public Accountants and Office of Management and Budget Bulletin 01-02.

- The Department continued to have serious internal control weaknesses in its financial systems and processes for producing financial statements. These weaknesses related to financial management systems; financial analyses and reporting, including CMS oversight of Medicare contractors; and grant accounting.

- Medicare information systems continued to lack adequate controls. Access controls, systems software controls, and entity-wide security programs remained the most troublesome areas. Such weaknesses increase the risk of (1) unauthorized access to and disclosure of sensitive information, (2) malicious changes that could interrupt data processing or destroy data files, (3) improper Medicare payments, and (4) disruption of critical operations.

Material weaknesses are those problems that are systemic across a number of operating divisions, as well as significant dollar issues affecting only one division. These weaknesses are synopsized in this report and are fully described in the individual financial statement audit reports which we released separately.

We are grateful for the cooperation the Department has extended to us in performing this audit. If you have any questions, please call me or have your staff contact Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities, at (202) 619-1157.

Attachment

cc:
Janet Hale
Assistant Secretary
for Budget, Technology, and Finance

George H. Strader
Deputy Assistant Secretary, Finance

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REPORT ON THE FINANCIAL STATEMENT AUDIT OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR FISCAL YEAR 2001

JANET REHNQUIST
INSPECTOR GENERAL

FEBRUARY 2002
A-17-01-00001

OFFICE OF INSPECTOR GENERAL

http://www.oig.hhs.gov/

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

Office of Audit Services

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

Office of Evaluation and Inspections

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

Office of Investigations

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Counsel to the Inspector General

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

INDEPENDENT AUDITOR'S REPORT

INSPECTOR GENERAL'S REPORT ON THE DEPARTMENT OF HEALTH AND HUMAN SERVICES CONSOLIDATED/COMBINED FINANCIAL STATEMENTS FOR FISCAL YEAR 2001

To: The Secretary of Health
and Human Services

We have audited the accompanying consolidated balance sheets of the Department of Health and Human Services (HHS) as of September 30, 2001 and 2000, and the related consolidated statements of net cost for the fiscal years (FY) then ended, as well as the consolidated statements of changes in net position and financing and the combined statement of budgetary resources for the FY ended September 30, 2001. These financial statements are the responsibility of HHS management. Our responsibility is to express an opinion on these financial statements based on our audits.

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

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of HHS as of September 30, 2001 and 2000, and its net costs for the years then ended, as well as the changes in net position, budgetary resources, and reconciliation of net costs to budgetary obligations for FY 2001 in conformity with accounting principles generally accepted in the United States.

We conducted our audits for the purpose of expressing an opinion on the financial statements referred to in the first paragraph. The information in the Overview and the Supplementary Information are not required parts of the HHS financial statements but are considered supplemental information required by OMB Bulletin 97-01, as amended, and OMB Bulletin

01-09, *Form and Content of Agency Financial Statements,* as applicable. Such information, including trust fund projections, has not been subjected to the auditing procedures applied in the audit of the financial statements. Accordingly, we express no opinion on it.

In accordance with *Government Auditing Standards*, we have also issued our reports dated February 1, 2002, on our consideration of HHS internal controls over financial reporting and on our tests of HHS compliance with certain provisions of laws and regulations. Those reports are an integral part of our audits; they should be read in conjunction with this report in considering the results of our audits.

February 1, 2002

REPORT ON INTERNAL CONTROLS

We have audited the consolidated balance sheets of HHS as of September 30, 2001 and 2000, and the related consolidated statements of net cost for the FYs then ended, as well as the consolidated statements of changes in net position and financing and the combined statement of budgetary resources for the FY ended September 30, 2001, and have issued our report, dated February 1, 2002, on those statements. We conducted our audits in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Bulletin 01-02, *Audit Requirements for Federal Financial Statements.*

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

Our consideration of internal controls over financial reporting would not necessarily disclose all matters in these controls that might be reportable conditions. Under standards issued by the American Institute of Certified Public Accountants, reportable conditions are matters coming to our attention relating to significant deficiencies in the design or operation of internal controls that, in our judgment, could adversely affect the HHS ability to record, process, summarize, and report financial data consistent with management assertions in the financial statements. Material weaknesses are reportable conditions in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements in amounts material to the financial statements may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Because of inherent limitations in internal controls, misstatements, losses, or noncompliance may nevertheless occur and not be detected. As discussed below, we noted certain matters involving internal controls and their operation that we consider to be reportable conditions. We consider the first two matters to be material weaknesses.

INTERNAL CONTROL WEAKNESSES

MATERIAL WEAKNESSES

1. Financial Systems and Processes (Repeat Condition)

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

In our view, the Department continues to have serious internal control weaknesses in its financial systems and processes for producing financial statements. These weaknesses related to financial management systems; financial analyses and reporting, including Centers for Medicare and Medicaid Services (CMS) oversight of Medicare contractors; and grant accounting.

Financial Management Systems Issues

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

Within the Department, CMS, the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and the Food and Drug Administration (FDA) are responsible for their own financial management and accounting. The remaining operating divisions rely on the Program Support Center's Division of Financial Operations (DFO) for these services.

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

Although major CMS and NIH system enhancements are under development, full implementation is not expected until 2007. The systems are expected to provide improved financial information for better decisionmaking, potential cost savings, and a means to meet Federal accounting and budgetary reporting requirements.

Centers for Medicare and Medicaid Services. The CMS, with about $350 billion in net outlays, is the Department's largest operating division. However, its financial management systems were not compliant with the FFMIA of 1996. As reported in prior years, the Medicare contractors' claims processing systems did not have general ledger capabilities, and limited system interfaces were available to process and prepare data for the CMS 750/751 reports. These reports, prepared by the contractors, are the culmination of transactions and activity since the beginning of the year.

Along with its Medicare contractors, CMS is responsible for managing and collecting many billions of dollars of accounts receivable each year. Medicare accounts receivable are primarily overpayments owed by health care providers to CMS and funds due from other entities when Medicare is the secondary payer. For FY 2001, the contractors reported about $23 billion in Medicare accounts receivable activity, which resulted in an ending gross balance of

approximately $6.2 billion—about 77 percent of the total CMS receivable balance. After allowing for doubtful accounts, the net balance was about $2.6 billion.

For several years, we have reported serious errors in contractor reporting of accounts receivable as a result of weak financial management controls. The CMS has taken steps by developing policies and procedures to improve consistency in reporting and internal control processes within the contractor environment. However, contractor control weaknesses were noted again this year; independent verification controls were not established or were not consistently applied to provide reasonable assurance that amounts reported to CMS were valid, accurately summarized, and sufficiently documented. Also, because the claim processing systems used by the contractors lacked general ledger capabilities, obtaining and analyzing financial data was a labor-intensive exercise requiring significant manual input and reconciliations between various systems and stand-alone spreadsheet applications. The lack of double-entry, integrated systems increased the risk that contractors could report inconsistent information or that information reported could be incomplete or erroneous.

To address previously identified problems in documenting and accurately reporting accounts receivable within the limitations of a nonintegrated, non-dual-entry accounting system, CMS began contracting with independent public accountants (IPAs) in FY 1999 to validate receivables. The CMS continued the validation effort in FYs 2000 and 2001. This effort assisted in adequately supporting the receivables balance as of the end of FY 2001.

The IPAs reviewed non-Medicare Secondary Payer accounts receivable activity at 12 Medicare contractors representing over 82 percent of the total Medicare accounts receivable balance at September 30, 2000. While the IPAs identified improvements, especially at the larger contractors, they continued to note certain weaknesses in processing receivables. Their review identified overstatements and understatements totaling $294 million (a net overstatement of $240 million) as of March 31, 2001:

- $198 million in periodic interim payment (PIP) receivables at one location and $23 million at another were overstated due to errors in manual spreadsheets. These are biweekly advance payments to providers that are later offset against claims submitted for payment. One contractor's spreadsheet calculation excluded one entire quarter of paid claims.

- $56 million was due to other miscellaneous clerical errors.

- $13 million was not supported by records.

- $2.9 million in PIP receivables was erroneously included as new/accrued receivables but should have been included as reclassified/adjustment receivables.

- $1.3 million in PIP receivables was erroneously recorded since the amount was eliminated through the cost report settlement process.

Our review of accounts receivable activities at September 30, 2001, identified similar deficiencies:

- Because of a system programming error, one contractor's Medicare Secondary Payer accounts receivable balance included $8.1 million in previously closed receivables.

- One contractor's non-Medicare Secondary Payer accounts receivable balance was overstated by $1.9 million due to an error in posting.

- At two contractors, whose PIP accounts receivable exceeded $289 million, the calculation of PIP received limited supervisory review. Of 45 items selected for testing, 15 disclosed no evidence of supervisory review. Since PIP claims accounted for $16 billion of the total fee-for-service payments in FY 2001, oversight of PIP activity is critical.

While it is quite clear that the root cause of the accounts receivable problem is the lack of an integrated, dual-entry accounting system, the Medicare contractors have not provided adequate monitoring or implemented compensating internal controls to ensure that receivables will be properly accounted for and reflected in their financial reports. To address its systems problem, CMS continued its efforts to implement the Healthcare Integrated General Ledger Accounting System (HIGLAS), a state-of-the-art integrated general ledger accounting system for contractor, regional office, and central office locations. This system will replace the cumbersome, ad hoc spreadsheets currently used to accumulate and report contractor financial information and will enable CMS to collect standardized accounting data. In addition, the system will replace the current accounting system, the Financial Accounting Control System, and will include an accounts receivable module to provide better control and support for receivables.

During FY 2001, CMS established a new program office to support the HIGLAS project. The office will manage all aspects of the project, which is expected to be fully operational in 2007.

National Institutes of Health. In FY 2001, NIH had net budget outlays of approximately $17 billion. The NIH financial system, which dates back to the early 1970s, was not designed for financial reporting purposes, lacks certain system interfaces, and has not fully adopted the U.S. Standard General Ledger. As a result, the NIH Office of Financial Management must spend an inordinate amount of time in consolidating and adjusting the numerous institutes' and centers' trial balances to prepare financial statements. For example:

- To compensate for system inadequacies, NIH used a manual, yearend process to create and post balances to the correct standard general ledger accounts. This process generated about 19,000 nonstandard accounting entries with an absolute value of about $348 billion, which increased the risk of bypassing accounting controls. The bulk of these transactions pertained to FY 2000 closing entries that were not recorded in the general ledger until February through April 2001.

- Additional nonstandard accounting entries totaling $3.8 billion were recorded throughout the year to properly adjust account balances, such as inventory, personal property, leave accruals, revenues, and expenses.

In 1998, NIH launched a project known as the NIH Business System to replace existing administrative and management systems. Once the new system is fully implemented, we believe that improved financial information will provide for better decisionmaking, potential cost savings, and a means to meet Federal accounting and budgetary reporting requirements. The system is expected to be fully operational in 2007.

Administration for Children and Families. In FY 2001, ACF, which had net budget outlays of $43 billion, prepared financial statements in less time than in the prior year. However, the preparation of statements from data in the CORE accounting system continued to be a manually intensive process that involved downloading necessary data into microcomputer software to process adjusting entries and compile the statements. In FY 2001, a total of 20 entries with an absolute value of $51 billion were recorded outside CORE in order to prepare financial statements. At times, the effect of these adjustments on net position was not fully investigated, and further adjustments were needed. This process absorbs many resources and limits those available for financial analyses and related research of unusual account relationships.

Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry. The CDC and ATSDR operate with combined net budget outlays of about $4 billion. Their central accounting system is not fully integrated with the reimbursable agreements subsidiary system and does not facilitate the preparation of financial statements. Manually intensive processes and 50 adjusting journal entries with an absolute value of almost $2 billion were necessary to prepare accurate financial statements. This process often resulted in the untimely reporting of financial information supporting management decisionmaking.

Financial Analyses and Reporting Issues

The OMB Circular A-123, *Management Accountability and Control*, provides guidance to Federal managers on improving management controls to ensure that programs achieve their intended results; resources are used consistent with agency missions; programs and resources are

protected from waste, fraud, and mismanagement; laws and regulations are followed; and reliable, timely information is obtained, maintained, reported, and used for decisionmaking.

During FY 2001, the HHS operating divisions made improvements in their financial accounting and supervisory review processes, including the preparation of more timely account analyses and periodic reconciliations. However, our review disclosed numerous weaknesses in some operating divisions' ability to report accurate, timely financial information. Certain reconciliation processes were not adequately performed to ensure that differences were properly identified, researched, and resolved in a timely manner and that account balances were complete and accurate. In addition, significant analysis by Department staff, as well as outside consultants, was necessary to determine proper balances months after the close of the FY. Had the operating divisions followed departmental policies and conducted all required financial analyses and reconciliations throughout the year, many account anomalies would have been detected earlier. The need for enhanced periodic reconciliation and analysis procedures was noted at CMS, NIH, ACF, and CDC/ATSDR.

Centers for Medicare and Medicaid Services. The CMS oversight of contractor operations and financial management controls continues to be a problem and has not provided reasonable assurance that material errors will be detected and corrected in a timely manner. We also noted that due to the volume of transactions processed by the contractors, they may have insufficient time and resources to thoroughly review financial data before submission to the central office. Pending implementation of HIGLAS, oversight of the contractors is critical to reduce the risk of material misstatement in financial systems.

The primary responsibility for identifying and managing Medicare debt owed to the Federal Government is dispersed among the Medicare contractors and the CMS central and regional offices. The contractors recover the majority of overpayments through offset procedures. However, when contractor collection efforts are unsuccessful, contractors are authorized, effective April 2001, to refer delinquent receivables through the central office to Treasury or a designated debt collection center without regional office involvement. This CMS action is consistent with our prior recommendation on centralizing the collection process to eliminate many of the problems we identified in reporting and managing accounts receivable activity. While the referral rate to Treasury has improved as a result, we found incorrect adjustments, unreported debt, clerical errors, and duplicated debt on the report to Treasury. Had a strong internal control structure with adequate regional and central office oversight been in place, these misstatements might have been prevented or detected. Examples of misstatements follow:

- $104 million resulted from receivables that should have been included on the report to Treasury but were not.

- $78 million resulted from clerical errors by the central and regional offices.

- $76 million resulted from duplicated debt at both the central office and the regional offices.

- $22 million resulted from incorrect central office adjustments.

While oversight duties for contractor processes and systems are shared by the central and regional offices, the regional offices play a critical oversight role in that they are the first point of contact with the contractors. During FY 2001, auditors visited two regional offices to assess their oversight function and found that certain procedures were not performed to ensure that contractors' financial data were reliable, accurate, and complete. For example:

- One regional office did not adequately monitor the Medicare contractors' reconciliation of 1522s, Monthly Contractor Financial Reports. The CMS requires the contractors to reconcile "total funds expended" reported on the 1522 report to adjudicated claims processed using the paid claims tape or systems-related summary reports. This reconciliation is an important control to ensure that all contractor amounts reported to CMS are accurate, supported, complete, and properly classified. It took one Medicare contractor over 4 months to properly submit the necessary reconciliations and revised 1522s to the CMS central office. For 1 month, the contractor understated Medicare expenditures reported on its 1522 by $47 million.

- Medicare entitlement benefits due and payable, which totaled about $27 billion at September 30, 2001, represent the cost of services provided to Medicare beneficiaries but not paid at the end of the FY. The CMS Office of the Actuary develops the payable estimate using a variety of information, including historical payment trends and information from Medicare contractors on actual claims processed but not paid. One contractor recorded $453 for claims processed but unpaid at September 30, 2001, but should have reported $15.6 million. These types of contractor errors could significantly reduce the validity of the actuarial payable liability reported on the CMS financial statements. Improved regional office oversight would help to detect these types of reporting errors.

- During FY 2001, the regional offices were directed to perform trend analyses of their accounts receivable activity to help detect unusual variances and fluctuations, identify unusual items, and more readily pinpoint problems and inconsistencies in financial reporting. Reviews over the past several years have identified millions of dollars in accounts receivable reporting errors. Our review at two regional offices showed that the trend analyses performed for September 30, 2001, were inadequate. The reviews were not consistently documented,

fluctuations were not consistently researched, and explanations were not fully detailed.

National Institutes of Health. Although NIH made progress in preparing financial statements, it needs to streamline and document processes to effectively assemble and analyze information and to prepare timely statements. In addition to the lack of an integrated financial system, factors contributing to this condition include untimely preparation of reconciliations and inadequate supervisory reviews. The Office of Financial Management needs to enhance internal control procedures to gain further assurance that transactions were processed and recorded properly, that information from the general ledger used in developing financial statements is reliable, and that the risk of material misstatement or omission is reduced to a low level. For example:

- Although NIH was able to issue preliminary statements by mid-December 2001, we noted that the agency made 64 entries totaling an absolute value of approximately $28 billion to adjust account balances in order to prepare the financial statements. As of January 2002, these entries had not been recorded in the general ledger. Enhanced procedures for supervisory reviews and reconciliation and analysis would provide for the more timely identification and resolution of any errors.

- Each Federal entity is required to prepare, certify, and report certain financial information to Treasury's Federal Agencies' Centralized Trial Balance System (FACTS II). Although the NIH report was prepared and submitted, a subsequent review of the document by NIH identified errors totaling $164 million.

- As of January 2002, two suspense account balances in the general ledger had $31 million in unreconciled yearend differences with Treasury. Some of these differences included items greater than a year old.

- A $193 million difference in undelivered orders was identified in the reconciliation of subsidiary ledgers to the general ledger. However, the difference was not investigated until auditors determined that it related to an improper account included in the reconciliation process.

- Accounts payable and undelivered order balances were not properly aged so that their validity could be adequately analyzed. Over $2 million in accounts payable and $87 million in undelivered orders related to years earlier than 1998.

Administration for Children and Families. Although ACF continued to improve its accounting operations, its financial review and analysis procedures need further refinement to

enable the more timely and efficient preparation of more reliable financial statements. For example:

- The ACF recorded miscellaneous adjustments of approximately $10 billion to various net position accounts during the year. One adjustment of about $9 billion related to the prior-year grant accrual that was not recorded in CORE in FY 2000. As a result, an adjustment to the net position accounts was required in FY 2001. The reconciliation of these accounts to amounts reflected in the Statement of Budgetary Resources was therefore difficult and time consuming.

- The initial Statements of Budgetary Resources and Financing prepared at September 30, 2001, contained several material errors identified during the audit. One transaction erroneously decreased, rather than increased, an account by approximately $2 billion.

- Program expenditure balances reported in the Statement of Net Cost were not completely analyzed until 2 months after financial statements were provided to auditors. Approximately $500 million in adjustments were made to the program cost amounts reflected on the initial draft statement.

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

Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry. Although CDC and ATSDR have taken initial steps in implementing formal procedures for the periodic review and preparation of financial statements, additional effort is needed to ensure the reliability of the financial information. For instance, periodic reconciliations relating to reimbursable agreements were not adequate. As a result, at yearend, a labor-intensive process was undertaken to reconstruct the reimbursable agreement subsidiary ledger (which contained about $200 million in activity) in order to identify corrections necessary for individual agreements.

Grant Accounting Issues

The Program Support Center's Division of Payment Management (DPM) provides centralized electronic funding and cash management services for approximately 65 percent of Federal civilian grants and certain contracts. In FY 2001, the DPM Payment Management System made

about 280,000 payments totaling approximately $200 billion to more than 24,500 grantees on behalf of HHS as well as 10 other Federal agencies and 42 subagencies.

Since launching a new Payment Management System in July 2000, DPM continued to make software changes to improve the adequacy and efficiency of the DPM financial reporting processes. From February 1, 2001, through September 30, 2001, IPAs determined that the controls were operating effectively. Although the prior-year problems were corrected, we remain concerned that the operating divisions did not routinely analyze accounts to detect accounting anomalies. The lack of adequate reconciliation and analyses between the Payment Management System and the OPDIV general ledgers did not ensure that differences were properly identified, researched, and resolved and that account balances were complete and accurate.

National Institutes of Health. Although actions were taken to improve the grant financial management and oversight processes, certain deficiencies persisted during FY 2001. For example, periodic comparisons of the data in the NIH general ledger with the data reported by DPM identified differences up to $1.5 billion for advances and up to $327 million for expenditures. Such differences adversely affect the ability to produce an accurate interim grant accrual. A formal review of those differences did not take place until after September 30, 2001.

Administration for Children and Families. The ACF made improvements in its grant analysis procedures; however, certain weaknesses continued. We noted the following matters during our testing:

- The ACF did not properly review expenditures reported in the Payment Management System before the deobligation of funds. For instance, one grantee's authorized award was decreased by $58 million. As a result, expenditures exceeded authorization amounts by $29 million in both CORE and the Payment Management System.

- A grant document, which was overadvanced by $73 million several years ago due to a disallowance, remained in ACF's subsidiary ledger as of September 30, 2001. Although ACF had removed this overadvance from its general ledger as of September 30, 2001, it had not fully corrected the situation with the grantee.

- A document was created in the CORE system to record $18 million in expenditures reflected in the Payment Management System. These expenditures were posted without a corresponding obligation recorded for the document.

- Grant transactions with an absolute value of $16 billion were misclassified between intragovernmental and nongovernmental accounts in the general ledger.

Entries to correct these errors were not posted to the general ledger system; instead, the correction was made by manually adjusting the financial statements.

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

- continue to support the development of HIGLAS and oversee its implementation;
- oversee and maintain close liaison with operating divisions during the implementation of any new systems (e.g., the NIH Business System);
- oversee the development of formal procedures to conduct periodic, detailed reviews and analyses of transactions within the subsidiary ledgers, and direct each operating division to establish controls to identify, research, and resolve significant accounting anomalies;
- direct the operating divisions' CFOs to work with their program office counterparts to develop procedures for analyzing and explaining unusual changes in account balances related to grant reporting;
- monitor CMS's corrective actions to strengthen regional office and contractor monitoring of accounts receivable to ensure that key financial reconciliations are performed timely;
- require each operating division to prepare quarterly reports on the status of corrective actions on recommendations identified in the specific operating division reports on internal controls; and
- oversee the preparation of interim financial statements in future years, as required by OMB Bulletin 01-09, *Form and Content of Agency Financial Statements*.

2. Medicare Information Systems Controls (Repeat Condition)

The CMS relies on extensive information systems operations at both 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 critical data while reducing the risk of errors, fraud, and other illegal acts.

The CMS central office systems maintain administrative data, such as Medicare enrollment, eligibility, and paid claims data, and process all payments for managed care. The Medicare contractors and data centers use several standard "shared" systems to process and pay fee-for-service claims. All of the shared systems interface with the CMS Common Working File (CWF) to obtain authorization to pay claims and to coordinate Medicare Part A and Part B benefits. This network accounted for and processed $191.8 billion in Medicare expenditures during FY 2001.

Increasing operational and technical challenges in day-to-day Medicare operations make Medicare systems difficult to maintain, enhance, and control. The move to electronic commerce and events such as those of September 11 have heightened security awareness. These evolving demands will continue to require that CMS address its increasing resource needs for security.

Our review of systems internal controls covered both general and application controls. General controls involve the entity-wide security program, access controls (physical and logical), application development and program change controls, segregation of duties, operating systems software, and service continuity. General controls affect the integrity of all applications operating within a single data processing facility and are critical to ensuring the reliability, confidentiality, and availability of CMS data. Application controls include input, processing, and output controls related to specific CMS applications.

We reviewed general systems controls at 22 sites: the CMS central office and 21 Medicare contractors. We reviewed application controls at the CMS central office for several systems integral to Medicare financial management. We also reviewed application controls at 2 of the 21 Medicare contractor sites. At one of these sites, we reviewed the Fiscal Intermediary Standard System (FISS); at the other, the Viable Information Processing Systems (VIPS) Medicare System (VMS).

As shown in the table below, a total of 337 weaknesses were identified from all review sources covering the 22 sites included in this year's scope. Of these, 181 were disclosed through audit procedures comparable to those performed in FY 2000, when a total of 124 weaknesses were reported for 18 sites. It should be noted that the results of this year's CMS-sponsored vulnerability testing at the central office (76 weaknesses) were included in the FY 2001 totals,

whereas the results of comparable testing in FY 2000 were neither tabulated nor included in that year's totals. This accounts for some, but not all, of the FY 2001 increase in the number of reported weaknesses. Additional weaknesses were disclosed this year through American Institute of Certified Public Accountants Statement on Auditing Standards (SAS) 70 control testing (48); additional procedures performed at certain sites to address upper management concerns (59); and more aggressive independent vulnerability testing at selected Medicare contractor sites (20).

The majority of the weaknesses were found at the Medicare contractors, and most (85 percent, compared with 80 percent in FY 2000) involved the same three general control areas as in FY 2000: access controls, systems software, and entity-wide security programs. Over 20 percent of the total findings were at the two Medicare contractor sites that received first-time general control reviews.

Our procedures found no evidence of an actual compromise of security; however, we consider the cumulative effect of the weaknesses found to be material.

General Control Audit Areas	Number of Weaknesses		Total
	Central Office	Medicare Contractors	
Access controls	44	154	198
Systems software	41	21	62
Entity-wide security programs	3	34	37
Application software development and change controls	3	17	20
Service continuity/contingency planning	1	15	16
Segregation of duties	-	4	4
Total	**92**	**245**	**337**

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

inappropriately used and/or disclosed. Access control weaknesses at a variety of levels of seriousness continue to be identified and, cumulatively, represent a significant risk to the Medicare program. Of the 337 systems control weaknesses reported, 198, or 59 percent, related to access controls, compared with 46 percent in FY 2000. The following problems are cited due to their pervasive impact on the overall integrity of access controls in the Medicare program.

- Administration of access controls (149 conditions: 106 at 18 Medicare contractor sites and 43 at the CMS central office). At one site, password administration procedures were not supported by written policies and procedures on password length, expiration, and frequency of change, limiting the effectiveness of password-based access controls. Also, in practice, passwords were not required to be either long or complex enough to significantly reduce the risk that they might be guessed. At a second site, management had neither documented procedures nor established clear lines of authority for requesting system access for new users. Consequently, system access privileges could be assigned in a manner inconsistent with job responsibilities.

- Access to sensitive data (10 conditions at 7 Medicare contractor sites). At one site, computer operations staff could view sensitive Medicare data and printed reports containing information about remittances and patient information, although this information was not required for their job duties. Management had not formally reviewed such access. At another site, some personnel had inappropriate access to Medicare data, reports, and related Medicare application functions that could result in unauthorized changes to sensitive data. This contractor's internal reviews had not identified the inappropriate access privileges. These weaknesses indicate the critical need to comprehensively and continuously review and assign access to Medicare data to authorized personnel commensurate with their job responsibilities.

- Access to Medicare applications software (nine conditions at five Medicare contractor sites). At one site, documented procedures were not in place to control access to, manage changes to, and monitor the use of the application system through which electronic Medicare claims are processed. At a second site, an operating systems programmer had logical access to the Medicare system management menu, resulting in potentially inappropriate access to Medicare programs and related data.

- Access to Medicare facilities (30 conditions: 29 at 11 Medicare contractor sites and 1 at the CMS central office). One site had no procedures to timely identify those temporary personnel and/or contractors whose physical access was no longer necessary due to termination of employment. Because security staff at a

second site did not continuously monitor activities within and outside the data processing center, safeguards were not sufficient to prevent unauthorized access to the center. At a third site, where a number of individuals had authorized access to the data center as a whole, restrictions within the center were inadequate to prevent access to sensitive sections by personnel whose job duties did not require such access.

Systems Software. Systems software is a set of computer programs designed to operate and control the processing activities for all applications processed on a specific system, including network servers, claim processing mainframe systems, and personal computers used to access Medicare data. Controls over access to, and use of, such software are therefore especially critical. Of the 337 total control weaknesses, 62, or 18 percent (compared with 17 percent in FY 2000), related to weaknesses in systems software controls. Significant weaknesses included:

- Changes to systems software (47 conditions: 37 at the CMS central office and 10 at 4 Medicare contractors). Because one site had not issued documented procedures for developing, testing, changing, and implementing systems software, the risk of unauthorized or improper changes was increased. At a second site, although certain system monitoring programs were used to track changes, system software programmers were able to change programs without proper authorization or approval. Vulnerability testing at this site further determined that unnecessary systems software programs had been installed on computers containing sensitive information and that there was no procedure to periodically review and remove these programs. Such unnecessary programs could result in unauthorized access to or changes in the system's configuration.

  These weaknesses indicate that unauthorized changes could be made to systems software and remain undetected. This could result in unplanned system failures or unauthorized access to sensitive data.

- Access to systems software programs and files (15 conditions: 11 at 5 Medicare contractors and 4 at the CMS central office). One site had not determined whether systems software programmers' access privileges were consistent with their job responsibilities and had not reviewed their activities to identify potential misuse or unauthorized changes to critical systems information. Vulnerability testing at another site disclosed that the network access rules programmed into the Internet firewall were not restrictive enough to prevent compromise of an internal system by an outside hacker. This weakness could have permitted an unauthorized person to initiate undesired critical functions.

Entity-Wide Security Programs. These programs are intended to ensure that security threats are identified, risks are assessed, control objectives are appropriately designed, relevant control techniques are implemented, and managerial oversight is consistently applied to ensure the overall effectiveness of security measures. Entity-wide security programs afford management the opportunity to provide appropriate direction and oversight of the design, development, and operation of critical systems controls. Of the 337 total control weaknesses reported, 37, or 11 percent (compared with 17 percent in FY 2000), related to security program weaknesses.

- Implementation of entity-wide security plans (29 conditions: 26 at 12 Medicare contractor sites and 3 at the CMS central office). At one site, management had not established policies and procedures for periodically classifying data files and systems according to their criticality and sensitivity and commensurate with the site's Medicare processing responsibilities. Another site lacked formal procedures for tracking personnel and removing the access privileges of inactive personnel. While a third site had an entity-wide plan in place, key security personnel did not adhere to the policies in the plan.

- Entity-wide security plans (eight conditions at eight Medicare contractor sites). At one site, a documented and approved entity-wide plan had not been developed and implemented to cover all requirements of OMB Circular A-130, *Management of Federal Information Resources*. Another site did not have an entity-wide plan and had not performed a formal, annual risk assessment that specifically addressed information technology requirements and the classification of critical Medicare information resources. A third site, which exchanged claim data with and depended on many other Medicare data processing sites, did not have a documented and approved entity-wide plan.

These weaknesses increase the risk of inconsistently administered access controls, unauthorized access, a lack of control over Medicare data, and a lack of awareness of the sensitivity of such data.

Application Software Development and Change Controls. Despite CMS's efforts, and primarily due to the extreme technical difficulties involved, the prior control weakness related to the Medicare data centers' access to the FISS source code and their ability to implement local changes to FISS programs remained unresolved. Such access to application source code may be abused, resulting in the implementation and processing of unauthorized programs at the data centers. To CMS's credit, last year's expansion of this condition to the CWF has been resolved.

Additional weaknesses in application software change controls follow:

- Systems development and program changes (19 conditions: 17 at 11 Medicare contractors and 2 at the CMS central office). At one site, a formal systems development life cycle had not been developed for all computer system projects. In such cases, there is increased risk that systems may not be modified appropriately to meet mission needs, that major changes to applications may not be appropriately approved or tested, and that unauthorized program changes might occur before being implemented in the production environment.

  While a second site had established procedures for testing changes in the primary Medicare claim payment system, such procedures had not been established for other systems that might also be critical to Medicare processing. When changes are not tested consistently for all systems, incorrect programmatic functions could occur with potentially adverse consequences to the completeness and accuracy of Medicare data.

Service Continuity. Service continuity relates to the readiness of a site in case of a system outage or other event that disrupts normal data processing operations. Without approved, documented, and regularly tested business continuity plans, there is no assurance that normal operations can be recovered timely.

- Incomplete and/or inadequately tested plans (16 conditions: 15 at 6 contractors and 1 at the CMS central office). Although one site had identified mission-critical systems, the Medicare business units had not prioritized the order of recovery for these systems. Also, managerial directives specified planning for continuity of operations for up to 6 weeks, but the recovery plan in place focused on providing limited backup support for a few days. While the contingency and recovery plan at another site had been documented, it had not been fully tested to ensure its readiness and completeness. Without testing, there was an increased risk that critical business processes might not be recovered timely in the event of a disaster.

Conclusion. During FY 2001, CMS made progress in developing systems security plans and approaches for improving systems controls at its central office and took steps to strengthen controls over entity-wide Medicare application software changes. In addition, CMS began a structured, multiyear effort to address some of the fundamental control weaknesses in contractor information security by establishing "core" general control requirements. The CMS also funded an extensive contractor self-assessment program to determine the nature and extent of necessary corrective actions.

From these self-assessments, CMS received feedback from the contractors that about $70 million would be needed over the next few years to remediate identified systems security weaknesses. The CMS's Y2K experience suggests that this estimate may be understated. Progress is largely

limited by the availability of resources. In this regard, the FY 2001 CMS budget estimate sent to the Congress by OMB for Medicare fee-for-service operations was slightly more than $770 million and did not include any resources for these new needs. Current CMS budget projections indicate that only $7 million, 10 percent of the estimated total needed, will be available in FY 2002 for systems security improvements at the Medicare contractors. The CMS must assess risks inherent in each weakness, identify underlying causes, reset priorities to address these root causes at all affected sites, and try to reallocate sufficient resources from those available to correct underlying deficiencies. Unless these substantive resource shortfalls are addressed, it is likely that symptomatic findings will continue to be identified.

Recommendation. We recommend that ASBTF (1) continue to oversee CMS's identification and implementation of corrective actions to address the fundamental causes of Medicare systems control weaknesses and (2) work with CMS in assessing, and finding ways to address, the shortfall in information technology resource needs. In addition, CMS should address control weaknesses as a critical agency concern—not only as a systems management issue; more focused top management attention and higher priority in the allocation of agency resources are needed. Detailed recommendations are contained in the CMS financial statement audit report and the individual Medicare contractor reports.

REPORTABLE CONDITIONS

1. Medicaid Estimated Improper Payments (Repeat Condition)

The Medicaid program, enacted in 1965 under Title XIX of the Social Security Act, is a grant-in-aid medical assistance program largely for the poor, the disabled, and persons with developmental disabilities requiring long-term care. Funded by Federal and State dollars, the program is administered by CMS in partnership with the States via approved State plans. Under these plans, States reimburse providers for medical assistance to eligible individuals, who numbered almost 34 million in 2001. In FY 2001, Federal and State Medicaid outlays totaled $217.3 billion; Federal expenses were $130.2 billion.

For the last 6 years, OIG has reviewed a statistical sample of Medicare claims and estimated the extent of payments that did not comply with laws and regulations. The majority of errors fell into four broad categories: documentation errors, medically unnecessary services, incorrect coding, and noncovered services. This information helped CMS to monitor and reduce improper Medicare payments. Because CMS has not established a similar methodology for the Medicaid program, it cannot reach conclusions on the extent of Medicaid payment errors.

We recognize that because Medicaid is a State-administered program, estimates of improper payments will require the States' cooperation. Toward that end, CMS appointed a project coordinator who submitted bids to States interested in participating in the Medicaid Payment

Accuracy Measurement Project. The coordinator received and approved proposals to participate from nine States. The CMS also contracted with a consulting firm to work with States and CMS in developing procedures and implementing a methodology for determining Medicaid payment accuracy.

Recommendation. We recommend that ASBTF and CMS continue to work with the States to develop procedures and implement a methodology for determining the extent of improper Medicaid payments.

2. Departmental Information Systems Controls (Repeat Condition)

The following summarizes some of the systemic information systems control weaknesses identified during FY 2001. Detailed descriptions of control weaknesses may be found in the individual financial statement audit reports and SAS 70 reports.

Division of Financial Operations. Last year we reported weaknesses in DFO's entity-wide security program, application change controls, and logical access controls. Most of these findings were still outstanding during FY 2001, as noted below:

- Entity-wide security. The DFO lacked a formal risk assessment, a formal security plan, and adequate personnel security policies. In addition, the security features of the DFO accounting system (CORE) were not accredited as required by OMB Circular A-130. Such weaknesses limited assurance that systems controls were adequate and operating effectively.

- Application change controls. The DFO policy for application change controls lacked a formal system development life-cycle methodology, formal test procedures, and adequate library management software. In addition, "before and after" images of program code were not compared to ensure that only approved changes were made to the CORE application.

- Segregation of duties. No periodic reviews or risk assessments were performed to determine that control techniques for segregating incompatible duties were functioning as intended. For instance, developers assisted with the final migration process by recompiling source code before moving program changes into the production environment.

- Access controls. Several access controls were not suitably designed to provide reasonable assurance that computer resources would be protected against unauthorized modification, disclosure, loss, or impairment. For instance, authorizations for dial-up access were not documented, and changes to security

profiles were not automatically logged or reviewed for all systems. Also, access control policies and techniques were not modified when violations indicated that such changes were appropriate.

- Service continuity. The contingency plan had not been updated since December 23, 1999, or tested since October 20, 1999.

Administration for Children and Families. Our review of accounting systems supporting ACF's CORE accounting system, such as the Grants Administration Tracking and Evaluation System, noted the following weaknesses:

- Service continuity. The ACF's response plan in the event of a long-term disruption in business operations was incomplete. The agency had not formally identified and prioritized all critical data and operations of its major applications and networks or the resources needed to recover in the event of a major interruption or disaster, nor had it integrated the contingency plans of its data centers, networks, and telecommunication facilities.

Food and Drug Administration. Although FDA strengthened software application change controls and service continuity since last year, weaknesses continued in entity-wide security and logical access controls.

- Entity-wide security. The FDA Office of Financial Management continued to lack security plans for some of its major applications, and the required certification and accreditation statements had not been completed for all major financial applications. Also, the FDA Office of Information Resource Management had not developed the recommended security plans and network documentation to address the vulnerabilities noted during a 1999 risk assessment.

- Access controls. The FDA had not adequately addressed its deficiencies related to system monitoring and the assignment of administrative rights. Several servers had not been configured to monitor actual or attempted unauthorized, unusual, or sensitive access. We also noted an excessive number of administrators.

Recommendation. We recommend that ASBTF oversee the efforts of the operating divisions and service organizations to improve security issues, system access controls, application change controls, and service continuity plans. Specific recommendations are covered in the individual audit reports.

3. Management Systems Planning and Development

During FY 1999, NIH initiated the planning and implementation of four new management systems with expected costs of approximately $400 million. The largest ($110 million) of these projects is the NIH Business System, which will replace the current NIH financial management system. During FY 2000, NIH elected to create an IT investment fund in its revolving fund, specifically the Service and Supply Fund (SSF), to support the purchase of the IT systems. The SSF was established to provide a means for consolidating the financing and accounting of business-type operations involving the sales of services, including mainframe computing, procurement, and other administrative activities.

In its budget, NIH estimated expected expenditures for the IT systems over the next 5 years. Every NIH institute and center was then required to transfer appropriated funds of at least 10 percent and a maximum of 40 percent of its share of the estimated systems cost to the SSF in FY 2001. Any money related to these systems that remained in the SSF at the end of the FY was to be carried over into future years. Any unobligated carryover of funds remaining in the SSF upon project completion will be returned to the institutes. The funds will then expire and no longer be available for obligation.

Although extensive planning took place in initiating these systems, we believe that the issues discussed below are inconsistent with certain requirements of OMB Circular A-123, *Management Accountability and Control*. For example, NIH did not adequately monitor and track activity, including obligations, advances, and costs, related to its new systems.

- During FYs 2000 and 2001, NIH directed its institutes and centers to advance to the IT investment fund within the SSF approximately $112 million. In FY 2001, about $106 million of this amount was contributed; about 75 percent was advanced during the third quarter and the remaining 25 percent during the fourth quarter. As of September 30, 2001, approximately $64 million had been obligated to systems planning and development, which included $36 million in incurred costs. According to NIH, the $48 million difference between the institutes' and centers' advances and the SSF obligations primarily resulted from delayed obligations and NIH's development of a $28 million contingency fund to support any unexpected project costs. The arbitrary method of determining contributions, as well as the large contributions transferred at the end of the FY, increased the amount available in the SSF for future IT systems costs.

- Although NIH stated that it reassessed project costs on a quarterly basis, advance contributions from the institutes and centers were reviewed only annually. The NIH indicated that to the extent that advances differed significantly from obligations incurred in a single year, it would adjust future years' advances to

ensure that overall contributions from the institutes and centers correlated with project costs. For instance, the FY 2002 contributions will be decreased by approximately $9 million to adjust for the delayed obligations. However, no adjustment will be made for the $28 million in advances held in the SSF contingency fund.

- We identified discrepancies in project plans versus their execution. For example, NIH management estimated budgeted costs based on a 5-year plan, even though the implementation plan projected costs over 8 years, and deviations between the implementation plan costs and actual costs incurred were not formally documented. Also, NIH management indicated that funding of IT projects was based not on implementation plans but on the priorities of a given year as defined by various IT and management committees.

- While reconciling its SSF deferred revenue accounts for the year ending September 30, 2001, NIH identified a $3.5 million error in deferred revenue related to its systems. The reconciliation was performed in January 2002.

- Testing of undelivered orders identified a negative $154,000 undelivered order for one institute related to the NIH Business System. The NIH indicated that the undelivered order was negative due to an error in billing the fourth-quarter allocation to the institutes. The NIH inadvertently excluded the allocation to two funds within the Office of the Director, thus causing the institutes' amounts to be higher than they should have been. The correction of this error, which totaled $2.2 million for all institutes and centers, was not recorded until January 31, 2002.

In addition, the NIH project office responsible for overseeing the NIH Business System initiative did not maintain documentation to support key decisions and approvals. For example:

- A binding agreement called for the institutes and centers to provide a Common Account Number (CAN) to the SSF. A CAN is a series of numbers used in the accounting system to summarize transactions related to a specific budget activity, cost center, or project. Additionally, NIH uses the CAN structure to move funds between the institutes and the SSF. However, NIH could not provide documentary evidence that two institutes, the National Institute of Allergy and Infectious Disease and the National Center for Complementary and Alternative Medicine, had submitted CANs. These institutes contributed $9.4 million and $844,000, respectively, to the NIH Business System during FY 2001.

- We noted a lack of documentary evidence to support HHS's affirmation to proceed with the NIH Business System.

Recommendation. Specific recommendations to NIH are contained in the individual audit report. We also recommend that ASBTF work with NIH in (1) strengthening internal controls to ensure that systems planning and development efforts are properly authorized, sufficiently documented, and effectively monitored and (2) reassessing the method by which the institutes and centers transfer appropriated funds to the SSF to ensure a closer correlation between these advances and those funds obligated or expended by the SSF.

OTHER MATTERS

Intragovernmental Transactions

Under OMB Bulletin 97-0l, *Form and Content of Agency Financial Statements*, technical amendments, dated January 7, 2000, Government entities are required to reconcile intragovernmental transactions with their trading partners. The Department is working with Treasury to develop and implement workable, Governmentwide procedures to meet this requirement. Until a process is operational, we expect that unresolved differences between operating divisions' records and those of their trading partners will continue.

Medicare National Error Rate

Estimated improper Medicare benefit payments made during FY 2001 totaled $12.1 billion, or about 6.3 percent of the $191.8 billion in processed fee-for-service payments reported by CMS. This estimate is almost half the $23.2 billion that we first estimated for FY 1996. There is convincing evidence that this reduction is statistically significant. However, the current 6.3 percent estimate may not be statistically different from the previous 3 years' estimates, which ranged from 6.8 to 8 percent. The decrease this year may be due to sampling variability; that is, selecting different claims with different dollar values and errors will inevitably produce a different estimate of improper payments.

As in past years, these improper payments could range from reimbursement for services provided but inadequately documented to inadvertent mistakes to outright fraud and abuse. The overwhelming majority (97 percent) of the improper payments were detected through medical record reviews coordinated by the OIG. When these claims were submitted for payment to Medicare contractors, they contained no visible errors. Although CMS has made substantial progress since FY 1996 in reducing improper payments in the Medicare program, continued efforts are needed.

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

February 1, 2002

REPORT ON COMPLIANCE WITH LAWS AND REGULATIONS

We have audited the consolidated balance sheets of HHS as of September 30, 2001 and 2000, and the related consolidated statements of net cost for the FYs then ended, as well as the consolidated statements of changes in net position and financing and the combined statement of budgetary resources for FY 2001 and have issued our report, dated February 1, 2002, 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 OMB Bulletin 01-02, *Audit Requirements for Federal Financial Statements*.

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

The results of our tests of compliance with laws and regulations described in the preceding paragraph, exclusive of FFMIA, disclosed an instance of noncompliance required to be reported under *Government Auditing Standards* and OMB Bulletin 01-02. The Department determined that 44 administrative staff among 2,700 individuals in the NIH Administratively Determined Pay Classification did not meet the requirements of Title 42, Chapter 1, The Public Health Service, because they were not scientists or "professionals." As a result, NIH canceled the previous promotions of these individuals.

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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, timely financial statements. The processes required extensive, time-consuming manual spreadsheets and adjustments in order to report accurate financial information.

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

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

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

Also, as reported in footnote 23 of the HHS financial statements, certain claims submitted by providers did not comply with Medicare laws and regulations.

Our report on internal controls includes information on the financial management systems that did not comply with requirements, relevant facts pertaining to the noncompliance, and recommended remedial actions. The HHS CFO prepared a 5-year plan to address FFMIA and other financial management issues. Although certain milestone dates have passed, we recognize that the plan will require periodic updating to reflect changed priorities and available resources.

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

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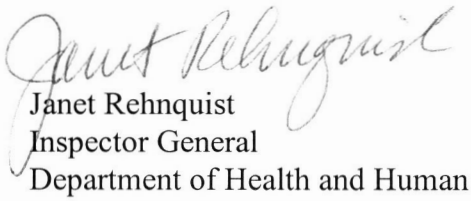
This report is intended solely for the information and use of HHS management, OMB, and the Congress. It is not intended to be and should not be used by anyone other than these specified parties.



Janet Rehnquist
Inspector General
Department of Health and Human Services

February 1, 2002
A-17-01-00001

Appendix I

FISCAL YEAR 2001 CFO REPORTS ON HHS OPERATING DIVISIONS AND SERVICE ORGANIZATIONS

Ten separate financial statement audits of HHS operating divisions were conducted for FY 2001:

- Administration for Children and Families *(A-17-01-00003)*
- Centers for Disease Control and Prevention *(A-17-01-00010)*
- Food and Drug Administration *(A-17-01-00008)*
- Centers for Medicare and Medicaid Services *(A-17-01-02001)*
- Health Resources and Services Administration *(A-17-01-00005)*
- Indian Health Service *(A-17-01-00006)*
- National Institutes of Health *(A-17-01-00009)*
- Program Support Center *(A-17-01-00007)*
- Substance Abuse and Mental Health Services Administration *(A-17-01-00004)*
- Administration on Aging *(A-17-01-00019)*

Four Statement on Auditing Standards 70 examinations were conducted:

- Center for Information Technology, NIH *(A-17-01-00012)*
- Central Payroll and Personnel System, Program Support Center *(A-17-01-00014)*
- Division of Financial Operations, Program Support Center *(A-17-01-00011)*
- Payment Management System, Program Support Center *(A-17-01-00013)*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

FEB 15 2002

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

Dear Ms. Rehnquist:

This letter responds to the Office of Inspector General opinion on the Department of Health and Human Services' fiscal year 2001 audited financial statements. We concur with your findings and recommendations.

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

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

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

Sincerely,

Janet Hale

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