DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

NOV 15 2005

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

SUBJECT: Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2005 (A-17-05-00001)

PURPOSE

Our purpose is to provide you with the independent auditors' reports on the Department of Health and Human Services (HHS) fiscal year (FY) 2005 financial statements, internal controls, and compliance with laws and regulations. The Chief Financial Officers Act of 1990 (Public Law 101-576), as amended, requires the Office of Inspector General (OIG) or an independent external auditor, as determined by OIG, to audit the HHS financial statements in accordance with applicable standards.

We contracted with the independent certified public accounting (CPA) firm of Ernst & Young, LLP (EY), to audit the FY 2005 HHS financial statements. We also contracted with the CPA firm of PricewaterhouseCoopers, LLP, to perform the financial statement audit of the Centers for Medicare & Medicaid Services (CMS). EY's opinion expressed on the FY 2005 HHS financial statements makes reference to the work performed by PricewaterhouseCoopers. The contracts required that the audits be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in the "Government Auditing Standards," issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 01-02, "Audit Requirements for Federal Financial Statements."

INFORMATION TEXT

Audit Results

Based on the work performed by both audit firms, EY reported that the FY 2005 HHS consolidated/combined financial statements were fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America. The report on internal controls noted two internal control weaknesses that were

considered to be material weaknesses under standards established by the American Institute of Certified Public Accountants and OMB Bulletin 01-02:

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

- *Managed Care Benefits Payment Cycle*—CMS lacks a comprehensive control environment related to the managed care benefits payment cycle, including oversight of managed care organizations. CMS implemented the Medicare Managed Care System despite known deficiencies in the system that led to erroneous payments. In addition, CMS failed to establish a process to ensure that accounting as well as operational issues were addressed throughout the new payment system implementation process. While the majority of these payments have been identified and corrected, existing policies and procedures are not sufficient to adequately reduce the risk of material benefit payment errors from occurring and not being detected and corrected in a timely manner.

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

Evaluation and Monitoring of Audit Performance

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

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

- reviewing the approach and planning of the audits;

- attending key meetings with auditors and HHS officials;

- monitoring the progress of the audits;

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

- reviewing the auditors' reports; and
- reviewing the HHS Management Discussion and Analysis, Financial Statements and Footnotes, and Supplementary Information.

EY is responsible for the attached reports dated November 11, 2005, and the conclusions expressed in the reports. Our review, as differentiated from an audit in accordance with U.S. generally accepted government auditing standards, was not intended to enable us to express, and accordingly we do not express, an opinion on HHS's financial statements, the effectiveness of internal controls, whether HHS's financial management systems substantially complied with the Federal Financial Management Improvement Act, or compliance with laws and regulations. However, our monitoring review, as limited to the procedures listed above, disclosed no instances in which EY did not comply, in all material respects, with U.S. generally accepted government auditing standards.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Joseph E. Vengrin, Deputy Inspector General for Audit Services, at (202) 619-3155 or through e-mail at Joseph.Vengrin@oig.hhs.gov. Please refer to report number A-17-05-00001 in all correspondence.

Attachment

cc:
Charles E. Johnson
Assistant Secretary for Budget, Technology and Finance

Terry L. Hurst
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Report of Independent Auditors

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

We have audited the accompanying consolidated balance sheets of the Department of Health and Human Services (HHS), as of September 30, 2005 and 2004, and the related consolidated statements of net costs, changes in net position and financing and the combined statements of budgetary resources for the fiscal years then ended. These financial statements are the responsibility of the HHS's management. Our responsibility is to express an opinion on these financial statements based on our audits. With the exception of the Health Programs (principally Medicaid) included therein, we did not audit the financial statements of the Centers for Medicare & Medicaid Services (CMS) as of and for the years ended September 30, 2005 and 2004. Those statements and financial information were audited by other auditors (the CMS auditors) whose report thereon has been furnished to us, and our opinion expressed herein, insofar as it relates to the amounts included for the CMS excluding the Health Programs aggregating combined assets of $353,986 million and $336,962 million and total combined net costs of $295,713 million and $269,748 million, as of and for the fiscal years ended September 30, 2005 and 2004, are based solely on the report of the other auditors.

We conducted our audits in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin No. 01-02, *Audit Requirements for Federal Financial Statements*. These standards and requirements require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the HHS's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the HHS's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

The information presented in the Management Discussion and Analysis, the required supplementary stewardship information, required supplementary information, the supplemental and other accompanying information is not a required part of the basic financial statements but is supplementary information required by OMB Circular A-136, *Financial Reporting Requirements*. We and other auditors have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the supplementary information. We did not audit the information and express no opinion on it. However, we were unable to assess control risk relevant to HHS's intra-governmental transactions and balances, as required by OMB Bulletin No. 01-02, because reconciliations were not performed with certain federal trading partners as required by OMB Circular A-136.

In our opinion, based on our audits and the report of other auditors, the financial statements referred to above present fairly, in all material respects, the financial position of the HHS as of September 30, 2005 and 2004, and its net costs, changes in net position, budgetary resources, and reconciliation of net costs to budgetary obligations for the years then ended, in conformity with accounting principles generally accepted in the United States.

In accordance with *Government Auditing Standards*, we have also issued our reports dated November 11, 2005, on our consideration of the HHS's internal control over financial reporting and on our tests of its compliance with certain provisions of laws and regulations and other matters. The purpose of those reports is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audits.

November 11, 2005
Washington, D.C.

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Report on Internal Control

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

We have audited the financial statements of the Department of Health and Human Services (HHS) as of and for the year ended September 30, 2005, and have issued our report thereon dated November 11, 2005. We conducted our audit in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin No. 01-02, *Audit Requirements for Federal Financial Statements*. With the exception of the Health Programs (principally Medicaid) included therein, we did not audit the financial statements of the Centers for Medicare & Medicaid Services (CMS) as of and for the year ended September 30, 2005. Those statements and the financial information which is included in HHS's financial statements were audited by other auditors whose report thereon has been furnished to us, and the comments reflected herein, insofar as they relate to the information included for the CMS, excluding the Health Programs, are based solely on the report of other auditors.

In planning and performing our audits, we considered HHS's internal control over financial reporting in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide an opinion on the internal control over financial reporting. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin No. 01-02. We did not test all internal controls relevant to operative objectives as broadly defined by the Federal Managers' Financial Integrity Act of 1982 (FMFIA), such as those controls relevant to ensuring efficient operations. However, we noted certain matters involving the internal control over financial reporting and its operation that we consider to be reportable conditions. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control over financial reporting that, in our judgment, could adversely affect the HHS's ability to initiate, record, process, and report financial data consistent with the assertions of management in the financial statements. The reportable condition we noted is described below.

A material weakness is a reportable condition 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 caused by error or fraud in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses. We noted the following matters involving the internal control and its operation that we consider to be reportable conditions. We consider the first two matters noted—Financial Systems and Processes, and Managed Care Benefits Payment Cycle —to be material weaknesses.

MATERIAL WEAKNESSES

Financial Systems and Processes (Repeat Condition)

Over the past year, we and other auditors (with respect to CMS) noted that HHS has made progress in addressing the financial systems and processes weakness noted during fiscal year (FY) 2004. For example, management indicated that:

- During April of 2005, HHS transferred payroll processing for its more than 65,000 employees to the Defense Finance and Accounting Service.

- As part of its modernization effort, HHS developed plans to reduce the number of financial management systems from five to two using the Unified Financial Management System (UFMS). The system is expected to integrate the HHS financial management structure to provide more timely and consistent information and to promote the consolidation of accounting operations that would substantially reduce the cost of accounting services throughout HHS. HHS initiated its implementation of the UFMS at the Centers for Disease Control (CDC) and the Food and Drug Administration (FDA) during April of 2005.

- CMS established a Risk Management and Financial Oversight Committee which ensures that there is cross-functional involvement in the monitoring of business activities to identify situations where accounting evaluation or decision-making may be necessary.

- CMS successfully transitioned four Medicare contractor sites to HIGLAS, the agency's fully integrated general ledger system. HIGLAS is now the system of record for these contractor sites.

- CMS enhanced its policies and procedures by developing a formal written process to evaluate and approve changes in accounting and financial reporting policies.

- CMS improved procedures for handling correspondence that relates to complaints and allegations about CMS employees or other matters causing legal, operational, or financial risk to CMS.

- CMS performed Continuous Quality Improvement (CQI) assessments in order to determine whether the managed care audits were timely, completed accurately, and in accordance with established procedures and guidelines. The CQI assessments provided the impetus for the development of additional training, updated monitoring guides, and additional standard policies and procedures.

While progress has been made, the HHS continues to have serious internal control weaknesses in its financial systems and processes for producing financial statements. These weaknesses caused delays in meeting milestones created to facilitate accelerated reporting and resulted in unexplained differences in reconciliations and account analyses. Within the context of the approximately $581 billion in departmental outlays, the ultimate resolution of such amounts is not material to the financial statements taken as a whole. However, these matters are indicative of serious systemic issues that must be resolved. These long-standing issues, including system and process limitations and expertise needed in meeting evolving financial reporting requirements, simultaneously with implementing new systems, will require a sustained commitment and qualified support team to resolve in preparation for FY 2006 and future years.

Financial Management Systems Issues

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

Within HHS, the CMS and the National Institutes of Health (NIH) are responsible for their respective financial management and accounting. The CDC/Agency for Toxic Substances and Disease Registry (ATSDR), and the FDA have implemented the UFMS in April 2005, eliminating their separate financial management systems. The remaining operating divisions, including the Administration for Children and Families (ACF), rely on the Program Support Center's Division of Financial Operations (DFO) for these services.

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

***CMS* -** CMS is the largest of the HHS's operating divisions, with approximately $313 billion and $171 billion in combined net FY 2005 budget outlays for Medicare and the Health Programs, respectively. CMS relies on decentralized processes and complex systems—many within the Medicare contractor organizations and CMS regional offices—to accumulate data for financial reporting. An integrated financial system, a sufficient number of properly trained personnel, and a strong oversight function are needed to ensure that periodic analyses and reconciliations are completed to detect and resolve errors and irregularities in a timely manner.

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

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

Other auditors reported that the lack of integration in financial reporting is clearly demonstrated through the results of the SAS 70 reviews performed at Medicare contractors during the current fiscal year. These reports noted a total of 35 auditor qualifications related to the control objectives regarding financial reports at nine of the 14 contractors where reviews were completed. This indicates a potential problem in relying upon the data as reported without completion of significant review by the regional and central office. This prevents the timely use and reliance of this information by both operations and financial reporting personnel. For example, the contractors are unable to report all information required for the completion of quarterly financial statements in accordance with OMB timelines and provide only minimal information at year-end that supports the completion of financial statements but does provide enough data for oversight and management of the contractors' activities.

NIH - In FY 2005, NIH had net budget outlays of approximately $27 billion. During FY 2004, because the legacy NIH Central Accounting System was not designed for financial reporting purposes and did not comply with the United States Standard General Ledger (USSGL) at the transaction level, NIH launched the Oracle General Ledger portion of the NIH Business System (NBS). Although the Oracle General Ledger became the official accounting system of record during FY 2004, we noted in FY 2005 that NIH was required to record approximately 120,000 nonstandard accounting entries with an absolute value of $5.6 billion to adjust budgetary and proprietary accounts. Additionally, the NBS does not provide for tracking manual or non-routine entries. As a result, adjustments and corrections cannot be readily identified. Finally, during our testing we noted that transaction codes for direct, reimbursable, and sponsored travel required manual intervention to assign an identifier, either direct or reimbursable, to the transaction within the NBS. This identifier assigns the required budgetary accounts to the transaction.

Entities Supported by the Program Support Center (PSC) - In FY 2005, the operating divisions serviced by the PSC had net budget outlays of approximately $62.7 billion. The PSC's DFO CORE accounting system, which supports the activities of these operating divisions, did not facilitate the preparation of timely financial statements. The necessary data had to be downloaded from CORE, with numerous adjusting entries processed throughout the year before compiling the statements. For example, in FY 2005, approximately 900 nonstandard accounting entries with an absolute value of almost $29.9 billion were recorded in CORE to compensate for noncompliance with the USSGL, to correct for misstatements, to record reclassifications, and to correct reported balances.

UFMS—FDA / CDC – The CDC/ATSDR and FDA operated with combined net budget outlays of about $5.9 billion and $1.3 billion in FY 2005, respectively. CDC and FDA continued to use their antiquated systems during FY 2005. These financial management systems were not fully integrated, and FDA's and CDC's ability to fully support financial balances in a timely fashion were impacted by the need for manual analysis to ensure balances were correct.

The CDC and FDA went live with UFMS in April 2005 for core financials, including modules for the general ledger, accounts payable, and accounts receivable and, in addition, Projects for CDC and iProcurement for FDA; however, we were unable to obtain complete documentation of the accounting processes involving UFMS until September 2005—five months after the system was implemented.

HHS has experienced significant challenges in resolving issues with the system conversion and implementation, including configuration issues, insufficient resources, inadequate training, and limited report capability of financial and budget activity within the system. HHS continues to experience significant challenges in resolving issues with the system conversion and implementation, including insufficient resources, untimely preparation of reconciliations, and insufficient training. For example:

- The UFMS executive leadership, consistent with the UFMS guiding principles, directed the initial scope of the core financial systems implementation, and the related financial

management process improvements with the primary focus on the mandatory JFMIP core financial management functions. For this reason, certain elements are not included within the scope of the HHS's UFMS system, including data warehousing and certain feeder systems—including travel, property, grants, budget formulation, and procurement—but are under the authority of the operating divisions. Furthermore, the UFMS, as currently configured, cannot produce financial statements. Therefore, FDA and CDC continue to use cumbersome processes to crosswalk the unadjusted trial balance to the financial statements.

- Both CDC and FDA continued to record thousands of nonstandard accounting entries both prior and subsequent to the UFMS conversion. FDA recorded 14 thousand non-standard accounting entries totaling an absolute value of approximately $9.4 billion to create the September 30, 2005 financial statements. FDA noted this was primarily due to the productivity dip and lack of familiarity with the system.

  To prepare the September 30, 2005 financial statements, CDC indicated that it was required to record the following:

  - Accounting entries totaling an absolute value of $11.3 billion either to its statements or another HHS operating division.
  - Adjustments totaling an absolute value of $24.4 billion with the Automated Desktop Integrator program. Generally, these adjustments related to conversion, data cleanup, corrections, account reclassifications, and other adjustments to conform to UFMS processing.
  - A $19.1 billion absolute value adjustment to the database used to generate financial statements as a result of conversion adjustments made in UFMS which could not be extracted into the database.

- An independent public accounting firm performed certain agreed-upon procedures, including comparing the UFMS transactional accounting treatment manual to the suggested transaction entry per the Treasury Financial Manual USSGL (USSGL). The report noted numerous scenarios where the UFMS accounting treatment differed from the Treasury suggested treatment.

  The UFMS Global Program Management Office noted that the goal in developing the transaction codes for UFMS was to have the net result of a given accounting event recorded based on USSGL guidance. We were informed that due to the standard functionality of the system, the UFMS required the use of additional transaction codes to achieve the same result of the suggested treatment within USSGL or to properly record converted budget authority.

- In some cases, CDC and FDA, in conjunction with HHS, had not completed the development of reports from the UFMS system. Ad-hoc extracts from UFMS and reports generated from the legacy systems were the primary means to support monthly

reconciliations and the interim and year-end financial statements. According to management, the reports and processes were not fully complete as FDA added minimal operating reports for their go-live, while CDC had 19 custom reports developed. As of September 30, 2005, many extracts from UFMS did not agree to the trial balance and had not been reconciled. Processes and data to prepare reports, rather than individual or summarized transactions, needed to aid in the review of account balances were not available to us or routinely available to managers in executing their duties. For example, for both CDC and FDA, we were unable to obtain a download or an aging of undelivered orders from UFMS that would support the undelivered orders within the financial statements. In addition, certain reports used by FDA and CDC budget personnel do not contain the level of detail needed to sufficiently monitor the budget. This monitoring must now be done at a high level or manually.

- Configuration issues and implementation of new business rules within the iProcurement requisitioning of UFMS delayed payment of invoices to vendors. This delay was due in part to instituting decentralized receiving and commitment accounting. For example, as of September 30, 2005, FDA had more than $10 million in invoices delayed for payment.

- Most required reconciliations relating to periods subsequent to the conversion were not completed in a timely fashion. Both FDA and CDC experienced lack of sufficient experienced resources to extract required data in a timely fashion, perform the reconciliation, and perform research to resolve open reconciling items. We have discussed further examples of this within the Department / Operating Division Periodic Analysis and Reconciliation.

- We understand that HHS management continues to develop and implement corrective actions to improve its implementation of UFMS, develop internal controls, train personnel and develop necessary reports, policies and procedures. Sustained efforts will be necessary to overcome the seriousness of the weaknesses noted. Because CDC and FDA comprise less than 1.2% of total HHS expenditures, we were able to determine that amounts were fairly stated within the context of the September 30, 2005 financial statements taken as a whole. However, as additional operating divisions implement UFMS, serious weaknesses could impact the HHS's ability to substantiate balances on its financial statements, if implementation procedures are not improved.

Financial Statement Preparation, Complex Accounting Processes and Substantiation

As noted in FY 2004, accelerating the timeliness of financial reporting, pending implementation of modern accounting systems that are compliant with the former JFMIP and fully support the financial reporting process, provided challenges for us and for the HHS. Accordingly, procedures need to be reassessed and modified to prepare accurate and complete financial statements in a more timely manner.

Financial Statement Preparation

HHS compiles its financial statements through a multistep process using a combination of manual and automated procedures. Furthermore, due to the system limitations, many operating divisions record numerous entries outside the general ledger systems and employ manually intensive procedures using Excel spreadsheets and database queries to prepare the financial statements. These processes increase the risk that errors may occur in the HHS's financial statements. Therefore, management must compensate for the financial management system weaknesses by implementing and strengthening additional controls. Although the HHS has taken additional steps to compensate for the financial management system weaknesses, including a process whereby certain personnel are assigned to review each operating division's financial statements and follow up on discrepancies or anomalies, a more rigorous review of interim and year-end financial statements is still needed. The following represents issues identified during the financial statement preparation process:

- To prepare financial statements, more than 270 entries with an absolute value of more than $208 billion were recorded outside the general ledger system. Many of these accounting entries were made to record year-end accruals, adjust between governmental and nongovernmental accounts, record expenditures not posted to the general ledger prior to the month-end close, adjust proprietary to budgetary accounts, and post reconciliation adjustments. A majority of the entries could have been eliminated by more timely analyses and reconciliations, as well as improved estimation methodologies.

- We noted various errors in supporting spreadsheet calculations used to produce the financial statements that we brought to management's attention. For example, on November 5, 2005, we noted that management incorrectly recorded a $2 billion adjustment relating to an omission of an undelivered order account in crosswalking the trial balance to the financial statements. A $1.5 billion adjustment was recorded on November 9, 2005 to correct the error.

- We identified unexplained adjustments on a consolidated basis totaling an absolute value of more than $3.6 billion in the calculation of the Statement of Budgetary Resources and the Statement of Financing.

- Our review of HHS's financial statement crosswalks identified certain general ledger accounts that were not used consistently with the USSGL. We noted that an absolute value of over $12 billion in general ledger balances were summarized inconsistently with guidance provided by Treasury. For example, the USSGL suggests that the 2190 account "Other Liabilities" should be reported as "Other Liabilities" on the Balance Sheet; however, HHS summarizes the 2190 account as part of "Accounts Payable."

While the errors, unexplained differences, and unsupported entries noted were not material to the Department-level financial statements taken as a whole, they serve to illustrate that errors are more likely to occur in an environment that necessitates a time-consuming, manually intensive

financial statement preparation process, as well as the need for additional strengthening of the HHS's financial statement preparation, review, and approval processes.

Complex Accounting Processes

In addition, HHS has certain complex accounting processes that require further expertise to ensure that the accounting and reporting of amounts are appropriate in the financial statements and footnote disclosures. For example:

- Lease Accounting—The NIH Service and Supply fund has more than 70 leases it procures with commercial entities. In the past three years, questions regarding capitalization and budget scoring of these leases continuously have required interpretations as to the appropriate reporting in the financial statements and to OMB. Currently, HHS has disclosed that the NIH has operating leases that do not have cancellation clauses and the obligation for the full term of the lease is not recorded. The issue is currently under review and resolution will not occur for the FY 2005 reporting period. The total liability for these leases over the life of the lease term is $553.8 million in FY 2005 and $578.6 million in FY 2004.

- National Stockpile Inventories—Certain stockpile materials recorded in Office of the Secretary accounts but maintained by CDC and other parties through interagency agreements monitored by CDC merit additional focus. CDC has acknowledged a need to comprehensively evaluate the management and financial controls in this area. We were unable to obtain a rollforward of activity from balances transferred when the HHS resumed custody of these stockpiles from the Department of Homeland Security in late 2004 through September 30, 2005, or a comparison of related obligation/expenditure transactions to changes, if any, in stockpile inventories. Furthermore, in November 2005, CDC identified a potential $186 million adjustment against its $1.4 billion balance in its accounting records based on an inventory taken by the custodian of the inventory. The CDC does not track stockpile activity during the year but instead adjusts its stockpile inventory account based on inventories taken by the custodians on a periodic basis. Appropriate accounting recognition for stockpile activity should include recording purchases at the time of receipt, monitoring and recording issuances from stock and disposal activity, and reconciling the resulting recorded inventory amounts with amounts reflected in periodic physical inventories, with research performed on cutoff and other reconciling items and/or the resulting shortage or overage reflected in the reconciliation.

- Credit Reform—We noted in our review of the Health Education Assistance Loan program that HHS's methodology for calculating amounts related to the loan liability were not consistent with credit reform guidance and certain footnote disclosures were not complete or clear. For example, we noted a greater than $147 million balance in net position that should be reflected as a payable to Treasury.

- UFMS Software Capitalization and Budget Process—Although software capitalization guidance has been issued, HHS continues to have difficulty implementing the guidance to ensure appropriate accounting of new systems, including UFMS. The project, which began in FY 2001, was initiated with the purchase of modules of an enterprise resource planning package and the contracting of a system integrator. As of September 30, 2005, the projected budget for the UFMS project was approximately $217 million with more than $138 million collected from the Operating Divisions through interagency agreements. Funds expended at the end of FY 2005 are more than $93 million or approximately 43% of the projected budget.

  As of September 30, 2005, approximately $136 million has been obligated for UFMS between FY 2001 and 2005. To date, HHS has incurred costs of approximately $93.6 million but has only capitalized $24.6 million despite the purchase of the software platform during FY 2001. Additionally, individual operating divisions did not follow Departmental policy in the accounting of the UFMS system. The capitalized costs are to be transferred to the Office of the Secretary on a quarterly basis, which has not occurred. As of September 30, 2005, the Office of the Secretary had not determined the costs associated with the deployment of UFMS at FDA and CDC in April 2005 and had not begun amortizing the capitalized balance for the portion of such costs related to the system placed in service. As a result, we were unable to fully substantiate the methodology and capitalized costs related to the UFMS that is currently being implemented throughout HHS.

These processes are currently immaterial to HHS taken as whole; however, the increase of activity or the sensitivity of these accounts may increase the profile of reported balances to financial statement users.

Reporting Substantiation

HHS does not maintain or have readily available sufficient documentation to support transactions included in its general ledger, the Performance and Accountability Report, and required submissions to OMB and Treasury. For example:

- Due to delays in obtaining amounts, disclosures, and supporting documentation from the operating divisions, HHS was unable to complete certain disclosures within its financial statements and related footnotes, the closing package, and other sections included within its Performance and Accountability Report until November 4, 2005.

- Although Treasury's closing submission date of the Federal Agencies' Centralized Trial Balance System (FACTS II) to Treasury was November 2, 2005, HHS was only able to provide FACTS II reconciliations with its trial balances for four of its 12 operating division as of November 5, 2005. As of the end of fieldwork, the differences had not been fully identified to us, but management represented that they consisted principally of year-end accruals.

- We noted that unsupported entries were recorded to the beginning-of-period unobligated balances to ensure that the trial balance agreed with the FY 2005 audited ending unobligated balances. Other unexplained differences existed in preparing budgetary reporting and other financial schedules.

Based on our observations and discussions with management, we noted that the complexity and the decentralized nature of HHS, resource limitations, post-system conversion-related issues, limited reviews of documentation files, and miscommunications and limited understandings of the audit process caused many documents to be either delayed or missing to support its September 30, 2005, financial statements.

Financial Analysis and Oversight

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

Because weaknesses exist in the financial management systems, management must compensate for the weaknesses by implementing and strengthening additional controls to ensure that errors and irregularities are detected in a timely manner. Our review of internal control disclosed a series of weaknesses that impact HHS's ability to report accurate financial information. During FY 2005, we found that certain 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. The following represents specific areas we noted that need enhanced periodic reconciliation and analysis procedures:

Department/Operating Division Periodic Analysis and Reconciliation

Consistent with FY 2004, during FY 2005, we found that certain 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. The following represents specific areas we noted that need enhanced periodic reconciliation and analysis procedures:

- Fund Balance With Treasury **-** On a monthly basis, the HHS is responsible for reconciling approximately 500 Treasury appropriation symbols. As of September 30, 2005, the general ledger and Treasury's records differed by an approximate absolute value of $544 million. Management could not explain the variance. Furthermore, we noted that:

- For the PSC-serviced operating divisions, four separate monthly reports are prepared that reconcile the general ledger with Treasury's records. One of the reports generated to compare detailed transactions in the general ledger with Treasury's records has lost its usefulness due to old and invalid items that remained in the general ledger. For example, the September 30, 2005 report identified an absolute value of approximately $5.5 billion of differences in transactions dating back as early as 1993. Management indicated that due to staffing limitations, the PSC primarily focused on the larger, more recent differences. Issues related to delays in reconciliation processes for entities supported by UFMS were noted earlier in this report. Additionally, we noted 53 of 105 reconciliations selected at NIH and PSC-serviced operating divisions were not completed in the HHS's allotted 30-day deadline—several taking up to 84 days to complete.

- FDA did not complete its June fund balance with Treasury reconciliation until September 28, 2005. However, the reconciliation included $84 million in suspense accounts that had not been investigated and almost $15 million of unexplained variances. The September reconciliation still identified a significant number of unresearched reconciling items. In some cases, contractors were used to assist in becoming up-to-date on required reconciliations; however, we noted that many of the reconciliations prepared by the contractor had not been reviewed by entity management.

- Grants Management - We identified more than 32,000 grants with remaining net obligation balances of $2.3 billion that are eligible for close out. These should be actively reviewed for closeout in the Payment Management System (PMS) and the operating divisions' grant subsidiary systems. Many of these grants have been eligible for closeout for several years. Further, CMS lacks sufficient integration or reconciliation and tracking processes to ensure that obligation activity within the PMS, which tracks draws for state grants, are consistent with obligation activity within CMS's general ledger. Currently, the states use a CMS 64 to report accrued expenditures to CMS while the states submit a PMS 272 to report expenditures on a cash basis to the PMS resulting in inconsistent expenditure activity within the two systems for the same grant. Although CMS personnel close out grants on the general ledger once obligations and expenditures match, old obligations are not always de-obligated within the PMS leaving unexpended balances available for draws by the states. The difference between net obligations more than two years old within the two systems was more than $1 billion at September 30, 2005.

- Net Position - Contrary to HHS policy, complete, periodic reconciliations of appropriated capital used and budgetary accounts were not performed until year-end. As a result, approximately 427 miscellaneous adjustments with an absolute value of $12.3 billion were recorded to various net position accounts.

- Medicaid and SCHIP Entitlement Benefits Due and Payable - Medicaid entitlement benefits due and payable (IBNR), totaling approximately $20 billion at September 30, 2005, represent the cost of services incurred by states on behalf of CMS but not paid at the end of the fiscal year. CMS bases its estimate of IBNR receivables and payables on historical trends of expenditures and prior year payables identified on surveys obtained from the states. CMS validates their estimate by considering current year program changes, performing analytical procedures, and evaluating significant differences. Although we believe the methodology currently employed by CMS can produce a reasonable IBNR estimate for Medicaid and is the best estimate currently available, the process is highly dependent on the various states. Errors, inconsistencies and varying interpretations at the state level can occur and significantly affect the CMS IBNR liability. It should be noted that a 15 month time lag exists from the date of the state IBNR information (typically June 30, 2004) to the date of CMS's fiscal year end calculation (September 30, 2005).

  Although the total draws and expenditures used in the overall Medicaid IBNR calculation, were reasonable, we noted various clerical errors in the spreadsheets that were used to calculate IBNR and for trending and analyses purposes. The internal control process over the Medicaid IBNR calculation did not detect the errors in a timely manner. Although the individual state entries in the spreadsheets were primarily used for analyses purposes and the total expenditures used in the national Medicaid calculation were reasonable, these discrepancies indicate that errors may occur without being identified and corrected.

  Further, we noted that although certain supervisory reviews of the IBNR calculation were performed in the Office of Financial Management, additional input from Program or OACT offices was not obtained. These individuals have additional expertise and knowledge that may identify anomalies impacting the estimate. While we believe the amount reported is reasonable based on CMS's and our analysis, there is insufficient assurance that the current process would identify significant anomalies. Adequate analysis, follow-up, and review is therefore, extremely important.

  For SCHIP, CMS has not implemented procedures to accrue an estimate for SCHIP IBNR payables and receivables at year-end. However, a portion of SCHIP expenditures is reimbursed on a fee-for-service basis, indicating the need for an IBNR accrual.

- Subsidiary Ledgers - For FY 2004 and prior years, approximately 151 thousand entries totaling $19.7 trillion remained in the detail supporting the general ledger. Most of these entries were posted to ensure agreement between the subsidiary ledgers and the general ledgers, to record budgetary entries, and to record depreciation for capitalized property maintained by the operating divisions. Maintaining supporting subsidiary ledgers would greatly facilitate the financial reporting process.

Medicaid Regional Office Oversight

Since the late 1990s, the Health Programs' regional office oversight has been identified as a weakness within CMS. The regional office oversight of the states is a key detect control in identifying errors within State submitted financial information related to Medicaid, SCHIP and other health programs. The CMS 64, Quarterly Medicaid Statement of Expenditures, is a key submission which reported the approximately $245 billion in FY 2005 in state expenditures to CMS, which flows directly to the financial statements. In September 2000, CMS issued financial review guides to assist the regional office analysts in examining budget and expenditure reports and to standardize the review procedures performed between analysts and regions. These review guides encompass all areas of the review process, but their use and documentation are currently not required but highly recommended.

The monitoring activities executed by CMS constitute critical oversight activities in light of the 11 states that, we have been informed, recently received disclaimers or qualified reports by independent auditors on compliance with Medicaid program requirements, compliance findings in single auditors' reports requiring resolution, and various differences in processes, systems, and issues from state to state. We noted the following during our review:

- *Documentation and Scope of Reviews* - Within the CMS regional offices analysts are not required to follow the CMS Financial Review Guide to assess each state's budget requests, quarterly expenditure reports, and other state activities related to SCHIP and Medicaid funding. We noted in the two regions visited that the regional office did not consistently use the review guide (for quarterly and budgetary reviews) and, when the guide was used (for CMS-64s), the reasons steps were not performed were not always documented. Additionally, we noted that documentation for certain line items on the CMS-64 supporting the analysts' review was lacking. The line items affected included those relating to adjustments and other expenditures for varying amounts. Finally, practically none of the documents examined in our sample had evidence (e.g. sign-off) that a supervisory review was performed.

- *Monitoring of state submissions* - Analysis of changes in quarterly budget and expenditure submissions is a major consideration in a regional office's recommendation to award a grant or validate expenditures and a step in the CMS Financial Review Guide. During our visit to the regional offices, we noted that analysts did not adequately perform trend analyses on Medical Assistance Payments (MAP), Administration (ADM), and SCHIP payments. For certain states, although evidence of trend analysis was available, the scope of the items selected for review was not documented in the workpapers and there was no evidence of which amounts were investigated. In many cases, explanations for variances were not sufficiently documented to assist a reviewer in verifying that CMS gathered appropriate evidence to support the execution of its oversight responsibilities over the Health Programs.

In FY 2005, CMS took steps to increase regional office personnel by hiring more than 100 analysts to work in the states to ensure compliance with Medicaid requirements. These analysts, who have undergone extensive training to ensure adequate knowledge of CMS policies and procedures, began their oversight activities in FY 2005. Additionally, our review in FY 2005 noted improvements in state oversight as compared to weaknesses identified during FY 2004; however, continued emphasis on the extent of reviews and documentation of procedures performed is still needed. It should be noted that our review encompassed the first two quarters of FY 2005; accordingly, we understand certain corrective actions implemented by CMS were not fully implemented at the time of our review.

Single Audit Monitoring

We noted that improvements are needed in the single audit follow-up process, including more timely responses to audit reports, resolution, and corrective actions._ During our review, we noted that ten out of the top 100 HHS grantees did not submit their single audit reports for their most current fiscal year. Further, we noted that HHS operating divisions were not performing timely follow-up to ensure that weaknesses noted in compliance reports are appropriately resolved. The monitoring activities executed by HHS constitute critical oversight activities in light of the number of grantees receiving disclaimers or qualified reports by independent auditors on compliance with program requirements; compliance findings in single auditors' reports requiring resolution; and various differences in processes, systems, and issues from grantee to grantee.

Recommendations

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

- Ensure that the operating divisions, in conjunction with HHS, implement corrective actions, pending full operation of HIGLAS, the NIH NBS, and the UFMS, to mitigate system deficiencies that impair the capability to support and report accurate financial information.

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

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

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

- Ensure, as required by OMB Circular A-136, *Financial Reporting Requirements*, the preparation of future years' interim financial statements supported by reconciliations and account analyses to ensure that such reporting is accurate for decision-making.

- Continue to refine its procedures to provide a mechanism for CMS central and regional offices to monitor states' activities and enforce compliance with CMS financial management procedure by:

    - Providing specific guidance in the use and preparation of the Financial Review Guides to ensure that the regional offices consistently use the guide to document procedures performed during the quarterly expenditure and budgetary reviews and that any decision to expand or curtail the scope of the review or review procedures be documented.

    - Developing a specific scope to be used to identify areas for review and that this scope or any deviations from the scope be documented within the trend analysis workpaper(s) along with explanations.

- Enlist the CMS's OACT to help review the annual Medicaid IBNR calculation. OACT is skilled in performing such estimates and brings a good understanding of how healthcare cost trends, program changes, etc., should affect the IBNR calculation. We further recommend that formal analytical review procedures (i.e., documented and reviewed) be developed to catch clerical errors in the spreadsheets and that CMS proactively obtain input from the states via the regional offices on trends, system changes, program changes, etc., associated with individual states. It would be beneficial to prepare a white paper every year addressing the various factors affecting IBNR and creating a link between qualitative information (e.g., trends, state system changes, OACT, regional office, and program office input, etc.) and the quantitative calculation. CMS should also calculate IBNR based on a three-year average using the current year survey (e.g., 2005, 2004, and 2003) as a reasonableness check on the IBNR calculated using state information 15 months in arrears. This procedure can help to detect/and factor in current trends affecting the IBNR calculation. Consideration should also be given to refining the average-days calculation, which does not currently appear to corroborate the IBNR used in the financial statements.

- In order to help strengthen the estimating process, we suggest CMS consider developing a methodology to collect the necessary data to estimate an IBNR amount from claims data maintained internally. We recognize that this is a formidable task and that validated claims information lags a few years; however, development of such a procedure may be helpful to CMS (particularly if OACT becomes involved in the Medicaid IBNR process)

in performing an independent check ("look-back") on the IBNR developed from state surveys if done several years in arrears to benchmark the existing process using actuarial concepts.

- Identify a methodology for estimating an IBNR for SCHIP-related expenditures. We understand CMS is currently pursuing an approach similar to that used for Medicaid, and we encourage finalization of this approach.

- Require reviews of the IBNR calculation and state surveys by the Program, Financial, and OACT divisions to identify any potential anomalies or changes to the Health Programs that could impact the IBNR calculation.

- Continue in the implementation of the pilot project to estimate improper payments for Medicaid, SCHIP and other high-risk programs' related payments within HHS where an error rate methodology has not been developed and fully implemented.

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

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

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

- Develop and implement a plan to provide for the identification and extraction/ maintenance from post-converted systems of required documentation and reports generally needed for analyses, reconciliations, and audit purposes.

Managed Care Benefits Payment Cycle

Other auditors reported that CMS lacks a comprehensive control environment related to the managed care benefits payment cycle and the oversight of managed care contractors which include Medicare Advantage Organizations (MAO) and Demonstration projects. The existence of a payment process outside the Office of Financial Management and lack of integration of accounting processes within operating procedures related to managed care organizations establishes an environment where the risk of inaccurate payments is not sufficiently mitigated.

Overview

The CMS Medicare benefits expense is composed of two major components: fee-for-service and managed care. Fee-for-service expenditures are processed and paid for by Medicare contractors,

while managed care expenditures are processed and paid by central office. In January of 2005, CMS completed a system conversion to the Medicare Managed Care System (MMCS) for payments to the managed care organizations which resulted in payment adjustments of $1.3 billion in the second quarter, $507 million in the third quarter, and $1.3 billion in the fourth quarter, compared to the adjustments in the first quarter in the previous system, which totaled $469 million.

While other auditors reported that the majority of these payment errors have been identified and corrected or accrued for at the managed care plan level as of November 7, 2005, existing CMS policies and procedures are not sufficient to adequately reduce the risk of material benefit payment errors from occurring and not being detected and corrected in a timely manner in the managed care benefits payment cycle.

Inadequate Procedures to Review and Process Managed Care Payments

Managed care organizations are paid using two methodologies: (1) a risk-based methodology in which multiple demographic and health factors are used to determine the reimbursement rate for a beneficiary and (2) a cost-based methodology in which a plan is reimbursed a predetermined amount per beneficiary which is then adjusted to actual cost incurred during the year through the cost settlement process.

Other auditors noted instances of inadequate policies, documentation, and supervisory review related to the authorization and payment process for risk-based payments as evidenced by the following:

- CMS has not established procedures to reconcile beneficiary-level payments that are calculated and authorized to the actual payment request sent to Treasury. Other auditors attempted to reconcile the total amount calculated by the MMCS system to the amount authorized for payment by DEPO on a monthly basis and noted unreconciled differences ranging from $1.7 million to $66 million.

- CMS did not maintain readily accessible and up-to-date logs of anomalies or errors resulting from their review of plan-level payments.

- The current methodology employed to analyze payment information is based on a simple fluctuation analysis on month-to-month payments. This simplistic model has identified some errors but fails to consider additional variables that may indicate potential payment issues (e.g., change in the number of enrollees).

- CMS was unable to provide accurate beneficiary-level payment information in a timely manner. Other auditors noted inaccuracies between the production files used to calculate the benefit payments and the amounts authorized for payment. These inaccuracies were caused by the maintenance of multiple production files and not properly identifying the beneficiary files used in the production of payment files.

- Adjustments were made to plan payments processed in MMCS based on prior months' actual payments from the predecessor system without considering other factors that may have caused changes. The adjustments ranged from a reduction of $630 thousand to an increase of $7.5 million for the individual plans.

- CMS failed to provide documentation to support the settlement of cost-reimbursed managed care organizations, as well as, documentation to support the recording of payables and receivables for cost settlements. Cost-based reimbursement represents approximately $1.6 billion in annual benefits expense. Other auditors sampled 45 plan settlements, of which CMS failed to provide any documentation for 16 (36%) of the settlements. For the remaining 29 plans in the sample, other auditors tested a total of 1,305 attributes in which the documentation for a total of 74 of the attributes did not meet CMS's requirements. These 74 exceptions were noted in 25 of the 29 files received.

- For risk-based plans, CMS processed manual adjustments for managed care payments without calculating or adjusting the amount at the beneficiary level which is the basis of the transaction (for example, in April 2005, CMS processed $13 million in manual adjustments). This methodology may lead to inaccurate payments.

- CMS was unable to provide policies and procedures related to the validation of the demonstration project payments and settlements.

- CMS has not established proper segregation of duties related to managed care payments. One division has the authority to manually adjust plan payments calculated by the MMCS system and is responsible for validating and authorizing the payments. This process is limited to a small group of people whose work is not subject to independent review.

Lack of Documentation and Procedures to Determine Eligibility of Organizations

- CMS was unable to provide comprehensive documentation of organizations that were approved during the fiscal year as either new managed care providers or for the expansion of their service areas. Other auditors noted exceptions in 19 (42%) of the 45 contracts reviewed where documentation did not meet CMS requirements. Examples of the missing documentation included audited financial statements, marketing materials, reviewer signoff, and state licensures.

- CMS does not have comprehensive policies and procedures for the review of new applications as evidenced by its inability to provide procedures related to new applications for special needs plans.

- CMS was unable to provide policies and procedures to document the acceptance and approval of demonstration projects.

Lack of Comprehensive Methodology in Implementation of New Payment System

- CMS implemented the MMCS system despite known deficiencies in the system that resulted in erroneous payments. The inability of CMS to correct these errors during the year resulted in an accrued payable of $500 million in the September 30th financial statements. Inaccurate payments were made throughout the year due to the use of inaccurate information such as:
  - Improper risk factors were applied.
  - Erroneous demographic factors were applied.
  - Incorrect End Stage Renal Disease payment balances were used.
  - Inaccurate frailty risk factors for institutional beneficiaries were used.
- CMS failed to establish a systematic method for identifying, documenting, and correcting errors found in the MMCS system as demonstrated by the following:
  - CMS was unable to provide, in a timely manner, a listing of system changes and their payment impact.
  - CMS did not establish expectations related to beneficiary population or payment dollar impact prior to implementation of system changes to enable the agency to validate the reasonableness of the payment changes.
  - CMS was unable to categorize managed care plan or beneficiary level adjustments that occurred on a monthly basis related to system changes versus normal payment activity.
  - CMS did not establish a comprehensive testing methodology to review the monthly payments made to managed care organizations. CMS relied on the managed care organizations to inform them of issues and the ad hoc review of system reports by CMS personnel.
  - CMS was unable to quantify the total amount of erroneous payments and corrections made during the fiscal year.
  - CMS was unable to explain unusual anomalies in corrected payment adjustments to managed care plans. For example, for a particular group of managed care plans, an additional payment of $250 per Medicare beneficiary member was paid to correct an earlier underpayment. However, the additional $250 was processed for only approximately 87,000 beneficiaries from a total population of approximately 180,000 beneficiaries. CMS was not able to provide documentation to adequately explain the

logic error that caused this underpayment affecting only a portion of a homogeneous beneficiary population.

- CMS failed to establish a process to ensure that accounting as well as operational issues were addressed throughout the new payment system implementation process. Throughout the testing phase of the audit, we noted significant uncertainty regarding the coordination of responsibilities among Centers for Beneficiary Choices, Office of Information Systems, Office of Financial Management, and other functional and program personnel related to information systems and payments in the managed care benefits payment cycle.

Inadequate Oversight of Managed Care Contractors

- The Health Plan Monitoring System (HPMS) used by the central office to monitor the execution and status of managed care organization oversight contains inaccurate information. This system is the core of the CMS monitoring process for MAOs. Inaccurate information within HPMS weakens the monitoring of MAOs and may cause CMS to pay plans that are ineligible. The following inaccuracies were noted by other auditors:

  - The HPMS monitoring review module does not contain all of the managed care organizations receiving payment from CMS. Thirteen percent of the managed care organizations included in our sample selected for testing were not included in HPMS. Incomplete information in the system may result in missed reviews and the payment of ineligible plans.

  - The HPMS monitoring review module contains inaccurate "organization type" information which is the basis for the timing and extent of oversight to be performed at the MAO. Incorrect review timing or type of review may result in the payment of ineligible plans.

  - The HPMS monitoring review module was not updated in accordance with CMS policy for the results of audits conducted during the fiscal year. The lack of timely information for management to rely upon in making determinations related to an organization's ability to meet contractual requirements may result in ineligible plans receiving payment.

- As discussed last year, CMS was unable to provide sufficient documentation to support the on going monitoring of managed care organizations by the regional offices in accordance with CMS's policies and procedures. During the FY 2005 audit, we continued to identify inconsistencies in the documentation that was available for review. The documentation maintained by the regional offices to support the execution of monitoring reviews performed at managed care organizations is inconsistent and in some instances incomplete due to the lack of established documentation policies for regional office reviews.

- CMS lacks comprehensive policies and procedures for monitoring reviews related to demonstration projects. These are specialized healthcare programs/services established to address the needs of specific beneficiary populations.

Recommendations

Other auditors recommended that CMS continue to develop and refine its financial management systems and processes to improve its accounting, analysis, and oversight of Medicare managed care activity. Specifically, CMS should:

- Ensure that the information systems are updated on a timely basis to provide information allowing for adequate management oversight.

- Ensure that established policies address standard documentation and retention requirements for regional office monitoring reviews of the managed care organizations.

- Establish policies for regional office monitoring of demonstration projects that include tailored procedures to address the unique requirements or risks of each demonstration project.

- Perform extensive beneficiary data and payment information analysis to identify potential errors, unusual variances or inappropriate payment trends. This analysis should evaluate information such as: (1) demographic makeup of the plan's population as compared to the coverage area's population and (2) enrollment fluctuations as compared to other plans and enrollment in the overall Medicare managed care program.

- Due to the importance of the payment function in ensuring the validity and accuracy of payments to the managed care organizations and to maximize the detection of payment errors, we recommend that DEPO perform a timely reconciliation of authorized payments made by Treasury. CMS should also establish a log to document anomalies and errors that are identified and resolved as part of the authorization process in order to further support decisions made as part of the authorization process.

- With the implementation of the new system to replace MMCS for the payment of MAOs and to pay expenses related to the new prescription drug plan, CMS should establish a multi-functional process integrating personnel and systems in the managed care program, finance, and information system areas with clear lines of responsibility to ensure that issues are addressed in a timely manner

- CMS should enhance their testing and documentation methodology related to the implementation of MAO payment systems. This methodology should include:

  - Parallel processing documenting differences between systems. Parallel processing should be completed for more than one payment cycle.
  - Development of a statistically-valid sampling methodology for the purpose of payment validation at the beneficiary level.
  - Process to establish expected impact of system changes prior to implementation.
  - Process to maintain an audit trail that identifies system changes and their impact at a beneficiary level.
  - Process to perform reconciliations of beneficiary level data to plan payments including plan level adjustments.

- CMS has established strong controls for monitoring fee-for-service contractors in many areas listed in this material weakness and should consider implementing many of those requirements for the MAO program. In particular, implementing the data analysis methodologies employed by Medicare Contractors and Program Safeguard Contractors should provide CBC with a foundation for improving internal control within the managed care benefits payment cycle.

REPORTABLE CONDITIONS

Medicare Electronic Data Processing Access Controls and Application Software Development and Change Control (Modified Repeat Condition)

Overview

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

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

Other auditor's audit included general controls reviews at 13 sites: the CMS central office and 12 Medicare contractors. They also reviewed application controls at the CMS central office and at Medicare contractors for systems integral to Medicare financial information including the Fiscal Intermediary Shared System (FISS), the Viable Information Processing Systems' (VIPS) Medicare System (VMS), and the Multi-Carrier System (MCS). Their audit also relied on the work and findings of the Statement on Auditing Standards (SAS 70) examinations for the 12 Medicare contractors audited.

Further, other auditors conducted vulnerability reviews of network controls at all 13 sites audited. The vulnerability reviews included both external and internal penetration testing and network vulnerability assessments at all 13 sites, including reviews of security configurations of network servers.

Other auditors' audit noted improvements in the following areas during the FY 2005 audit:

- Entity wide Security Program (EWSP) - These programs provide the foundation for the security culture and awareness of the organization. A sound EWSP is the cornerstone to ensure effective security controls throughout the organization. Other auditors' audit noted improvements in the entity wide security programs reviewed during the FY 2005 audit when compared to the FY 2004 programs reviews. Other auditors noted improvements regarding assessment of risks, identification of controls to reduce risk, overall security policies and procedures, completeness of EWSP plans, and training of security personnel.

- Systems Software – Systems software is a set of computer programs designated to operate and control the processing activities for all applications processed on a specific computer, including network servers, mainframe systems, and personal computers. Controls over access to, and use of, such software are especially critical. Other auditors noted considerable improvement regarding mainframe security software and operating system settings when compared to the FY 2004 audit. Other auditors noted that mainframe security settings were generally in compliance with policies, monitoring controls for mainframe activities had been enhanced, and documentation over mainframe operating components, such as exits and supervisor calls, had been enhanced at most of the contractor sites audited. Other auditors also noted the creation and implementation of distributed platform security configuration templates and standards at practically all sites audited. Additionally, although some failure to comply with the templates and standards were noted at contractors, the number of settings and the severity of the weaknesses noted were, in general, reported by other auditors as being significantly reduced when compared to the FY 2004 audit.

- Service Continuity Planning and Testing – Service continuity relates to the readiness of a site in the case of a system outage or an event that disrupts normal processing of operations. Without approved, documented, and tested business and system continuity plans, there is no assurance that normal operations may be recovered efficiently and

timely. Other auditors reported that in FY 2005, they noted significant improvement in the continuity plans and testing of the plans when compared to the FY 2004 audit. The FY 2005 audit noted that plans existed for all contractors and CMS headquarter sites audited and that practically all of the plans had been tested and, in most cases, used to update the prior plan.

During FY 2005, other auditors noted that CMS made significant progress by continuing its reviews of contractors, including penetration tests and reviews of configuration settings on servers. Further, during FY 2005, CMS undertook a campaign to review, analyze, and thoroughly discuss the proposed corrective action plans of contractors and those of CMS headquarters. This process included extensive discussions both on-site at CMS headquarters, with contractor management in attendance, and remotely with contractor management. The result of the efforts and hours dedicated to this project are clearly evident in the improvement noted in the areas of EWSP, Systems Software and Service Continuity and, other auditors noted that this is the reason for the reduction in risk over IT weaknesses that have resulted in two reportable conditions versus the previously noted material weakness at CMS.

Other auditors reported that during FY 2005, to address the weaknesses noted regarding the control of front end system edits for FISS, MCS and VMS, CMS management issued a new change request (CR) 3862 which provides guidance on the control of edits for the FISS, MCS, and VMS systems. Further, CMS launched a project to determine contractor readiness regarding compliance with CR 3862. Initial results of the testing clearly indicate improved policies and procedures for the control of front end edits for these three systems and enhancements within all three systems which allow automated logging and tracking of edit changes for review, analysis and follow-up.

During FY 2004, CMS launched a program to evaluate the security levels of all contractors regarding their compliance with the Federal Information Security Management Act (FISMA) under the requirements of the Medical Modernization Act for Medicare. This evaluation program includes all eight key areas of FISMA: periodic risk assessments, policies and procedures to reduce risk, systems security plans, security awareness training, periodic testing and evaluation of the effectiveness of IT security policies and procedures, remedial activities, processes and reporting for deficiencies, incident detection, reporting and response, and continuity of operations for IT systems. This program was continued for FY 2005 and other auditors noted that they believe that the evaluations obtained as a result of this effort have served and continue to serve CMS in better understanding the current state of security operations at all Medicare contractors, not just those contractors testing during the financial statement audit or for which a SAS 70 was conducted.

In addition to the steps noted above, to address the reportable conditions noted, other auditors reported that CMS continues its programs to review the contractors through SAS 70 audits, an extensive contractor self-assessment program, and reporting process and greater central oversight by contractor management. Additionally, CMS continues to request and receive system security

plans and risk assessments from its contractors and has a certification and accreditation program initiative featuring system vulnerability assessments for all contractors.

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

Inadequate Logical Access Controls

Access controls ensure that critical system assets are physically protected from unauthorized access and that logical controls provide assurance that only authorized personnel may access data and programs maintained on systems. Other auditors noted numerous findings regarding logical access during their controls testing. Other auditors noted that numerous security weaknesses existed that would allow internal users to access and update sensitive systems, programs, and data without proper authorization. Other auditors' review did not disclose any exploitation of critical systems tested; however, clear potential existed.

Other auditors consistently noted employees who did not require direct access to data and application software programs to perform their job responsibilities but who nevertheless had been granted inappropriate update access to Medicare data and application software programs. Other auditors also noted that many contractors and, in one instance, CMS central office had not performed procedures to recertify access granted to employees on an annual basis as required by CMS standards.

As a result, they noted inconsistencies regarding access assignments, removal of access for terminated or transferred employees and the enforcement of policies and procedures regarding the administration of access approval and maintenance at the contractor sites.

Inadequate Application Security, Development, and Program Change Control

Application security, development, and program change controls provide assurance that programs are developed with standards that ensure their effectiveness, efficiency, accuracy, security, and maintenance and that only authorized and properly tested programs are implemented for production use. Other auditors noted again that contractor processing sites have the ability to turn on and off front end edits in the FISS, MCS and VMS systems without consistent procedures to ensure that edits are only turned off when required, that changes to edits are properly approved prior to the change and that a complete analysis of the effect of the change to an edit and has been conducted and used to assess the overall effect on Medicare processing.

Changes to edits represent a very important area of concern because the ability to negate system edits degrades the ability to ensure that only proper data is introduced into these systems and ultimately, the Common Working File (CWF) and the National Claims History (NCH) System and other databases used to analyze claims and make decisions.

Other auditors also noted again, although at fewer contractor sites, that application changes are being implemented without documented testing and approval and that application change control procedures were not followed at several contractor sites.

Finally, other auditors noted once again that there were numerous contractor sites at which application programmers had the ability to directly update production source code for applications, thereby allowing them to bypass application change controls.

Recommendations

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

- Target contractor access control policies and procedures to ensure their sufficiency and enforcement, including recertification of access annually and assurance of proper segregation of duties for application and systems programmers.
- Provide more specific guidance to the contractors regarding procedures to formally assess and reduce risk on an ongoing basis by specifically identifying and matching controls to mitigate risks noted in their systems security plans and by specifically requiring ongoing and consistent tests of mitigating controls to ensure their continued effectiveness.
- Continue the process to assess the enforcement of CR 3862, especially with regard to the approval of changes to shared system coded edits and the use of the newly developed audit trails in the FISS, MCS and VMS systems to analyze the effect of edit modifications on Medicare claims processing and approval. The analysis of edit modifications from the system audit trails should be used to match the results to error trends resulting from contractor claims processed during periods when edits are turned off and include specific matching of error types to contractors from which the errors emanated.
- Continue and enhance processes to continuously monitor and track compliance with the security configuration models for all platforms maintained within, the CMS contractor sites, the maintainer sites, and the CMS central office. CMS should greatly encourage the use of automated tools to monitor, detect, and report to the CMS Information Security Office, all noncompliance with contractor, maintainer or CMS headquarter platform security configuration standards for distributed servers, including WINDOWS, UNIX, router, switches, Web server, and Oracle database servers on a quarterly basis.

Departmental Information Systems Controls (Repeat Condition)

Many of the business processes that generate information for the financial statements are supported by information systems. Adequate internal controls over these systems are essential to the integrity, confidentiality, and reliability of critical data while reducing the risk of errors, fraud, and other illegal acts. As part of our assessment of internal controls, we have conducted general control reviews for systems that are relevant to the financial reporting process. General controls involve the 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 impact the integrity of all applications operating within a single data processing facility and are critical to ensure the reliability, confidentiality, and availability of financial information.

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

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

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

Entity-wide security programs: These programs are intended to ensure that security threats are identified, risks are assessed, control objectives are appropriately designed and formulated, relevant control techniques are developed and implemented, and managerial oversight is consistently applied to ensure the overall effectiveness of security measures. Security programs typically include formal policies on how and which sensitive duties should be separated to avoid conflicts of interest. Similarly, policies on background checks during the hiring process are usually stipulated. Entity-wide security programs afford management the opportunity to provide appropriate direction and oversight of the design, development, and operation of critical systems controls. Inadequacies in these programs can result in inadequate access controls and software change controls affecting mission-critical, systems-based operations. Our procedures identified the following issues:

- Security Plans: Security plans for some of the systems have not been updated, finalized, approved, and communicated.

- Certification & Accreditation: Required certification and accreditation statements for some of the major financial applications and general support systems have expired or have not been reviewed or updated recently.

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

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

Access controls (physical and logical): Access controls ensure that critical systems assets are physically safeguarded and that logical access to sensitive application, system utilities, and data is granted only when authorized and appropriate. Access controls over operating systems, network components, and communications software are also closely related. These controls help to ensure that only authorized users and computer processes can access sensitive data in an appropriate manner. Weaknesses in such controls can compromise the integrity of sensitive program data and increase the risk that such data may be inappropriately used and/or disclosed. Our procedures identified the following issues:

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

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

- Password Controls: The password controls applied to some of the systems do not provide an adequate level of authentication controls.

Systems software: Systems software is a set of computer programs designed to operate and control the processing activities for a variety of applications on computer hardware and related equipment. The systems software helps coordinate the input, processing, output, and data storage associated with all of the applications that are processed on a specific system. Some systems software is designed to change data and programs without leaving an audit trail. Overall, problems in managing routine changes to systems software to ensure an appropriate implementation and related configuration controls were identified. Our procedures identified the following issues:

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

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

Application software development and change controls: A well defined and effectively controlled development and change management process should be in place to ensure that only authorized, tested, approved, and documented new programs or changes to existing programs are applied to the production environment. Additionally, the process facilitates that new or changed programs meet the requirements with regards to security and controls; such as providing for programmed integrity controls, audit trails, logging capabilities, etc. Our procedures identified the following issues:

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

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

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

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

Additionally, we noted the following weaknesses within the Division of Financial Operations, the Centers for Information Technology, and Human Resource SAS 70s.

- The Independent Service Auditors' Report for the Human Resource Service Personnel and Payroll Systems' General Information Technology and Application Controls identified certain controls related to the application software development and change controls for the Commissioned Corp Personnel/Payroll System (COPPS) that were not operating effectively.

- The Independent Service Auditors' Report for the Division of Financial Operations related to the general information technology and application control environment over the CORE Accounting Systems and feeder systems identified certain controls related to the application software development and change controls, computer resources' protection against unauthorized modification, disclosure, loss, or impairment and changes to existing systems software and implementation of new system software that were not operating effectively.

- The Independent Service Auditors' Report for the Center for Information Technology related to its general information technology and application control environment identified certain controls related to changes to hardware and operating systems software in the Windows and Mainframe environment that were not operating effectively.

Recommendations

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

- Maintenance of updated security plans to provide security and controls commensurate with the risk associated with any given system.
- Completion of certification and accreditation activities, including the corresponding risk assessments, to limit the residual risk to an acceptable level.
- Training of all employees and contractors on security awareness and responsibilities to effectively communicate security policies and expectations.
- Strengthening of incident response capabilities through formalized policies and procedures and relevant tools and technologies to increase the likelihood that security relevant events are detected, isolated, and properly treated.
- Maintenance of access approval records to provide for accountability.
- Revalidation of access rights on a periodic basis to limit systems access on a need-to-have basis.
- Strengthening technical password controls to provide an effective mechanism for user authentication.
- Optimizing technical system settings to strengthen security and integrity controls of databases and operating systems.
- Development of an effective patch management process for all critical systems to reduce systems vulnerabilities to a minimum.
- Maintaining effective program change controls processes for all applications to limit the risk of unauthorized changes to the production systems.

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

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

- Enhance policies and procedures to ensure that (1) system administrators perform periodic reviews of access authorizations for all applications and (2) a process exists for communicating terminated employees to the administrators and for the timely removal of those employees.

OTHER MATTERS

Integration of Performance Reporting With Financial Reporting

As reported in FY 2004, the HHS manages more than 300 programs under its 12 operating divisions and uses more than 650 performance measures to direct program activities and assess progress and achievement. Due to the complexity and volume of the measures, HHS faces significant challenges in meeting the consolidated performance reporting requirements of the Government Performance and Results Act of 1993 and OMB Circular A-11, *Preparation, Submission, and Execution of the Budget.* In FY 2005, OMB provided the following specific guidance to HHS on how to best meet the consolidated performance reporting requirements:

- "HHS will present measures that represent the Department's key priorities in both the Management Discussion and Analysis and the Annual Performance Report sections of the Performance and Accountability Report with reference to individual Operating Division performance budgets submitted to Congress in February;

- Consistent with the Government Performance and Results Act also know as GPRA (P.L. 103-62), OMB Circular A-11, and past HHS practice, the FY 2007 OPDIV performance budgets submitted to Congress in February 2006 will address all performance measures included in the FY 2005 performance plans/budgets; and

- The Secretary will certify the reliability and completeness of the data in the PAR in November as well as for the Congressional submission in February."

Working with OMB, the HHS has taken steps toward integrating performance reporting requirements in its FY 2005 Annual Performance Plan. However, additional efforts are needed to reassess the consistency and data availability of the indicators reported as significant. For example:

- HHS spotlighted 31 measures as significant in the Management Discussion and Analysis as compared to eight measures from the prior year.

- During our review, we noted that one that indicator agreed to by OMB as significant was not included in the MD&A or section II of the Performance and Accountability Report.

- We noted four indicators that were not included in the FY 2006 HHS Annual Plan.

- Fifteen indicators reported did not have actual performance results for FY 2005, and eight indicators identified as significant had no actual results for FY 2004. Management indicated that this was due to natural data lags for the collection and verification of data.

Additionally, although there appears to be a robust review process of the performance information for the budget process, we noted certain deficiencies in the review process of the performance information reported in the Performance and Accountability Report, including inconsistencies within the Management Discussion and Analysis and Section II, inadequate or lack of supporting documentation and lack of linkage between the Management Discussion and Analysis and the HHS Statement of Net Cost. Currently, although the HHS develops the performance information included in the Management Discussion and Analysis, the HHS does not receive nor does it review the documentation supporting the data reported. The supporting documentation was maintained at the Operating Division level. In FY 2005, the Secretary limited his assertion of the reliability and completeness of the performance data in performance information in the PAR by stating "except as noted in the OPDIV performance plans." As previously noted, the Operating Divisions' plans will not be submitted until February 2006; therefore we cannot assess the magnitude of this limitation.

As recommended in FY 2004, HHS should continue to work with OMB on consolidated performance reporting requirements and should ensure that for future Performance and Accountability Report reporting HHS identifies a process for producing the most appropriate measures; that are reflective of HHS's strategic goals and initiatives. In addition, HHS should implement corrective action to assist in addressing the limitations regarding the reliability and completeness of the performance data.

Intragovernmental Transactions

Under OMB Circular A-136, *Financial Reporting Requirements*, government entities are required to reconcile intragovernmental transactions with their trading partners. Some operating divisions were not able to timely and accurately eliminate trading partner information.

Beginning in FY 1996, CMS's accrued expenses for Medicaid benefits incurred but not reported. As of September 30, 2005, these accrued expenses exceeded the available unexpended Medicaid appropriations by $8.9 billion. CMS's Office of General Counsel determined that the indefinite authority provision of the Medicaid appropriations allowed the entire accrued expense to be reported as a funded liability. While Department of the Treasury officials agreed that there was a legal basis for recording the accrued benefit liability, they did not agree to recognize the accounting entry on their records.

A somewhat similar problem occurred in the Supplementary Medical Insurance Program, where section 1844 of the Social Security Act authorizes funds to be appropriated to match Medicare beneficiary premiums. The appropriated amount is an estimate calculated annually by CMS. This year's funding estimate was insufficient to match beneficiaries' premiums by $5.1 billion. HHS discussed these issues with OMB officials, who agreed that the long-standing accounting for these issues should continue for FY 2004 and 2005. Until such time when these matters are resolved, differences between records of the operating divisions and the Department of the Treasury will remain.

Finally, HHS is not performing adequate analysis or confirmation procedures with its trading partners to identify differences in its intragovernmental balances. Based on our review of the 3rd and 4th Quarter Material Differences / Status of Disposition Certification Report from the Financial Management Service's (FMS) IRAS for intra governmental data submitted by HHS, the absolute value of differences between HHS and its trading partners totaled approximately $29.3 billion and $1.6 billion, respectively. These differences were identified primarily as reporting errors and differences in accounting treatment by the two agencies.

Improper Payment Information Act of 2002 (IPIA)

The IPIA requires agencies to review annually all programs and activities they administer and identify those which may be susceptible to significant erroneous payments. HHS has informed us that it coordinated its implementation of the IPIA (IPIA) with the OMB throughout FY 2005 to ensure that their improper payment estimating strategies are substantially consistent with the intent of OMB regulations implementing the IPIA. While an improper payment rate estimate has been prepared for the largest HHS program, Medicare, methodologies for estimating improper payments for several other HHS programs are under development, and therefore were not reported in the FY 2005 Performance and Accountability Report. For example, although both Medicaid and SCHIP have been identified as programs which are susceptible to improper payments, CMS has not completed its implementation of a process to estimate improper payments. CMS is not expected to report a national estimate for Medicaid or SCHIP until FY 2007.

STATUS OF PRIOR YEAR FINDINGS

Summary of FY 2004 Material Weaknesses and Reportable Conditions

Issue Area	Summary Control Issue	FY 2005 Status
Material Weaknesses:		
Financial Systems and Processes	Documentation regarding significant accounting events, recording of non-routine transactions and post-closing adjustments, as well as correction and other adjustments made in connection with data conversion issues must be strengthened. Processes to prepare financial statements need improvement. Financial systems are not FFMIA-compliant. Weaknesses were identified in Department/Operating Division Periodic Analysis, Oversight and Reconciliations	Modified Repeat Condition
Medicare Information Systems Control	Strengthened controls over Medicare electronic data processing are needed.	Progress identified by other auditors. downgraded to reportable condition
Reportable Conditions:		
Departmental Information Systems Control	General and application control environments in the departmental operating divisions need strengthening.	Repeat condition
Internal Control Over Payroll	Documentation was incomplete and not readily available to support calculations of employee pay and deductions. Untimely interaction of payroll systems with core financial systems. Inadequate internal control to ensure human resources and payroll systems are secured and operating effectively, as intended. Training is needed to ensure appropriate knowledge of HHS policies.	In FY 2005, we noted that although certain issues surrounding the payroll and personnel issues still exist, sufficient progress has been made to reduce the weakness for reporting in the management letter; certain areas related to payroll have been included elsewhere within this report.

Issue Area	Summary Control Issue	FY 2005 Status
Omissions and Delays in Obtaining Documentation Impacts the Audit Process	Certain documentation was unable to be provided or not readily available to support financial statement transactions.	Combined into Financial Systems and Process Material Weakness
Other Matters		
Integration of Performance Reporting with Financial Reporting	HHS should identify a process for producing the most appropriate measures; that are reflective of HHS's strategic goals and initiatives	Repeat Condition
Intragovernmental Transactions	Operating divisions were not able to timely and accurately eliminate trading partner information.	Repeat Condition

* * * * *

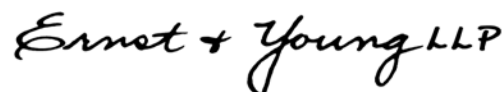
It is our understanding that management agrees with the facts as presented.

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

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

We noted other matters involving internal control over financial reporting, which we have reported to management in a separate letter dated November 11, 2005.

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



November 11, 2005
Washington, DC

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Report on Compliance with Laws and Regulations

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

We have audited the financial statements of the Department of Health and Human Services (HHS) as of and for the year ended September 30, 2005, and have issued our report dated November 11, 2005. We have conducted our audit in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin No. 01-02, *Audit Requirements for Federal Financial Statements*. With the exception of the Health Programs (principally Medicaid) included therein, we did not audit the financial statements of the Centers for Medicare & Medicaid Services (CMS) as of and for the year ended September 30, 2005. Those statements and the financial information which is included in the HHS's financial statements were audited by other auditors whose report thereon has been furnished to us, and the comments reflected herein, insofar as they relate to the information included for the CMS, excluding the Health Programs, are based solely on the report of other auditors.

The management of the HHS is responsible for complying with laws and regulations applicable to the HHS. As part of obtaining reasonable assurance about whether the HHS's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts and certain other laws and regulations specified in OMB Bulletin No. 01-02, including the requirements referred to in the Federal Financial Management Improvement Act of 1996 (FFMIA). We limited our tests of compliance to these provisions, and we did not test compliance with all laws and regulations applicable to the HHS.

The results of our tests disclosed an instance of noncompliance with the laws and regulations discussed in the preceding paragraph exclusive of FFMIA that is required to be reported under *Government Auditing Standards* or OMB Bulletin No. 01-02. HHS has coordinated its implementation of the Improper Payment Information Act of 2002 (IPIA) with the OMB, and management has informed us that the progress made in fiscal year (FY) 2005 and the plans put in place to develop estimates of improper payments and mitigate their causes are substantially consistent with the intent of OMB regulations implementing the IPIA. While an improper payment rate estimate has been prepared for the largest HHS program, Medicare, nationwide estimates of Health Programs improper payments and rates for several other significant HHS programs are under development. Accordingly, HHS has potentially not fully complied with the IPIA requirements.

We were unable to fully test consolidated performance reporting requirements of the Government Performance and Results Act (GPRA) (Public Law 103-62), OMB Circular A-11, and OMB Circular A-136, *Financial Reporting Requirement*. In a letter dated August 10, 2005, OMB said that for FY 2005 performance reporting, HHS should present a key set of measures that HHS management has identified as representing HHS's key priorities for FY 2005 in the Management Discussion and Analysis with reference to individual operating division plans. Because the issuance of the operating divisions' plans will be subsequent to the completion of our fieldwork, we were unable to fully assess compliance with the GPRA, OMB Circular A-11, and OMB Circular A-136 as they relate to consolidated performance reporting requirements.

Under FFMIA, we are required to report whether HHS's financial management systems substantially comply with Federal financial management systems requirements, applicable Federal accounting standards, and the United States Standard General Ledger (USSGL) 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 in which the HHS's financial management systems did not substantially comply with certain requirements discussed in the preceding paragraph. We have identified the following instances of noncompliance.

- The financial management systems and processes used by HHS and the operating divisions made it difficult to prepare reliable and timely financial statements. The processes required the use of extensive, time-consuming manual spreadsheets and adjustments in order to report reliable financial information.
  - The 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 former Joint Financial Management Improvement Program.
  - At most operating divisions, suitable systems were not in place to adequately support sufficient reconciliations and analyses of significant fluctuations in account balances. In addition, some systems were not designed to apply the USSGL at the transaction level.
- General and application controls over CMS's financial management systems, as well as systems of certain other operating divisions, were departures from requirements specified in OMB Circular No. A-127, Financial Management Systems, and OMB Circular No. A-130, Management of Federal Information Resources.
- The Independent Service Auditors' Report for the Human Resource Service Personnel and Payroll Systems' General Information Technology and Application Controls identified certain controls related to the application software development, and change

controls for the Commissioned Corp Personnel/Payroll System that were not operating effectively.

- The Independent Service Auditors' Report for the Division of Financial Operations related to the general information technology and application control environment over the CORE Accounting Systems and feeder systems identified certain controls related to the application software development and change controls, computer resources' protection against unauthorized modification, disclosure, loss, or impairment, and changes to existing systems software and implementation of new system software that were not operating effectively.

- The Independent Service Auditors' Report for the Center for Information Technology related to its general information technology and application control environment identified certain controls related to changes to hardware and operating systems software in the Windows and Mainframe environment that were not operating effectively.

* * * * *

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

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

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

Ernst + Young LLP

November 11, 2005
Washington, D.C.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

11/11/2005

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

Dear Mr. Levinson:

This letter responds to the opinion submitted by the Office of Inspector General on the Department of Health and Human Services' fiscal year 2005 audited financial statements. We concur with your findings and recommendations.

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

We also acknowledge that we continue to have material 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). UFMS was successfully implemented at CDC and FDA in April 2005 and the financial statement data was successfully extracted for the preparation of the financial statements. In accordance with the implementation plan, HHS will fully implement the UFMS Departmentwide by fiscal year 2007 and will comply with the requirements of the Federal Financial Management Improvement Act.

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

Sincerely,

Charles E. Johnson
Assistant Secretary for Budget,
Technology and Finance

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