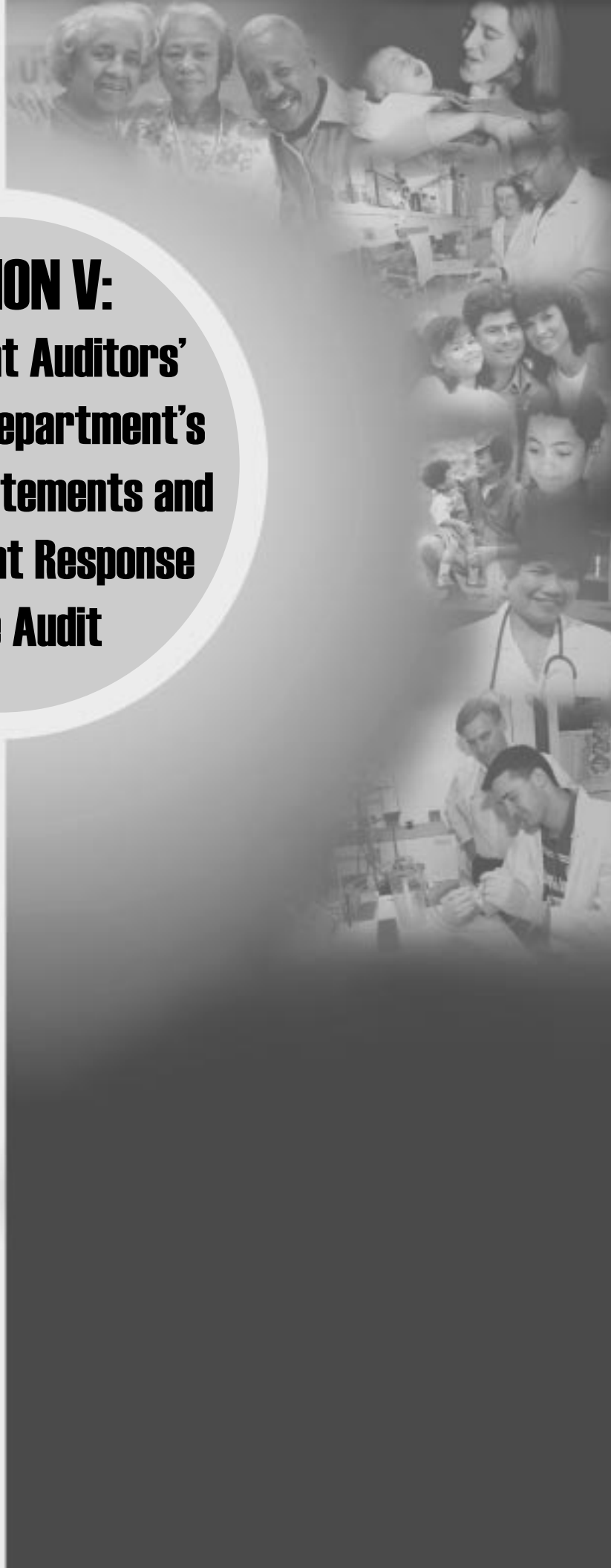

SECTION V:
Independent Auditors' Report on Department's Financial Statements and Management Response to the Audit

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

FEB 26 2001

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

From: Acting Inspector General

Subject: Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2000 (CIN: A-17-00-00014)

PURPOSE

Our purpose is to provide you with our audit report on the Department's Consolidated/Combined Financial Statements for Fiscal Year (FY) 2000. This audit is required by the Government Management Reform Act of 1994.

The attached report reiterates problems reported at the Health Care Financing Administration (HCFA) and highlights weaknesses noted during audits of other operating division 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) FY 2000 financial statements present fairly, in all material respects, the HHS assets, liabilities, and net position at September 30, 2000; the consolidated net costs and changes in net position; and the combined budgetary resources and financing for the year then ended in accordance 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.

- Financial systems and processes remain a significant challenge for the Department. This year, data from a new grant processing system proved unreliable and caused significant delays in preparing the financial statements of operating divisions and the Department. Adjustments to the financial statements were made late in February 2000, more than 5 months after the fiscal year ended. We again note the need for HHS to operate a fully

functioning, integrated financial system. This system should include installation of dual-entry accounting systems at the Medicare contractors and culminate in the production of auditable HHS financial statements. We also point out the need for periodic reconciliations and account analyses throughout the year to improve the timeliness and quality of financial information, as well as stronger HCFA regional office and contractor monitoring of Medicare accounts receivable.

- The Medicare contractors continue to lack adequate electronic data processing controls. Access controls, entity-wide security programs, and systems software controls are most problematic. Such weaknesses do not effectively prevent (1) unauthorized access to and disclosure of sensitive information, (2) malicious changes that could interrupt data processing or destroy data files, (3) improper Medicare payments, or (4) disruption of critical operations.

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 contact me or have your staff contact Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities, at (202) 619-1157.

Michael F. Mangano

Attachment

cc:
Dennis Williams
Acting Assistant Secretary
for Management and Budget

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 2000

FEBRUARY 2001
A-17-00-00014

INDEPENDENT AUDITOR'S REPORT

INSPECTOR GENERAL'S REPORT ON THE DEPARTMENT OF HEALTH AND HUMAN SERVICES CONSOLIDATED/COMBINED FINANCIAL STATEMENTS FOR FISCAL YEAR 2000

To: The Secretary 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, 2000; the related consolidated statements of net cost and changes in net position; and the combined statements of budgetary resources and financing (principal financial statements) for the fiscal year (FY) then ended. These financial statements are the responsibility of HHS management. Our responsibility is to express an opinion on them based on our audit.

We conducted our audit 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 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 provides a reasonable basis for our opinion.

In our opinion, the principal financial statements referred to above present fairly, in all material respects, the HHS assets, liabilities, and net position at September 30, 2000; the consolidated net costs and changes in net position; and the combined budgetary resources and financing for the year then ended in conformity with accounting principles generally accepted in the United States.

Our audit was conducted for the purpose of forming an opinion on the principal financial statements referred to in the first paragraph. The information in the Overview and the Supplementary Information are not required parts of the principal financial statements but are considered supplemental information required by OMB Bulletin 97-01, *Form and Content of Agency Financial Statements,* as amended. Such information, including trust fund projections,

has not been subjected to the auditing procedures applied in the audit of the principal financial statements. Accordingly, we express no opinion on it.

In accordance with *Government Auditing Standards*, we have also issued our reports dated February 26, 2001, on our consideration of HHS internal controls over financial reporting and on our tests of HHS compliance with certain provisions of laws and regulations. These reports are an integral part of our audit; they should be read in conjunction with this report in considering the results of our audit.

February 26, 2001

REPORT ON INTERNAL CONTROLS

We have audited the principal financial statements of HHS as of and for the year ended September 30, 2000, and have issued our report thereon dated February 26, 2001. 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.*

In planning and performing our audit, 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 of 1982, such as those controls relevant to ensuring efficient operations. The objective of our audit was not to provide assurance on internal controls. Consequently, we do not provide an opinion on internal controls.

Our consideration of internal controls over financial reporting would not necessarily disclose all matters in these controls that might be reportable conditions. Under standards issued by the American Institute of Certified Public Accountants, reportable conditions are matters coming to our attention relating to significant deficiencies in the design or operation of internal controls that, in our judgment, could adversely affect the 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. However, we noted certain matters discussed below involving internal controls and their operation that we consider to be reportable conditions and material weaknesses.

In addition, we considered the HHS internal controls over Required Supplementary Stewardship Information by obtaining an understanding of the HHS internal controls, determining whether these controls had been placed in operation, assessing control risk, and performing tests of controls as required by OMB Bulletin 01-02. Our procedures were not intended to provide assurance on these controls; accordingly, we do not provide an opinion on them.

Finally, with respect to internal controls related to performance measures reported in the *FY 2000 HHS Accountability Report*, we obtained an understanding of the design of significant internal controls related to existence and completeness assertions, as required by OMB Bulletin 01-02. Our procedures were not designed to provide assurance on internal controls over performance measures; accordingly, we do not provide an opinion on such controls.

Using the criteria and standards established by the American Institute of Certified Public Accountants and OMB Bulletin 01-02, we identified two internal control weaknesses that we consider to be material and two reportable conditions, as follows:

INTERNAL CONTROL WEAKNESSES*

* "Financial Systems and Processes," called "Financial Systems and Reporting" in our FY 1999 report, has been retitled to incorporate continued problems with Medicare accounts receivable and Health Care Financing Administration oversight of Medicare contractors. The reportable condition for "Property, Plant, and Equipment" has been removed.

MATERIAL WEAKNESSES

1. Financial Systems and Processes (Repeat Condition)

Since passage of the Chief Financial Officers (CFO) Act, 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 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 controls and systems, criteria for which may be found in OMB Circular A-123, *Management Accountability and Control*, and OMB Circular A-127, *Financial Management Systems*. Taken together, the criteria require agencies to record, classify, and report on the results of transactions accurately and promptly. Although manual processes may be used, the system(s) must be efficient and effective to accomplish the agency mission and to satisfy financial management needs.

In our view, the Department continues to have serious internal control weaknesses in its financial systems and processes for producing financial statements. Because many systems were not fully integrated and, in some cases, were in the process of being updated or replaced, the preparation of financial statements required numerous manual account adjustments involving billions of dollars. In addition, significant analysis by Department staff, as well as outside consultants, was necessary to determine proper balances months after the close of the fiscal year. Had the operating divisions followed departmental policies and conducted financial analyses and reconciliations throughout the year, many account anomalies would have been detected earlier. While we observed steady improvement in the financial statement process, system and process weaknesses still did not ensure the production of timely and reliable financial statements. These weaknesses related to grant and other accounting issues, Medicare accounts receivable, and Health Care Financing Administration (HCFA) oversight of Medicare contractors.

Background

In addition to the individual operating divisions, two divisions of the Program Support Center play important roles in the departmental financial process: the Division of Financial Operations (DFO) and the Division of Payment Management (DPM).

The DFO provides financial management and accounting services to the Administration for Children and Families (ACF), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), the Indian Health Service, the Administration on Aging, the Program Support Center, the Agency for Healthcare Research and Quality, and the Office of the Secretary. The remaining operating divisions — HCFA, 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 accounting.

The DPM provides centralized electronic funding and cash management services for approximately 65 percent of Federal civilian grants and certain contracts. In FY 2000, the DPM Payment Management System made almost 274,000 payments totaling approximately

$195 billion to more than 24,000 grantees on behalf of HHS as well as 10 other Federal agencies and 42 subagencies.

After awarding grants, agencies transmit award amounts and grant payment limits to DPM. Based on these parameters, grantees withdraw funds to pay the expenses of their operations, and they report their expenses to DPM quarterly. The DPM records the withdrawals and expenses and issues reports on these transactions to granting agencies and the Department of the Treasury.

Grant Accounting Issues

From 1970 until July 2000, grant transactions were processed by the DPM Payment Management System on a mainframe computer at the NIH Center for Information Technology. In FY 1994, it was determined that expanding this legacy system was not practical and that the system should be replaced with a new client server, web-enabled system. Programming of the new system began in early FY 1998. In February 1999, a decision was made to defer implementation of the new system until after January 2000, and efforts were then focused on remediating the legacy system for Y2K compliance. Independent public accountants (IPAs) determined that for the period September 1, 1999, through July 28, 2000, the legacy system's internal controls were operating effectively. In July 2000, after successfully running parallel for about a month to test the more critical functions, such as fund transfers, the new Payment Management System was brought online without major incident. Grant authorizations, payment requests, and fund transfers were processed through the system at expected volumes.

However, the expenditure subsystem used to produce and process forms 272, Federal Cash Transactions Report, was not fully tested. The DPM determined that this subsystem could be tested after the new system was implemented and before recipients began returning their completed June 30 (third quarter) expenditure reports in September. While processing the June 30 expenditure reports, two programming problems surfaced. As a result, incomplete or erroneous data were reported to the operating divisions and other customer agencies. First, the algorithm used to allocate expenditures to a common accounting number (CAN) did not function properly. While total expenditures were captured, the amounts were incorrectly distributed to the CANs. Although we noted certain concerns with the allocation of disbursements among the operating divisions, we determined that total cash disbursements charged to the operating divisions, in the aggregate, equaled net cash disbursements reported to the Department of the Treasury and distributed to grant recipients. Second, the new system could not process paper 272 reports; this produced a backlog of about $2.1 billion in unprocessed reports. Compounding these problems, the lead programmer working on the expenditure process unexpectedly left the employment of the system development contractor in August.

After correcting the programming problems, DPM began processing the backlog of expenditure reports. In late September, an expenditure file was distributed to the operating divisions reflecting what DPM thought was the majority of grantee expenditure reports. **Because DPM was of the opinion that any remaining expenditure amounts would be immaterial, it did not notify any of its customers of this problem.** These assumptions were incorrect. In actuality, many of the paper 272 reports involved large grantees and totaled about $2.1 billion in unprocessed third quarter expenditures. The DPM should have analyzed the unprocessed reports and determined the extent and seriousness of the problem rather than speculate that it was immaterial. These problems were not fully communicated to senior operating division management or the auditors until February 2001. As a result, grant expenditures, grant advances, and the grant accrued expense calculation contained billions of dollars in errors until final correction. The errors caused account anomalies noted by auditors and substantially delayed final conclusion of the audits of NIH, ACF, HRSA, SAMHSA, and CDC and the Department's compilation of the financial statements:

- The DFO, the operating divisions, and/or auditors analyzed grant expenditures reported on the Statement of Net Cost and found that the yearend balances contained aggregate errors of $2.7 billion. This amount included understatements of $2.1 billion ($1 billion for ACF, $1 billion for NIH, and $100 million for CDC) and overstatements of $628 million ($420 million for HRSA, $97 million for CDC, $91 million for SAMHSA, and $20 million for ACF). As a result of these errors, the financial statements initially were materially misstated. Certain operating divisions did not detect these errors through their internal controls.

- The DFO extensively analyzed July and August grant advance transactions reported by DPM and determined that advances recorded in the general ledger were understated by $858 million: $449 million for ACF, $335 million for HRSA, and $74 million for SAMHSA.

- From October 1, 1999, to June 30, 2000, many accounts in the subsidiary detail were not properly classified as intragovernmental or nongovernmental transactions. The absolute value of classification errors in the subsidiary detail was approximately $6.4 billion: $5.4 billion for ACF, $552 million for HRSA, and $445 million for SAMHSA. The DFO ultimately corrected these errors ("outside the general ledger") in its manual yearend process of preparing financial statements.

- The ACF grant transactions of approximately $1.1 billion were recorded to the wrong CAN. As a result, these amounts were reported in the wrong appropriation. We were informed that this occurred because of discrepancies in

the CAN table that were not identified until several months after the end of the fiscal year.

Although these four problems were eventually corrected, we remain concerned that the operating divisions did not routinely analyze accounts to detect such accounting anomalies. When such analyses are not performed in the normal business cycle, material errors and irregularities will not be promptly detected and the resulting financial statements will be at risk of inaccuracies. Also, procedures should be established to ensure that detected anomalies are effectively communicated to top management.

Medicare Accounts Receivable

The HCFA is the Department's largest operating division with about $316 billion in net outlays. Along with its Medicare contractors, HCFA 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 HCFA and funds due from other entities when Medicare is the secondary payer. For FY 2000, the contractors reported about $30 billion in Medicare accounts receivable activity which resulted in an ending gross balance of approximately $7.1 billion — over 87 percent of HCFA's total receivable balance. After allowing for doubtful accounts, the net balance was about $3.2 billion.

For several years, we have reported serious errors in contractor reporting of accounts receivable that resulted from weak financial management controls. Control weaknesses were noted again this year. 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 ad hoc spreadsheet applications. The lack of double-entry systems and the use of ad hoc supporting schedules 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, HCFA began a substantial validation of its receivables by contracting with IPAs in FY 1999. The HCFA continued the validation effort this year. As a result, the receivables balance was adequately supported as of the end of FY 2000.

The IPAs reviewed accounts receivable activity at 14 Medicare contractors which represented over 68 percent of the total Medicare accounts receivable balance at September 30, 1999. While they noted significant improvement in the HCFA central office's analysis of information included in its financial statements, along with improvement in contractors' processing and reporting of receivables, their review identified overstatements and understatements totaling

$374 million as of March 31, 2000. This amount included errors of $201 million in Medicare Secondary Payer (MSP) receivables and $173 million in non-MSP receivables. Most of the MSP misstatements were due to a lack of supporting documentation for the amounts reported in the contractors' quarterly financial reports to HCFA. Misstatements of non-MSP receivables were attributed to the following:

- $74 million resulted from clerical and other errors.
- $50 million should have been eliminated when providers eventually filed their cost reports. Until a provider files a cost report, all outstanding interim payments are considered technical overpayments and are recorded as receivables.
- $47 million was not supported by records.
- $2 million concerned receivables transferred to a HCFA regional office but still included on the contractor's books and thus recorded twice.

While it is quite clear that the root cause of the accounts receivable problem is the lack of an integrated, dual-entry accounting system, HCFA and the Medicare contractors have not provided adequate oversight 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, HCFA plans to develop a state-of-the-art Integrated General Ledger Accounting System. This system will replace the cumbersome, ad hoc spreadsheets currently used to accumulate and report contractor financial information and will enable HCFA to collect standardized accounting data. In addition, the system will replace HCFA's current accounting system, the Financial Accounting Control System, and will include an accounts receivable module to provide better control and support for receivables. A HCFA-wide project team has been formed under the guidance of the CFO and the Chief Information Officer. Depending on funding, HCFA does not expect to implement the new system until FY 2007.

HCFA Oversight of Medicare Contractors

Pending implementation of a fully integrated accounting system, HCFA's oversight of the Medicare contractors becomes critical to reducing the risk of material misstatement in the financial statements. However, as discussed below, HCFA oversight of contractor operations and financial management controls has not provided reasonable assurance that material errors will be detected in a timely manner.

The responsibility for collecting delinquent provider overpayments is dispersed among the 54 Medicare contractors, the 10 HCFA regional offices, the HCFA central office, and external

agencies. The majority of overpayments are recovered by the contractors through offset procedures. However, when the contractors' collection efforts are unsuccessful, delinquent receivables are transferred to the regional offices and then possibly to various other locations, including the central office, the HCFA Office of General Counsel, the Department of Justice, and the Department of the Treasury's Debt Collection Center.

In an October 28, 1999, report to HCFA (*Safeguarding Medicare Accounts Receivable*, A-17-99-11999), we noted significant weaknesses in regional office accounting for debt. Our review showed that regional and central office accounts receivable were misstated by $184.5 million. Examples of the misstatements included:

- an overstatement of $96.9 million in receivables with no supporting documentation,
- overstatements and understatements totaling $33.9 million due to various reporting and clerical errors, and
- an understatement of $21 million in improperly recorded transfers of receivables from the Medicare contractors to the regional offices.

Not only did the regional offices not safeguard debt in their custody, their monitoring of contractor financial information was inadequate to prevent errors in financial reports and data. As mentioned above, it was necessary for HCFA to hire IPAs to properly determine the accounts receivable balance for the past 2 years. For non-MSP receivables during this period, the IPAs identified about $590 million in recorded debt that the Medicare contractors could not support. While these receivables were written off because of the lack of support, it is possible that some of these receivables were actually debt due to Medicare and should have been collected. Had the regional offices been required to conduct reviews similar to those conducted by the IPAs, many of these problems could have been detected or prevented more timely.

Similarly, stronger regional office oversight of the contractors' reconciliations would help to ensure that contractors have adequate controls in place to prepare accurate and complete financial reports. The HCFA requires all Medicare contractors to reconcile "total funds expended" reported on the prior month's HCFA 1522, Monthly Contractor Financial Report, to adjudicated claims processed using the paid claims tape. This reconciliation is an important control to ensure that all amounts reported to HCFA by Medicare contractors are accurate, supported, complete, and properly classified. However, of the 10 contractors in our sample, 9 did not conduct this reconciliation using the actual paid claims tape. Numerous errors and omissions in contractor reporting resulted. For example, at one contractor, over $65 million in paid claims from the current month's HCFA 1522 was inadvertently included in the previous month's HCFA 1522.

The contractor's HCFA 1522 had to be resubmitted because an unreported manual payment of $6.3 million had not been posted to the contractor's financial records.

Other Accounting Issues

While the timeliness of the HHS financial statements has improved, delays were noted again this year. Numerous adjusting entries at yearend were needed to correct errors and to develop accurate financial statements. Many of these adjustments would not have been necessary had management routinely reconciled and analyzed accounts throughout the year, recorded transactions using prescribed accounts, and refrained from making "financial statement only" adjustments. These controls help to promptly identify and correct accounting aberrations, provide more reliable financial information during the year, and prevent a material misstatement of the financial statements at yearend. Some examples follow:

National Institutes of Health. The NIH financial system, which dates back to the early 1970s, was not designed for financial reporting purposes and lacks certain system interfaces. Because the accounting function is decentralized among the 25 NIH Institutes and Centers, the NIH Office of Financial Management spent considerable time in consolidating and adjusting 23 trial balances in order to prepare financial statements. The NIH, which had net budget outlays of $15.4 billion, was unable to prepare reliable financial statements for September 30, 2000, until February 2001.

During FY 2000, NIH recorded approximately 9.4 million entries in its financial system. About 18,000 of these entries, with an absolute value of about $200 billion, were recorded using nonstandard accounting entries which could circumvent accounting controls. The bulk of these transactions pertained to FY 1999 manual closing entries. Many of these entries were incorrect and were not corrected until months after the original transactions were recorded. For example, entries totaling $140 million were recorded three times in April 2000. Four months later, the duplicate entries were reversed, leaving the correct entries in the system. In addition, we noted that NIH, as in past years, delayed entering some of the prior year's financial statement adjustments, valued at $5.1 billion, to its general ledger for nearly a full year. Such delays cause the general ledger to be misleading and inaccurate during the year.

For FY 2000, to compensate for system inadequacies, NIH developed an ad hoc, yearend process to create and post correct standard general ledger accounts. The output of this process formed the trial balance. However, an additional 95 entries, totaling an absolute value of approximately $28 billion, were necessary in order to adjust the trial balance to prepare the financial statements.

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