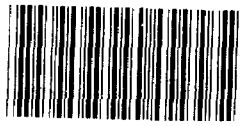
GAO

Report to the Secretary of Health and Human Services

November 1985

INTERNAL CONTROLS

Second-Year Implementation of the Financial Integrity Act in HHS



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GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-216946

November 8, 1985

The Honorable Margaret M. Heckler
The Secretary of Health and
Human Services

Dear Madam Secretary:

This report presents the results of our review of your Department's efforts to implement and comply with the Federal Managers' Financial Integrity Act of 1982. Our review was part of a GAO assessment of 23 federal agencies' efforts to implement the act during the second year.

The report contains recommendations to you in chapters 2 through 5. As you know, 31 U.S.C. 720 requires the head of a federal agency to submit a written statement on actions taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report. Under the law, the statement must also be submitted to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

We are sending copies of this report to the chairmen of the above-mentioned committees and other cognizant legislative committees. Copies are also being sent to the Director, Office of Management and Budget, and other interested parties.

Sincerely yours,

Edward A Densmore

for Richard L. Fogel
Director

Executive Summary

The Federal Managers' Financial Integrity Act of 1982 was enacted to strengthen federal agencies' systems of internal control and accounting, which are fundamental to sound management. When present, they help assure accountability for resources and achieve program objectives. When absent, the potential for abuse increases.

To assess the act's implementation, GAO reviewed the Department of Health and Human Services (HHS) and 22 other departments and agencies. HHS disbursed $292.3 billion during fiscal year 1984, primarily for benefits under the Social Security, Medicare, and Medicaid programs. (See ch. 1.)

Background

The act requires that each executive agency annually evaluate its systems of internal control and report to the President and the Congress whether its systems comply with standards prescribed by the Comptroller General and with the act's three statutory objectives. The act further requires that the agencies report whether their accounting systems conform to the Comptroller General's principles, standards, and related requirements.

The Secretary's 1984 report did not state whether HHS' internal controls comply with the required standards and objectives, or whether its accounting systems conformed to the Comptroller General's requirements. Instead, she stated that none of the disclosed weaknesses or instances of noncompliance significantly impair the Department's ability to carry out its mission.

Results in Brief

In GAO's opinion, the Secretary did not adequately disclose whether HHS' systems complied with the act's requirements. GAO's review showed that (1) internal controls at the Health Care Financing Administration (HCFA) were inadequate, (2) internal controls for many other major HHS programs and activities were not evaluated, including major automatic data processing (ADP) controls, (3) internal control evaluations performed were inadequate, (4) material internal control weaknesses identified remained uncorrected, and (5) three major accounting systems did not conform to the Comptroller General's requirements, and HHS was not in a position to state whether most of the remaining systems conformed. (See ch. 2.)

Principal Findings

Accounting Systems and ADP Controls

The Secretary's report revealed serious problems in three of HHS' major accounting systems. The systems are two Social Security Administration (SSA) systems, which accounted for about $174 billion in benefit payments in fiscal year 1984, and HHS' major grants and contract payments system, which disbursed about $44 billion. In GAO's opinion, these systems do not conform to the Comptroller General's principles, standards, and related requirements.

Also, notwithstanding its dependency on ADP to effectively operate accounting systems and accomplish various missions, HHS did not adequately evaluate its ADP internal controls. Reviews focused too narrowly on physical security controls and did not include evaluations of computer application controls. In addition, reviews in both the ADP and accounting system areas did not adequately document the work or perform sufficient testing. (See ch. 3.)

Health Care Financing Administration

HCFA excluded from its evaluations the adequacy of internal controls over about $80 billion in benefit payments made by paying agents under the Medicare and Medicaid programs. GAO reviewed the policies and procedures for the 21 monitoring programs that HCFA uses to review paying agents' performance. GAO also evaluated four of the programs with $20 billion in payments by Medicare paying agents. GAO found the following weaknesses.

- The program for reviewing paid claims for payment errors was susceptible to manipulation by those making the payments and did not include adequate assessments for identifying internal control problems that allowed the errors.
- The four programs were not comprehensive enough to assure that payments were made only for covered and medically necessary services, services were provided as claimed, and services were rendered only by licensed providers.

Because of these and other weaknesses disclosed in other GAO reports, GAO believes that HCFA's internal controls over benefit payments are not adequate. (See ch. 4.)

Social Security Administration

Notwithstanding the substantial efforts by SSA to implement the act, GAO believes that SSA's 1984 assessment of its internal controls was not sufficient to determine whether its internal controls complied with the act's requirements.

- Controls in less than 5 percent of the identified internal control areas at SSA headquarters were reviewed. SSA's headquarters components develop policies and procedures for administering the various Social Security programs, which pay about $190 billion annually.
- SSA's reviews at 359 of its 1,350 field offices identified and corrected thousands of instances of noncompliance with policies and procedures. However, the reviews did not address the adequacy and effectiveness of existing internal controls or the need for additional controls. (See ch. 5.)

Public Health Service

The Public Health Service did not evaluate its internal controls in key areas, such as grants, drug regulation, in-house research, and health care delivery. Also, the agency neither adequately tested whether controls were in place and functioning effectively nor documented review results. Accordingly, GAO believes the agency was not in a position to determine whether its internal controls comply with the act's requirements. (See ch. 6.)

Recommendations

GAO recommends that the Secretary of HHS, in future reports to the Congress and the President,

- clearly state whether all or any of HHS' internal control systems do or do not comply with the act's requirements;
- clearly state whether all or any of HHS' accounting systems do or do not conform to the Comptroller General's requirements; and
- identify the internal control and accounting systems that have not been sufficiently evaluated to determine whether they comply with or conform to applicable requirements. (See p. 21.)

GAO is also making recommendations to improve evaluations of internal controls and accounting systems. (See pp. 35, 48, 49, and 59.)

Agency Comments and Our Evaluation

HHS said that GAO did not adequately recognize its 1985 actions to improve the review process or recognize the policy issues raised by the Office of Management and Budget on reasonable assurance. Also, HHS said the report contained inaccuracies and the late issuance weakened

its utility. Because HHS believed the report contained technical problems, it did not respond to GAO's recommendations.

Although GAO's review focused on the act's implementation in 1984, GAO believes it adequately recognized HHS' 1985 actions. Also, with regard to the policy issues on reasonable assurance, GAO believes that its approach for determining the adequacy of internal controls is both appropriate and consistent with the act. In addition, GAO believes that the report does not contain inaccuracies or technical problems, and there is adequate disclosure of the status of HHS' efforts. Although GAO agrees that earlier report issuance would have been desirable, it should be noted that the matters included in the report were discussed with component agency officials between June and August 1985. GAO continues to believe its recommendations will be useful to the Department. GAO's evaluation of HHS' and its component agencies' comments are included at the ends of chapters 2 through 6 and in appendix IV.

Contents

Abbreviations

ADP	automatic data processing
ASMB	Office of the Assistant Secretary for Management and Budget
FMFIA	Federal Managers' Financial Integrity Act
GAO	General Accounting Office
HART	HCFA Accounting Reporting Tracking
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
ICR	internal control review
OIG	Office of Inspector General
OMB	Office of Management and Budget
OS/HDS	Office of the Secretary/Office of Human Development Services
PHS	Public Health Service
QAP	Carrier Quality Assurance Program
RASC	Regional Administrative Support Center
RSDI	Retirement, Survivors and Disability Insurance
SSA	Social Security Administration

Introduction

Responding to continuing disclosures of fraud, waste, and abuse across a wide spectrum of government operations, the Congress in August 1982 passed the Federal Managers' Financial Integrity Act (FMFIA) (31 U.S.C. 3512(b) and (c)). It was intended to strengthen the Accounting and Auditing Act of 1950, which places the responsibility for establishing and maintaining systems of accounting and internal control upon the head of each executive agency.

FMFIA provides a framework for identifying and remedying longstanding internal control and accounting system problems. The Department of Health and Human Services (HHS) is 1 of 23 departments and agencies whose FMFIA progress we reviewed during 1984. Its fiscal year 1984 budget expenditures were $292.3 billion. This is our second report on HHS' implementation of FMFIA. Our first report[1] identified weaknesses in the FMFIA procedures and proposed corrective actions.

FMFIA Requirements

Section 2 of FMFIA requires that agencies' internal accounting and administrative controls (1) be established and comply with standards prescribed by the Comptroller General under the act and (2) provide reasonable assurances that

- obligations and expenditures comply with applicable law;
- funds, property, and other assets are safeguarded against waste, loss, unauthorized use, or misappropriation; and
- revenues and expenditures applicable to agency operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the assets.

The House Committee on Government Operations, in its report, First-Year Implementation of the Federal Managers' Financial Integrity Act (House Report 98-937, Aug. 2, 1984), said that the term "internal controls," as envisioned by FMFIA, is synonymous with "management controls" and clearly encompasses program and administrative areas as well as the more traditional accounting and financial management areas. The Committee report further stated that internal controls are integral to all systems (whether related to administration, program operations, or accounting) used by management to achieve the objectives of programs or functions.

[1] The Department of Health and Human Services' First-Year Implementation of the Federal Managers' Financial Integrity Act (GAO/HRD-84-47, May 9, 1984).

Agencies must report annually on whether their internal control systems fully comply with FMFIA requirements. To the extent systems do not comply, the agencies are to identify material weaknesses in their systems and corrective actions.

Section 4 of FMFIA further requires the agencies to separately report on whether their accounting systems conform to the principles, standards, and related requirements prescribed by the Comptroller General under the Accounting and Auditing Act of 1950.[2]

Federal Framework to Implement FMFIA

To provide a framework for implementing section 2, the Comptroller General issued standards for agencies' internal control systems. The Office of Management and Budget (OMB), in consultation with GAO, established guidelines for agencies to use in evaluating, improving, and reporting on their internal control systems. The guidelines direct departments and agencies to (1) segment their programs and functions into assessable units; (2) determine the vulnerability of those assessable units to waste, loss, unauthorized use, or misappropriation; (3) perform more detailed internal control reviews (ICRs) of those assessable units where vulnerability assessments indicate that such reviews are needed; and (4) take corrective actions. However, the guidelines provide that the departments and agencies may deviate from the specific guidelines' procedures if they use acceptable alternative internal control evaluation approaches.

In addition, on May 20, 1985, OMB issued a booklet, entitled Guidelines for Evaluating Financial Management/Accounting Systems, outlining a recommended approach to evaluating systems and preparing required reports, such as agencies' FMFIA annual reports on accounting systems. The guidelines are based on the experience gained by agencies during the first 2 years of implementing FMFIA.

[2]The GAO Policy and Procedures Manual for Guidance of Federal Agencies contains the principles, standards, and related requirements to be observed by federal agencies. Specifically, title 2 prescribes the overall accounting principles and standards, while titles 4, 5, 6, and 7 specify requirements governing claims; transportation; pay, leave, and allowances; and fiscal procedures, respectively. Also, agency accounting systems must include internal controls that comply with the Comptroller General's internal control standards and related requirements, such as the Treasury Financial Manual and Office of Management and Budget circulars.

HHS Implementation of FMFIA

HHS' implementation efforts are made up of two initiatives. The first is directed at evaluating, improving, and reporting on its systems of internal control (section 2). The second is directed at evaluating and reporting on its accounting systems (section 4).

The Assistant Secretary for Management and Budget is HHS' internal control manager. He has authority to issue directives, monitor and evaluate performance, and advise the Secretary on the status of internal controls. The Assistant Secretary appointed a steering committee whose mission is to provide advice on developing overall departmental FMFIA policy. The committee has two subcommittees—internal controls subcommittee and systems review subcommittee. Committee members include officials from HHS' headquarters divisions and its major operating components, such as the Social Security Administration (SSA) and the Health Care Financing Administration (HCFA). Staff within the Office of the Assistant Secretary for Management and Budget (ASMB) are responsible for administering the internal controls and systems review initiatives.

The Office of Inspector General (OIG) monitors HHS' implementation of FMFIA and provides technical assistance through such means as active membership on the steering committee. Monitoring efforts covered all HHS operating divisions and some staff divisions and regional components in 1984. The OIG evaluated (1) actions to correct previously reported material weaknesses, (2) measures to upgrade internal control evaluation procedures, (3) effectiveness in evaluating its accounting systems, and (4) compliance with HHS guidelines for performing ICRs. According to OIG officials, the steering committee forum provides an opportunity to review the work of the task forces and influence HHS' FMFIA practices.

Internal Control Systems

The head of each operating and staff division is responsible for assuring that internal controls are employed in all aspects of his or her organization. (See app. I for a list of HHS' operating and staff divisions.) Each division head appointed an internal control officer to assure that HHS' FMFIA directives were properly implemented. In 1984, divisions generally followed HHS directives. Although there are differences between

HHS' directives and OMB's guidelines, HHS' process, as described below, generally parallels OMB's.

Segmenting

Initially, each operating and staff division segmented its components using a list of 16 specific functions suggested by ASMB. An "internal control area" was to be established for each function performed by an organizational component. For 1983, HHS identified 6,238 internal control areas. Although two additional functions were added in 1984, the number of internal control areas remained substantially the same. (See app. II for a description of the 18 functional areas.)

Vulnerability Assessments

HHS defined a vulnerability assessment as a review of the susceptibility of an internal control area to loss or unauthorized use of resources, errors in reports and information, illegal or unethical acts, and/or adverse or unfavorable public opinion. A major goal of the vulnerability assessment process was to rank internal control areas' vulnerability to fraud, waste, and abuse. The ranking was to be used in scheduling areas for more detailed internal control reviews.

Internal Control Reviews

HHS defined an ICR as a detailed examination of an internal control area to determine whether adequate control techniques existed. HHS initially required highly vulnerable areas to be reviewed during 1983 and all other areas within 5 years. HHS' internal controls manual issued in February 1985 removes the 5-year requirement.

HHS guidance provided that reviews, such as those performed by GAO and the OIG and those ongoing by management, may be substituted for ICRs, provided they met ICR requirements or could do so with minimum modifications. Internal control officers were responsible for determining whether substitutes (referred to as "ongoing efforts") were acceptable.

Accounting Systems

Before OMB issued guidelines on May 20, 1985, HHS developed a program for evaluating and reporting on its 79 accounting systems which included

- a questionnaire for reviewers to use in evaluating their systems;

- procedures requiring (1) a written explanation of negative or nonapplicable questionnaire responses, (2) verification of affirmative questionnaire responses through statistical sampling techniques, interviews, and on-site observations, and (3) documentation of the review results; and
- a plan under which all systems in the inventory will be reviewed by September 30, 1987.

Efforts to Improve FMFIA Policies and Procedures

Our March 20, 1984, draft report on HHS' first-year implementation of FMFIA included 16 recommendations for improving procedures. In commenting on the draft, HHS concurred with our recommendations and said it would develop an action plan to implement them. By August 1984, HHS had made little progress. However, after we discussed the delay with HHS officials, the FMFIA steering committee met in September 1984 and developed an implementation plan. As a part of the plan, 12 task forces—6 to concentrate on internal controls and 6 on accounting systems—were formed to review and, where appropriate, modify existing directives.

As of July 1985, HHS was still developing revised methodologies for reviewing its accounting systems but had completed an internal controls manual for component agencies' use for 1985 section 2 FMFIA efforts. The manual, which was issued in February 1985, addresses many of our recommendations.

Year-End Reporting to the President and the Congress

On January 31, 1985, the Secretary issued her annual report on HHS' accounting systems and systems of internal control. The report indicated that (1) HHS had corrected 180 of the 200 material internal control weaknesses identified in 1983 and (2) in 1984 it had conducted 1,224 new ICRs,[3] which identified 18 material weaknesses, 10 of which had been corrected. The Secretary also reported that HHS had corrected 6 of the 21 instances of nonconformance with accounting principles and standards found in 1983 and, for 1984, reported 15 additional examples of nonconformance of HHS' accounting systems. Most of the uncorrected weaknesses and instances of nonconformance were to be resolved in 1985.

[3]In addition to the 1,224 new ICRs performed in 1984, about 280 additional ICRs were performed which repeated 1983 ICRs.

Objectives, Scope, and Methodology

Our objectives were to evaluate the status of HHS' implementation of FMFIA and the reasonableness of its annual report for 1984 on the status of its internal controls and accounting systems. Our review was performed in accordance with generally accepted government audit standards and coordinated with the OIG.

We evaluated HHS' FMFIA efforts in the following areas:

- Providing the President and the Congress with an annual report on the condition of its internal controls and accounting systems.
- Conducting internal control reviews.
- Conducting evaluations of accounting systems.
- Correcting identified weaknesses.
- Making changes and improvements that address our proposals of last year for strengthening the ICR process.

Internal Controls

Regarding section 2 of FMFIA, we reviewed HHS and OMB instructions and guidelines and their application at HHS' five operating divisions and two of its Regional Administrative Support Centers (RASCs). We also reviewed the OIG's involvement in the FMFIA effort.

Our review was performed at HHS headquarters, Office of Community Services headquarters, Office of Human Development Services headquarters, and St. Elizabeth's Hospital in Washington, D.C.; SSA and HCFA headquarters in Baltimore, Maryland; Public Health Service (PHS) and its component agencies' headquarters in Rockville, Maryland; National Institutes of Health headquarters in Bethesda, Maryland; and Centers for Disease Control headquarters in Atlanta, Georgia. Regional components of these agencies were reviewed as shown in table 1.1.

Table 1.1: Regional Components of HHS Agencies Visited

	HHS components			
HHS region	**SSA**	**HCFA**	**PHS**	**RASC**
Philadelphia (III)	X			
Atlanta (IV)	X	X	X	X
Kansas City (VII)	X			
Denver (VIII)		X		X
San Francisco (IX)	X			
Seattle (X)		X		

As shown in table 1.2, our review also involved an examination of ICRs, which included discussions with persons who performed them.

Table 1.2: Internal Control Reviews Reported by HHS and Examined by GAO

	ICRs performed by HHS	ICRs examined by GAO
SSA	1,080	96
HCFA	31	1
PHS	197	22
RASC	19	2
Office of Human Development Services	6	1
Office of Community Services	14	10
Other HHS components	157	0
Total	**1,504**	**132**

The ICRs were selected judgmentally so that we could examine them for a cross-section of organizational units and functional areas.

We also analyzed HHS' and its component agencies' evaluation of automatic data processing (ADP) internal controls. This analysis was performed principally at SSA, HCFA, and PHS. At each, we interviewed the systems security officer, internal control officer or his representative, and other officials. We also interviewed the chairman and members of the Department's FMFIA ADP task force.

In addition, because our preliminary review of HCFA showed that it had, in effect, excluded from its FMFIA evaluations the adequacy of internal controls over benefit payments under the Medicare and Medicaid programs, we undertook a review to identify what HCFA does in its day-to-day activities to assure the propriety of payments made on behalf of Medicare and Medicaid beneficiaries. We identified 21 programs, referred to as monitoring programs, that are HCFA's principal means of assuring the propriety of benefit payments made by HCFA's paying agents. We reviewed the policies and procedures for all 21 programs, but because of the number and complexity of these programs, we concentrated our evaluation on four of the programs used to review payments by certain Medicare paying agents at three regional offices.

Accounting Systems

We performed our review of section 4 activities at HHS headquarters in Washington, D.C.; SSA and HCFA headquarters in Baltimore, Maryland; PHS/Centers for Disease Control in Atlanta, Georgia; PHS/Health Resources and Services Administration and PHS/Food and Drug Administration in Rockville, Maryland; PHS/National Institutes of Health in Bethesda, Maryland; and the Atlanta and Denver RASCs.

We reviewed HHS' instructions and their implementation to assess the adequacy of accounting systems review efforts. We assessed the Department's review of the following 10 systems:

- Office of the Secretary/Office of Human Development Services Accounting System.
- HCFA Accounting Reporting Tracking (HART) System.
- HCFA/HART Letter of Credit System.
- HCFA/HART Payment Subsystem.
- SSA Retirement, Survivors and Disability Insurance (RSDI) Post-Entitlement System.
- SSA/RSDI Initial Claims System.
- PHS/Centers for Disease Control Accounting System.
- PHS/Food and Drug Administration Accounting System.
- PHS/Health Resources and Services Administration Accounting System.
- Regional Accounting System at departmental headquarters and two regions.

In addition to these 10, HHS reported on the condition of 2 other systems—its Payment Management System and the PHS/National Institutes of Health Central Accounting System—in its 1984 report to the President and the Congress.

We also reviewed the OIG's evaluation of HHS' second-year FMFIA efforts, and ASMB's efforts in (1) developing and overseeing HHS' approach to evaluating and reporting on its accounting systems and (2) monitoring the actions proposed to correct identified weaknesses.

Our review included discussions with appropriate personnel and examinations of the analyses and documentation available for the accounting systems reviews selected. Also, we reviewed background material on the implementation of FMFIA, prior GAO and OIG reports on HHS' accounting systems, internal reports on second-year efforts to implement section 4, and planned and completed actions for correcting weaknesses. We also coordinated with HHS in developing a mutually acceptable inventory of accounting systems subject to FMFIA.

Assessment of the Secretary's Second-Year FMFIA Statement

The Secretary's 1984 FMFIA statement to the President and the Congress did not provide an accurate perspective on the status of HHS' internal controls, whether its accounting systems conform to the Comptroller General's requirements, and the seriousness of its internal control and accounting system weaknesses.

FMFIA directs the head of each executive agency to annually evaluate and report on its systems of internal control. The agency head's report must state whether its systems were established in accordance with standards prescribed by the Comptroller General and provide reasonable assurance that the three statutory objectives are satisfied. (See p. 10.) The agency head's report must also state whether the agency's accounting systems conform to the Comptroller General's principles, standards, and related requirements. For 1984, the Secretary made the following statement:

"The department has made substantial progress in implementing the FMFIA. Reviews identified a number of internal control weaknesses and instances of non-compliance with the GAO principles and standards which are discussed in the enclosed report. However, based on the results of the review work completed to date, none of the weaknesses or instances of non-compliance significantly impair the ability of the Department to carry out its mission. During 1985 we plan to enhance the system, make additional reviews, and continue to correct identified weaknesses."

We do not believe this limited statement adequately informs the Congress of whether the Secretary concludes that HHS' systems comply with the act's requirements. Our review showed that (1) internal controls in major programs and activities, including major ADP controls, were not evaluated; (2) internal control evaluations performed were inadequate; (3) material internal control weaknesses remained uncorrected; and (4) three major accounting systems did not conform to the Comptroller General's requirements, and HHS was not in a position to state whether most of the remaining accounting systems conformed.

ADP systems that are vital to HHS' major programs have not been adequately evaluated. At SSA and HCFA, ADP systems control about $270 billion in annual disbursements for retirement, disability, and health benefit payments. HHS' ADP evaluations focused on physical security controls and did not include evaluations of controls related to specific computer applications. (See ch. 3.)

HCFA's internal controls over benefit payments made under the Medicare and Medicaid programs are not adequate. HCFA did not evaluate the adequacy of its internal controls over Medicare and Medicaid benefit payments, which in 1984 amounted to about $80 billion, or over 95 percent of HCFA's expenditures. Because HCFA had not evaluated these internal controls, we reviewed the 21 methods—referred to as monitoring programs—that HCFA uses to review the performance of paying agents (e.g., state agencies and insurance companies). These monitoring programs were not comprehensive and contained serious internal control weaknesses. The four monitoring programs that we reviewed in detail were susceptible to manipulation by the paying agents and were also not comprehensive enough to assure that payments were made for only covered, medically necessary services that were actually provided. (See ch. 4.)

SSA did not adequately evaluate the internal controls of its headquarters components or field offices. SSA headquarters components develop nationwide policies and procedures for the efficient and effective administration of the various social security programs, which annually pay about $190 billion in benefits. Also, SSA's field review efforts were compliance oriented and did not determine the adequacy and effectiveness of the existing internal controls. In addition, material internal control weaknesses remained uncorrected. (See ch. 5.)

PHS had not evaluated its internal controls in important areas such as grants, drug regulation, in-house research, and health care delivery. In addition, our review disclosed that the ICRs performed, generally, did not adequately test the internal controls. (See ch. 6.)

HHS' accounting systems contained material weaknesses that affect a substantial portion of its annual budget. Many of these weaknesses are longstanding and difficult to correct. In addition, none of the accounting system reviews that we evaluated adequately tested the accounting systems in operation, and only three adequately documented review results. Also, automated accounting system controls were not adequately evaluated.

Such serious problems existed in three of HHS' major accounting systems that, in our opinion, they did not conform to the Comptroller General's requirements. The systems are two of SSA's systems, which accounted for about $174 billion in benefit payments in fiscal year 1984, and HHS' major grants and contracts payment system, which disbursed about $44 billion.

In addition, in view of the inadequate evaluation of ADP controls, the lack of testing of systems in operation, and inadequate documentation, we believe that the Secretary was not in a position to state whether most of HHS' remaining accounting systems conformed to the Comptroller General's requirements. (See ch. 3.)

Conclusions

We recognize that the wide range and magnitude of HHS' programs and operations makes a determination on the overall adequacy of its internal controls difficult. However, we believe that the Secretary's statement should have clearly informed the President and the Congress whether she concluded that some or any of HHS' systems comply with the act's requirements. Further, we believe that the Secretary should have informed the President and the Congress of those systems that had not been sufficiently evaluated to support a conclusion of compliance or noncompliance in order to provide a better perspective and to be more informative about the status of HHS' controls.

We believe that the Secretary's 1984 FMFIA statement did not adequately disclose (1) that major programs and activities were not evaluated, (2) that there were limitations in the scope of evaluations performed, and (3) all uncorrected material weaknesses. If the recommendations in chapters 3 through 5 of this report are implemented, we believe future internal control evaluations will be more comprehensive and effective and will provide a more meaningful basis for the Secretary's statement.

In making a determination on the adequacy of internal controls, we believe the Secretary should collectively consider the (1) significance of the weaknesses disclosed, (2) status of corrective actions, and (3) comprehensiveness and quality of evaluation work performed. We also believe the Secretary should clearly disclose HHS' basis for its opinion by identifying those functions and operations where (1) controls are adequate, (2) controls are not adequate, and (3) controls have not been sufficiently evaluated to know whether they are adequate.

Regarding HHS' accounting systems, we believe that the Secretary should have stated that, in view of the lack of testing of accounting systems in operation, inadequate documentation of review results, and inadequate evaluation of ADP controls, she was not in a position to state whether most of HHS' accounting systems conformed to the Comptroller General's requirements. In addition, we believe the Secretary should have stated

that, because of serious problems in three of HHS' major accounting systems, the systems did not conform to the Comptroller General's requirements.

Recommendations

We recommend that the Secretary of HHS, in future year-end FMFIA statements to the President and the Congress,

- clearly state whether all or any of HHS' internal control systems do or do not comply with the act's requirements that they be established in accordance with the Comptroller General's standards and provide reasonable assurance that the three statutory objectives are satisfied;
- clearly state whether all or any of HHS' accounting systems do or do not conform to the Comptroller General's principles, standards, and related requirements; and
- identify the internal control and accounting systems that have not been sufficiently evaluated to determine whether they comply with or conform to applicable requirements.

Agency Comments and Our Evaluation

In commenting on our draft report, HHS said that

- our report was not timely enough to be of assistance,
- we did not consider factors other than the results of the internal control evaluation process in formulating our conclusions on reasonable assurance,
- the report did not adequately acknowledge actions it had taken to revise the FMFIA process, and
- our report contained inaccuracies.

HHS also provided us the comments prepared by its component agencies and concluded that because of numerous technical problems in the report, it would not comment on the recommendations. (See app. V.)

We do not believe the report contains inaccuracies or technical problems and regret that HHS did not address the merits of our recommendations. We continue to believe that their implementation would strengthen HHS' internal controls and accounting systems. Our evaluation of HHS' comments follows. Our evaluation of component agency comments are in chapters 3 through 6 and in appendix IV.

Timeliness of Our Report

HHS suggested that issuing our report almost 1 year after the period covered significantly weakened its utility. Also, HHS stated that although the report covers only the period through September 30, 1984, its issuance now implies that it characterizes the situation now.

We disagree. The fieldwork for our report was conducted between July 1984 and May 1985. On November 26, 1984, prior to issuance of the Secretary's 1984 report, we sent a letter to the Chairman of HHS' FMFIA steering committee, which discussed our initial observations on many of the matters discussed in this report. (See app. VI.) Also, between June and August 1985, close-out meetings were held with major component agency FMFIA officials. During those meetings, the matters contained in this report were discussed thoroughly. Further, we believe that a constructive reading of our report will provide HHS with guidance in the preparation of its 1985 FMFIA year-end report to the President and the Congress on the status of HHS' internal controls and accounting systems—particularly since the major problems discussed continue to exist. For example, internal controls at HCFA are still inadequate; internal controls for many other major HHS programs, including major ADP controls, have not been evaluated; material internal control weaknesses remain uncorrected; and major accounting systems do not conform to the Comptroller General's requirements.

Therefore, while we agree that earlier issuance of the report would have been desirable, our discussion of the status of controls at HHS and our recommendations for improvements will still be useful to the Department.

Our Consideration of Reasonable Assurance

According to HHS, our report does not recognize that policy issues regarding reasonable assurance have been raised by OMB. In particular, OMB differs with GAO as to what constitutes reasonable assurance and does not believe it realistic to establish minimum evaluation criteria for agencies to achieve before they can provide a reasonable assurance statement. HHS also stated that, according to OMB, agency management is expected to consider more than the results of the internal control evaluation process in determining whether there is reasonable assurance that the objectives of internal control are being achieved for the agency as a whole. In addition, HHS stated the report fails to set forth the costs and benefits associated with implementing each of our recommendations.

We have raised questions about OMB's FMFIA guidelines. In our overall first-year report on FMFIA (GAO/OCG-84-3), we recommended that OMB

clarify and revise its guidance on the agency head's year-end reporting statement. We suggested an approach that would more fully disclose the status of controls and material weaknesses by identifying those functions and operations where (1) controls are adequate, (2) controls are not adequate, and (3) controls have not been sufficiently evaluated to know whether they are adequate. Such an approach would lead to more informative reporting. The House Committee on Government Operations, in its August 2, 1984, report, also recommended that OMB revise its annual reporting guidance. OMB did not act on these recommendations.

Our approach is consistent with the FMFIA requirement that agencies make their year-end statements based on whether their systems provide reasonable assurance that the statutory objectives are met and not on absolute assurance. We recognize that management judgment is involved in reaching a conclusion on the adequacy of internal control systems. The size of the organization, diversity of operations, and degree of centralization are among the many factors that agency management must consider in establishing and maintaining such systems.

However, in making such judgments, we believe that agencies should evaluate their key systems and, in doing so, consider four factors: (1) the comprehensiveness and quality of the evaluation work performed, (2) the significance of the weaknesses disclosed, (3) the status of corrective actions, and (4) the extent to which accounting systems conform to the Comptroller General's requirements. These factors should collectively serve as the foundation for the agency's assessment of whether its systems of internal control provide reasonable assurance. They do not, in our view, represent minimum evaluation criteria beyond that contemplated by the act. We do not believe these factors were considered collectively in preparing the Secretary's 1984 FMFIA statement because, as stated on page 20 of this report, that statement did not adequately disclose (1) that major programs and activities were not evaluated, (2) that there were limitations in the scope of evaluations performed, and (3) all uncorrected material weaknesses.

We agree with the OMB guidance that says agency management should consider more than the results of the internal control evaluation process. In our review, we did that. For example, because HCFA excluded the adequacy of internal controls over Medicare and Medicaid benefit payments from its FMFIA evaluations, we reviewed the monitoring programs HCFA uses to review the performance of its paying agents.

With respect to addressing the cost implications of implementing the act, we recognize that the cost of implementing internal controls should not exceed the benefits. However, because benefits and costs are often not precisely quantifiable and can vary substantially with how a control is implemented, we believe HHS should weigh the benefits of internal controls against implementation costs.

Limited Acknowledgement of HHS' Actions

HHS stated that our report does not adequately acknowledge actions taken to revise the review process in 1985. The objectives of our review were to evaluate the status of HHS' implementation of FMFIA and the reasonableness of its annual report for 1984. Therefore, our work did not focus on 1985 activities.

However, the specific actions that HHS said we failed to adequately recognize, do not, in our opinion, support HHS' statement that "HHS management at all levels aggressively pursued the Department goal of fully implementing the FMFIA in an efficient and orderly manner." For example:

1. HHS said that the entire internal control system was restructured and on December 31, 1984, a comprehensive manual was issued which addresses all phases of the internal control process. As noted on page 14, we met with HHS officials in August 1984 to discuss the lack of progress in implementing the corrective actions they agreed to in response to our first-year report recommendations. At that meeting, we discussed efforts to improve FMFIA policies and procedures. At another meeting, in September 1984, the Assistant Secretary for Management and Budget stated that very little progress had been made in implementing our recommendations between March and September 1984. In response to this situation, the Department established six task forces to improve their FMFIA internal control procedures. The task force effort led to the development of the manual, which was transmitted to HHS components on February 14, 1985.

2. HHS stated that it had decided to expand the internal control program to cover Medicare intermediaries beginning with the 1986 FMFIA cycle. HHS also stated that, during the 1985 cycle, HCFA developed guidelines, policies, cost estimates, etc., to prepare for implementing HHS' decision. This statement is misleading because in October 1985, FMFIA personnel at HCFA said they had requested estimates on how much it would cost to have Medicare paying agents conduct self-assessments of their internal controls but that they had not yet received these estimates. Also, we do

not believe that the action being taken is timely. We had pointed out in our May 1984 report on HHS' first-year implementation of FMFIA that HCFA was not covering the propriety of benefit payments under the Medicare and Medicaid programs.

3. HHS said that from the program's inception, its directives stressed the importance of testing and documentation. We agree that HHS has recognized the need for testing and documentation, but note that we found problems in testing and documentation in both our first- and second-year reviews. These problems may be alleviated by the more specific instructions included in the new internal controls manual. However, problems continue regarding the adequacy of HHS' testing of its accounting systems, which is discussed in chapter 3 of this report.

4. HHS stated that it was developing a formal training program during the 1985 FMFIA cycle. We agree that there is a need for HHS to complete the development of a formal FMFIA training program.

5. HHS stated that its reports are structured to disclose fully all weaknesses and the status of corrective actions. We agree that HHS has a system for tracking reported internal control weaknesses and corrective actions taken. However, as shown on pages 45, 58, and 59, important weaknesses we reported on HCFA and SSA activities were not included in HHS' reporting systems.

Purported Inaccuracies in Our Report

HHS stated that our report (1) incorporated headlines that were not supported by facts and (2) made an inappropriate presentation that did not provide full disclosure. The example it cited as an unsupported headline is the SSA chapter title— "SSA's Assessment of Internal Controls Was Inadequate." HHS states that our report indicates that SSA reviewed 359 (about 26 percent) of its field offices but does not explain why a 26-percent sample is inadequate.

We disagree. Our report states that our conclusions are based on inadequacies in SSA's reviews and not the sample size. As our report notes, SSA field office reviews are effective in assessing how well field offices are adhering to established controls. Our concern is that the reviews do not address the adequacy of established controls or the need for additional internal controls.

Also, on page 54, our report points out that as of June 30, 1985, only 17 ICRs had been performed at SSA headquarters. Only one of these—the

general ledger system— included elements related to SSA's major programs and activities, which pay out over $190 billion annually. The headquarters reviews were concentrated in administrative areas, such as personnel administration and property, plant, and equipment. Because SSA's major programs depend on policies and procedures—including internal control procedures—developed at headquarters, we believe that SSA's FMFIA evaluations will not be adequate until these procedures are evaluated.

As an example of our making an inappropriate presentation without full disclosure, HHS cites the following statements that we made concerning the status of PHS' FMFIA efforts:

- Eleven of PHS' functional areas, including the largest involving the administration of grants, were not covered by ICRs or reliable vulnerability assessments.
- Many important PHS activities were excluded from PHS' inventory of internal control areas, including drug regulation, in-house research, and delivery of health care services.

HHS states that an appropriate presentation would have disclosed that PHS conducted ICRs for its grants function during the 1985 FMFIA cycle and significantly expanded its inventory of internal control areas by including programmatic activities, such as the ones stated in our report.

We believe that statements included in our draft report on PHS' future plans provided adequate disclosure on the status of its FMFIA efforts. Our draft report stated PHS officials informed us that:

- They had developed a methodology for evaluating the grants areas and planned to complete ICRs by the end of the fiscal year.
- In-house research would be added to the list of functional areas and that other areas, such as drug regulations and health care delivery, were being considered.

HHS Needs to Adequately Evaluate and Strengthen Its Accounting Systems and ADP Internal Controls

The Secretary's 1984 year-end statement to the President and the Congress reveals serious problems in three of HHS' major accounting systems. The systems are two of SSA's systems, which accounted for about $174 billion in benefit payments in fiscal year 1984, and HHS' major grants and contract payments system, which disbursed about $44 billion. In our opinion, these systems do not conform to the Comptroller General's principles, standards, and related requirements.

Also, HHS did not adequately evaluate ADP internal controls. Such an evaluation is necessary because (1) operation of HHS' programs heavily depend on ADP and (2) internal controls, including ADP controls, are key to good accounting systems. In view of the lack of testing of systems in operation, inadequate documentation of review results, and inadequate evaluation of ADP controls, the Secretary was not in a position to state whether the remainder of HHS' accounting systems conformed to the Comptroller General's requirements. In addition, HHS did not act on our first-year suggestions to provide guidance and training to reviewers and to monitor system evaluations.

Background

HHS' accounting systems cover a wide range of activities, including Social Security, Medicare, and Medicaid benefits and accountability of biological products at PHS' Centers for Disease Control. In 1984, HHS reported it had 79 accounting systems and, in the Secretary's year-end statement, reported on the condition of 12 of them. These included many of HHS' largest systems (seven of the eight general ledger systems, the department-wide Payment Management System, and two of SSA's largest benefit payment systems). A list of these 12 systems appears in chapter 1.

HHS developed a department-wide program for evaluating and reporting on its accounting systems. It centers on (1) a questionnaire (outlining the Comptroller General's April 18, 1983, Statement of Accounting Principles and Standards for Federal Agencies) for reviewers to use in evaluating their systems; (2) procedures requiring a written explanation of negative or nonapplicable questionnaire responses; (3) verification of affirmative questionnaire responses through statistical sampling techniques, interviews, and on-site observations; and (4) documentation of the review results.

Material Weaknesses Exist in Key Accounting Areas

Three of HHS' major systems, accounting for about $218 billion in annual expenditures, did not conform to the Comptroller General's principles, standards, and related requirements. In addition, HHS made only limited progress in correcting accounting system weaknesses identified in 1983.

Three Systems Did Not Conform to Comptroller General Requirements

In 1984, HHS cited significant and wide-ranging weaknesses related to SSA benefit payment systems, including its automated internal controls. Based on the weaknesses identified by a private contractor's 1983 review of two of SSA's accounting systems—the RSDI Initial Claims system and Postentitlement system—SSA's Acting Commissioner concluded in her 1984 report to the Secretary that the identified weaknesses precluded adequate assurance that SSA's systems as a whole conform to the Comptroller General's requirements. In fiscal year 1984 these systems accounted for about $174 billion in benefit payments, or approximately two-thirds of HHS' total budget.

The specific weaknesses cited were:

- The control over system operations is not sufficiently documented, is inconsistent in execution, and is so fragmented across organizational units that it is not effective.
- There is insufficient control to insure that only authorized transactions enter the automated systems and that those entered have been processed.
- There is insufficient control to insure that all output created by the automated systems is produced and distributed.

According to SSA officials, the corrective actions needed to address these weaknesses center on modernizing computer equipment to upgrade SSA's processing capabilities and automating many of the manual processes used to compute benefit payments.

HHS also disclosed weaknesses in its department-wide Payment Management System. This system accounts for, controls, and makes most cash advances to states, local governments, schools, and nonprofit medical research activities under grants, contracts, loans, and other financial agreements. In 1984, this system accounted for about $44 billion in disbursements.

Although the Payment Management System was implemented in January 1984, the weaknesses disclosed by HHS were longstanding in that, in

1979, GAO had identified them as weaknesses in the predecessor system.[1] HHS stated that the current system did not provide sufficient control of overadvances to recipients. Also, these overadvances are not being collected because of inadequate departmental policies and procedures. In addition, the system does not include key subsystems for charging its appropriations and managing its grant recipient accounts, which are intended to correct deficiencies we identified in the areas of cash management and debt collection and in the liquidation of receivables. HHS plans to finish implementing these subsystems in 1986.

Limited Progress in Correcting Accounting System Weaknesses

HHS has made limited progress in correcting accounting system weaknesses. Of the 21 material accounting system weaknesses identified during 1983 affecting key areas, such as property and payroll, HHS had corrected only 6. We recognize that some of the uncorrected material weaknesses may require long-term corrective efforts. However, until corrected, such weaknesses may cause an accounting system to not conform to the Comptroller General's requirements.

Reported property system weaknesses involved not reconciling the Regional Accounting System and the Office of the Secretary/Human Development Services Accounting System with departmental property management records. This weakness affects about $33 million in property.

For payroll, most of the weaknesses in HHS' Centralized Personnel/Payroll System reported in 1983 have not been corrected. These weaknesses include the lack of a general ledger system and an inadequate debt collection system. This system accounts for about $4 billion in payroll disbursements.

Corrective actions for the 1983 weaknesses involve system enhancements that are part of HHS' long-term efforts to develop an HHS-wide accounting system—namely, the Financial and Administrative Integrated Management System. Once implemented, the system is intended to be a single, uniform accounting/administrative system that will integrate the following applications: general ledger, fund control/budget execution, accounts receivable, accounts payable, stock inventory, fixed assets, and procurement. HHS officials predict that the system will be fully operational in 1987.

[1] HEW Must Improve Control Over Billions in Cash Advances (FGMSD-80-6, Dec. 28, 1979).

Additional Work Is Needed to Determine System Conformance

HHS did not adequately evaluate its ADP internal controls on which the soundness of the internal control and accounting systems heavily depend. Also, HHS system reviewers did not sufficiently test operations for most of the accounting systems reviewed in 1984 or adequately document the review results. These problems were also disclosed in our first-year report. In addition, HHS did not generally address our other first-year proposals to improve accounting system reviews.

Need to Evaluate Internal Controls of Computer Applications

Notwithstanding its heavy dependency on ADP, HHS did not adequately evaluate ADP internal controls during 1984. This occurred primarily because HHS relied on its ADP security program established in response to OMB Circular A-71, which focused on physical security controls and did not include evaluations of controls related to specific computer applications. Also, the security program reviews did not adequately document the work performed or test ADP controls.

HHS' ADP security program requires agencies to perform "sensitivity assessments" and "risk analyses" of their ADP systems. A sensitivity assessment examines physical security matters, such as the size and location of the system and the sensitivity of the data being processed. It shows the susceptibility of an ADP system to a breach of security. Risk analyses identify any material security weaknesses. HHS directed that sensitivity assessments and risk analyses be used in place of vulnerability assessments and ICRs.

ADP internal controls can be divided into two major categories: general controls and application controls. General controls apply to the processing carried out by an ADP center. Application controls relate to specific computer applications and often are categorized as data origination, input, processing, and output controls. HHS' ADP security program emphasizes evaluations of ADP general controls and generally excludes evaluations of application controls even though they can be found in every major HHS ADP system.

In addition, ADP security program reviews at the three major HHS operating divisions—SSA, HCFA, and PHS—generally did not include adequate testing of ADP general controls and documentation of work performed. The SSA systems security officer's second-year report consisted of a summary of SSA's planned actions to correct one material ADP weakness and was based solely on discussions with other agency officials. He said his involvement in documenting ADP internal control review activities was minimal.

The systems security officer at HCFA gave the HCFA internal control officer short synopses describing four material ADP weaknesses reported by HCFA and its planned corrective actions. The HCFA systems security officer stated the synopses were supported by personal knowledge, undocumented discussions with HCFA personnel, and a memorandum from ASMB addressing the lack of security clearances for contractor personnel.

The PHS systems security officer did not report anything to HHS. He said he was not asked to report on ADP in 1984.

Need to Test Accounting Systems

In addition to not testing ADP internal controls, HHS' 1984 evaluation efforts did not include sufficient testing of its accounting systems to determine if they were operating in accordance with established policies and procedures.

In 1984, we recommended that HHS ensure that future accounting system reviews adequately test systems. HHS alerted system reviewers about our concerns. However, of the 10 systems we reviewed in 1984, reviewers did only limited testing of 9 and no testing for the other. The extent of the limited testing of the nine systems varied. For example, one HHS component tested only two transactions for the review of its general ledger system, while another component tested some types of transactions (e.g., travel advances, accounts receivable, accounts payable, and fund control) in its general ledger by tracing them from output reports back through the system to their source.

To determine whether a financial system conforms to the principles, standards, and related requirements prescribed by the Comptroller General, the system must be reviewed and tested in operation. Although agency personnel may have extensive systems knowledge, systems may operate differently than they believe. Therefore, testing should be done on all critical aspects of the system and may include

- interviewing persons who operate the system,
- observing operating procedures,
- examining system documentation,
- applying procedures to live transactions and comparing results,
- directly testing computer-based systems by use of simulated transactions, and
- reviewing error reports and evaluating error follow-up procedures.

Tests should be designed to disclose whether valid transactions are processed properly, and whether the system rejects invalid transactions. The tests should cover the entire transaction, from initial authorization through processing, posting to the accounts, and reporting. Accordingly, manual as well as automated operations must be included. In developing test plans, consideration should be given to the results of any prior system testing.

These testing criteria have been adopted by OMB and included in Appendix H of its publication, Guidelines for Evaluating Financial Management/Accounting Systems (May 20, 1985). In determining the appropriate tests for any system, more than one of the above techniques are generally needed to test all important aspects of an accounting system.

Need to Adequately Document Results of Accounting System Reviews

HHS instructions require that (1) assertions of conformance (i.e., affirmative responses to the questionnaire) be verified through statistical sampling techniques, interviews, and on-site observations and (2) negative and nonapplicable questionnaire responses be fully explained in writing and retained as part of the review file. However, for seven of the eight HHS systems for which we reviewed the support, HHS did not adequately do this. Specifically, the support for the seven reviews did not always include adequate information on the scope and methodology of the system review efforts, the source of the information gathered, and the basis for conclusions reached.

On the other hand, one of the systems we evaluated complied with the HHS instructions. Specifically, files of PHS' Health Resources and Services Administration's system reviewers contained the scope and methodology of the review, records of interview, copies of accounting manual procedures, flowcharts, on-site observations of activities, results of transaction testing, and copies of various reports and other data. Such information can serve as the basis for future reviews, thereby saving time and promoting review continuity.

Need to Provide Guidance and Training

In 1984, we proposed that HHS publish additional instructions on the degree, types, and completeness of testing and on the documentation required for system reviews and that HHS provide training to system reviewers. HHS did not issue such guidance but reemphasized its 1983 guidance in a memorandum alerting its system review managers to our concerns.

With regard to training, HHS system reviewers told us that they had not received any training on how to conduct system reviews. Two system reviewers expressed concern that they did not know to what extent their systems should be tested or what constituted adequate review support. We believe this contributed to the inadequate reviews performed in 1984.

Need to Monitor Conformance Evaluation Process

In 1984, we proposed that HHS monitor the procedures used during system reviews to insure reviews are performed adequately. HHS, however, did not develop a monitoring program for the 1984 system reviews and, in fact, reduced its monitoring efforts. In March 1984, HHS announced a reorganization and reduction in staff within the Office of the Secretary. In accordance with the reorganization, ASMB's technical assistance and monitoring roles were reduced and the OIG was given the principal monitoring responsibility for the Department's FMFIA efforts. Monitoring by the OIG is, however, limited to "after-the-fact" evaluations of completed systems reviews.

Day-to-day monitoring could identify problems in their early stages so that necessary corrections can be made early. In addition, we believe that the components should monitor their individual efforts to insure the quality of the compliance evaluations. Recognizing this need, PHS, for example, has developed an "up front" monitoring program for its 1985 reviews. This program requires PHS staff to make on-site visits to components in order to assess the status of system reviews being performed and to monitor the procedures being used in conducting the reviews. However, for the 1984 reviews, most HHS components did not have monitoring plans.

Conclusions

In our opinion, three of HHS' accounting systems did not conform to the Comptroller General's requirements and HHS was not in a position to state whether its remaining systems conformed. Actions are being taken to correct the material weaknesses in the three accounting systems that do not conform. However, further actions need to be taken regarding HHS' review process before the Secretary will be in a position to determine whether additional problems exist in these three systems and to state whether these and the other HHS accounting systems conform. Specifically, ADP controls need to be adequately evaluated, accounting systems need to be tested in operation, reviewers' work needs to be properly documented, and system reviewers need to be provided proper guidance.

Recommendations

We recommend that the Secretary direct the Assistant Secretary for Management and Budget to issue policy and procedures to insure that:

- Accounting systems are sufficiently tested to determine conformance with the Comptroller General's principles, standards, and related requirements. Specifically, testing should determine whether valid transactions are processed in accordance with the system design, and whether the system reacts appropriately to invalid transactions.
- System reviewers are provided proper guidance on the degree, types, and completeness of testing.
- System reviews are effectively monitored to insure that they are complete and that they adequately document conclusions regarding system compliance.
- ADP application controls are evaluated and both ADP general and application controls are adequately tested and work performed documented. This guidance should extend not only to automated accounting systems, but also to other automated systems used by the Department.

Agency Comments and Our Evaluation

HHS indicated that testing of the Department's Office of the Secretary/Office of Human Development Services (OS/HDS) Accounting System, Regional Accounting System, and Payment Management System was consistent with the requirements of OMB Circular A-127, Financial Management Systems (see pp. 86 to 90). This circular, dated December 19, 1984, provides that a review shall be conducted annually by system managers in accordance with a separately issued OMB review guide. The review guide,[2] issued in May 1985, requires that each system be examined and evaluated in detail at least every 3 years, including testing of both valid and invalid transactions. It also requires that limited reviews be made annually for each financial system component and subsystem not subject to detailed evaluation.

HHS said that transactions were examined in various areas generally through output reports, including tracing back to source documents to determine processing problems. The limited system reviews also included (1) interviewing persons who operate the system, (2) observing operating procedures, (3) examining system documentation, and/or (4) reviewing error reports and evaluating error follow-up procedures. In commenting on the OS/HDS Accounting System and the Payment Management System, HHS also stated that detailed reviews would not be conducted until after the 1985 FMFIA review cycle.

[2]OMB, Guidelines for Evaluating Financial Management/Accounting Systems.

In our opinion, an adequate review of an accounting system's compliance with the Comptroller General's requirements must include testing of both valid and invalid transactions. The HHS reviews we evaluated had not adequately included such tests. Therefore, until HHS performs reviews that include transaction testing, we do not believe it will have an adequate basis to conclude whether its accounting systems meet the Comptroller General's requirements.

In commenting on our statement that the OS/HDS and Payment Management systems reviews were inadequately documented, HHS said that the reviews were extensively documented. However, we found instances where the OS/HDS system review documentation of work done and conclusions reached was not sufficient to support a statement regarding whether the system conformed with all of the Comptroller General's requirements. In addition, in a December 20, 1984, report to the Assistant Secretary for Management and Budget, the OIG stated that HHS' review of the Payment Management System was inadequately documented.

Our draft report stated that the Payment Management System does not include key subsystems for charging its appropriations and managing its grant recipient accounts. HHS commented that we should recognize that interim subsystems are in place and system controls over payments are fully operational.

It should be pointed out that the Secretary reported that the Department's Payment Management System had a material weakness because it had not implemented key subsystems due to turnover of ADP staff. HHS made no reference in the Secretary's report to interim subsystems being in place, even though HHS personnel advised us in October 1985 that they represent manual processes that have been in place for years.

In our draft report, we also stated that HHS did not adequately evaluate its ADP internal controls. In commenting on this, the SSA internal control officer noted that SSA is following HHS' Internal Control Manual, issued in early 1985. He said that SSA's ADP emphasis in the implementation of FMFIA is oriented to its Systems Modernization Plan. He stated that, given limited resources, SSA believes that the best place to develop strong controls is in redesigned systems and processes. The internal control officer also noted that control weaknesses in programmatic processes have been identified from many reviews conducted over the years by SSA and others, some safeguards have been implemented, and

other efforts are underway that emphasize the need for improved internal controls.

We agree that some of the efforts specifically mentioned by the internal control officer could result in improved internal controls. However, these efforts were either not completed in 1984 or were not formally designated by the agency as 1984 FMFIA efforts. For example, as we discuss in our report, SSA's Progress in Modernizing Its Computer Operations (IMTEC-85-15, Aug. 30, 1985), agency officials told us that SSA will not be fully using its redesigned software until at least the early 1990's. Also, the Systems Engineering Technology Manual, when it is completed, may help resolve some automated internal control weaknesses, such as poor documentation and inadequate systems security. Implementing an improved access control method is another possible improvement. Based on our review of the ADP sections of the Internal Control Manual, and based on agency officials' comments, however, we do not believe that the new manual provides adequate guidance to agencies responsible for FMFIA ADP activity.

We believe there is a need to better integrate ongoing ADP activities at SSA with the FMFIA process to ensure that sufficient information is available to the Commissioner to make a determination of reasonable assurance on the status of SSA's internal controls. The SSA systems security officer told us that his involvement in documenting 1984 ADP internal control review activity was minimal. His report on 1984 FMFIA activities at SSA consisted of a summary of SSA's planned actions to correct one ADP material weakness which was based solely on discussions with other officials. No other activities were included in that report.

Notwithstanding the activities mentioned by the SSA internal control officer, we do not believe there is reason to change our conclusion on the adequacy of the ADP review efforts.

HCFA's Controls Over Medicare and Medicaid Payments Are Not Adequate

HCFA's internal controls over benefit payments made under the Medicare and Medicaid programs are not adequate. Benefit payments accounted for more than 95 percent of HCFA's fiscal year 1984 expenditures of about $83 billion. Nearly all of these payments were made by paying agents. HCFA's principal means of controlling the propriety of these payments is through 21 programs[1] that it uses to review agents' performance. Our evaluation of four Medicare-related programs,[2] covering about one-fourth of the Medicare and Medicaid benefit payments, disclosed the following control weaknesses.

1. The Carrier Quality Assurance Program (QAP), HCFA's principal means of identifying claims processing errors by Medicare carriers,[3] is susceptible to manipulation by the carriers, and errors missed by carriers' QAP reviewers were not analyzed for the underlying causes of the errors. Better internal controls could reduce payment errors.

2. The four monitoring programs are not comprehensive enough to assure that payments are made only for covered and medically necessary services; services were provided as claimed; services were rendered by licensed providers, as required by law; and deficiencies are effectively tracked until they are corrected.

In addition, (1) benefit payments were not an internal control area that HCFA evaluated under FMFIA, (2) HCFA's 21 monitoring programs do not include steps that are essential in evaluating the sufficiency of internal controls, and (3) we have discussed in other reports material internal control weaknesses in both Medicare and Medicaid benefit payment systems.

[1]Appendix III describes HCFA's monitoring role and its monitoring programs in effect during fiscal year 1984.

[2]Carrier Quality Assurance Program, Contractor Performance Evaluation Program, Carrier Systems Testing Project, and Carrier Medical Utilization Review Reports.

[3]HCFA's Medicare agents that pay for services provided by physicians and other noninstitutional providers are called carriers, and those that pay for services provided primarily by hospitals and other institutions are called intermediaries.

Quality Assurance Program Does Not Adequately Cover Claims Processing

QAP, HCFA's principal means of identifying claims processing errors by Medicare carriers, is intended to provide statistically valid and uniform data on the quality of carrier performance. HCFA provides carriers with computer program tapes for selecting (1) samples of paid claims for review by their quality assurance staffs and (2) subsamples for re-review by HCFA regional staff. Carriers aggregate the results of their reviews, and the regional office re-reviews and send the results to HCFA headquarters. HCFA uses the data to evaluate carrier performance and to prepare quality control reports that rank them by error rates.[4]

The program's requirement that sample claims be reviewed for errors is similar to FMFIA testing requirements for internal control reviews. However, QAP has the following drawbacks:

- Data are susceptible to manipulation because carriers control the claims selection process.
- While the carriers are required to analyze errors they detect, HCFA did not analyze errors missed by carriers' QAP reviewers to identify systemic internal control weaknesses.
- Information on payment errors could be better analyzed to identify and correct the underlying internal control weaknesses.

QAP Process Is Susceptible to Manipulation

HCFA provides carriers with computer programs for claims selection. These programs have been modified over the years (1) to reflect changes in Medicare reimbursement procedures and (2) to make them compatible with individual carrier computer systems. Through the mid-1970's, a group of federal computer programmers implemented these modifications. HCFA personnel said they therefore had full knowledge of all carriers' computer programs and kept master programs that were used to determine if the carriers were selecting the claims properly. However, the personnel said that after a major carrier claimed the carriers could make the modifications more cheaply, HCFA devolved the modification responsibility to them. HCFA does not oversee the modifications that are made and no longer determines if carriers select claims properly.

HCFA's experience with a former carrier demonstrates the need to monitor the claims selection process. This former carrier was experiencing

[4]QAP data show two basic kinds of error rates. The occurrence error rate reflects all identified data processing errors whether or not they result in payment errors. The other error rate, which HCFA calls the payment/deductible error rate and which we call the payment error rate, reflects errors that have resulted in erroneous payments.

high claims processing error rates and was put on notice that its contract would not be renewed unless it reduced them. The carrier's QAP reports for the next two years showed declining error rates, and HCFA continued to renew the contract. After a newspaper report that the carrier had withheld claims from the QAP claims selection process, HCFA determined that the carrier had manipulated the process to prevent the selection of claims that were large and complex or had been processed by inexperienced personnel. Later, HCFA did not renew the carrier's contract.

A February 1984 report by a firm retained by HCFA to review the QAP pointed out that the integrity of the data was questionable because (1) carriers have the opportunity to make changes in the computer programs for selecting samples, (2) low error rates are in the carriers' interest, (3) HCFA lacks information on the validity of the data, and (4) HCFA lacks systems that would allow it to readily detect security violations. The contractor concluded that the most secure QAP would be one to which the carriers have no access, but that it is not possible to totally restrict carrier access. However, the study pointed out that HCFA could restrict carrier access to certain parts of the system and suggested several actions that could detect manipulation.

HCFA has not yet corrected the QAP problems, and the system remains subject to manipulation. As of July 1985, HCFA was obtaining data on carriers' QAP computer programs. This is a step in addressing the QAP system's security, but no target date has been set for enhancing the system's integrity.

Carriers also report to HCFA headquarters the results of reviews by their QAP staffs as well as HCFA regional office QAP staffs. This reporting process is also subject to manipulation because HCFA has not established oversight procedures for assuring that review results are accurately and fully incorporated into the reports.

HCFA Did Not Analyze Errors Missed by Carrier QAP Reviewers

HCFA regional office personnel re-review about 10 percent of the sample claims reviewed by carriers' QAP staffs. Table 4.1 shows that the QAP staff at the three carriers in our review missed one payment error for every two they identified.

Table 4.1: Payment Errors Identified in Sample Claims Reviewed by Carriers and the Regions

	Carrier A[a]	Carrier B[b]	Carrier C[a]	Total
Carrier-identified payment errors	127	26	141	**294**
Additional payment errors the regions identified	56	30	63	**149**
Total	**183**	**56**	**204**	**443**
Ratio of errors caught to errors missed	2.27:1	.87:1	2.24:1	**1.97:1**

[a]Data are for fiscal year 1984.

[b]Data are for the year ended June 30, 1984.

HCFA requires carriers to analyze errors to identify and correct claims processing problems. However, the three regional offices we visited did not analyze errors missed by QAP reviewers. Headquarters personnel stated that HCFA procedures require regional personnel to re-review claims and resolve all errors discovered by the regional office. However, we could not find a statement in the procedures that regional personnel are to identify and correct the underlying causes of the errors.

The regional office records on re-reviewed claims generally were not complete enough to identify why the errors occurred. However, some of the records did contain additional information on possible problems with carrier QAP reviews. For example, regional re-reviews conducted through the year ended June 30, 1984, showed that one carrier's QAP reviewers had not reported any errors relating to "diagnosis missing or questionable," whereas regional office reviewers identified 23 claims processing errors, including 4 payment errors, in this category. In resolving these errors with the carrier, regional office personnel learned that, contrary to Medicare's requirement that claims include both the diagnosis and the procedures performed, the carrier's medical consultant had advised claims processors not to deny electrocardiogram or chest X-ray claims for lack of diagnosis.

Better Controls Could Reduce Payment Errors

QAP reports on carrier estimates of benefit payment errors disclosed about $275 million in overpayments and $195 million in underpayments for the year ended June 30, 1984. Our analysis of QAP data showed that some carriers consistently had relatively high payment error rates and that coding and data-entry errors have traditionally represented about one-half of the Medicare carrier payment errors that are identified.

One of the carriers we visited, which had made payments of about $120 million for the 11 months ended June 30, 1984, estimated overpayments of about $6 million and underpayments of about $2.4 million for that time period. During the 4 years ended in March 1984, this carrier consistently had one of the 10 highest error rates.

We believe that better internal controls over the coding and entry of data could alleviate the benefit payment errors. None of the three carriers we visited used dual data-entry techniques that minimize data-entry errors. Our previous work[5] has shown that the Internal Revenue Service uses double keying data-entry techniques to enter payment-critical data into machine readable format and that virtually all data-entry errors are caught before they are entered into the computer. For Medicare and Medicaid claims processing operations, using dual data-entry techniques might be cost beneficial for such payment-critical data as amounts charged, diagnosis codes, and procedure codes.

Monitoring Programs Not Sufficiently Comprehensive

The four monitoring programs we reviewed, including QAP, included evaluations of certain internal controls but did not adequately assess the reliability of carrier-submitted monitoring data. These programs were not comprehensive enough to assure that the services paid for were (1) covered and medically necessary, (2) provided as claimed, and (3) rendered by licensed providers, as required by law. In addition, the programs did not effectively track deficiencies to assure corrective action.

Reviews for Coverage and Medical Necessity Do Not Include Sufficient Testing

HCFA's monitoring programs do not adequately evaluate carrier determinations of whether claimed services are covered by Medicare and are medically necessary. The monitoring programs are generally limited to analyses of reports and other information submitted by carriers. Reliability assessments of the information are not made, and evaluations do not include adequate assessments of carriers' screens to identify claims of questionable coverage or medical necessity.

One of the four monitoring programs we reviewed—the Carrier Systems Testing Project—is of limited value for reviewing coverage and medical necessity determinations because it tests few services and test results are susceptible to manipulation. Under this program, HCFA gives carriers

[5]Computer Technology at IRS: Present and Planned (GAO/GGD-83-103, Sept. 1, 1983) and IRS Can Do More to Identify Tax Return Processing Problems and Reduce Processing Costs (GAO/GGD-83-8, Oct. 14, 1982).

a package of about 160 test claims covering various situations and error conditions. The program tests only 10 of the over 400 services either not covered or partially covered by Medicare. The carriers are supposed to process the test claims from initial receipt and computer input to payment or other disposition, then transmit the results to HCFA for evaluation. Because the claims are readily identifiable as test claims, carriers can easily give special attention to them and control the reporting.

Another monitoring program, the Contractor Performance Evaluation Program, only partly addresses carrier coverage because it includes neither reliability assessments of carrier-submitted information nor adequate assessments of carriers' screens to identify claims of questionable coverage or medical necessity. However, it does require HCFA staff to analyze data from two other monitoring program reports, Carrier Medical Utilization Review Reports and QAP reports.

The Carrier Medical Utilization Review Reports show savings attributable to each carrier's existing controls and can be helpful in identifying, for possible nationwide application, screens reported to have been effectively used by some carriers to prevent payments for medically unnecessary services. However, HCFA does not verify the information in these reports.[6] QAP error rates are of limited usefulness to HCFA in evaluating carriers' medical necessity decisions. QAP staff at the regions we visited do not have medical training. They told us that, in reviewing claims, they relied mostly on carriers' determinations of coverage and medical necessity.

The questionable value of the Contractor Performance Evaluation Program in assessing medical necessity is illustrated by HCFA's determining that one carrier exceeded program expectations for medical review. In contrast, a regional OIG review concluded that this carrier's prepayment and postpayment utilization review systems were inadequate and ineffective due to insufficient medical review. Beginning with fiscal year 1985, HCFA added a requirement that regional reviewers determine the accuracy of medical necessity decisions for a sample of claims. However, no guidance is provided on how such accuracy is to be determined.

[6]In July 1985, HCFA personnel said they were developing plans for using contractors to selectively verify the accuracy of these reports.

HCFA Does Not Have Sufficient Assurance That Services Were Provided As Claimed

HCFA's monitoring programs for determining whether services were provided as claimed evaluate carriers' compliance with program requirements for sending beneficiaries explanatory statements. If questions are not raised through this process, a claim's validity is not likely to be questioned. Explanatory statements can be valuable to the beneficiary and in identifying inappropriate payments. However, HCFA does not require carriers to clearly specify in explanatory statements what services were provided. The statements, for example, might show that payments were made on a beneficiary's behalf for services provided between two specified dates. In rulings on a Medicare beneficiary appeals process, the U.S. Court of Appeals, District of Columbia Circuit, has found shortcomings with explanations in the statements. As of June 1985, HCFA was working to overcome these shortcomings. In implementing explanatory statement changes, HCFA should assure that carriers are required to clearly show what services were provided.

Monitoring Programs Do Not Assure That Services Were by Licensed Providers

HCFA does not require regional reviewers to determine whether carriers are making payments to providers who have lost their licenses to practice. In February 1983, we reported[7] that the carrier for the state of Michigan had at least 55 physicians on its rolls of qualified Medicare providers who did not have valid licenses and that some of them had received Medicare payments. This occurred because the carrier had not removed these providers from the rolls promptly after receiving state licensing board reports that their licenses had been revoked, suspended, or otherwise inactivated.

HCFA should require regional Contractor Performance Evaluation Program reviewers to evaluate the effectiveness of carrier efforts to maintain an effective liaison with state licensing boards, as well as other efforts to prevent payments to ineligible providers. For example, reviewers should evaluate the promptness of carrier action to remove from Medicare rolls the names of providers (1) whose licenses have been invalidated or (2) whom HHS has determined to be no longer eligible to provide services to Medicare patients.

[7]Review of Medicare and Medicaid Duplicate Payments in Michigan (GAO/HRD-83-43, Feb. 22, 1983).

Benefit Payment Deficiencies Are Not Effectively Tracked

No benefit payment control deficiencies identified as a result of HCFA's monitoring programs, and only one of several such GAO-reported weaknesses, were included in an FMFIA reporting and tracking system.

HHS' year-end FMFIA report for 1983 included no material weaknesses for HCFA's benefit payment programs, and this year's report contained only one weakness pertaining to these programs. This weakness, which had been identified in a GAO report,[8] was that carriers are paying for medically unnecessary services because of too few automated screens. In the past HCFA has required carriers to use automated screens to detect claims for only one kind of service (physician visits to nursing home patients) that might be unnecessary. However, in response to our report, it has recently expanded this requirement to some additional services and is considering expanding it further.

Other GAO-reported weaknesses involving benefit payments were not included in an FMFIA tracking system. These weaknesses include unclear guidelines for allowing capital costs claimed by proprietary hospitals and insufficient controls to prevent (1) duplicate payments, (2) unlicensed practitioners from participating in the Medicare and Medicaid programs, and (3) repeated Medicare payments for once-in-a-lifetime physician procedures. All of these weaknesses have resulted in overpayments.

Other Problems Involving Internal Controls Over Benefit Payments

HCFA has not evaluated benefit payment internal controls under FMFIA, and its 21 monitoring programs do not include steps that are essential in evaluating the sufficiency of these controls. In addition, in prior reports, we have noted internal control weaknesses in benefit payments made under the Medicare and Medicaid programs.

Benefit Payments Not Evaluated Under FMFIA

In fiscal year 1984, Medicare and Medicaid paying agents made about $79 billion in benefit payments, and HCFA itself made about an additional $1 billion in Medicare benefit payments. In our report on HHS' first-year FMFIA efforts, we reported that HCFA had not evaluated the propriety of benefit payments. In response to a June 1984 directive from HHS' FMFIA Steering Committee Chairman that components reassess FMFIA coverage of their programs and include GAO-reported program

[8]Improving Medicare and Medicaid Systems to Control Payments for Unnecessary Physicians' Services (GAO/HRD-83-16, Feb. 8, 1983).

areas that had previously been omitted, HCFA is planning an effort to cover benefit payments under FMFIA.

Benefit payments made by paying agents was not one of HCFA's 135 internal control areas established in its first-year FMFIA effort. HCFA had included monitoring of these payments in the internal control area for its Bureau of Program Operations' "procurement and purchasing" function. However, it was unclear whether benefit payments should be assessed, and the person performing the assessment covered only the area's vulnerability for administrative purchases of supplies and furniture. He said he did not cover benefit payments because he did not know they were included.

HCFA personnel said that Medicare payments made directly by HCFA—about 1 percent of all Medicare and Medicaid benefit payments—were covered in two internal control areas, and vulnerability assessments showed these areas to be of low and moderate vulnerability. However, this conclusion is questionable because as we pointed out in our first-year report, HHS' vulnerability assessment process produced unreliable results.[9] Also, in subsequent work involving beneficiaries enrolled in health maintenance organizations, we found that a carrier and HCFA had both paid for about 17 percent of the physicians' charges we reviewed. Many of the "duplicate" payments occurred because HCFA did not promptly notify carriers of beneficiaries' enrollment in health maintenance organizations. In addition, we found that because HCFA had not provided correct information to the intermediary in about one-fifth of the hospital admissions we reviewed, various payment errors were occurring. We therefore concluded that benefit payments related to Medicare's Health Maintenance Organization program were highly vulnerable to error.

HCFA officials believe they executed their 1984 internal control program according to HHS specifications and said that they are working to improve benefit payment coverage under FMFIA. They stated that recent initiatives on internal controls (vulnerability assessments completed near the end of fiscal year 1985 and ICRs scheduled for fiscal year 1986) will identify weaknesses and bring about appropriate modifications in their monitoring programs. Also, in response to an HHS Inspector General recommendation that Medicare paying agents conduct FMFIA evaluations

[9]In our first-year report we noted that HHS' assessment forms did not include all the factors necessary for making adequate vulnerability assessments. The scoring system used on these forms was biased against achieving highly vulnerable ratings, some assessment forms were inaccurately completed, and assessors received little or no training.

of their operations,[10] HCFA plans to involve carriers and intermediaries in the FMFIA evaluation process by adding additional requirements to their contracts. To reasonably assure the adequacy of benefit payment internal controls based on paying agent self-evaluations, HCFA must develop effective methods for assuring that the evaluations are comprehensive and adequately performed and that the results are properly reported.

Essential Evaluation Steps Not Included in HCFA's Monitoring Programs

HCFA's 21 monitoring programs are generally designed to determine compliance by paying agents with federal laws, HCFA regulations, and terms of agreements with the agents. While they assess the agents' implementation of many federal requirements designed to detect fraud, waste, and abuse, they do not include (1) identification of internal control objectives, (2) evaluations of whether control techniques are adequate for meeting the objectives, and (3) adequate testing. These three steps are essential in evaluating the sufficiency of internal controls.

Benefit payment control objectives include assuring that payments are made only on behalf of eligible beneficiaries for covered and medically necessary services made by licensed providers. HCFA's monitoring programs review paying agents' compliance with numerous requirements, many of which prescribe benefit payment control techniques. However, the programs often do not relate the techniques to the objectives they are intended to accomplish. In addition, reviews of compliance with benefit payment control techniques are spread throughout the monitoring programs, and the programs do not provide for consolidating the reviews to determine whether the techniques in use are adequate for meeting control objectives.

Also, the monitoring programs rely heavily on information submitted by paying agents. HCFA did not adequately verify the carrier-submitted data we reviewed. In addition, appendix III, summarizing all of HCFA's monitoring programs, shows that those covering the Medicare intermediary and Medicaid programs also rely greatly on paying-agent-submitted data. Some of these programs are very similar to the carrier monitoring programs we reviewed. For example, the Carrier Systems Testing Project and the Intermediary Systems Testing Project both involve reviews of data from paying agents on test claims processed through their systems. Our review of the Carrier Systems Testing Project showed that test results are susceptible to manipulation because

[10]Examination of Internal Control Reviews Performed by HCFA Under the A-123 Initiative (OIG Audit Report-ACN 14-42150, Feb. 24, 1984).

they are readily identifiable as test claims and carriers process them and transmit the results to HCFA.

Prior GAO Reports Indicating Benefit Payment Internal Control Weaknesses

We have discussed in several prior reports benefit payment internal control weaknesses that have resulted in overpayments. These weaknesses include unclear Medicare guidelines for allowing capital costs claimed by proprietary hospitals and insufficient controls to prevent (1) duplicate payments, (2) unlicensed practitioners from participating in the Medicare and Medicaid programs, (3) repeated Medicare payments for once-in-a-lifetime physician procedures, and (4) Medicaid payments for which private insurers are responsible.

Conclusions

While HCFA's monitoring programs assess paying agents' implementation of many federal requirements designed to detect fraud, waste, and abuse, they were generally not designed to evaluate the adequacy of internal controls over benefit payments. However, they are the only means HCFA has in its day-to-day activities to assure the propriety of payments made on behalf of Medicare and Medicaid beneficiaries.

The monitoring programs need to be strengthened before they can be effectively used to evaluate the adequacy of internal controls over HCFA's paying agents. For example, (1) the programs we reviewed were susceptible to manipulation, (2) HCFA did not analyze benefit payment errors missed by paying agents' QAP reviewers to identify systemic internal control weaknesses, and (3) better internal controls over carriers' coding and data entry could reduce benefit payment errors.

Also, the monitoring programs were not comprehensive enough because they did not

- include adequate evaluations as to whether claimed services are covered and are medically necessary and
- assure that services were provided as claimed and by licensed providers.

Recommendations

We recommend that the Secretary of HHS direct the Administrator of HCFA to strengthen the Medicare and Medicaid monitoring programs to better ensure that the paying agents' internal controls are adequate to prevent waste, fraud, and abuse. As part of these efforts, HCFA should

- under the Carrier Quality Assurance Program, monitor the processes of (1) selecting claims for review and (2) reporting review results;
- include in the Carrier Quality Assurance Program (1) a specific requirement that regional reviewers conduct analyses to identify systemic problems that cause program staff to miss errors and (2) more emphasis on identifying and correcting the underlying internal control weaknesses that allow payment errors;
- assess the adequacy and effectiveness of carriers' screens to detect claims of questionable coverage or medical necessity; and
- evaluate the adequacy of carriers' procedures for ensuring that claims from unlicensed providers are not paid.

In addition, we recommend that the Secretary direct the Administrator to include in the FMFIA reporting and tracking system internal control weaknesses identified by HCFA's benefit payment monitoring programs, as well as those identified in GAO, OIG, and other reports.

Agency Comments and Our Evaluation

In commenting on our draft report (see pp. 91 to 94), HCFA stated that it believed the focus of our work was too limited to characterize all of its internal controls as inadequate because we had evaluated only 4 of HCFA's 21 monitoring programs and only 1 of the 31 ICRs it conducted. HCFA also stated that in 1983 it had developed a 5-year ICR plan which included the scheduled evaluation of benefit payments in calendar year 1985, and contrary to the implication in our report, it never planned to review benefit payments in 1984. In addition, HCFA commented on (1) other FMFIA actions it took, (2) action initiated to include Medicare contractors under its internal control program during 1986, and (3) three of our recommendations.

We clarified the scope of our work to more adequately show that we reviewed the policies and procedures for all 21 of HCFA's monitoring programs and evaluated the implementation of 4 programs at three regional offices. Our evaluation showed that the four programs covered one-fourth of the Medicare and Medicaid benefit payments made in fiscal year 1984 and disclosed material internal control weaknesses, such as HCFA's monitoring efforts being largely limited to reviews of unverified data submitted by paying agents. We also noted that HCFA's other monitoring programs rely heavily on reviews of paying-agent-submitted data, and as we have discussed in other reports, material weaknesses exist in controls over both Medicare and Medicaid benefit payments. We therefore believe that we have an adequate basis for concluding that HCFA's controls over benefit payments are not adequate.

We acknowledge that HCFA's 5-year ICR plan did not include the evaluation of benefit payments in 1984 and agree that HCFA has evaluated internal controls of many of its administrative activities. However, these activities accounted for less than 5 percent of HCFA's FY 1984 expenditures. In the absence of broader coverage—evaluation of internal controls over benefit payments—we do not believe that HCFA had an adequate basis to state whether its internal controls were adequate, particularly when HCFA's benefit payments under Medicare and Medicaid account for about 30 percent of the Department's annual expenditures. In this context, we believe our reporting that HCFA excluded from its evaluations the adequacy of internal controls over about $80 billion in benefit payments is appropriate.

In commenting on our recommendation that it monitor the QAP claims selection process, HCFA stated that to prevent tampering with the selection of claims, it would have to assume full control and operation of the process and that this action would not be feasible. We believe that HCFA could discourage such tampering through routine tests. One test may be to periodically pick cases from payment records and determine if they were properly considered in the QAP claims selection process. In addition, both a HCFA contractor's report and HCFA personnel who said they once monitored the claims selection process noted that HCFA could improve the integrity of the QAP sample selection process without assuming full control and operation of it.

In response to our recommendation that HCFA place more QAP emphasis on identifying and correcting internal control weaknesses, HCFA noted that, under the QAP, regional offices are to routinely provide carriers with information on error findings but that the carrier has the primary responsibility for correcting the underlying causes of claims processing deficiencies. HCFA noted that regional offices already provide carriers with information on error findings but, in response to our recommendation, said it will issue a communication to remind the regional offices that they should be providing the carriers with this information.

The basic internal control weakness we found in the carrier monitoring programs was that HCFA's oversight of them is inadequate to provide reasonable assurance that carriers are carrying out their benefit payment responsibilities. We do not believe that HCFA's proposed response to our finding—to remind regional offices to provide carriers with information on error findings—will correct this weakness.

HCFA also stated that our recommendation to place more QAP emphasis on identifying and correcting internal control weaknesses appears to be based on the fact that about half of the payment errors are the result of coding and data-entry errors and that these errors could be virtually eliminated by using dual data-entry techniques. It stated that dual data-entry techniques sound reasonable, but it would be necessary to determine if they would be feasible and cost beneficial. Our intent was to illustrate that HCFA could do more to identify internal control weaknesses by pointing out the longstanding coding and data-entry error problem. We noted this problem during our analysis of QAP reports, which contained considerable data on carrier error rates but little evidence that HCFA was using the data to assure that underlying payment system weaknesses were identified and corrected. We recognize that cost benefit should be considered when deciding to implement an internal control and believe that HCFA should attempt to determine if dual data entry is cost beneficial.

In addition, HCFA stated that, to be included in the FMFIA tracking system, weaknesses should fit HHS' definition of a material weakness or be identified as a result of an ICR or vulnerability assessment. We believe that no matter how the benefit payment weaknesses are identified, HCFA needs adequate assurance that they are corrected. FMFIA provides for an internal control weakness tracking system which could provide such assurance.

We believe that implementation of our recommendations would significantly strengthen HCFA's oversight of its controls over payments made by Medicare carriers.

SSA's Assessment of Internal Controls Was Inadequate

During 1984, SSA reviewed and reported on 3 of its 125 headquarters internal control areas. It also made compliance reviews in 359 of its 1,350 field offices which identified and corrected thousands of instances where established policies and procedures were not being followed. Notwithstanding the substantial efforts put forth and the improvements resulting from the field reviews, we believe that SSA's assessment of its internal controls did not provide a sufficient basis for stating whether they were adequate.

- During 1983 and 1984, controls in less than 5 percent of the identified internal control areas at headquarters were reviewed. The areas reviewed were generally administrative and not directly related to SSA's major programs and activities.
- Field reviews were performed to determine compliance with existing policies and procedures but did not determine the adequacy and effectiveness of existing internal controls.

In addition, corrective actions had not been completed on identified material weaknesses from the previous year, such as inadequate controls over the system that maintains earnings records to ensure workers' earnings are accurately and timely recorded.

We recognize that the wide range and magnitude of SSA's programs and operations makes a determination on the overall adequacy of internal controls difficult. We also recognize that the Acting Commissioner, in her November 9, 1984, statement to the Secretary on the status of SSA's internal controls, commented on only those areas that SSA actually assessed during 1984. However, we believe that when an agency such as SSA has not sufficiently evaluated its internal controls to know whether they are adequate overall, a statement to that effect would be more complete and informative.

Background

SSA is HHS' largest operating component. Its 79,000 employees represent almost 60 percent of HHS' work force. SSA programs pay out hundreds of billions of dollars in benefits and grants to millions of people each year. For example, during fiscal year 1984:

- About 36 million individuals received $174 billion in benefit payments from the Old-Age and Survivors Insurance and the Disability Insurance programs.
- About 10.8 million people received $7.7 billion in federal assistance under the Aid to Families with Dependent Children program.

- An average of 3.6 million individuals received about $7.5 billion in federal payments from SSA's Supplemental Security Income program, which assures a minimum income level for the aged, blind, and disabled.

SSA's workload to accomplish its mission is immense. In addition to making regular monthly payments to millions of beneficiaries, SSA also maintains and annually updates earnings records on workers' accounts, processes millions of new claims for benefits each year, and adjusts its records to recognize changes of address, death notifications, and other events affecting benefit payments.

SSA is headed by a Commissioner, who is assisted by four Deputy Commissioners, each of whom is responsible for a specific functional area.

- Programs and Policy. Within this area, the headquarters Offices of Retirement and Survivors Insurance, Disability Insurance, and Supplemental Security Income develop, coordinate, and promulgate nationwide operational policies and procedures for these programs.
- Operations. Included in this area is the Office of Central Operations, which directs headquarters components responsible for central records operations, the six SSA program service centers, three data operations centers, the Division of International Operations, and central disability operations. Also included is a network of 10 regional offices and about 1,350 district and branch offices and teleservice centers. These offices serve as the primary point of contact with the public in providing SSA services.
- Systems. This group directs the planning, development, operation, and maintenance of SSA's ADP and data communications, which directly support virtually all of SSA's program activities. It also develops and maintains automated systems that produce statistical and management information.
- Management and Assessment. This group is responsible for the overall management of SSA's resources and assessment and evaluation activities.

Implementation of FMFIA at SSA is under the direction of the agency's internal control officer. The Director, Office of Management Planning and Analysis, under the Deputy Commissioner for Management and Assessment, is the current internal control officer. SSA initially identified about 4,500 internal control areas. Of these, 121 areas (later increased to 125) were at SSA headquarters, and the rest in field components.

Limited Progress Made in Reviewing Headquarters Activities

Although there has been a continuing dialogue between the Deputy Commissioner for Management and Assessment's FMFIA staff and the staffs of the other Deputy Commissioners on the need for SSA to evaluate the headquarters internal control areas, progress and cooperation have been limited. Plans submitted by SSA to HHS provided for evaluating and reporting on 23 of the headquarters internal control areas during 1983 and 1984. However, SSA reviewed only 6 of the 125 headquarters internal control areas during this time. Further, only the evaluation of the general ledger system included elements related to SSA's major programs and activities. The other five evaluations reported on were the following administrative areas.

1. Property, plant and equipment.

2. Sales of SSA resources, such as waste paper and silver reclaimed from negatives.

3. Employee identification card file record system.

4. General criminal investigation file record system.

5. Personnel administration.

All six evaluations are within the area of responsibility of the Deputy Commissioner for Management and Assessment. As of June 30, 1985, SSA completed 11 more evaluations at headquarters which were also related to the management and assessments area.

The Deputy Commissioner for Management and Assessment recognizes that the evaluation of internal controls of other SSA headquarters components is critical because these components develop policies and procedures for efficiently and effectively administering the various social security programs. In March 1984, he sent a memorandum to the Acting Deputy Commissioner for Programs and Policy emphasizing the importance of internal controls in implementing policies and procedures.

He stated that the basic objective of the internal control system is to include controls needed to ensure that payments are made only within allowable amounts to eligible recipients and activities are conducted economically and efficiently. He also stated that operating policies and procedures are the vehicle for establishing programmatic controls to achieve that objective. He further stated that operating policies and procedures largely define SSA's adjudicative process and the requirements

that must be met by both the manual and automated parts of the process.

Field Office Reviews Did Not Adequately Assess Internal Controls

Under SSA's organizational structure, field offices are the primary point of contact in providing SSA services to the public. In providing these services, the field offices follow the policies and procedures established by various headquarters components. During 1983 and 1984, SSA conducted reviews of its field office operations and counted these reviews as part of its FMFIA program. In our opinion, these reviews were effective in assessing how well field offices were following the headquarters-established procedures and in promoting an awareness in these offices of the need to adhere to procedures. The reviews, however, did not assess either the appropriateness of the internal controls within the policies and procedures or the need for additional controls.

In July 1983, SSA sent its regional offices a working draft of its Security and Operations Review Guide for use in reviewing field office operations. The guide was designed to meet several review requirements, including FMFIA. This guide and an April 1984 update entitled Security and Controls Review Guide were used by regional security officers and their staffs to review 359 field offices which were then submitted as 1984 FMFIA efforts. Three functional areas were reviewed in each office—cash; procurement and purchasing; and subsidies, entitlements, and benefit payments.

The revised guide requires reviewers to assess how well offices are adhering to established policies and procedures in handling their imprest funds; controlling refunds and other remittances received from the public; purchasing supplies; processing applications for social security numbers, initial claims for benefits, and changes to beneficiaries' accounts; transmitting data to the central office; maintaining an effective security program; and in several other areas. Examples of the types of weaknesses that these reviews have identified are shown below.

1. Most weaknesses in the cash function related to offices not following procedures regarding the accountability over cash receipt books maintained by field office staff and the completion of the cash receipt forms by the staff. The reviews found that many offices were not complying with imprest fund procedures regarding the fund's size, control, authorized use, or security safeguards and that written receipts for imprest fund activity were incomplete, inaccurate, or not processed in a timely manner. However, the reviews did not assess whether the procedures

being followed were adequate to ensure, for example, that all cash receipts were recorded in receipt books.

2. In the subsidies, entitlements, and benefit payments function, most weaknesses identified related to offices not following procedures in processing, routing, and controlling applications for social security numbers. However, the review guide did not include an examination of whether the procedures in place were sufficient to ensure that only valid applications were accepted and entered into the SSA system.

We discussed SSA's field reviews with reviewers in four SSA regions, examined documentation supporting reviews of 32 of 146 offices in the four SSA regions that were submitted as 1984 FMFIA efforts, accompanied SSA staff on reviews of six field offices, and visited 16 field offices to follow up on corrective actions taken. We found that most corrective actions we selected for review had been implemented. Field reviews we observed were conducted in a professional manner by experienced staff, review findings were generally documented in the supporting workpapers, and deficiencies identified in the reviews were communicated to the district and branch office managers for corrective action. The reviews did not, however, address the appropriateness of the internal controls in place.

Material Weaknesses at SSA

SSA reported material weaknesses in 1984 in two of its records systems—earnings records and the system used to issue, record, and control social security numbers—and in its property and ADP functional areas. However, other significant weaknesses at SSA should have been included in its 1984 assurance letter to HHS on the adequacy of SSA's internal controls. Both the reported and unreported weaknesses are discussed below.

In its November 9, 1984, assurance letter to HHS, SSA reported four material weaknesses—three uncorrected and one corrected. Reported uncorrected weaknesses were:

- Controls over the system that maintains earnings records appear inadequate to ensure that workers' earnings are completely accurate and timely recorded in their earnings records. This weakness concerned improvements needed in SSA's processing of earnings records. SSA reported that this deficiency is being addressed chiefly through a redesign of the system as part of a systems modernization plan during 1985.

- SSA's principal data center lacks a firm backup arrangement should it be destroyed or made inoperative for an extended period. This was also a 1983 reported material weakness. In its 1984 assurance letter, SSA said that a cooperative project with other HHS components was at a standstill and it was considering contracting commercially to address the problem. As of August 1985, SSA planned to award a contract but had not yet done so.
- Lack of control over personal property. Reported initially in 1983, this weakness consisted of five parts and existed primarily because SSA had not taken an inventory since 1974. Personal property at SSA headquarters amounted to almost $233 million as of April 1985. SSA reported that corrective actions had been taken for four parts, including the completion of a physical inventory at headquarters. However, we found that inventories taken in several headquarters components were not reconciled until several months later and a few inventories were not reconciled as of August 1985. These inventory figures are needed to verify general ledger figures in SSA's financial accounting system.

The weakness reported as corrected was:

- Controls in the system to issue, record, and control social security numbers appeared inadequate to assure accurate records and preclude duplicate numbers. SSA reported correcting these weaknesses by making improvements in its automated name and number files.

Except for the compliance reviews performed in the field offices and the headquarters review of the general ledger system, SSA had neither performed any internal control evaluations of its subsidies, entitlements, and benefit payments function nor reported any material internal control weaknesses in this functional area in its assurance letter to HHS. However, we noted that weaknesses had been identified in this and in other functional areas.

For example, as discussed in chapter 3, the Acting Commissioner of SSA reported material weaknesses in the RSDI Initial Claims and Postentitlement accounting systems that precluded her from providing adequate assurance that SSA's accounting systems as a whole conform to the

Comptroller General's principles, standards and related requirements.[1] We believe that these accounting systems weaknesses also represent material weaknesses in SSA's internal controls because of the interaction between the programmatic systems and the accounting systems and should, therefore, have also been reported as internal control weaknesses.

Other weaknesses involving SSA's programs that were recently reported on by GAO but not included in SSA's assurance letter on internal controls are:

- At least 2.5 million beneficiaries were underpaid about $2 billion for an extended period because of delays in recomputing benefit amounts to consider additional earnings by beneficiaries.[2]
- About $65 million in overpayments were made to beneficiaries because events that can affect their benefits (such as marriage, death, and cessation of school attendance) were not promptly reported to SSA. SSA primarily relies on beneficiaries to voluntarily report changes affecting their benefits in a timely manner. SSA had no data showing the extent that beneficiaries reported late or the resulting overpayments.[3]
- About $43 million in disability insurance overpayments resulted because either claimants failed to report benefits received under other benefit programs or SSA failed to follow up on information in the case files.[4]

SSA also did not include in its 1984 assurance letter weaknesses in its systems acquisition process that we reported[5] on in July 1984. Several weaknesses, including inadequacies in the agency's management of two contracts with the Paradyne Corporation (one a $115 million contract to

[1]SSA's Old-Age and Survivors Insurance program provides retired individuals with a supplemental retirement income, while its Disability Insurance program provides benefit payments to workers and the families of workers who become disabled before reaching retirement age. The Initial Claims and Postentitlement accounting systems establish benefit payments for initial social security insurance claimants and provide the capability for changes to be made to a beneficiary's eligibility to receive payment.

[2]Delays in Recomputing Social Security Benefits Cause Underpayments for Extended Periods (GAO/HRD-84-71, Sept. 13, 1984).

[3]Social Security Could Improve Its Management and Direction of Postentitlement Changes by Using Postadjudicative Appraisal Data (GAO/HRD-84-27, Jan. 20, 1984).

[4]Better Case File Monitoring of the Workers' Compensation Offset Provision by the Social Security Administration Could Save Millions (GAO/HRD-83-90, Sept. 30, 1983).

[5]Social Security Administration's Data Communications Contracts With Paradyne Corporation Demonstrate the Need for Improved Management Controls (GAO/IMTEC-84-15, July 9, 1984).

install over 1,800 data communications terminals in 1,350 social security offices nationwide), resulted in SSA acquiring a data communications system that did not begin to consistently meet contractual performance requirements until nearly 2 years after the first terminals were installed. In our 1984 report, we stated that these weaknesses in SSA's systems acquisition process continued to exist and presented a threat to the integrity of upcoming major systems procurements.

We believe that if SSA included these other weaknesses in its assurance letter on internal controls to HHS, it would have provided a better perspective on the status of its internal controls.

Conclusions

Because the efficient and effective administration of the various social security programs depends on the policies and procedures developed by SSA's headquarters components, we believe that SSA's evaluations of its internal controls will not be adequate until it reviews the headquarters internal control areas that directly affect its major programs. At headquarters, SSA has reviewed only a few administrative functions. Also, SSA's field review efforts were compliance oriented and did not determine the adequacy and effectiveness of the existing internal controls. In addition, material internal control weaknesses remain uncorrected.

We believe that SSA would have provided a better perspective of the status of its internal controls in its 1984 assurance letter to HHS if it had (1) stated that it did not have a basis for making a statement on its controls overall and (2) included all significant internal control weaknesses. Although SSA is in the process of reviewing its internal controls, we believe that, because of the limited progress SSA has made to date on reviewing its headquarters activities, closer monitoring by HHS is needed.

Recommendation

We recommend that the Secretary of HHS direct the Assistant Secretary for Management and Budget to monitor SSA's progress in completing its evaluations of the internal controls of SSA's major entitlement programs.

Agency Comments and Our Evaluation

In commenting on our draft report, SSA agreed that it made only limited progress in conducting reviews of its headquarters activities during 1984. (See pp. 95 to 98.) It stated that headquarters involvement was a major priority for 1985 and cited specific accomplishments made in this area. SSA's 1985 efforts include analyzing results of field reviews to

determine patterns of weaknesses, developing a new inventory of internal control areas in headquarters that better reflects programmatic responsibilities, and conducting new vulnerability assessments. These efforts should help SSA determine the status of its internal controls in 1985.

SSA disagreed with our conclusions on the adequacy of its field efforts. SSA said that the actual reviews measured compliance with existing procedures and that a field operations risk analysis, developed before the issuance of the field office review guide, addressed the adequacy of internal controls related to the field operations.

SSA's risk analysis was performed by a work group composed primarily of field personnel who "brainstormed" to identify vulnerabilities in field operations and determine the risks involved with the vulnerabilities. The risk analysis resulted in recommendations regarding corrective actions and safeguards. However, the analysis did not look in detail at the internal controls for each field office procedure. Also, weaknesses identified were not entered in the FMFIA tracking system, nor was the analysis used as an internal control review by SSA in either 1983 or 1984. Further, since the work group performed its analysis in 1982 and early 1983, the study may not be a good indicator of the adequacy of SSA's internal controls in 1984. Some of the vulnerabilities identified by the work group, however, were considered in the development of the field office review guide, and others were provided to SSA components for consideration and action. In that context, the work-group effort provided a good basis for improving the process after 1983.

In commenting on the significant weaknesses involving SSA programs that had been recently reported by GAO but not included in SSA's 1984 assurance letter to HHS, SSA said that it developed its list of material weaknesses with the assistance of GAO and OIG. We did give SSA copies of recently issued GAO reports involving SSA programs, but did not participate in decisions regarding whether specific findings should or should not be classified as material weaknesses. Similarly, the OIG told us that it gave SSA copies of its reports but did not participate in classifying material weaknesses.

For 1984, SSA commented only on the status of the internal controls in the areas it actually reviewed during the year. We stated that SSA would have provided a better perspective on the status of its internal controls if it had stated in its assurance letter that it did not have a basis for

making a statement on its controls overall. SSA responded that a determination on the appropriate kind of statement to be made and the basis for such a statement needs to be made by HHS staff. While HHS officials ultimately make these determinations for HHS, they rely to a large extent on the opinions provided by component agencies, such as SSA. Consequently, we believe that HHS officials would have had a better perspective of SSA controls if SSA had informed the Secretary that it did not have a basis for making a statement on SSA's overall internal controls.

PHS' Assessment of Internal Controls Was Inadequate

The Public Health Service's 1984 FMFIA efforts did not provide a sufficient basis to state whether its internal controls were adequate because:

- Eleven of PHS' functional areas, the largest involving the administration of grants, were not covered by ICRs or reliable vulnerability assessments.
- Many important PHS activities were not included in the original list of 16 functions that HHS provided to operating components for FMFIA coverage and were subsequently excluded from PHS' inventory of internal control areas and FMFIA coverage. These included drug regulation, in-house research, and delivery of health care services.
- For 12 of the 22 ICRs we reviewed, little or no testing was performed, and reviews were not adequately documented.

These deficiencies also existed at the time of PHS' first-year FMFIA efforts and were discussed in our May 1984 report along with proposed corrective actions. Although HHS agreed with our proposals, new FMFIA procedures were not implemented until after the end of the second year (see ch. 1).

Although the scope of PHS' FMFIA coverage was not adequate, it established an effective system for correcting identified internal control weaknesses. In 1983, PHS reported 90 material weaknesses to the Secretary. We examined 31 of these during 1984 and found that corrective actions generally had been fully implemented.

Background

PHS goals are to promote the protection and advancement of the nation's physical and mental health. As shown in table 6.1, it is composed of the Office of the Assistant Secretary for Health and five component agencies with 1984 disbursements totaling over $8 billion.

Table 6.1: Public Health Service Components and Their 1984 Disbursements

(000 omitted)

Components	1984 disbursements
Office of the Assistant Secretary for Health	$ 18,141
National Institutes of Health	4,157,294
Health Resources and Services Administration	2,190,725
Alcohol, Drug Abuse and Mental Health Administration	911,273
Food and Drug Administration	389,584
Centers for Disease Control	360,128
Total 1984 disbursements	**$8,027,145**

In implementing section 2 of FMFIA, PHS generally followed the ASMB guidance. Internal control officers were appointed for PHS and each of its five component agencies. Also, as a quality control measure, PHS established procedures to review each vulnerability assessment and ICR. In 1982, PHS conducted vulnerability assessments on each of its approximately 1,000 internal control areas covering 15 of the 16 functional areas recommended by ASMB.[1] During 1983 and 1984, 128 and 197 ICRs were performed. These were new control areas that were formed as a result of reorganizations.

Most Functional Areas Not Covered

The FMFIA process at PHS did not provide a reliable basis for determining the vulnerability of 11 of its 15 functional areas because they were not subjected to either a reliable vulnerability assessment or an ICR. This included the grants area, which accounted for over 60 percent of PHS' 1984 disbursements.

Our May 1984 report stated that HHS vulnerability assessments conducted in 1982 were not a reliable basis for scheduling and guiding later ICRs because

- the process did not include all of the factors necessary to identify highly vulnerable areas,
- some assessment forms were inaccurately completed, and
- some assessors received little or no training and said they would have rated their areas differently had they known more about the process.

ASMB officials informed us that HHS had not emphasized the vulnerability assessment process because HHS' requirement to conduct ICRs on all internal control areas within 5 years reduced their importance. However, as stated in our May 1984 report, the purpose of a vulnerability assessment is to make an initial identification of the most vulnerable areas so resources can be directed to identifying and correcting the most significant problems first. Under the HHS approach, the FMFIA process could not be relied on to identify and correct problems until all significant internal control areas had received ICRs.

PHS has generally adopted the policy of reviewing selected functional areas each year. Table 6.2 shows the status of PHS' internal control review process at the end of its second year FMFIA effort.

[1]PHS excluded the functional area "subsidies, entitlements, and benefit payments" as not being applicable.

As the table shows, ICRs adequately covered only 4 of PHS' 15 functional areas and therefore could not be used as an indicator of the quality of internal controls for the remaining 11 areas. The lack of functional area coverage was made more acute because PHS had not scheduled ICRs on its most significant activity—grants—until 1986. For fiscal year 1984, PHS' obligations for grants were about $5.3 billion, or over 60 percent of its total disbursements. In July 1984 the OIG recommended that the grants area receive priority. After the OIG's report, ASMB directed PHS to reschedule its grants ICRs for fiscal year 1985. In September 1985, a PHS official informed us that ICRs for the grants area were underway and would be completed by the end of the fiscal year.

Table 6.2: Status of Internal Control Reviews As of End of Second-Year FMFIA

Functional areas	Internal control areas	Completed ICRs
1. General policy and direction	75	0
2. Budget planning and formulation	86	0
3. Cash	14	14
4. Receivables, loans, and advances	112	112
5. Inventories	48	0
6. Property, plant, and equipment	10	0
7. Payables	17	0
8. Budget execution, fund control, and government equity	91	0
9. Sales	3	0
10. Procurement and purchasing	130	2
11. Personnel	89	0
12. Travel	149	144
13. Grants	83	0
14. ADP	[a]	
15. Records systems	52	53[b]
Total	**959**	**325**

[a]The number of internal control areas for ADP was not compiled by PHS because HHS had not determined how these areas should be evaluated.

[b]The number of internal control areas shown for records systems is smaller than the number of **icrs** performed because recent changes in PHS' organization reduced the number of control areas below what it was when these **icrs** were conducted.

Some PHS Activities Excluded From FMFIA

In its 1982 segmentation process, PHS attempted to identify internal control areas by matching its activities against HHS' list of 16 functional areas. HHS' instructions stated that the 16 areas might not be all inclusive and agency components could add to them if necessary. However,

because PHS officials did not believe FMFIA extended to program functions, they did not look for additional control areas.

PHS' action to exclude program functions from the FMFIA process is inconsistent with statements made by the House Committee on Government Operations and OMB. OMB's August 1984 publication Questions and Answers on Circular A-123 (Revised) indicates that internal controls include those controls used by management to achieve the objectives of agency programs, functions, and activities. The Committee's comments are contained on page 10 of this report.

Our first-year report identified several program areas where management controls were excluded from PHS' inventory of internal control areas. These included in-house research, delivery of health care services, and drug regulation. The OIG also reported that PHS' inventory of internal control areas was incomplete. In its April 1984 response to our first-year draft report, HHS said it would update its inventory of internal control areas.

On June 29, 1984, the Assistant Secretary for Management and Budget directed all HHS operating division internal control officers to review the original 16 functional areas and the areas mentioned in our report and prepare lists of functions that should be added or deleted. If the control officers concluded that any GAO-recommended functions should be deleted, a narrative rationale explaining the decision was required. The memo stated its goal was to implement necessary changes to the list of functional areas by January 1, 1985. In September 1985, PHS stated that in-house research had been added to the list of functional areas. The Indian Health Service's health delivery services; the Food and Drug Administration's new drug evaluations and field laboratory operations; and the Centers for Disease Control's health hazard evaluations, health training verification, and laboratory proficiency testing will be added in fiscal year 1986.

Internal Control Reviews Need Improvement

ICRs performed by PHS during the second-year FMFIA effort, like the first year, did not generally test internal controls to verify that they were operating properly or adequately document what was done. We do not believe an ICR can be considered reliable without adequate testing to determine if internal controls are in place and adequate to accomplish their objective.

In its response to our first-year report, which pointed out the testing and documentation weaknesses, HHS stated it would revise the ICR procedures it provided to PHS and the other HHS agencies. However, the revised guidance was not issued until February 1985. Consequently, the 1984 PHS ICRs were performed according to the same guidance used in 1983 and generally experienced the same problems we reported in 1983.

Testing Not Always Performed

In our sample of 22 of the 197 ICRs PHS performed in 1984, we found 12 ICRs where little or no testing was performed. For example, the two travel ICRs at the Health Resources and Services Administration, which we reviewed, indicated that the ICR team did not test samples of travel records to determine whether travelers were complying with regulations requiring submission of trip reports and approval of travel vouchers by proper officials. The ICR team relied on questionnaire answers and interviews with agency officials, which indicated to them that travelers were submitting trip reports and obtaining proper approval of vouchers. However, we found that travel voucher approval was not being done by the appropriate officials and that few trip reports were submitted.

At the Centers for Disease Control, an ICR team stated it did little testing in a records control area because (1) no one instructed the team to do detailed testing and (2) the team had limited time. Only 1 of 78 questionnaire responses was tested.

Need for Better Documentation of ICRs

HHS' instructions stress the need to document the ICR process. The individual performing an ICR is supposed to obtain sufficient evidence through inspections, observations, and inquiries to provide a reasonable basis for an opinion on the adequacy of internal controls for a control area. That individual is also supposed to document the review. Documentation should include such items as review procedures, the key factors considered, and narrative explanations in sufficient detail to fully explain the review process.

Similarly, PHS' ICR guidelines contain specific documentation requirements. These were not always followed by PHS review teams during the first- and second-year FMFIA efforts.

During the first year, PHS officials relaxed the documentation requirement to insure that the ICRs were completed on time. During the second year, four of PHS' six components improved their ICR documentation through such means as better (1) indexing of questionnaire answers to

supporting information, (2) documentation of specific items tested and test results, and (3) preparation of detailed interview writeups. However, further improvements are needed. None of the 21 ICRs for 1984, for which we reviewed documentation, indexed the ICR reports to the supporting documentation, and most did not provide complete documentation. For example, the documentation for one travel ICR at the Office of the Assistant Secretary for Health did not show what sampled vouchers were tested for or the test results. The ICR did, however, (1) include regulations and other documentation to support questionnaire answers, (2) index the documentation to individual questionnaire questions, and (3) document what travel vouchers and supporting records were tested.

However, two PHS agencies showed little improvement in their ICR documentation. For example, at the Centers for Disease Control, the four 1984 travel ICRs we reviewed did not contain documentation for interviews with travel control officials. The internal control officer stated that they do not require detailed documentation.

We noted similar testing and documentation deficiencies during our review of ICRs at the Office of Human Development Services, the Office of Community Services, and two RASCs (see app. IV).

PHS Acted to Correct Weaknesses It Identified

PHS reported that all but 2 of the 90 internal control weaknesses it identified during the first-year effort were resolved as of November 1984. We examined 31 of the 88 reported corrected weaknesses and found corrective action had been fully implemented in 29 cases and partially implemented in the other 2 cases.[2] We did not generally evaluate the effectiveness of the actions.

One weakness for which corrective action is not yet fully implemented involves two PHS loan programs at the Atlanta Regional Office. The weakness involves loan applications not being reviewed to determine applicants' credit worthiness or ability to repay. This situation occurred because loan applications were examined solely by program staff, and as a result, the customary checks and balances between financial management and program management did not exist. To correct this problem, outside staff from the Office of Grants Management were assigned to evaluate applicants' credit worthiness and ability to pay. However,

[2]We noted similar successes in correcting internal control weaknesses at the Office of Community Services, ASMB, and two of ASMB's RASCs (see app. IV).

we found that because of other priorities, these evaluations still were not being performed.

PHS has recognized that this problem still exists, not only in Atlanta but also in its other regional offices, and is revising and standardizing its loan application review procedures.

Conclusions

In our opinion, PHS was not in a position to state whether its internal controls were adequate. This is primarily because (1) it had not evaluated its internal controls in such important areas as grants, drug regulation, in-house research, and health care delivery and (2) in performing ICRs, it had not adequately tested whether controls were in place and functioning effectively and documented review results.

Agency Comments and Our Evaluation

In our draft report, we included a proposed recommendation that the Secretary of HHS direct the Assistant Secretary for Management and Budget to monitor progress by PHS to cover its important areas of internal control in order to ensure proper coverage of management controls.

In commenting on our draft report (see pp. 90 to 101), PHS stated that it does not need monitoring to ensure proper coverage of management controls. PHS said the draft report was unreasonable in its criticism of coverage of PHS functional areas in 1984 and failed to reflect very substantial PHS progress in both 1984 and 1985. PHS also said it is firmly committed to vigorous and effective implementation of the provisions of FMFIA, it has committed substantial resources to the effort, and the efforts were recently strengthened by consolidation of responsibility for both sections 2 and 4 of the act in a single component at the PHS level.

PHS explained that, in the absence of specific guidance from HHS for 6 months after issuance of our first report, PHS management reviewed proposed functional areas and decided to focus on those areas appearing to have the greatest vulnerability. All then-known factors were taken into consideration by management in establishing priorities. Although obligations for grants represented a substantial percentage of the total PHS budget, existing management review and control mechanisms gave adequate assurance that incorporation of grants could be delayed while other areas of lower budgetary impact, but significantly higher potential vulnerability, were incorporated immediately into the internal control process.

PHS also stated that it has continued to systematically expand the functional area coverage. For example, in fiscal year 1985, it incorporated grants and intramural research and in fiscal year 1986, it will include the Indian Health Service's health delivery services; the Food and Drug Administration's new drug evaluations and field laboratory operations; and the Centers for Disease Control's health hazard evaluations, health training verification, and laboratory proficiency testing.

We agree that PHS has made significant progress in implementing FMFIA. In view of this progress and PHS' strong statement of commitment to expanding coverage of internal control evaluations to other PHS activities, we have deleted the proposed recommendation included in our draft report.

Department of Health and Human Services' Operating and Staff Divisions

Operating Divisions:	Public Health Service Social Security Administration Health Care Financing Administration Office of Human Development Services Office of Community Services
Staff Divisions:	Office of the Assistant Secretary for Legislation Office of the Assistant Secretary for Planning and Evaluation Office of the Assistant Secretary for Personnel Administration Office of the General Counsel Office of Inspector General Office for Civil Rights Office of the Assistant Secretary for Public Affairs Office of the Assistant Secretary for Management and Budget Immediate Office of the Secretary

Department of Health and Human Services' 18 Internal Control Functional Areas

General Policy and Direction - Encompasses the communication by management of its programmatic objectives and responsibilities, as well as the policies and procedures to be employed in obtaining the desired results. Includes management's formal plan of organization.

Budget Planning and Formulation - Encompasses budget planning and formulation for an organization. Includes policies and procedures used in the planning, formulation, and review of the budget of an organization.

Cash - Covers all actions associated with cash transactions, such as receipt, safeguarding, and depositing of cash, checks, money orders, and negotiable securities. Also covers all actions associated with imprest funds, including advances and disbursements.

Receivables, Loans, and Advances - Encompasses all policies, procedures, and operations of an organization for controlling, monitoring, collecting, and accounting for all receivables, loans, and advances due from both the public and private sectors.

Inventories - Encompasses all policies, procedures, and operations for controlling and managing all materials, supplies, work-in-process, and finished goods used in achieving an organization's purpose or mission. Includes the taking of physical inventories, physical security over stores and supplies, and the maintenance of the appropriate accounting records.

Property, Plant, and Equipment - Includes all policies, procedures, and operations for the acquisition, maintenance, storage, disposition, and physical security of all property, plant, and equipment of an organization. Also, includes the maintenance of the appropriate accounting records.

Payables - Encompasses all aspects of handling and accounting for the various types of liabilities incurred by an organization to both the public and private sectors. Includes vendor billings, voucher packages, purchase orders, receiving reports, etc.

Budget Execution, Fund Control, and Government Equity - Encompasses all procedures regarding budget execution, fund control, and government equity. Includes the use of budgetary accounts (appropriations,

apportionments, allotments), fund control accounts (obligations, commitments), and government equity accounts (expended funds, earned and estimated reimbursements) as they affect an organization.

Sales - Encompasses all policies and procedures for the sale of an organization's resources. Includes all aspects of sales, such as customer orders, billings, shipping documents, and the overall accounting treatment of the proceeds from different types of sales.

Procurement and Purchasing - Covers all actions associated with the process employed in acquiring goods and services both from the private sector and from government entities. Covers the entire cycle from the point where the initial request for goods or services is made until the final action is taken and payment is authorized.

Personnel - Encompasses the entire federal personnel system as it affects the organization. Includes three discrete areas: (1) personnel administration, which is performed by servicing personnel offices, or staff offices that issue policies and procedures to direct servicing personnel offices; (2) personnel management, which is performed by various levels of the management chain of command; and (3) time, attendance, and payroll functions that are performed within the organization.

Travel - Includes all travel policies and procedures of an organization and covers all travel performed by members of an organization. Encompasses the use of travel orders, travel advances, vouchers, and liquidation of outstanding travel advances.

Grants (discretionary and formula) - Includes the entire grants process, from the development of policies and procedures to all operational aspects of grantee selection, award, administration, management, evaluation, and the processes associated with grant closure and/or accountability.

Subsidies, Entitlements, and Benefit Payments - Encompasses all policies, procedures, and operations for controlling and accounting for subsidies, entitlements, and benefit payments administered by an organization. Includes the entire process from the time an applicant applies for benefits until the time that payment to the applicant is initiated or other final disposition of the application.

Automatic Data Processing - Encompasses all aspects of ADP for an organization. Includes physical controls over computer hardware and software, as well as all policies and procedures for operating ADP systems. Also includes systems documentation, operating logs and controls, file protection and retention, input controls, output controls, and program controls.

Records Systems - Encompasses records systems, such as the Earnings Records System maintained by SSA. Includes all records systems where information is queried to determine applicant eligibility for program assistance or of a nature restricted by the Privacy Act.

A-76 - Encompasses all aspects of the selection, review, and rendering of a cost-efficient method of performance (by either contractors or in-house staff) of commercial-type activities performed in support of governmental functions.

Monitoring - Encompasses evaluating and assuring that Medicare contractors, Medicaid state agencies, and peer review organizations are fulfilling their program responsibilities.

HCFA's Role in Monitoring Medicare and Medicaid Benefit Payments

Under the Medicare program, HCFA administers contracts with insurance companies to pay for services provided to Medicare beneficiaries. The contractors that pay for services provided by physicians and other noninstitutional providers are called carriers. Those that pay for services provided primarily by hospitals and other institutions are called intermediaries. Under the Medicaid program, the federal share of payments for services provided to Medicaid beneficiaries is made through grants to state-operated Medicaid programs.

HCFA is responsible for assuring that benefit payments include reductions for deductibles and other amounts for which the programs are not liable and that they are for covered and medically necessary services, in reasonable amounts, and for services by licensed providers. HCFA's four headquarters bureaus and its regional offices carry out these responsibilities. The bureaus direct the monitoring activities, make national trend analyses, and perform some overall monitoring; the regional offices monitor individual carriers, intermediaries, and state Medicaid agencies.

Through analysis of information provided by HCFA officials, we identified the following 21 methods—referred to as monitoring programs—in effect during fiscal year 1984 for monitoring the performance of organizations that make benefit payments.

Table III.1: HCFA Programs for Monitoring Organizations That Make Benefit Payments

Program	Objective	Responsible organizations	Output
Programs for Monitoring Medicare Carriers			
1. Contractor Performance Evaluation Program[a]	To enhance the quality of carrier performance	Bureau of Quality Control Bureau of Program Operations Health Standards and Quality Bureau Regional offices	Annual contractor evaluation reports, which are used to identify poor performers for possible termination or other contract actions.
2. Quality Assurance Program	To assess carrier performance in processing claims.	Bureau of Quality Control Regional offices	Statistical reports based on data from carriers. Results are used in the Contractor Performance Evaluation Program.
3. Carrier Systems Testing Project	To detect weaknesses in claims processing systems.	Bureau of Program Operations Regional offices	Data from carriers on test claims processed through their systems.
4. Carrier Medical Utilization Review Reports	To provide information on the costs and benefits of carriers' reviews of necessity of medical services.	Health Standards and Quality Bureau Regional offices	Report from carriers on the costs and savings from audit and medical review. Results are reported to the Congress and used in the Contractor Performance Evaluation Program.
Programs for Monitoring Medicare Intermediaries			
5. Contractor Performance Evaluation Program[a]	To enhance the quality of intermediary performance.	Bureau of Quality Control Bureau of Program Operations Health Standards and Quality Bureau Regional offices	Annual contractor evaluation reports, which are used to identify poor performers for possible termination or other contract actions.
6. Target Rate Implementation Program[b]	To determine the quality of intermediaries' performance of base-year audits and to establish the target amount per discharge under the Prospective Payment System.	Bureau of Quality Control Regional offices	Evaluation of the target amount per discharge established under the Prospective Payment System. Results are used in the Contractor Performance Evaluation Program.
7. Home Office Target Rate Implementation Program[b]	To verify that intermediaries develop a reliable plan for auditing chain home office cost statements of multi-institution providers.	Bureau of Quality Control Regional offices	Used in conjunction with the Target Rate Implementation Program.
8. Interim Payment Review Program	To measure intermediaries' compliance with HCFA's interim reimbursement instructions for prospective payments.	Bureau of Quality Control Regional offices	Regional office reports to the Bureau of Quality Control and the intermediaries. Results are used in the Contractor Performance Evaluation Program.
9. Home Health Agency Reimbursement Review Program	To measure intermediary performance in reviewing, adjusting, and settling home health agencies' cost reports.	Bureau of Quality Control Regional offices	Findings reported to the intermediary and the Bureau of Quality Control. Results are used in the Contractor Performance Evaluation Program.
10. Intermediary Systems Testing Project	To evaluate the performance of intermediary claims processing systems.	Bureau of Program Operations Regional offices	Data from intermediaries on test claims processed through their systems.

Program	Objective	Responsible organizations	Output
11. Medical Coding Monitor Review	To monitor the quality of medical code reporting for inpatient hospital bills for the Medicare program.	Bureau of Data Management and Strategy	Quarterly reports from intermediaries to HCFA. Results are used in the Contractor Performance Evaluation Program.
12. Reviews of intermediaries' report of benefit savings	To monitor contractor compliance with the Tax Equity and Fiscal Responsibility Act for audit and medical claims review.	Health Standards and Quality Bureau Regional offices	Reports from intermediaries on the costs and savings from audit and medical review. Results are reported to the Congress and used in the Contractor Performance Evaluation Program.
13. Hospital Reimbursement Review Program	To measure intermediary performance in reviewing, adjusting, and settling hospital cost reports.	Bureau of Quality Control Regional offices	Regional office reports to the intermediaries and the Bureau of Quality Control. Results are used in the Contractor Performance Evaluation Program.
14. Reviews of intermediaries' and Professional Review Organizations' reports of medical and utilization reviews.	To determine the consistency of reviews and to identify problems.	Health Standards and Quality Bureau Regional offices	The Health Standards and Quality Bureau informs HCFA regional offices of problems. Regional offices inform intermediaries and are responsible for overseeing corrective action.
Programs for Monitoring State Medicaid Agencies			
15. Medicaid Quality Control System	State-run program to identify, measure, and eliminate or reduce dollar losses in eligibility, claims processing, and third-party liability.	Bureau of Quality Control Regional offices State Medicaid agencies	State-submitted reports on payment errors due to patient ineligibility. Used in reducing federal financial participation if payment error rate exceeds 3 percent.
16. Systems Performance Review	To improve the effectiveness and efficiency of the Medicaid program on an individual state basis.	Bureau of Quality Control Regional offices	Regional office reports to the Bureau of Quality Control and the states. Review results are a determining factor for either reapproval or disapproval of funds for a state's Medicaid Management Information System.
17. State Assessment Target Area Review	To monitor state expenditures of program funds and compliance with laws, regulations, guidelines, and state plans in selected target areas, such as eligibility.	Bureau of Quality Control Regional offices	Regional office reports to the states.
18. Utilization Control	To determine if states are performing appropriate medical reviews of all participating facilities.	Bureau of Quality Control Regional offices	Regional office quarterly reports to the Bureau of Quality Control and reports of findings to the states used as a basis for reducing federal medical assistance payments where states fail to comply with utilization control requirements.

Program	Objective	Responsible organizations	Output
Medicaid Monitoring Programs			
19. Systems Test for Alternative Reimbursement	To evaluate the quality of states' actions in setting, adjusting, and monitoring Medicaid reimbursement rates for hospitals.	Bureau of Quality Control Regional offices	Regional office reports to the Bureau of Quality Control and the state agency.
20. Long-Term Care Systems Test for Alternative Reimbursement	To evaluate the quality of states' actions in setting, adjusting, and monitoring Medicaid reimbursement rates for long-term care facilities.	Bureau of Quality Control Regional offices	Regional office reports to the state agency and to the Bureau of Quality Control.
21. Claims Processing Assessment System	State-run program to improve claims processing quality.	Bureau of Quality Control Regional offices	State-submitted data that are used in the Systems Performance Review and the State Assessment Target Area Review programs.

[a]This program is in two parts and covers two distinct types of contractors—carriers and intermediaries.

[b]These programs were implemented in response to the Social Security Amendments of 1983 (Public Law 98-21), requiring that Medicare's payment for inpatient operating costs will be made prospectively on a per-discharge basis. After a 3-year transition period, these programs will be eliminated.

FMFIA Efforts at Other Operating and Staff Divisions

In addition to our review of FMFIA activities at the Department's major operating divisions—SSA, HCFA, and PHS—we reviewed ICRs and corrective actions taken on identified internal control weaknesses at the Office of Human Development Services, the Office of Community Services, the Office of the Assistant Secretary for Management and Budget, and two Regional Administrative Support Centers.

These smaller organizations generally succeeded in implementing corrective actions for weaknesses they identified. Corrective actions were taken on all but 2 of the 43 reported weaknesses we reviewed. However, the ICRs frequently did not adequately (1) test internal controls to verify that they were functioning and effective and (2) document what was done so that management and independent reviewers could verify that they were properly performed.

Background

The Office of Human Development Services, the Office of Community Services, ASMB, and the RASCs perform various functions for HHS. The Office of Human Development Services primarily administers grant programs with a broad range of objectives, such as helping families remain together, providing permanent homes for children, preventing abuse, helping needy people find employment, and preventing unnecessary institutionalization. Its fiscal year 1984 budget was $5.5 billion.

The Office of Community Services provides grants to states for implementing the community services block grant program. It also provides funding for a variety of activities, including economic development in depressed areas, migrant and seasonal farm worker assistance, and a national youth sports program. Its fiscal year 1984 budget was $352 million.

ASMB provides advice and guidance to the Secretary on administrative and financial management matters and directs and coordinates them throughout HHS. The RASCs provide administrative and financial management support to HHS' 10 regional offices by providing such services as contracting and procurement, payroll processing, accounting, and financial reporting.

ICR Deficiencies

ICRs performed by the Office of Human Development Services, the Office of Community Services, and the RASCs did not generally evaluate internal controls to determine whether they were adequate and functioning. As shown in table IV.1, our review of 13 of 23 ICRs performed in 1984

showed they did not generally test internal controls to verify that they were operating properly or document completely what was done.

Table IV.1: ICR Deficiencies

	ICRs performed	ICRs reviewed by GAO	ICRs with testing problems	ICRs with documentation problems
Office of Human Development Services	6	1	1	1
Office of Community Services	13	10	10	10
Two RASCs	4	2	1	2
Total	**23**	**13**	**12**	**13**

At the Office of Human Development Services, the ICR we reviewed covered the management activities of the Administration for Native Americans in administering grants awarded to implement social and economic development strategies. The ICR was based on a review of documentation, interviews with officials of the Administration for Native Americans, and a review of a draft internal report on their grants management practices prepared by ASMB's Office of Evaluation and Compliance. The reviewer neither tested the internal controls nor satisfied himself that the prior evaluation included adequate testing of the functions covered by the ICR. Also, the internal report and the other documentation he reviewed did not indicate that any testing had been done.

The ICR report concluded that no material weaknesses were disclosed and that internal controls were adequate for prevention of fraud and abuse. However, in our opinion, the report does not provide a valid basis for this conclusion. It states the work performed in general terms but does not include reference to any testing procedures to substantiate its findings.

We do not believe an ICR can be considered reliable without adequate testing to determine if internal controls are in place and adequate to accomplish their objective. In response to our assessment, the Office of Human Development Services agreed that some testing is needed to provide reasonable assurance that controls purported to be in place are indeed functioning. It believed that HHS' instructions should be clearer on the extent of testing it wants the reviewers to perform.

At the Office of Community Services, we reviewed 10 ICRs and interviewed the reviewers and internal control officer on the substance of their findings and recommendations. While the results of the ICRs

appeared reasonable and recommended corrective actions appeared adequate, sufficient documentation and testing were lacking. For example:

1. Six ICRs, which were performed as a unit, lacked clear documentation to show the basis for the reviewer's conclusions. Our examination of two questionnaires pertaining to these ICRs disclosed conflicting information. The reviewer told us that in these instances she based her conclusions on the response of the person whom she knew to have more experience in the area.

2. One reviewer didn't consider it necessary to test any transactions because of his familiarity with the function. The other reviewers said they did limited testing.

At the Atlanta RASC, an ICR of property, plant, and equipment showed no documentation of work performed other than a questionnaire which did not show how answers were arrived at. Also, the review team said it did no testing because it did not consider testing mandatory. Similarly, an ICR team at the Denver RASC said they did some limited testing but did not document it because of a short time frame.

Correcting Internal Control Weaknesses

We reviewed corrective actions taken regarding 21 internal control weaknesses identified by the Office of Community Services in 1984, and 6 by ASMB and 16 by RASCs in 1983. Our review of the weaknesses reported by the Office of Community Services and ASMB indicated that the proposed corrective actions adequately address the weaknesses.

In 1983, the Denver and Atlanta RASCs reported 2 and 14 weaknesses, respectively. At Denver, the corrective actions had been implemented and appeared adequate. At Atlanta, 12 weaknesses had been corrected. However, in the other two cases, corrective actions were not being implemented.

In the first case, collections of cash and checks were not always deposited according to written policy. According to RASC officials, collections of $1,000 or more should be deposited by the next day. We examined 19 such checks recorded in June and August 1984 and found that 7 of them took from 2 to 14 days to be deposited. RASC officials said that a heavy workload and personnel shortages caused the delays.

In the second case, cash collections were not being recorded in a timely manner at the point of receipt. This case was reported to have been corrected in December 1983. However, we found that the correcting procedures had not been implemented due to personnel shortages.

Agency Comments and Our Evaluation

HHS did not comment on our evaluation of ICRs at the Office of Human Development Services and the Office of Community Services. ASMB and the Office of Human Development Services did, however, comment on our review of two ICRs performed by the Denver and Atlanta RASCs and one ICR performed by the Office of Human Development Services. (See pp. 90 and 102 to 103.) ASMB stated that ICRs performed by these support centers were not always documented to the level that traditional audits are because they are not intended to be formal audits. ASMB also stated that support center ICRs reportedly included test checks of documents and related procedures to determine whether internal controls were working. The Office of Human Development Services stated that internal control requirements were tested against interviews with officials and program specialists who described their activities.

HHS' guidelines and instructions require that the results of each ICR be documented. Individuals assigned responsibility for performing an ICR are responsible for preparing working papers to document the review. Working papers include such items as review procedures, key factors considered, and narrative detail to fully explain the review process. Documentation for the two ICRs we reviewed consisted of completed control questionnaires with narrative explanations of the answers. The documentation, in our opinion, did not meet HHS' requirements.

Regarding testing by the RASCs, our report indicates that testing for one of the two ICRs was inadequate. In this case, members of the review team informed us that no testing was done and that they did not understand testing to be mandatory. In the other case, the review team informed us that some limited testing was done, but not documented. One reviewer said that testing and documentation were limited because of the short time frame allowed for completing the ICR.

Regarding the Office of Human Development Services' comment on testing, on page 79 we state that testing is required to determine if internal controls are in place and adequate to accomplish their objective. Interviews do not provide such assurances. Adequate testing requires verification that the procedures are being followed and an analysis of their effectiveness.

Advance Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

OCT - 8 1985

Mr. Richard L. Fogel
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

Thank you for the opportunity to comment on your draft report, "Second-Year Implementation of the Federal Managers' Financial Integrity Act in the Department of Health and Human Services." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GENERAL ACCOUNTING OFFICE'S DRAFT REPORT, "SECOND-YEAR IMPLEMENTATION OF THE FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES"

This responds to the September 5, 1985, request by the General Accounting Office for comments on the draft report to the Secretary titled "Second-Year Implementation of the Federal Managers' Financial Integrity Act (FMFIA) in the Department of Health and Human Services" (HHS).

We believe the utility of the report is significantly weakened by its late issuance. The draft report was not released until one year after the period covered (FY 1984) and not formally issued until after the succeeding period (FY 1985). Although the report coverage is only through September 30, 1984, its issuance at this time implies that it characterizes the situation at the present time, which it does not.

The report does not adequately acknowledge actions taken by the Department to effect the complete revision of the review process in FY 1985. The entire internal control system was restructured and a comprehensive manual issued and implemented during the FY 1985 FMFIA cycle.

The report does not recognize that policy issues have been raised by the Office of Management and Budget (OMB), which, according to the Act provides guidelines for agencies, and does not take into account restraints on implementation of recommendations (OMB Circular A-127 and related correspondence). In particular, GAO differs with OMB as to what constitutes "reasonable assurance." OMB has not established, nor believes it realistic to establish, minimum evaluation criteria for agencies to achieve before they can provide a reasonable assurance statement. According to OMB, agency management is expected to consider more than the results of the internal control evaluation process required by the Act in determining whether there is reasonable assurance that the objectives of internal control are being achieved for the agency as a whole. The other factors to be considered consist of the assurances given by agency officials and other available information, including the known internal control weaknesses and the affect of the IG, GAO, and other evaluative work performed within the agency. Thus, the sum and substance of all information available to management is to be considered in making the reasonable assurance determination for use in the year-end internal control statement.

Now on p. 62.

General Comments

1. We note that the report covers the 1984 FMFIA cycle yet its contents were not disclosed to Departmental officials until the end of the 1985 cycle, thus precluding implementation of GAO's recommendations until the 1986 cycle (a span of two cycles). We further note that even though GAO was apparently aware of the Department's 1985 accomplishments and corrective actions the report fails to highlight them. For example, on page 53 the report states that Public Health Services' (PHS) efforts were inadequate because--

--Eleven of PHS' functional areas, including, the largest involving the administration of grants, were not covered by ICRs or reliable vulnerability assessments.
--Many important PHS activities were not included in the original listing of 16 functions that HHS provided to operating components for FMFIA coverage and were subsequently excluded from PHS' inventory of internal control areas and FMFIA coverage. These included drug regulation, in-house research, and delivery of health care services.

An appropriate presentation would have disclosed that PHS conducted Internal Control Reviews (ICRs) for its grants function during the 1985 FMFIA cycle in addition to signficantly expanding its inventory of internal control areas by including programmatic activities such as the ones stated in your report.

We believe that the report fails to recognize that:

(1) the Department restructured the entire Internal Control System and issued a comprehensive manual on December 31, 1984, which addressed all phases of the internal controls process including--

-- general policy
-- vulnerability assessments
-- internal control reviews
-- reporting

The manual was implemented during the 1985 FMFIA cycle.

(2) the Assistant Secretary for Management and Budget (ASMB), in consultation with the Inspector General (IG), decided to expand the internal control program to cover the Medicare Intermediaries beginning with the 1986 FMFIA cycle;

(3) the Health Care Financing Administration (HCFA) during the FMFIA 1985 cycle developed appropriate guidelines, policies, cost estimates, etc., in preparation for the implementation of ASMB's decision regarding Medicare;

(4) the Departmental directives stressed the importance of testing and documentation from inception of the program;

(5) the Department was developing a formal training program during the 1985 FMFIA cycle;

(6) the HHS management at all levels aggressively pursued the Departmental goal of fully implementing the FMFIA in an efficient and orderly manner; and

(7) the Department's reports are structured to disclose fully all weaknesses and the status of corrective actions.

2. GAO unfortunately released the report for formal comments without affording the Department the usual exit conference. Also, the GAO staff has not met with Department level staff to discuss matters in the report since December 1984.

3. The GAO report appears to be intentionally composed on a preconceived negative theme incorporating headlines which are all encompassing but are not supported by the actual facts. For example, the headline on page 42 states--

Now on p. 52.

-- "SSA'S ASSESSMENT OF INTERNAL CONTROLS WAS INADEQUATE"

Yet, GAO reports that SSA reviewed 359 (about 26 percent) of its field offices which identified (and corrected) deficiencies. The report however failed to explain why a 26 percent sample is inadequate or that the reviews are part of an overall plan, at the end of which all SSA offices will be reviewed.

4. The report fails to set forth the costs and benefits associated with implementating each recommendation made to the Department. Such information is vital to HHS management in deciding the propriety of implementing the recommendations and, where appropriate, to support requests for resources through the budget process.

Because of the numerous technical problems with the report, we are not responding to GAO's specific recommendations. We are however attaching comments from the Department's individual components that may be useful in providing some perspective on this matter.

DEPARTMENT OF HEALTH & HUMAN SERVI

ATTACHMENT NO. 1

HHS' COMMENTS TO GAO'S REPORT
RE: FMFIA

September 17, 1985

MEMORANDUM

TO : Guy Linza, Departmental Internal Control Coordinator

FROM : ASMB Internal Control Officer

SUBJECT: ASMB Comments on GAO Draft Report: HHS' Second Year Implementation of the FMFIA - Action Memorandum

ASMB has reviewed the subject draft GAO report and is providing comments in the attachment. Please contact me if you have any questions.

William G. Tanniello

Attachment

Finance Comments on the Draft GAO Report: HHS' Second Year Implementation of FMFIA

Now on p. 19.

-- Page 13: Lack of adequate testing and documentation of accounting system reviews:

Now on p. 17.

Finance Comment: GAO states (on page 9) that it assessed the review of ten HHS systems including Finance's OS/HDS Accounting system and the Regional Accounting System and that none of the reviews adequately tested or documented review results. Our comments with respect to these findings, the findings on page 13 and the related findings on page 22 applicable to the 3 Finance systems reviewed are as follows:

Now on p. 19.
Now on p. 32.

-- OS/HDS Accounting System Review

Finance believes that the 1984 review of the OS/HDS accounting system was extensively documented. GAO staff who performed an on-site post-review audit at the time indicated no deficiencies with respect to documentation. Transactions were examined in various areas through output reports generally, including error reports, and tracing these back to source documents to determine processing problems. The use of this procedure led to the identification of a material weakness concerning unmatched commitments and obligations due to system edits which created the potential for a duplicate drawdown of the allowance and a loss of fund control. In addition to the above, certain GAO-recommended procedures were followed as decribed on page 22 as follows: (a) interviewing persons who operate the system; (b) observing operating procedures; (c) examining system documentation (flow charts).

Now on p. 32.

Under OMB Circular A-127, transaction testing is required for detailed reviews of systems which are to be performed at least once every three years. The Circular also provides for limited reviews (which may take the form of a desk review according to OMB) and these may be performed annually for those system components not subject to detailed evaluation in the current year. The 1984 review of the OS/HDS accounting system is consistent with the limited review requirement. A limited A-127 review of the OS/HDS accounting system is also being performed in 1985. The required tri-annual detailed review under A-127 to include detailed transaction testing will be scheduled after the FY 1985 review cycle.

-- Regional Accounting System (RAS) Review

In 1984, the RAS was reviewed in 5 regions and in headquarters. Regional offices involved in the review provided the results of their reviews to headquarters for consolidation into a report on the RAS review including the headquarters system. The RAS reviews in Regions IV and VIII, which were audited by GAO, included, once again, an examination of test data from output reports to hard copy documents in both regions; although audit trails of the test checks performed was reportedly not always adequately documented. Testing of RAS data at headquarters was not deemed feasible or necessary since RAS is a decentralized system and the review of operational test procedures should be performed at the operational site. The 1984 approach to RAS testing is consistent with limited reviews under A-127.

In 1985, a limited review of the RAS under A-127 is also being performed including on-site reviews in 2 Regions - Region IX and X - which includes limited transaction testing based on output reports as appropriate.

-- Payment Management System (PMS)

GAO findings on the Payment Management System (PMS) are limited to the cited non-compliance of PMS with GAO Principles and Standards based on the weaknesses identified in the 1984 PMS review involving the lack of planned sub-systems to complete the PMS implementation, as well as the lack of a debt collection policy to address the continuing problem of over-advances. Comments on these findings which appear on pages 17-18 of the draft report appear below.

Now on pp. 29-30.

Finance believes however, that with respect to the issue of the adequacy of testing and documentation, the 1984 PMS review included extensive documentation and test data. These test data consisted mainly of PMS output reports and the tracing of transactions from PMS back to an OPDIV accounting system, including recording of the award (obligation), recording of the payment and the status of reconciliation of certain PMS accounts with the accounting system records - in this case the OS/HDS accounting system. In addition, the PMS review included, as recommended by GAO on page 22 of the draft report: (1) interviewing persons who operate the system; (2) observing operating procedures; (3) reviewing error reports and evaluating error follow-up procedures. Simulated live transaction testing of the PMS system was not performed, but this approach is again consistent with A-127 limited reviews. The 1985 review of PMS does include substantial testing of disbursement transactions but this is not considered to be a detailed review under A-127. Such a review will be scheduled after the FY 1985 review cycle.

Now on p. 32.

-- Page 12: ADP systems have not been adequately evaluated

Now on p. 18.

Finance Comment: In 1984, a contract was awarded to perform a major risk analysis of the Payment Management System (PMS) to comply with A-71 and A-123 requirements for ADP security evaluations. The PMS risk analysis also includes an examination of the Central Registry (CRS) which is a PMS sub-system. The risk analysis was not started until the 3rd quarter, FY 1985 due to delays in obtaining required security clearances for contractor personnel after award. The risk anaysis is currently on-going and is expected to be completed after January 1, 1986.

Pages 17-18: GAO states that PMS not in compliance with GAO Principles and Standards due to the existence of long-standing weaknesses involving the control of over-advances to HHS financial assistance recipients and the liquidation of receivables which were to have been corrected by the implementation of key sub-systems - Appropriation Charging and Accounts Management - the lack of which GAO notes as contributing to these deficiencies, as well as inadequate Departmental policies and procedures regarding the collection of the over-advances.

Now on pp. 29-30.

Finance Comment: Finance believes that the GAO report should point out that due to severe turnover of ADP staff (8 of 9 experienced people) during the last 6 months of FY 1984, the remaining PMS sub-systems (2 of 9 planned) noted by GAO could not be implemented. This deferral was disclosed in the Secretary's report. Also, GAO should recognize that interim sub-systems are in place and PMS controls over payments are fully operational. While it would be desirable to have PMS fully implemented, deferral of the final two sub-systems and the use of interim processes does not impair the ability of PMS to carry out its mission. We note that GAO does not cite any adverse consequences of using the interim processes while the remaining sub-systems are being developed.

Now on p. 30.

-- Page 19: Reported property system weaknesses involving not reconciling accounting records with Departmental property management records in the Regional Accounting System and in the OS/HDS accounting system have not been corrected.

Finance Comment: In 1985, regional offices have taken steps to correct the noted deficiency involving property through creation of an interim property accoutability and control management information system to replace the outdated Departmental Property Accounting System (PAS) in the regions. The interim system is planned for region-wide implementation by October 1, 1985. Regional offices, with Departmental functional management oversight, have been taking required physical inventories of assets and plan to reconcile these with the property accounting records this fiscal year. Based on the increase in the capitalization criteria from $300 to $5,000, as recommended by GAO, affecting both the regional (RAS) as well as headquarters (OS/HDS accounting system) operations, the GAO-noted property deficiencies including reconciliation and maintenance of property accounting records for capitalized assets is expected to be corrected. In the Division of Accounting Operations which manages the OS/HDS system, contractor assistance is planned to alleviate staffing shortages as a necessary action to achieve this corrective action.

The long term solution to property accounting in both headquarters and regional offices is the implementation of the planned FAIMS system which currently is not expected until FY 1988.

Now on p. 32.

Page 22: Need to Test Accounting Systems

Now on p. 19.

Finance Comment: See comments related to individual system reviews - Regional Accounting System (RAS), OS/HDS Accounting System and the Payment Management System - under page 13 GAO findings above.

Now on p. 33.

Page 23: Need to Adequately Document Results of Accounting System Reviews

Finance Comment: All of the Finance reviews provided extensive documentation of the reviews performed. In all cases, the questionnaire based on the GAO Principles and Standards was completed. However, in the case of PMS, most of the questions were not applicable because, as the reviewer indicated in his report, PMS is a payment system and not a general ledger system. The need for a questionnaire tailored to a payment system rather that a general ledger accounting system has not been met under current policy. Both the OS/HDS and the PMS reviews contained extensive documentation in the form of multiple appendices which contained the working papers, exhibits or reports examined, and other sources for information gathered. All of the Finance systems reviews disclosed the scope and methodology for the reviews in the final written reports.

Now on pp. 33-34.

-- Page 24: HHS Needs to Provide Guidance and Training

Finance Comment: We agree with GAO that the there is a need for professional training of systems reviewers and system managers on Section 4 OMB and GAO requirements as well as for revised guidance on how to conduct systems reviews. A draft methodology for conducting Section 4 reviews was developed in 1985 but is being piloted in PHS and was not available for use by systems managers in other OPDIVs including OS for the 1985 reviews. Finance's systems review manager and the ASMB Regional Liaison (retired) commented jointly on the draft which appeared to be an important management tool for Section 4 reviews pending some further refinements which may result from the pilot test. In the absence of this revised methodology, the Department issued and Finance is using the original Section 4 policy guidance (Technical Memorandum #6) supplemented by OMB Circular A-127 and the Revised GAO Principles and Standards.

Now on pp. 78 and 80-81.

-- Page 74 and 77-78: Smaller HHS Organizations (Including Region IV and VIII RASCs) did not adequately test internal controls nor document the ICRs performed (and) corrective action for certain material weaknesses is still outstanding.

Finance Comment: The ICRs performed by Regions IV and VIII were not always thoroughly documented to the level that traditional audits are documented in part because the ICR is not intended to be a formal audit. However, the RASC ICRs reportedly did include test checks of documents and related procedures to determine whether internal controls were working. Continued staffing shortages in the regions and increased workload have contributed to these deficiencies including the existence of uncorrected material weaknesses. Despite this, we note that GAO found that corrective actions had been implemented and appeared adequate in Region VIII. The continued loss of regional staff requires a re-structuring of regional offices to maximize the use of existing staff resources. Such a re-structuring is currently being studied by the Department.

DEPARTMENT OF HEALTH & HUMAN SERVICES

ATTACHMENT 2

HHS' COMMENTS TO GAO's REPORT
RE: FMFIA

OCT 4 1985

Date

From C. McClain Haddow
Acting Administrator
Health Care Financing Administration

Subject GAO Draft Report, "Second-Year Implementation of the Federal Managers' Financial Integrity Act in the Department of Health and Human Services"—ACTION

To John J. O'Shaughnessy
Assistant Secretary for Management and Budget
Office of the Secretary

The following comments are being offered for your consideration in preparing the Department's response to GAO's draft report on the Federal Managers' Financial Integrity Act (FMFIA). In general, we believe it is inappropriate for GAO to characterize all of HCFA's internal controls as "inadequate". GAO evaluated only four of HCFA's 21 monitoring programs and only 1 of the 31 internal control reviews (ICRs) conducted by HCFA in 1984. We do not believe that this limited and focused review supports GAO's finding that "...internal controls at the Health Care Financing Administration were inadequate...". Many recipients of the final GAO report, in both the public and private sectors, will read only the Executive Summary and will formulate an inaccurate opinion of HCFA's performance. Since it is essential that the Executive Summary present the "Results in Brief" clearly as well as accurately and fairly, GAO should revise this section to reflect the facts rather than a subjective opinion.

In addition, that section of the Executive Summary titled "Principal Findings" reports that "HCFA excluded from its evaluations the adequacy of internal controls over about $80 billion in benefit payments made under the Medicare and Medicaid programs". We would note that in 1983, HCFA developed a 5-year Internal Control Review Plan (1983-1987) which included the scheduled evaluation of benefit payments in calendar year 1985. (The GAO report leaves the impression that the evaluation was scheduled in 1984 but never completed). In 1984, under the HHS Internal Control Program Initiative, HCFA completed 31 ICRs. (Although the report stated that GAO reviewed one of the 31 ICRs, it failed to indicate whether HCFA's review effort was either adequate or inadequate. In fact, the entire chapter on HCFA was primarily devoted to reporting the results of GAO's review of the four carrier monitoring programs.)

We would also like to point out that in 1984 HCFA:

- revised internal procedures for conducting ICRs and updating vulnerability assessments and the inventory;
- updated the HCFA internal control inventory and vulnerability assessments;

Page 2 - John J. O'Shaughnessy

- conducted internal control training sessions for HCFA senior and mid-level managers;

- reviewed corrective action plans and negotiated changes as required;
- monitored corrective action plans to assure that recommended corrective actions were implemented; and,

- initiated action to include Medicare contractors under the HCFA Internal Control Program during FY 1986.

The report incorrectly implies that HCFA had planned to review the adequacy of internal controls over Medicare and Medicaid benefit payments in 1984 and did not. HCFA never planned to review benefit payments in 1984 and explained that decision to GAO in a November 1984 meeting. We made it quite clear to GAO that HCFA would continue to execute the 1984 HCFA Internal Control Review Plan which did not include an evaluation of either benefit payments or Medicare contractors. When GAO agreed that it understood what HCFA was scheduled to complete in 1984 and how we planned to address the question of benefit payments under the revised HHS Program, we asked GAO to ensure that the final report correctly state that HCFA had executed its 1984 Internal Control Program according to HHS expectations and that GAO was aware of these activities.

We agree, however, that HCFA's contractor monitoring programs should always strive to do more to assure cost-effective internal controls over benefit payments. Recent initiatives on internal controls (vulnerability assessments just completed and internal control reviews scheduled for FY 86) will identify weaknesses and bring about appropriate modifications to our monitoring programs, including the Contractor Performance Evaluation Program, where indicated.

All of these activities are designed to highlight any weaknesses in HCFA's internal controls over benefit payments. Appropriate modifications to our monitoring programs will follow. However, at present, HCFA thoroughly monitors contractors' performance and the GAO report does not adequately reflect the scope of such monitoring. Adding additional review items to enhance internal controls over benefit payments will need to be carefully coordinated with existing review programs.

One very practical consideration for HCFA relative to internal controls for contractors is the cost. Excessively elaborate internal control systems that meet EOMB's standards may require extensive additional resources in the contractor community. In the current budget climate, HCFA plans to invest in those activities that result in program savings and, at the same time, satisfy realistic internal control requirements.

The following comments provide a detailed response to certain of GAO's recommendations.

Recommendation:
Monitor the sample claims selection process in the Carrier Quality Assurance (QA) Program and reliability in reporting of the sample results.

Page 3 - John J. O'Shaughnessy

Comment:
This issue has been studied internally by HCFA and also by a management consultant. The general consensus was that in order to properly secure the QA system it would be necessary for HCFA to assume full control and operation of the system. Short of that effort, it would be impossible to prevent tampering with the computerized programs. HCFA has determined that because of the complexities of the multiple systems, as well as the enormous costs to develop, install and maintain them, it would not be feasible to operate the systems centrally.

Recommendation:
Include in the Carrier Quality Assurance Program (1) a specific requirement that regional reviewers conduct analyses to identify systemic problems which cause Carrier Quality Assurance Program (QAP) staff to miss errors and (2) more emphasis on identifying and correcting the underlying internal control weaknesses which allow payment errors.

Comment:
The two basic objectives of the QAP are to (1) determine the number and type of processing errors associated with its adjudicated claims and dollar amount related to those errors and (2) provide each carrier with management information which can be used to improve the quality of its claims processing operation.

All errors found by the regional office are included in the overall error rate for the carrier regardless of whether or not the carrier found less errors than the regional office. In addition, QA policy requires that all occurrence errors identified by the regional office which were not found by the carrier be brought to the carrier's attention for consideration. Under the QAP, the regional office and the carrier have the primary responsibility for identifying processing errors. The carrier has the primary responsibility for taking action to correct the underlying causes of claims processing deficiencies. Regional offices analyze error findings and provide this information to carriers. However, in response to GAO's recommendation, we will issue a communication to remind the regional offices that they should be routinely providing carriers with information on error findings.

The second aspect of this recommendation appears to be based on the fact that about one-half of the payment errors are the result of coding and data entry errors. The report suggests by using dual entry techniques these errors could be virtually eliminated. Although dual entry techniques sound reasonable, it would be necessary to determine if, in fact, they would be feasible and cost beneficial.

Recommendation:
Include in the FMFIA reporting and tracking system internal control weaknesses identified by HCFA's benefit payment monitoring programs, as well as those identified in GAO, OIG, and other reports.

Page 4 - John J. O'Shaughnessy

Comment:
We believe that only the following two types of weaknesses should be included in the FMFIA reporting and tracking system:

- any weakness which fits the HHS definition of a material weakness; and,
- any weakness identified as a result of a vulnerability assessment and/or internal control review.

Should your staff have any questions on these comments or require any additional information, please contact Ron Miller of the Office of Executive Secretariat on FTS 934-7490.

DEPARTMENT OF HEALTH & HUMAN SE

Refer to: SMP22

ATTACHMENT NO. 3

HHS' COMMENTS TO GAO'S REPORT
RE: FMFIA

Date: SEP 25 1985

From: Internal Control Officer, SSA

Subject: General Accounting Office (GAO) Draft Report: Second Year Implementation of the Federal Managers' Financial Integrity Act (FMFIA) in the Department of Health and Human Services (DHHS) (Your Memo, 9/6/85)--INFORMATION

To: Chairman
Federal Managers' Financial Integrity Act Steering Committee

We offer the following comments on the subject draft report:

Chapter 2, Assessments of the Secretary's Second - Year FMFIA Statement

1. GAO Statement

ADP systems which are vital to HHS' major programs have not been adequately evaluated.

SSA Comment

GAO's report of HHS' first year implementation of the Federal Managers' Financial Integrity Act (May 9, 1984) recommended that HHS "revise its ADP security program to meet the requirements for assessments and reviews under OMB guidelines for implementing the Financial Integrity Act."

HHS concurred with this recommendation, and ADP was included within the new Internal Control Handbook issued early in 1985. SSA is following the Handbook.

2. GAO Statement

SSA did not adequately evaluate the internal controls of its headquarters or field offices.

SSA Comment (Headquarters)

SSA agrees that it made only limited progress in conducting reviews of headquarters activities in 1984. Our major concern was focused on the number of reviews that SSA needed to conduct during 1984 and the quality of those reviews. Headquarters involvement is a major priority in 1985, and we have taken a number of actions to address this concern.

The SSA Internal Control Officer's support staff has worked intensively with Programs and Policy staff to incorporate an evaluation of operating policies and procedures in the internal control process. These efforts have resulted in a refined inventory which is more reflective of programmatic responsibilities and a vulnerability assessment for each internal control area that provides a basis for an evaluation of susceptability to fraud, waste, abuse, and mismanagement.

SSA has also performed an analysis of field office reviews conducted during 1984. While the focus of the analysis was on field office weaknesses, high frequency weaknesses and patterns of weaknesses may reflect on the adequacy and appropriateness of internal controls in the headquarters - developed procedures. We are using the analysis as a tool for this purpose. Additionally, information developed from a field operations environmental risk analysis, dicussed below, also has provided feedback on the adequacy of headquarter's procedures.

Finally, SSA has refined its inventory of internal control areas within the Office of Systems. The new inventory aligns internal control areas for systems with internal control areas under the cognizance of the Office of Programs and Policy and also achieves a close synchronization with accounting systems responsibilities.

SSA Comment (Field)

SSA disagrees with the GAO statement as it relates to field reviews. The actual review itself measures compliance with procedures; however, in the process of developing the review guide the adequacy of internal controls was evaluated.

As the Security and Control Review Guide was being developed, SSA conducted a field operations environmental risk analysis. A work group with participation from all regions identified vulnerabilities associated with all aspects of field operations, determined the degree of risk associated with the vulnerabilities, and made recommendations regarding corrective actions and safeguards. The results of this effort were incorporated in the review process. Thus, SSA did address the adequacy of internal controls through the risk analysis vehicle.

Chapter 3, HHS Needs to Adequately Evaluate and Strengthen its Accounting Systems and ADP Internal Controls

SSA's ADP emphasis in the implementation of FMFIA is oriented to the Systems Modernization Plan. Numerous reviews made by the Social Security Administration (SSA) personnel and by outside agencies over

the years have identified control weaknesses in programmatic processes, not just in the area of physical security, as indicated in the draft report. In situations where the missing control was critical, some safeguards have been implemented. In other situations, the cost of implementing controls, especially in a piecemeal way, appeared to be greater than the potential losses from the perceived weakness. Since control weaknesses have been identified and reiterated in subsequent reviews, it seems to us that a better use of limited resources is in developing strong controls. The best place to do this is in redesigned systems and processes.

We are also emphasizing the need for controls in the processes being modernized through reviews by SSA security and control personnel, contractors, and personnel from the Office of the Inspector General. We have made progress in developing and implementing controls over the development process itself by the publication of the Software Engineering Technology (SET) manual. Its publication is a significant accomplishment and further improvements in the SET are planned. In addition, progress has been achieved in systems testing and validation activities. Work in these areas is continuing to improve our ability to stress systems before and after implementation. SSA has already implemented improved access control methods over systems resources. Vendor proposals for a back-up site are now in the technical evaluation stage. This contract will be the first step in acquiring back-up resources and implementing a reliable contingency plan.

The report fails to mention or passes over with very minimal comment these accomplishments. These improvements in the control environment, albeit limited, demonstrate a commitment to the goals of the FMFIA and real accomplishment in meeting those goals. We do need to improve our handling of FMFIA requirements in SSA, and we are taking steps to put SSA in a better position vis-a-vis FMFIA. These needed improvements should not, however, screen real accomplishments.

We believe that the narrow focus of the report leads to conclusions that are more negative than reality would suggest.

Chapter 5, SSA's Assessment of Internal Controls Was Inadequate

1. GAO Statements

- During 1983 and 1984, internal controls in less than 5 percent of the identified internal control areas at headquarters were reviewed. The areas reviewed were generally administrative in nature and not directly related to SSA's major programs and activities.

- Field reviews were performed to determine compliance with existing policies and procedures but did not determine the adequacy and effectiveness of existing internal controls.

SSA Comments

Our comments pertaining to item 2 of chapter 2 address these statements.

2. GAO Statement

Other weaknesses involving SSA's programs recently reported on by GAO were not included in SSA's assurance letter on internal controls.

SSA Comment

For 1984 SSA developed its list of material weaknesses with the assistance of GAO and OIG. SSA has requested that both GAO and OIG identify material weaknesses from their report findings and recommendations on an ongoing basis.

3. GAO Statement

SSA should state in its assurance letter that it did not have a basis for making a statement on its controls overall.

SSA Comment

SSA shall consider and seek advice on whether to state that it does not have a basis for making a statement on its controls overall or whether to make a statement on those internal control areas upon which it has some basis for making an evaluation. A determination of the appropriate kind of statement and the basis for making such a statement needs to be made by HHS staff after considering both OMB and GAO positions on this matter.

Jack Buffington

Jack Buffington

DEPARTMENT OF HEALTH & HUMA

ATTACHMENT NO. 4

HHS' COMMENTS TO GAO'S REPORT
RE: FMFIA

Date SEP 26 1985

From Deputy Assistant Secretary for Health Operations and
Director, Office of Management

Subject Comments on the Draft Report, "Second Year Implementation of the Federal Managers' Financial Integrity Act In the Department of Health and Human Services"

To Assistant Secretary for Management and Budget, OS

Attached are the PHS comments on the GAO draft report for your consideration in preparing the HHS response to be provided by your office. In summary, we are strongly concerned because the GAO report fails to give a balanced assessment of PHS actions in implementing internal control during the period following issuance of the first GAO report. The current report is unreasonable in its criticism of coverage of PHS functional areas in 1984 and fails to reflect very substantial PHS progress in both 1984 and 1985 prior to preparation of the current GAO report. A more detailed explanation of our concerns is reflected in the attachment.

In light of the impact acceptance of GAO's position would have on development of internal control, including substantial expansion of resources required for future implementation, we recommend that the HHS response take a strong stand against GAO's interpretation of the "reasonable assurance" standard required by the Act.

Wilford J. Forbush

Attachment

COMMENTS OF THE PUBLIC HEALTH SERVICE ON THE GENERAL ACCOUNTING OFFICE'S DRAFT REPORT, "SECOND YEAR IMPLEMENTATION OF THE FEDERAL MANAGER'S FINANCIAL INTEGRITY ACT IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES"

GENERAL COMMENTS

The Public Health Service (PHS) believes the General Accounting Office's (GAO) draft report is not fully reflective of the development of the internal control system in PHS and presents an unbalanced picture of PHS management's efforts to implement provisions of the Federal Managers' Financial Integrity Act (FMFIA) of 1982. The report is deficient in two major areas with respect to criticism of PHS.

- The report called for unreasonable coverage of PHS functional areas in 1984.
- The report failed to reflect substantial PHS progress in 1984 and 1985, prior to preparation of the report.

PHS is firmly committed to vigorous and effective implementation of the provisions of FMFIA and has committed substantial resources to the effort. Recently, that effort was strengthened by consolidation of responsibility for both Part 2 and Part 4 of the Act in a single component at the PHS level. Moreover, PHS has continued to expand the scope and depth of the internal control system. GAO's recommendation would not be supportable if a balanced review had been made of PHS's implementation of FMFIA, inasmuch as the findings then would reflect significant progress in the evolutionary implementation of the process.

GAO Recommendation

We recommend that the Secretary of HHS direct the Assistant Secretary for Management and Budget to monitor progress by PHS to cover its important areas of internal control in order to ensure proper coverage of management controls

PHS Comment

We do not accept the need for extraordinary monitoring of PHS to ensure proper coverage of management controls. The GAO report is deficient in its conclusions and recommendation critical of PHS for the following reasons.

Unreasonable Coverage of PHS Functional Areas Called for By GAO

GAO's criticism of PHS's coverage of functional areas in 1984 is unreasonable. Both OMB and HHS general guidance have indicated that the

costs of internal control should not exceed the benefits derived therefrom and we have focused coverage on selected areas in the development of the system. In the absence of specific guidance from HHS for six months following issuance of the first GAO report, PHS management reviewed proposed functional areas and decided to focus on those areas appearing to have the greatest vulnerability. All then-known factors were taken into consideration by management in establishing priorities. Although obligations for grants represented a substantial percentage of the total PHS budget, existing management review and control mechanisms gave adequate assurance that incorporation of grants could be delayed while other areas of lower budgetary impact, but significantly higher potential vulnerability, were incorporated immediately into the internal control process. PHS management's careful approach provided a reasonable level of assurance.

PHS has continued to systematically expand the functional area coverage and in FY 1985 incorporated grants and intramural research and in FY 1986 will include IHS health delivery services, FDA new drug evaluations and field laboratory operations and CDC health hazard evaluations, health training verification and laboratory proficiency testing. PHS management's implementation of internal control has been in consonance with OMB and HHS guidance and reflects a reasonable approach to implementation of FMFIA.

The Acting Director, OMB's August 25, 1985 letter to the Comptroller General of the United States, commenting on the recurrent theme in GAO reports on internal control also reflected in the HHS report, confirms the reasonableness of the approach taken by PHS management.

Report Fails to Reflect Substantial PHS Progress

The report examines activities occurring one year or more ago. This has resulted in a misleading assessment of PHS's internal control progress. Excluded from reportage was substantial progress in both coverage of functional areas and development of more effective operating procedures by PHS during the period following the first GAO report.

Substantial information was available to GAO, including internal control directives issued by PHS in January, March and April 1985 which provided guidance in the areas of segmentation, vulnerability assessment and internal control review. Special emphasis was placed on sufficient documentation of internal control reviews. Moreover, task forces were created in May, 1984 to develop the approach to extending the internal control process into the areas of grants and intramural research. The report fails to give recognition to PHS's active participation in the HHS Steering Committee and the Department-wide changes that resulted from the PHS contribution.

PHS has taken a very large number of major steps to improve the internal control system in 1984 and 1985. PHS continues to make substantial progress in developing and implementing a system that provides "reasonable assurance," as required by the Act.

DEPARTMENT OF HEALTH & HUMAN SERVI

ATTACHMENT NO. 5

HHS' COMMENTS TO GAO'S REPORT
RE: FMFIA

DATE : [illegible] 13 [illegible]

FROM : Norman Goldstein
HDS Internal Control Officer

SUBJECT: GAO Second Year Implementation of FMFIA in HHS Report

TO : Guy F. Linza
Program Manager

A you requested, a review of the GAO Second Year Implementation of the Federal Managers Financial Integrity Act report was conducted. GAO referred to the Office of Human Development Services twice in that report. The following are our comments.

Now on p. 30.

The first reference is on page nineteen of the report where it is stated, "Reported property system weaknesses involved not reconciling accounting records with departmental property management records in the Regional Accounting System and Office of the Secretary/Human Development Services Accounting System." We draw to your attention that HDS does not have such a system and we are assuming that this statement refers to a system operated by the Office of the Secretary. If GAO is under the impression that HDS operates this system, that impression should be corrected.

The second reference is in attachment IV where statements are made about an internal control review conducted during the month of December 1984 in the Administration on Native Americans for the area of discretionary grants. GAO states that the review "did not generally test internal controls to verify that they were operating properly or document completely what was done." HDS is not in agreement with this statement.

The report of this particular internal control review specified that only the functions performed by the Administration on Native Americans (ANA) were reviewed. It was stated in the review report, and should be emphasized, that ANA only performs program functions. It does not perform financial functions, those are performed by the Office of Management Services.

The internal control documents that specify program discretionary grant responsibilities are the HHS Grants Administration Manual and the OHDS Grants Administration Staff Handbook. To conduct the internal control review, program functions related to discretionary grants were identified from and tested against the processes defined in those documents.

Through interviews, officials and program specialists described their activities that were then tested against the standards and requirements of the handbooks. It was found that the processes followed in ANA conformed to those of the internal control documents, and no material weaknesses were identified. However, as a result of the evaluation several program improvements were suggested. Among these were to use panelists who are from and familiar with the geographic areas where proposed Native American projects were to be located, to provide a system to integrate scores of the reviewing panels to produce a single ranking according to comparative quality, to make grant monitoring activities a critical element in the staff performance evaluations of project officers, and to better provide for placing program monitoring reports in the official grantee file.

You are asked to forward our comments to the GAO for consideration in revising their report.

Letter to the Chairman, HHS FMFIA Steering Committee

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

November 26, 1984

B-216944

Mr. Andrew J. Kapfer
Chairman, Federal Managers' Financial
Integrity Act Steering Committee
Department of Health and Human Services

Dear Mr. Kapfer:

This responds to your November 5, 1984, letter requesting written comments on a draft letter to the President and the Congress transmitting the Secretary's 1984 Federal Managers' Financial Integrity Act (FMFIA) report. The draft letter concludes that

> "With the exception of the weaknesses and instances of non-compliance stated above, we believe that the systems of accounting and administrative control, taken as a whole, comply with the Comptroller General's principles and standards and provide reasonable assurance that the objectives of internal control were achieved."

We have not completed our evaluation of the Department of Health and Human Services' (HHS') second-year implementation of FMFIA. However, our evaluation thus far reveals that HHS' component agencies have not evaluated some important systems of accounting and internal control. Further, a number of the agencies' systems have material weaknesses or instances of noncompliance, some of which have not yet been corrected. The number of systems--accounting and internal control--not yet evaluated and instances of noncompliance and material weaknesses detract from HHS' ability to state that, taken as a whole and acknowledging weaknesses and instances of noncompliance, its systems comply with the Comptroller General's principles and standards, and the objectives of internal controls. Therefore, we believe that the draft letter's conclusion does not accurately reflect the condition of HHS' accounting systems and internal controls.

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In our report to the Secretary on HHS' first-year implementation of FMFIA (GAO/HRD-84-47, May 9, 1984), we reported that although HHS had made progress in implementing FMFIA, improvements were needed. Also, we advised the Office of Management and Budget (OMB) of our expectations as to what each agency should reasonably be able to accomplish during its second-year efforts. OMB provided these expectations to all federal agencies, including HHS. In our expectations, we indicated that, before reasonable assurance statements can be made this year, we expect the agencies to have undertaken a comprehensive and thorough review process. Moreover, we stated that such a process should include

--verification that the total agency has been covered for purposes of section 2 of FMFIA;

--completion of reliable vulnerability assessments for all assessable units; and

--evaluations of accounting systems' compliance with GAO's principles, standards, and related requirements, or at least a demonstration of meaningful progress in evaluating major systems.

As discussed in the following sections of this letter, HHS has not undertaken a comprehensive and thorough review that included the above expectations. The following sections also discuss several instances of noncompliance and internal control weaknesses that we want to bring to your attention.

The Secretary's draft letter indicates that during 1984 HHS has focused its efforts on enhancing its FMFIA systems and procedures to conform them to the proposals in our May 9, 1984, report. However, substantive work was not started until early September 1984, and the enhancements are not scheduled for completion and implementation until the beginning of the 1985 cycle. The current status of the enhancements prevents us from commenting, at this time, on their consistency with our proposals.

The Secretary's draft letter also states that its evaluation of internal controls was conducted in accordance with OMB's Internal Control Guidelines, which HHS tailored to its organizational and operational environment. Our May 1984 report commented on HHS' noncompliance with the guidelines during 1983 in that HHS deviated from OMB's guidance by excluding certain program activities from the overall process and certain evaluation factors from the assessment and review processes.

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Since neither the OMB guidelines nor the HHS procedures have changed substantially, our previous comments remain pertinent.

ACCOUNTING SYSTEMS

HHS' components have been working this year to finalize their inventory of systems and, through several task forces, are developing methodologies for reviewing different types of accounting systems. (These methodologies will not be completed until Mar. 1985.) Some components have also begun to improve last year's process by conducting limited testing. We have found, however, that:

--Some of HHS' largest accounting systems have not been evaluated this year. For example, the Social Security Administration (SSA) did not review any of its eight systems, which account for and control about $185 billion in benefit and assistance payments.

--Some significant instances of noncompliance known to the components have not been included in their reports to the Office of the Secretary. For example, the Health Care Financing Administration's (HCFA's) section 4 report did not disclose that $150 million in accounts receivable were not recorded in its general ledger, as was reported by the Inspector General. Likewise, an SSA official told us they do not plan to report under section 4 all of the serious internal control problems in their accounting systems that we identified as part of our profile of HHS' financial management structure (AFMD-84-15-5, Aug. 10, 1984).

--Testing has not been made a meaningful and integral part of HHS' process. For instance, before submitting its report the Food and Drug Administration (FDA) verified disbursements made by headquarters during one day--although after submitting its report FDA tested obligations and commitment transactions as well. The Centers for Disease Control's testing was limited to looking at two transactions related to obligations. HCFA's testing consisted of reviewing error and reconciliation listings to see whether automated edit and control checks worked. The Office of the Secretary did no headquarters level testing of its regional accounting system.

--Documentation of review results has not always been sufficient to support conclusions on systems' compliance with prescribed accounting principles and standards.

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This situation existed at FDA and the Office of the Secretary, even though they had attempted to prepare documentation for such things as answers to questionnaires used in their accounting system reviews.

--Some previously identified areas of noncompliance have not been corrected. For example, last year HHS reported problems in property accounting for the regional accounting system and the Office of the Secretary/Office of Human Development Services general ledger system. We were advised that this area of noncompliance will be reported again this year for these systems. Also, last year's report noted several problems with HHS' centralized personnel/payroll system. We were told that corrective actions for many of these problems are scheduled for future years.

We do not expect all aspects of agency systems to be reviewed and tested in detail every year, and we recognize that some corrective actions will take time to accomplish. We believe, however, that it would be premature and inappropriate for an agency to report that its accounting systems, taken as a whole and acknowledging instances of noncompliance, comply with the Comptroller General's principles, standards, and related requir ats if some of its largest systems have not been evaluated, known areas of significant noncompliance are not disclosed, and the review process needs improvement.

ADP COVERAGE

In our report on HHS' first-year implementation of FMFIA, we found that management had apparently given only limited emphasis to considering and evaluating ADP activities as part of the process prescribed by the OMB guidelines for implementing FMFIA. We concluded that HHS needed to improve coverage of ADP activities and proposed that HHS revise its existing ADP security program to include the assessments and reviews required by OMB guidelines. HHS recognized the need to improve ADP coverage under its internal control evaluation program and to better integrate its ADP assessments and reviews with those conducted for the other internal control functions. In response to our proposal, HHS advised us that it believed its efforts to combine the ADP security program with FMFIA requirements would succeed.

However, SSA, HCFA, and Public Health Service (PHS) officials told us that they are waiting for final HHS policy before initiating FMFIA evaluations of ADP internal controls. Without

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such reviews, HHS lacks a basis to determine whether the objectives of internal control for HHS' ADP systems are being achieved. This is particularly significant since Social Security and other HHS programs depend heavily on ADP to process and control hundreds of billions of dollars in benefit and assistance payments.

SOCIAL SECURITY ADMINISTRATION

During 1984, SSA conducted reviews of internal controls at headquarters and field offices. As of September 30, 1984, about 210 of SSA's approximately 1,350 field offices had been reviewed in each of the functional areas of (1) cash; (2) procurement and purchasing; and (3) subsidies, entitlements, and benefit payments. SSA expects to have reviewed 361 offices by the end of 1984. At headquarters, only two internal control reviews have been completed, both of records systems. SSA plans to complete 15 reviews at headquarters during 1984.

The reviews of the field offices represent the bulk of SSA's 1984 effort. Despite the significant commitment of resources to reviews of its field offices, we do not believe that it has sufficiently reviewed its programs and operations to provide reasonable assurance that its internal controls are operating as called for in FMFIA.

SSA's strategy is in keeping with HHS' guidelines that component agencies substitute ongoing efforts in lieu of new internal control reviews wherever possible. The ongoing reviews in the field, however, concentrate primarily on examining an office's adherence to existing policies and procedures. They do not, for example, determine the appropriateness of those policies and procedures or the need for additional controls, as required by OMB guidelines. Also, the reviews do not appear to be identifying and reporting systemic weaknesses because of their limited focus on areas within a district or branch manager's responsibility. Further, the internal control review activity in headquarters has not yet reported significant systemic problems in major program areas.

Recognizing that improvements were needed in its security and integrity activities, in August 1984, SSA began an organizational study of these activities. The study should help SSA delineate and evaluate current activities to determine if external and internal requirements are being met and to assess reporting channels. The study report is expected in January 1985.

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HEALTH CARE FINANCING ADMINISTRATION

In our report on HHS' first-year implementation of FMFIA, we noted that HCFA had, in effect, not covered the propriety of benefit payments under the Medicare and Medicaid programs. During the second year HCFA established a function (monitoring) to cover these payments. However, the internal control areas established under this function, while including at least some regional office responsibilities, excluded headquarters responsibilities. In addition, as of mid-November 1984, no vulnerability assessments or internal control reviews of this function had been performed or planned.

Because of HCFA's slow progress, we undertook a review of the day-to-day activities which might help to reduce the vulnerability of benefit payments to fraud, waste, and abuse. The activities we identified are included in HCFA's reviews of paying agents, which emphasize compliance with its requirements, including determining that paying agents have adequate internal controls over the propriety of benefit payments.

While HCFA's reviews include a number of elements that deal with whether the paying agents are exercising required controls over these payments, our preliminary observation is that the reviews do not include adequate determinations that these controls are sufficient and are effectively operated. Accordingly, we do not believe that HCFA can be viewed as having reasonable assurance over the propriety of Medicare and Medicaid benefit payments. These payments exceed $90 billion annually and constitute over 95 percent of HCFA's budget.

PUBLIC HEALTH SERVICE

Not all of PHS' significant activities have been included in the internal control evaluation process. In our report on HHS' first-year implementation of FMFIA, we reported that PHS' evaluation process did not include such important program activities as in-house research, health care services delivery, drug regulation, and disease surveillance and prevention. Similarly, in December 1983, HHS' Inspector General reported omissions for Indian Health Service hospital operations and FDA district office laboratory operations.

HHS has indicated that it is determining ways to include these and other important activities in its evaluation process. However, as of mid-November 1984, PHS had not added any activities to its FMFIA assessment and review process. Thus, the PHS

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internal control evaluation process cannot, as currently implemented, provide assurance of the adequacy of internal controls for these program activities.

Also, PHS has not adequately assessed its most significant activity--grants. For fiscal year 1984, PHS' obligations for grants are estimated at $5.3 billion, or over 60 percent of its total budget. Despite its significance, the grants activity has been subjected to neither internal control reviews nor a reliable vulnerability assessment process. PHS has generally adopted the policy of reviewing entire functional areas at one time. Reviews performed in 1983 and 1984 were generally in the areas of (1) cash; (2) receivables, loans, and advances; (3) travel; and (4) records systems. The grants area is not scheduled for review until 1986.

In addition, the grants area in PHS (in accordance with HHS guidance) has not been subjected to a reliable vulnerability assessment process to determine its susceptibility to internal control weaknesses. Our May 1984 report stated that assessments resulting from that process were not a reliable basis for scheduling and guiding subsequent internal control reviews. This was true for a number of reasons:

--The process did not include all the factors necessary to identify highly vulnerable areas.

--The scoring system is biased toward low and moderate ratings.

--Some assessment forms were inaccurately completed.

--Some preparers of vulnerability assessments received little or no training and said they would have rated their areas differently had they known more about the process.

Thus, as currently implemented, the PHS internal control evaluation process does not provide reasonable assurance of the adequacy of internal controls in the grants area. For the reasons stated above, we do not believe that PHS has an adequate basis for asserting that its systems of internal controls, taken as a whole and acknowledging instances of weaknesses, provide reasonable assurance that the objectives of internal control were achieved.

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In view of the above comments, we do not believe that the draft letter you submitted for our review accurately describes the situation concerning HHS' implementation of FMFIA during its second-year effort.

Sincerely yours,

Richard L. Fogel

Richard L. Fogel
Director

cc: Mr. O'Shaughnessy, Assistant Secretary
for Management and Budget
Mr. Dukes, Deputy Assistant Secretary
for Management and Budget

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