Independent Auditor's Report

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

NOV 15 2006

TO: The Secretary
Through: DS _____
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FROM: Inspector General

SUBJECT: Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2006 (A-17-06-00001)

This memorandum transmits the independent auditors' reports on the Department of Health and Human Services (HHS) fiscal year (FY) 2006 financial statements, conclusions about the effectiveness of 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 PricewaterhouseCoopers, LLP (PwC), to audit the HHS consolidated balance sheet as of September 30, 2006, and the related consolidated statements of net cost, changes in net position and financing, the combined statement of budgetary resources for the year then ended, and the statement of social insurance as of January 1, 2006. The contract required that the audit 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 06-03, Audit Requirements for Federal Financial Statements.

The financial statements of HHS as of September 30, 2005, and for the year then ended were audited by the CPA firm of Ernst & Young, LLP, whose report dated November 11, 2005, expressed an unqualified opinion on those statements.

Results of Independent Audit

Based on its audit, PwC found that the FY 2006 HHS financial statements were fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America. However, PwC noted two matters involving internal controls over financial reporting that were considered to be material weaknesses under standards established by the American Institute of Certified Public Accountants:

- *Financial Management Systems and Reporting.* As in prior years, HHS continued to have serious internal control weaknesses in its financial management systems and processes for producing timely and reliable financial statements. Substantial manual procedures, significant adjustments to balances, and numerous accounting entries recorded outside HHS's general ledger system were necessary.

- *Departmental Information Systems Controls.* For several systems, PwC reported numerous issues in the areas of access to data and controls over changes to edits. In addition, weaknesses continued in the Entitywide Security Program and Service Continuity Planning and Testing, and some slippage occurred in systems software controls since the FY 2005 audit.

PwC also noted instances in which HHS's financial management systems did not substantially comply with Federal financial management systems requirements and the U.S. Government Standard General Ledger at the transaction level.

Evaluation and Monitoring of Audit Performance

In accordance with the requirements of OMB Bulletin 06-03, we reviewed PwC's 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 audit;

- attending key meetings with auditors and HHS officials;

- monitoring the progress of the audit;

- 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.

PwC is responsible for the attached reports dated November 14, 2006, 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 PwC 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-17-06-00001.

Daniel R. Levinson

Attachment

cc:
Charles E. Johnson
Assistant Secretary for Resources and Technology

Sheila Conley
Deputy Assistant Secretary, Finance

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Report of Independent Auditors

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

We have audited the accompanying consolidated balance sheet of the Department of Health and Human Services (HHS) and its components as of September 30, 2006, and the related consolidated statements of net cost, changes in net position and financing, the combined statement of budgetary resources for the year then ended, and the statement of social insurance as of January 1, 2006. These financial statements are the responsibility of HHS's management. Our responsibility is to express an opinion on these financial statements based on our audit.

The financial statements of HHS as of and for the year ended September 30, 2005 were audited by other auditors whose report thereon dated November 11, 2005 expressed an unqualified opinion on those statements.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America; 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. 06-03, *Audit Requirements for Federal Financial Statements*. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, based on our audit, the consolidated and combined financial statements referred to above and the statement of social insurance, present fairly, in all material respects, the financial position of HHS and its components as of September 30, 2006, and their net cost of operations, changes in net position, budgetary resources and reconciliation of net cost to budgetary obligations for the year then ended, and the financial condition of its social insurance program as of January 1, 2006, in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 1 to the financial statements, the Office of Management and Budget has exempted HHS from certain requirements of OMB Circular No. A-11, *Preparation, Submission and Execution of the Budget*. Specifically, for the Medicare program, HHS is exempted from reporting recoveries of prior year obligations on the statement of budgetary resources.

As discussed in Note 1 to the financial statements, HHS adopted Statement of Federal Financial Accounting Standard (SFFAS) No. 27, *Earmarked Funds*, beginning October 1, 2005. This standard does not permit the restatement of prior periods.

As discussed in Note 31 to the financial statements, HHS adopted SFFAS No. 25, *Reclassification of Stewardship Responsibilities and Eliminating the Current Services Assessment*, requiring that the statement of social insurance (SOSI) be presented as basic financial statements beginning in fiscal year 2006. The SOSI presents the projected 75-year actuarial present value of the income and expenditures of HHS's Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds, designed to illustrate the long-term sustainability of this social insurance program. In preparing the SOSI, management considers and selects assumptions and data that it believes provides a reasonable basis for the assertions in the statement. However, because of the large number of factors that affect the SOSI and the fact that such assumptions are inherently subject to substantial uncertainty, arising from the likelihood of future changes in general economic, regulatory, and market conditions, as well as other more specific future events, significant uncertainties and contingencies, many that cannot be reliably anticipated and most of which are beyond HHS's control particularly over more distant timeframes such as the 75-year projection period used for the SOSI, actual future expenditures are likely to differ significantly from the projections, and those differences may be material and could affect the long-term sustainability of this social insurance program. In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, the SMI Part D projections have an added uncertainty in that they were prepared using very little program experience upon which to base the estimates.

As discussed in Note 32 to the financial statements, the projected SMI Part B expenditure growth reflected in the accompanying SOSI is likely understated due to the structure of physician payment updates, which under current law would result in multiple years of significant reductions in physician payments, totaling an estimated 37 percent over the next nine years. Since these reductions are required in the future under the current-law payment system, they are reflected in the accompanying SOSI as required under generally accepted accounting principles. However, in practice it is not possible to anticipate what actions Congress might take, either in the near or long term, to alter the physician payment updates. For example, Congress has overridden scheduled reductions in physician payments for each of the last four years. The potential magnitude of the understatement of Part B expenditures, due to the physician payment updates can differ materially from the amount presented in the SOSI. In Note 32, management has illustrated the potential effects using two hypothetical examples of changes to current law. Under current law and as presented in the SOSI, the projected 75-

year present value of future Part B expenditures is $17.6 trillion. In management's hypothetical examples, if Congress were to set future physician payment updates at zero percent per year, then, absent other provisions to offset these costs, the projected present value would increase to $22.3 trillion. Alternatively, if Congress were to set future physician payment updates equal to the Medicare Economic Index (projected to be 2 to 2.5 percent per year), the present value would be $24.4 trillion. Management's hypothetical examples have not been audited, and accordingly, we express no opinion on them.

The Management's Discussion and Analysis (MD&A), Required Supplementary Information (RSI) and Required Supplementary Stewardship Information (RSSI) are not a required part of the financial statements but are supplementary information required by the Federal Accounting Standards Advisory Board and OMB Circular A-136, *Financial Reporting Requirements.* We have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the MD&A, RSI and RSSI. However, we did not audit the information and express no opinion on it.

Our audit was conducted for the purpose of forming an opinion on the consolidated and combined financial statements of HHS and its components taken as a whole. The additional information presented on the statement of social insurance is not a required part of the statement and is presented for purposes of additional analysis. Such information has been subjected to the auditing procedures applied in the audit of the consolidated and combined financial statements and, in our opinion, is fairly stated in all material respects in relation to the consolidated and combined financial statements taken as a whole.

The other accompanying information is presented for purposes of additional analysis and is not a required part of the financial statements. Such information has not been subjected to the auditing procedures applied in the audit of the consolidated and combined financial statements and, accordingly, we express no opinion on it.

In accordance with *Government Auditing Standards,* we have also issued reports dated November 15, 2006 on our consideration of HHS's internal control and on its compliance 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 read in conjunction with this report in considering the results of our audits.

PricewaterhouseCoopers LLP

November 15, 2006

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Report of Independent Auditors on Compliance and Other Matters

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

We have audited the accompanying consolidated balance sheet of the Department of Health and Human Services (HHS) and its components as of September 30, 2006 and the related consolidated statements of net cost, changes in net position and financing, the combined statement of budgetary resources for the year then ended, and the statement of social insurance as of January 1, 2006, and have issued a report thereon dated November 15, 2006. We conducted our audit in accordance with auditing standards generally accepted in the United States of America; 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. 06-03, *Audit Requirements for Federal Financial Statements.*

The management of HHS is responsible for compliance with laws and regulations. As part of obtaining reasonable assurance about whether the financial statements are free of material misstatement, we performed tests of the compliance with certain provisions of laws and regulations, non-compliance 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. 06-03, including the requirements referred to in the Federal Financial Management Improvement Act of 1996 (FFMIA). Under FFMIA, we are required to report whether the HHS financial management systems substantially comply with the Federal financial management systems requirements, applicable Federal accounting standards, and the United States Government Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA section 803(a) requirements. We limited our tests of compliance to these provisions and we did not test compliance with all laws and regulations applicable to HHS. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion.

The results of our tests of HHS's compliance with laws and regulations, described in the preceding paragraph, exclusive of FFMIA or other matters that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 06- 03, resulted in one instance of non-compliance as described below.

HHS has begun to implement the requirements of the Improper Payments Information Act of 2002 (IPIA). Although HHS has not complied with IPIA, HHS currently measures payment accuracy rates for several of its high-risk programs and has plans in place to measure payment accuracy rates for the remaining high-risk programs.

In the accompanying Performance and Accountability report, HHS has reported the discovery of internal control weaknesses in a program managed by one of its component entities, which resulted in probable violations of the Anti-Deficiency Act (ADA). HHS reported that these weaknesses occurred over a period of several prior fiscal years and any amounts which could be involved would not be material to any year's financial statements and that management is investigating these weaknesses and is committed to promptly resolving the internal control weaknesses in this program, and complying with all aspects of the ADA.

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 30, 2006, OMB said that for FY 2006 performance reporting, HHS should present a key set of measures that HHS management has identified as representing HHS's key priorities for FY 2006 in the Management Discussion and Analysis (MD&A) 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 GPRA, OMB Circular A-11, and OMB Circular A-136 as they relate to consolidated performance reporting requirements. In addition, HHS has not met all of the reporting requirements related to these measures as required by OMB Circular A-136 in their presentation in the MD&A.

Under FFMIA, we are required to report whether HHS's financial management systems substantially comply with the Federal financial management systems requirements, applicable Federal accounting standards, and the United States Government Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA section 803(a) requirements. The results of our tests disclosed instances, noted below, where HHS's financial management systems did not substantially comply with Federal financial management systems requirements and the U.S. Government Standard General Ledger at the transaction level.

In our report on internal control dated November 15, 2006, we reported two material weaknesses related to Financial Management Systems and Reporting and Information Systems Controls and reportable conditions related to the Managed Care Benefit Payment Cycles (Part C and D) and Program Analysis and Oversight. We believe that these matters, taken together, represent substantial non-compliance with the Federal financial management system requirements under FFMIA. Further details surrounding these findings, together with our recommendations for corrective action, have been reported separately to HHS in our report on internal control dated November 15, 2006.

PRICEWATERHOUSECOOPERS

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

PricewaterhouseCoopers LLP

November 15, 2006

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Report of Independent Auditors on Internal Control

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

We have audited the accompanying consolidated balance sheet of the Department of Health of and Human Services and its components (HHS) as of September 30, 2006 and the related consolidated statements of net cost, changes in net position and financing, the combined statement of budgetary resources for the year then ended, and the statement of social insurance as of January 1, 2006, and have issued a report thereon dated November 15, 2006. We conducted our audit in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and the Office of Management and Budget (OMB) Bulletin No. 06-03, *Audit Requirements for Federal Financial Statements.*

In planning and performing our audit, we considered HHS's internal control over financial reporting by obtaining an understanding of HHS's internal control, determined whether internal controls had been placed in operation, assessed control risk, and performed tests of controls in order to determine our auditing procedures for the purpose of expressing our opinion on the consolidated and combined financial statements and not to provide an opinion on the internal controls. We limited our control testing to those controls necessary to achieve the following OMB control objectives that provide reasonable, but not absolute assurance, that: (1) transactions are properly recorded, processed, and summarized to permit the preparation of the consolidated and combined financial statements and Required Supplementary Stewardship Information (RSSI) in accordance with accounting principles generally accepted in the United States of America, and to safeguard assets against loss from unauthorized acquisition, use, or disposition; (2) transactions are executed in accordance with laws governing the use of budget authority and any other laws, regulations, and government-wide policies identified in Appendix E of OMB Bulletin No. 06-03 that could have a direct and material effect on the consolidated and combined financial statements or RSSI ; and (3) transactions and other data that support reported performance measures are properly recorded, processed, and summarized to permit the preparation of performance information in accordance with criteria stated by management. We did not test all internal controls relevant to the operating objectives broadly defined by the Federal Managers' Financial Integrity Act of 1982. Our purpose was not to provide an opinion on HHS's internal control. Accordingly, we do not express an opinion on internal control.

Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control over financial reporting that might be material weaknesses. Under standards issued by the American Institute of Certified Public Accountants (AICPA) and OMB, reportable conditions are matters coming to our attention, that in our judgment, should be communicated because they represent significant deficiencies in the design or operation of the internal control that could adversely affect the HHS's ability to meet the internal control objectives related to the reliability of financial reporting, compliance with laws and regulations, and the reliability of performance reporting previously noted. Material weaknesses are reportable conditions in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that errors, fraud or noncompliance in amounts that would be material in relation to the consolidated and combined financial statements being audited, or material to a performance measure or aggregation of related performance measures, may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. We noted five matters, discussed below, involving the internal control and its operation that we consider to be reportable conditions (of which two are considered material weaknesses).

Material Weakness I

Financial Management Systems and Reporting (Repeat Condition)

Overview

OMB Circular A-127 requires that financial statements be the culmination of a systematic accounting process. The statements are to result from an accounting system that is an integral part of a total financial management system containing sufficient structure, effective internal control, and reliable data. HHS relies on a decentralized processes and complex systems to accumulate data for financial reporting. An integrated financial system, 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.

Within HHS, the Centers for Medicare and Medicaid Services (CMS) and the National Institutes of Health (NIH) have stand alone financial management and accounting systems, Financial Accounting and Control Systems (FACS) and NIH Business System (NBS), respectively. The Centers for Disease Control and Prevention (CDC), Agency for Toxic Substances and Disease Registry (ATSDR), and the Food and Drug Administration (FDA) have implemented the Unified Financial Management System (UFMS) eliminating their separate financial management systems. The remaining eight components utilize the Program Support Center’s (PSC) Division of Financial Operations (DFO) CORE accounting system.

Financial Management System Control Weaknesses

HHS's financial management systems are not compliant with the Federal Financial Management Improvement Act of 1996 (FFMIA). FFMIA requires agencies to implement and maintain financial management systems that comply with Federal financial management systems requirements as defined by the Joint Financial Management Improvement Program (JFMIP). More specifically, FFMIA requires Federal agencies to have an integrated financial management system that provides effective and efficient interrelationships between software, hardware, personnel, procedures, controls, and data contained within the systems, compliance with the United States Standard General Ledger (USSGL) at the transaction level and applicable Federal accounting standards.

The lack of an integrated financial management system, non-compliance with the USSGL at the transaction level and weaknesses in internal controls impair HHS's ability to efficiently and effectively support and analyze accounts, as well as, prepare timely and reliable financial statements. 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 the existing systems:

- In the NBS system, which supports net outlays of more than $27 billion, more than 900 nonstandard accounting entries with an approximate value of $1.4 billion to adjust budgetary and proprietary accounts were recorded for financial reporting purposes. Additionally, the NBS does not provide for tracking manual or non-routine entries. As a result, adjustments and corrections cannot be readily identified. 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.

- The CORE accounting system, which supports net outlays of more than $93 billion, is a legacy accounting system and does not support all functionality required by USSGL and JFMIP standards. Accordingly, it does not capture all transactions properly and does not facilitate the timely preparation of financial statements. The necessary data has to be downloaded from CORE, with numerous adjusting entries processed throughout the year before compiling the statements. In fiscal year FY 2006, approximately 100 miscellaneous journal vouchers were posted into CORE, each representing multiple accounting transactions with an approximate value of $107 billion to reconcile the general ledger to subsidiary ledgers, perform data clean-up in preparation of conversion to UFMS, and record accounting entries that are not supported through standard transaction codes.

- Currently, UFMS supports net outlays of $7.9 billion. HHS continues to experience significant challenges in resolving issues related to the UFMS conversion and implementation. This is evidenced by the following:

    - Despite the implementation of UFMS, HHS recorded more than 1,000 manual entries during the year totaling in excess of $10 billion to correct conversion balances, correct opening balances, and record financial transactions in order to complete the financial reporting process.

    - HHS has not completed the implementation of the UFMS reports module. Ad-hoc extracts from UFMS and reports generated from the legacy systems continue to be used to support monthly reconciliations and the interim and year-end financial statements.

In addition, as related to Medicare program financial information, HHS currently relies 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 HHS 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 HHS, and its Medicare 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 HHS. Likewise the reporting mechanism used by the Medicare 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 HHS.

The financial management systems issues prevent the timely use and reliance on this information by both operations and financial reporting personnel. For example, HHS is not able to report all information required for the completion of quarterly financial statements, such as the Entitlement Benefits Due and Payable accrual, in accordance with OMB timelines and provides only minimal information at year end which supports the completion of the financial statements. Just as important, these reporting deficiencies do not provide sufficient data for oversight and management.

Financial Statement Preparation

HHS compiles its financial statements through a multi-step process using a combination of manual and automated procedures. Due to system limitations, many components 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 financial statements. The following issues were identified during the financial statement preparation process:

- To prepare financial statements, more than 200 journal vouchers representing multiple transactions with a value of more than $143 billion were recorded outside the CORE accounting 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, post reconciliation adjustments, and correct for the CORE accounting systems posting logic errors that are non-USSGL compliant. In addition, the prior quarter journal entries must be manually re-recorded into Access databases used to create the financial statements since they are not posted to the general ledger.

- We noted numerous errors in supporting spreadsheets, calculations, and journal vouchers used to produce the financial statements that were brought to management's attention, to include the following:

    - An incorrect journal voucher with a value of approximately $1 billion was recorded. This entry was made to balance an edit check and caused the Undelivered Orders balance to be understated and Unapportioned Authority to be overstated. This error made it appear monies were available for obligation which were not. This error was subsequently corrected.

    - Multiple errors where the accounting entries made through a journal voucher were not properly posted to the financial statements. This resulted from HHS's inability to process this transaction through the system, therefore, it had to be manually mapped to the affected line items on the Statement of Budgetary Resources (SBR). These errors resulted in revisions to the SBR and Statement of Financing (SOF) requiring the SF133s to be updated during the FACTS II revision period.

    - A $1.8 billion error was found in the SBR related to funds permanently not-available. The error was the result of an inconsistent application of the HHS accounting policy.

    - More than 118 errors in the spreadsheets and databases that were used to compile the financial statements. These errors included incorrect formulas, instances of amounts input incorrectly and failure to include all accounts. This resulted in errors on the financial statements in excess of $6.8 billion. Significant errors were corrected while those of a clearly inconsequential amount were not.

- Our review identified over 100 instances with an approximate value of over $3 billion general ledger accounts and crosswalks were not used consistently or in compliance with the Treasury guidance. For example, when certain changes and corrections are

posted in the CORE system, activity is erroneously posted to the upward and downward adjustments accounts. In order to compensate for these postings and prevent abnormal balances on the SBR, HHS must net all amounts in these accounts in order to produce the financial statements. These accounts are then inconsistently mapped to the recoveries or the obligations line item on the SBR.

- Despite the implementation of UFMS, the process for compiling the financial statements requires significant manual intervention to record numerous accounting entries and precipitate the use of spreadsheets. In fiscal year 2006, there were 40 adjusting entries with an approximate value of $2.5 billion posted at year end.

Overall, HHS does not maintain a uniform financial statement crosswalk to facilitate the financial reporting process. This results in significant manual "work arounds" and delays in financial reporting. We received multiple cross-walks which are inconsistent and non-compliant with the USSGL. 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 strengthening of the HHS's financial statement preparation, review, and approval processes.

Financial Reporting Analysis and Reconciliations

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 2006, 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:

- On a monthly basis, HHS is responsible for reconciling approximately 500 Treasury appropriation symbols. As of September 30, 2006, the general ledger and Treasury's records differ by an approximate value of $300 million in the Fund

Balance with Treasury account. Management could not explain the variance. Furthermore, we noted:

- HHS is not performing a reconciliation of the suspense account related to fund balance with treasury with a total balance of $219 million at year end.

- HHS policy and procedures do not provide thresholds that personnel are required to follow in determining whether a difference with Treasury has to be investigated. This permits individual staff members to determine threshold amounts that may be inconsistent with managements needs and may allow for invalid disbursements to occur from Treasury.

- Reconciliations are not being performed within the time frame established by HHS policies.

- Management's grant monitoring report identified more than 64,000 grants, with remaining total net obligation balance of $1.6 billion, that are eligible for close out. For 75% of the grants identified as eligible for closeout by management, the project period had expired more than 2 years ago. HHS lacks sufficient reconciliation and tracking processes to ensure that obligation and expenditure activity within the Payment Management System, which tracks draws and expenditures for grants, are consistent with activity within the component general ledgers.

- HHS components are not completing a detailed review of non-grant open obligations. We noted that over 14% of our non-grant obligation testing contained errors related to open undelivered orders. These errors consisted of obligations remaining open for more then two years, final de-obligation transactions not being used to remove completed orders, and the inability to provide documentation for outstanding obligations. In some instances we noted open undelivered orders were outstanding for almost five years.

- HHS components are not following departmental policy and performing reconciliations between FACTS II and the SBR. In addition, a large number of the journal vouchers that are recorded outside the general ledger system are not posted at an appropriation / fiscal year level and therefore are not submitted in the FACTS II reporting process. Even at components that perform reconciliations they are at the general ledger account level and not the line item level. PwC identified more than $10 billion in differences between the 4th quarter FACTS II submission and the SBR in aggregate at the component level

The control processes in place to ensure the accuracy of the HHS Performance and Accountability Report are not working as intended by management. We noted numerous deficiencies as noted below:

- The initial draft of the Statement of Changes in Net Position provided was not completed in accordance with OMB Circular No. A-136.

- Information in the financial statements related to contingencies was inconsistent with the legal representation letters received from the Office of General Counsel at interim. Subsequently, it was determined that the financial statements contained an erroneous contingent liability of approximately $550 million which was corrected.

- The information in the MD&A did not meet the requirements of OMB Circular No. A-136 due to the lack of trend data, forward looking information, and performance highlights.

- Information related to the Obligations not covered by Budgetary Resources for the Medicaid program was incorrectly classified in the footnotes and the balance sheet.

- Inconsistencies between the CMS financial report and the HHS PAR were identified by the auditors and ultimately corrected.

- A $1.8 billion error on the SBR went undetected when management failed to investigate the variance from the prior year as required under current policies and procedures.

- Ending balances from the prior year financial statements did not agree to the opening balances for FY 2006.

- The current review checklists in use are not adequate for a reviewer to ensure the information provided is compliant with applicable OMB guidance and generally accepted accounting standards.

PAR Reporting and Communication

HHS lacks a coordinated end-to-end process among cross-functional teams of financial and program management, information technology, actuarial, and operations personnel to monitor business activities and identify those situations where accounting evaluation or decision-making may be necessary. Further, upon the identification of issues with an accounting impact, no standardized, documented process exists to ensure timely resolution of accounting and reporting questions with the appropriate personnel. For example:

- A formal communication process is not in place to track and account for necessary accruals for the Part C managed care program and the Part D prescription drug program. The lack of a formal process to provide financial accounting personnel with the detailed information to support the need for an accrual of payments due to and from individual managed care and prescription drug program contractors can lead to the misstatement of assets and/or liabilities. We noted that the final accrual

methodology was not finalized until October 2006, subsequent to fiscal year end. Clearly, the inability to provide a detailed accrual subsequent to year end indicates the misstatement of quarterly financial statements.

- With respect to the Statement of Social Insurance (SOSI), a new basic financial statement requirement for FY 06, we did not note evidence of proactive involvement of the HHS financial reporting function personnel in designing or executing internal control for the SOSI financial reporting process. While the underlying SOSI assumptions, computations and processes are driven by the HHS actuarial function personnel, the ultimate financial statement is an integral part of the HHS-wide financial statement package. Accordingly, there should be standardized, documented policies and procedures that explain the role and responsibility of the financial reporting function personnel in the SOSI financial reporting process.

HHS's current financial reporting process lacks the framework needed to effectively and efficiently implement changes to their financial statements. Procedures do not exist to ensure changes/updates to HHS's accounting and financial reporting policies are properly vetted and approved in writing. Furthermore, HHS does not have sufficient policies and procedures in place to ensure that changes/updates or the preparation of the financial statements are supported by generally accepted accounting principles or department and OMB guidance. For example:

- The agency has not completed a formalized process for implementing changes related to the requirements introduced by OMB Circular A-136. This was evidenced by the fact that a written approved "white paper" had not been completed prior to the requests by auditors and the completion of interim financial statements. In particular, we noted HHS did not have departmental policies and procedures related to the breakout of earmarked funds.

- In relation to the other accounting matters, HHS had not completed agency-wide policies to ensure the consistent application of generally accepted accounting principles related to accounting for leases, application of FASAB interpretation No. 6, documentation of the basis for the grant accrual, advance charging algorithm (which is the key process in allocating cash draws to advances) and the Commissioned Corps Pension Liability prior to the auditors identification and request for department-wide policy and procedures.

The MD&A met some but not all of the requirements outlined in the OMB Circular A-136. Section II.2.6 of OMB Circular A-136 states that the MD&A should include highlights of performance goals and results for the applicable year related to and consistent with major goals and objectives in the entity's strategic and performance plans, including trend data where applicable. However, based on our review, we noted the following weaknesses:

- While HHS presents strategic goal highlights, much of the discussion does not correlate to HHS's strategic goals and objectives.

- HHS presents a performance scorecard in the MD&A that summarizes its performance results. However, the scorecard does not explain the department's programs, performance targets, measures, or trends, thereby making it difficult for the reader to understand the meaning and significance of its performance data and results.

- HHS only reports FY 2006 results for only about half of the limited number of performance measures presented as result of data limitations.

- The performance measures show little about the department's FY 2006 contributions toward outcome-oriented goals. For example, less than half of the measures reported under each strategic goal are outcomes.

- The Circular also encourages entities to provide information in the PAR to help the reader to assess the relative efficiency and effectiveness of entity programs and operations. However, the MD&A does not link its goals and results to cost information to show the "cost effectiveness" of the programs.

Recommendations

We recommend that HHS management:

- Enhance the documentation related polices and procedures for the preparation of financial statements and ensure compliance through a monitoring process.

- Ensure that the components (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.

- Establish appropriate policies, procedures and protocols to address situations or transactions that require cross-functional involvement to determine the appropriate accounting treatment. The financial management function should serve as the primary coordinator to facilitate the input and involvement of the other cross-functional units whose involvement and input are important factors to consider in formulating accounting treatment and financial reporting policies.

- Continue to establish an integrated financial management system for use by HHS to promote consistency and reliability in recording and reporting financial information.

- Develop formal written procedures to consider and approve policy changes. This would include a process to prepare a "white paper" to support any significant

changes/updates to the financial statements. These papers should include references to the applicable guidance that supports the changes/updates, and HHS's conclusion/opinion for making the changes/updates. The white papers should be approved by the Chief Financial Officer.

- Re-design the current procedures used to prepare its Performance and Accountability Report. This process should include the use of a cross-functional team representing all components that are responsible for information which is included in the PAR. This group should be led by the finance office to ensure that all information is accurate and supported by the responsible functional areas. This group should be responsible for the reviews of the financial statements to ensure internal consistency and accuracy. The following should be considered in this re-design:

    - All information prepared and supporting documentation prepared by components for use and review by the department in the preparation of the PAR.

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

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

    - A review should be conducted by someone independent of the financial statements to ensure that amounts within the PAR are internally consistent.

- Receive, review, and maintain a copy of all documentation used to support the information in the PAR.

- HHS should implement policies and procedures to expand the current reconciliations performed around undelivered orders to ensure that stale and outdated orders are removed and require supporting documentation be retained.

Material Weakness

II. Departmental Information Systems Controls

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.

Medicare Electronic Data Processing

Overview

Management relies on extensive information systems operations 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.

Our internal control testing for the audit 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. Our audit included various general controls testing for thirty contractors and site visits to fourteen data centers supporting Medicare claims processing. We also reviewed application controls for systems integral to Medicare financial information including the Fiscal Intermediary Shared System (FISS), the Viable Information Processing Systems' (VIPS) Medicare System (VMS), the Multi-Carrier System (MCS) and the Common Working File (CWF),Financial Accounting Control System (FACS), Contractor Administrative Budget and Financial Management System (CAFM), Retiree Drug Subsidy System (RDS), Health Plan Management System (HPMS), Medicare Advantage prescription Drug System (MARx), HIGLAS and MBES/CBES.

We conducted vulnerability reviews of network controls at nine data centers sites and headquarters. Further, desktop based audit procedures were conducted to review the high level management controls regarding platform security settings at all data centers supporting Medicare claims processing. The vulnerability reviews included both external and internal penetration testing and network vulnerability assessments at nine sites, and internal penetration testing at headquarters.

Our audit noted numerous issues in the areas of direct update access to Medicare claims data and that controls over changes to edits and proper edit settings for the FISS, VMS and MCS systems were not is use during most of the audit period. We also noted no significant improvements regarding prior year weaknesses noted in the areas of Entity-wide Security Program, and Service Continuity Planning and Testing and a worsening of controls in the area of Systems Software when compared to the prior year.

During FY 2006, management continued their program to review, analyze and thoroughly discuss the proposed corrective action plans of contractors and at headquarters. This process included extensive discussions both on-site at headquarters, with contractor management in attendance, and remotely with contractor management. Management deserves great credit for this undertaking. Further, management solicited help from the contractors and formed key working groups to address the control of edits within the FISS, VMS and MCS systems. However, the results of the work from these groups and implementation of suggested changes was not accomplished during the audit period. The completion of this effort should help greatly to resolve issues noted regarding the control of edits for the key front-end Medicare claims processing systems.

During FY 2005, to address the weaknesses noted regarding the control of front end system edits for FISS, MCS and VMS, management issued a new change request (CR 3862) which provides guidance on the control of edits for the FISS, MCS and VMS systems. Furthermore, management launched a project to determine contractor readiness regarding compliance with CR 3862. Initial results of the testing during September and October of 2005 clearly indicated 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. We support management's efforts in this area and believe that these procedures when combined with the actual implementation of the workgroup recommendations to control edits should provide the foundation to correcting the edits weaknesses noted.

During FY 2004 management 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 FY

2006 and we believe that the evaluations obtained as a result of this effort have served and continue to serve management greatly in better understanding the current state of security operations at all Medicare contractors; not just those contractors testing as a consequence of the financial statement audit or for which a SAS 70 was conducted.

In addition to the steps noted above, to address the reportable conditions, management continues its programs to review the contractors through Statement on Auditing Standard (SAS) 70 audits, an extensive contractor self-assessment program, and reporting process and greater central oversight by contractor management. Additionally, management 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.

Efforts to address the findings noted in our review have been and will continue to be challenged by budgetary constraints and the decentralized nature of Medicare operations and the complexity of fee-for-service processing. According to management, the modernization program represents a long-term solution to simplify the application software code and change controls needed for more robust security. Management is also in the process of its contractor reform initiative, including data center consolidation, which should reduce the number of contractors and data centers. This process has already begun and should, when completed, further reduce the number of IT security weaknesses noted as a result of testing.

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. Our audit noted numerous findings regarding logical access during our controls testing. We noted that numerous security weaknesses existed that would allow internal users to access and update sensitive systems, programs and data without proper authorization. Our review did not disclose any exploitation of critical systems tested; however, clear potential existed. We 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 standing update access to Medicare data and application software programs.

We also noted that many contractors had not performed procedures to recertify access granted to employees on an annual basis as required. As a result, we 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. Although this issue was also noted during the FY 2005 audit, our audit noted many more instances where employees who did not require direct access to data and application software programs to perform their job responsibilities had been granted inappropriate standing update access to Medicare data and application software programs without mitigating controls such as logging and review of the use of this access.

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. A key element of system changes is the proper use and control of edits within the FISS, VMS and MCS applications which process Medicare claims.

We noted that although HHS and contractor management have created workgroups to determine edits within FISS, VMS and MCS that should be turned on to prevent improper processing, the completion of the suggested changes to edits for the VMS and MCS systems and the implementation of the changes were still in process as of August 2006. Additionally, for the FISS system, the process of determining edits that should be turned on in the system and the implementation of these edits was still ongoing at September 30, 2006.

Control of edits represents a very important area of concern because the edits are a key control in the prevention of improper processing of Medicare claims. The volume of claims processed requires strong automated preventative controls to ensure proper claims processing. Claims volume is far too great to rely on non-automated controls.

We also noted that automated program code used to process claims did not always provide a proper audit trail to allow review of changes to the program code used to process claims or to review actual changes made by the code to claims data. We also noted that application changes were, in some cases, being implemented without documented testing and approval and that application change control procedures were not followed at all sites tested. Finally, we noted numerous contractor sites at which application programmers had the ability to directly update production data and/or source program code for applications thereby allowing then to bypass application change controls.

During our application review, we noted a number of problems with access controls within the applications at the contractors and at headquarters, which included both inappropriate or unsubstantiated access as well as segregation of duties weaknesses. Security violation reports were not being reviewed for many of the applications. Further, we were unable to obtain evidence of change control procedures for the MARx application and, as such, we could not determine whether or not the application was functioning appropriately.

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. We noted that most of the contractor sites audited showed no measurable improvement in this area when compared to the FY 2005 audit and that for two sites, significant issues existed regarding the control of systems software. Further, we noted numerous instances across the fourteen data centers audited, where security settings for

platforms were not consistent with NIST standards and failed to provide sufficient security settings for computer platforms.

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. We noted no significant improvements in the entity-wide security programs reviewed during the FY 2006 audit when compared to the FY 2005 programs reviews.

Service Continuity Planning and Testing

Service continuity relates to the readiness of a site in the case of a system outage or 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. We noted no significant improvements in the continuity plans and testing of the plans when compared to the FY 2005 audit.

Recommendations

During FY 2006, many contractors, upon realizing they would not continue to process Medicare claims and/or act as data centers under future contracts, did not apply the same vigor to ensuring controls and their effectiveness. We recommend management begin now to address this issue for future years. Management must work to create clear methods to gain cooperation from their contractors. Without a direct intervention by management, we believe that the trend noted during the FY 2006 audit will worsen and may gain momentum in the coming years.

Additionally, we recommend 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 specifically limiting update access to Medicare data and/or programs.
- Complete the workgroup efforts to determine edits that should be turned on within the FISS, VMS and headquarters systems and ensure implementation of the workgroup recommendations promptly.
- 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.

- Work with their contractors and maintainers of the FISS, VMS and headquarter systems to ensure add on programs such as SuperOps and SCF maintain complete audit trails and that changes to program code associated with these systems follow the rules outlined in CR 3011 for testing and approval.
- Provide more specific guidance to the contractors regarding procedures to formally assess and reduce risk on an ongoing basis by identifying and matching controls to mitigate risks noted in their systems security plans and by requiring ongoing and consistent tests of mitigating controls to ensure their continued effectiveness.
- Continue to enhance processes to monitor and track compliance with the security configuration models for all platforms maintained within, the contractor sites, the maintainer sites and central office. Management should greatly encourage the use of automated tools to monitor, detect and report to the Information Security Office, all noncompliance with contractor, maintainer or headquarter platform security configuration standards for distributed servers including WINDOWS, UNIX, router, switches, Web server and Oracle database servers on a quarterly basis.

Other Components and Programs

Although HHS has made efforts to strengthen controls over its systems, our testing noted 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, and
- Systems software.

Of particular concern, we noted the lack of pervasive IT security standards for areas such as IT security settings on platforms and policies regarding the control and use of passwords, for HHS at the department level. Our testing consistently noted that management of the various component entities within HHS either had developed their own IT security standards or simply stated that they do not follow HHS standards.

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 information technology general controls and applications audited. The following discusses the summary results 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:

- **Information System Platform and Database Security Controls:** HHS lacks accepted and used standards for information system platform security settings that are consistent with NIST standards for securing information system platforms and databases.
- **Information System Platform and Database Security Control Monitoring:** HHS lacks processes to monitor security settings ongoing to ensure they remain effective.
- **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.

Access controls (logical and physical): 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.
- Access Assignments: Access assignments were excessive for some systems and did not provide an adequate segregation of duties.

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.
- Change Management: Change management procedures were insufficient to ensure only properly authorized changes were implemented into some production 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.

Additionally, we noted the following weaknesses within the Division of Financial Operations, the Centers for Information Technology, Division of Payment Management, and the Human Resource Services operation, based on SAS 70 Reviews.

- Change Management: Evidence to support that change management procedures and processes were followed, was not provided.
- Access Controls: Periodic reviews of user access permissions were not conducted and/or not documented. Procedures to approve access assignments and to control terminated and transferred employees were either non-existent or not followed.
- Application Controls: Output reports were not properly reviewed and used to correct any issues that would be noted and to ensure the accuracy of information stored on systems.
- Configuration Controls: Password controls and system lockouts for incorrect password attempts were not sufficient to provide effective security. Platform security configuration settings were also insufficient to provide effective security.

Recommendations

To provide a secure computing environment for critical applications throughout all the operating divisions, HHS should:

- Develop overall HHS platform configuration security standards for all operating platforms and databases, following the guidance issued by NIST, for all components.
- Ensure the acceptance and implementation of the platform configuration security standards by all components.
- Develop and implement effective tools, policies and procedures to review platform security settings for all components, on an ongoing basis.
- Develop an effective patch management process for all critical systems to reduce systems vulnerabilities to a minimum.
- Enhance policies and procedures to ensure that system administrators perform periodic reviews of access authorizations for all applications and that a process exists for communicating terminated employees to administrators for their timely removal.
- Revalidate access rights on a periodic basis to limit systems access on a need-to have basis.
- Complete certification and accreditation activities, including the corresponding risk assessments, to limit the residual risk to an acceptable level.
- Maintain system security plans to provide security and controls commensurate with risk changes associated with systems.
- Train all employees and contractors on security awareness and responsibilities to effectively communicate security policies and expectations.
- Maintain effective program change controls processes for all applications to limit the risk of unauthorized changes to the production systems.

Reportable Conditions

I. Managed Care (Part C) and Prescription Drug (Part D) Benefits Payment Cycle

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

Overview

The 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 and prescription drug expenditures are processed and paid by

the Central Office. In January 2006, HHS completed a system conversion to the Medicare Advantage Prescription Drug System (MARx) for payments to the managed care organizations and prescription drug plans for both Part C and Part D.

The MARx payment errors have been identified and are in the process of being corrected or accrued for at the plan level, during fiscal year 2006, policies and procedures were not sufficient to adequately reduce the risk of benefit payment errors occurring and not being corrected in a timely manner. System errors have gone uncorrected for more then seven months.

Inadequate Procedures to Review and Process Managed Care and Prescription Drug Payments (Part C and Part D)

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 which represents 95% of all Managed Care Payments 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. PwC noted instances of inadequate policies and documentation for risk-based payments as evidenced by the following:

- During the monthly payment validation process management noted that various payments made to the managed care and prescription drug providers were in error. These errors are being tracked and a detailed analysis is performed, but the errors are not corrected in a timely manner. In one instance an error noted with the Working Aged adjustment in the January payment has yet to be corrected. In addition, CMS identified cases where the amount of Part D Low Income Premium Subsidy included in the Monthly Membership Report was incorrect. These items remain as systems errors and are accounted for via an accrual.

- Management has not performed a timely reconciliation of beneficiary level payments that are calculated and authorized to the actual payment request sent to Treasury. The reconciliation for the first quarter of the year was not performed until September 2006. Once the reconciliations were completed and differences were identified no explanations were provided. Differences were noted between the detail calculation of payments and the payments made at the Plan level, as well as, the actual payments made by Treasury and the approved payments.

- Management did not maintain readily accessible and up-to-date logs of anomalies or errors resulting from their review of plan level payments. In addition, the monthly review binders are not created timely and documentation supporting the payment approval is not retained.

- For risk based plans, management 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 August 2006 HHS processed approximately $1 billion in manual adjustments). This methodology may lead to inaccurate payments.

Lack of Documentation and Procedures to Determine Eligibility of Organizations

- Management was unable to provide adequate documentation of organizations that were approved during the fiscal year as either new managed care providers and or prescription drug providers. Exceptions were noted in the following areas where documentation did not meet requirements.
  - Business Organization Reviews for Part D applications were not provided for fourteen sample items out of forty-five selected. In addition, we noted one instance where the review tool was incomplete and an additional instance was noted where the reviewer did not sign the business organization review tool.
  - Part C transitional applications were approved with no formal review performed when transitioning from a demonstration plan into a managed care provider.
  - No application review tools were provided for the review and acceptance of new managed care providers. PwC noted that twelve sample items out of forty-five were not provided.
  - No documentation was provided for four out of the forty-five items selected for the testing of new managed care provider applications.
  - Management was unable to provide comprehensive documentation of new managed care organizations that were approved during the fiscal year. We noted exceptions in thirteen of the forty-five contracts reviewed, where documentation did not meet requirements. Examples of the missing documentation included: review tools, incomplete recommendation reports, site visit letters, and state licensures.

Inadequate Oversight of Managed Care Organizations

The Health Plan Monitoring System (HPMS) used by the management to monitor the execution and status of managed care organization oversight contains inaccurate information. This system lies at the core of the monitoring process for Medicare Advantage Organizations (MAOs). Inaccurate information within HPMS weakens the monitoring of MAOs and may cause HHS to pay plans that are ineligible. The following inaccuracies were noted during the audit which included selecting a sample of forty-five monitoring reviews:

- The HPMS monitoring review module does not contain all of the managed care organizations receiving payment. One of the managed care organizations included in our sample selected for testing was 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 was not updated in accordance with the policy for the results of audits conducted during the current fiscal year. The lack of 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.

- Management was unable to provide sufficient documentation to support the on-going monitoring of managed care organizations by the Regional Offices in accordance with policies and procedures. We identified 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. In addition, we found instances where the corrective action plans were not received, released, and/or approved within the prescribed time frame. In some instances the review report was issued after the forty-five day time frame.

- Regional Offices did not retain documentation to support exception items noted in the reviews of the managed care organizations. We noted three instances where the documentation noting exceptions were not retained in HMPS.

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

Recommendation

We recommend that HHS develop and refine its financial management systems and processes to improve its accounting, analysis, and oversight of Medicare managed care activity.

Specifically, HHS should:

- Ensure that relevant data 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 management perform a timely reconciliation of authorized payments made by Treasury. They 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.

- Develop a process to perform reconciliations of beneficiary level data to plan payments including plan level adjustments.

Management has established strong controls for monitoring fee-for service contractors in many areas listed in this reportable condition and should consider implementing many of those requirements for the managed care and prescription drug programs. In particular, implementing the data analysis methodologies employed by Medicare Contractors and Program Safeguard Contractors should provide the Center for Beneficiary Choices (CBC) with a foundation for improving internal control within the managed care benefits payment cycle.

II. Medicaid and Other Health Programs Oversight

Overview

The CMS Health Program's Regional Office oversight of the States is a monitoring control designed to detect potential errors within State-submitted financial information related to Medicaid, SCHIP and other health programs. CMS-64, the Quarterly Medicaid Statement of Expenditures, is a key submission from the States in which Medicaid program expenditures

are reported to CMS. CMSO issued financial review guides to assist the Regional Office analysts in examining budget and expenditure reports as well as to standardize the review procedures performed between analysts and regions. These review guides encompass all areas of the review process yet Region Office adherence to the guides is sporadic.

During FY 2006, CMSO achieved the following accomplishments: (1) conducted initial testing of the automated initial grant award that will use the MBES; (2) revised the Regional Office Review Guides for forms CMS-64, 37, 21, and 21b to include updated statutory and regulatory citations and to capture the all review steps for the ROs; (3) developed the MBES waiver initiative to capture emergency initiatives such as the Disaster Waiver initiatives involving both Hurricanes Katrina and Rita; (4) developed methodologies to calculate the Medicaid and SCHIP IBNR accruals; and (5) placed the Medicaid and SCHIP IBNR surveys on the MBES platform.

While progress has been made during the current year, we noted control weaknesses regarding Medicaid program oversight and reporting as follows:

Lack of Regional Office Oversight

Within the Regional Offices, analysts are not required to follow the 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 that the Regional Offices did not consistently use the review guide (for quarterly and budgetary reviews) and, when the guide was used, the reasons that 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.

An analysis of changes in quarterly budget and expenditure submissions is a major consideration in the Regional Office's recommendation to award a grant or validate expenditures. Furthermore, it is a significant 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 nor was there evidence of which amounts were investigated. In many cases, explanations for variances were not sufficiently documented to assist a reviewer in verifying that reviewers gathered appropriate evidence to support the execution of its oversight responsibilities over the Health Programs.

The Regional Offices obtain and review the Medicaid and Other Health Program findings identified in the State Single Audit and Office of Inspector General Audit reports. These reports are entered in the Audit Tracking and Reporting System (ATARS) by each regional office as it relates to the particular state within their region. Currently, the agency does not have a central oversight function to ensure that all reports that should be entered in ATARS have been actually entered. In addition, we noted during our testing that the status annotated

in the system ("Closed versus Open") was not always correct. Also, we identified several reports in ATARS that were dated with fiscal years prior to 2005 and no action has been taken to follow up on the issues noted.

State Plan Amendments (SPA) and State Plan Waivers (SPW) are processed at the Regional Offices throughout the year. The Regional Offices were provided guidance for processing state plan amendments and waivers in a memorandum from CMSO issued March 19, 2004. During our review, we noted that acknowledgement letters were missing from the files along with other source documents, such as the Form CMS-179. In addition, we noted that approval letters were signed by someone other than the Associate Regional Administrator. In addition, there is no formal guidance regarding how State Plan Amendments should be reviewed and approved.

The Regional Offices process Medicaid and SCHIP deferrals and disallowances. These deferrals and disallowances are entered into the agency's FACS for reporting purposes. We noted the following observations as a result of our testing: Medicaid and SCHIP deferrals were not consistently being entered into FACS on a timely basis nor were they being consistently captured in the Financial Issues Report (FIR). In addition, disallowance letters could not be made readily available to support approved disallowances.

Lack of Central Office Oversight

HHS uses its Payment Management System (PMS) to process and manage Medicaid payments to the States. Management does not have policies and procedures in place to review the SAS 70 review conducted at DPM to assess the impact of exceptions and findings on the financial statements.

In addition, HHS lacks sufficient integration or reconciliation and tracking processes to ensure that obligation and expenditure activity within PMS, which tracks draws for State grants, are consistent with activity within the general ledger. Currently, the States use the CMS 64 to report accrued expenditures while submitting a PMS 272 to report expenditures on a cash basis to PMS resulting in inconsistent expenditure activity between the two systems for the same grant. Although component personnel close out grants in the General Ledger once obligations and expenditures match, the obligations are not always de-obligated within PMS, leaving unexpended balances available for draws by the States. As of September 30, 2006 over $1 billion in grants eligible for close out were not closed. In addition, management does not perform a detailed review of the information retained within PMS.

HHS does not have formal policies that require periodic reconciliation of State cash draws to the quarterly expenditure reports. During our testing, we noted that management is currently not reconciling State cash draws to the State expenditure reports. During our review of State expenditures, we noted states that exhibited significant variances from the prior year to the current year. We requested an explanation from the management, but they could not readily provide a response. Periodic reviews are submitted by the Regional Offices; however, an analysis of the results is not documented.

The Regional Offices are not performing a timely review, within 30 days of submission, and approval of State expenditure and budget submissions, primarily because of late submissions by the States. In many cases, grants are approved when prior expenditures reports have been outstanding for six months (two quarters). In addition, the Regional Offices lack formal documented policies identifying alternative analyses that should be performed to support an approval when routine information is not available. We also noted that the Regional Offices do not have polices and procedures that require documenting follow-up communication with the grantee on late expenditure and budget submissions.

Lack of Controls over the Medicaid Accruals

Approved state plans are the basis for claims that are eligible for federal matching in the Medicaid program. Plans are subject to amendment throughout the year, these amendments are effective on the date of submission not the date of approval and may have a payment impact on the financial reimbursement the state receives. CMS lacks formalized policies and procedures to track and calculate accruals for the Medicaid program related to the impact of retroactive state plan amendments. Currently the impact of these waivers is tracked on a spreadsheet maintained by CMSO and is not subject to any type of formalized internal control review.

Recommendations

As a result of not consistently adhering to the CMS Financial Review Guide to assist in monitoring and providing oversight of State Operations, deficiencies in internal control may allow significant misstatements to occur without being identified. HHS should require the Regional Offices analysts to follow the Financial Review Guide to assess each State's budget requests, quarterly expenditure reports, and other State activities related to SCHIP and Medicaid funding. In addition, standard documentation policies should be established to ensure consistency among regions.

HHS should revise its procedures to provide a mechanism for Central and Regional Offices to monitor states' activities and enforce compliance with HHS financial management procedures by:

- Provide 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.

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

- Management should enhance employee training initiatives on records retention and deferral and disallowance reporting. In addition, task responsibilities should be clearly assigned to employees to ensure proper performance.

HHS should enhance their current policies and procedures to ensure that the ATARS is complete and accurate. In addition, these policies and procedures should include steps to closely monitor the findings and ensure that they are resolved within a specified timeframe.

The oversight of SPA and SPW should be improved to ensure Regional Offices are retaining evidential matter to support their reviews and approvals. Similar to State Plan Waivers, (3.3 Instructions), the agency should develop and provide guidance on how to review and approve each type of State Plan Waiver.

III. Statement of Social Insurance Preparation Processes

Overview

The Statement of Social Insurance (SOSI) is a long-term projection of the present value of income to be received from or on behalf of existing and future participants of social insurance programs, the present value of the benefits to be paid to those same individuals, and the difference between the income and benefits. In prior years this information was presented as required supplemental information, therefore not subject to a detailed review of internal controls. During our review we noted several areas where controls were not effective.

Lack of Change Controls

During our review of the models used in the SOSI projection process we noted a lack of controls associated with change management. The following items were identified:

- Changes subject to change management policy and procedures are not clearly defined. In fact, OACT implemented significant changes to the projection process during the current year that did not go through their established change control process.
- The current change management process does not require formal tracking of the status of authorized changes which are in progress.
- The current change management process does not require that the person who requests the change be different from the authorizer.
- Outdated worksheets are kept in the working directory with the updated worksheets, so outdated worksheets could be used in error.

Inadequate change controls may lead to unauthorized changes to the models/spreadsheets which may cause a misstatement in the projection.

Lack of Access Controls

We identified a lack of controls around the access to models and spreadsheets used to calculate the amounts reported on the SOSI. Specifically, quarterly review of user access rights needs to be strengthened and procedures have not been established to terminate user access immediately when the user's employment is terminated for cause. In addition, the addition or deletion of user access to working or final directories is not formally documented, and some production directories do not have associated working directories.

Inadequate access controls may allow unintentional and/or intentional errors to be introduced to the models/spreadsheets.

Lack of Formalized Policies and Procedures over Input and Processing Controls

OACT policies and procedures in place over inputs and processing controls are not consistently implemented. The following items where noted:

- Inappropriate controls in place to ensure final assumptions used in the projection are appropriately reviewed, led to instances where assumptions documented and approved by the Chief Actuary did not agree to the assumptions used within the models/spreadsheets. HHS asserts that the correct assumptions were ultimately used in the projection.

- During our review of 123 OACT models/spreadsheet used in the projection process, we noted 184 instances of cells with referencing issues, where the cells reference an invalid location. In addition, we noted 42 instances were formulas are dividing by zero (or black cells) or were the formulas are referencing cells that contain erroneous values. Although the anomalies noted did not cause an error in the projection, inaccurate formulas or unused information in the models/spreadsheets could pose a risk to the projection.

Lack of Appropriate Documentation

During our testing of the Statement of Social Insurance the following documentation issues were noted:

- Inconsistencies and errors in the model/spreadsheet inventory exist. The lack of completeness of the list resulted in models/spreadsheets being used during the projection process that were not validated by OACT. In one instance, the lack of appropriate validation of all spreadsheets involved in the projection process resulted in a formula error affecting the projection.

- Inconsistencies and a lack of proper Model/Spreadsheet documentation regarding the use of outputs (i.e. how and where the output is subsequently used including file, sheet, column etc.) may lead to errors in the projection process.
- A standard file naming convention is not used which may result in version control failures.
- Internally developed sources of significant models/spreadsheets are not always maintained. The lack of retention of source file limits management's ability to validate the accuracy and completeness of data introduced into their models.
- OACT did not appropriately document controls in place to ensure the reasonableness of data developed by other HHS departments or by other agencies/outside sources. For example, communications with outside data sources regarding errors or discrepancies are not documented and, as such there is no record of actions taken by OACT to mitigate the risk of errors in their calculations due to inaccurate data sources.
- OACT did not appropriately document or maintain evidence of input controls. We noted that specific steps taken to ensure the accuracy and completeness of data input to the models/spreadsheets were not documented. Lack of appropriate documentation of controls, limits OACT's ability to ensure controls are performed as intended.

Recommendations

HHS should enhance its controls over the Statement of Social Insurance through the implementation of formal polices and procedures related to change, access, input and processing controls, and in the formulization of documentation through the following:

- Establish an appropriate change control policy and ensure its consistent application.
- Enhance access controls procedures in order to ensure that only authorized individuals have access to OACT directories including production, working directories, and final directories.
- Ensure appropriate controls and documentation exists over approved assumptions, methods and/or techniques.
- Ensure models/spreadsheets used in the projection process are free of formula anomalies, and only contain information used during the current year's projection.
- Create a complete inventory of models used for the projection process, in order to ensure appropriate controls are in place.
- Appropriately document the use of outputs from spreadsheets that serve as inputs to subsequent spreadsheets.
- Implement a standard file naming convention.
- Implement policies and procedures requiring the retention of all source information used in the preparation of the statement.

- Appropriately document and maintain evidence of input controls in place, including controls in place to ensure the reasonableness of data obtained from sources outside of OACT.

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Internal Control Related to Key Performance Indicators and RSSI

With respect to internal control relevant to data that support reported performance measures included in the MD&A, we obtained an understanding of the design of significant internal control relating to the existence and completeness assertions, as required by OMB Bulletin No. 06-03. Our procedures were not designed to provide assurance on the internal control over reported performance measures and, accordingly, we do not express an opinion on such control. In addition, we considered HHS's internal control over RSSI by obtaining an understanding of HHS's internal control, determined whether these internal controls had been place in operation, assessed control risk, and performed tests of controls as required by OMB Bulletin No. 06-03 and not to provide assurance on these controls. Accordingly, we do not provide an opinion on such controls.

We also identified other less significant matters that will be reported to HHS's management in a separate letter. This report is intended solely for the information and use of the management the Department of Health and Human Services, the Office of the Inspector General of the Department of Health and Human Services, OMB, and Congress. This report is not intended to be and should not be used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

November 15, 2006

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Washington, D.C. 20201

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

NOV 15 2006

Dear Mr. Levinson:

This letter responds to the audit report submitted by the Office of Inspector General in connection with the Department of Health and Human Services' fiscal year 2006 financial statement audit. We concur with the findings and recommendations presented to us.

We are pleased that, once again, your report reflects an unqualified, or "clean," audit opinion for the Department. Through our joint efforts, the audit was completed on-time, which is significant in that the Statement of Social Insurance was audited for the first time in 2006.

We acknowledge that we have material weaknesses in internal controls relating to financial systems and processes, and information technology (IT) controls. The Department's long-term strategic plan to resolve the financial systems and processes weakness is to replace the existing accounting systems and certain other financial systems within the Department with the Unified Financial Management System (UFMS) and strengthen the Department's financial reporting processes and controls. The UFMS has been implemented at two Departmental Operating Divisions and, in October 2006, the Program Support Center successfully deployed UFMS thus increasing the number of other Departmental Operating Divisions supported by UFMS. We are working towards complying with the requirements of the Federal Financial Management Improvement Act by October 2007 for UFMS.

The Department will be formulating short-term and long-term goals for correcting IT weaknesses in logical access controls; application security, development and program change control; and systems software. The Centers for Medicare and Medicaid Services will be working to strengthen the internal controls related to Medicare electronic data processing operations at its central office and Medicare contractor sites as well.

I would like to extend my appreciation to you and your staff for the professionalism that was demonstrated in working with us through this particularly challenging year.

Sincerely,

Charles E. Johnson
Assistant Secretary for Resources
and Technology