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Report of Independent Auditors

The Secretary and the Inspector General of the
U.S. Department of Health and Human Services

Report on the Financial Statements

We have audited the accompanying consolidated balance sheets of the U.S. Department of Health and Human Services (HHS) as of September 30, 2018 and 2017, and the related consolidated statements of net cost and changes in net position, and the combined statements of budgetary resources for the fiscal years then ended, and the related notes to the principal financial statements. We were also engaged to audit the sustainability financial statements, which comprise the statements of social insurance as of January 1, 2018, 2017, 2016, 2015, and 2014, the related statements of changes in social insurance amounts for the periods ended January 1, 2018 and 2017, and the related notes to the sustainability financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express opinions on these financial statements based on our audits. Except as discussed in the Basis for Disclaimer of Opinion paragraphs with respect to the accompanying statements of social insurance as of January 1, 2018, 2017, 2016, 2015, and 2014, the related statements of changes in social insurance amounts for the periods ended January 1, 2018 and 2017, and the related notes to these financial statements, we conducted our audits in accordance with auditing standards generally accepted in the United States, and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget (OMB) Bulletin No. 19-01, *Audit Requirements for Federal Financial Statements*. Those standards and OMB Bulletin No. 19-01 require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to HHS's preparation and fair presentation of the financial statements in order to design



audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion on the consolidated balance sheets as of September 30, 2018 and 2017, and the related consolidated statements of net cost and changes in net position, and the combined statements of budgetary resources for the fiscal years then ended, and the related notes to the principal financial statements.

Basis for Disclaimer of Opinion on the Statement of Social Insurance and the Related Changes in the Social Insurance Program

As discussed in Note 22 to the financial statements, the statement of social insurance presents the actuarial present value of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds' estimated future income to be received from or on behalf of the participants and estimated future expenditures to be paid to or on behalf of participants during a projection period sufficient to illustrate long-term sustainability of the social insurance program. The sustainability financial statements are intended to aid users in assessing whether future resources will likely be sufficient to sustain public services and to meet obligations as they come due. The statements of social insurance and changes in social insurance amounts are based on income and benefit formulas in current law and assume that scheduled benefits will continue after any related trust funds are exhausted. The sustainability financial statements are not forecasts or predictions. The sustainability financial statements are not intended to imply that current policy or law is sustainable. In preparing the statement of social insurance, management considers and selects assumptions and data that it believes provide a reasonable basis for the assertions in the statement. Because of the large number of factors that affect the statement of social insurance and the fact that future events and circumstances cannot be known with certainty, there will be differences between the estimates in the statement of social insurance and the actual results, and those differences may be material. Projections of Medicare costs are sensitive to assumptions about future decisions by policymakers and about the behavioral responses of consumers, employers, and health care providers as policies, incentives, and the health care sector change over time. In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, and as discussed below, significant additional variability and issues regarding the sustainability of the underlying assumptions under current law were introduced by the passage of the Patient Protection and Affordable Care Act (ACA) and the Medicare Access and Children Health Insurance Program (CHIP) Reauthorization Act (MACRA).



As further described in Note 23 to the financial statements, with respect to the estimates for the social insurance program presented as of January 1, 2018, 2017, 2016, 2015, and 2014, management has assumed in the projections of the program that the various cost-reduction measures will occur as the ACA and the specified physician updates established by MACRA require. Management has developed an illustrative alternative scenario and projections intended to quantify the potential understatement of projected Medicare costs to the extent that certain payment provisions were not fully implemented in all future years. The range of the social insurance liability estimates in the scenarios is significant. As described in Note 23, the ability of health care providers to sustain these price reductions will be challenging, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services and that physician costs will grow at a faster rate than the specified updates. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time. Absent a change in the health care delivery system or level of update by subsequent legislation, beneficiaries' access to Medicare-participating providers and quality care may become significant issues in the long term under current law. Overriding the price updates in current law, as lawmakers repeatedly did in the case of physician payment rates, would lead to substantially higher costs for Medicare in the long range than those projected in this report. As a result of these limitations, we were unable to obtain sufficient audit evidence for the amounts presented in the statements of social insurance as of January 1, 2018, 2017, 2016, 2015, and 2014, and the related statements of changes in social insurance amounts for the periods ended January 1, 2018 and 2017.

Disclaimer of Opinion on the Statement of Social Insurance and the Related Changes in the Social Insurance Program

Because of the significance of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the financial condition of the HHS social insurance program as of January 1, 2018, 2017, 2016, 2015, and 2014, and the related changes in the social insurance program for the periods ended January 1, 2018 and 2017.

Opinion

In our opinion, the consolidated balance sheets, consolidated statements of net cost and changes in net position, and combined statements of budgetary resources referred to above present fairly, in all material respects, the consolidated financial position of HHS as of September 30, 2018 and 2017, and its net cost, changes in net position, and budgetary resources for the years then ended in conformity with U.S. generally accepted accounting principles.



Other Matters

Required Supplementary Information

U.S. generally accepted accounting principles require that the Management’s Discussion and Analysis, Required Supplementary Stewardship Information, and Required Supplementary Information as identified on HHS’s Agency Financial Report Table of Contents, be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Federal Accounting Standards Advisory Board, which considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management’s responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audits of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Financial Information and Other Information

Our audits were conducted for the purpose of forming opinions on the financial statements that collectively comprise HHS’s basic financial statements. The Other Financial Information, as identified on HHS’s Agency Financial Report Table of Contents, is presented for purposes of additional analysis and is not a required part of the basic financial statements.

The Other Financial Information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. Such information has been subjected to the auditing procedures applied in the audits of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the Other Financial Information is fairly stated, in all material respects, in relation to the basic financial statements as a whole.

Except for the Other Financial Information described above, the Other Information has not been subjected to the auditing procedures applied in the audits of the basic financial statements, and, accordingly, we do not express an opinion or provide any assurance on it.



Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we also have issued our reports dated November 14, 2018, on our consideration of HHS’s internal control over financial reporting and on our tests of its compliance with certain provisions of laws and regulations, contracts and grant agreements, and other matters. The purpose of those reports is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of HHS’ internal control over financial reporting or on compliance. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* in considering HHS’s internal control over financial reporting and compliance.

Ernst & Young LLP

November 14, 2018



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Report of Independent Auditors on Internal Control over Financial Reporting Based on an Audit of Financial Statements Performed in Accordance With *Government Auditing Standards*

The Secretary and the Inspector General of the
U.S. Department of Health and Human Services

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial statement audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and Office of Management and Budget (OMB) Bulletin No. 19-01, *Audit Requirements for Federal Financial Statements*, the consolidated financial statements of the U.S. Department of Health and Human Services (HHS or the Department), which comprise the consolidated balance sheet as of September 30, 2018, and the related consolidated statements of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal year (FY) then ended, and the related notes to the principal financial statements, and we were also engaged to audit the sustainability financial statements, which comprise the statement of social insurance as of January 1, 2018, and the related statement of changes in social insurance amounts for the period ended January 1, 2018, and have issued our report thereon dated November 14, 2018. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2018, and the related statement of changes in social insurance amounts for the period ended January 1, 2018.

Internal Control over Financial Reporting

In planning and performing our audit of the financial statements, we considered HHS' internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of HHS's internal control. Accordingly, we do not express an opinion on the effectiveness of HHS' internal control. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin No. 19-01. We did not test all internal controls relevant to operating objectives as broadly defined by the *Federal Managers' Financial Integrity Act of 1982*, such as those controls relevant to ensuring efficient operations.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a



material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and, therefore, material weaknesses or significant deficiencies may exist that have not been identified. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified. We did identify certain deficiencies in internal control related to Financial Information Systems and Financial Systems, Analysis and Reporting, as described below, to be significant deficiencies.

Significant Deficiencies

Financial Information Systems

As a part of our procedures for the FY 2018 HHS financial statement audit, we noted that the Department continues to make strides to improve the controls within its supporting information technology (IT) financial systems. In particular, management has continued to establish a governance model and consistent tone at the top focused on strengthening the maturity of the Department's IT controls. Specifically, management has taken a leadership role in monitoring remediation activities across all IT systems in scope, with a focus on general ledger systems and high-risk control deficiencies of the consolidated FY 2018 financial statement audit. These efforts have led to a significant reduction of the number of high-risk internal control deficiencies noted in prior year audits. The following summarizes some additional improvements achieved that resulted from this increased attention:

- Management continues to make continuous improvement to their Managers' Internal Control Program (MICP) leading to the proactive remediation of issues, with a focus on higher risk issues identified during the audit, allowing for the residual risk of the issue to be minimized.
- Differential investments in key financial systems' leading to the implementation of more robust automated controls supporting material processes



The following is a summary of the deficiencies that we considered most critical at the application layer. When assessed in aggregate, our conclusion of IT significant deficiency are based on the following:

- **Access controls** – We identified access controls exceptions across three of the eight applications in scope of our review, which spanned non-Centers for Medicare and Medicaid Services’ (CMS) systems. Specifically, we noted: (1) the tool utilized for one application is not configured to automatically disable user accounts after a period of inactivity, (2) there was no method to pull a list of terminated users over the course of the FY since accounts are deleted from the system when an individual is terminated, (3) lack of user access monitoring procedures for generic ID’s and retention of support for the review of audit logs, and (4) no monitoring procedures exist when an application team ceased service with a third-party tool. We identified similar exceptions at CMS: (1) CMS management did not perform or adequately perform periodic reviews of user access, including users with privileged access, (2) procedures for adding or removing users were not consistently followed, and (3) integration of user populations in the CMS enterprise identity management system and key financial systems and underlying infrastructure components was not complete.
- **Configuration management** – We identified configuration management exceptions in three of the eight applications in scope of our review, which spanned non-CMS systems. Specifically, we noted: (1) we were not able to validate the full population of changes made to various application in order to verify that only changes that went through the configuration management process were put into production, (2) no formal process in place to periodically monitor for unauthorized changes, (3) no formal process to monitor activity performed by individuals with access to both development and production environments, and (4) extended use of a previous version of the application exposing risk on an unsupported platform in which the enhancement patches addressing security issues are not implemented in a timely manner. CMS continues to experience deficiencies in the implementation and monitoring of compliance with its information systems control standards and processes at both the Medicare fee-for-service contractors and the Central Office. In addition, several vulnerabilities related to system configurations were identified with the Central Office information systems.
- **Segregation of duties (SOD)** – We identified segregation of duties exceptions across five of our eight applications in scope of our review, which spanned non-CMS systems. Specifically, we noted: (1) monitoring was not in place for the entire FY for a portion of the SOD controls and there are a number of high-risk SOD controls that do not have monitoring procedures implemented to date, (2) Cross-application SOD between two systems was not documented or monitored and there are a number of users who have conflicting roles between the two systems, (3) a number of SOD waivers were missing for a key financial system and the users with missing waivers were not identified within the



periodic review/user recertification process, and (4) a user exists with access to a shared account which provides access to the production environment and in combination with the user's individual account, the user can both develop and migrate front-end application and configuration changes into production. CMS did not have adequate segregation of duties for those users conducting user access reviews and privileged application functions were not consistently implemented.

- **Risk management** – Findings identified by internal and external audits remain unresolved during the audit period. This includes the findings that sufficient security controls have not been implemented to ensure the resiliency of Medicare enrollment data. CMS' risk management strategy is decentralized and lacks an enterprise viewpoint, which has resulted in several control deficiencies in areas where business units share responsibility for oversight. Furthermore, risk management procedures have not been tailored to manage specific risks based on the role of IT systems within the CMS environment.

Recommendations

HHS should continue the focus achieved in FY 2018 to remediate the remaining deficiencies contributing to the significant deficiency and focus on continuous improvement. The following are some specific considerations:

- Management should continue to focus on high-priority remediation activities ultimately strengthening the IT controls maturity, with specific attention on the remaining high-risk control deficiencies identified as a part of the consolidated FY 2018 financial statement audit centered on access controls, configuration management and segregation of duties;
- Management should work to strengthen overarching governance / oversight to improve sustainability of remediation activities limiting the identification of new, high-risk observations during the audit;
- Execute on planned modernization of legacy systems with further investment, while ensuring that any major changes to the IT environment are performed with internal controls at the forefront, leading to strengthened overarching governance / oversight to improve sustainability of controls; and
- Continue to build on the maturity of the IT controls enterprise and strengthen all aspects of the HHS/CMS IT enterprise, to include operating system, data tier, and application layer, while being cognizant of the identification of new high-risk control deficiencies on material systems.



We have performed a separate financial statement audit of CMS for FY 2018 and in conjunction with our reports on that audit have provided recommendations specific to CMS on our IT internal control findings. Those findings and recommendations were considered in our overall HHS conclusions.

Financial Systems, Analysis and Reporting

During FY 2018, HHS made significant progress in addressing certain issues that have impaired its ability to overcome its significant deficiencies in the past. Improvements included:

- Continued development of policies and procedures over financial processes,
- Execution of analyses to remediate certain data quality issues allowing for data cleanup activities, and the
- Implementation of certain processes to automate and strengthen controls around the National Institutes of Health’s (NIH) non-standard journal entries. We noted a reduction of total non-standard entries by over an approximate \$276.0 billion during FY 2018 compared to FY 2017.

Although progress in certain areas has been identified, our review of internal control disclosed a series of deficiencies in financial systems and processes for producing financial statements, including lack of integrated financial management systems, antiquated processes that impacted journal entries to their financial and budgetary amounts, and/or insufficient analysis and oversight of certain significant accounts or programs. We identified the following items in the current year’s audit that indicate additional improvements in the financial reporting systems and processes are required.

Non-Standard Journal Voucher Processes

HHS posts a significant number of non-standard journal vouchers to record entries that are unable to be recorded through routine systematic processing. The majority of these entries are generated by NIH; however in comparison to their budgetary resources, many of the other operating divisions also have a significant number of non-standard entries recorded to ensure consolidated financial statement amounts are accurate. During FY 2018, although HHS’ annual total budgetary resources was \$1.8 trillion, HHS was required to process approximately 9,914 manual entries totaling an absolute value of more than \$471.0 billion to its NIH Business System (NBS) or Unified Financial Management Systems (UFMS). These entries consist of non-standard postings to record both the proprietary and budgetary effects of certain financial activities for which either the financial system is not configured properly to post automatically or to post differences identified during the various reconciliations or analyses performed by HHS personnel. Although necessary to ensure



balances are accurate, the volume and dollar value of manual entries is significant compared to the HHS's overall activity. We noted that HHS made significant improvements in FY 2018 with a reduction in the number and amount of non-standard entries as compared to the FY 2017.

CMS Oversight Processes

We performed a separate audit of the financial statements of CMS and reported on the results of our audit, including a report on its internal controls, dated November 6, 2018. In that report, we outlined details of deficiencies noted and made recommendations for improvement in its financial management controls. Consistent with our findings in the previous year, we concluded that the aggregation of these deficiencies to be a significant deficiency for the CMS internal control over financial reporting.

The most significant of those deficiencies fell within the oversight of the CMS Medicaid program and the Statements of Social Insurance.

Medicaid Oversight

The Medicaid program is the primary source of medical assistance for low-income Americans. Medicaid operates as a partnership between the states and the Federal government. The Federal government establishes the minimum requirements and provides oversight for the program and the states design, implement, administer and oversee their own Medicaid programs within the Federal parameters.

As of June 2018, CMS completed implementation of the Transformed-Medicaid Statistical Information System (T-MSIS). T-MSIS modernizes and enhances the way states submit operational data about beneficiaries, providers, health plans, claims and encounters. Although operational data is currently available, CMS must continue to work with states to assess and improve T-MSIS state data quality to support national and state level program analysis with timely, accurate, and complete data for policymaking and research. At this time the information contained within T-MSIS requires additional verification before it would be considered reliable. CMS should continue to enhance the usefulness of T-MSIS data so they will be able to perform robust analytical procedures and develop benchmarks to monitor and identify risks associated with the Medicaid program. Examples of risks to monitor could include outliers and unusual or unexpected results that demonstrate abnormalities in state-related Medicaid expenditures and/or allow CMS to assess the reliability of the T-MSIS data. Given that CMS does not currently maintain reliable historical claims level detail for Medicaid, data analyses have been limited. At this time, CMS is unable to perform a claims-level detailed look-back analysis for the Medicaid Entitlement Benefits Due and Payable (EBDP) to determine the reasonableness of the various state calculations of incurred (unpaid claims) but not reported liability. The Medicaid EBDP is a significant liability on the FY 2018 financial statements and is subject to volatility based on the complexity and judgement required in establishing this estimate. From time to time, claim processing cycle changes, such as



a claims inventory buildup, may arise. As such, the lack of detailed claims data limits the ability to detect this type of situation on a timely basis or consider the potential volatility from this occurrence. With the implementation of T-MSIS, CMS now has access to data on which to base a claims-level detailed look-back analysis for Medicaid EBDP; however CMS must continue to evaluate and improve the quality and completeness of data reported by the states in T-MSIS. Until further analysis is developed and performed to verify the reliability of T-MSIS data, there remains a risk that potential updates to CMS' analysis will not be reflected in CMS' financial statements in a timely manner.

Statements of Social Insurance

The Statements of Social Insurance (SOSI) for CMS presents a long-term projection of the present value of the benefits to be paid for the closed and open groups of existing and future participants of the Medicare social insurance programs less the inflows to be received from, or on behalf of, those same individuals. The SOSI models are complex, 75-year projections that contain a high degree of estimation. The models and their results are heavily reviewed by actuaries and others within CMS. The veracity of the underlying data remains critical to the accuracy of the model, and as a result the reviews of the underlying data is robust, in line with CMS' policies and procedures. As part of this review, the input into the spreadsheet is checked against the original data sources to ensure that no input errors have been made. In addition, output data, including those that are generated from updating and running any macro in the spreadsheet, are checked by the reviewer. These checks include a comparison to the results from the year before, and testing of the formulas that are part of the spreadsheet or macro, to ensure that the projection output from the program is as expected and reasonable. During our procedures, two formula errors were identified, one of which was significant, that were not detected by the organization's monitoring and review function, and accordingly, the related control was not functioning as designed.

Recommendations

We recommend that HHS continue to develop and refine their financial management systems and processes to improve their accounting, analysis, and oversight of financial management activity. This will require focused efforts and continued prioritization of issues related to controls within and surrounding their financial information management systems. Specifically, we recommend the following:

- For non-standard journal processes, we recommend that HHS continue to focus on automating and reducing the number of non-standard journal vouchers by determining the cause and the ability to upgrade systems to allow for automated posting of high-volume routine transactions and to ensure financial data is accurate.



- We recommend that CMS continue to refine its financial management controls as a means to improve its accounting, analysis, and oversight of financial management activity, primarily relating to the oversight of the Medicaid program. Additionally, we recommend that CMS continue to adhere to established policies and procedures to ensure that the SOSI model methodology and related calculation and estimates are reviewed at a level of sufficient precision. More detailed recommendations related to our specific findings on these topics are included in our CMS Report on Internal Control.

Status of Prior Year Findings

In the reports on the results of the FY 2017 audit of the HHS consolidated financial statements, a number of issues were raised relating to internal control over financial reporting. The chart below summarizes the current status of the prior year items:

Material Weakness		
Issue Area	Summary Control Issue	FY 2018 Status
Financial Information Systems	<ul style="list-style-type: none"> • Access Controls • Configuration Management • Segregation of Duties 	Significant progress noted; certain issues need continued focus. Classified as a significant deficiency
Significant Deficiency		
NIH and CMS Financial Systems, Analysis, and Reporting	<ul style="list-style-type: none"> • National Institutes of Health • Centers for Medicare and Medicaid Services 	Progress noted within operating divisions financial reporting processes. Modified Repeat Condition.

HHS’s Response to Findings

HHS’s response to the findings identified in our audit are included in the accompanying letter dated November 14, 2018. HHS’s response was not subjected to the auditing procedures applied in the audit of the consolidated financial statements, and, accordingly, we express no opinion on it.



Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control. Accordingly, this communication is not suitable for any other purpose.

Ernst + Young LLP

November 14, 2018



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Report of Independent Auditors on Compliance and Other Matters Based on an Audit of the Financial Statements Performed in Accordance With *Government Auditing Standards*

The Secretary and the Inspector General of the
U.S. Department of Health and Human Services

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and the Office of Management and Budget (OMB) Bulletin No. 19-01, *Audit Requirements for Federal Financial Statements*, the consolidated financial statements of the Department of Health and Human Services (HHS or the Department), which comprise the consolidated balance sheet as of September 30, 2018, and the related consolidated statements of net cost and changes in net position and the combined statement of budgetary resources for the fiscal year (FY) then ended, and the related notes to the principal financial statements, and we were also engaged to audit the sustainability financial statements, which comprise the statement of social insurance as of January 1, 2018, and the related statement of changes in social insurance amounts for the period ended January 1, 2018, and have issued our report thereon dated November 14, 2018. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2018, and the related statement of changes in social insurance amounts for the period ended January 1, 2018.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether HHS's consolidated financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts, and certain other laws and regulations specified in OMB Bulletin No. 19-01, including the requirements referred to in the *Federal Financial Management Improvement Act of 1996* (FFMIA) (P.L.104-208). However, providing an opinion on compliance with those provisions was not an objective of our audit, and, accordingly, we do not express such an opinion. We limited our tests of compliance to these provisions, and we did not test compliance with all laws and regulations applicable to HHS. The results of our tests disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 19-01, as described below.



During FY 2018, HHS’s management determined that it may have potential violations of the Anti-Deficiency Act (P.L. 101-508 and OMB Circular A-11) related to an obligation of funds for conference spending at FDA and certain contract obligations serviced by the Program Support Center occurring between FY 2006 and FY 2011. Additionally, HHS’s management determined that its Medicare appeals process did not adjudicate appeals within the statutory decisional time frames required by the *Social Security Act*.

The *Improper Payments Information Act of 2002* (IPIA) (P.L. 107-300) as amended by the *Improper Payments Elimination and Recovery Act of 2010* (IPERA) (P.L. 111-204) and the *Improper Payments Elimination and Recovery Improvement Act of 2012* (P.L. 112-248) (hereinafter, the “Acts”) require federal agencies to identify the program and activities that may be susceptible to significant improper payments and estimate the amount of the improper payments. While the Department continues to make progress, HHS currently is not in full compliance with the requirements of the Acts. For example, HHS has reported improper payment error rates for each of its high-risk programs, or components of such programs, except for the Temporary Assistance for Needy Families (TANF). HHS indicated that it is unable to compel states to collect the necessary information required to conduct an improper payment measurement for TANF due to Section 411 of the *Social Security Act*, which specifies the data elements that HHS may require states to report, and Section 417 of the same *Social Security Act*, which dictates that the federal government may only regulate the conduct of states where Congress has given them the express authority. Accordingly, HHS states that it does not have the authority to collect data pertaining to case and payment accuracy for TANF since the information is not included under the *Social Security Act*. Additionally, we noted certain programs that did not meet their identified targets. Also, HHS is not in full compliance with Section 6411 of the *Patient Protection and Affordable Care Act*, as HHS has not yet implemented recovery activities of the identified improper payments for the Medicare Advantage (Part C) program.

Under FFMIA, we are required to report whether HHS’s financial management systems substantially comply with federal financial management systems requirements, applicable federal accounting standards, and the United States Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA Section 803(a) requirements. The results of our tests disclosed no instances in which HHS’s financial management systems did not substantially comply with requirements as discussed above.

* * * * *

HHS’s Response to Findings

HHS’ response to the findings identified in our audit are described in their letter dated November 14, 2018. HHS’s response was not subjected to the auditing procedures applied in the audit of the financial statements, and, accordingly, we express no opinion on it. Additionally, HHS is updating its Department-wide corrective action plan to address the financial management issues discussed above.

1811-2946300

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Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of compliance and the results of that testing, and not to provide an opinion on HHS’s compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering HHS’s compliance. Accordingly, this communication is not suitable for any other purpose.

Ernst & Young LLP

November 14, 2018

