Department of Health and Human Services

FY 2013

Agency Financial Report

Administration · Agency for Healthcare Research and ances and Disease Registry · Centers for Disease Control dicare & Medicaid Services · Food and Drug Administration · Health Resources and Services Administration · Indian Health Service · National Institutes of Health · Substance Abuse & Mental Health

TABLE OF CONTENTS

MESSAGE FROM THE SECRETARY

Kathleen Sebelius

I am pleased to present the *FY 2013 Agency Financial Report* for the Department of Health and Human Services.

Our Department's mission is to improve the health and well-being of all Americans through effective health and human services and by fostering sound, sustained advances in care, research, public health, and social services.

We manage one of the largest budgets in the world and improve the health and lives of Americans every day. We administer more grant dollars than all other federal agencies combined. Our initiatives are as diverse as the people whom we serve. It is our obligation to make the investments that will reach the most people, build most effectively on our partners' efforts, and lead to the biggest gains in health and opportunity for the American people.

One of our most notable initiatives is our work to implement the *Affordable Care Act*. Today, health care cost growth has been driven down to the lowest levels in 50 years, and millions of Americans are already benefitting from new rights and consumer protections. With the new Health Insurance Marketplace, choice and competition among private market plans is now available to millions of uninsured and underinsured Americans. We are committed to improving the consumer experience with the Marketplace and our work will not be done until every eligible American has the opportunity to access affordable, quality health coverage.

As Secretary of HHS, I recognize that we are accountable, above all, to the American public. Our departmental financial statement audit is one of the best tools the American people have to assess our financial information. This year, we obtained a clean opinion on our Consolidated Balance Sheet, Statement of Net Cost, Statement of Changes in Net Position, and the Combined Statement of Budgetary Resources. The auditors did not audit nor express an opinion on the FY 2013 Statement of Social Insurance and Statement of Changes in Social Insurance Amounts that reflect current law as presented in the *2013 Medicare Trustees Report.*

As required by the *Federal Managers' Financial Integrity Act of 1982* (FMFIA) and the Office of Management and Budget's Circular A-123, *Management's Responsibility for Internal Control*, we also evaluated our internal controls and financial management systems. We found one material weakness in the Department related to Information Systems Controls and Security and one material noncompliance with the *Improper Payments Information Act* related to error rate measurement. We have already begun taking actions to improve our financial reports and systems. Further details may be found in the Management's Discussion and Analysis section of our report.

None of our accomplishments would be possible without the dedication and commitment of our employees and the strong support of our state, local, and nonprofit partners. I am proud of the work we do and the progress we have made. We are delivering on our promise of providing better care, helping Americans achieve better health, and lowering the costs of health care for all Americans.

/Kathleen Sebelius/
Kathleen Sebelius
Secretary
December 16, 2013

ABOUT THE AGENCY FINANCIAL REPORT

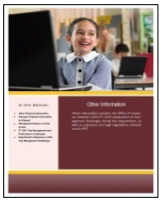
The Department of Health and Human Services (HHS or the Department) Fiscal Year (FY) 2013 *Agency Financial Report* (AFR) provides fiscal and summary performance results that enable the President, Congress and the American people to assess our accomplishments for the reporting period beginning October 1, 2012 and ending September 30, 2013. Challenges and accomplishments arising after September 30, 2013 will be addressed in the FY 2014 AFR. This report provides an overview of our programs, accomplishments, challenges and management's accountability for the resources entrusted to us. We have prepared this report in accordance with the requirements of the Office of Management and Budget (OMB) Circular A-136*, Financial Reporting Requirements.* This document consists of three primary sections:

Management's Discussion and Analysis

The Management's Discussion and Analysis (MD&A) section provides an overview of the entire report. Specifically, the MD&A presents an overview of performance and financial highlights for FY 2013. It also discusses HHS' compliance with legal and regulatory requirements, a summary of audit and management assurances and gives a brief look ahead to FY 2014.

Financial Section

The Financial Section includes the Department's Principal Financial Statements and the Report of the Independent Auditors. It also contains the Notes to the Principal Financial Statements, Required Supplementary Stewardship Information (RSSI) and Required Supplementary Information (RSI).



Other Information

The Other Information (OI) section contains additional financial information including the Schedule of Spending, the Office of Inspector General's (OIG) FY 2013 assessment of management challenges facing the Department, a Management Report on Final Action and the Improper Payments Information Act Report, as well as a glossary and legal regulations relevant to this AFR.

Agency Financial Report Availability

We present our FY 2013 AFR, which conforms to OMB Circular A-136, *Financial Reporting Requirements*. The FY *2013 AFR* will be available December 16 and the *FY 2014 Congressional Budget Justification* will be available in February 2014, as will the *Summary of Performance and Financial Information*. These reports will be available on our website at http://www.hhs.gov at that time. This suite of reports provides readers and decision-makers with enhanced and more transparent financial and performance information.

We Welcome Your Comments

Thank you for your interest in the Department of Health and Human Services. The FY 2013 AFR is available at http://www.hhs.gov. We welcome your comments and questions regarding this AFR and appreciate any suggestions. Please contact us at hhsdeputycfo@hhs.gov or at:

Department of Health and Human Services
Office of Finance/OFPR
Mail Stop 522D
200 Independence Avenue, S.W.
Washington, DC 20201

In this Section:

- About the Department of Health and Human Services
- Performance Goals, Objectives and Results
- Analysis of Financial Statements and Stewardship Information
- Systems, Legal Compliance and Internal Controls
- Statement of Assurance
- Summary of Financial Statement Audit
- Summary of Management Assurances
- Looking Ahead to 2014

Management's Discussion and Analysis

The Management's Discussion and Analysis (MD&A) section provides an overview of the entire report. Specifically, the MD&A presents an overview of performance and financial highlights for FY 2013. It also discusses HHS' compliance with legal and regulatory requirements, a summary of audit and management assurances and gives a brief look ahead to FY 2014.

ABOUT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

HHS is the United States (U.S.) Government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

Mission Statement

Our mission is to enhance the health and well-being of Americans by providing for effective health and human services, and by fostering sound, sustained advances in the sciences, underlying medicine, public health, and social services.

HHS represents almost a quarter of all federal outlays and administers more grant dollars than all other federal agencies combined. As the nation's largest health insurer, HHS' Medicare program handles more than one billion claims per year. Medicare and Medicaid together provide health care insurance for one in four Americans.

HHS works closely with state and local governments and many HHS-funded services are provided at the local level by state or county agencies, or through private sector grantees. The HHS Office of the Secretary (OS) and its eleven operating divisions (OPDIVs) administer more than 300 programs, covering a wide spectrum of activities. In addition to the services they deliver, HHS programs provide for equitable treatment of beneficiaries nationwide and enable the collection of national health and other data.

Our vision is to provide the building blocks that Americans need to live healthy, successful lives. We fulfill our mission and vision daily by providing millions of children, families and seniors with access to high-quality health care, helping people find jobs, assisting parents to find affordable childcare, keeping the food on Americans' shelves safe and pushing the boundaries of how we diagnose and treat disease. Each HHS OPDIV contributes to our mission and vision as follows:

The Administration for Children and Families (ACF) is responsible for federal programs that promote the economic and social well-being of families, children, individuals and communities. For more information, please visit: http://www.acf.hhs.gov.

The Administration for Community Living (ACL) is responsible for providing national leadership and direction to plan, manage, develop and raise awareness of comprehensive and coordinated systems of long-term services and support that enable older Americans and individuals with disabilities to maintain their health and independence in their homes and communities. For more information, please visit: http://www.hhs.gov/acl.

ACL serves as the Federal agency responsible for increasing access to community supports, while focusing attention and resources on the unique needs of older Americans and people with disabilities across the lifespan.

The Agency for Healthcare Research and Quality (AHRQ) improves the quality, safety, efficiency and effectiveness of health care for all Americans. AHRQ fulfills this mission by conducting health services research in order to identify the most effective ways to organize, manage, finance, deliver high-quality health care, reduce medical errors and improve patient safety. For more information, please visit: http://www.ahrq.gov.

The Agency for Toxic Substances and Disease Registry (ATSDR) serves the public by using the best science, taking responsive public health actions and providing trusted health information to prevent harmful exposures or disease-related exposures to toxic substances. For more information, please visit: http://www.atsdr.cdc.gov.

The Norton Sound Regional Hospital in Nome, Alaska operates under the umbrella of the Indian Health Service.

The Centers for Medicare and Medicaid Services (CMS) administers public insurance programs which serve as the primary sources of health care coverage for seniors and a large population of medically vulnerable individuals and acts as a catalyst for enormous changes in the availability and quality of health care for all Americans. In addition to these programs, CMS has the responsibility to ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries. CMS also is responsible for helping to implement many provisions of the *Affordable Care Act* (ACA). For more information, please visit: http://www.cms.gov.

The Centers for Disease Control and Prevention (CDC) collaborates to create the expertise, information and tools that people and communities need to protect their health – through health promotion; prevention of disease, injury and disability; and preparedness for new health threats. For more information, please visit: http://www.cdc.gov.

The Food and Drug Administration (FDA) is responsible for protecting the public health by assuring the safety, efficacy and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics and products that emit radiation. FDA is also responsible for advancing the public health by helping to speed innovations that make medicines and foods effective, affordable and safe. Additionally, it helps the public get the most accurate, science-based information it needs to use medicines and foods to improve its health. For more information, please visit: http://www.fda.gov.

An FDA field inspector checks imported food for contaminants and prepares samples for laboratory analysis.

The Health Resources and Services Administration (HRSA) is responsible for improving health care and achieving health care equity through access to quality services, a skilled health workforce and innovative programs. HRSA focuses on uninsured, underserved and special needs populations in its goals and program activities. For more information, please visit: http://www.hrsa.gov.

The Indian Health Service (IHS) is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally recognized tribes grew out of the special government-to-government relationship between the Federal Government and Indian tribes. This relationship, established in 1787, is based on Article I, Section 8, of the U.S. Constitution and has been given form and substance by numerous treaties, laws, Supreme Court decisions and Executive Orders. IHS is the principal federal health care provider and health advocate for Indian people, with the goal of raising Indian health status to the highest possible level. The IHS

provides a comprehensive health service delivery system for approximately 2.2 million American Indians and Alaska Natives who belong to 566 federally recognized tribes in 35 states. For more information, please visit: http://www.ihs.gov.

The National Institutes of Health (NIH) is the steward of medical and behavioral research for the nation. NIH promotes science in pursuit of fundamental knowledge about the nature and behavior of living systems. It also utilizes the application of that knowledge to extend healthy life and reduce the burdens of illness and disability. For more information, please visit: http://www.nih.gov.

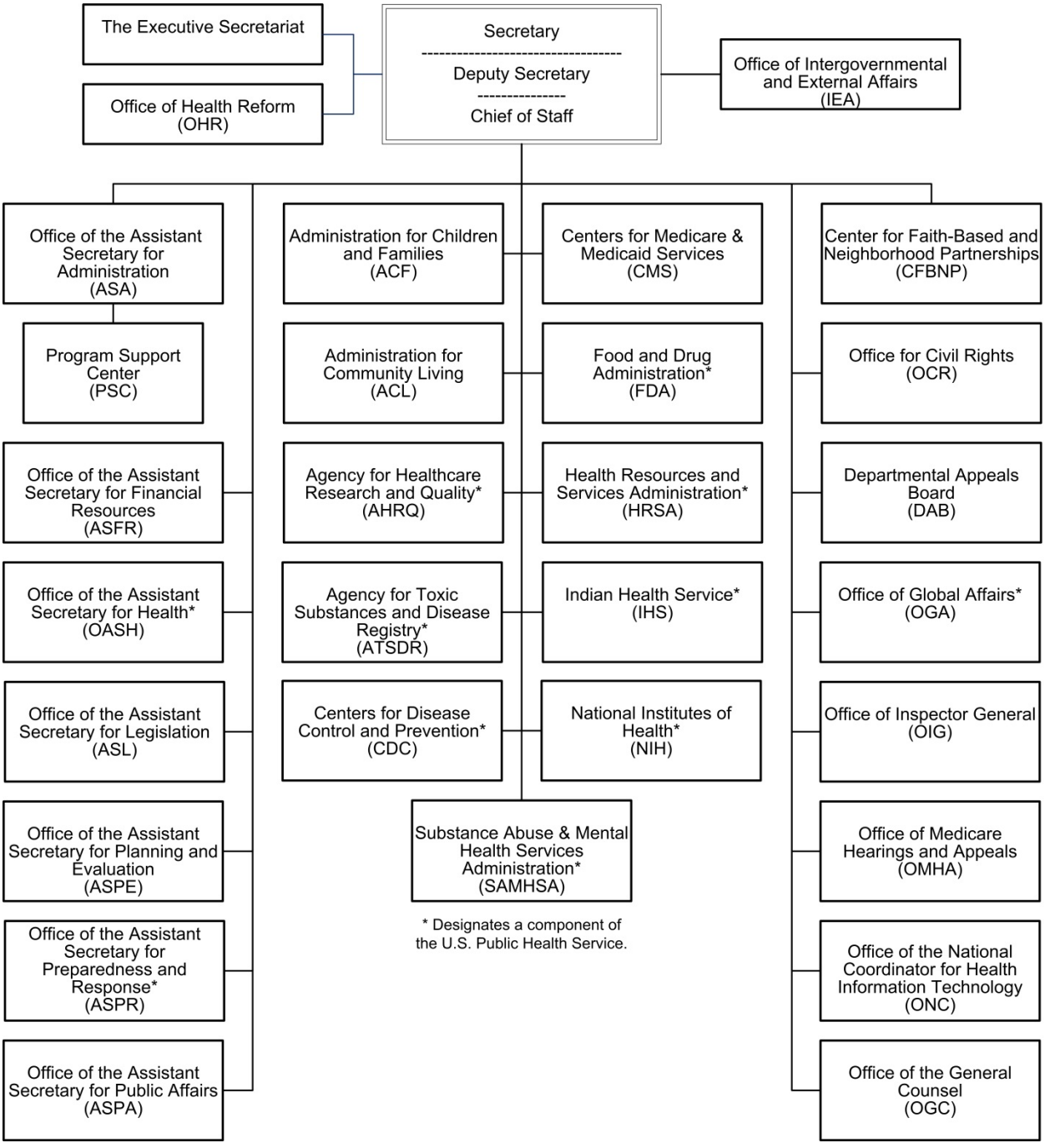
NIH scientists prepare equipment for research at the National Eye Institute.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is responsible for reducing the impact of substance abuse and mental illness on America's communities. SAMHSA accomplishes its mission by providing leadership, developing service capacity, communicating with the public, setting standards and improving practice in communities, primary and specialty care settings. For more information, please visit: http://www.samhsa.gov.

The Office of the Secretary (OS), with our Secretary, leads HHS and its eleven OPDIVs, listed above, to provide a wide range of services and benefits to the American people. In addition, the following staff divisions (STAFFDIVs) report directly to the Secretary, managing programs and supporting the OPDIVs in carrying out our mission. They are:

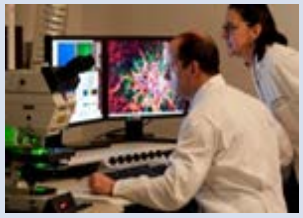
- Office of the Assistant Secretary for Administration (ASA) http://www.hhs.gov/asa/
- Office of the Assistant Secretary for Financial Resources (ASFR) http://www.hhs.gov/asfr/
- Office of the Assistant Secretary for Health (OASH) http://www.hhs.gov/ash/
- Office of the Assistant Secretary for Legislation (ASL) http://www.hhs.gov/asl/
- Office of the Assistant Secretary for Planning and Evaluation (ASPE) http://www.aspe.hhs.gov/
- Office of the Assistant Secretary for Public Affairs (ASPA) http://www.hhs.gov/aspa/
- Office of the Assistant Secretary for Preparedness and Response (ASPR) http://www.phe.gov/preparedness/
- Center for Faith-Based and Neighborhood Partnerships (CFBNP) http://www.hhs.gov/partnerships/
- Departmental Appeals Board (DAB) http://www.hhs.gov/dab/
- Office for Civil Rights (OCR) http://www.hhs.gov/ocr/
- Office of the General Counsel (OGC) http://www.hhs.gov/ogc/
- Office of Global Affairs (OGA) http://www.globalhealth.gov/
- Office of Inspector General (OIG) http://www.oig.hhs.gov/
- Office of Intergovernmental and External Affairs (IEA) http://www.hhs.gov/intergovernmental/
- Office of Medicare Hearings and Appeals (OMHA) http://www.hhs.gov/omha/
- Office of the National Coordinator for Health Information Technology (ONC) http://www.healthit.hhs.gov/

Below, we present our organizational chart, which consists of the Office of the Secretary http://www.hhs.gov/secretary/ and the noted STAFFDIVs and OPDIVs. To find further information regarding our organization, components and programs, visit our website at http://www.hhs.gov.



PERFORMANCE GOALS, OBJECTIVES AND RESULTS

Health and Human Services Performance Results



Scientists at NIH

Throughout FY 2013, HHS continued to improve its performance management processes in alignment with the *Government Performance and Results Modernization Act*. This activity supports HHS' mission to enhance the health and well-being of Americans. HHS' performance management efforts during this period have reinforced progress while finding new efficiencies.

Performance Management Process Milestones

In FY 2013, HHS ensured the prominence of program performance to support the Department's mission of protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. These efforts are shown through the successes of the HHS Priority Goals and the innovative and results-oriented solutions developed and delivered throughout the Department. Furthermore, the alignment of Department activities to the HHS Strategic Plan provides the framework to simultaneously address current issues and prepare to meet future challenges. This Plan is available at http://www.hhs.gov/secretary/about/priorities/priorities.html and outlines five Strategic Goals:

1. Strengthen health care
2. Advance scientific knowledge and innovation
3. Advance the health, safety and well-being of the American people
4. Increase efficiency, transparency and accountability of HHS programs
5. Strengthen the nation's HHS infrastructure and workforce

With collaboration from stakeholders throughout the Department, HHS has continued to pursue six Priority Goals for FY 2012-2013. These efforts have supported significant improvements in near-term outcomes and advanced progress toward longer-term, outcome-focused strategic objectives. These goals include efforts to:

- Increase the number of health centers certified as Patient Centered Medical Homes
- Improve patient safety
- Improve health care through meaningful use of Health Information Technology
- Improve the quality of early childhood education
- Reduce cigarette smoking
- Reduce food-borne illness in the population

An FDA shellfish specialist (left) and a New Jersey state inspector look at a map of the waters where clams were harvested. The risks associated with eating raw or partially cooked shellfish are often related to the quality of water from which they are harvested.

The performance results reported in the AFR represent key measures and performance highlights demonstrating progress toward each HHS Strategic Goal. Additional performance measures and trends are available in the FY 2014 HHS Annual Performance Plan and Report which was published in April 2013 and is located at www.hhs.gov/budget/fy2014/opa_040513.pdf. Detailed FY 2013 performance results will be available in February

2014 in the HHS FY 2015 *Annual Performance Report* (APR) and the FY 2015 *Congressional Budget Justification*. These reports can be located at www.hhs.gov upon approval and issuance. A synopsis of FY 2013 performance information will also be contained in the FY 2014 *Summary of Performance and Financial Information*.

The accomplishments and performance trends below, including progress on HHS Priority Goals, underscore HHS' dedication to sustained performance improvement and emphasis on working to meet the Departments' five Strategic Goals. Targets presented within the tables represent performance expectations based on a number of factors and may not exceed the previous years' results, although they may represent an improvement over previous years' targets. The results displayed in bold within each Strategic Goal indicate targets that were met or exceeded for the applicable period. Some results were not available at the time of this report due to data collection requirements. The target is displayed to show planned progress, with results expected in FY 2014.

A CDC researcher inspects equipment.

Strategic Goal One: Strengthen Health Care

HHS continues to drive the effort to strengthen and modernize health care to improve patient outcomes. Through its programs, HHS also promotes efficiency and accountability, ensures patient safety, encourages shared responsibility and works toward high-value health care. In addition to addressing these responsibilities, HHS is improving access to culturally competent, quality health care for uninsured, underserved and vulnerable populations.

HHS' efforts in patient safety as well as health care quality are reflected in Improve Patient Safety Priority Goal, in order to reduce Healthcare-Associated Infections (HAIs). These infections can lead to significant morbidity and mortality, with tens of thousands of lives lost each year. Of these hospital-acquired events, central line-associated bloodstream infections (CLABSI) have a strong potential to cause serious illness or death and catheter-associated urinary tract infections (CAUTI) are among the most common, and reduction of these two HAIs in hospitals is the target of the Priority Goal.

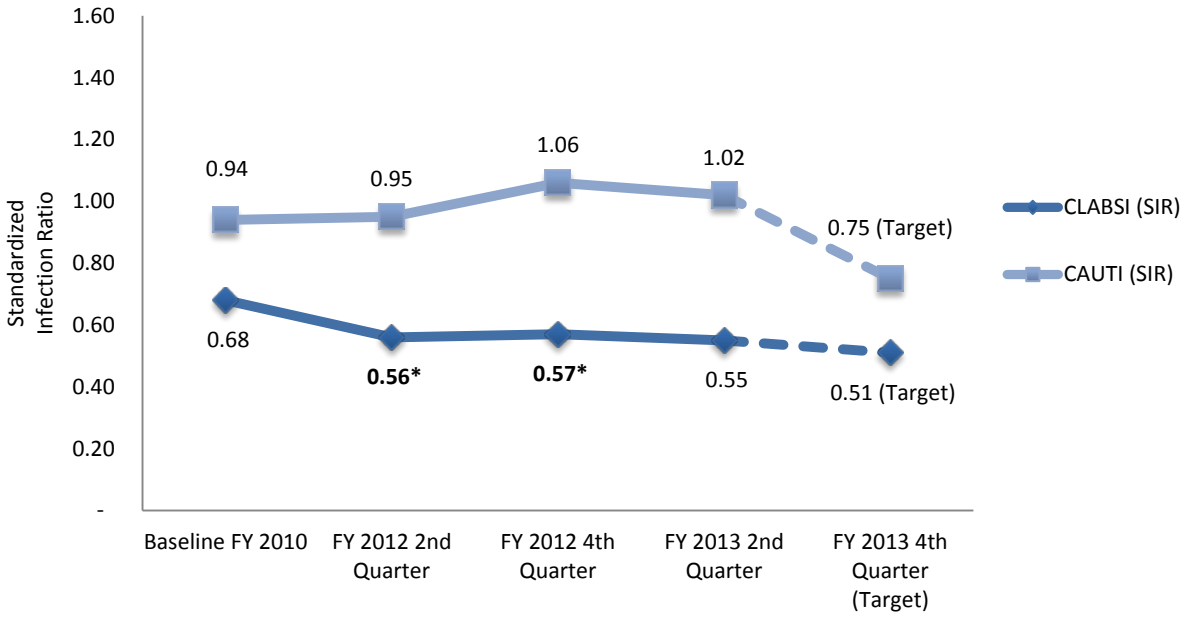
Indiana University–Purdue University Fort Wayne received a grant that will help better prepare its nursing students for the rapid changes in today's health care industry.

Leveraging the combined programmatic efforts within HHS, including AHRQ, CDC, CMS and OASH, the Improve Patient Safety Priority Goal worked to reduce CLABSI by 25 percent and CAUTI by 20 percent in hospitals nationwide by the end of FY 2013. This is measured over the FY 2010 Standardized Infection Ratios (SIRs) of 0.68 and 0.94, respectively (SIR is calculated by dividing the actual (observed) infections by the expected infections using data gathered through the CDC National Healthcare Safety Network (NHSN)). As of August 2013, NHSN has over 12,000 health care facilities participating for local quality improvement and the success of this capacity building effort to measure quality of care more effectively has had the intended effect of supporting a whole host of quality improvement initiatives, including this priority goal.

HHS program efforts that help health care partners achieve these goals include the AHRQ's Comprehensive Unit-based Safety Program (CUSP), CDC's development and maintenance of NHSN, CMS' Quality Improvement Organizations (QIO) and Partnership for Patients initiative and strategic direction and support from OASH, including the National Action Plan to Prevent HAIs.

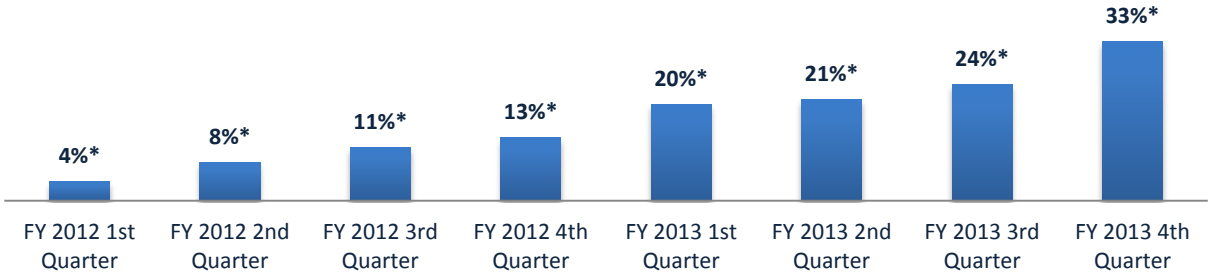
The FY 2013 Q2 CLABSI NHSN data was calculated at 0.55 SIR, or a 19 percent reduction in the SIR over the baseline of 0.68, significantly contributing to reduced central line-associated bloodstream infections, which saves lives and provides better patient outcomes. The FY 2013 Q2 CAUTI NHSN data was calculated at 1.02 SIR or a 9 percent increase in the SIR over the baseline of 0.94. The plan is to focus on efforts to continue and sustain the successes seen in CLABSI reduction while intensifying work to improve progress toward reducing CAUTIs through maximizing collaboration, ensuring accuracy in reporting, and identifying regional focus area through data.

Standardized Infection Ratio of Hospital-Acquired Infection
HHS Priority Goal- Improve Patient Safety
(result exceeded target)*



The Patient Centered Medical Home (PCMH) Initiative was established to enhance the quality of care in health centers and support health center efforts to achieve national PCMH certification under the medical home program. As of Q4 of FY 2013, 978 health center grantees have initiated certification surveys (far exceeding the FY13 target of 460) demonstrating their desire to participate in the program's service delivery model designed to improve the quality of care through enhanced access, planning, management, and monitoring of patient care. Most importantly, 33 percent of health centers now have at least one site recognized as a PCMH also exceeding the quarterly target.

Percentage of Health Centers with at least One Site Recognized as a PCMH
HHS Priority Goal- Increase the Number of Health Centers Certified as PCMH
(result exceeded target)*




Toxicology Research at FDA

Using data to improve health care quality, reduce unnecessary health care costs, decrease paperwork, expand access to affordable care, improve population health, and support reformed payment structures is critical to HHS's strategy to strengthen and modernize health care. This focus on utilizing data is also facilitating new means of improving the quality, efficiency, and patient-centeredness of care. A key step in this strategy is to provide incentive payments to eligible providers serving Medicare and Medicaid beneficiaries who adopt and meaningfully use certified electronic health records (EHR) technology. Progress on this step has exceeded expectations as the annual goal of 230,000 providers was met in Q2 and has been exceeded by over 90,000 providers as of Q4. Concurrently, IHS tracking of Meaningful Use payments indicates that, as of July 2013, 1,819 eligible providers from IHS, tribal, and urban Indian health programs have registered with CMS, and 931 eligible providers have received CMS EHR incentive payments contributing to health care modernization.

Number of Eligible Providers who Receive an Incentive Payment from
CMS Medicare and Medicaid Electronic Health Records Incentive Programs
HHS Priority Goal- Improve Health Care through Meaningful Use of Health Information Technology
(result exceeded target)*

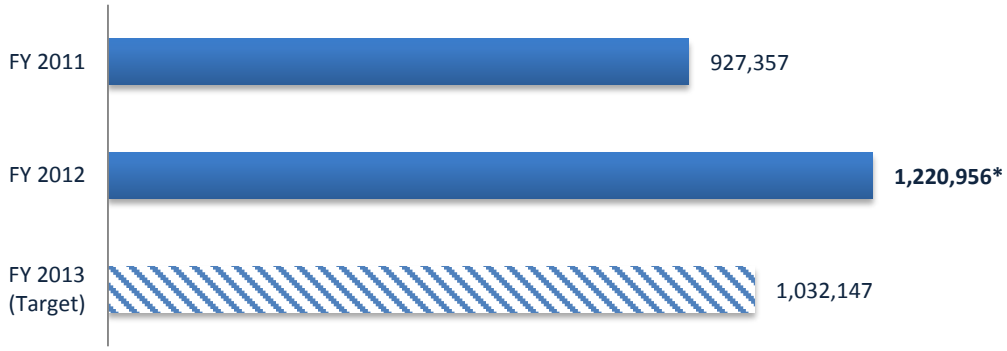
Strategic Goal Two: Advance Scientific Knowledge and Innovation

HHS is expanding its scientific understanding of how best to advance health care, public health, human services, biomedical research, and to ensure the availability of safe medical and food products. Chief among these efforts is the identification, implementation, and rigorous evaluation of new approaches in science, health care, public health, and human services that encourage efficiency, effectiveness, sustainability and sharing or translating that knowledge into better products and services.

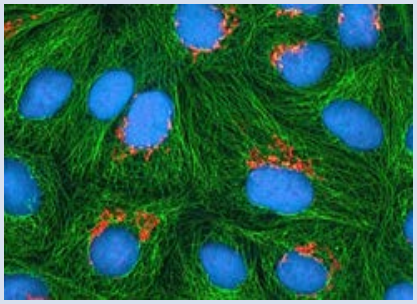
The *Guide to Community Preventive Services* is a compilation of the recommendations from the nonfederal, independent Community Preventive Services Task Force (Task Force) and the systematic reviews on which the recommendations are based. Task Force recommendations provide evidence-based options for programs, services, and policies from which decision makers, practitioners, and researchers can choose those that best meet the needs, preferences, available resources, and constraints of their constituents. To achieve their maximum health impact, Task Force recommendations must be disseminated, adopted, and used. Fiscal year trends through August 2013 show increased page views above FY 2012 levels. These results serve as a proxy measure indicating increased awareness and use of the *Community Guide*.

Number of Page Views of the "Guide to Community Preventive Services"

(result exceeded target)*



NIH's Genotype-Tissue Expression (GTEx) program provides data on how human DNA variation correlates with variation in gene expression levels, which strengthens the power of genome-wide association studies to identify potential new gene targets for therapies. Following an initial two-year pilot, GTEx underwent an expansion in FY 2013 to build a comprehensive data and sample resource of genetic variation and gene expression profiles in multiple tissues. The GTEx program has been highly successful in procuring samples, extracting high-quality RNA from tissues, and obtaining data from gene expression array and RNA sequencing experiments. Additionally, data and biospecimens made available to the research community to support additional molecular analyses of GTEx samples have added scientific value to the resource as a whole.



Cultured HeLa cells counterstained for DNA (cyan).

Strategic Goal Three: Advance the Health, Safety and Well-Being of the American People

HHS is striving to promote the health, economic and social well-being of children, people with disabilities, and older adults while improving wellness for all. To meet this goal, the Department is employing evidence-based strategies to strengthen families and to improve outcomes for children, adults, and communities. Underlying each objective and strategy associated with this goal is a focus on prevention.

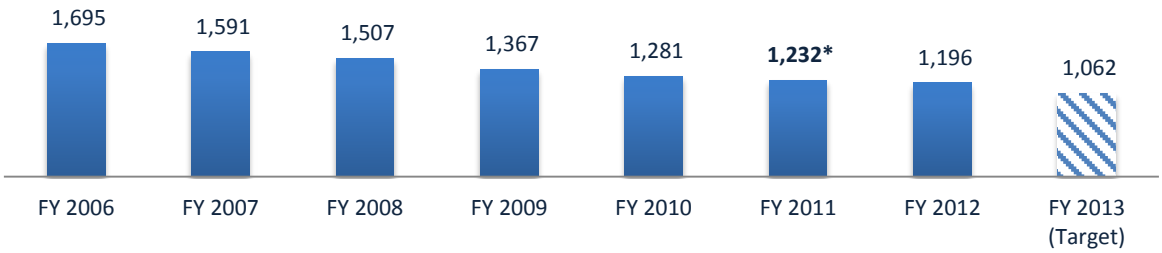
Secretary of Health and Human Services, Kathleen Sebelius, met with students at Lowry Elementary School in Denver, CO.

The Improve Quality of Early Childhood Education Priority Goal calls for actions to improve the quality of programs for low-income children. For the child care program, the aim is to increase the number of states with Quality Rating and Improvement Systems (QRIS) that meet the seven high-quality benchmarks for child care and other early childhood programs developed by the HHS, in coordination with the Department of Education. QRIS is a mechanism by which to improve the quality of child care available in communities and increase parents' knowledge and understanding of the child care options available to them. Through technical assistance and other support from ACF, an additional seven states have demonstrated significant progress by meeting at least six (of the seven) quality benchmarks toward the overall target of 25 states shown below.

Number of States Implementing QRIS that are Meeting the QRIS High-Quality Benchmarks
HHS Priority Goal- Improve the Quality of Early Childhood Education

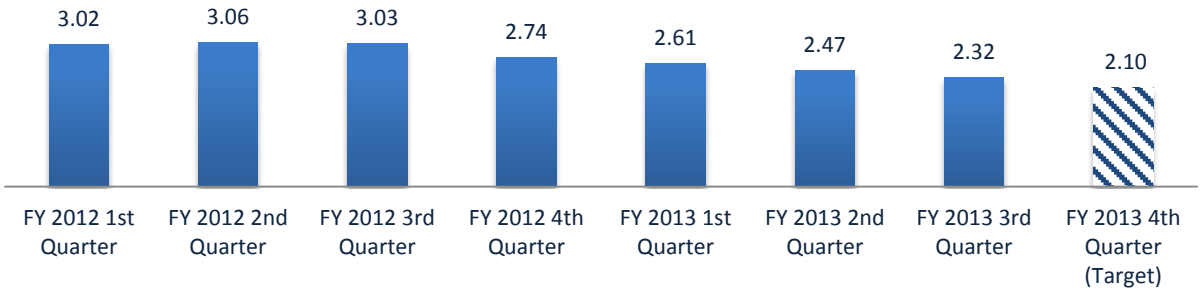
Smoking, and secondhand smoke, kills an estimated 443,000 people in the United States each year. For every smoker who dies from a smoking-attributable disease, another 20 live with a serious smoking-related disease. Smoking costs the U.S. $96 billion in medical costs and $97 billion in lost productivity each year. While smoking among adults in the United States is down significantly from a decade ago, the decline in adult smoking rates has slowed, concurrent with reductions in state investments in tobacco control programs. However, the coordinated efforts of this Priority Goal have continued reductions in adult cigarette consumption based on FY 2012 results (reported in June 2013).

Annual Per Capita Cigarette Consumption by Adults in the United States
HHS Priority Goal- Reduce Cigarette Smoking
(result exceeded target)*



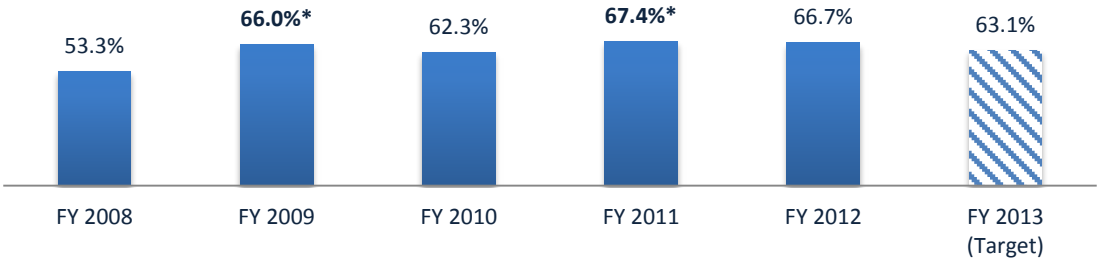
Salmonella is the leading known cause of bacterial foodborne illness and death in the United States. Salmonella serotype enteritidis (SE), a subtype of Salmonella, is now the most common type of salmonella in the United States and accounts for approximately 20 percent of all salmonella cases in humans. The most significant sources of foodborne SE infections are shell eggs (FDA-regulated) and broiler chickens (USDA-regulated). Therefore, reducing SE illness from shell eggs is the most appropriate FDA strategy for reducing illness from SE. Preventing salmonella infections depends on actions taken by regulatory agencies, the food industry and consumers to reduce contamination of food, as well as actions taken for detecting and responding to outbreaks. CDC, as part of a shared vision to reduce foodborne illness, is working to improve data to better estimate sources of illness. Efforts throughout FY 2013 have produced a reduction in the SE rate each quarter through 3rd Quarter.

Rate of Salmonella Enteritidis Illness in the Population
HHS Priority Goal- Reduce Food-Borne Illness in the Population



One of the goals of SAMHSA's Strategic Initiative on Recovery Support is to ensure that permanent housing and supportive services are available for individuals with mental and substance use disorders. A way to meet this goal is to ensure that the most vulnerable individuals who experience chronic homelessness receive access to sustainable permanent housing, treatment, and recovery supports through grant funds and mainstream funding sources. A measure of the effectiveness of this effort is to determine overall health status, both physical and emotional mental health, from the consumer's perception of his or her recent functioning. Questions are asked specifically about how the consumer was able to deal with everyday life and how frequently the consumer experienced psychological distress within the past 30 days. Following the initial 13 percent increase from FY 2008 to FY 2009, the percentage has been maintained over 60 percent since, and FY 2013 progress supports continued sustained performance.

Percentage of Adults Receiving Homeless Support Services who Report Positive Functioning at 6 Month Follow-up
(result exceeded target)*



A woman participates in an AoA exercise program in Juneau, AK.

ACL's Administration on Aging (AoA) Family Caregiver Support Services enables family members who have a loved one with disabilities or conditions that require assistance to use an array of supportive services including: respite care, information and assistance, support groups, and training. Caregivers are frequently under substantial strain with the responsibilities of caring for their ill relative while also caring for children or other family members while employed. Since 2008, Family Caregiver Support Services clients have rated services good to excellent consistently above the target level of 90 percent.

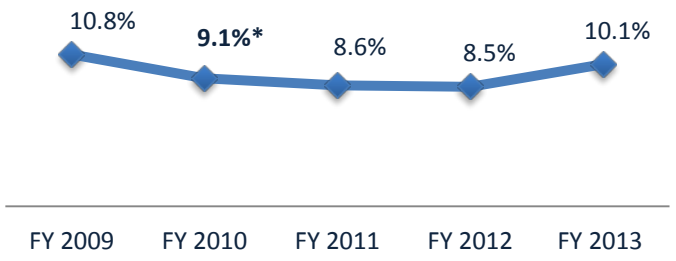
Strategic Goal Four: Increase Efficiency, Transparency and Accountability of HHS Programs

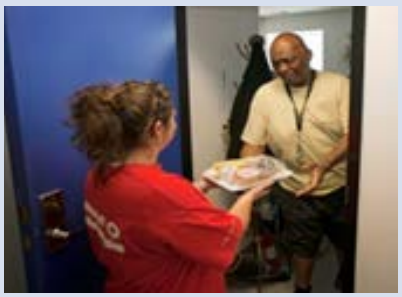
As the largest grant-awarding agency in the Federal Government and the nation's largest health insurer, HHS places a high priority on ensuring the integrity of its expenditures. HHS manages hundreds of programs in basic and applied science, public health, income support, child development, and health and social services which award over 75,000 grants annually. The Department has robust processes in place to manage the resources and information employed to support programs and activities.

One of CMS' key goals is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries. Paying correctly the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable Medicare Trust Fund dollars. The Medicare Fee-for-Service (FFS) improper payment estimate is calculated under the Comprehensive Error Rate Testing (CERT) Program. Between FY 2009 and FY 2012, the improper payment rate consistently improved. Recent data from FY 2013 indicates an increase in this rate and efforts are currently in progress to investigate and resolve the drivers causing this increase.

Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program

(result exceeded target)*



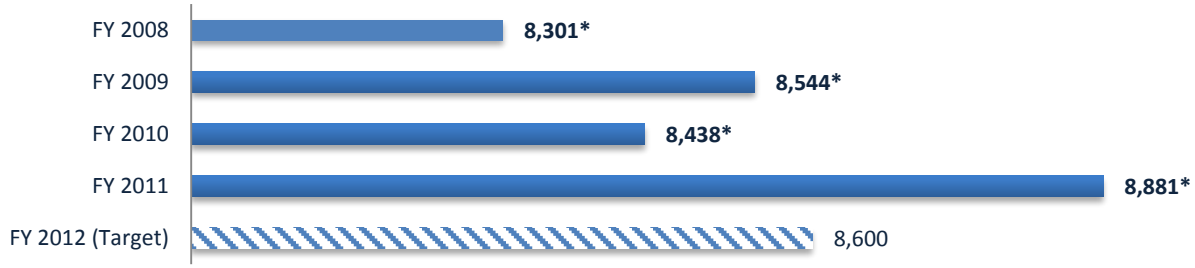


An older man receives a home-delivered meal from a volunteer in Baltimore, MD as part of an ACL program.

Access to and quality of home and community-based services is foundational to the success of ACL's programs. According to the most recent data reported in early FY 2013, the Aging Services Network served 8,881 clients per million dollars of *Title III Older Americans Act* (OAA) funding in FY 2011 continuing to demonstrate the success of the Aging Services Network in employing available tools to enhance the use of OAA funds as this indicator has achieved its efficiency performance targets for the past seven years. This also serves to address performance efficiency at all levels of ACL's AoA in the provision of home and community-based services, including caregiver services.

Number of Clients Served by the Home and Community-Based Services, including Nutrition and Caregiver Services, per Million Dollars of Title III Older Americans Act funding

(result exceeded target)*

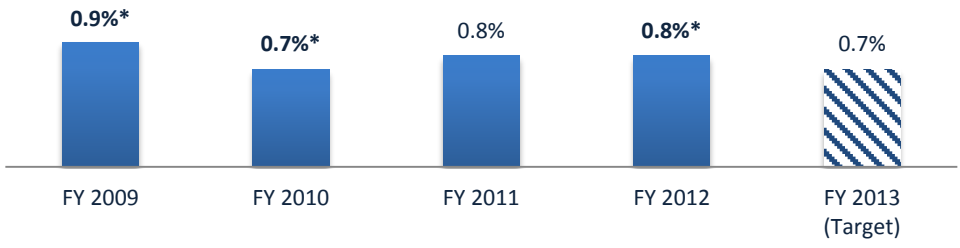


ACF's Head Start program works to ensure that the maximum number of children are served and that federal funds are used appropriately and efficiently by measuring under-enrollment across programs. Since Head Start grantees range in size from super-grantees with multiple delegate agencies serving up to 20,000 children to individual centers that serve as few as 15 children, a national under-enrollment rate better captures the under-enrollment than the proportion of grantees that meet under-enrollment targets.

The most recent data available indicate that, during the FY 2011-2012 program year, Head Start grantees had, on average, not enrolled 0.8 percent of the children they were funded to serve, continuing steady improvement in this area. Further improvements are expected in FY 2013 resulting from continued program support and technical assistance.

Decrease in the Under-Enrollment Rate of Head Start Programs; Increased Number of Children Served Per Dollar

(result exceeded target)*



As part of its program assessment, the OMHA is evaluating its customer service through an independent evaluation. This will assure appellants and related parties are satisfied with their Administrative Law Judge Medicare Level III appeals experience based on beneficiary survey results. The data shows that, on a scale of 1 to 5, where 5 equals "very satisfied," evaluations have consistently been over 4, which exceeds the yearly targets for this measure since FY 2008.

Strategic Goal Five: Strengthen the Nation's HHS Infrastructure and Workforce

The nation faces shortages of critical health care workers, including primary care physicians, nurses, behavioral health and long-term care workers, as well as public health and human service professionals. More than 64 million people currently live in an area that has a shortage of primary care health professionals. HHS programs seek to address these shortages, and ensure that there is an able health care workforce in the other areas that fall under the Department's purview, such as biomedical research.

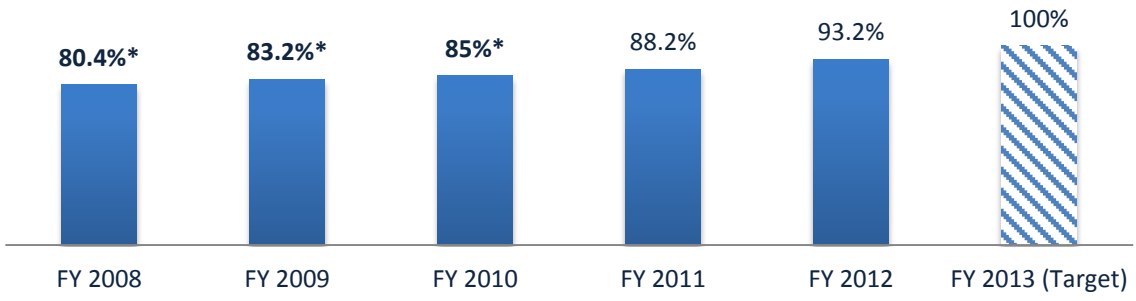
DID YOU KNOW

Officially coming into existence on April 11, 1953, the Cabinet-level Department of Health, Education and Welfare (HEW) was created under President Eisenhower. In 1979, the Department of Education Organization Act was signed into law, providing for a separate Department of Education. HEW became the Department of Health and Human Services, officially arriving on May 4, 1980.

Head Start has shown a steady increase in the number of Head Start teachers with an Associate of Arts (AA), Bachelor of Arts (BA), or other advanced degree in early childhood education, supported by plans to improve the qualifications of staff. Based on the most recent data as of early FY 2013, 93.2 percent of Head Start teachers had an AA degree or higher, missing the target of 100 percent but improving significantly over the previous result. The total FY 2012 figure represents an increase of 2,227 degreed teachers over the previous year demonstrating Head Start teachers are better equipped to deliver quality instruction to Head Start children.

Percentage of Head Start Teachers with AA, BA, Advanced Degree, or Other Degree in a Field Related to Early Childhood Education

(result exceeded target)*

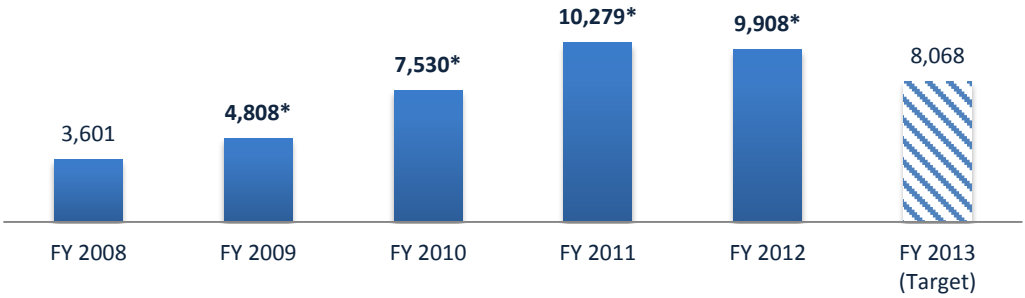


The National Health Service Corps (NHSC) addresses the nationwide shortage of health care providers in health professional shortage areas by providing recruitment and retention incentives in the form of scholarship and loan repayment support to health professionals committed to a career in primary care and service to underserved communities. The NHSC field strength indicates the number of providers fulfilling active service obligations with the NHSC in underserved areas in exchange for scholarship or loan repayment support. As funding is available, the program will continue to maximize this funding to build the primary care workforce. In FY 2012, the NHSC field strength was 9,908 representing almost triple the field strength of FY 2008.

Absentee Shawnee Little Axe Health Center in Norman, OK.

Field Strength of the NHSC, as Measured by the Number of Providers Fulfilling Active Service Obligations in Exchange for Scholarship and Loan Repayment Agreements

(result exceeded target)*

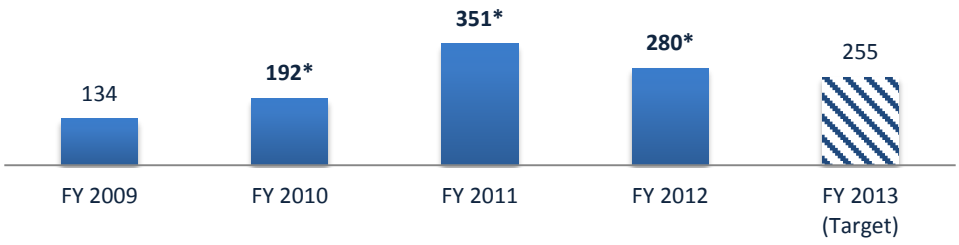


CDC Researcher

The CDC has over 30 years of international experience training public health leaders through its Field Epidemiology Training Programs (FETPs), a two-year applied capacity development program, modeled on the U.S. Epidemic Intelligence Service. Through FETPs, CDC helps establish a network of disease detectives around the globe that are the first line of defense in detecting and responding to outbreaks in their respective countries as well as neighboring countries. Since 1980, CDC has developed 50 international FETPs serving 94 countries and graduated over 2,800 epidemiologists, in addition to continuing to add capacity as shown below by the number of new residents to the program.

Capacity of Epidemiology and Laboratory within Global Health Ministries through FETP
As measured by the Number of New Residents

(result exceeded target)*



ANALYSIS OF FINANCIAL STATEMENTS AND STEWARDSHIP INFORMATION

The financial statements were prepared in accordance with federal accounting standards and audited by the independent accounting firm of Ernst & Young LLP, under the direction of our Inspector General. The *Chief Financial Officers Act* requires the preparation and audit of these statements, which are part of our efforts for continuous improvement of financial management. Accurate, timely and reliable financial information is necessary for making sound decisions, assessing performance and allocating resources. The Financial Section of this report presents our audited financial statements and notes.

Financial Condition: What is Our Financial Picture?

The table below summarizes trend information concerning components of our financial condition as of September 30 each year. The Consolidated Balance Sheet, found in the Financial Section of this report, presents our financial condition as of September 30, 2013, compared to September 30, 2012, and displays assets, liabilities and net position.

Another presentation of our financial picture is our Consolidated Statement of Net Cost, also found in the Financial Section, with further detailed presentations, which can be found in the Other Information section. Year-over-year summary changes for each of these statements are discussed in the following sections and provided in greater detail in the Notes to the Principal Financial Statement found in the Financial Section of this report.

Summary of Financial Condition Trends

(in Billions)

	2009	2010	2011	2012	2013	$ Change (2012-13)	% Change (2012-13)
Total Assets	$ 562.8	$ 563.7	$ 532.9	$ 530.7	$ 470.2	$ (60.5)	(11.4)
Fund Balance with Treasury	162.0	182.2	166.9	197.3	159.2	(38.1)	(19.3)
Investments, Net	381.1	359.9	325.4	306.4	281.7	(24.7)	(8.1)
Other Assets	19.7	21.6	40.6	27.0	29.3	2.3	8.5
Total Liabilities	$ 94.4	$ 99.2	$ 104.9	$ 99.5	$ 107.5	$ 8.0	8.0
Accounts Payable	1.1	1.6	1.2	1.1	1.2	0.1	9.1
Entitlement Benefits Due and Payable	72.2	72.7	80.9	72.5	77.3	4.8	6.6
Accrued Grant Liability	4.0	4.2	4.5	3.7	3.9	0.2	5.4
Federal Employee and Veterans' Benefits	9.7	10.0	10.2	11.0	11.6	0.6	5.5
Other Liabilities	7.4	10.7	8.1	11.2	13.5	2.3	20.5
Net Position	$ 468.4	$ 464.5	$ 428.0	$ 431.2	$ 362.7	$ (68.5)	(15.9)
Total Liabilities and Net Position	$ 562.8	$ 563.7	$ 532.9	$ 530.7	$ 470.2	$ (60.5)	(11.4)

Assets: What Do We Own and Manage?

Assets represent the value of what we own and manage. Our total assets were $470.2 billion on September 30, 2013. This amount represents a decrease of $60.5 billion or 11.4 percent less than last year's assets. This $60.5 billion decrease in assets is primarily attributable to a decrease in Net Investments of $24.6 billion for the Medicare Trust Funds. In addition, the assets included a decrease in Fund Balance with Treasury in FY 2013 compared to FY 2012 of $38.1 billion ($159.2 billion and $197.3 billion, respectively). The decrease is primarily attributable to a decrease in Supplementary Medical Insurance (SMI) of $14.3 billion and a decrease by Medicaid in the amount of $15.8 billion. The decrease was also offset by an increase in the Hospital Insurance (HI) program in the amount of $0.5 billion.

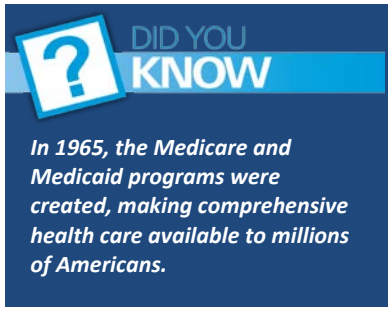
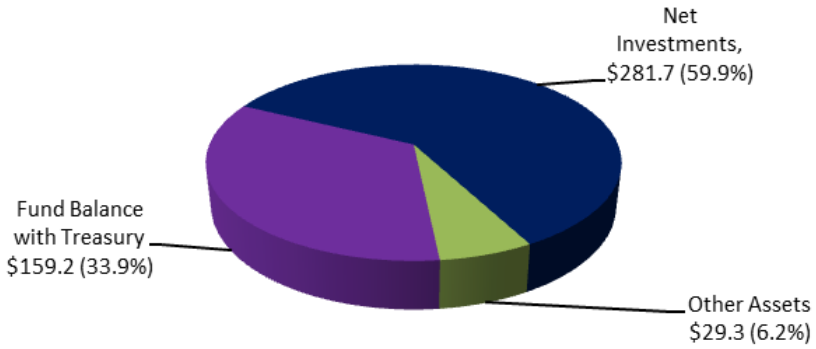


Figure 1: FY 2013 Assets by Type

(In Billions)



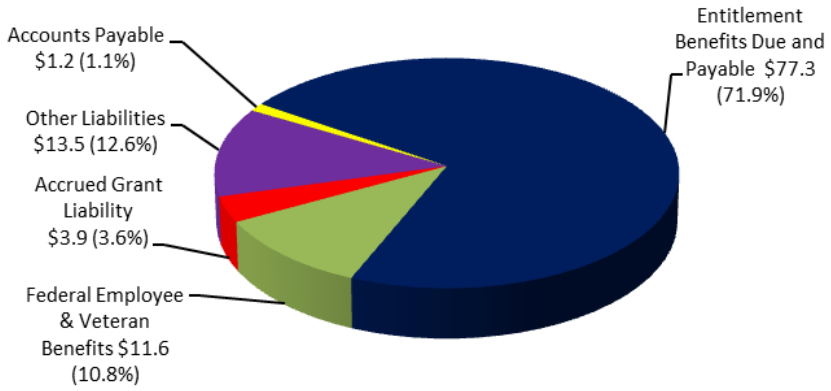
The Federal Government does not set aside assets to pay future benefits associated with Medicare. Treasury securities (our Net Investments) are the funds from dedicated collections for the Medicare program. Trust fund holdings not necessary to meet current expenditures are invested in interest-bearing U.S. Treasury securities. The securities held by the Medicare Trust Fund provide the authority to make expenditures. As a result, our Net Investments declined by $24.6 billion in FY 2013 for Medicare. The investment decreased to meet the cash requirements related to Medicare, primarily for the HI program in the amount of $22.6 billion and the SMI program in the amount of $2.0 billion. Although *Federal Insurance Contributions Act* (FICA) and *Self Employment Contributions Act* (SECA) contributions, or revenues, are beginning to grow following the national recession, the HI investments continue to decrease as expenses exceed revenues.

We have experienced a slight change in the overall composition of our assets in FY 2013 compared to FY 2012. The Fund Balance with Treasury and Net Investments together currently comprise 93.8 percent of our total assets compared to 94.9 percent at the end of FY 2012. The remaining FY 2013 assets, totaling $29.3 billion or 6.2 percent, consists of: Accounts Receivable; Inventory and Related Property; General Property, Plant and Equipment; Advances; and Other Assets, compared to FY 2012, which represented 5.1 percent of our total assets. This change in asset composition is directly related to a decrease in advance payments by CMS for the Medicare Advantage and Prescription Drug plans for services provided in October 2012.

Liabilities: What Do We Owe?

Our liabilities, or amounts that we owe from past transactions or events, were $107.5 billion on September 30, 2013. This represents an increase of $8.0 billion, or 8.0 percent more than the FY 2012 liabilities, primarily due to Entitlement Benefits Due and Payable and Other Liabilities. Entitlement Benefits Due and Payable increased by $4.8 billion, or a 6.6 percent change from FY 2012, due to the Medicare and Medicaid programs. This represents 71.9 percent and 72.9 percent of our total liabilities in FY 2013 and FY 2012, respectively. Additionally, Other Liabilities increased by $2.3 billion, or a 20.5 percent change from FY 2012, primarily due to contingencies related to the Medicaid audit and program disallowances and reimbursements of State Plan Amendments for program audit deferrals.

Figure 2: FY 2013 Liabilities by Type
(in Billions)



Consistent with federal accounting standards, we recognize the responsibility for future program participants of Medicare as a social insurance program, rather than a pension program. Accordingly, we have not recognized a liability for future payments to current and future program participants. The estimated long-term cost for Medicare is included in the Statement of Social Insurance (SOSI) and discussed later in this analysis. A more extensive discussion is provided in the Notes to the Principal Financial Statements located in the Financial Section of this report.

Ending Net Position: What Have We Done Over Time?

Our net position represents the difference between assets and liabilities. Changes in our net position result from changes that occur within the Cumulative Results of Operations and Unexpended Appropriations. Our net position decreased by $68.5 billion (15.9 percent), from $431.2 billion in FY 2012 to $362.7 billion in FY 2013. The $362.7 billion includes $248.5 billion for funds from dedicated collections (compared to $287.5 billion in FY 2012) and $114.2 billion for FY 2013 for all other funds (compared to the FY 2012 ending balance of $143.7 billion).

The FY 2013 decrease of $68.5 billion includes a decrease of $16.0 billion in funds from dedicated collections unexpended appropriations, $30.1 billion in unexpended appropriations for all other funds and $23.0 billion in funds from dedicated collections cumulative results of operation. The decrease was offset by an increase of $0.6 billion in cumulative results of operations for all other funds. Net position is the sum of the cumulative results of operations since inception and unexpended appropriations that represent those appropriations provided to HHS that remain unused at the end of the fiscal year.

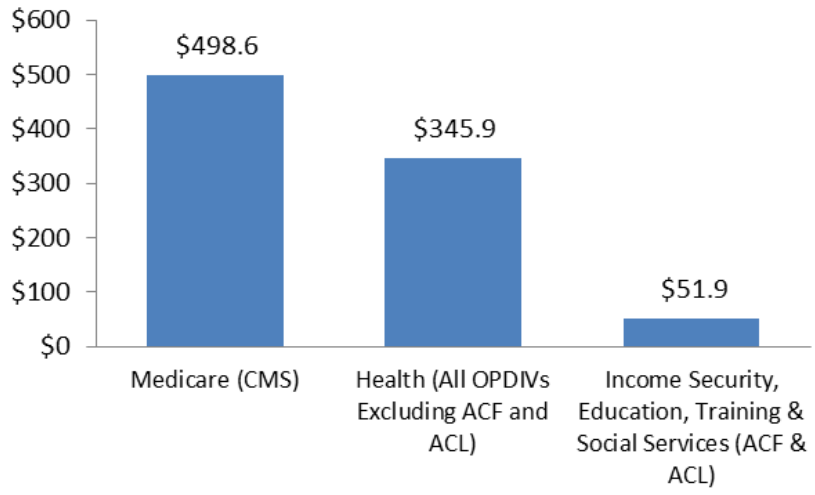
Net Cost of Operations: What Are Our Sources and Uses of Funds?

Our net cost of operations represents the difference between the costs incurred by our programs less associated revenues. We receive the majority of our funding through Congressional appropriations and reimbursement for the provision of goods or services to other federal agencies. Our Net Cost of Operations for the year ended September 30, 2013, totalled $896.3 billion.

Figure 3 depicts our FY 2013 Combined Net Cost of Operations by major budget function and significant components. The majority of FY 2013 net costs relate to Medicare ($498.6 billion) and Health ($345.9 billion) programs, or more than 94.2 percent of our annual net costs. During FY 2013, the Medicare budget function experienced growth of 4.4 percent ($20.9 billion) and Health increased 5.7 percent ($18.5 billion).

The growth in the Medicare budget function is primarily attributable to benefit expenses increases in SMI of $9.8 billion and HI of $11.0 billion.

Figure 3: FY 2013 Combined Net Cost of Operations by Budget Function
(in Billions)



The FY 2013 Net Cost represents an increase of $40.7 billion or 4.8 percent more than the FY 2012 Net Cost of Operations. Approximately 86.9 percent of the Net Cost of Operations ($779.2 billion) relates to Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and other health programs managed CMS. The Table on the next page depicts our Net Cost of Operations by major component for the last five years.

Net Cost of Operations

(in Billions)

	2009	2010	2011	2012	2013	$ Change (2012-13)	% Change (2012-13)
Responsibility Segments							
CMS Gross Cost	$ 749.0	$ 789.7	$ 817.4	$ 802.3	$ 848.9	$ 46.6	5.8
CMS Exchange Revenue	(57.3)	(60.7)	(63.7)	(65.1)	(69.7)	(4.6)	7.1
CMS Net Cost of Operations	$ 691.7	$ 729.0	$ 753.7	$ 737.2	$ 779.2	$ 42.0	5.7
Other Segments:							
Other Segments Gross Cost of Operations	$ 116.0	$ 130.9	$ 128.2	$ 121.5	$ 121.0	$ (0.5)	(0.4)
Other Segment Exchange Revenue	(3.8)	(3.2)	(3.8)	(3.2)	(3.9)	(0.7)	21.9
Other Segments Net Cost of Operations	$ 112.2	$ 127.7	$ 124.4	$ 118.3	$ 117.1	$ (1.2)	(1.0)
Net Cost of Operations	$ 803.9	$ 856.7	$ 878.1	$ 855.5	$ 896.3	$ 40.8	4.8

Budgetary and Non-Budgetary Resources: What Were Our Resources and the Status of Funds?

The Combined Statement of Budgetary Resources provides information on availability of budgetary and non-budgetary resources at the end of the year. FY 2013 total resources were $1.3 trillion, representing an increase of $33.9 billion, or 2.6 percent, over FY 2012. FY 2013 total obligations of $1.3 trillion increased by $76.2 billion, or 6.3 percent, compared to FY 2012. Our year-end resources were $41.7 billion, of which $9.6 billion are not yet available for expenditure as of September 30, 2013. Total net outlays (cash disbursed for HHS' obligations) of $888.2 billion increased by $40.0 billion or 4.7 percent from FY 2012 net outlays of $848.2 billion.

Statement of Social Insurance

The SOSI presents the 75-year actuarial present value of the income and expenditures of the HI and SMI Trust Funds. Future expenditures are expected to arise from the formulas specified in current law for current and future program participants. This projection is considered to be important information regarding the potential future cost of the program. These projected potential future obligations under current law are not included in the Consolidated Balance Sheet, Statements of Net Cost and Changes in Net Position, or Combined Statement of Budgetary Resources.

The SOSI presents the following estimates:

- The present value of future income (income excluding interest) to be received from or on behalf of current participants who have attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income to be received from or on behalf of current participants who have not yet attained eligibility age and the future cost of providing benefits to those same individuals;

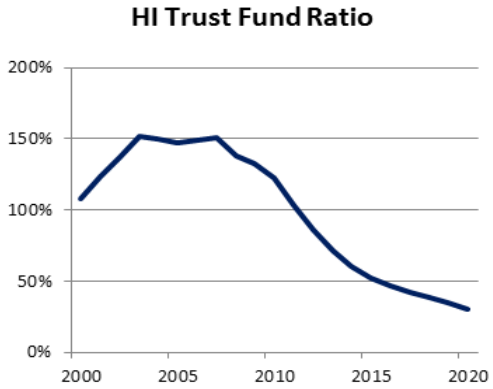
- The present value of future income less future cost for the closed group, which represents all current participants who attain age 15 or older in the first year of the projection period, plus the assets in the combined HI and SMI Trust Funds as of the beginning of the valuation period;
- The present value of income to be received from or on behalf of future participants and the cost of providing benefits to those same individuals;
- The present value of future income less future cost for the open group, which represents all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program, plus the assets in the combined HI and SMI Trust Funds as of the beginning of the valuation period; and
- The present value of future cash flows for all current and future participants over the next 75 years (open group measure) increased from $(5.6) trillion, determined as of January 1, 2012, to $(4.8) trillion, determined as of January 1, 2013.

Including the combined HI and SMI Trust Fund assets increases the present value, as of January 1, 2013, of future cash flow for all current and future participants to $(4.5) trillion for the 75-year valuation period. The comparable closed group of participants, including the combined HI and SMI Trust Fund assets, is $(9.4) trillion.

HI Trust Fund Solvency

Pay-As-You-Go Financing

The HI Trust Fund is deemed to be solvent as long as assets are sufficient to finance program obligations. Such solvency is indicated, for any point in time, by the maintenance of positive Trust Fund assets. In recent years, current expenditures have exceeded program income for the HI program, and thus, the HI Trust Fund assets have been declining. The following table shows that HI Trust Fund assets, expressed as a ratio of the assets at the beginning of the fiscal year to the expenditures for the year. This ratio has steadily dropped from 134 percent at the beginning of FY 2009 to 85 percent at the beginning of FY 2013.



Trust Fund Ratio[1]
Beginning of Fiscal Year

	2009	2010	2011	2012	2013
HI	134.0%	124.0%	106.0%	94.0%	85.0%

[1] Assets at the beginning of the year to expenditures during the year.

Short-Term Financing

The HI Trust Fund is deemed adequately financed for the short term when actuarial estimates of Trust Fund assets for the beginning of each calendar year are at least as large as program obligations for the year. Estimates in the *2013 Trustees Report* indicate that the HI Trust Fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the *2013 Trustees Report*, the HI Trust Fund ratio is estimated to steadily decline to about 48 percent by the beginning of calendar year 2022. From the end of 2012 to the end of 2022, assets are expected to decline by 13 percent, from $220 billion to $192 billion.

Long-Term Financing

HI financing is not projected to be sustainable over the long term with the tax rates and expenditure levels projected in current law. Program cost will exceed total income in all years of the 75-year projection period. In 2026, the HI Trust Fund will be exhausted according to the projections by the CMS Office of the Actuary. Under current law, when the HI Trust Fund is exhausted, full benefits cannot be paid on a timely basis. Tax revenues are projected to be sufficient to support 87 percent of projected expenditures after the HI Trust Fund exhaustion in 2026, declining to 73 percent of projected expenditures in 2087.

The primary reasons for the projected long-term inadequacy of financing under current law relate to the fact that the ratio of the number of workers paying taxes relative to the number of beneficiaries eligible for benefits drops from 3.43 in 2012 to about 2.1 by 2087. In addition, health care costs continue to rise faster than the taxable wages used to support the program. In present value terms, the 75-year shortfall is $4.6 trillion, which is 1.1 percent of taxable payroll and 0.5 percent of Gross Domestic Product (GDP) over the same period.

Significant uncertainty surrounds the estimates for the SOSI. In particular, the actual future values of demographic, economic, and programmatic factors are likely to be different from the near-term and ultimate assumptions used in the projections. For more information, please refer to the *Required Supplementary Information: Social Insurance* disclosures required by the Federal Accounting Standards Advisory Board (FASAB).

SMI Trust Fund Solvency

The SMI Trust Fund consists of two accounts—Part B and Part D. In order to evaluate the financial status of the SMI Trust Fund, each account needs to be assessed individually, since financing rates for each part are established separately, their program benefits are quite different in nature, and there is no provision for transferring assets.

While differences between the two accounts exist, the financing mechanism for each part is similar in that the financing is determined on a yearly basis. The Part B account is generally financed by premiums and general revenue matching appropriations determined annually to cover projected program expenditures and to provide a contingency for unexpected program variation. The Part D account is financed by premiums, general revenues, and transfers from state governments. Unlike the Part B account, Part D has a flexible general revenue appropriation, which means that general revenues cover the remaining cost of providing Part D benefits, thereby eliminating the need to maintain a normal contingency reserve.

Since both the Part B and Part D programs are financed on a yearly basis, from a program perspective, there is no unfunded liability in the short or long-range. Therefore, in this financial statement the present value of estimated future excess of income over expenditures for current and future participants over the next 75 years is $0. However, from a government-wide perspective, general fund transfers as well as interest payments to the Medicare Trust Funds and asset redemption, represent a draw on other Federal resources for which there is no earmarked source of revenue from the public. Hence, from a government-wide perspective, the corresponding estimate of future expenditures less income for the 75-year projection period is $(22.5) trillion.

Even though from a program perspective, the unfunded liability is $0, there is concern over the rapid cost of the SMI program as a percent of GDP. In 2012, SMI expenditures were 1.99 percent of GDP. By 2087, SMI expenditures are projected to grow to 4.01 percent of the GDP.

The following table presents key amounts from our basic financial statements for FY 2011 through FY 2013.

Table of Key Measures[2]
Based on the CMS Financial Statements[3]
(in Billions)

	2013	2012	2011
Net Position (end of fiscal year)			
Assets	$ 370.2	$ 424.8	$ 424.2
Less Total Liabilities	88.3	80.5	87.5
Net Position (assets net of liabilities)	$ 281.9	$ 344.3	$ 336.7
Change in Net Position (end of fiscal year)			
Net Costs	$ 779.7	$ 737.8	$ 754.1
Total Financing Sources	756.1	710.8	730.4
Change in Net Position	$ (23.6)	$ (27.0)	$ (23.7)
Statement of Social Insurance (calendar year basis)			
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), current year valuation	$ (4,772)	$ (5,581)	$ (3,252)
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), prior year valuation	(5,581)	(3,252)	(2,683)
Change in present value	$ 809	$ (2,329)	$ (569)

[2] The table or other singular presentation showing the measures described above. Although, the closed group measure is not required to be presented in the table or other singular presentation, the CMS presents the closed group measure and open group measure.
[3] Available at http://www.cms.gov.

Statement of Changes in Social Insurance Amounts (SCSIA)

The SCSIA reconciles the change (between the current valuation period and the prior valuation period) in the present value of future tax income less future cost for current and future participants (the open group measure) over the next 75 years. This reconciliation identifies those components of the change that are significant and provides reasons for the changes.

The present value as of January 1, 2013, would have decreased by $285 billion due to advancing the valuation date by one year and including the additional year 2087. However, changes in the projection base, demographic assumptions, economic and health care assumptions, and legislation changes increased the present value of future cash flows by $308 billion, $724 billion, $31 billion, and $31 billion, respectively.

Required Supplementary Information (RSI)

As required by Statement of Federal Financial Accounting Standards (SSFAS) Number 17, *Accounting for Social Insurance* (as amended by SFFAS Number 37, *Social Insurance: Additional Requirements for Management Discussion and Analysis and Basic Financial Statements*), CMS has included information about the Medicare Trust Funds—HI and SMI. The RSI presents required long-range cash-flow projections, the long-range projections of the ratio of contributors to beneficiaries (dependency ratio), and the sensitivity analysis illustrating the effect of the changes in the most significant assumptions on the actuarial projections and present values. The SFFAS Number 37 does not eliminate or otherwise affect the SFFAS Number 17 requirements for the supplementary information, except that actuarial projections of annual cash flow in nominal dollars are no longer required; as such, it will not be reported in the RSI. The RSI assesses the sufficiency of future budgetary resources to sustain program services and meet program obligations as they come due. The information is drawn from the *2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare Trust Funds.

Limitations of the Principal Financial Statements

The principal financial statements in the Financial Section have been prepared to report our financial position and results of operations, pursuant to the requirements of 31 U.S.C. §3515(b). Although the statements have been prepared from our books and records in accordance with generally accepted accounting principles (GAAP) for federal entities and the formats prescribed by the OMB, the statements are in addition to the financial reports used to monitor and control budgetary resources, which are prepared from the same books and records.

The statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation providing HHS with resources and budget authority.

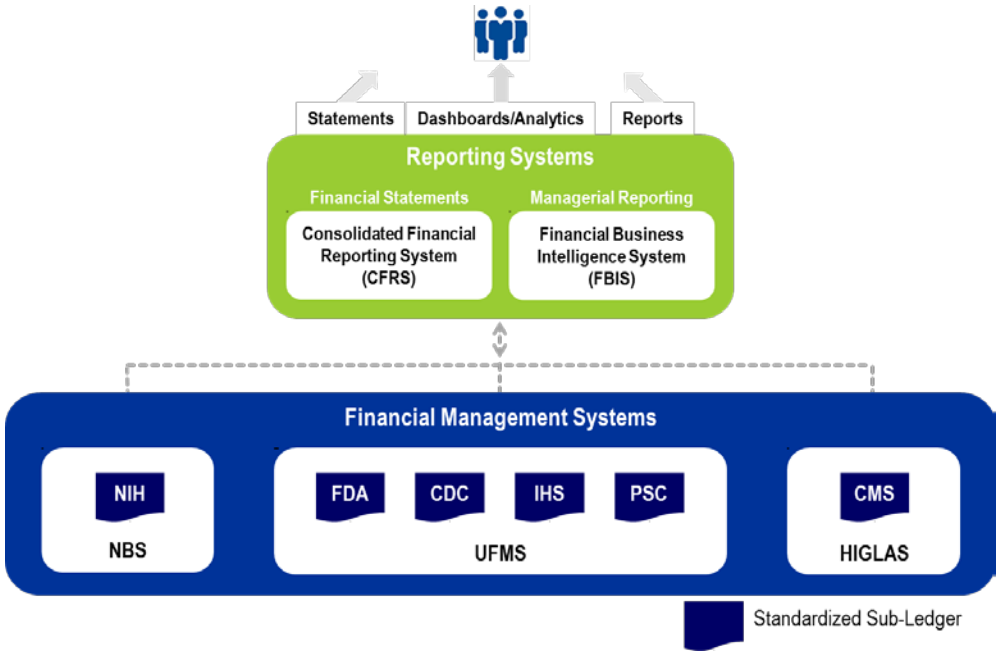
The RSI section is unique to Federal financial reporting. This section is required under OMB Circular A-136, *Financial Reporting Requirements*, and is unaudited.

SYSTEMS, LEGAL COMPLIANCE AND INTERNAL CONTROLS

SYSTEMS

HHS financial management systems are designed to support effective internal controls and to produce accurate, reliable and timely financial information. Our current financial systems portfolio, referred to as "Global UFMS" hereinafter, is depicted in the image below:

Global Unified Financial Management System (Global UFMS)



Global UFMS and its major components are described below.

1. The financial management systems component (shown above in the Financial Management Systems layer), consists of three financial management and accounting systems that offer HHS a platform for effectively processing and tracking its financial and accounting transactions, while meeting the unique business needs of the users. The specific systems are shown below:

    - UFMS is the integrated financial management system with four standardized sub-ledgers (one for each of the OPDIVs shown above with the Program Support Center (PSC) supporting five OPDIVs and the Office of the Secretary);
    - The Healthcare Integrated General Ledger Accounting System (HIGLAS) at CMS serves 15 Medicare Administrative Contractors (MACs) processing medical payments with its single standardized sub-ledger; and
    - The National Institutes of Health Business System (NBS) serves 27 separate research institutes and centers supporting health research, an integral part of the HHS mission, with its single standardized sub-ledger.

Built upon a web-based commercial off-the-shelf (COTS) solution, these three systems allow HHS to reliably execute financial management procedures and business processes over a common infrastructure across the enterprise.

2. The reporting systems component of Global UFMS (shown above in the Reporting Systems layer) consists of two reporting solutions that accept data from the financial management systems and facilitate reconciliation, financial analysis and management reporting. The specific systems are described below:

    - The Consolidated Financial Reporting System (CFRS), implemented during FY 2011, enables HHS to systematically consolidate information from the three financial management systems. It generates the formal, HHS-wide consolidated financial statements and other managerial reports on a consistent, timely and reliable basis.
    - The Enterprise Financial Business Intelligence System (FBIS), which HHS is implementing in phases, with the second phase rolled out during FY 2013, currently gathers information from core financial systems into a sustainable business intelligence platform for integrated, timely, and accurate reporting and analysis. This system facilitates the delivery of actionable data to the appropriate users across all financial systems. HHS leadership primarily accesses this data using executive dashboards and scorecards for strategic decision-making. Management employees primarily rely on financial reports and alerts for making tactical decisions and managing operations. Staff employees throughout the Department utilize operational reports, ad hoc queries and drill-down capabilities to support their transactional processing responsibilities. FBIS is currently integrated directly with UFMS and indirectly to HIGLAS and NBS, thereby providing access to the financial and accounting data of these systems.

The primary goals for Global UFMS are to consistently strengthen internal controls, to maintain data integrity and transparency and to report reliable financial information on a timely basis. In addition, it is one of HHS priorities to ensure continual systems improvement that is accomplished by addressing weaknesses identified in audits and by performing self-evaluations and monitoring of our financial management controls, systems and processes.

These objectives align with the requirement to abide by all relevant federal laws, regulations and authoritative guidance. In addition, HHS seeks to comply with federal financial management systems requirements such as those listed below:

- *Federal Managers' Financial Integrity Act of 1982*
- *Chief Financial Officers Act*
- *Government Management Reform Act of 1994*
- *Federal Financial Management Improvement Act of 1996*
- *Clinger-Cohen Act of 1996*
- *Federal Information Security Management Act of 2002*
- OMB Regulations related to these laws.

In line with the goals described above and, anticipating the need to meet new business and reporting demands, HHS has developed a Department-wide financial systems improvement strategy and is executing it incrementally over time based on a high-level roadmap. The most critical component of this multi-year initiative addresses the need to upgrade the three financial management systems since the software vendor will end its support for the current version of the software in December 2014. By upgrading, HHS will maintain a secure and reliable systems

environment while protecting its investment. Through this strategy, HHS will also implement data standards that will improve data integrity, enhance the accuracy of financial reporting and reduce the need for burdensome and manual reconciliations. Another key component of this strategy is the pursuit of sharing initiatives, ranging from the standardization of accounting treatment across systems to the transitioning of financial management systems environment to managed cloud / hosting providers. At the same time, HHS will expand the use of business intelligence incrementally to further enhance financial management information and reporting, strengthen internal controls and facilitate effective decision-making.

To support the financial systems improvement strategy, HHS is also establishing a Department-wide governance structure to provide oversight of the financial management systems portfolio as well as manage the integration and alignment of the related core financial projects. This governance structure will ensure efficient execution of project responsibilities and Department-wide coordination of project activities.

LEGAL COMPLIANCE

Anti-Deficiency Act

As noted in our FY 2012 AFR, HHS investigated potential reportable violations. As required by the *Anti-Deficiency Act*, we are in the process of notifying all appropriate authorities of such violations. HHS notifications may be found at http://www.gao.gov/legal/lawresources/antideficiencyrpts.html

HHS management has taken and continues to take, all necessary steps to prevent future violations. With respect to other possible issues, we are working through investigations and further assessment where necessary. We remain fully committed to resolving these matters appropriately and complying with all aspects of the law.

Federal Managers' Financial Integrity and Federal Financial Management Improvement Acts

In 1982, Congress enacted the *Federal Managers' Financial Integrity Act* (FMFIA). Under FMFIA, federal agencies must provide reasonable assurances that agencies have established internal accounting and administrative controls to prevent waste or misuse of agency funds or property and to assure the accountability of assets, including conformance of the agency's accounting system with government-wide standards. The FMFIA also requires a plan and schedule for correction of any weaknesses identified in the report.

In 1996, Congress enacted the Federal Financial Management Improvement Act (FFMIA). As described in OMB Circular No. A-127, *Financial Management Systems,* FFMIA expanded upon FMFIA by requiring that agencies implement and maintain financial management systems that comply substantially with federal financial management systems requirements, applicable federal accounting standards and the U.S. Standard General Ledger at the transaction level.

The material weakness that resulted in the non-compliance with FFMIA is related to system security controls that are described in the Statement of Assurance section of the AFR. This section also describes the corrective action plan that HHS will execute to resolve this weakness as it continues working towards its goal of making Global UFMS fully compliant with FFMIA. This multi-faceted effort also encompasses improvements to all HHS financial management and reporting systems, as well as enhanced policies and procedures.

The following briefly describes our accomplishments during FY 2013.

UFMS and its Related Reporting Systems

HHS carefully reviewed the weaknesses related to UFMS and its related reporting systems and has developed corrective action plans. HHS also significantly strengthened its FFMIA compliance process by updating its A-127-related system inventory, formalizing the review/approval procedures that the business owner and OPDIVs utilize throughout the year, and providing additional FFMIA training. In addition, HHS is committed to its corrective action plans through active management engagement in its compliance process to remove the identified system weaknesses.

HHS recently implemented Financial Business Intelligence System (FBIS) which has been of particular assistance during the process. FBIS provides users with integrated financial reporting and business analytics capabilities using data from HHS' distinct financial management systems and other data sources. Among the many benefits that this system offers, those shown below are especially helpful for attaining and then maintaining compliance with FFMIA:

- Improves data integrity and reduces manual review efforts;
- Consolidates and reconciles data sourced from different systems;
- Strengthens internal controls to ensure that errors and irregularities are detected in a timely manner; and
- Provides tools for verifying accounting data and for analyzing reported account balances in a timely fashion.

HIGLAS

HIGLAS is a single, integrated dual-entry accounting system that standardizes and centralizes federal financial accounting and replaces the existing accounting/payment systems for Medicare and Medicaid. Although Medicare contractors' claims processing systems were operating effectively in adjudicating health care claims in the past, before the phased rollout of HIGLAS, the systems were not designed to meet the requirements of a dual-entry general ledger accounting system. As a result, they did not meet the provisions of FFMIA.

Following the guidance of the OMB Circular A-130, *Management of Federal Information Resources*, CMS acquired a COTS product. As a result, in FY 2012 CMS became substantially compliant with the FFMIA and considers its financial systems to be integrated in accordance with OMB Circular A-127. Through the implementation of HIGLAS among the Medicare Administrative Contractors (MACs) and the implementation of the administrative program accounting functions at the CMS Central office, CMS core program dollars (i.e., Medicare, Medicaid and CHIP) are accounted for in HIGLAS. Since going "live" in May 2005, HIGLAS has processed more than 4.75 billion financial transactions and over 181.8 million payments worth $1.71 trillion, as of June 2013.

HIGLAS will continue to enhance CMS' oversight of MACs' financial operations and the accounting and reporting of other CMS activities, while also providing high-quality, timely data for decision-making and performance measurement.

NBS

NBS is a fully integrated financial, property, acquisition and logistics management system that supports NIH's core administrative and financial operations. NBS fosters NIH's mission through the provision of secure, accurate and timely business transaction capabilities that enable the NIH scientific community and supporting organizations to acquire needed assets, goods and services. It also provides accurate source information that facilitates data-driven decision-making by the NIH management community regarding budgets, finance, acquisitions and property management. Overall, NBS supports HHS' goal of "achieving excellence in management practices" through accountability and transparency. NBS management is actively remediating application security management audit findings related to audit log monitoring and segregation of duties. The audit finding related to audit log monitoring

is undergoing review for potential closure in FY 2013, while the segregation of duties finding is targeted for closure during FY 2014.

Collectively, these improvements have significantly enhanced HHS' financial management systems' compliance with FFMIA. However, management will continue to improve policies and implement corrective actions on any deficiencies identified.

Improper Payments Reporting

The *Improper Payments Elimination and Recovery Act* (IPERA; signed into law on July 22, 2010) and the *Improper Payments Elimination and Recovery Improvement Act* (IPERIA; signed into law on January 10, 2013), amended the *Improper Payments Information Act* (IPIA; signed into law on November 26, 2002). The IPIA, as amended, requires each federal agency to review all programs and activities that it administers and identify all such programs and activities that may be susceptible to significant improper payments. For programs that are identified as susceptible to significant improper payments (known as high-risk programs), it also requires that each agency report improper payment estimates and various other related information. In addition, the IPIA as amended by IPERA significantly increases our recovery auditing efforts by expanding the definition of payments recovered to include program payments. More recently, the IPIA as amended by IPERIA requires federal agencies to utilize the Do Not Pay solution to identify, prevent, and reduce improper payments. The Other Information section of this report contains detailed information on our improper payment activities.

HHS has shown tremendous leadership in the improper payments arena. HHS has published an error rate for Medicare FFS since FY 1996 and reported Foster Care error rates since FY 2004. Between FY 2004 and FY 2012, the Head Start error rate declined from 3.9 percent to 0.6 percent. In FY 2013, based on Head Start's strong internal controls, monitoring systems, and low reported error rates, the Office of Management and Budget (OMB) granted HHS relief from reporting annual error rate estimates for Head Start. In lieu of an annual error rate measurement, HHS will oversee Head Start's performance through existing internal controls and monitoring systems, and incorporate the program into the improper payment risk assessment cycle. In addition, beginning in September 2014, HHS will submit an annual report to OMB that describes Head Start's policies, controls, and corrective actions to prevent and mitigate improper payments in the program, as well as any control deficiencies, risks, and trends that are identified.

HHS continues to face challenges in developing an improper payment estimate for the Temporary Assistance for Needy Families (TANF) program. Due to statutory limitations, HHS is unable to compel States to collect the information needed to conduct an improper payment measurement. When legislation is considered to reauthorize TANF, HHS plans to encourage Congress to include changes that would allow for reliable error rate measurement. In the meantime, HHS continues to encourage States to implement corrective actions to reduce and prevent improper payments.

Table 1 in the Improper Payments Reporting section (found in the Other Information section of this report) displays HHS specific error rate results and associated notes for the current year (CY) 2013, the prior year (PY) 2012, as well as the targets for the years 2014 through 2016. In FY 2013, HHS is reporting improper payment estimates for seven high-risk programs, of which five are reporting lower error rate estimates in FY 2013 than were reported in FY 2012. Two programs – Medicare Fee-For-Service (FFS) and Medicare Part D –reported an increase in the FY 2013 error rates compared to the FY 2012 error rates. While HHS strives to decrease its error rates, sometimes an increase occurs. However, an increase in an error rate does not necessarily indicate a breakdown in the program's internal control structure. For example, one reason for the increase in the reported FY 2013 Medicare FFS error rate is that the program issued new policies (e.g., a policy requiring documentation of face-to-face encounters with physicians prior to providing home health services). Although this policy change will

ultimately strengthen the integrity of the program, there is a change management aspect to implementing new policies. Since it takes time for providers and suppliers to fully implement new policies, especially those with new documentation requirements, it is not unusual to see increases in error rates following the implementation of new policies. As a result, increases in error rates may not necessarily indicate increases in internal control risk.

INTERNAL CONTROLS

FMFIA and OMB Circular A-123*, Management's Responsibility for Internal Control,* require agencies to evaluate and report on the effectiveness of internal controls in place to ensure effectiveness and efficiency of operation, compliance with applicable laws and regulations and reliable financial reporting. HHS has completed these very rigorous assessments since FY 2006.

Managers throughout HHS are responsible for ensuring that effective internal controls are implemented in their areas of responsibility. Senior management throughout HHS provide assurance statements annually concerning the effectiveness and efficiency of internal controls within programs, the reliability of internal control over financial reporting and compliance with applicable laws and regulations. The HHS Risk Management and Financial Oversight Board (RMFOB) assesses all senior management assurances and provides the Secretary with a recommendation to sign the Agency's Statement of Assurance, included on the next page.

Located at the foot of Capitol Hill in Washington D.C., the Hubert H. Humphrey Building is the headquarters building of the U.S. Department of Health and Human Services. The naming of the building in 1977 marked the first time that a federal building had been dedicated to a living person. Hubert Humphrey, who served as U.S. senator from Minnesota and Vice President of the United States, was born in 1911 and died in 1978.

HHS continues to strengthen our internal control assessment process to be more effective and inclusive so that management can identify risks and implement timely corrective actions. The HHS FY 2013 self-assessment, as well as the financial statement audit, identified one material weakness, which also constitutes a non-conformance under Section 4 of FMFIA, and one material noncompliance, which are respectively: (1) Information System Controls and Security and (2) Error Rate Measurement.

HHS believes that maintaining integrity and accountability in all programs and operations is critical to our mission and demonstrates responsible stewardship over assets and resources. It also promotes responsible leadership, ensures the effective delivery of high quality services to our customers and maximizes desired program outcomes.

STATEMENT OF ASSURANCE

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

The Department of Health and Human Services' (HHS or the Department) management is responsible for establishing and maintaining effective internal control and financial management systems that meet the objectives of the *Federal Managers' Financial Integrity Act* (FMFIA) and the Office of Management and Budget (OMB) Circular A-123, *Management's Responsibility for Internal Control*, dated December 21, 2004. These objectives are to ensure (1) effective and efficient operations; (2) compliance with applicable laws and regulations; and (3) reliable financial reporting.

As required by OMB Circular A-123, *Management's Responsibility for Internal Control*, HHS has evaluated its internal control and financial management systems to determine whether these objectives are being met. Accordingly, HHS provides a qualified statement of reasonable assurance that its internal control and financial systems meet the objectives of FMFIA. This statement is qualified due to one material weakness, which also constitutes a non-conformance under Section 4 of FMFIA, and one material noncompliance with the *Improper Payments Information Act* (IPIA):

1. Information System Controls and Security
2. Error Rate Measurement

Internal Control over Financial Reporting

HHS conducted its assessment of the effectiveness of internal control over financial reporting, which includes safeguarding of assets and compliance with applicable laws and regulations, in accordance with the requirements of Appendix A, OMB Circular A-123, *Management's Responsibility for Internal Control*. Based on the results of this assessment, HHS identified one material weakness in its internal control over financial reporting relating to the Department's information system controls and security. Other than this exception, the Department provides reasonable assurance that internal controls were operating effectively as of June 30, 2013, and no other material weaknesses were found in the design or operation of the internal control over financial reporting.

Internal Control over Operations and Compliance

HHS conducted its assessment of internal control over the effectiveness and efficiency of operations and compliance with applicable laws and regulations, in accordance with OMB Circular A-123, *Management's Responsibility for Internal Control*. Based on the results of this evaluation, HHS identified one material weakness in its internal control over the effectiveness and efficiency of operations under Section 2 of FMFIA relating to the Department's information system controls and security, which also constitutes a non-conformance under Section 4 of FMFIA, and one material noncompliance with IPIA related to error rate measurement, as of September 30, 2013. Other than these exceptions, the Department provides reasonable assurance that internal controls over operations and compliance with applicable laws and regulations as of September 30, 2013, were operating effectively and no other material weaknesses were found in the design or execution of the internal controls over operations and compliance.

/Kathleen Sebelius/
Kathleen Sebelius
Secretary
December 16, 2013

Summary of Material Weaknesses, Non-Compliance and System Non-Conformances

Control Areas	FMFIA Section 2			FMFIA Section 4
	Operations (As of 9/30/2013)	Compliance (As of 9/30/2013)	Financial Reporting (As of 6/30/2013)	System Non-Conformance (9/30/2013)
1. Information System Controls and Security	**1**	0	**1**	**1**
2. Error Rate Measurement	0	**1**	0	0

1. Information System Controls and Security

HHS acknowledges an internal control weakness related to system security, including general and application controls in our financial management systems, and other information security weaknesses identified through the *Federal Information Security Management Act* (FISMA) annual review process. Although no one financial management system had a material weakness, the pervasive nature of the findings across our organization leads management to conclude that these findings warrant classification as a material weakness. While the Department has made progress in the remediation of the financial management systems' finding, our systems are not yet in substantial conformance with the *Federal Financial Management Improvement Act* (FFMIA) *of 1996* and its associated regulatory guidelines, as established by the appropriate governing bodies with respect to overall system security, as of September 30, 2013.

2. Error Rate Measurement

HHS did not identify any material weaknesses in our controls over compliance; however, we did identify one process limitation relating to the Temporary Assistance for Needy Families (TANF) program that led to a material noncompliance with IPIA. The TANF program is not reporting an error rate for Fiscal Year (FY) 2013 as statutory limitations prohibit HHS from requiring States to participate in a TANF improper payment measurement. When legislation is considered to reauthorize TANF, HHS plans to encourage Congress to include changes that would facilitate reliable error rate measurement.

Corrective Action Plans and Impact of Material Weakness, Non-Compliance and System Non-Conformance

The following table lists the corrective action dates for the material weakness, noncompliance and system non-conformance and their impact on the Department's financial statements.

Control Areas	Corrective Action Date	Impact on Financial Statements
1. Information System Controls and Security	FY 2015	Compensating controls exist through manual efforts that partially mitigate the risk of misstating the financial statements.
2. Error Rate Measurement	Ongoing	While error rate measurements do not directly impact HHS' financial statements, we are unable to report in our Agency Financial Report (AFR) an estimate of improper payments for TANF, as required by IPIA.

1. Information System Controls and Security

The range of challenges resulting in HHS' Information Technology (IT) material weakness and system non-conformance will require additional work beyond FY 2013 to address. In FY 2014, we will continue our efforts to remediate this IT material weakness by continuing to work with the established joint Chief Financial Officer (CFO) and Chief Information Officer (CIO) partnership to meet corrective action plan milestones and objectives. This partnership expands ongoing efforts of the CFO, CIO, and Chief Information Security Officer (CISO) to address the issues underlying the IT material weakness and system non-conformance. We will continue to identify high risk areas and key drivers of HHS' financial systems, mixed financial systems and associated IT infrastructure and collaborate with the various executive sponsor-led cross-cutting teams. The executive sponsors of each of these teams are accountable to the Risk Management and Financial Oversight Board to drive results and establish effective operational controls to reduce risk.

2. Error Rate Measurement

HHS is limited with respect to corrective actions it can take to develop an error rate for TANF; however, when legislation is considered to reauthorize TANF, HHS plans to encourage Congress to include changes that would allow for a reliable error rate measurement.

SUMMARY OF FINANCIAL STATEMENT AUDIT
TABLE 1

Audit Opinion			Unqualified for Four Financial Statements. No Opinion Expressed on Statement of Social Insurance and Statement of Changes in Social Insurance Amounts		
Restatement			No		
Material Weaknesses	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Ending Balance**
Financial Reporting, Systems, Analyses & Oversight	–	–	–	–	–
Financial Management Information Systems	***1***	–	–	–	***1***
Total Material Weaknesses	***1***	***0***	***0***	***0***	***1***

Definition of Terms – Tables 1 and 2

Beginning Balance: The beginning balance shall agree with the ending balance of material weaknesses from the prior year.

Resolved: The total number of material weaknesses that have dropped below the level of materiality in the current year.

Consolidated: The combining of two or more findings.

Reassessed: The removal of any finding not attributable to corrective actions (e.g., management has re-evaluated and determined a material weakness does not meet the criteria for materiality or is redefined as more correctly classified under another heading (e.g., Section 2 to a Section 4 and vice versa).

Ending: The agency's year-end balance.

SUMMARY OF MANAGEMENT ASSURANCES
TABLE 2

Effectiveness of Internal Control over Financial Reporting (FMFIA #2)						
Statement of Assurance	Qualified					
Material Weaknesses	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Reassessed**	**Ending Balance**
Information System Controls and Security	-	-	-	-	*1*	*1*
Total Material Weaknesses	***0***	***0***	***0***	***0***	***1***	***1***

Effectiveness of Internal Control over Operations (FMFIA #2)						
Statement of Assurance	Qualified					
Material Weaknesses	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Reassessed**	**Ending Balance**
Information System Controls and Security	*1*	-	-	-	-	*1*
Error Rate Measure	*1*	-	-	-	-	*1*
Total Material Weaknesses	***2***	***0***	***0***	***0***	***0***	***2***

Conformance with Financial Management System Requirements (FMFIA #4)						
Statement of Assurance	Do not conform to financial management system requirements					
Non-Conformances	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Reassessed**	**Ending Balance**
Information System Controls and Security	*1*	-	-	-	-	*1*
Total Non-Conformances	***1***	***0***	***0***	***0***	***0***	***1***

Compliance with *Federal Financial Management Improvement Act* (FFMIA)		
	Agency	**Auditor**
Overall Substantial Compliance	No	No
1. System Requirements	Noncompliance Noted	
2. Accounting Standards	No Noncompliance Noted	
3. USSGL at Transaction Level	Noncompliance Noted	

LOOKING AHEAD TO 2014
Management Challenges and High-Risk Areas

HHS is the United States Government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. Guided by the *HHS Strategic Plan*, 2014 will be a critical year in enabling the Health Insurance Marketplaces to begin operations as well as many other efforts in a number of exciting and challenging areas.

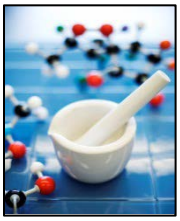
Strengthen Health Care

HHS is responsible for implementing many of the provisions included in the *Affordable Care Act* which makes health insurance coverage more secure and reliable for Americans, makes coverage more affordable and accessible for families and small business owners, and helps bring down health care costs. The *Affordable Care Act* also expands consumer choice and supports informed decision-making and increases health insurance coverage for low-income populations, partly through the advent of Health Insurance Marketplaces, which launched on October 1, 2013. Efforts in FY 2014 will include enrolling individuals in the Marketplace and continued improvements to the Healthcare.gov portal to enhance the customer experience. HHS is also committed to offering alternative enrollment options to facilitate the application process and ensure that every American who wants to enroll in a health insurance plan can access these new options for care.

HHS is also providing technical assistance to states that are transitioning to state-based Marketplaces. The expansion of health insurance to individuals with behavioral health needs will require action to strengthen state behavioral health systems, to disseminate the most effective evidence-based practices and provide quality training to existing providers.

Efforts will continue to ensure access to quality, culturally competent care for vulnerable populations and the population at large in many areas. This will include investments in health centers to provide increased access to quality care in underserved areas, both rural and urban, with access to comprehensive primary and preventive health care services. In addition, implementation of best practices to reduce health care associated infections and investment to encourage and expand the meaningful use of health information technology will contribute to overall efforts to ensure patient safety, promote efficiency and accountability, and reduce health care costs.

Advance Scientific Knowledge and Innovation



HHS is working to advance scientific knowledge and innovation to prevent, diagnose, and treat diseases and disorders, address emerging health threats, and sustain a vital and cutting edge workforce and scientific infrastructure. Future HHS plans include accelerating the development of opportunities in substance use and abuse, research toward the treatment and prevention of Alzheimer's disease and related dementias, as well as HIV, and reverse the national epidemic of obesity and diabetes.

Advance the Health, Safety and Well-Being of the American People

Over the next several years, HHS' focus will align with the *National Prevention Strategy*, which will create environments that promote healthy behaviors such as preventing and reducing tobacco use, and implementing a 21st century food safety system to reduce foodborne illness in the population. HHS will also help Americans achieve and maintain healthy weight through school-based, workplace-based, and community-based strategies.

FDA's Emergency Operations Center monitoring Hurricane Sandy

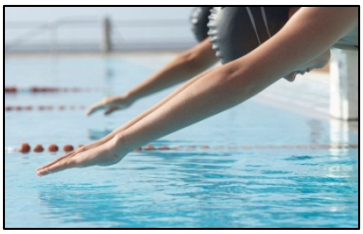
HHS plans to continue investing in efforts to prevent and manage chronic diseases and conditions, enhancing clinical efforts including childhood and adult immunizations, threat detection and response, and supporting behavioral and primary health integration. This will serve to support overall public health as well as protect Americans' health and safety during emergencies, and foster resilience in response to emergencies.

Response teams moving supplies during Hurricane Sandy

Continued partnering between HHS and state, local, tribal, urban Indian, and other service providers will sustain an essential safety net of services that protect children and youth, promote their emotional health and resilience in the face of adversity, and ensure their healthy development from birth through the transition to adulthood. Health and early intervention services ensure children get off to a good start from infancy. In support of this, HHS will maintain efforts to improve the quality of early childhood education for all children, and other efforts that will put children and youth on the path to successful futures. Furthermore, by implementing evidence-based strategies in home visiting, foster care, and teen pregnancy prevention, HHS will ensure that this population is given the chance to succeed in adulthood and can contribute to America's success.

Ensure Efficiency, Transparency, Accountability, and Effectiveness

HHS will stay committed to developing effective systems, workforce, and infrastructure that can address complicated and emerging challenges. These efforts will allow HHS to continue to towards its goal of improved health and well-being among Americans. Specifically, HHS will continue its evaluation efforts, including program integrity reviews to ensure compliance with federal program integrity regulations, provide technical assistance and identify areas to improve efficiency and effectiveness. Also, HHS will further integrate strategic planning, program performance and integrity, and budget management efforts to provide better and more efficient public service.



Recruiting, developing, retaining, and supporting a skilled and diverse workforce to provide effective and efficient services and promote responsible stewardship will remain a priority. Currently, there are areas in the nation that face shortages of critical health care workers, including primary care physicians, nurses, behavioral health and long-term care workers, as well as public health and human service professionals. To address this, HHS will continue to foster a 21st century workforce to deliver high-quality care, improve population health, and maximize limited resources.

In this Section:

- Message from the Chief Financial Officer
- Report of the Independent Auditors
- Department's Response to the Report of the Independent Auditors
- Principal Financial Statements
- Notes to the Principal Financial Statements
- Required Supplementary Stewardship Information
- Required Supplementary Information

Financial Section

The Financial Section includes the Department's Principal Financial Statements and the Report of the Independent Auditors. It also contains the Notes to the Principal Financial Statements, Required Supplementary Stewardship Information (RSSI) and Required Supplementary Information (RSI).

MESSAGE FROM THE CHIEF FINANCIAL OFFICER

The Department of Health and Human Services (HHS or the Department) is one of the largest, most complex financial organizations in the world. This Agency Financial Report represents our accountability report for FY 2013. We will issue the FY 2013 Annual Performance Report, the *FY 2015 Congressional Budget Justification* and the *Summary of Performance and Financial Information* in February, 2014.

Through collaboration, our Chief Financial Officer (CFO) community manages financial accountability, transparency, compliance and risk across the Department by maximizing resources to drive results. We are vigilant in using taxpayer resources wisely to carry out the Department's mission to enhance the health and well-being of Americans.

During 2013, we continued in our role as stewards of the public trust and worked together collaboratively to address our challenges. For example:

- Our CFO executives continued to work together as a community to improve financial reporting and systems. We made significant progress to improve controls surrounding governance, oversight, and systems security, reflecting our continued management commitment to maintain full financial accountability, transparency and effective stewardship. As part of this effort, we worked together with the Chief Information Officer community to monitor and remediate corrective actions designed to reduce system and security risks. We continue work to monitor and reduce system and security risks.
- Planned timeframes for correcting audit weaknesses and non-compliances can be found in the Management's Discussion and Analysis section (see "Planned Action Plan and Impact of Material Weakness").
- We continued to refine our reporting processes and successfully performed our annual, internal control assessment as required by OMB Circular A-123, *Management's Responsibility for Internal Control*. We present the Secretary's annual Statement of Assurance in the Management's Discussion and Analysis section of this report, which reflects the results of our assessment and planned corrective actions.
- We successfully launched release two of the Enterprise Financial Business Intelligence System which moved the Department towards improved reporting and management controls. This system provides a business analytics tool to users and management for strategic decision-making at the enterprise level.

This year we obtained a clean opinion on our Consolidated Balance Sheet, Statement of Net Cost, Statement of Changes in Net Position and the Combined Statement of Budgetary Resources. However, the auditors did not audit nor express an opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts. These statements were developed using information from the *2013 Medicare Trustees Report*, reflect current law, and, are prepared in accordance with the standards issued by the Federal Accounting Standards Advisory Board. Please refer to the Financial Section of this *Agency Financial Report* for further information.

I want to thank our employees and partners. This report and the accomplishments it describes, is a reflection of their extraordinary dedication to our mission. Together, we look forward to further improving the Department's financial management capabilities.

/Ellen G. Murray/
Ellen G. Murray
Assistant Secretary for Financial Resources and
Chief Financial Officer
December 16, 2013

REPORT OF THE INDEPENDENT AUDITORS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

DEC 16 2013

TO: The Secretary

Through: DS _____
COS _____
ES _____

FROM: Inspector General Daniel R. Levinson

SUBJECT: OIG Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2013 (A-17-13-00001)

This memorandum transmits the independent auditors' reports on the Department of Health and Human Services (HHS) fiscal year (FY) 2013 financial statements, conclusions about the effectiveness of internal controls, and compliance with laws and other matters. The Chief Financial Officers Act of 1990 (P.L. No. 101-576), as amended, requires the Office of Inspector General (OIG) or an independent external auditor, as determined by OIG, to audit the HHS financial statements in accordance with applicable standards.

We contracted with the independent certified public accounting firm of Ernst & Young, LLP, to audit the HHS (1) consolidated balance sheet as of September 30, 2013 and 2012, and the related consolidated statements of net cost and changes in net position; (2) the combined statement of budgetary resources for the years then ended; and (3) the statement of social insurance as of January 1, 2013, and the related statement of changes in social insurance amounts. The contract required that the audit be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in the *Government Auditing Standards*, issued by the Comptroller General of the United States; and the Office of Management and Budget (OMB) Bulletin 14-02, *Audit Requirements for Federal Financial Statements.*

Results of the Independent Audit

Based on its audit, Ernst & Young found that the FY 2013 HHS consolidated balance sheet and the related consolidated statements of net cost and changes in net position and combined statement of budgetary resources were presented fairly, in all material respects, in conformity with U.S. generally accepted accounting principles. As presented beginning in note 22 to the financial statements, with respect to the estimates for the Centers for Medicare & Medicaid Services (CMS) Social Insurance Program as of January 1, 2013 and 2012, CMS management

has noted that actual future costs for Medicare are likely to exceed those projections estimated to implement current law, including the Patient Protection and Affordable Care Act (P.L. No. 111-148). The Medicare Board of Trustees, in their annual report to Congress, references an alternative scenario to illustrate, when possible, the potential understatement of Medicare costs and projection results. As a result, Ernst & Young was unable to obtain sufficient evidential support for the amounts presented in the statements of social insurance as of January 1, 2013, 2012, 2011 and 2010, and the related statements of changes in social insurance amounts for the periods ended January 1, 2013 and 2012, to enable them to express an opinion on whether the statements were presented fairly. Ernst & Young provided unqualified opinions on the statement of social insurance as of January 1, 2009.

Ernst & Young also noted two matters involving internal controls with respect to the financial reporting. Under the standards established by the American Institute of Certified Public Accountants and *Government Auditing Standards*, issued by the Comptroller General of the United States, Ernst & Young identified a material weakness in HHS's financial information management systems and a significant deficiency in its financial reporting systems, analyses, and oversight:

- *Financial Information Management Systems*—Ernst & Young noted that HHS had continued to make strides to improve controls within the Information Technology infrastructure that supports the financial application systems, although additional improvements are still needed. HHS operating divisions continued to address and implement the existing governance, financial process and practices, and system tools needed to enhance controls over application information security and contingency planning. HHS established a standard operating procedure and further implemented automated tools to remediate segregation of duties conflicts among users. HHS also established system-level contingency plans and backup policies and procedures to improve redundancy and the availability of infrastructure that supports financial application systems. As in previous fiscal years, Ernst & Young indicated a focused effort is still needed to more completely remediate long outstanding deficiencies to a level that supports an auditor's reliance on controls within the financial systems. Deficiencies were noted over controls related to segregation of duties, change management, and access to HHS financial systems. The deficiencies found continue to constitute a material weakness in internal control.

- *Financial Reporting Systems, Analyses, and Oversight*—During the FY 2013 audit, Ernst & Young noted continued progress in improving financial management processes. While progress continued, HHS's financial management systems were still not in compliance with the Federal Financial Management Improvement Act of 1996 (P.L. No. 104-208). The audit identified internal control deficiencies that impact HHS's ability to report accurate financial information on a timely basis. Ernst & Young continued to note that HHS lacks an integrated financial management system, which impairs HHS's and its operating divisions' abilities to adequately support and analyze account balances in a timely fashion. Ernst & Young also found certain controls were not consistently performed and additional improvements were needed in financial reporting systems and processes. During control testing over the Statement of Social Insurance, Ernst & Young

also noted policies and procedures regarding documentation were not always followed. These deficiencies found collectively constitute a significant deficiency in internal control.

Also, given the significant changes in programs effective January 1, 2014, related to the continued implementation of the provisions of the Patient Protection and Affordable Care Act that include the insurance exchanges, premium subsidies, risk corridors, and reinsurance provisions, Ernst & Young also noted the importance of CMS's and HHS's developing accounting policies and procedures early in FY 2014, including internal controls related to significant processes to ensure that resources are properly utilized. In addition, Ernst & Young also noted that CMS and HHS should analyze the impact of those provisions and establish the appropriate accounting treatment in the financial statements.

Ernst & Young identified several instances of noncompliance with laws and other matters. During FY 2013, HHS's management identified that various operating divisions had violated certain provisions of the Anti-Deficiency Act (P.L. No. 101-508) and OMB Circular A-11 related to compensation of time-limited employees appointed under section 207 (f) and 207 (g) of the Public Health Services Act (42 U.S.C § 209 (f) and § 209 (g)). Also, HHS was not currently in full compliance with the requirements of the Improper Payments Information Act of 2002 (P.L. No. 107-300), the Improper Payment Eliminations and Recovery Act of 2010 (P.L. No. 111-204), and section 6411 of Patient Protection and Affordable Care Act related to the implementation of recovery activities for the Medicare Advantage Program. As noted above, Ernst & Young concluded that HHS also did not comply with the Federal Financial Management Improvement Act of 1996.

Evaluation and Monitoring of Audit Performance

In accordance with the requirements of OMB Bulletin 14-02, we reviewed Ernst & Young's audit of the HHS financial statements by:

- evaluating the independence, objectivity, and qualifications of the auditors and specialists;
- reviewing the approach and planning of the audit;
- attending key meetings with auditors and HHS officials;
- monitoring the progress of the audit;
- examining audit documentation including those related to the review of internal controls over financial reporting;
- reviewing the auditors' reports, and;
- reviewing the HHS *FY 2013 Agency Financial Report*.

Ernst & Young is responsible for the attached reports and the conclusions expressed in those reports. Our review, as differentiated from an audit in accordance with U.S. generally accepted government auditing standards, was not intended to enable us to express, and accordingly we do not express, an opinion on HHS's financial statements, the effectiveness of internal controls, whether financial management systems substantially complied with the Federal Financial Management Improvement Act of 1996, or compliance with laws and regulations. However, our monitoring review, as limited to the procedures listed above, disclosed no instances in which Ernst & Young did not comply, in all material respects, with U.S. generally accepted government auditing standards.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Gloria L. Jarmon, Deputy Inspector General for Audit Services, at (202) 619-3155 or through e-mail at Gloria.Jarmon@oig.hhs.gov. Please refer to report number A-17-13-00001.

Attachment

cc:
Ellen Murray
Assistant Secretary for Financial Resources
and Chief Financial Officer

Sheila Conley
Deputy Assistant Secretary, Finance
and Deputy Chief Financial Officer

Ernst & Young LLP
Westpark Corporate Center
8484 Westpark Drive
McLean, VA 22102

Tel: 703-747-1000
www.ey.com

Building a better working world

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, 2013 and 2012, 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, the statements of social insurance as of January 1, 2009, and the related notes to the financial statements. We were engaged to audit the statements of social insurance as of January 1, 2013, 2012, 2011 and 2010, and the related statements of changes in social insurance amounts for the periods ended January 1, 2013, 2012 and the related notes to these 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, 2013, 2012, 2011 and 2010, the related statements of changes in social insurance amounts for the periods ended January 1, 2013 and 2012 and the related notes to these financial statements, we conducted our audits in accordance with auditing standards generally accepted in the United States, the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget (OMB) Bulletin No. 14-02, *Audit Requirements for Federal Financial Statements*. Those standards and bulletin 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' 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, 2013 and 2012, 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, the statement of social insurance as of January 1, 2009 and the related notes to these financial statements.

Basis for Disclaimer of Opinion on the Statements 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 CMS' 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. 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, the SMI Part D projections have an added uncertainty in that they were prepared using very little program data upon which to base the estimates, 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).

As further described in Note 23 to the financial statements, with respect to the estimates for the CMS social insurance program presented as of January 1, 2013, 2012, 2011 and 2010, management has reflected in the projections of the program the direct impact, but has not fully reflected the secondary impacts of productivity adjustments (reductions in anticipated rates of increase) indicated in the ACA and reductions in Medicare payment rates for physician services mandated in current law. Management has noted that actual future costs for Medicare are likely to exceed those shown by the current-law projections, and has developed illustrative alternative

scenarios and projections intended to provide additional context to users of the actuarial estimates regarding the long-term sustainability of the social insurance program. In addition, legislation mandating reductions in provider payments has in the past been overridden in whole or in part by new legislation, including frequent adjustments to scheduled reductions in physician payments and to prior efforts to adjust payments for inpatient hospital services. 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, 2013, 2012, 2011 and 2010, and the related statements of changes in social insurance amounts for the periods ended January 1, 2013 and 2012.

Disclaimer of Opinion on the Statements 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, 2013, 2012, 2011 and 2010, and the related changes in the social insurance program for the periods ended January 1, 2013 and 2012.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of HHS as of September 30, 2013 and 2012, and its net cost, changes in net position, and budgetary resources for the years then ended, and the financial condition of its social insurance program as of January 1, 2009, in conformity with U.S. generally accepted accounting principles.

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' 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, who 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 audit 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 audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise HHS' basic financial statements. The Other Financial Information, as identified on HHS' 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 audit 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.

The Other Information has not been subjected to the auditing procedures applied in the audit 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 December 16, 2013, on our consideration of HHS' internal control over financial reporting and on our tests of its compliance with certain provisions of laws and regulations and other matters. The purpose of those reports is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* in considering HHS' internal control over financial reporting and compliance.

/Ernst & Young LLP/

December 16, 2013

Ernst & Young LLP
Westpark Corporate Center
8484 Westpark Drive
McLean, VA 22102

Tel: 703-747-1000
www.ey.com

Building a better working world

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 audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and Office of Management and Budget (OMB) Bulletin No. 14-02, *Audit Requirements for Federal Financial Statements*, the 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, 2013, and the related consolidated statements of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal year then ended, and the related notes to the financial statements, and we were engaged to audit the statement of social insurance as of January 1, 2013, and the related statement of changes in social insurance amounts for the period ended January 1, 2013, and have issued our report thereon dated December 16, 2013. 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, 2013, and the related statement of changes in social insurance amounts for the period ended January 1, 2013.

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' internal control. Accordingly, we do not express an opinion on the effectiveness of the HHS' internal control. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin No. 14-02. We did not test all internal controls relevant to operating objectives as broadly defined by the Federal Managers' Financial Integrity Act of 1982 (FMFIA), 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 were not identified. Given these limitations, during our audit, we did identify certain deficiencies related to Financial Information Management Systems, described below, to be a material weakness. We also identified certain deficiencies related to Financial Reporting Systems, Analyses, and Oversight, described below, to be a significant deficiency.

Material Weakness

Financial Information Management Systems

DHHS continued to make strides during fiscal year (FY) 2013 to improve the controls within its supporting information technology (IT) infrastructure and financial application systems. We noted attention amongst the operating divisions (OPDIVs) to address the existing governance, financial processes and practices, and system tools related to controls over application information security, and contingency planning for financial systems. The following summarizes some of the improvements achieved that resulted from this increased attention.

- Established a standard operating procedure and practices to facilitate remediation and further implementation of automated tools, reports, and review mechanisms to prevent and remediate segregation of duties (SoD) conflicts among users.

- Established system-level contingency plans, backup policies and procedures that align to the continuity of operations plan (COOP) and consistent testing practices in order to improve redundancy and availability of the supporting IT infrastructure and financial application systems.

Additionally, the Department has obtained an Agency Authorization to Operate (ATO) utilizing a FedRAMP-accredited Third-Party Assessor Organization (3PAO) for the Amazon Web Services (AWS) GovCloud, which is used by GrantSolutions.

A focused effort is still necessary to more completely remediate the long-outstanding deficiencies to a level that supports an auditor's reliance on controls within these systems for the financial statement audit. Plans were indicated to be in place by management to decrease the number and severity of the deficiencies remaining in the other significant systems, including the two primary general ledger applications – Unified Financial Management System (UFMS) and NIH Business System (NBS). Specifically, we believe there will be a positive impact from the successful completion of these efforts in these areas.

Building a better working world

The remaining un-remediated deficiencies continue to constitute a material weakness in internal control. These deficiencies fall into the following categories:

- Segregation of Duties – efforts necessary include:
  - completely implementing role-based security
  - establishment of least privileged access considerations for all users, and
  - performance of a onetime clean-up activities for roles in conflict,
- Change management – which consists of:
  - implementation of automated mechanisms to support change management activities
  - verification that changes were not made that did not go through the change approval and management process.

The following is a summary of the deficiencies that we considered most critical. When assessed in aggregate, we continue to conclude they could have a material effect on the financial statements and as a result this forms the basis for our conclusion of an IT material weakness:

- Segregation of Duties – GrantSolutions (GS), UFMS, NBS, IMPACII, Health and Human Services Consolidated Acquisitions Solution (HCAS), Grants Administration Tracking and Evaluation System (GATES), and Enterprise Human Resources & Payroll (EHRP) systems did not document and implement adequate segregation of duties. Process Owners have not completely identified segregation of duty conflicts that can exist for GATES, GS, NBS, IMPACII, and EHRP and the roles and users with these conflicts. In addition, UFMS, and EHRP applications, developer(s) had full access to both development and production system. CMS continues to experience difficulties in implementing its policy of least privilege access, preventing and monitoring for inconsistencies in access rights to various systems, and mitigating the potential impact on adequate segregation of duties. We found several deficiencies that may result in a potential lack of segregation of duties at both the Medicare fee-for-service contractors and across the enterprise.
- Change Management – CM processes for NBS, HCAS, GATES, GS, and EHRP were insufficient to ensure only properly authorized changes were implemented into production systems. We also found that GATES baseline configuration is not documented for the application and database levels. Some CMS applications did not have adequate segregation of duties as it relates to implementing new program code. In addition, the documentation for authorization, testing, and approval of changes was not retained.

Several vulnerabilities in system configurations, program coding, input validation, and incident response procedures were observed for the Medicare fee-for-service network.

- Access Controls – Access controls exceptions were identified across the UFMS, HCAS, GATES, GS, EHRP and CFRS systems. Specifically, proactive user access reviews and subsequent actions that were needed to be performed were not done in a timely manner. Additionally, for HCAS and UFMS, certain users were certifying their own access and evidence of access modifications performed as a part of the certification were not documented. At CMS, we noted that business users for one key application were able to increase their access capabilities, such as maintaining system codes and the system configuration files. Additionally, we noted inconsistent and inappropriate access was granted to certain users for several key applications at CMS, in some cases without a business justification, resulting in the risk of incorrectly configured user profiles and potentially unauthorized changes to Medicare financial data files and programs.

- FISMA compliance – The security management program, as required by the Federal Information Security Management Act (FISMA) of 2002, provides a framework to ensure that security threats are identified, risks are assessed, control objectives are appropriately designed and formulated, relevant control techniques are developed and implemented, and managerial oversight is consistently applied to provide for the overall effectiveness of security measures. Without a fully integrated security management program, the design and implementation of security controls may be inadequate; user roles and responsibilities may be unclear; and management, operational and technical controls may be inconsistently implemented. Such conditions will lead to insufficient protection of sensitive or critical resources. As a part of our FY13 FISMA assessment, we performed our procedures at the following OPDIVs: (1) Indian Health Service (IHS), (2) U.S. Food and Drug Administration, (3) National Institutes of Health (NIH), (4) Centers for Medicare & Medicaid Services (CMS), and (5) HHS Office of the Secretary. Our procedures identified the following deficiencies identified across the OPDIVs reviewed:

  – Patch Management – The OPDIVs assessed do not have an effective process for timely implementation of critical system patches.

  – Identity and Access Management – Based on the OPDIVs assessed, the Department needs to standardize identification and access management procedures to provision, recertify and de-provision user accounts.

  – Remote Access Management – Based on the OPDIVs assessed, the Department has not fully implemented adequate security controls over remote access to the HHS networks. We found deficiencies related to policies and procedures and VPN user account maintenance.

– Plan of Action and Milestones – The assessed OPDIVs' security management has not fully implemented an effective POA&M process to ensure that all fields for each POA&M record are entered and updated on a timely basis and that all POA&M records are resolved and closed in a timely manner.

Recommendations

DHHS should continue the focus achieved in FY 2013 to remediate the remaining deficiencies. The following are some specific considerations:

- Continue to identify, assess, modify, and monitor Access Controls, Configuration Management, and SoD to further enhance the security posture of all applications. Specific recommendations for the non-CMS OPDIV applications include:

  – Develop and implement procedures to monitor, review and investigate user access to include users with known SOD conflicts in a timely manner. Additionally, ensure that all reviews and modifications/removal of access or other actions performed as a result of the review process are documented in a timely manner.

  – Continue to review and verify that user access to critical financial applications is properly granted and to recertify or remove access on a periodic basis. In addition, password controls should be implemented consistent with DHHS policy.

  – For GATES/GS, ACF management should consistently implement the GATES and GS SOD matrices and monitor compliance to ensure that access to each system is granted in accordance with the SOD matrix and commensurate with user's job roles and responsibilities.

  – For UFMS, HCAS, EHRP, NBS, and IMPACII, management should develop a plan to implement controls for identifying, documenting, and monitoring segregation of duties conflicts within the change management process. SoD conflicts should be considered when granting access to the development, test, and production environments in order to limit the number of users with conflicting access to only those users that require access specifically for their job function, including business justification for any allowable conflicts. Additionally, management should segregate all access to both the development and production environments for any single user.

  – Continue to test, track, and authorize all system changes planned for released into the production environment. Management should periodically review the list of changes made in the production environment and confirming that the changes made have gone through the formal change management process and that only authorized changes were implemented into the production environment.

- We have performed a separate financial statement audit of CMS for FY 2013 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.

- Throughout the course of this year's audit, we noted a handful of DHHS applications, to include GATES and EHRP, were going to be retired in the near future and replaced by other internal systems or other Governmental centers of excellence. However, a focused effort should still be made to remediate weaknesses identified across all systems currently in operation, including systems that will be retired in the coming years, so as to mitigate risk and exposure to exploitation.

Significant Deficiency

Financial Reporting Systems, Analyses, and Oversight

During FY 2013, our audit identified further progress as HHS continued to implement new processes, upgrade its various legacy systems, improve communication, develop new guidance, hire new experienced personnel, and provide training to address significant long-standing issues. We noted further improvements in controls within the payroll, intragovernmental and Fund Balance with Treasury reconciliation processes. However, HHS' and its OPDIVs' internal reviews and the results of our testing of internal control continued to identify internal control deficiencies in financial systems and processes for producing financial statements, including lack of integrated financial management systems and insufficient analysis of certain significant accounts. In many cases, the progress noted above and related processes continued to be developed throughout FY 2013 and will require additional refinements in FY 2014. Within the context of the approximately $900 billion in departmental net outlays, the ultimate resolution of our specific 2013 findings were not material to the financial statements taken as a whole. However, these matters are indicative of systemic issues that must continue to be resolved.

Lack of Integrated Financial Management System

In FY 2004, HHS began its implementation of a commercial web-based, off-the-shelf accounting system product modified to replace five legacy accounting systems and numerous subsidiary systems with one modern accounting system with three components. The three components include:

- HIGLAS – developed to support the financial activities of the CMS and its Medicare contractors by integrating the CMS contractors' standard claims processing systems and CMS' mainframe-based financial system with a web-based accounting system.

- NBS – developed to support the financial activities at NIH. NIH completed certain aspects of its implementation in FY 2008 and continues to add more ancillary modules in the succeeding years.

- UFMS – developed to support the financial activities at the remaining OPDIVs with full implementation completed in FY 2008. Certain processes to refine the implementation and address systemic issues are ongoing.

The Federal Financial Management Improvement Act of 1996 (FFMIA) requires Federal agencies to have an integrated financial management system that provides effective and efficient interrelationships between software, hardware, personnel, procedures, controls, and data contained within the systems and compliance with the United States Standard General Ledger (USSGL) at the transaction level and applicable Federal accounting standards. The lack of an integrated financial management system continues to impair HHS' and its OPDIVs' abilities to adequately support and analyze account balances reported in a timely fashion. Although progress continues to be achieved, HHS' financial management systems are not yet compliant with the FFMIA. Specific deficiencies noted include the following:

- Although significant progress was made with the automation of certain transactions, including intradepartmental delegations of authority (IDDAs), during FY 2013, over 11,000 manual journal vouchers (JVs) in excess of $1.6 trillion in absolute value were required to be recorded in UFMS and NBS to post certain types of transactions – including transactions to record certain proprietary and budgetary entries, record accruals, perform adjustments between governmental and nongovernmental accounts, perform adjustments to agree budgetary to proprietary accounts, perform other reconciliation adjustments at period-end, and correct errors identified related to configuration issues within UFMS and NBS. These entries are postings to UFMS and NBS to record both the proprietary and budgetary effects of certain financial activities for which the financial system may not be configured properly to post automatically. Although these entries are required to be posted to the general ledger in order for the financial statements to be accurate and internal controls over manual vouchers were found to be operating effectively, including supervisory reviews and properly maintained documentation to support each entry, many of these entries should be configured as routine systematic entries within the systems. HHS' management indicated that it continues to develop and implement corrective actions to reduce the number of manual entries in future years. For NBS financial statement closing entries, although the entry is recorded in NBS for financial statement preparation purposes, the entry may be recorded in aggregate and reversed until such time that either the routine process captures the activity or the entries are carried forward to the next reporting period.

- As discussed in further detail above, reviews of general and application controls over financial management systems identified certain departures from requirements specified

in OMB Circulars A-127, *Financial Management Systems*, and A-130, *Management of Federal Information Resources*.

- Within a decentralized complex organization like HHS, an integrated financial system with strong internal controls is required for up-to-date accurate financial information needed for certain decision-making responsibilities. Many of the OPDIVs within HHS have their own financial management systems with individual data structures. Accordingly, accurate information needed for decision-making at all levels of the organization may not be readily available on a day-to-day or even monthly basis as required by FFMIA. With the implementation of CFRS, certain program, financial, and budgetary consolidated and OPDIV information is pulled into a common system on a quarterly basis; however, more timely and standard information is necessary to respond to congressional requests and for decision-making purposes. In certain cases, the department is required to use surveys or data calls to the OPDIVs or to the specified programs to obtain information for specific requests. Management indicated that with the expansion of certain aspects of CFRS and its continued implementation of the Financial Business Intelligence System, which started in FY 2012, it is working to improve upon its readily available information to support information analysis and to address potential requests from Congress, OMB, the President, and other entities.

- Certain subsidiary systems are not fully integrated with the Unified Financial Management System (UFMS) and are not complemented by sufficient manual preventative and detective type controls. HHS continues to resolve certain system issues within the National Institutes of Health's (NIH) Business System (NBS). As a result, although progress was made in FY 2013, NIH's NBS continues to have certain transactions which are captured incorrectly as compared to the Treasury Standard General Ledger at the transaction level and require adjustments to the accounting records. Additionally, CMS continues its efforts to implement a web-based accounting system, the Healthcare Integrated General Ledger Accounting System (HIGLAS), which integrates the reporting of financial data related to the CMS contractors' standard claims processing systems. HIGLAS is the system of record and CMS is preparing financial statements using HIGLAS, however, the full functionality of HIGLAS may not have been implemented yet. The Medicare Administrative Contractors' (MACs) accounts receivable balances are recorded at Central Office through the manual journal voucher process. In addition, the creation of the periodic financial statements is largely system dependent; however, there is a need for system interventions to properly categorize the information within the financial statements, as required by OMB A-136. Finally, the durable medical equipment (DME) MACs have not implemented HIGLAS. For these contractors, the accuracy of the financial reports remains heavily dependent on inefficient, labor-intensive, manual processes that are also subject to an increased risk of inconsistent, incomplete or inaccurate information being submitted to CMS.

Resource limitations and other priorities were noted as causes for delays in upgrading certain system and financial internal control processes limiting HHS' ability to comply with requirements under FFMIA. HHS will need to continue to review its available resources as resources become even more restrained with (1) potential further budget cuts expected in future years, (2) the continued implementation of the Government-wide Treasury Account Symbol Adjusted Trial Balance System (GTAS) and (3) the continued implementation of new laws, regulations, and policies.

Financial Analysis and Oversight

Because deficiencies continue to exist in the financial management systems, management must compensate for the deficiencies by implementing and strengthening additional controls to ensure that errors and irregularities are detected in a timely manner. Our review of internal control disclosed a series of deficiencies that impact HHS' ability to report accurate financial information on a timely basis. Consistent with prior years, we found that certain controls were not consistently performed to ensure differences were properly identified, researched, and resolved in a timely manner, and that account balances were complete and accurate. We noted the following items in the current year's audit that indicate additional improvements in the financial reporting systems and processes are required:

Department/Operating Division Periodic Analysis and Reconciliation

When deficiencies exist in financial systems, as discussed above, management must compensate by implementing and strengthening other manual controls to ensure that errors and irregularities are prevented or detected in a timely manner. These manual and compensating controls would include monitoring of budgets, reconciliations of accounts, analyses of fluctuations, aging of accounts, and manual and supervisory reviews. During our audit, we found that certain controls still required further improvements. The following represent specific areas we noted that need enhanced periodic reconciliation and analysis procedures:

- *Departmental Review of OPDIV Financial Statements* – We noted that although desk officers have been assigned the responsibility of reviewing specific OPDIV financial reporting, the desk officers do not consistently review the supporting documentation to ensure that the submissions are accurate or fully supported. In our review of the OPDIV and Department-level draft financial statements, we identified approximately $1.2 billion in differences that could not be identified or were not identified on a timely basis and inconsistencies in disclosures reported within the AFR. Further, we found that certain OMB and Treasury required submissions contained mistakes that were ultimately identified through controls and edit checks located outside of HHS. For example, for the fourth quarter Intergovernmental Reporting submission, HHS had reported $2.8 billion against an incorrect trading partner which was identified when the Treasury system performed the match between agencies.

- *Property, Plant and Equipment* – We found that sufficient documentation was not readily available to support certain amounts and disclosures related to property, plant and equipment. Additionally, we noted that certain assets that were purchased in prior years and put into service were not recorded to the accounting records until fiscal year 2013. Finally, we noted differences (1) between the property subsidiary ledgers and the amounts reported on the financial statements and (2) when the operating division rolled forward its beginning balances to balances reported at year-end.

Policies and Procedures

During our internal control documentation and testing phases, we noted that, although various internal control processes had been changed or updated, the Department had not completed its updating of procedural manuals to ensure sufficient knowledge of financial management systems/processes or consistency and adequacy of internal control exist. Additionally, we noted that HHS utilizes several different means of providing guidance to its personnel; however, the guidance is located at different intranet locations and may be at different stages of updating, thus, making it very confusing for the personnel to locate the most updated guidance. It is our understanding that the Department and its OPDIVs are currently updating all financial management procedures.

Further, as part of the accounting centers' monthly processes, the Department has instituted a policy whereby the accounting centers certify the status of completing required periodic reconciliations. For each required reconciliation, the preparer and approver sign off and provide a date of completion. On a monthly basis, the document is forwarded to the Department. No supporting documentation is required to be provided as part of the submission. Our review of the OPDIVs' submissions and the supporting documentation maintained at the OPDIVs identified inconsistencies in the procedures performed, the reports utilized, and the results provided among the various OPDIVs. Additionally, we noted that although the financial statements are submitted to OMB on the 21st day after the end of the quarter, the Department's policy did not require reconciliations to be completed and certified until the end of the month.

Finally, given the significant changes in programs effective January 1, 2014, related to the continued implementation of the provisions of the ACA (for example, the insurance exchanges, premium subsidies, risk corridors, re-insurance provisions), it is important that HHS and CMS develop accounting policies and procedures early in FY 2014, including internal controls related to the significant processes to ensure that the resources are properly utilized. In addition, HHS and CMS should analyze the impact of the provisions and establish the appropriate accounting treatment in the financial statements.

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. In general, states pay for the health benefits provided, and the Federal government in turn matches qualified state expenditures based on the Federal medical assistance percentage. The Federal government controls over Medicaid expenditures were designed assuming that the states would have their own set of procedures and controls over program costs and that the states would have an incentive to enforce compliance with their procedures and controls to protect the integrity of their own program costs as well as the expenditures shared by the Federal government.

In recent years, as CMS has separately identified and reconciled the states' annual funds, there has been an increase in the number of adjustments, which have become more difficult to resolve timely, highlighting the weaknesses of their oversight of the program expenditures. As of September 30, 2013, a $1.9 billion accounts receivable and a $1.6 billion accounts payable balance were recorded in the CMS financial statements related to the Medicaid program, some of which dates back to FY 2009 and prior. In FY 2013, CMS has established a protocol to address negative balances and implemented review procedures to compare the quarterly expenditures, budgeted grant awards and quarterly draws. Although the FY 2012 grant finalizations were performed more consistently and timely for the states in 2013, our analyses of this process still identified deficiencies in the Medicaid program.

CMS has been working on a multi-year project to define data and analytics to improve its program and financial management. That program is not operational at a level that it currently provides controls supporting program integrity. CMS should continue to enhance its financial management systems and its related data analyses capability to develop robust analytical procedures and measures against benchmarks to monitor and identify risks associated with the Medicaid program, including outliers and unusual or unexpected results that may identify abnormalities in state-related Medicaid expenditures.

Financial Management Controls at CMS

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 December 9, 2013. In that report, we outlined details of deficiencies noted and made recommendations for improvement in their financial management controls. Consistent with our findings in the previous year, we concluded that the aggregation of these deficiencies and those related to Medicaid oversight, business partner risk management, and Statement of Social Insurance (SOSI) noted elsewhere in this report to be a significant deficiency for the CMS internal control over financial reporting. Our observations related to financial management controls included:

- CMS failed to timely record, report and return to Treasury approximately $2.2 billion in unobligated borrowing authority for the Consumer Operated and Oriented Plan (CO-OP) program as of September 30, 2012. Although CMS identified the error in January 2013,

the unobligated borrowing authority was not identified and returned to Treasury timely. In addition, the unobligated borrowing authority was not reported correctly in the FACTS II submission to Treasury for fiscal year 2012. In this example, CMS had not implemented appropriate controls around the evaluation of the final amounts of unobligated authority required to be recorded, reported and returned to Treasury.

- As CMS continues to enhance its data analyses capability, further improvement can be made by developing robust analytical procedures or measures against benchmarks to monitor and mitigate risks associated with the decentralized nature of CMS operations. To the extent more robust analysis occurs within Centers and Offices, identifying, evaluating and reviewing such analysis would assist in ensuring that a perspective that incorporates a financial reporting point of view is captured and considered. It may be beneficial for CMS to identify a cross-functional working group to perform such analysis, for example: (i) identify and document the reasons behind the changes in program expenditures and (ii) corroborating analysis between the changes in Medicare Part C and Part D beneficiaries and the changes in the monthly plan payments.

Business Partner Risk Management at CMS

CMS relies heavily on third-party contractors as it outsources substantially all the day-to-day operations for its information technology systems, the payment of Medicare fee-for-service and Medicaid claims and certain services related to the Medicare Part C and Part D programs. We continued to identify areas where improvements could be made in the control environment related to the oversight of third-party contractors.

The contracts between CMS and its Medicare fee-for-service contractors include provisions that require the Medicare Administrative Contractors (MACs) to develop and follow objectives established by CMS. Through the established procedures, the MACs are required to (a) periodically certify to the completeness and accuracy of the financial information transmitted; (b) document specific objectives and maintain supporting documentation for review and audit; and (c) provide monthly shared system reports and related support for recorded amounts. Through its OMB Circular No. A-123, *Management's Responsibility for Internal Control* (A-123), Statement on Standards for Attestation Engagements No. 16, *Reporting on Controls at a Service Organization*, (SSAE 16), and regional office processes, CMS monitors the MACs' compliance with its policies and procedures, established controls and the accuracy of financial reporting.

While this approach to financial integrity supports monitoring of the MACs' financial controls, the oversight/monitoring process has not been fully effective in identifying and resolving financial recording and reporting issues or ensuring that the issues are timely remediated by the MACs. During our audit activities, we identified deficiencies relating to: (1) the claims completeness validation process between the claims submitted by the providers and the claims received by the MACs; (2) the Medicare Summary Notices which are returned to the MACs and

are not investigated, as to why they are returned, as there currently is no existing CMS policy that addresses the actions in this circumstance; (3) the claims outstanding greater than one year, as there is no policy or procedure in place to periodically review, track or monitor those aged claims; and (4) the provider records as there are no procedures in place to reconcile, review and monitor provider records, and eligibility status on a periodic basis to verify that all changes were timely, accurately and completely processed.

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. In recognition of the importance of the underlying data, CMS has developed and implemented a change management process over the SOSI model, which applies to significant changes or changes in the methodology of each model. In addition, CMS' policies and procedures require that the input or output data within the SOSI model are documented to properly understand the flow of the data. During our control testing, we noted that one significant change made to a model and a few instances where the input and output data within the models were not properly documented in accordance with the policy.

Recommendations

We recommend that HHS continue to develop and refine its financial management systems and processes to improve its accounting, analysis, and oversight of financial management activity. Specifically, we recommend that HHS:

- Continue to devise short-term and long-term resolutions to systematic and integration issues that complicate use of UFMS and NBS. HHS should continue to assess whether systems used to prepare the financial statements are working effectively and have been sufficiently tested prior to year-end reporting dates.

- Continue to offer updated guidance to personnel to ensure consistent application of policies among the various Operating Divisions and Headquarters.

- Continue to advance management initiatives to streamline the processes for responding to financial information requests through implementation of the Enterprise Federal Business Intelligence System and IT system consolidation or standardization to more effectively

utilize CFRS to provide for more timely and up-to-date financial and business information.

- Perform specific and high-level analysis, including the corroboration of the results, over the Medicaid account balances and related expenditures. In addition, the accounts receivable and payable Medicaid balances should be analyzed and validated through the use of a subsidiary ledger.

- Challenge whether the newly implemented protocol and detect controls address the underlying root cause of why states continue to have negative balances within their PMS subaccounts. Evaluate the current protocol and determine if additional procedures and controls should be implemented to continuously monitor the state Medicaid draws and perform grant oversight activities to ensure that the states deposit the funds back after a deferral is issued and report timely, accurately, and consistently on the funds drawn to both CMS and PMS. In addition, CMS should encourage the states to reconcile the FFR, CMS-64 and PMS subaccounts on a timely manner so that they can perform the grant close out process timely and consistently within PMS to eliminate any erroneous draws to grant awards with remaining authority.

- CMS should strengthen the Medicaid program oversight controls that will serve to prevent, detect and resolve errors timely and to deter fraud, waste and abuse of Federal government resources. With respect to state-operated programs, CMS should perform additional oversight and analysis procedures related to the state costs.

- Establish a process to perform a claims-level detailed look-back analysis on the Medicaid EBDP to determine the reasonableness of the methodology utilized to record the approximately $27.6 billion accrual.

- Establish a policy individual or group to analyze the accounting and reporting of unique, non-routine or significant transactions, enhance the financial reporting process, address or identify transactions that required cross-functional input as well as to develop robust analytical procedures or measures against benchmarks to monitor and mitigate risks associated with the decentralized nature of CMS operations. Enhancement of this process may assist to develop, document and validate the new critical accounting matters that are identified during the year and improve the timeliness, accuracy and completeness of the white papers. Prepare required presentations and disclosures to ensure adequate time for analysis and feedback from key stakeholders. The internal controls and financial reporting implications of the significant provisions of ACA that commence in fiscal year 2014 require management's attention and may need to be addressed prior to formalizing further changes to the white paper process.

- Continue to develop and implement policies and procedures within the budget and financial reporting process to ensure that the unobligated authority required to be returned to Treasury is determined and finalized timely.

- Revise and enhance the design of the financial review guidance provided to the various Centers, regional offices and MACs to incorporate more analyses and scrutiny in the review of the financial information.

- Improve the contingent liability process to ensure that sufficient documentation is maintained to support or corroborate management's conclusions and to evidence that the controls are operating effectively and as designed.

- Consider expediting the CERT, PERM, Part C and Part D error rate development, analysis, and reporting so that a more thorough analysis of the findings and plans for remediation can be completed prior to the required reporting deadline. Error rate results should be developed at a sufficient level of detail to analyze specific causes, scrutinize contributing factors and identify anomalies to begin investigations of the root causes of the errors and prevention, mitigation and recovery plans.

- Continue to adhere to established policies and procedures to ensure that the SOSI model methodology and related calculation and estimates are consistently documented. Adherence to these policies will ensure that the model is evaluated to verify that the input/output data is appropriate based on the expected results of the data and spreadsheet changes and the model is accurate and complete.

Additionally, we recommend that CMS continue to develop and refine its financial management controls and business partner risk management as a means to improve its accounting, analysis and oversight of financial management activity. More detailed recommendations related to our specific findings on these topics are included in our CMS Report on Internal Control.

Building a better working world

Status of Prior-Year Findings

In the reports on the results of the FY 2012 audit of the HHS 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 2013 Status**
Financial Management Information Systems	• Non-CMS OPDIV Financial Management Information Systems • Non-CMS OPDIV Application Security Management • CMS Information Systems Controls	Certain progress noted; certain issues need continued focus. Modified Repeat Condition
Significant Deficiency		
Financial Reporting Systems, Analyses, and Oversight	• Lack of Integrated Financial Management System • Financial Analysis and Oversight • Statement of Social Insurance	Certain progress noted, including improvements within the payroll, intra-governmental and Fund Balance with Treasury Reconciliation areas. However, certain issues identified require continued focus. Modified Repeat Condition

HHS' Response to Findings

HHS' response to the findings identified in our audit and examination are included in its letter dated December 16, 2013, which has been included at the end of this report. HHS' response was not subjected to either the auditing procedures applied in the audit of the financial statements or the attest procedures applied in the examination of internal control 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 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/

December 16, 2013

Ernst & Young LLP
Westpark Corporate Center
8484 Westpark Drive
McLean, VA 22102

Tel: 703-747-1000
www.ey.com

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. 14-02, *Audit Requirements for Federal Financial Statements*, the financial statements of the Department of Health and Human Services (HHS), which comprise the consolidated balance sheet as of September 30, 2013, and the related consolidated statements of net cost and changes in net position and the combined statements of budgetary resources for the fiscal year then ended, and the related notes to the financial statements, and we were engaged to audit the statement of social insurance as of January 1, 2013, and the related statement of changes in social insurance amounts for the period ended January 1, 2013, and have issued our report thereon dated December 16, 2013. 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, 2013, and the related statement of changes in social insurance amounts for the period ended January 1, 2013.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether HHS' financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts, and certain other laws and regulations specified in OMB Bulletin No. 14-02, 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 certain provisions of laws and regulations 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 of compliance with the laws and regulations described in the second paragraph of this report disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 14-02, as described below.

During fiscal year (FY) 2013, HHS' management determined that various operating divisions had violated certain provisions of the Anti-Deficiency Act (P.L. 101-508 and OMB Circular A-11) related to compensation of time-limited employees appointed under sections 207(f) and 207(g) of the Public Health Service Act (42 U.S.C. § 209(f) and § 209(g), respectively.

Additionally, the Improper Payments Information Act (IPIA) of 2002 (P.L. 107-300) as amended by the Improper Payments Elimination and Recovery Act (IPERA) of 2010 (P.L. 111-204) and the Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2013 (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 it continues to make progress, HHS is currently not in full compliance with the requirements of the Acts. HHS has reported error rates for each of its high-risk programs, or components of such programs, except for the Temporary Assistance for Needy Families (TANF); and the Medicare Fee-For-Service error rate is greater than the statutorily required maximum of 10 percent. As for improper payment estimates in the TANF program, HHS indicated that it is unable to compel states to collect the necessary information required to conduct an improper payment measurement 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 Act dictates that the federal government may only regulate the conduct of states where Congress has given them the express authority. Accordingly, HHS feels 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 Act. In addition, HHS is not in full compliance with Section 6411 of the Affordable Care Act as HHS has not yet implemented recovery activities of the identified improper payments for the Medicare Advantage (Part C) program. To date, HHS has received and analyzed comments related to a Part C recovery audit contractor program, continues to explore implementation options and anticipates executing a contract in FY 2014.

Under FFMIA, we are required to report whether HHS' financial management systems substantially comply with federal financial management systems requirements, applicable federal accounting standards, and the United States Standard General Ledger (USSGL) at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA Section 803(a) requirements. The results of our tests disclosed instances in which HHS' financial management systems did not substantially comply with certain requirements as discussed above. We have identified the following instances of noncompliance related to FFMIA:

- Certain subsidiary systems are not fully integrated with the Unified Financial Management System (UFMS) and are not complemented by sufficient manual preventative and detective type controls. HHS continues to resolve certain system issues within the National Institutes of Health's (NIH) Business System (NBS). As a result, although progress was made in FY 2013, NIH's NBS continues to have certain transactions which are captured incorrectly as compared to the Treasury Standard General

Ledger at the transaction level and require adjustments to the accounting records. Additionally, although CMS has determined its Healthcare Integrated General Ledger Accounting System (HIGLAS) to be substantially compliant with FFMIA, the Medicare Administrative Contractors' (MACs) accounts receivable balances are being recorded at Central Office through the manual journal voucher process. In addition, the creation of the periodic financial statements is largely system dependent; however, there is a need for system interventions to properly categorize the information within the financial statements, as required by OMB A-136. Finally, the durable medical equipment (DME) MACs have not implemented HIGLAS. For these contractors, the accuracy of the financial reports remains heavily dependent on inefficient, labor-intensive, manual processes that are also subject to an increased risk of inconsistent, incomplete or inaccurate information being submitted to CMS.

- During fiscal year 2013, thousands of manual journal vouchers were required to be recorded in UFMS/NBS to post certain types of transactions, including budgetary and proprietary, not currently configured correctly within UFMS and for the purpose of developing monthly financial statements.

- Certain reconciliations and clearance of differences are not completed timely due to the use of ad hoc inquiries and system limitations on matching debits and credits to resolve certain issues.

- Although progress was noted, reviews of general and application controls over financial management systems identified certain departures from requirements specified in OMB Circulars A-127, *Financial Management Systems*, and A-130, *Management of Federal Information Resources*. Additionally, the Office of Inspector General (OIG) identified certain issues, including access control deficiencies related to systems as part of its Federal Information Security Management Act and other OIG engagements. Finally, HHS management has identified certain weaknesses within its information technology general and application controls during its assessment of corrective action status and its OMB A-123 processes.

- Currently, accurate information needed for decision-making at all levels of the organization may not be readily available on a day-to-day or even monthly basis as required by FFMIA. HHS is currently working on implementing the Enterprise Financial Business Intelligence System (FBIS) to provide access to more timely information to support decision-making.

* * * * *

HHS' Response to Findings

Our Report on Internal Control dated December 16, 2013, includes additional information related to the financial management systems that were found not to comply with the requirements, relevant facts pertaining to the noncompliance to FFMIA, and our recommendations related to the specific issues presented. It is our understanding that management agrees with the facts as presented and that relevant comments from HHS' management responsible for addressing the noncompliance are provided in their letter dated December 16, 2013. We did not audit management's comments and, accordingly, we express no opinion on them. Additionally, HHS is updating its agency-wide corrective action plan to address FFMIA and other financial management issues.

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' compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering HHS' compliance. Accordingly, this communication is not suitable for any other purpose.

/Ernst & Young LLP/

December 16, 2013

DEPARTMENT'S RESPONSE TO THE REPORT OF THE INDEPENDENT AUDITORS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

To: Daniel R. Levinson, Inspector General

From: Ellen G. Murray, Assistant Secretary for Financial Resources and Chief Financial Officer

Subject: FY 2013 Financial Statement Audit

We would like to thank the Office of Inspector General and your contractors, Ernst & Young LLP, for your efforts on our behalf. We appreciate the professionalism exhibited by your staff and contractors during the audit.

We appreciate the opportunity to comment on the draft reports provided to us. We generally concur with the findings in the Final Report which has been included in this FY 2013 *Agency Financial Report*. In response to your reports, we will prepare corrective action plans to address the identified findings within the next 60 days.

HHS management is committed to working toward resolving these challenges. We look forward to continued collaboration with the Office of Inspector General to improve our stewardship of taxpayer funds.

/Ellen G. Murray/

Ellen G. Murray
Assistant Secretary for Financial Resources and
Chief Financial Officer
December 16, 2013

PRINCIPAL FINANCIAL STATEMENTS

U.S. Department of Health and Human Services

Consolidated Balance Sheet

As of September 30, 2013 and 2012

(in Millions)

	2013	2012
Assets (Note 2)		
Intragovernmental Assets:		
Fund Balance with Treasury (Note 3)	$ 159,192	$ 197,348
Investments, Net (Note 4)	281,723	306,381
Accounts Receivable, Net (Note 5)	3,649	820
Advances (Note 8)	103	48
Total Intragovernmental Assets	444,667	504,597
Accounts Receivable, Net (Note 5)	10,933	10,943
Inventory and Related Property, Net (Note 6)	8,602	8,072
General Property, Plant and Equipment, Net (Note 7)	5,364	5,401
Advances (Note 8)	34	1,244
Other Assets	655	396
Total Assets	$ 470,255	$ 530,653
Stewardship Property, Plant and Equipment (Note 1)		
Liabilities (Note 9)		
Intragovernmental Liabilities		
Accounts Payable	$ 565	$ 659
Other Liabilities (Note 13)	2,009	1,430
Total Intragovernmental Liabilities	2,574	2,089
Accounts Payable	662	425
Entitlement Benefits Due and Payable (Note 10)	77,277	72,493
Accrued Grant Liability (Note 12)	3,949	3,748
Federal Employee and Veterans' Benefits (Note 11)	11,566	11,008
Contingencies and Commitments (Note 14)	8,900	6,766
Other Liabilities (Note 13)	2,581	2,962
Total Liabilities	107,509	99,491
Net Position		
Unexpended Appropriations - Funds from dedicated collections (Note 21)	4,469	20,418
Unexpended Appropriations - Other funds	105,728	135,768
Unexpended Appropriations, Total	110,197	156,186
Cumulative Results of Operations - Funds from dedicated collections (Note 21)	243,996	267,009
Cumulative Results of Operations - Other funds	8,553	7,967
Cumulative Results of Operations, Total	252,549	274,976
Total Net Position	362,746	431,162
Total Liabilities and Net Position	$ 470,255	$ 530,653

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Consolidated Statement of Net Cost
For the Years Ended September 30, 2013 and 2012
(in Millions)

	2013	2012
Responsibility Segments		
Centers for Medicare & Medicaid Services (CMS)		
Gross Cost	$ 848,967	$ 802,301
Exchange Revenue (Note 16)	(69,745)	(65,078)
CMS Net Cost of Operations	779,222	737,223
Other Segments:		
Administration for Children and Families (ACF)	50,566	49,143
Administration for Community Living (ACL)	1,449	1,488
Agency for Healthcare Research and Quality (AHRQ)	606	635
Centers for Disease Control and Prevention (CDC)	10,771	10,380
Food and Drug Administration (FDA)	3,394	3,250
Health Resources and Services Administration (HRSA)	8,720	8,653
Indian Health Service (IHS)	5,551	6,726
National Institutes of Health (NIH)	30,691	31,834
Office of the Secretary (OS)	3,900	3,684
Program Support Center (PSC)	1,636	1,774
Substance Abuse and Mental Health Services Administration (SAMHSA)	3,432	3,480
Other Segments Gross Cost of Operations before Actuarial Gains and Losses	$ 120,716	$ 121,047
Actuarial (Gains) and Losses Commissioned Corp Retirement and Medical Plan (Note 11)	230	497
Other Segments Gross Cost of Operations after Actuarial Gains and Losses	$ 120,946	$ 121,544
Exchange Revenue (Note 16)	(3,918)	(3,220)
Other Segments Net Cost of Operations	117,028	118,324
Net Cost of Operations (Note 16)	$ 896,250	$ 855,547

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Consolidated Statement of Changes in Net Position
For the Year Ended September 30, 2013
(in Millions)

	2013			
	Funds From Dedicated Collections	All Other Funds	Eliminations	Consolidated Total
Cumulative Results of Operations:				
Beginning Balances	$ 267,009	$ 7,967	$ -	$ 274,976
Budgetary Financing Sources:				
Appropriations Used	247,682	397,158	-	644,840
Non-exchange Revenue				
Non-exchange Revenue - Tax Revenue	213,106	-	-	213,106
Non-exchange Revenue - Investment Revenue	12,051	3	-	12,054
Non-exchange Revenue - Other	4,761	-	-	4,761
Donations and Forfeitures of Cash and Cash Equivalents	50	-	-	50
Transfers-in/out without Reimbursement	(3,363)	2,313	-	(1,050)
Other (+/-)	-	4	-	4
Other Financing Sources (Non-Exchange):				
Donations and Forfeitures of Property	-	7	-	7
Transfers-in/out Without Reimbursement (+/-)	(2)	(5)	-	(7)
Imputed Financing	37	687	(189)	535
Other (+/-)	1	(478)	-	(477)
Total Financing Sources	474,323	399,689	(189)	873,823
Net Cost of Operations (+/-)	497,336	399,103	(189)	896,250
Net Change	(23,013)	586	-	(22,427)
Cumulative Results of Operations:	$ 243,996	$ 8,553	$ -	$ 252,549
Unexpended Appropriations:				
Beginning Balances	$ 20,418	$ 135,768	$ -	$ 156,186
Budgetary Financing Sources:				
Appropriations Received	249,300	401,316	-	650,616
Appropriations Transferred in/out	-	120	-	120
Other Adjustments	(17,567)	(34,318)	-	(51,885)
Appropriations Used	(247,682)	(397,158)	-	(644,840)
Total Budgetary Financing Sources	(15,949)	(30,040)	-	(45,989)
Total Unexpended Appropriations	4,469	105,728	-	110,197
Net Position	$ 248,465	$ 114,281	$ -	$ 362,746

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Consolidated Statement of Changes in Net Position
For the Year Ended September 30, 2012
(in Millions)

	2012			
	Funds From Dedicated Collections	All Other Funds	Eliminations	Consolidated Total
Cumulative Results of Operations:				
Beginning Balances	$ 293,362	$ 7,807	$ -	$ 301,169
Budgetary Financing Sources:				
Appropriations Used	231,390	376,985	-	608,375
Non-exchange Revenue				
Non-exchange Revenue - Tax Revenue	205,006	-	-	205,006
Non-exchange Revenue - Investment Revenue	13,890	2	-	13,892
Non-exchange Revenue - Other	3,417	-	-	3,417
Donations and Forfeitures of Cash and Cash Equivalents	47	-	-	47
Transfers-in/out without Reimbursement	(3,637)	2,232	-	(1,405)
Other (+/-)	-	1	-	1
Other Financing Sources (Non-Exchange):				
Donations and Forfeitures of Property	-	6	-	6
Transfers-in/out Without Reimbursement (+/-)	(3)	2	-	(1)
Imputed Financing	35	633	(158)	510
Other (+/-)	-	(494)	-	(494)
Total Financing Sources	450,145	379,367	(158)	829,354
Net Cost of Operations (+/-)	476,498	379,207	(158)	855,547
Net Change	(26,353)	160	-	(26,193)
Cumulative Results of Operations:	$ 267,009	$ 7,967	$ -	$ 274,976
Unexpended Appropriations:				
Beginning Balances	$ 4,236	$ 122,558	$ -	$ 126,794
Budgetary Financing Sources:				
Appropriations Received	250,966	398,108	-	649,074
Appropriations Transferred in/out	-	9	-	9
Other Adjustments	(3,394)	(7,922)	-	(11,316)
Appropriations Used	(231,390)	(376,985)	-	(608,375)
Total Budgetary Financing Sources	16,182	13,210	-	29,392
Total Unexpended Appropriations	20,418	135,768	-	156,186
Net Position	$ 287,427	$ 143,735	$ -	$ 431,162

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Combined Statement of Budgetary Resources
For the Years Ended September 30, 2013 and 2012
(in Millions)

	2013		2012	
	Budgetary	Non-Budgetary Credit Reform Financing Account	Budgetary	Non-Budgetary Credit Reform Financing Account
Budgetary Resources:				
Unobligated Balance, Brought Forward, Oct 1	$ 80,780	$ 3,175	$ 51,730	$ 71
Recoveries of Prior Year Unpaid Obligations	24,598	-	25,746	-
Other Changes in Unobligated Balance	(1,221)	(1)	(4,524)	-
Unobligated Balance from Prior Year Budget Authority, Net	104,157	3,174	72,952	71
Appropriations (Discretionary and Mandatory)	1,193,733	-	1,191,860	-
Borrowing Authority (Discretionary and Mandatory) (Note 17)	-	(2,064)	-	3,194
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	25,409	(685)	20,122	1,636
Total Budgetary Resources	$ 1,323,299	$ 425	$ 1,284,934	$ 4,901
Status of Budgetary Resources:				
Obligations Incurred (Note 18)	$ 1,281,722	$ 314	$ 1,204,154	$ 1,726
Unobligated Balance, End of Year:				
Apportioned	29,993	40	71,919	3,134
Exempt from Apportionment	2,059	-	184	-
Unapportioned	9,525	71	8,677	41
Total Unobligated Balance, End of Year	41,577	111	80,780	3,175
Total Budgetary Resources	$ 1,323,299	$ 425	$ 1,284,934	$ 4,901
Change in Obligated Balance:				
Unpaid Obligations:				
Unpaid Obligations, Brought Forward, Oct 1	$ 180,754	$ 1,602	$ 188,534	$ -
Obligations Incurred (Note 18)	1,281,722	314	1,204,154	1,726
Outlays (Gross)	(1,249,330)	(668)	(1,186,188)	(124)
Actual Transfers, unpaid obligations	106	-	-	-
Recoveries of Prior Year Unpaid Obligations	(24,598)	-	(25,746)	-
Unpaid Obligations, End of Year	$ 188,654	$ 1,248	$ 180,754	$ 1,602
Uncollected Payments:				
Uncollected Customer Payments from Federal Sources, Brought Forward, Oct 1	$ (10,103)	$ (1,587)	$ (10,360)	$ -
Change in Uncollected Customer Payments from Federal Sources	(915)	1,051	257	(1,587)
Uncollected Payments from Federal Sources, End of Year	$ (11,018)	$ (536)	$ (10,103)	$ (1,587)
Memorandum (non-add) Entries:				
Obligated Balance, Start of Year	$ 170,651	$ 15	$ 178,174	$ -
Obligated Balance, End of Year	$ 177,636	$ 712	$ 170,651	$ 15
Budget Authority and Outlays, Net:				
Budget Authority, Gross (Discretionary and Mandatory)	$ 1,219,142	$ (2,749)	$ 1,211,982	$ 4,830
Actual Offsetting Collections (Discretionary and Mandatory)	(24,812)	(366)	(20,291)	(48)
Change in Uncollected Customer Payments from Federal Sources (Discretionary and Mandatory)	(915)	1,051	257	(1,587)
Budget Authority, Net (Discretionary and Mandatory)	$ 1,193,415	$ (2,064)	$ 1,191,948	$ 3,195
Outlays, Gross (Discretionary and Mandatory)	$ 1,249,330	$ 668	$ 1,186,188	$ 124
Actual Offsetting Collections (Discretionary and Mandatory)	(24,812)	(366)	(20,291)	(48)
Outlays, Net (Discretionary and Mandatory)	1,224,518	302	1,165,897	76
Distributed Offsetting Receipts	(336,655)	-	(317,777)	-
Agency Outlays, Net (Discretionary and Mandatory)	$ 887,863	$ 302	$ 848,120	$ 76

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services

Statement of Social Insurance

75-Year Projection as of January 1, 2013 and Prior Base Years
(in Billions)

	Estimates from Prior Years				
	(unaudited) 2013	(unaudited) 2012	(unaudited) 2011	(unaudited) 2010	2009
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 22 and 23)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 8,147	$ 7,929	$ 7,581	$ 7,216	$ 6,348
SMI Part B	15,227	14,431	13,595	12,688	16,323
SMI Part D	5,871	5,866	6,438	6,355	6,144
Have attained eligibility age (age 65 and over)					
HI	301	302	262	248	209
SMI Part B	2,620	2,395	2,122	1,972	1,924
SMI Part D	722	694	695	646	595
Those expected to become participants					
HI	7,744	7,367	7,260	6,944	5,451
SMI Part B	3,530	3,333	3,223	3,077	4,909
SMI Part D	2,617	2,568	2,817	2,714	2,632
All current and future participants					
HI	16,192	15,598	15,104	14,408	12,008
SMI Part B	21,377	20,159	18,940	17,737	23,156
SMI Part D	9,211	9,128	9,950	9,715	9,371
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 22 and 23)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 14,629	$ 14,919	$ 12,887	$ 12,032	$ 18,147
SMI Part B	15,075	14,303	13,489	12,587	16,342
SMI Part D	5,871	5,866	6,438	6,355	6,144
Have attained eligibility age (age 65 and over)					
HI	3,422	3,369	2,923	2,648	2,958
SMI Part B	2,887	2,646	2,343	2,166	2,142
SMI Part D	722	694	695	646	595
Those expected to become participants					
HI	2,913	2,891	2,546	2,411	4,673
SMI Part B	3,415	3,211	3,108	2,984	4,672
SMI Part D	2,617	2,568	2,817	2,714	2,632
All current and future participants					
HI	20,963	21,179	18,356	17,090	25,778
SMI Part B	21,377	20,159	18,940	17,737	23,156
SMI Part D	9,211	9,128	9,950	9,715	9,371
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 22 and 23)					
HI	$ (4,772)	$ (5,581)	$ (3,252)	$ (2,683)	$ (13,770)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Additional Information					
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 22 and 23)					
HI	$ (4,772)	$ (5,581)	$ (3,252)	$ (2,683)	$ (13,770)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Trust Fund assets at start of period					
HI	220	244	272	304	321
SMI Part B	66	80	71	76	59
SMI Part D	1	1	1	1	1
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) and Trust Fund assets at start of period over expenditures (Notes 22 and 23)					
HI	$ (4,551)	$ (5,337)	$ (2,980)	$ (2,378)	$ (13,449)
SMI Part B	66	80	71	76	59
SMI Part D	1	1	1	1	1

Please note for the entirety of the Statement of Social Insurance:

Totals do not necessarily equal the sum of the rounded components.

Current participants are assumed to be the "closed group" of individuals who are at least age 15 at the start of the projection period and are participating in the program as either taxpayers, beneficiaries or both.

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Statement of Social Insurance (Continued)
75-Year Projection as of January 1, 2013 and Prior Base Years
(in Billions)

	Estimates from Prior Years				
	(unaudited) 2013	(unaudited) 2012	(unaudited) 2011	(unaudited) 2010	2009
Medical Social Insurance Summary					
Current Participants:					
Actuarial present value for the 75-year projection period from or on behalf of:					
Those who, in the starting year of the projection period, have attained eligibility age:					
Income (excluding interest)	$ 3,643	$ 3,391	$ 3,079	$ 2,866	$ 2,729
Expenditures	7,031	6,709	5,961	5,459	5,695
Income less expenditures	(3,388)	(3,319)	(2,882)	(2,593)	(2,967)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	29,244	28,227	27,615	26,259	28,815
Expenditures	35,574	35,088	32,814	30,974	40,634
Income less expenditures	(6,330)	(6,861)	(5,199)	(4,715)	(11,819)
Actuarial present value of estimated future income (excluding interest) less Expenditures (closed-group measure)	(9,718)	(10,180)	(8,081)	(7,308)	(14,786)
Combined Medicare Trust Fund assets at start of period	288	325	344	381	381
Actuarial present value of estimated future income (excluding interest) less Expenditures plus Trust Fund assets at start of period	(9,430)	(9,855)	(7,737)	(6,927)	(14,405)
Future Participants:					
Actuarial present value for the 75-year projection period:					
Income (excluding interest)	13,891	13,268	13,300	12,735	12,991
Expenditures	8,945	8,669	8,471	8,109	11,976
Income less expenditures	4,946	4,599	4,829	4,626	1,016
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(4,772)	(5,581)	(3,252)	(2,683)	(13,770)
Combined Medicare Trust Fund assets at start of period	288	325	344	381	381
Actuarial present value of estimated future income (excluding interest) less expenditures plus Trust Fund assets at start of period	$ (4,484)	$ (5,256)	$ (2,908)	$ (2,302)	$ (13,390)

Please note for the entirety of the Statement of Social Insurance:

Totals do not necessarily equal the sum of the rounded components.

Current participants are assumed to be the "closed group" of individuals who are at least age 15 at the start of the projection period and are participating in the program as either taxpayers, beneficiaries or both.

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Statement of Changes in Social Insurance Amounts (unaudited)

For the Two Year Period Ending September 30, 2013

Medicare Hospital and Supplementary Medical Insurance

(in Billions)

	Actuarial present value over the next 75 years (open group measure)			Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures		
Total Medicare *(Note 24)*					
As of January 1, 2012	$ 44,885	$ 50,467	$ (5,581)	$ 325	$ (5,256)
Reasons for change					
Change in the valuation period	1,972	2,257	(285)	(46)	(331)
Change in projection base	(944)	(1,252)	308	9	317
Changes in the demographic assumptions	1,219	495	724	-	724
Changes in economic and health care assumptions	(342)	(374)	31	-	31
Changes in law	(11)	(42)	31	-	31
Net changes	1,893	1,084	809	(37)	772
As of January 1, 2013	$ 46,779	$ 51,550	$ (4,772)	$ 288	$ (4,484)
HI - Part A *(Note 24)*					
As of January 1, 2012	$ 15,598	$ 21,179	$ (5,581)	$ 244	$ (5,337)
Reasons for change					
Change in the valuation period	631	916	(285)	(29)	(314)
Change in projection base	(258)	(566)	308	5	313
Changes in the demographic assumptions	764	40	724	-	724
Changes in economic and health care assumptions	(544)	(576)	31	-	31
Changes in law	-	(31)	31	-	31
Net changes	593	(216)	809	(24)	786
As of January 1, 2013	$ 16,192	$ 20,963	$ (4,772)	$ 220	$ (4,551)
SMI - Part B *(Note 24)*					
As of January 1, 2012	$ 20,159	$ 20,159	$ -	$ 80	$ 80
Reasons for change					
Change in the valuation period	874	874	-	(17)	(17)
Change in projection base	(504)	(504)	-	3	3
Changes in the demographic assumptions	212	212	-	-	-
Changes in economic and health care assumptions	647	647	-	-	-
Changes in law	(12)	(12)	-	-	-
Net changes	1,217	1,217	-	(13)	(13)
As of January 1, 2013	$ 21,377	$ 21,377	$ -	$ 66	$ 66
SMI - Part D *(Note 24)*					
As of January 1, 2012	$ 9,128	$ 9,128	$ -	$ 1	$ 1
Reasons for change					
Change in the valuation period	467	467	-	-	-
Change in projection base	(182)	(182)	-	-	-
Changes in the demographic assumptions	242	242	-	-	-
Changes in economic and health care assumptions	(446)	(446)	-	-	-
Changes in law	1	1	-	-	-
Net changes	83	83	-	-	-
As of January 1, 2013	$ 9,211	$ 9,211	$ -	$ 1	$ 1

Totals do not necessarily equal the sum of the rounded components.

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Statement of Changes in Social Insurance Amounts (unaudited)
For the Two Year Period Ending September 30, 2013
Medicare Hospital and Supplementary Medical Insurance
(in Billions)

	Actuarial present value over the next 75 years (open group measure)				
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures	Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
Total Medicare *(Note 24)*					
As of January 1, 2011	$ 43,993	$ 47,245	$ (3,252)	$ 344	$ (2,908)
Reasons for change					
Change in the valuation period	2,011	2,136	(125)	(28)	(153)
Change in projection base	113	(173)	286	9	295
Changes in the demographic assumptions	(1,189)	(1,092)	(97)	-	(97)
Changes in economic and health care assumptions	24	2,570	(2,546)	-	(2,546)
Changes in law	(66)	(219)	153	-	153
Net changes	892	3,221	(2,329)	(19)	(2,348)
As of January 1, 2012	$ 44,885	$ 50,467	$ (5,581)	$ 325	$ (5,256)
HI - Part A *(Note 24)*					
As of January 1, 2011	$ 15,104	$ 18,356	$ (3,252)	$ 272	$ (2,980)
Reasons for change					
Change in the valuation period	634	759	(125)	(34)	(159)
Change in projection base	15	(271)	286	6	292
Changes in the demographic assumptions	(84)	13	(97)	-	(97)
Changes in economic and health care assumptions	(71)	2,475	(2,546)	-	(2,546)
Changes in law	-	(153)	153	-	153
Net changes	494	2,824	(2,329)	(28)	(2,357)
As of January 1, 2012	$ 15,598	$ 21,179	$ (5,581)	$ 244	$ (5,337)
SMI - Part B *(Note 24)*					
As of January 1, 2011	$ 18,940	$ 18,940	$ -	$ 71	$ 71
Reasons for change					
Change in the valuation period	845	845	-	6	6
Change in projection base	152	152	-	2	2
Changes in the demographic assumptions	(339)	(339)	-	-	-
Changes in economic and health care assumptions	623	623	-	-	-
Changes in law	(61)	(61)	-	-	-
Net changes	1,220	1,220	-	8	8
As of January 1, 2012	$ 20,159	$ 20,159	$ -	$ 80	$ 80
SMI - Part D *(Note 24)*					
As of January 1, 2011	$ 9,950	$ 9,950	$ -	$ 1	$ 1
Reasons for change					
Change in the valuation period	533	533	-	-	-
Change in projection base	(54)	(54)	-	-	-
Changes in the demographic assumptions	(767)	(767)	-	-	-
Changes in economic and health care assumptions	(528)	(528)	-	-	-
Changes in law	(5)	(5)	-	-	-
Net changes	(822)	(822)	-	-	-
As of January 1, 2012	$ 9,128	$ 9,128	$ -	$ 1	$ 1

Totals do not necessarily equal the sum of the rounded components.
The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

NOTES TO THE PRINCIPAL FINANCIAL STATEMENTS

For the years ended September 30, 2013 and 2012

Note 1. Summary of Significant Accounting Policies

A. Reporting Entity

The accompanying financial statements include activities and operations of the United States Department of Health and Human Services (HHS or the Department).

HHS is a Cabinet-level agency of the executive branch of the Federal Government. Its predecessor, the Department of Health, Education and Welfare (HEW), was officially established on April 11, 1953. In 1979, the *Department of Education Organization Act* was signed into law, creating a separate Department of Education. The HEW officially became HHS on May 4, 1980. HHS is responsible for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

Organization and Structure of HHS

HHS is composed of the Office of the Secretary (OS) and eleven Operating Divisions (OPDIVs) with diverse missions and programs. OS and the OPDIVs are each responsible for carrying out a mission, conducting a major line of activity or producing one or a group of related products and/or services. Although organizationally located within OS, the Program Support Center (PSC) reports on its activity separately because its business activities encompass offering services to other Federal agencies and HHS OPDIVs. The Agency for Toxic Substances and Disease Registry (ATSDR) is combined with the Centers for Disease Control and Prevention (CDC) for financial reporting purposes. Therefore, references to the CDC responsibility segment include ATSDR. Managers of the responsibility segments report directly to the Department's top management and the resources and results of operations can be clearly distinguished from those of other responsibility segments. The 12 responsibility segments are:

1. Administration for Children and Families (ACF)
2. Administration for Community Living (ACL)
3. Agency for Healthcare Research and Quality (AHRQ)
4. Centers for Disease Control and Prevention (CDC) and Agency for Toxic Substances and Disease Registry (ATSDR)
5. Centers for Medicare and Medicaid Services (CMS)
6. Food and Drug Administration (FDA)
7. Health Resources and Services Administration (HRSA)
8. Indian Health Service (IHS)
9. National Institutes of Health (NIH)
10. Office of the Secretary (OS) – excluding the Program Support Center
11. Program Support Center (PSC)
12. Substance Abuse and Mental Health Services Administration (SAMHSA)

HHS partners with other governmental agencies to accomplish its mission. One such partnership is with the Department of Homeland Security (DHS) for the Biodefense Countermeasures Fund. It is reported on HHS financial statements under the OS responsibility segment.

B. Basis of Accounting and Presentation

HHS financial statements have been prepared to report the financial position and results of operations of the Department, pursuant to the requirements of 31 U.S. Code (U.S.C.) §3515(b), the *Chief Financial Officer Act*, as amended by the *Government Management Reform Act* (GMRA), and presented in accordance with the requirements in the Office of Management and Budget (OMB) Circular A-136, *Financial Reporting Requirements* (OMB Circular A-136). These statements have been prepared from HHS' financial records using an accrual basis in conformity with accounting principles generally accepted in the United States (U.S.). The generally accepted accounting principles (GAAP) for federal entities are the standards prescribed by the Federal Accounting Standards Advisory Board (FASAB) and recognized by the American Institute of Certified Public Accountants (AICPA) as federal GAAP. These statements are, therefore, different from financial reports prepared pursuant to other OMB directives that are primarily used to monitor and control the use of budgetary resources.

Transactions are recorded on an accrual and budgetary basis of accounting. Under the accrual method of accounting, revenues are recognized when earned and expenses are recognized when resources are consumed, without regard to the payment of cash. Budgetary accounting principles are designed to recognize the obligation of funds according to legal requirements, which, in many cases, is prior to the occurrence of an accrual-based transaction. The recognition of budgetary accounting transactions is essential for compliance with legal constraints and controls over the use of federal funds.

The financial statements consolidate the balances of approximately 250 appropriations and fund accounts. The fund accounts include accounts used for suspense, collection of receipts and general government functions. Transactions and balances within HHS have been eliminated in the presentation of the Consolidated Balance Sheet and Statements of Net Cost and Changes in Net Position. The Combined Statements of Budgetary Resources are presented on a combined basis. Therefore, transactions and balances within HHS have not been eliminated from these statements. Supplemental information is accumulated from the OPDIVs' reports, regulatory reports and other sources within HHS. These statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation providing resources and budget authority for HHS.

C. Use of Estimates in Preparing Financial Statements

Financial statements prepared in accordance with accounting principles generally accepted in the U.S. are based on the selection of accounting policies and the application of significant accounting estimates. Some estimates require management to make significant assumptions. Further, the estimates are based on current conditions that may change in the future. Actual results could differ materially from the estimated amounts. The financial statements include information to assist the reader in understanding the effect of changes in assumptions on the related information.

D. Parent/Child Reporting

Allocation transfers are legal delegations by one agency of its authority to obligate budget authority and outlay funds to another agency. HHS is party to allocation transfers with other federal entities as both a transferring (parent) entity and a receiving (child) entity.

HHS received an exception to the Parent/Child reporting requirements of OMB Circular A‑136, as it pertains to the allocation transfer from DHS to HHS for the Biodefense Countermeasures Fund for Fiscal Year (FY) 2008 and beyond. Under this exception, HHS, as the child, assumed the financial statement reporting responsibilities of this fund.

HHS allocates funds, as the parent, to the Department of Interior's Bureau of Indian Affairs, and Treasury (Internal Revenue Service). HHS receives allocation transfers, as the child, from the Departments of Agriculture, Justice and State.

E. Reclassifications and Adjustments

Certain FY 2012 balances have been reclassified to conform to FY 2013 financial statement presentations. The effects are immaterial. In accordance with OMB Circular A-136, the format of the Combined Statement of Budgetary Resources changed in FY 2013; therefore, the FY 2012 balances have been presented in the FY 2013 format.

F. Funds from Dedicated Collections

On June 1, 2012 the Federal Accounting Standards Advisory Board (FASAB) issued Statement of Federal Financial Accounting Standard (SFFAS) Number 43, *Funds from Dedicated Collections: Amending Statement of Federal Financial Accounting Standard 27, Identifying and Reporting Earmarked Funds.* This Statement amended SFFAS Number 27 by changing the term "earmarked funds" to "funds from dedicated collections" and clarifying certain aspects of the requirements.

Funds from dedicated collections are financed by specifically identified revenues, often supplemented by other financing sources which remain available over time. Dedicated collections must meet the following criteria:

- A statute committing the Federal Government to use specifically identified revenues and/or other financing sources that are originally provided to the Federal Government from a non-federal source only for designated activities, benefits or purposes;
- Explicit authority for the dedicated collections to retain revenues and/or other financing sources not used in the current period for future use to finance the designated activities, benefits or purposes; and
- A requirement to account for and report on the receipt, use and retention of the revenues and other financing sources that distinguishes the dedicated collections from the Federal Government's general revenues.

HHS' major funds from dedicated collections are described in the sections below.

Medicare Hospital Insurance (HI) Trust Fund – Part A

Section 1817 of the *Social Security Act* established the Medicare HI Trust Fund. Medicare contractors are paid by HHS to process Medicare claims for hospital in-patient services, hospice and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the HI Trust Fund. A portion of HHS payments to Medicare Advantage Plans (previously known as Managed Care Plans) is also charged to this fund. The financial statements include the HI Trust Fund activities administered by the Treasury. The HI Trust Fund has permanent indefinite authority.

Employment tax revenue is the primary source of financing for the Medicare HI program. Medicare's portion of payroll and self-employment taxes is collected under the Federal Insurance Contributions Act (FICA) (26 U.S.C. Ch 21) and Self Employment Contributions Act (SECA) of 1954 (Ch 2 of Subtitle A of the Internal Revenue Code, 26 U.S.C. §1401 through §1403). Employees and employers are both required to contribute 1.45 percent of earnings, with no limitation, to the HI Trust Fund. Self-employed individuals contribute the full 2.9 percent of their self-employment income. The *Social Security Act* requires the transfer of these contributions from the Treasury General Fund to the HI Trust Fund based on the amount of wages certified by the Commissioner of Social Security from the Social Security Administration (SSA) records of wages. The SSA uses the wage totals reported by employers via the

quarterly Internal Revenue Service, Employer's Quarterly Federal Tax Return, as the basis for conducting quarterly certification of regular wages.

Medicare Supplementary Medical Insurance (SMI) Trust Fund – Part B

Section 1841 of the *Social Security Act* established the Medicare SMI Trust Fund. Medicare contractors are paid by HHS to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, end–stage renal disease treatment, rural health clinics, laboratory services and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the SMI Trust Fund. A portion of HHS payments to Medicare Advantage Plans is also charged to this fund. The financial statements include SMI Trust Fund activities administered by the Treasury. The SMI Trust Fund has permanent indefinite authority.

SMI benefits and administrative expenses are generally financed by monthly premiums paid by Medicare beneficiaries and are matched by the Federal Government through the General Fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the *Social Security Act* authorizes appropriated funds to match SMI premiums collected and prescribes the ratio for the match as well as the method to fully compensate the Trust Fund if insufficient funds are available in the appropriation to match all premiums received in the fiscal year.

Medicare SMI Trust Fund – Part D

The *Medicare Prescription Drug, Improvement and Modernization Act (Medicare Modernization Act, or MMA)* established the Medicare Supplementary Medical Insurance Trust Fund – Part D, Prescription Drug Benefit. The Prescription Drug Benefit makes a prescription drug benefit available to all Medicare beneficiaries who opt into the program. Beneficiaries eligible for Medicaid are automatically enrolled unless they have other credible drug coverage. HHS reports the Prescription Drug Benefit within the financial statements as part of the SMI Trust Fund, in the Medicare column. Drug plans are offered by insurance companies and other private companies approved by Medicare and are of two types: Medicare Prescription Drug Plans, which add coverage to FFS Medicare; and Medicare Advantage Prescription Drug Plans and other Medicare Health Plans in which drug coverage is offered as part of a benefit package that includes Part A and Part B services. Medicare helps employers and unions continue to provide retiree drug coverage that meets Medicare's standards through the Retiree Drug Subsidy. The Low Income Subsidy helps those with limited income and resources.

Medicare Integrity Program

The *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* established the Medicare Integrity Program and codified the Medicare Integrity Program activities previously known as "payment safeguards." The HIPAA also established the Health Care Fraud and Abuse Control Account, which includes a dedicated appropriation for carrying out the Medicare Integrity Program. Through the Medicare Integrity Program, HHS contracts with eligible entities to perform such activities as medical and utilization reviews, fraud reviews and cost report audits. In addition, the Department educates providers and beneficiaries, with respect to payment integrity and benefit quality assurance issues. The Medicare Integrity Program is funded by the HI Trust Fund.

G. Revenue and Financing Sources

HHS receives the majority of funding needed to support its discretionary programs through Congressional appropriation and user fees. The U.S. Constitution prescribes that no money may be expended by an agency unless the funds have been made available by Congressional appropriation. Appropriations are recognized as financing sources when related expenses are incurred or assets are purchased. Revenues from reimbursable agreements are recognized when the goods or services are provided by HHS. Other financing sources, such as donations and transfers of assets without reimbursements, are also recognized on the Consolidated Statement of Changes in Net Position.

Appropriations

HHS receives annual, multi-year and no-year appropriations that may be used within statutory limits. For example, funds for general operations are normally made available for one fiscal year, funds for long-term projects such as major construction will be available for the expected life of the project and funds used to establish revolving fund operations are generally available indefinitely (i.e., no-year funds).

Permanent Indefinite Appropriations

HHS permanent indefinite appropriations are open-ended and the dollar amount is unknown at the time the authority is granted. These appropriations are available for specific purposes without current year action by Congress.

Borrowing Authority

HHS uses indefinite borrowing authority under the *Federal Credit Reform Act*, as amended, for its loan programs. Borrowing authority increases budgetary resources and enables costs to be financed by borrowing from Treasury. Any unobligated borrowing authority does not carry forward to the next fiscal year. HHS has three programs with borrowing authority: the CMS Consumer Operated and Oriented Plan (CO-OP) Loan Program, the Health Center Loan Program and the Health Education Assistance Loan Program.

- **Direct Loans.** Under the *Patient Protection and Affordable Care Act*, the CO-OP Loan Program was established to provide loans for start-up costs and repayable grants to assist the applicant in meeting State solvency requirements. This provision fosters the creation of qualified, non-profit health insurance issuers who will offer qualified health plans in the individual and small-group markets of each State. These loans will be repaid in a manner consistent with federal requirements and terms and conditions of the loan agreement. In FY 2012, HHS awarded the first loan agreements for both start-up and solvency requirements. Disbursements have been made for both types of loans.
- **Loan Guarantees**. HHS administers guaranteed loan programs for the Health Center and the Health Education Assistance Loan Programs. Loans receivable represent defaulted guaranteed loans which have been paid to lenders under these programs and also include interest due to HHS on the defaulted loans. The liabilities for loan guarantees are valued at the present value of the cash outflows from HHS less the present value of related inflows.

HHS reports loans and loan guarantees in accordance with the *Federal Credit Reform Act*. Due to the immateriality of these Direct Loans and Loan Guarantees, the related receivables and liabilities are reported in Other Assets and Other Liabilities, respectively. Budgetary related activity is reported separately within the Combined Statement of Budgetary Resources.

Exchange Revenue

Exchange revenue results when HHS provides goods or services to another entity for a price and is recognized when earned (i.e., when goods have been delivered or services have been rendered). These revenues reduce the cost of operations.

HHS pricing policy for reimbursable agreements is to recover full cost and should result in no profit or loss for HHS. In addition to revenues related to reimbursable agreements, HHS collects various user fees to offset the cost of its programs. Certain fees charged by HHS are based on an amount set by law or regulation and may not represent full cost.

With minor exceptions, all revenue receipts by federal agencies are processed through the Treasury central accounting system. Regardless of whether they are derived from exchange or non-exchange transactions, all receipts not earmarked by Congressional appropriation for immediate HHS use are deposited in the General or Special Funds of the Treasury. Amounts not retained for use by HHS are reported as Transfers-in/out Without Reimbursement to other government agencies on HHS Consolidated Statement of Changes in Net Position.

Non-Exchange Revenue

Non-exchange revenue results from donations to the government and from the government's sovereign right to demand payment, including taxes. Non-exchange revenues are recognized when a specifically identifiable, legally-enforceable claim to resources arises, but only to the extent that collection is probable and the amount is reasonably estimable.

Non-exchange revenue is not considered to reduce the cost of the Department's operations and is separately reported on the Consolidated Statement of Changes in Net Position. Employment tax revenue collected under FICA and SECA is considered non-exchange revenue.

Imputed Financing Sources

In certain instances, HHS' operating costs are paid out of funds appropriated to other federal entities. For example, by law, certain costs of retirement programs are paid by the Office of Personnel Management and certain legal judgments against HHS are paid from the Judgment Fund maintained by the Treasury. When costs are identifiable to HHS and directly attributable to HHS' operations and are paid by other agencies, HHS recognizes these amounts as imputed costs within the Consolidated Statement of Net Cost and as an imputed financing source on the Consolidated Statement of Changes in Net Position.

H. Intragovernmental Transactions and Relationships

Intragovernmental transactions are business activities conducted between two different federal entities. Transactions with the public are transactions in which either the buyer or seller of the goods or services is a non-federal entity.

If a federal entity purchases goods or services from another federal entity and sells them to the public, the exchange revenue is classified as with the public, but the related costs would be classified as intragovernmental. The purpose of the classifications is to enable the Federal Government to provide consolidated financial statements and not to match public and intragovernmental revenue with costs incurred to produce public and intragovernmental revenue.

In the course of operations, HHS has relationships and financial transactions with numerous federal agencies including the SSA and the Treasury. The SSA determines eligibility for Medicare programs and also deducts Medicare Part-B premiums from Social Security benefit payments for Social Security beneficiaries who elect to enroll in the Medicare Part-B program and elect to deduct their premiums from their benefit checks. SSA then transfers those funds to the Medicare Part-B Trust Fund. The Treasury receives the cumulative excess of Medicare receipts and other financing over outlays and issues interest-bearing securities in exchange for the use of those monies. Medicare Part-D is primarily financed by the General Fund of the Treasury, as well as beneficiary premiums and payments from States.

I. Entity and Non-Entity Assets

Entity assets are assets the reporting entity has authority to use in its operations (i.e., management has the authority to decide how the funds are used), or management is legally obligated to use the funds to meet the entity obligations.

Non-entity assets are assets held by the reporting entity, but not available for use. HHS non-entity assets are composed of delinquent child support payments for the Child Support Enforcement Program, which are withheld from federal tax refunds and interest accrued on over-payments and cost settlements reported by the Medicare contractors.

J. Fund Balance with Treasury (FBWT)

HHS maintains its available funds with the Treasury. The FBWT is available to pay current liabilities and finance authorized purchases. Cash receipts and disbursements are processed by the Treasury and HHS FBWT accounts are reconciled with those of Treasury on a regular basis.

K. Custodial Activity

In accordance with guidance set forth in OMB Circular A-136, HHS reports custodial activities on its Consolidated Balance Sheet. However, HHS does not prepare a separate Statement of Custodial Activity since custodial activities are incidental to its operations and the amounts collected are immaterial.

ACF receives funding from the Internal Revenue Service for outlay to the States for child support. This funding represents delinquent child support payments withheld from federal tax refunds. The FDA custodial activity involves collections of Civil Monetary Penalties (CMP) assessed by the Department of Justice on behalf of the FDA. The FDA is charged with assessing penalties for violations in areas such as illegally manufactured, marketed and distributed animal food and drug products. The CDC custodial activity consists of the collection of interest on outstanding receivables and funds received from debts in collection status.

L. Investments, Net

HHS invests entity Medicare Trust Fund balances in excess of current needs in U.S. securities. The Treasury acts as the fiscal agent for the U.S. Government's investments in securities. Sections 1817 and 1841 of the *Social Security Act* require that Trust Funds not necessary to meet current expenditures be invested in interest-bearing obligations or in obligations guaranteed as to both principal and interest by the U.S. Government. The cash receipts, collected from the public as dedicated collections, are deposited with the Treasury, which uses the cash for general governmental purposes. Treasury securities are issued by the Bureau of Public Debt to the HI and SMI Trust Funds as evidence of their receipt and are reported as an asset for the Trust Funds and a corresponding liability of the Treasury. The Federal Government does not set aside assets to pay future benefits or other expenditures associated with the HI or SMI Trust Funds.

The Treasury securities provide the HI and SMI Trust Funds with authority to draw upon the U.S. Treasury to make future benefit payments or other expenditures. When the Trust Funds require redemption of these securities to make expenditures, the government finances the expenditures by raising taxes, raising other receipts, borrowing from the public or repaying less debt, or curtailing other expenditures. This is the same way that the government finances all expenditures.

The Treasury securities issued and redeemed to the HI and SMI Trust Funds are Non-Marketable (Par Value) securities. These investments are carried at face value as determined by Treasury. Interest income is compounded semi-annually (June and December) by Treasury and at fiscal year-end is adjusted to include an accrual for interest earned from July 1 to September 30 (See Note 4).

The Vaccine Injury Compensation Trust Fund, a dedicated collections fund similar to the HI and SMI Trust Funds, invests in Non-Marketable, Market-Based securities issued by the Bureau of Public Debt in the form of One Day Certificates and Market-Based Bills, Notes and Bonds.

The NIH Gift Funds are invested in Non-Marketable, Market-Based Bills issued by the Bureau of Public Debt. Funds are invested for either a 90 or 180-day period based on the need for funds. No provision is made for unrealized gains or losses on these securities since it is HHS' intent to hold investments to maturity.

The *Children's Health Insurance Program Reauthorization Act* (CHIPRA) established a Child Enrollment Contingency Fund to provide additional funding to States that experience shortfalls in their Children's Health Insurance Programs (CHIP). The *Affordable Care Act* extended the availability of the fund through 2015. This fund is invested in Non-Marketable, Market-Based Bills issued by the Bureau of Public Debt. These investments will be redeemed as funds are needed by the States to cover short-term shortfalls in the program.

M. Accounts Receivable, Net

Accounts Receivable, Net consists of the amounts owed to HHS by other federal agencies and the public for the provision of goods and services, less an allowance for uncollectible amounts on public receivables. Intragovernmental accounts receivable consists of the amounts owed to HHS by other federal agencies for reimbursable work. No allowance for uncollectible amounts is established for intragovernmental accounts receivable because they are considered fully collectible. Accounts Receivable, Net from the public is primarily composed of provider and beneficiary over-payments, Medicare Prescription Drug over-payments, Medicare premiums, CMPs & Other Restitutions, State phased-down contributions, audit disallowances, and the recognition of Medicare Secondary Payer (MSP) accounts receivable.

Accounts Receivable, Net from the public is presented net of an allowance for uncollectible amounts. The allowance is based on past collection experience and an analysis of outstanding balances. For Medicare accounts receivable, HHS calculates the allowance for uncollectible amounts based on the collection activity and the age of the debt for the most current fiscal year, while taking into consideration the average uncollectible percentage for the preceding five years. The Medicaid accounts receivable have been recorded at a net realizable amount based on historical analyses of actual recoveries and the rate of disallowances found in favor of the States.

N. Advances and Accrued Grant Liability

HHS awards grants to various grantees and provides advance payments to meet grantees' cash needs to carry out HHS programs. Advance payments are liquidated upon grantees reporting expenditures on the quarterly *Federal Financial Report*. In some instances, grantees incur expenditures before drawing down funds that, when claimed, would reduce the Advances account to a negative balance. An Accrued Grant Liability occurs when the accrued grant expenses exceed the outstanding advances to grantees.

HHS grants are classified into two categories: "Grants Not Subject to Grant Expense Accrual" and "Grants Subject to Grant Expense Accrual." "Grants Not Subject to Grant Expense Accrual" represents formula grants (also referred to as "block grants") under which grantees provide a variety of services or payments to individuals and local agencies. Expenses are recorded on the cash-basis of accounting, as the grantees draw funds. These grants are funded based on allocations determined by budgets and agreements approved by the sponsoring OPDIV. Therefore, they are not subject to grant expense accrual.

For "Grants Subject to Grant Expense Accrual," commonly referred to as "non-block grants," grantees draw funds based on their estimated cash needs. As grantees report their actual disbursements quarterly, the amounts are recorded as expenses and their advance balances are reduced. At year-end, the OPDIVs report both actual payments made through the fourth quarter and an unreported grant expenditure estimate for the fourth quarter

based on historical spending patterns of the grantees. The year-end accrual estimate equals the estimated fourth quarter disbursements plus an average of two weeks annual expenditures for expenses incurred prior to the cash draw. For the Foster Care Program, the year-end accrual estimate equals the estimated fourth quarter disbursements, plus one-week average of foster care annual expenditures for expenses incurred prior to the cash draw.

Exceptions to the definition of "block" or "non-block" grants for reporting purposes are the Temporary Assistance for Needy Families Program and the Child Care Development Fund Program. These two programs are referred to as "block" grants but, since the programs report expenses to HHS, they are treated as "non-block" grants for the estimate of the grant accrual.

O. Inventory and Related Property, Net

Inventory and Related Property, Net primarily consists of Inventory Held for Sale, Operating Materials and Supplies and Stockpile Materials.

Inventory Held for Sale consists of small equipment and supplies held by the Service and Supply Funds (SSFs) for sale to HHS components and other federal entities. Inventories Held for Sale are valued at historical cost using the weighted average valuation method for the PSC SSF's inventories and using the moving average valuation method for the NIH SSF's inventories.

Operating Materials and Supplies include pharmaceuticals, biological products and other medical supplies used to provide medical services and conduct medical research. They are recorded as assets when purchased and are expensed when consumed. Operating Materials and Supplies are valued at historical cost using the first-in/first-out (FIFO) cost flow assumption.

Stockpile Materials are held in reserve to respond to local and national emergencies. HHS maintains several stockpiles for emergency response purposes, which include the Strategic National Stockpile (SNS), Vaccines for Children (VFC) and Avian Influenza (H5N1). The H5N1 vaccine stockpile is held in reserve to respond to an avian pandemic declaration. The stockpile contains several million doses of vaccine in bulk which are stored and maintained for possible use.

Project BioShield has increased the preparedness of the nation by procuring medical countermeasures that include anthrax vaccine, anthrax antitoxins, botulin antitoxins and blocking and decorporation agents for a radiological event. All stockpiles are valued at historical cost, using various cost flow assumptions, including the FIFO for SNS and specific identification for VFC and H5N1.

P. General Property, Plant and Equipment, Net

The General Property, Plant and Equipment, Net consists of buildings, structures and facilities used for general operations, land acquired for general operating purposes, equipment; assets under capital lease, leasehold improvements, construction-in-progress; and internal use software. The basis for recording purchased Property, Plant and Equipment is full cost, including all costs incurred to bring the Property, Plant and Equipment to a form and location suitable for its intended use and is presented net of accumulated depreciation.

The cost of Property, Plant and Equipment acquired under a capital lease is the amount recognized as a liability for the capital lease at its inception. When property is acquired through a donation, the cost recognized is the estimated fair market value on the date of acquisition. The cost of Property, Plant and Equipment transferred from other federal entities is the transferring entity's net book value. Except for internal use software, HHS capitalizes all Property, Plant and Equipment with an initial acquisition cost of $25,000 or more and an estimated useful life of two years or more.

Property, Plant and Equipment is depreciated using the straight-line method over the estimated useful life of the asset. Land and land rights, including permanent improvements, are not depreciated. Normal maintenance and repair costs are expensed as incurred.

In accordance with SFFAS Number 10, *Accounting for Internal Use Software*, capitalization of internally developed, contractor-developed/commercial off-the-shelf software begins in the software development phase. HHS' capitalization threshold for internal use software costs for appropriated fund accounts is $1 million and the threshold for revolving fund accounts is $500 thousand. Costs below the threshold levels are expensed. Software is amortized using the straight line method over a period of seven to ten years consistent with the estimated life used for planning and acquisition purposes. Capitalized costs include all direct and indirect costs.

Q. Stewardship Property, Plant and Equipment

Stewardship Property, Plant and Equipment consists of stewardship land whose physical properties resemble those of General Property, Plant and Equipment that are traditionally capitalized in the financial statements. In accordance with SFFAS Number 8, *Supplementary Stewardship Reporting*, HHS does not report a related amount on the balance sheet.

HHS' stewardship assets support the IHS day-to-day operations of providing health care to American Indians and Alaskan Natives in remote areas of the country where no other facilities exist.

Indian Trust lands do not meet the definition of Stewardship land (i.e., land other than that acquired for or used in connection with capitalized General Property, Plant and Equipment), but have always been held by the U.S. Government as separate and distinct because of its long-term trust responsibility. IHS has built health care facilities on these Trust lands. Trust lands, when no longer needed by the IHS in connection with its general use Property, Plant and Equipment, must be returned to the Department of the Interior's Bureau of Indian Affairs for continuing trust responsibilities and oversight.

HHS asset accountability reports differentiate Indian Trust land parcels from General Property, Plant and Equipment situated thereon. The Required Supplementary Information section provides additional information for Stewardship Property, Plant and Equipment.

R. Liabilities

Liabilities are recognized for amounts of probable and measurable future outflows or other sacrifices of resources as a result of past transactions or events. Since HHS is a component of the U.S. Government, a sovereign entity, its liabilities cannot be liquidated without legislation that provides resources to do so. Payments of all liabilities other than contracts can be abrogated by the sovereign entity. In accordance with public law and existing federal accounting standards, no liability is recognized for future payments to be made on behalf of current workers contributing to the Medicare HI Trust Fund, since liabilities are only those items that are present obligations of the government. HHS' liabilities are classified as covered by budgetary resources or not covered by budgetary resources.

Liabilities Covered by Budgetary Resources

Available budgetary resources include new budget authority, spending authority from offsetting collections, recoveries of expired budget authority, unobligated balances of budgetary resources at the beginning of the year, permanent indefinite appropriation and borrowing authority.

Liabilities Not Covered by Budgetary Resources

Sometimes funding has not yet been made available through Congressional appropriation or current earnings. The major liabilities in this category include contingencies, employee annual leave earned, but not taken, and amounts billed by the Department of Labor (DOL) for the *Federal Employees' Compensation Act* (FECA) of 1916 (5 U.S.C.

751) disability payments. The actuarial FECA liability determined by the DOL but not yet billed is also included in this category.

S. Accounts Payable

Accounts Payable primarily consists of amounts due for goods and services received, progress in contract performance, interest due on accounts payable and other miscellaneous payables.

T. Fiduciary Activities

Effective FY 2009, the SFFAS Number 31, *Accounting for Fiduciary Activities*, requires federal entities to distinguish the information relating to fiduciary activities of the federal entity from all other activities. The fiduciary activities are Federal Government activities that relate to the collection or receipt and the subsequent management, protection, accounting, investment and disposition of cash or other assets in which non-federal individuals or entities have an ownership interest that the Federal Government must uphold. HHS does not have reportable activities as defined by SFFAS Number 31.

U. Accrued Payroll and Benefits

Accrued Payroll and Benefits consists of salaries, wages, leave and benefits earned by employees but not disbursed at the end of the reporting period. A liability for annual and other vested compensatory leave is accrued as earned and reduced when taken. At the end of each fiscal year, the balance in the accrued annual leave liability account is adjusted to reflect current pay rates. Annual leave earned but not taken is considered an unfunded liability since it will be funded from future appropriations when it is actually taken by employees. Sick leave and other types of leave are not accrued and are expensed when taken. Intragovernmental Accrued Payroll and Benefits consists primarily of HHS FECA liability.

V. Entitlement Benefits Due and Payable

Entitlement Benefits Due and Payable represents a liability for Medicare and Medicaid owed to the public for medical services Incurred But Not Reported (IBNR) as of the end of the reporting period. The Medicare and Medicaid programs are the largest entitlement programs in HHS.

Medicare

The Medicare liability is developed by the CMS Office of the Actuary and includes:

- An estimate of claims incurred that may or may not have been submitted to the Medicare contractors, but not yet approved for payment;
- Actual claims approved for payment by the Medicare contractors for which checks have not yet been issued;
- Checks issued by the Medicare contractors in payment of claims that have not yet been cashed by payees;
- Periodic interim payments for services rendered in the current fiscal year but paid in the subsequent fiscal year;
- An estimate of retroactive settlements of cost reports submitted to the Medicare contractors by health care providers.

HHS develops estimates for medical costs IBNR using an actuarial process that is consistently applied, centrally controlled and automated. The actuarial models consider factors such as time from date of service to claim receipt, claim backlogs, medical care professional contract rate changes, medical care consumption and other medical cost trends. HHS estimates liabilities for physician, hospital and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies.

Each period, HHS re-examines previously established medical cost payable estimates based on actual claim submissions and other changes in facts and circumstances. As the liability estimates recorded in prior periods become more exact, HHS adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. In every reporting period, HHS operating results include the effects of more completely developed Medicare benefits payable estimates associated with previously reported periods.

Medicaid

The Medicaid estimate represents the net federal share of expenses incurred by the States but not yet reported to HHS. This estimate is developed based on historical relationships between prior Medicaid net payables and current Medicaid activity.

W. Federal Employee and Veterans' Benefits

HHS administers the Public Health Service (PHS) Commissioned Corps Retirement System (authorized by the *Public Health Service Act*), a defined non-contributory benefit plan, for its active duty officers, retiree annuitants and survivors. The plan does not have accumulated assets and funding is provided entirely on a pay-as-you-go basis by Congressional appropriation. HHS records the present value of the Commissioned Corps pension and post-retirement health benefits.

The liability for federal employee and veterans' benefits also includes a liability for actual and estimated future payments for workers' compensation pursuant to the FECA. The FECA provides income and medical cost protection to federal employees injured on the job or who sustained a work-related occupational disease. It also covers beneficiaries of employees whose deaths are attributable to job-related injury or occupational disease. The FECA program is administered by the DOL which pays valid claims and subsequently bills the employing federal agency. The FECA liability consists of two components: (1) actual claims billed by the DOL to agencies but not yet paid; and (2) an estimated liability for future benefit payments as a result of past events such as death, disability and medical costs.

Most HHS employees participate in the Civil Service Retirement System (CSRS), a defined benefit plan, or the Federal Employees' Retirement System (FERS), a defined benefit and contribution plan. For employees covered under CSRS, the Department contributes a fixed percentage of pay. Most employees hired after December 31, 1983, are automatically covered by the FERS. For employees covered under FERS, HHS contributes the employer's matching share for Social Security and Medicare Insurance. FERS offers a Thrift Savings Plan into which HHS automatically contributes one percent of employee pay and matches the first three percent of employee contributions dollar for dollar. Each dollar of the employee's next two percent of basic pay is matched at 50 cents on the dollar.

The Office of Personnel Management is the administering agency for both of these benefit plans and, thus, reports CSRS and FERS assets, accumulated plan benefits and unfunded liabilities applicable to federal employees. Therefore, HHS does not recognize any liability on its Consolidated Balance Sheet for pensions, other retirement benefits and other post-employment benefits of its federal employees with the exception of the PHS Commissioned Corps. HHS does, however, recognize an expense in the Consolidated Statement of Net Cost and an imputed financing source for the annualized unfunded portion of pension and post-retirement benefits in the Consolidated Statement of Changes in Net Position. Gains or losses from changes in assumptions in the PHS Commissioned Corps retirement benefits are recognized at year-end.

X. Contingencies

A loss contingency is an existing condition, situation or set of circumstances involving uncertainty as to possible loss to HHS. The uncertainty ultimately should be resolved when one or more future events occur or fail to occur. The likelihood that the future event or events will confirm the loss or the incurrence of a liability can range from probable to remote. SFFAS Number 5, *Accounting for Liabilities of the Federal Government*, as amended by SFFAS Number 12, *Recognition of Contingent Liabilities from Litigation*, contains the criteria for recognition and disclosure of contingent liabilities.

HHS and its components could be parties to various administrative proceedings, legal actions and claims brought by or against it. With the exception of pending, threatened or potential litigation, a contingent liability is recognized when a past transaction or event has occurred, a future outflow or other sacrifice of resources is more likely than not to occur and the related future outflow or sacrifice of resources is measurable. For pending, threatened or potential litigation, a contingent liability is recognized when a past transaction or event has occurred, a future outflow or other sacrifice of resources is likely to occur and the related future outflow or sacrifice of resources is measurable.

Y. Statement of Social Insurance

The Statement of Social Insurance (SOSI) presents the projected 75-year actuarial present values of the income and expenditures of the HI and SMI Trust Funds. Future expenditures are expected to arise from the health care payment provisions specified in current law for current and future program participants and from associated administrative expenses. Actuarial present values are computed on the basis of the intermediate set of assumptions specified in the *Annual Report of the Medicare Board of Trustees*. These assumptions represent the Trustees' best estimate of likely future economic, demographic and health care-specific conditions. The projected potential future income and expenditures under current law are not included in the accompanying Consolidated Balance Sheet, Statements of Net Cost and Changes in Net Position or Combined Statement of Budgetary Resources.

In order to make projections regarding the future financial status of the HI and SMI Trust Funds, various assumptions have to be made. As stated previously, the estimates presented here are based on the assumption that the Trust Funds will continue to operate under the law in effect May 31, 2013. In addition, the estimates depend on many economic, demographic and health care-specific assumptions. These include changes in per beneficiary health care cost, wages, the gross domestic product (GDP), the consumer price index (CPI), fertility rates, mortality rates, immigration rates and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period. The assumed growth rates for per beneficiary health care costs vary throughout the projection period.

The assumptions underlying the SOSI actuarial projections are drawn from the *Social Security and Medicare Trustees Reports for 2013*. Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization and intensity of each type of service.

Z. Affordable Care Act

In FY 2010, President Barack Obama signed health insurance reform legislation giving Americans more control over their health care. The *Patient Protection and Affordable Care Act* and the *Health Care and Education Reconciliation Act* collectively referred to as the *Affordable Care Act* ensures that all Americans have access to quality, affordable health care, while helping to reduce health care costs. Further information is available at http://www.healthcare.gov.

Under the *Affordable Care Act*, HHS was authorized to execute several new programs, which include the Pre-existing Condition Insurance Plan Program, Early Retiree Reinsurance Program, Health Insurance Marketplaces and the CO-OP Program. A brief description of these programs and their impact on the financial statements is presented below.

Pre-existing Condition Insurance Plan Program

This program offers coverage to uninsured Americans who have been unable to obtain health coverage because of a pre-existing health condition. This program is administered directly by States or by the Federal Government in those states that do not operate their own programs. Congress appropriated $5 billion for the life of this interim program, which enables coverage until the Marketplaces become operational in 2014.

The *Affordable Care Act* provides the HHS Secretary significant authorities to ensure the financial sustainability of this program, including, under Section 1101 Paragraph (g) (2), the authority to eliminate deficits under the program if available funds are less than estimated expenses. The Secretary also has the authority under Paragraph (g) (4) to stop taking applications to comply with funding limitations, and in February 2013, CMS announced it would stop accepting applications in both the Federally-run and State-run programs.

Early Retiree Reinsurance Program

Pursuant to the *Affordable Care Act*, HHS established a temporary reinsurance program to reimburse a portion of the employer cost of providing health insurance coverage for early retirees. The *Affordable Care Act* imposes limitations on the amounts of such reimbursements per claim. Congress appropriated $5 billion for the life of this program. The *Affordable Care Act* authorizes the HHS Secretary to stop taking applications for participation in the program based on the availability of funding. On June 29, 2010, HHS began accepting applications from employers. The program permits approved applicants to submit for reimbursement expenses incurred after June 1, 2010. Based on the large number of approved applications and the rate of reimbursement, and in anticipation of the complete distribution of Early Retiree Reinsurance Program (ERRP) funds, the program ceased accepting applications for participation in the program on May 6, 2011. The program will end in 2014, and CMS issued a Federal Register notice on March 21, 2012, indicating that plan sponsors are expected to use ERRP funds by December 31, 2014.

Health Insurance Marketplaces

Grants have been provided to the States to establish Affordable Insurance Exchanges, better known as Health Insurance Marketplaces. As of September 30, 2013, HHS has awarded about $4.1 billion to date in cumulative Marketplace grants to states, including Establishment grants to 37 states and D.C.

Consumer Operated and Oriented Plan Program

The CO-OP Program fosters qualified non-profit health insurance issuers created to offer qualified health plans to the individual and small group markets. Under this program, HHS provides assistance to organizations applying to become qualified non-profit health insurance issuers through loans to assist in meeting start-up costs and to assist the applicant meet State solvency requirements. In accordance with regulations as well as legislative requirements, start-up loans shall be repaid within five years and the solvency loans within 15 years after disbursement, considering State reserve requirements and solvency regulations. Congress appropriated $6 billion to carry out this program under the *Affordable Care Act*. In the last two years, Congress has rescinded $4.9 billion from the original appropriations. The FY 2011 April Continuing Resolution rescinded $2.2 billion, the FY 2012 December Omnibus Appropriation rescinded an additional $0.4 billion, and the American Taxpayer Relief Act rescinded $2.3 billion. CO-OP Program loans have been awarded in 24 states.

Note 2. Entity and Non-Entity Assets (in Millions)

	2013	2012
Non-Entity Intragovernmental Assets		
Fund Balance with Treasury	$ -	$ 1
Accounts Receivable	11	6
Total Non-Entity Intragovernmental Assets	11	7
Accounts Receivable With the Public	30	22
Total Non-Entity Assets	41	29
Total Entity Assets	470,214	530,624
Total Assets	$ 470,255	$ 530,653

Note 3. Fund Balance with Treasury (in Millions)

Fund Balance with Treasury	2013	2012
Trust Funds	$ 9,916	$ 23,544
Revolving Funds	1,263	1,205
Appropriated Funds	147,965	171,893
Other Funds	48	706
Total	$ 159,192	$ 197,348

Status of Fund Balance with Treasury		
Unobligated Balance		
Available	$ 32,092	$ 75,237
Unavailable	9,596	8,718
Obligated Balance not yet Disbursed	178,348	170,666
Non-Budgetary Fund Balance with Treasury	(60,844)	(57,273)
Total	$ 159,192	$ 197,348

Other Funds include balances in deposit, suspense and related non-spending accounts. The Unobligated Balance includes funds that are restricted for future use and not apportioned for current use of $13.0 billion and $16.3 billion as of September 30, 2013 and September 30, 2012, respectively. The restricted amount is primarily for the *Affordable Care Act* programs, Children's Health Insurance Program, CMS Program Management, State Grants and Demonstrations and the Recovery Act Health Information Technology Program. In FY 2013, $21.5 billion was apportioned under the *Affordable Care Act*, of which $9.6 billion is restricted for future use.

The Non-Budgetary FBWT negative balances reported for September 30, 2013 and 2012 are primarily due to CMS Medicare Trust Funds temporarily precluded from obligation.

Note 4. Investments, Net (in Millions)

2013	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 273,395	$ -	$ 2,778	$ 276,173	$ 276,173
Non-Marketable: Market-Based	5,711	(191)	30	5,550	5,550
Total, Intragovernmental	$ 279,106	$ (191)	$ 2,808	$ 281,723	$ 281,723

2012	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 297,616	$ -	$ 3,193	$ 300,809	$ 300,809
Non-Marketable: Market-Based	5,692	(156)	36	5,572	5,572
Total, Intragovernmental	$ 303,308	$ (156)	$ 3,229	$ 306,381	$ 306,381

HHS investments consist primarily of Medicare Trust Fund (funds from dedicated collections) investments. Medicare Non-Marketable: Par Value Bonds are carried at face value and have maturity dates ranging from June 30, 2014 through June 30, 2026, with interest rates ranging from 1.75 percent to 6.5 percent. Medicare Non-Marketable: Par Value Certificates of Indebtedness mature on June 30, 2014, with an interest rate of 2.375 percent.

Securities held by the Vaccine Injury Compensation Trust Fund (funds from dedicated collections) will mature through fiscal year 2019. The Market-Based Notes paid from 1.0 percent to 4.125 percent during October 1, 2012 to September 30, 2013 and 1.875 percent to 4.125 percent during October 1, 2011 to September 30, 2012. The Market-Based Bonds pay 9.125 percent through FY 2018.

The Market Based Bills held in the NIH gift funds during the fiscal year ended September 30, 2013, yielded from 0.04 percent to 0.15 percent depending on the date purchased and the time to maturity.

The investments held by the CHIP Child Enrollment Contingency Fund in the amount of $2.1 billion as of September 30, 2013, are short term Non-Marketable Market-Based Bills purchased at a discount which are fully amortized at the maturity date.

Note 5. Accounts Receivable, Net (in Millions)

2013	Accounts Receivable Principal	Interest Receivable	Penalties, Fines, & Admin Fees Receivable	Accounts Receivable, Gross	Allowance	Net HHS Receivables
Intragovernmental						
Entity	$ 3,638	$ -	$ -	$ 3,638	$ -	$ 3,638
Non-Entity	11	-	-	11	-	11
Total, Intragovernmental	$ 3,649	$ -	$ -	$ 3,649	$ -	$ 3,649
With the Public						
Entity						
Medicare	$ 8,811	$ -	$ -	$ 8,811	$ (1,595)	$ 7,216
Other	4,580	13	2	4,595	(908)	3,687
Non-Entity	52	2	-	54	(24)	30
Total With the Public	$ 13,443	$ 15	$ 2	$ 13,460	$ (2,527)	$ 10,933

2012	Accounts Receivable Principal	Interest Receivable	Penalties, Fines, & Admin Fees Receivable	Accounts Receivable, Gross	Allowance	Net HHS Receivables
Intragovernmental						
Entity	$ 814	$ -	$ -	$ 814	$ -	$ 814
Non-Entity	6	-	-	6	-	6
Total, Intragovernmental	$ 820	$ -	$ -	$ 820	$ -	$ 820
With the Public						
Entity						
Medicare	$ 9,014	$ -	$ -	$ 9,014	$ (1,408)	$ 7,606
Other	3,882	11	3	3,896	(581)	3,315
Non-Entity	50	5	-	55	(33)	22
Total With the Public	$ 12,946	$ 16	$ 3	$ 12,965	$ (2,022)	$ 10,943

Note 6. Inventory and Related Property, Net (in Millions)

	2013	2012
Inventory Held for Current Sale, Net	$ 8	$ 12
Operating Materials and Supplies Held for Use	113	129
Stockpile Materials Held for Emergency or Contingency	8,481	7,931
Inventory and Related Property, Net	$ 8,602	$ 8,072

Note 7. General Property, Plant and Equipment, Net (in Millions)

2013

	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	$ 52	$ -	$ 52
Construction in Progress	-	-	756	-	756
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	5,747	(2,448)	3,299
Equipment	Straight Line	3-20 Yrs	1,861	(1,087)	774
Internal Use Software	Straight Line	7-10 Yrs	1,167	(774)	393
Assets Under Capital Lease (Note 15)	Straight Line	1-30 Yrs	119	(50)	69
Leasehold Improvements	Straight Line	*Life of Lease	50	(29)	21
Totals			$ 9,752	$ (4,388)	$ 5,364

2012

	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	$ 52	$ -	$ 52
Construction in Progress	-	-	704	-	704
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	5,648	(2,282)	3,366
Equipment	Straight Line	3-20 Yrs	1,783	(999)	784
Internal Use Software	Straight Line	7-10 Yrs	1,131	(732)	399
Assets Under Capital Lease (Note 15)	Straight Line	1-30 Yrs	119	(46)	73
Leasehold Improvements	Straight Line	*Life of Lease	49	(26)	23
Totals			$ 9,486	$ (4,085)	$ 5,401

*7 to 15 years or the life of the lease, whichever is shorter.

Note 8. Advances (in Millions)

	2013	2012
Intragovernmental		
Advances to Other Federal Entities	$ 103	$ 48
With the Public		
Travel Advances & Emergency Employee Salary Advances	$ 1	$ 1
Part D Prescription Drug Plan	-	1,188
Other Prepayments & Deferred Charges	33	55
Total With the Public	$ 34	$ 1,244

The decrease in advances is primarily due to the advance payments of $1.2 billion made in September of FY 2012 for Part D Prescription Drug Plan services provided in October of FY 2013. This advance payment was not necessary in FY 2013.

Note 9. Liabilities Not Covered by Budgetary Resources (in Millions)

	2013	2012
Intragovernmental		
Accrued Payroll and Benefits	$ 63	$ 62
Other	174	170
Total Intragovernmental	$ 237	$ 232
Federal Employee and Veterans' Benefits (Note 11)	11,566	11,008
Accrued Payroll and Benefits	603	638
Contingencies and Commitments (Note 14)	8,900	6,766
Other	165	110
Total Liabilities Not Covered by Budgetary Resources	$ 21,471	$ 18,754
Total Liabilities Covered by Budgetary Resources	86,038	80,737
Total Liabilities	$ 107,509	$ 99,491

Note 10. Entitlement Benefits Due and Payable (in Millions)

	2013	2012
Medicare	$ 48,614	$ 46,436
Medicaid	27,588	24,955
Other	1,075	1,102
Totals	$ 77,277	$ 72,493

Medicare benefits payable consists of a $38.7 billion estimate ($38.8 billion in FY 2012) of Medicare services incurred, but not paid as of September 30, 2013, calculated by the CMS Office of the Actuary.

Medicare Advantage and Prescription Drug Program benefits payable consists of $8.2 billion in FY 2013 ($5.3 billion in FY 2012) consists of a $4.5 billion estimate ($2.8 billion in FY 2012) for amounts owed to plans relating to risk and other payment-related adjustments and $3.7 billion in FY 2013 ($2.5 billion in FY 2012) owed to plans after the completion of the Prescription Drug payment reconciliation.

The Medicare Retiree Drug Subsidy (RDS) consists of a $1.7 billion estimate ($2.4 billion in FY 2012) of payments to plan sponsors of retiree prescription drug coverage incurred but not paid as of September 30, 2013. As part of the *Medicare Modernization Act*, the RDS program makes subsidy payments available to sponsors of retiree prescription drug coverage. The program is designed to strengthen employer- and union-based retiree prescription drug plans.

Medicaid benefits payable of $27.6 billion as of September 30, 2013 ($25.0 billion in FY 2012) is an estimate of the net federal share of expenses that have been incurred by the states but not yet reported to HHS. This estimate incorporates claim activity tracked under *Recovery Act* of $0.2 billion ($0.2 billion in FY 2012). An estimated CHIP benefits payable of $0.7 billion has been recorded as of September 30, 2013, ($0.7 billion in FY 2012) for the net federal share of expenses that have been incurred by the states but not yet reported to HHS as of September 30, 2013.

Note 11. Federal Employee and Veterans' Benefits (in Millions)

	2013	2012
With the Public		
Liabilities Not Covered by Budgetary Resources		
PHS Commissioned Corp Pension Liability	$ 10,712	$ 10,131
PHS Commissioned Corp Post-retirement Health Benefits	561	603
Workers' Compensation Benefits (Actuarial FECA Liability)	293	274
Total, Federal Employee and Veterans' Benefits	$ 11,566	$ 11,008

Public Health Service (PHS) Commissioned Corps

HHS administers the PHS Commissioned Corps Retirement System for 6,778 active duty officers and 6,330 retiree annuitants and survivors. As of September 30, 2013, the actuarial accrued liability for the retirement benefit plan was $10.7 billion and $0.6 billion for non-Medicare coverage of the Post-Retirement Medical Plan.

The Commission Corp Retirement System and Post-Retirement Benefits are not funded. Therefore, in accordance with SFFAS Number 33, the discount rate should be based on long-term assumptions, for marketable securities (such as Treasury marketable securities) of similar maturity to the period over which the payments are to be made. The discount rates should be matched with the expected timing of the associated expected cashflow. A single discount rate may be used for all the projected cashflows, if the resulting present value is not materially different than the resulting present value using multiple rates.

The significant assumptions used in the calculation of the pension and medical program liability, as of September 30, 2013 and September 30, 2012, were:

	2013	2012
Interest on federal securities	4.68 percent	4.88 percent
Annual basic pay scale increase	2.90 percent	2.92 percent
Annual inflation	2.40 percent	2.42 percent

The following shows key valuation results as of September 30, 2013 and 2012, in conformance with the actuarial reporting standards set forth in the SFFAS Number 5, *Accounting for Liabilities of the Federal Government* and SFFAS Number 33, *Pensions, Other Retirement Benefits and Other Postemployment Benefits: Reporting the Gains and Losses from Changes in Assumptions and Selecting Discount Rates and Valuation Dates*. The valuation is based upon the current plan provisions, membership data collected as of June 30, 2013 and actuarial assumptions. The September 30, 2013 valuation includes an increase in liabilities of $539 million resulting from an increase in costs and an actuarial loss from changes in assumptions and experience. Volatility of the discount rate significantly affects the liabilities for these benefits. Therefore, to mitigate the impact of this volatility, SFFAS Number 33 also provides for the use of historical average rates to prevent the undue influence of current or near term rates.

	2013	2012
Beginning Liability Balance	$ 10,734	$ 9,950
Expense		
Normal Cost	$ 263	$ 240
Interest on the liability balance	491	475
Actuarial (Gain)/Loss		
From experience	(18)	182
From assumption changes		
Change in discount rate assumption	282	294
Change in inflation/salary increase assumption	(29)	(87)
Change in Others	(5)	108
Net Actuarial (Gain)/Loss	230	497
Total expense	$ 984	$ 1,212
Less amounts paid	(445)	(428)
Ending Liability Balance	$ 11,273	$ 10,734

Workers' Compensation Benefits

The actuarial liability for future workers' compensation benefits includes the expected liability for death, disability, medical and miscellaneous costs for approved compensation cases, plus a component for incurred but not reported claims. The liability utilizes historical benefit payment patterns to predict the ultimate payment related to that period. In FY 2013, the fund effected a change in accounting estimate to refine the methodology used for selecting the interest rate assumptions and enhance matching between the timing of cash flows and interest rates. For FY 2013, projected annual payments were discounted to present value based on OMB's interest rate assumptions which were interpolated to reflect the average duration in years for income payments and medical

payments. In FY 2012 and prior years, these projected annual benefit payments were discounted to present value using OMB's economic assumptions for 10-year Treasury notes and bonds. Interest rate assumptions utilized for discounting as of September 30, 2013 and September 30, 2012 appear below.

	2013	2012
Wage Benefits	2.727% in Year 1 3.127% in Year 2 and thereafter	2.293% in Year 1 3.138% in Year 2 and thereafter
Medical Benefits	2.334% in Year 1 2.860% in Year 2 and thereafter	2.293% in Year 1 3.138% in Year 2 and thereafter

To provide specifically for the effects of inflation on the liability for future workers' compensation benefits, wage inflation factors, cost of living adjustments (COLA) and medical inflation factors such as consumer price index-medical (CPIM) are applied to the calculations for projected future benefits. These factors are also used to adjust historical payments to current year dollars. The anticipated percentages for COLA and CPIM used in projections are:

FY	COLA	CPIM
2013	N/A	N/A
2014	1.67%	3.46%
2015	1.80%	3.82%
2016	2.20%	3.83%
2017	2.20%	3.82%
2018	2.20%	3.82%

Note 12. Accrued Grant Liability (in Millions)

	2013	2012
Estimated Accrual for Amounts Due to Grantees	$ 22,410	$ 21,994
Offsetting Grant Advances	(18,461)	(18,246)
Net Accrued Grant Liability	$ 3,949	$ 3,748

Note 13. Other Liabilities (in Millions)

	2013		2012	
	Intra-governmental	With the Public	Intra-governmental	With the Public
Accrued Payroll & Benefits	$ 101	$ 983	$ 115	$ 1,103
Advances from Others	360	98	315	125
Deferred Revenue	-	445	-	455
Capital Lease Liability (Note 15)	59	19	63	20
Custodial Liabilities	930	18	736	15
Other	559	1,018	201	1,244
Total Other Liabilities	$ 2,009	$ 2,581	$ 1,430	$ 2,962

Note 14. Contingencies and Commitments

HHS is a party in various administrative proceedings, legal actions and tort claims which may ultimately result in settlements or decisions adverse to the Federal Government. HHS has accrued contingent liabilities where a loss is determined to be probable and the amount can be estimated. Other contingencies exist where losses are reasonably possible and an estimate can be determined or an estimate of the range of possible liability has been determined. Selected contingencies and commitments are described below.

Medicaid Audit and Program Disallowances

The Medicaid amount of $6.1 billion ($3.9 billion in FY 2012) consists of Medicaid audit and program disallowances of $3.0 billion ($1.9 billion in FY 2012) and of $3.1 billion ($2.0 billion in FY 2012) for reimbursement of State Plan amendments. Contingent liabilities have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the States. In all cases, the funds have been returned to HHS. HHS will be required to pay these amounts if the appeals are decided in favor of the States. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a State. There are also outstanding reviews of the State expenditures in which a final determination has not been made.

Appeals at the Provider Reimbursement Review Board

Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. However, historical cases that have been appealed and settled by the PRRB are considered in the development of the actuarial Medicare IBNR liability, resulting in a projected liability for the 7,124 cases (5,041 in FY 2012) remaining on appeal as of September 30, 2013. In FY 2013, a total of 3,907 new cases were filed (652 in FY 2012). The PRRB rendered decisions on 210 cases in FY 2013 (98 in FY 2012); and 1,623 additional cases (2,215 in FY 2012) were dismissed, withdrawn or settled prior to an appeal hearing. The PRRB receives no information on the value of cases that are settled prior to a hearing.

Other Accrued Contingent Liabilities

The U.S. Supreme Court decision in Salazar v. Ramah Navajo Chapter, dated June 18, 2012, is likely to result in increased claims against the Indian Health Service. Tribes are expected to file claims for prior years and seek to consolidate their claims in a class action lawsuit. It is not clear if these will be filed as administrative cases or filed in Federal District Court. An estimated loss relating to this matter is accrued in the financial statements.

The Vaccine Injury Compensation Program is administered by HRSA and provides compensation for vaccine-related injury or death. A contingent liability has been accrued in the financial statements for the estimated future payment of injury claims.

Obligations Related to Canceled Appropriations

Payments may be required of up to one percent of current year appropriations for valid obligations incurred against prior year appropriations that have been canceled pursuant to the *National Defense Authorization Act*. The total potential payments related to canceled appropriations are estimated at $1.1 billion as of both September 30, 2013 and 2012.

Note 15. Leases (in Millions)

Capital Leases

HHS has entered into various capital leases with private entities and with the General Services Administration (GSA) for offices and laboratory space. Lease terms vary from one to 30 years. Capitalized assets acquired under capital lease agreements and the related liabilities are reported at the present value of the minimum lease payments. Assets under Capital Lease amounts are reported in Note 7, General Property, Plant and Equipment.

Operating Leases

HHS has commitments under various operating leases with private entities and GSA for offices, laboratory space and land. Leases with private entities have initial or remaining non-cancelable lease terms from 1 to 50 years. The GSA leases, in general, are cancelable with 120 days' notice and not included in the table below. Under an operating lease, the cost of the lease is expensed as incurred.

Future Minimum Payments

	2013	2012
Year 1	$ 89	$ 85
Year 2	93	81
Year 3	90	81
Year 4	69	80
Year 5	70	79
After 5 Years	444	482
Total Operating Lease Liability	$ 855	$ 888

Note 16. Revenue (in Millions)

2013 Consolidated Gross Cost and Exchange Revenue by Budget Function Classification

	Education Training & Social Services	Health	Medicare	Income Security	OPDIV Combined Totals	Intra-HHS Eliminations	Consolidated Totals
Intragovernmental							
Gross Cost	$ 141	$ 5,736	$ 1,022	$ 56	$ 6,955	$ (2,684)	$ 4,271
Exchange Revenue	(38)	(3,179)	(43)	(10)	(3,270)	2,495	(775)
Net Cost, *Intragovernmental*	$ 103	$ 2,557	$ 979	$ 46	$ 3,685	$ (189)	$ 3,496
With the Public							
Gross Cost	$ 13,556	$ 347,006	$ 566,826	$ 38,318	$ 965,706	$ -	$ 965,706
Exchange Revenue	-	(3,704)	(69,229)	(19)	(72,952)	-	(72,952)
Net Cost, *With the Public*	$ 13,556	$ 343,302	$ 497,597	$ 38,299	$ 892,754	$ -	$ 892,754
Total Gross Cost	$ 13,697	$ 352,742	$ 567,848	$ 38,374	$ 972,661	$ (2,684)	$ 969,977
Total Exchange Revenue	(38)	(6,883)	(69,272)	(29)	(76,222)	2,495	(73,727)
Total Net Cost of Operations	$ 13,659	$ 345,859	$ 498,576	$ 38,345	$ 896,439	$ (189)	$ 896,250

2012 Consolidated Gross Cost and Exchange Revenue by Budget Function Classification

	Education Training & Social Services	Health	Medicare	Income Security	OPDIV Combined Totals	Intra-HHS Eliminations	Consolidated Totals
Intragovernmental							
Gross Cost	$ 108	$ 5,809	$ 1,013	$ 35	$ 6,965	$ (2,660)	$ 4,305
Exchange Revenue	(42)	(3,080)	(19)	(9)	(3,150)	2,502	(648)
Net Cost, *Intragovernmental*	$ 66	$ 2,729	$ 994	$ 26	$ 3,815	$ (158)	$ 3,657
With the Public							
Gross Cost	$ 13,240	$ 327,474	$ 541,532	$ 37,298	$ 919,544	$ -	$ 919,544
Exchange Revenue	(2)	(2,808)	(64,839)	(5)	(67,654)	-	(67,654)
Net Cost, *With the Public*	$ 13,238	$ 324,666	$ 476,693	$ 37,293	$ 851,890	$ -	$ 851,890
Total Gross Cost	$ 13,348	$ 333,283	$ 542,545	$ 37,333	$ 926,509	$ (2,660)	$ 923,849
Total Exchange Revenue	(44)	(5,888)	(64,858)	(14)	(70,804)	2,502	(68,302)
Total Net Cost of Operations	$ 13,304	$ 327,395	$ 477,687	$ 37,319	$ 855,705	$ (158)	$ 855,547

Exchange Revenue

HHS recognizes its revenue from exchange transactions when goods and services are provided. Total exchange revenue was $73.7 billion and $68.3 billion through September 30, 2013 and 2012, respectively. HHS' exchange revenue consists primarily of Medicare premiums collected from beneficiaries. HHS also charges user fees and collects revenues related to reimbursable agreements with other government entities.

Note 17. Terms of Borrowing Authority Used and Available Borrowing Authority

HHS has indefinite borrowing authority for direct and guaranteed loan programs discussed in Note 1 Section G.

Requirements for Repayments of Borrowings

Borrowings are repaid on nonexpenditure transfers as maturity dates become due. For financing accounts, maturity dates are based on the period of time used in the subsidy calculation, not the contractual term of the loans. There has been repayment of debt in the amount of $0.2 billion FY 2013 (none in FY 2012). As of September 30, 2013, HHS had borrowing authority available of $0.2 billion ($3.1 billion in FY 2012).

Financing Sources for Repayments of Borrowings

HHS will use interest received as well as principal repayments on direct loans to repay debt in the non-budgetary direct loan program financing accounts. HHS will also use residual unobligated balances, where applicable, as another source for repayment.

Other Terms of Borrowing Authority Used

In general, borrowings are for periods of between one year and approximately 50 years depending upon the loan program/cohort. Interest rates on borrowings in the financing accounts are assigned on the basis of the Treasury rate in effect during the period of loan disbursements. Some individual loans are disbursed over several quarters or years. Consequently, several interest rates can be applicable to an individual loan. Thus, a single weighted average interest rate is maintained for each cohort and is adjusted each year until the disbursements for the cohort have been made. Each year, the current average annual interest rate is weighted by current year disbursements and merged with the prior years' weighted average to calculate a new weighted average.

Non-Budgetary Credit Reform Financing Account

The negative balance for borrowing authority of $2.1 billion under the FY 2013 Non-Budgetary Credit Reform Financing Account column on the Combined Statement of Budgetary Resources reflects an adjustment occurring in the current year to return FY 2012 indefinite borrowing authority of $2.2 billion that should have been made at September 30, 2012. In addition, the negative balance of $0.7 billion for spending authority from offsetting collections under that column represents a reduction to unfilled orders for a $0.9 billion overstatement at September 30, 2012. These adjustments were immaterial to the HHS financial statements and do not warrant a restatement.

Note 18. Apportionment Categories of Obligations Incurred and Undelivered Orders (in Millions)

	2013		
	Direct	Reimbursable	Total
Category A (Distributed by Quarter)	$ 90,955	$ 7,287	$ 98,242
Category B (Restricted and Distributed by Activity)	637,450	1,973	639,423
Exempt from Apportionment	544,371	-	544,371
Total Obligations Incurred	$ 1,272,776	$ 9,260	$ 1,282,036

	2012		
	Direct	Reimbursable	Total
Category A (Distributed by Quarter)	$ 94,380	$ 7,310	$ 101,690
Category B (Restricted and Distributed by Activity)	590,300	936	591,236
Exempt from Apportionment	512,954	-	512,954
Total Obligations Incurred	$ 1,197,634	$ 8,246	$ 1,205,880

Obligations incurred consist of expended authority and the change in undelivered orders. OMB has exempted CMS from the OMB Circular Number A-11*, Preparation, Submission and Execution of the Budget*, requirement to report Medicare's refunds of prior year obligations separately from refunds of current year obligations on the SF-133, *Report on Budget Execution and Budgetary Resources*.

Undelivered Orders include obligations that have been issued but are not yet drawn down and goods and services ordered that have not been received. HHS reported $93.3 billion of budgetary resources obligated for undelivered orders as of September 30, 2013 and $96.8 billion as of September 30, 2012.

Note 19. Legal Arrangements Affecting Use of Unobligated Balances

The unobligated balances at year end on the Combined Statement of Budgetary Resources consist of trust funds, appropriated funds, revolving funds, management funds, gift funds, Cooperative Research and Development Agreement (CRADA) funds and royalty funds. Annual appropriations are available for new obligations in the year of appropriation and for adjustments to valid obligations for five subsequent years. Other appropriations are available for obligation for multiple years or until expended based on Congressional authority.

All trust fund receipts collected in the fiscal year are reported as new budget authority in the Combined Statement of Budgetary Resources. The portion of trust fund receipts collected in the fiscal year that exceeds the amount needed to pay benefits and other valid obligations in that fiscal year is precluded by law from being available for obligation. This excess of receipts over obligations is Temporarily Not Available Pursuant to Public Law and is included in the calculation for appropriations on the Combined Statement of Budgetary Resources and, therefore, is not classified as budgetary resources in the fiscal year collected. However, all such excess receipts are assets of the trust funds and become available for obligation as needed. The entire trust fund balances in the amount of $245.0 billion as of September 30, 2013, ($245.4 billion in FY 2012) are included in Investments on the Consolidated Balance Sheet.

Note 20. Explanation of Differences between the Combined Statement of Budgetary Resources and the Budget of the United States Government (in Millions)

The *Budget of the United States Government* (also known as the *President's Budget*), with the actual amounts for FY 2013, has not been published, therefore, no comparisons can be made between FY 2013 amounts presented in the Combined Statement of Budgetary Resources with amounts reported in the Actual column of the *President's Budget*. The *FY 2015 President's Budget* is expected to be released in February 2014 and may be obtained from OMB's website, http://www.whitehouse.gov/omb/budget, or from the Government Printing Office.

HHS reconciled the amounts of the FY 2012 column on the Combined Statement of Budgetary Resources to the actual amounts for FY 2012 from the Appendix in the *FY 2014 President's Budget* for budgetary resources, obligations incurred, offsetting receipts and net outlays (gross outlays less offsetting collections) as presented below.

2012	Budgetary Resources	Obligations Incurred	Distributed Offsetting Receipts	Net Outlays (Gross Outlays less Offsetting Collections)
Combined Statement of Budgetary Resources	$ 1,289,835	$ 1,205,880	$ 317,777	$ 1,165,973
Expired Accounts	(8,390)	-	-	-
Other	(1,284)	(52)	(269)	(332)
Budget of the U.S. Government	$ 1,280,161	$ 1,205,828	$ 317,508	$ 1,165,641

For the budgetary resources reconciliation, the amount used from the *President's Budget* was the total budgetary resources available for obligation. Therefore, a reconciling item that is contained in the Combined Statement of Budgetary Resources and not in the *President's Budget* is the budgetary resources that were not available. The Expired Accounts line in the above schedule includes expired authority, recoveries and other amounts included in the Combined Statement of Budgetary Resources that are not included in the *President's Budget*.

The Other differences in the budgetary resources include an adjustment made to CMS CO-OP subsidy calculation in the amount of $0.9 billion reported in the *President's Budget*, an adjustment made to reclassify credit balance in the upward adjustments of prior-year undelivered orders account to the downward adjustments of prior-year unpaid undelivered orders account, and a back dated warrant processed for the Payments to Health Care Trust Funds during the SF-133 revision window.

The Other differences in the offsetting receipts consist of General Fund Proprietary Receipts and Collections of Receivables from Canceled Accounts, and a back dated warrant processed for the Payments from the General Fund for Health Care Fraud and Abuse Control Account. In addition, NIH made adjustments to prior year entry recorded in the Combined Statement of Budgetary Resources but not included in the *President's Budget* and other differences related to Intra-Departmental Delegation of Authority in the Combined Statement of Budgetary Resources.

Lastly, the Other differences in the net outlays include outlays reported on the HHS' Combined Statement of Budgetary Resources and included in the *Department of Homeland Security's President's Budget for Project Bioshield*, and a back dated warrant processed for the Payments to Health Care Trust Funds during the revision window.

Note 21. Funds from Dedicated Collections (in Millions)

Medicare is the largest dedicated collections fund group managed by HHS and is presented in a separate column in the schedule below. The Medicare programs include the HI Trust Fund, the Medicare SMI Trust Fund, the Medicare SMI Prescription Drug Benefit – Part D and the Medicare Integrity Program. See Note 1 Section F for a description of each fund's purpose and how HHS accounts for and reports the fund. Portions of the Program Management appropriation have been allocated to the HI and SMI Trust Funds.

SMI benefits and administrative expenses are generally financed by monthly premiums paid by Medicare beneficiaries and are matched by the Federal Government through the General Fund Appropriation, Payments to the Health Care Trust Funds. The standard monthly SMI premium per beneficiary was $104.90 for January 1, 2013, through September 30, 2013 and $99.90 from October 1, 2012, through December 31, 2012. The funds from dedicated collections financial statement balances are shown below.

Consolidated Balance Sheet as of September 30

	2013		
	Medicare	Other	Total
Fund Balance with Treasury	$ 9,448	$ 2,711	$ 12,159
Investments	276,173	3,452	279,625
Other Assets	11,025	215	11,240
Total Assets	$ 296,646	$ 6,378	$ 303,024
Entitlement Benefits Due and Payable	$ 48,614	$ -	$ 48,614
Other Liabilities	5,318	627	5,945
Total Liabilities	$ 53,932	$ 627	$ 54,559
Unexpended Appropriations	$ 4,569	$ (100)	$ 4,469
Cumulative Results of Operations	238,145	5,851	243,996
Total Liabilities and Net Position	$ 296,646	$ 6,378	$ 303,024

Consolidated Statement of Net Cost for the Period Ended September 30

Gross Program Costs	$ 567,848	$ 738	$ 568,586
Less: Exchange Revenues	69,272	1,978	71,250
Net Cost of Operations	$ 498,576	$ (1,240)	$ 497,336

Consolidated Statement of Changes in Net Position for the Period Ended September 30

Net Position Beginning of Period	$ 282,319	$ 5,108	$ 287,427
Non-Exchange Revenue	$ 229,649	$ 269	$ 229,918
Other Financing Sources	229,322	(866)	228,456
Net Cost of Operations	(498,576)	1,240	(497,336)
Change in Net Position	$ (39,605)	$ 643	$ (38,962)
Net Position End of Period	$ 242,714	$ 5,751	$ 248,465

Consolidated Balance Sheet as of September 30

	2012		
	Medicare	Other	Total
Fund Balance with Treasury	$ 23,254	$ 1,935	$ 25,189
Investments	300,809	3,477	304,286
Other Assets	8,651	255	8,906
Total Assets	$ 332,714	$ 5,667	$ 338,381
Entitlement Benefits Due and Payable	$ 46,436	$ -	$ 46,436
Other Liabilities	3,959	559	4,518
Total Liabilities	$ 50,395	$ 559	$ 50,954
Unexpended Appropriations	$ 20,519	$ (101)	$ 20,418
Cumulative Results of Operations	261,800	5,209	267,009
Total Liabilities and Net Position	$ 332,714	$ 5,667	$ 338,381

Consolidated Statement of Net Cost for the Period Ended September 30

Gross Program Costs	$ 542,545	$ 308	$ 542,853
Less: Exchange Revenues	64,858	1,497	66,355
Net Cost of Operations	$ 477,687	$ (1,189)	$ 476,498

Consolidated Statement of Changes in Net Position for the Period Ended September 30

Net Position Beginning of Period	$ 293,197	$ 4,401	$ 297,598
Non-Exchange Revenue	$ 221,987	$ 326	$ 222,313
Other Financing Sources	244,822	(808)	244,014
Net Cost of Operations	(477,687)	1,189	(476,498)
Change in Net Position	$ (10,878)	$ 707	$ (10,171)
Net Position End of Period	$ 282,319	$ 5,108	$ 287,427

Note 22. Statement of Social Insurance (Unaudited)

The SOSI presents the projected 75-year actuarial present values of the income and expenditures of the HI and SMI Trust Funds. Future expenditures are expected to arise from the health care payment provisions specified in current law for current and future program participants and from associated administrative expenses. Actuarial present values are computed on the basis of the intermediate set of assumptions specified in the *Annual Report of the Medicare Board of Trustees*. These assumptions represent the Trustees' best estimate of likely future economic, demographic, and health care-specific conditions. As with all of the assumptions underlying the Trustees' financial projections, the Medicare-specific assumptions are reviewed annually and updated based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. The most recent review occurred with the 2010-2011 Technical Review Panel. Please see Note 23 below for further information on this panel ("the Panel").

The SOSI projections are based on current law, and reflect the effects of the *Patient Protection and Affordable Care Act*, as amended by the *Health Care and Education Reconciliation Act of 2010*, which is referred to collectively as the "Affordable Care Act." The *Affordable Care Act* improves the financial outlook for Medicare substantially; however, the full effects of some of the law's provisions on Medicare are not known at this time, with the result that the projections are very uncertain, especially in the long-range future. It is important to note that the substantially improved results for HI and SMI Part B depend in part on the long-range feasibility of lower increases in Medicare payment rates to most categories of providers, as mandated by the *Affordable Care Act*. Without fundamental change in the current delivery system, these adjustments would probably not be viable indefinitely. Please see Note 23 below for further information on the impact of the *Affordable Care Act*.

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. The Trustees' projections are based on the current Medicare laws, regulations, and policies in effect on May 31, 2013, and do not reflect any actual or anticipated changes subsequent to that date. The present values are calculated by discounting the future annual amounts of non-interest income and expenditures (including benefit payments as well as administrative expenses) at the projected average rates of interest credited to the HI Trust Fund. HI income includes the portion of *FICA* and *SECA* payroll taxes allocated to the HI Trust Fund, the portion of Federal income taxes paid on Social Security benefits that is allocated to the HI Trust Fund, and receipts from fraud and abuse control activities. SMI income includes premiums paid by, or on behalf of, beneficiaries and transfers from the general fund of the Treasury made on behalf of beneficiaries. Fees related to brand-name prescription drugs, required by the *Affordable Care Act*, are included as income for Part B of SMI, and transfers from state governments are included as income for Part D of SMI. Since all major sources of income to the trust funds are reflected, the actuarial projections can be used to assess the financial condition of each trust fund.

The Part A present values in the SOSI exclude the income and expenditures for the roughly 1 percent of beneficiaries who are 65 or over but are "uninsured" because they do not meet the normal insured status or related requirements to qualify for entitlement to Part A benefits. The primary purpose of the SOSI is to compare the projected future costs of Medicare with the program's scheduled revenues. Since costs for the uninsured are separately funded either through general revenue appropriations or through premium payments, the exclusion of such amounts does not materially affect the financial balance of Part A. In addition, such individuals are granted coverage outside of the social insurance framework underlying Medicare Part A. For these reasons, it is appropriate to exclude their income and expenditures from the Statement of Social Insurance.

Actuarial present values of estimated future income (excluding interest) and estimated future expenditures are presented for three different groups of participants: (1) current participants who have not yet attained eligibility age; (2) current participants who have attained eligibility age; and (3) new entrants, those who are expected to become participants in the future. Current participants are the "closed group" of individuals who are at least age 15 at the start of the projection period, and are participating in the program as either taxpayers, beneficiaries, or both.

The SOSI sets forth, for each of these three groups, the projected actuarial present values of all future expenditures and of all future non-interest income for the next 75 years. The SOSI also presents the net present values of future net cash flows, which are calculated by subtracting the actuarial present value of future expenditures from the actuarial present value of future income. The HI Trust Fund is expected to have an actuarial deficit indicating that, under these assumptions as to economic, demographic, and health care cost trends for the future, HI income is expected to fall short of expenditures over the next 75 years. Neither Part B nor Part D of SMI has similar problems because each account is automatically in financial balance every year due to its statutory financing mechanism.

In addition to the actuarial present value of the estimated future excess of income (excluding interest) over expenditures for the open group of participants, the SOSI also sets forth the same calculation for the "closed group" of participants. The "closed group" of participants consists of those who, in the starting year of the projection period, have attained retirement eligibility age or have attained ages 15 through 64. In order to calculate the actuarial net present value of the excess of future income over future expenditures for the closed group, the actuarial present value of estimated future expenditures for or on behalf of current participants is subtracted from the actuarial present value of future income (excluding interest) for current participants.

Since its enactment in 1965, the Medicare program has experienced substantial variability in expenditure growth rates. These different rates of growth have reflected new developments in medical care, demographic factors affecting the relative number and average age of beneficiaries and covered workers, and numerous economic factors. The future cost of Medicare will also be affected by further changes in these factors that are inherently uncertain. Consequently, Medicare's actual cost over time, especially for periods as long as 75 years, cannot be predicted with certainty and such actual cost could differ materially from the projections shown in the SOSI. Moreover, these differences could affect the long-term sustainability of this social insurance program. Please see Note 23 below for important information on the further uncertainty, resulting from the provisions in the *Affordable Care Act*, associated with the current-law projections presented in the SOSI. In order to make projections regarding the future financial status of the HI and SMI Trust Funds, various assumptions have to be made. As stated previously, the estimates presented here are based on the assumption that the trust funds will continue to operate under the law in effect on May 31, 2013. In addition, the estimates depend on many economic, demographic, and health care-specific assumptions, including changes in per beneficiary health care cost, wages, and the consumer price index (CPI), fertility rates, mortality rates, immigration rates, and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period. The assumed growth rates for per beneficiary health care costs vary throughout the projection period.

The most significant underlying assumptions, based on current law, used in the projections of Medicare spending displayed in this section, are included in the following table. The assumptions underlying the 2013 SOSI actuarial projections are drawn from the *Social Security and Medicare Trustees Reports for 2013*. Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The projected beneficiary cost increases summarized on the next page reflect the overall impact of these more detailed assumptions. Detailed information, similar to that denoted within Table 1, for the prior years is publicly available on the CMS website at: http://www.cms.hhs.gov/CFOReport/.

Table 1: Significant Assumptions and Summary Measures Used for the Statement of Social Insurance 2013

					Annual percentage change in:						
								Per beneficiary cost[8]			
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	SMI B	SMI D	Real-interest rate[9]
2013	1.91	1,155,000	722.2	0.87	2.67	1.80	2.2	−0.9	0.4	0.3	−0.3
2020	2.06	1,255,000	670.2	1.35	4.15	2.80	2.3	3.9	5.3	6.6	2.8
2030	2.03	1,115,000	613.0	1.20	4.00	2.80	2.0	4.7	4.9	5.5	2.9
2040	2.00	1,080,000	564.1	1.15	3.95	2.80	2.2	5.3	4.5	5.3	2.9
2050	2.00	1,065,000	521.1	1.11	3.91	2.80	2.1	4.2	4.1	5.0	2.9
2060	2.00	1,060,000	483.3	1.10	3.90	2.80	2.0	3.9	4.0	4.8	2.9
2070	2.00	1,055,000	449.7	1.10	3.90	2.80	2.1	4.1	4.0	4.7	2.9
2080	2.00	1,055,000	419.8	1.13	3.93	2.80	2.1	3.8	3.8	4.5	2.9

[1]Average number of children per woman.
[2]Includes legal immigration, net of emigration, as well as other, non-legal, immigration.
[3]The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2000, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year.
[4]Difference between percentage increases in wages and the CPI.
[5]Average annual wage in covered employment.
[6]Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services.
[7]The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth.
[8]These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.
[9]Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

The projections presented in the Statement of Social Insurance are based on various economic and demographic assumptions. The values for each of these assumptions move from recently experienced levels or trends toward long-range ultimate values. These ultimate values assumed for the current year and the prior four years are summarized in Table 2 on the next page. They are based on the intermediate assumptions of the respective Medicare Trustees Reports.

Table 2: Significant Ultimate Assumptions Used for the Statement of Social Insurance, FY 2013-2009

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[9]
FY 2013	2.0	1,055,000	419.8	1.1	3.93	2.8	2.1	3.8	3.8	4.5	2.9
FY 2012	2.0	1,030,000	446.0	1.1	3.92	2.8	2.0	3.7	3.8	4.5	2.9
FY 2011	2.0	1,030,000	443.2	1.2	4.0	2.8	2.1	3.3	3.7	4.4	2.9
FY 2010	2.0	1,025,000	446.1	1.2	4.0	2.8	2.1	3.3	3.8	4.4	2.9
FY 2009	2.0	1,025,000	458.2	1.1	3.9	2.8	2.1	4.4	4.3	4.3	2.9

[1]Average number of children per woman. The ultimate fertility rate is assumed to be reached in the 25th year of the projection period.
[2]Includes legal immigration, net of emigration, as well as other, non-legal, immigration. The ultimate level of net legal immigration is 790,000 persons per year and the assumption for annual net other immigration varies throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080.
[3]The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2000, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year. The annual rate declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.
[4]Difference between percentage increases in wages and the CPI. The value presented is the average of annual real-wage differentials for the last 65 years of the 75-year projection period, is consistent with the annual differentials shown in table 1, and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080.
[5]Average annual wage in covered employment. The value presented is the average annual percentage change from the 10th year of the 75-year projection period to the 75th year, and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080.
[6]Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services. The ultimate assumption is reached within the first 10 years of the projection period.
[7]The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth. The annual rate declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.
[8]These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The annual rate of growth declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.
[9]Average rate of interest earned on new trust fund securities, above and beyond rate of inflation. The ultimate assumption is reached soon after the 10th year of each projection period.

Part D Projections

In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, the Part D program is still relatively new (having begun operations in January 2006), with relatively little actual program data currently available. The actual 2006 through 2013 bid submissions by the private plans offering this coverage, together with actual data on beneficiary enrollment and program spending through 2012, have been used in the current projections. Nevertheless, there remains a high level of uncertainty surrounding these cost projections, pending the availability of sufficient data on actual Part D expenditures to establish a trend baseline.

Note 23. Affordable Care Act and SMI Part B Physician Payment Update Factor (Unaudited)

The financial projections for the Medicare program reflect substantial, but very uncertain, cost savings deriving from provisions of the *Affordable Care Act*. It is important to note, however, that these improved results for HI and SMI Part B since 2010 depend in part on the long-range feasibility of the various cost-saving measures in the *Affordable Care Act*—in particular, the lower increases in Medicare payment rates to most categories of health care providers. Without fundamental change in the current delivery system, these adjustments would probably not be viable indefinitely. It is possible that health care providers could improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. For such efforts to be successful in the long range, however, providers would have to generate and sustain unprecedented levels of productivity gains—a very challenging and uncertain prospect.

A transformation of health care in the U.S., affecting both the means of delivery and the method of paying for care, is also a possibility. The *Affordable Care Act* takes important steps in this direction by initiating programs of research into innovative payment and service delivery models, such as accountable care organizations, patient-centered "medical homes," improvement in care coordination for individuals with multiple chronic health conditions, improvement in coordination of post-acute care, payment bundling, "pay for performance," and assistance for individuals in making informed health choices. If researchers and policy makers can demonstrate that the new approaches developed through these initiatives will improve the quality of health care and/or reduce costs, then the Secretary of Health and Human Services can adopt them for Medicare without further legislation. Such changes have the potential to reduce health care costs and cost growth rates and could, as a result, help lower Medicare cost growth rates to levels compatible with the lower price updates payable under current law.

The ability of new delivery and payment methods to significantly lower cost growth rates is uncertain at this time, since specific changes have not yet been designed, tested, or evaluated. Hopes for success are high, but at this time there is insufficient evidence to support an assumption that improvements in efficiency can occur of the magnitude needed to align with the statutory Medicare price updates.

The reductions in provider payments updates, if implemented for all future years as required under current law, could have secondary impacts on provider participation, beneficiary access to care; quality of services; and other factors. These possible impacts are very speculative, and at present there is no consensus among experts as to their potential scope. Further research and analysis will help to better inform this issue and may enable the development of specific projections of secondary effects under current law in the future.

In addition, the Medicare Part B projections reflect a reduction of almost 25 percent in payment rates for physician services in 2014, as required under current law. If lawmakers act to prevent this decrease, as they have for 2003 through 2013, then actual Part B and total SMI costs will significantly exceed the projections shown in this report.

Because knowledge of the potential long-range effects of the productivity adjustments, delivery and payment innovations, and certain other aspects of the *Affordable Care Act* is so limited, in August 2010 the Secretary of the Department of Health and Human Services, working on behalf of the Board of Trustees, established an independent group of expert actuaries and economists to review the assumptions and methods used by the Trustees to make projections of the financial status of the trust funds. The members of the Panel began their deliberations in November 2010 and were asked to focus their immediate attention on the long-range Medicare cost growth assumptions. In December 2011, the panel members unanimously recommended a new approach that builds on the longstanding "GDP plus 1 percent" assumption while incorporating several key refinements. Both the Office of the Actuary at CMS and the Board of Trustees support these recommendations, and they form the basis

for the long-range cost growth assumptions used in this annual report. The methodology is explained in more detail in section IV.D of the *2013 Medicare Trustees Report*:

> The Panel also recommended the continued use of a supplemental analysis, similar to the illustrative alternative projection in the 2010 through 2012 Trustees Reports, for the purpose of illustrating the higher Medicare costs that would result if the reduction in physician payment rates and the productivity adjustments to most other provider payment updates are not fully implemented as required under current law.[4]

The SOSI projections must be based on current law. Therefore, the productivity adjustments are assumed to occur in all future years, as required by the *Affordable Care Act*. In addition, an approximate 25 percent reduction in Medicare payment rates for physician services in January 2014, as estimated in the *2013 Trustees Report*, is assumed to be implemented as required under current law, despite the virtual certainty that Congress will continue to override this reduction. Therefore, it is important to note that the actual future costs for Medicare are likely to exceed those shown by these current-law projections.

Illustrative Scenario

The Medicare Board of Trustees, in their annual report to Congress, references an alternative scenario to illustrate, when possible, the potential understatement of Medicare costs and projection results. This alternative scenario assumes that the productivity adjustments are gradually phased down during 2020 to 2034 and that the physician fee reductions are overridden. These examples were developed for illustrative purposes only; the calculations have not been audited; no endorsement of the illustrative alternative to current law by the Trustees, CMS, or the Office of the Actuary should be inferred; and the examples do not attempt to portray likely or recommended future outcomes. Thus, the illustrations are useful only as general indicators of the substantial impacts that could result from future legislation affecting the productivity adjustments and physician payments under Medicare and of the broad range of uncertainty associated with such impacts. The table on the next page contains a comparison of the Medicare 75-year present values of income and expenditures under current law with those under the alternative scenario illustration.

[4]The Panel's final report is available at http://aspe.hhs.gov/health/reports/2013/MedicareTech/TechnicalPanelReport2010-2011.pdf.

Medicare Present Values
(in Billions)

	Current law (Unaudited)	Alternative scenario[1, 2] (Unaudited)
Income		
Part A	$ 16,192	$ 16,214
Part B	21,377	27,510
Part D	9,211	9,224
Expenditures		
Part A	20,963	25,396
Part B	21,377	27,510
Part D	9,211	9,224
Income less expenditures		
Part A	(4,772)	(9,182)
Part B	0	0
Part D	0	0

[1]These amounts are not presented in the *2013 Trustees Report*.
[2]At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare Trust Fund projections that differs from current law. No endorsement of the illustrative alternative to current law by the Trustees, CMS, or the Office of the Actuary should be inferred.

As expected, the differences between the current-law projections and the illustrative alternative are substantial, although both represent a sizable improvement in the financial outlook for Medicare compared to the laws in effect prior to the *Affordable Care Act.* This difference in outlook serves as a compelling reminder of the importance of developing and implementing further means of reducing health care cost growth in the coming years. All Part A fee-for-service providers are affected by the productivity adjustments, so the current law projections reflect an estimated 1.1 percent reduction in annual Part A cost growth each year. If the productivity adjustments were gradually phased out, as illustrated under the alternative scenario, the present value of Part A expenditures is estimated to be roughly 20 percent higher than the current-law projection. As indicated above, the present value of Part A income is basically unaffected under the alternative scenario.

The Part B expenditure projections are significantly higher under the alternative scenario than under current law, both because of the assumed gradual phase-out of the productivity adjustments and the assumption that the scheduled physician fee reductions would be overridden and based on 0.7 percent annual increases through 2022, based on a recommendation by the 2010-2011 Medicare Technical Review Panel. The productivity adjustments are assumed to affect more than half of Part B expenditures at the time their phase-out is assumed to begin. Similarly, physician fee schedule services are assumed to be roughly 25 percent higher under the alternative scenario than under current law at that time. The combined effect of these two factors results in a present value of Part B expenditures under the alternative scenario that is approximately 29 percent higher than the current-law projection.

The Part D projections are basically unaffected under the alternative projection because the services are not impacted by the productivity adjustments or the physician fee schedule reductions. The very minor impact is the result of a slight change in the discount rates that are used to calculate the present values.

The extent to which actual future Part A and Part B costs exceed the projected current-law amounts due to changes to the productivity adjustments and physician payments depends on both the specific changes that might be legislated and on whether Congress would pass further provisions to help offset such costs. As noted, these examples only reflect hypothetical changes to provider payment rates.

It is likely that in the coming years Congress will consider, and pass, numerous other legislative proposals affecting Medicare. Many of these will likely be designed to reduce costs in an effort to make the program more affordable. In practice, it is not possible to anticipate what actions Congress might take, either in the near term or over longer periods.

Note 24. Statement of Changes in Social Insurance Amounts (Unaudited)

The Statement of Changes in Social Insurance Amounts (SCSIA) reconciles the change (between the current valuation and the prior valuation) in the (1) present value of future income (excluding interest) for current and future participants; (2) present value of future expenditures for current and future participants; (3) present value of future noninterest income less future expenditures for current and future participants (the open-group measure) over the next 75 years; (4) assets of the combined Medicare Trust Funds; and (5) present value of future noninterest income less future expenditures for current and future participants over the next 75 years plus the assets of the combined Medicare Trust Funds. The Statement of Changes shows the reconciliation from the period beginning on January 1, 2012 to the period beginning on January 1, 2013, and the reconciliation from the period beginning on January 1, 2011 to the period beginning on January 1, 2012. The reconciliation identifies several components of the change that are significant and provides reasons for the changes.

Because of the financing mechanism for Parts B and D of Medicare, any change to the estimated expenditures has the same effect on estimated total income, and vice versa. Therefore, any change has no impact on the future net cashflow. In order to enhance the presentation, the changes in the present values of income and expenditures are presented separately.

The five changes considered in the Statement of Changes in Social Insurance Amounts are, in order:

1. change in the valuation period,
2. change in the projection base,
3. changes in demographic assumptions,
4. changes in economic and health care assumptions, and
5. changes in law

All estimates in the Statement of Changes in Social Insurance Amounts represent values that are incremental to the prior change. As an example, the present values shown for demographic assumptions, represent the additional effect that these assumptions have, once the effects from the change in the valuation period and projection base have been considered.

Assumptions Used for the Statement of Changes in Social Insurance Amounts

The present values included in the Statement of Changes in Social Insurance Amounts are for the current and prior year and are based on various economic and demographic assumptions used for the intermediate assumptions in the Trustees Reports for those years. Table 1 of Note 22 summarizes these assumptions for the current year.

Period beginning on January 1, 2012 and ending January 1, 2013

Present values as of January 1, 2012 are calculated using interest rates from the intermediate assumptions of the *2012 Trustees Report*. All other present values in this part of the Statement are calculated as a present value as of January 1, 2013. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are determined using the interest rates under the intermediate assumptions of the *2012 Trustees Report*. Since interest rates are economic assumptions,

the estimates of the present values of changes in economic assumptions are presented using the interest rates under the intermediate assumptions of the *2013 Trustees Report*.

Period beginning on January 1, 2011 and ending January 1, 2012

Present values as of January 1, 2011 are calculated using interest rates from the intermediate assumptions of the *2011 Trustees Report*. All other present values in this part of the Statement are calculated as a present value as of January 1, 2012. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are determined using the interest rates under the intermediate assumptions of the *2011 Trustees Report*. Since interest rates are economic assumptions, the estimates of the present values of changes in economic assumptions are presented using the interest rates under the intermediate assumptions of the *2012 Trustees Report*.

Change in the Valuation Period

Period beginning on January 1, 2012 and ending January 1, 2013

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2012-86) to the current valuation period (2013-87) is measured by using the assumptions for the prior valuation period and applying them, in the absence of any other changes, to the current valuation period. Changing the valuation period removes a small negative net cashflow for 2012 and replaces it with a much larger negative net cashflow for 2087. The present value of future net cashflow (including or excluding the combined Medicare Trust Fund assets at the start of the period) was therefore decreased (made more negative) when the 75-year valuation period changed from 2012-86 to 2013-87. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming all values projected in the prior valuation for the year 2012 are realized. The change in valuation period decreased the level of assets in the combined Medicare Trust Funds.

Period beginning on January 1, 2011 and ending January 1, 2012

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2011-85) to the current valuation period (2012-86) is measured by using the assumptions for the prior valuation period and applying them, in the absence of any other changes, to the current valuation period. Changing the valuation period removes a small negative net cashflow for 2011 and replaces it with a much larger negative net cashflow for 2086. The present value of future net cashflow (including or excluding the combined Medicare Trust Fund assets at the start of the period) was therefore decreased (made more negative) when the 75-year valuation period changed from 2011-85 to 2012-86. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming all values projected in the prior valuation for the year 2011 are realized. The change in valuation period decreased the level of assets in the combined Medicare Trust Funds.

Change in the Projection Base

Period beginning on January 1, 2012 and ending January 1, 2013

Actual income and expenditures in 2012 were different than what was anticipated when the *2012 Trustees Report* projections were prepared. Part A income and expenditures were lower than anticipated, based on actual experience. Part B total income and expenditures were also lower than estimated based on actual experience. For Part D, actual income and expenditures were both slightly lower than prior estimates. The net impact of the Part A, B, and D projection base changes is an increase in the future net cashflow. Actual experience of the Medicare Trust Funds between January 1, 2012 and January 1, 2013 is incorporated in the current valuation and is slightly more than projected in the prior valuation.

Period beginning on January 1, 2011 and ending January 1, 2012

Actual income and expenditures in 2011 were different than what was anticipated when the *2011 Trustees Report* projections were prepared. Part A income was slightly higher than estimated and Part A expenditures were lower than anticipated, based on actual experience. Part B total income and expenditures were higher than estimated based on actual experience. For Part D, actual income and expenditures were both slightly lower than prior estimates. The net impact of the Part A, B, and D projection base changes is an increase in the future net cashflow. Actual experience of the Medicare Trust Funds between January 1, 2011 and January 1, 2012 is incorporated in the current valuation and is slightly more than projected in the prior valuation.

Changes in Demographic Assumptions

Period beginning on January 1, 2012 and ending January 1, 2013

The demographic assumptions used in the Medicare projections are the same as those used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (SSA).

For the current valuation (beginning on January 1, 2013), changes in ultimate assumptions and recent data for immigration have significant effects.

- The assumed ultimate annual immigration of "other immigrants", that is, those entering the country without legal permanent resident (LPR) status, is 1.4 million in the current valuation, compared with 1.5 million assumed for the prior valuation.
- The assumed ultimate annual number of persons attaining LPR status is 1.05 million for the current valuation, compared with 1.03 million assumed for the prior valuation. The distribution of the ultimate number between those entering the country with LPR status and those adjusting status after having already entered the country was also revised.

Otherwise, the ultimate demographic assumptions for the current valuation are the same as those for the prior valuation. However, the starting demographic values, and the way these values transition to the ultimate assumptions, were changed.

- Final mortality data for 2008 and 2009 show substantially larger reductions in death rates for the current valuation than were expected in the prior valuation. The new data show a lower starting level of death rates and a faster rate of decline in death rates over the next 25 years.
- Final fertility (birth) data for 2009 and 2010, and preliminary data for 2011, indicate lower birth rates for these years than were assumed in the prior valuation.
- New historical data for marital status, for the number of new marriages, for "other immigration", and for the size of the population (based on the 2010 Census) were used in the current valuation.

These changes increased the Part A present values of future expenditures and income. Since overall population projections are higher compared to the prior valuation, these changes increase the Part B and Part D present values of expenditures, and also income because of the financing mechanism in place for both.

Period beginning on January 1, 2011 and ending January 1, 2012

The demographic assumptions used in the Medicare projections are the same as those used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (SSA).

The ultimate demographic assumptions for the current valuation period are the same as those for the prior valuation period. However, the starting demographic values were changed.

- Preliminary birth rate data for 2009 and 2010 are lower than were expected in the prior valuation. During the period of transition to their ultimate values, the birth rates in the current valuation are generally lower than they were in the prior valuation.
- The current valuation incorporates final data on legal immigration levels for 2010. The levels are slightly lower than the estimates used in the prior valuation.
- Updated starting population levels and the interaction of these levels with the changes in the fertility and immigration assumptions result in higher ratios of retirement age population to working age population than in the prior valuation.

These changes have little impact on the Part A present values of future expenditures and income. However, since overall population projections are lower compared to the prior valuation, these changes lower the Part B and Part D present values of expenditures, and also income because of the financing mechanism in place for both.

Changes in Economic and Health Care Assumptions

Period beginning on January 1, 2012 and ending January 1, 2013

The economic assumptions used in the Medicare projections are the same as those used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (SSA).

The ultimate economic assumptions for the current valuation (beginning on January 1, 2013) are the same as those for the prior valuation. Other changes include:

- The real interest rate is projected to be lower over the first ten years of the current valuation.
- The starting economic values and near-term economic growth rate assumptions were updated.

The health care assumptions are specific to the Medicare projections. The following health care assumptions were changed in the current valuation.

- Utilization rate and case mix increase assumptions for skilled nursing facilities were decreased.
- Lower projected Medicare Advantage program costs that reflect recent data suggesting that certain provisions of the *Affordable Care Act* will reduce growth in these costs by more than was previously projected.
- Administrative action that increased Medicare Advantage payment rates beginning in 2014 to reflect assumed future legislative overrides of the physician payment reductions.
- Larger than previously projected impact from patent expiration of several major prescription drugs in 2012.
- Lower projected prescription drug trend for 2013.

The net impact of these changes resulted in a slight increase in the future net cashflow for total Medicare. For Part A, these changes resulted in a decrease to the present value of expenditures and income, with an overall slight increase in the future net cashflow. For Part B, these changes increased the present value of expenditures (and also income). On the other hand, the above-mentioned changes lowered the present value of expenditures (and also income) for Part D.

Period beginning on January 1, 2011 and ending January 1, 2012

The economic assumptions used in the Medicare projections are the same as those used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (SSA).

The ultimate economic assumptions for the current valuation period are the same as those for the prior valuation period. However, the starting economic values and near-term economic growth rate assumptions were changed. The economic recovery has been slower than was assumed for the prior valuation period.

- For the current valuation period, HI taxable earnings are considerably lower for the starting year, 2011, than were projected for the prior valuation period. The projected level of taxable earnings grows more slowly through 2017 for the current valuation period.
- Price inflation in 2011 was higher than expected, with the cost-of-living adjustment in December 2011 being 2.9 percentage points higher than was assumed in the prior valuation.
- The real interest rate is projected to be lower over the first ten years of the current valuation period.

Inclusion of each of these economic revisions decreases the present value of future net cashflow.

The health care assumptions are specific to the Medicare projections. The following health care assumptions were changed in the current valuation.

- Case mix growth assumptions for inpatient hospitals were lowered.
- Utilization rate and case mix increase assumptions for skilled nursing facilities and home health agencies were increased.
- Growth in hospice services was increased.
- Increase in average pre- *Affordable Care Act* "baseline" growth rate from GDP+1% to GDP+1.4% to better account for the level of payment rate updates for Medicare (prior to the *Affordable Care Act*) compared to private health insurance and other payers of health insurance in the U.S.
- Use of the "factors contributing to growth" model, developed by the Office of the Actuary at CMS, for year-by-year growth rate assumptions in long range. The impact of this change, in association with the baseline growth rate assumption described just above, has the biggest effect on the change in the net present value of income less expenditures. It resulted in an increase in the present value of Part A and Part B expenditures of roughly $1 trillion and $570 billion, respectively. Since the present value of Part A income is unaffected by these changes and the present value of Part B income is also higher by $570 billion, the net present value of income less expenditures is lower by about $1 trillion. Therefore, approximately $1 trillion of the $2.3 trillion is due to these changes.
- Lower assumed growth rate for prescription drug expenditures in the U.S. overall.
- Explicit projection of Part B services indexed by the CPI (e.g., ASC, lab, and DME services). The impact of this change lowers the present value of Part B expenditures and income by roughly $570 billion, and has no effect on the net present value of income over expenditures.

The net impact of these changes resulted in a decrease in the future net cashflow for total Medicare. For Part A, these changes resulted in an increase to the present value of expenditures and a very slight decrease on the present value of income, with an overall decrease in the future net cashflow. For Part B, these changes increased the present value of expenditures (and also income). On the other hand, the above-mentioned changes lowered the present value of expenditures (and also income) for Part D.

Changes in Law

Period beginning on January 1, 2012 and ending January 1, 2013

Although Medicare legislation was enacted since the prior valuation date, many of the provisions have a negligible impact on the present value of the 75-year income, expenditures, and net cashflow. The American Taxpayer Relief Act of 2012 included several provisions that had an impact on the Medicare program. These include the extension

of the zero percent physician payment update through 2013, which slightly increases the present value of Part B expenditures; payments for inpatient hospital services in 2014-2017 are reduced in order to recoup $11 billion in overpayments associated with documentation and coding adjustments during 2008-2010 that were not previously recovered, which lowers the present value of Part A expenditures; reductions to the end-stage renal disease (ESRD) bundled payment rate to reflect changes in the utilization of certain drugs and biological and a delay in the inclusion of oral-only ESRD drugs in the rate, which reduces the present value of Part B expenditures and increases the present value of Part D expenditures; and the coding intensity adjustment used in determining payments to Medicare Advantage plans was revised, which lowers the present value of Part A and Part B expenditures.

Period beginning on January 1, 2011 and ending January 1, 2012

Although Medicare legislation was enacted since the prior valuation date, many of the provisions have a negligible impact on the present value of the 75-year income, expenditures, and net cashflow. However, there were three specific provisions enacted that had a fairly substantial impact on the Medicare program. These include the 2 percent sequestration of expenditures in February 2013 through January 2022 required by the *Budget Control Act* of 2011, which reduces the present value of expenditures for Medicare; the extension of the 0 percent physician payment update through 2012 required by the *Temporary Payroll Tax Cut Continuation Act of 2011* and the *Middle Class Tax Relief and Job Creation Act of 2012*, which slightly increases the present value of Part B expenditures; and the reduction in bad debt payments required by the *Middle Class Tax Relief and Job Creation Act of 2012*, which reduces the present value of Part A and Part B expenditures.

Note 25. Reconciliation of Net Cost of Operations (Proprietary) to Budget (in Millions)

	2013	2012
Resources Used to Finance Activities:		
Budgetary Resources Obligated		
Obligations Incurred	$ 1,282,036	$ 1,205,880
Spending Authority from Offsetting Collections and Recoveries	(49,640)	(47,415)
Obligations Net of Offsetting Collections and Recoveries	1,232,396	1,158,465
Distributed Offsetting Receipts	(336,655)	(317,777)
Net Obligations	$ 895,741	$ 840,688
Other Resources		
Net Non-Budgetary Resources Used to Finance Activities	58	21
Total Resources Used to Finance Activities	$ 895,799	$ 840,709
Resources Used to Finance Items Not Part of the Net Cost of Operations:		
Change in Budgetary Resources Obligated for Goods, Services and Benefits Ordered but Not Yet Provided	$ (3,623)	$ (13,909)
Resources That Fund Expenses Recognized in Prior Periods	54	138
Budgetary Offsetting Collections and Receipts That Do Not Affect Net Cost of Operations	(1,202)	(1,255)
Resources That Finance the Acquisition of Assets or Liquidations of Liabilities	1,314	1,652
Other Resources or Adjustments to Net Obligated Resources That Do Not Affect Net Cost of Operations	7,089	1,995
Total Resources Used to Finance Items Not Part of the Net Cost of Operations	3,632	(11,379)
Total Resources Used to Finance the Net Cost of Operations	$ 892,167	$ 852,088
Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period		
Components Requiring or Generating Resources in Future Periods	$ 2,495	$ 2,870
Components Not Requiring or Generating Resources	1,588	589
Total Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period	4,083	3,459
Net Cost of Operations	$ 896,250	$ 855,547

REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

Investment in Human Capital (in Millions)

For the Year Ended September 30, 2013

Responsibility Segment Program	2013	2012	2011	2010	2009
Administration for Children and Families					
Administration for Intellectual and Developmental Disabilities	$ 6	$ 6	$ 11	$ 9	$ 10
Health Resources and Services Administration					
Scholarships Loan Repayments and Loans	766	705	761	691	447
National Institutes of Health					
Research Training and Career Development	1,621	1,858	1,920	1,915	1,862
Totals	$ 2,393	$ 2,569	$ 2,692	$ 2,615	$ 2,319

Investments in Human Capital are expenses incurred by federal education and training programs for the public, which are intended to maintain or increase national productive capacity. Three HHS OPDIVs conduct education and training programs under this category: ACF, NIH and HRSA.

Administration for Children and Families

Projects of National Significance (PNS) grants are awarded to public or private non-profit institutions to enhance the independence, productivity, integration and inclusion into the community of people with developmental disabilities. These monies also support the development of national and state policy to serve this community. While administered by the Administration for Community Living as part of a 2012 reorganization, funding for this and other Administration for Intellectual and Developmental Disabilities (AIDD) programs continues to be provided first to ACF and then transferred to ACL. ACF is able to estimate Investment in Human Capital for AIDD using existing data collection activities. Under AIDD, as of September 30, 2013, 20 PNS grants have been awarded for FY 2013. Grants awarded total $6 million as of September 30, 2013.

Health Resources and Services Administration

Under Clinician Recruitment and Service, the National Health Service Corps (NHSC) is a network of 8,900 primary care providers and 14,000 sites working in communities with limited access to health care across the country. To support their service, the NHSC provides clinicians with financial support in the form of loan repayment and scholarships. In addition, the Nursing Education Loan Repayment and Scholarship programs help alleviate the critical shortage of nurses by providing financial incentives in exchange for their service at Critical Shortage Facilities.

The Health Professions Training programs make grants to health professions schools and training programs, which use the funds to develop, expand and enhance their efforts to train the health workforce America needs. They include programs focused on increasing diversity, encouraging clinicians to practice in underserved areas and preparing health care providers equipped to meet the needs of the aging U.S. population. Primary care medicine and dentistry, nursing, public health, psychology, allied health and chiropractic training programs benefit from specific grant programs. The Bureau of Health Professions (BHPr) also administers a scholarship for disadvantaged students and student loan programs for health professions schools.

National Institutes of Health

The NIH Research Training Program and Career Development Program address the need for trained personnel to conduct medical research. The primary goal of the support that NIH provides for graduate training and career development is to produce new, highly trained investigators who are likely to perform research that will benefit the nation's health. NIH's ability to maintain the momentum of recent scientific progress and international leadership in medical research depends upon the continued development of new, highly trained investigators.

Investment in Research and Development (in Millions)

As of September 30, 2013

Responsibility Segments	Basic	Applied	Develop-mental	2013 Total	2012	2011	2010	2009	Grand Total
ACF	$ -	$ 1	$ -	$ 1	$ 2	$ 7	$ 9	$ 16	$ 35
AHRQ	-	342	30	372	401	333	263	203	1,572
CDC	131	298	28	457	408	457	465	755	2,542
FDA	88	-	6	94	80	58	48	36	316
NIH	17,597	11,731	-	29,328	30,681	32,902	31,342	27,889	152,142
Totals	$ 17,816	$ 12,372	$ 64	$ 30,252	$ 31,572	$ 33,757	$ 32,127	$ 28,899	$ 156,607

The research and development programs in HHS include the following:

Administration for Children and Families

ACF oversees research and development programs that contribute to a better understanding of how to improve the economic and social well-being of families and children, so that they may lead healthier and more productive lives.

Agency for Healthcare Research and Quality

AHRQ is the lead federal agency charged with improving the quality, safety, efficiency and effectiveness of health care for all Americans. AHRQ supports health services research that will improve the quality of health care and promote evidence-based decision making.

Centers for Disease Control and Prevention

Diseases, Occupational Safety and Health, Health Promotion and Environmental Health and Injury Prevention were the primary areas where CDC's research and development was invested.

Food and Drug Administration

FDA has two programs that meet the requirements of research and development investments: Orphan Products Development (OPD) Program and FDA Research Grants Program. While the FDA's center components conduct scientific studies, FDA does not consider this type of research as "research and development" because it is used to support FDA's regulatory policy and decision-making processes.

The OPD Program was established by the *Orphan Drug Act* with the purpose of identifying orphan products and facilitating their development. An orphan product is a drug, biological product, medical device or medical food

that is intended to treat a rare disease or condition (i.e., one with a prevalence of fewer than 200,000 people in the United States).

The FDA Research Grants Program is a grants program whose purpose is to assist public and non-public institutions and for-profit organizations to establish, expand and improve research, demonstration, education and information dissemination activities concerned with a wide variety of FDA areas.

National Institutes of Health

The NIH Research Program includes all aspects of the medical research continuum, including basic and disease-oriented research, observational and population-based research, behavioral research and clinical research, including research to understand both health and disease states, to move laboratory findings into medical applications, to assess new treatments or compare different treatment approaches; and health services research. NIH regards the expeditious transfer of the results of its medical research for further development and commercialization of products of immediate benefit to improved health as an important mandate.

REQUIRED SUPPLEMENTARY INFORMATION

Combining Statement of Budgetary Resources (in Millions)

As of September 30, 2013

	CMS					
Budgetary Resources:	Medicare HI	Medicare SMI	Medicaid	Other Agency Budgetary Accounts[5]	Agency Combined Totals	Non-Budgetary Credit Reform Financing Account
Unobligated Balance, Brought Forward, Oct 1	$ -	$ -	$ 21,090	$ 59,690	$ 80,780	$ 3,175
Recoveries of Prior Year Unpaid Obligations	141	97	18,132	6,228	24,598	-
Other Changes in Unobligated Balance	(54)	20	9	(1,196)	(1,221)	(1)
Unobligated Balance from Prior Year Budget Authority, Net	87	117	39,231	64,722	104,157	3,174
Appropriations (Discretionary and Mandatory)	276,583	252,305	245,836	419,009	1,193,733	-
Borrowing Authority (Discretionary and Mandatory)	-	-	-	-	-	(2,064)
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	439	11	528	24,431	25,409	(685)
Total Budgetary Resources	$ 277,109	$ 252,433	$ 285,595	$ 508,162	$ 1,323,299	$ 425
Status of Budgetary Resources:						
Obligations Incurred	$ 277,109	$ 252,433	$ 283,313	$ 468,867	$ 1,281,722	$ 314
Unobligated Balances, End of Year:						
Apportioned	-	-	2,282	27,711	29,993	40
Exempt from Apportionment	-	-	-	2,059	2,059	-
Unapportioned	-	-	-	9,525	9,525	71
Total Unobligated Balance, End of Year	-	-	2,282	39,295	41,577	111
Total Status of Budgetary Resources	$ 277,109	$ 252,433	$ 285,595	$ 508,162	$ 1,323,299	$ 425
Change in Obligated Balance:						
Unpaid Obligation:						
Unpaid Obligations, Brought Forward, Oct 1	$ 24,209	$ 24,404	$ 26,837	$ 105,304	$ 180,754	$ 1,602
Obligation Incurred	277,109	252,433	283,313	468,867	1,281,722	314
Outlays (Gross)	(276,074)	(252,049)	(262,141)	(459,066)	(1,249,330)	(668)
Actual Transfers, unpaid obligations (net)	-	-	-	106	106	-
Recoveries of Prior Year Unpaid Obligations	(141)	(97)	(18,132)	(6,228)	(24,598)	-
Unpaid Obligations, End of Year	$ 25,103	$ 24,691	$ 29,877	$ 108,983	$ 188,654	$ 1,248
Uncollected Payments:						
Uncollected Customer Payments from Federal Sources, Brought Forward, Oct 1	$ (1)	$ -	$ -	$ (10,102)	$ (10,103)	$ (1,587)
Change in Uncollected Customer Payments from Federal Sources	1	-	-	(916)	(915)	1,051
Uncollected Payments from Federal Sources, End of Year	$ -	$ -	$ -	$ (11,018)	$ (11,018)	$ (536)
Memorandum (non-add) Entries:						
Obligated Balance, Start of Year	$ 24,208	$ 24,404	$ 26,837	$ 95,202	$ 170,651	$ 15
Obligated Balance, End of Year	$ 25,103	$ 24,691	$ 29,877	$ 97,965	$ 177,636	$ 712

[5] "Other Agency Budgetary Accounts" includes the budgetary accounts of the 11 HHS responsibility segments other than CMS, as well as the remaining budgetary accounts not reported by CMS under Medicare and Medicaid. This includes budgetary resources of $3.6 billion and net outlays of $3.8 billion for the Vaccine for Children Program which are appropriated to the Medicaid program and transferred to the CDC.

Combining Statement of Budgetary Resources (Continued) (in Millions)

	CMS					
	Medicare HI	Medicare SMI	Medicaid	Other Agency Budgetary Accounts[6]	Agency Combined Totals	Non-Budgetary Credit Reform Financing Account
Budget Authority and Outlays, Net:						
Budget Authority, Gross (Discretionary and Mandatory)	$ 277,022	$ 252,316	$ 246,364	$ 443,440	$ 1,219,142	$ (2,749)
Actual Offsetting Collections (Discretionary and Mandatory)	(440)	(11)	(528)	(23,833)	(24,812)	(366)
Change in Uncollected Customer Payments from Federal Sources (Discretionary and Mandatory)	1	-	-	(916)	(915)	1,051
Budget Authority, Net (Discretionary and Mandatory)	$ 276,583	$ 252,305	$ 245,836	$ 418,691	$ 1,193,415	$ (2,064)
Outlays, Gross (Discretionary and Mandatory)	$ 276,074	$ 252,049	$ 262,141	$ 459,066	$ 1,249,330	$ 668
Actual Offsetting Collections (Discretionary and Mandatory)	(440)	(11)	(528)	(23,833)	(24,812)	(366)
Outlays, Net (Discretionary and Mandatory)	275,634	252,038	261,613	435,233	1,224,518	302
Distributed Offsetting Receipts	(29,435)	(306,366)	-	(854)	(336,655)	-
Agency Outlays, Net (Discretionary and Mandatory)	$ 246,199	$ (54,328)	$ 261,613	$ 434,379	$ 887,863	$ 302

Summary of Other Agency Budgetary Accounts

	Budgetary Resources	Status of Budgetary Resources	Net Outlays
ACF	$ 51,744	$ 51,744	$ 49,606
ACL	1,445	1,445	1,440
AHRQ	416	416	319
CDC	10,905	10,905	10,388
CMS	378,532	378,532	319,897
FDA	4,941	4,941	1,576
HRSA	9,066	9,066	8,644
IHS	6,469	6,469	4,272
NIH	33,799	33,799	31,104
OS	5,695	5,695	3,446
PSC	1,603	1,603	461
SAMHSA	3,547	3,547	3,226
Totals	$ 508,162	$ 508,162	$ 434,379

[6] "Other Agency Budgetary Accounts" includes the budgetary accounts of the 11 HHS responsibility segments other than CMS, as well as the remaining budgetary accounts not reported by CMS under Medicare and Medicaid. This includes budgetary resources of $3.6 billion and net outlays of $3.8 billion for the Vaccine for Children Program which are appropriated to the Medicaid program and transferred to the CDC.

Deferred Maintenance and Repairs

For the Years Ended September 30, 2013 and 2012

FASAB issued SFFAS Number 40, *Definitional changes to Deferred Maintenance; Amending SFFAS Number 6, Accounting for Property, Plant, and Equipment*, effective for periods after September 30, 2011. This standard clarifies that repair activities should be included to better reflect asset management practices, and improve reporting on deferred maintenance and repairs. Deferred maintenance and repairs are maintenance and repairs activities not performed when they should have been or were scheduled to be, and then were put off or delayed for a future period. Maintenance and repairs are the activities directed toward keeping fixed assets in acceptable condition, including preventive maintenance, normal repairs, replacement of parts and structural components and other activities needed to preserve the asset so that it continues to provide acceptable service and achieves its expected life. Maintenance and repairs do not include activities aimed at expanding the capacity of an asset or otherwise upgrading it to serve needs different from, or significantly greater than, those originally intended. Maintenance and repair expenses are recognized as incurred. CDC, NIH and FDA all use the condition assessment survey for all classes of property. IHS uses two types of surveys to assess installations – annual general inspections and deep look surveys.

Category of Asset (in Millions)	Condition	Estimated Cost to Return to Acceptable Condition 2013	2012
General PP&E			
Buildings	1-4	$ 2,249	$ 2,038
Equipment	3-4	12	14
Other Structures	1-4	13	30
Total		$ 2,274	$ 2,082

In a condition assessment survey, asset condition is assessed on a scale of 1-5 as follows: Excellent-1; Good-2; Fair-3; Poor-4; Very Poor-5. A “fair” or 3 rating is considered acceptable operating condition. Although Property, Plant and Equipment categories may be rated as acceptable, individual assets within a category may require maintenance work to return them to acceptable operating condition. Therefore, asset categories with an overall rating of “fair” or above may still report necessary costs to return them to acceptable condition.

Stewardship Property, Plant and Equipment

As of September 30, 2013

HHS has Indian Trust Lands that are considered a type of property, plant and equipment for stewardship reporting purposes. Indian Trust Lands are those lands that do not meet the definition of stewardship land (i.e., land other than those acquired for or used in connection with general Property, Plant and Equipment), but have always been held by IHS as separate and distinct, because of the government's long-term trust responsibility. All Trust Lands, when no longer needed by the IHS in connection with its general use Property, Plant and Equipment, must be returned to the Department of the Interior's Bureau of Indian Affairs for continuing Trust responsibilities and oversight.

For the purpose of SFFAS Number 29, *Heritage Assets and Stewardship Land*, heritage assets are any real property assets that are individually listed on the National Register of Historic Places. As of September 30, 2013, IHS has no individually listed properties.

The IHS accountability reports differentiate Indian Trust Land parcels from general Property, Plant and Equipment situated thereon. The IHS Trust Land balances are removed from HHS FY 2013 Consolidated Balance Sheet and reported as Stewardship Assets - Indian Trust Lands.

The table below provides a summary of the Distribution of Stewardship Assets by Type and Area, as of September 30, 2013.

Distribution of Stewardship Assets by Type and Area

	Indian Trust Lands	
	Number of Sites	Total Hectares
Aberdeen	9	75
Albuquerque	4	3
Bemidji	2	9
Billings	7	48
Navajo	35	255
Oklahoma City	1	2
Phoenix	12	14
Portland	3	1
Tucson	5	12
Total	78	419

Social Insurance

Medicare, the largest health insurance program in the country, has helped fund medical care for the nation's aged and disabled for almost five decades. A brief description of the provisions of Medicare's Hospital Insurance (HI, or Part A) Trust Fund and Supplementary Medical Insurance (SMI, or Parts B and D) Trust Fund is included in this financial report.

The Required Supplementary Information (RSI) contained in this section is based on current law and is presented in accordance with the requirements of the Federal Accounting Standards Advisory Board (FASAB). Included are descriptions of the long-term sustainability and financial condition of the program and a discussion of trends revealed in the data.

RSI material is generally drawn from the *2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare Trust Funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

The projections in this report incorporate the sequestration of non-salary Medicare expenditures as required by the *Budget Control Act of 2011* (Public Law 112-25, enacted on August 2, 2011), as amended by the American Taxpayer Relief Act of 2012. Under the sequestration, Medicare benefit payments are reduced by an estimated 2 percent and administration expenses are reduced by an estimated 5 percent. The reduction in benefit payments will end on March 31, 2022, and the administrative expense reductions will end on September 30, 2021.

The projections shown here also incorporate the effects of the *Patient Protection and Affordable Care Act*, as amended by the *Health Care and Education Reconciliation Act of 2010*. This legislation, referred to collectively as the *"Affordable Care Act,"* contained roughly 165 provisions affecting the Medicare program by reducing costs, increasing revenues, improving benefits, combating fraud and abuse, and initiating a major program of research and development to identify alternative provider payment mechanisms, health care delivery systems, and other changes intended to improve the quality of health care and reduce costs.

The financial projections for the Medicare program reflect substantial, but very uncertain, cost savings deriving from provisions of the *Affordable Care Act*. These improved results for HI and SMI Part B depend in part on the long-range feasibility of the various cost-saving measures in the *Affordable Care Act* —in particular, the lower increases in Medicare payment rates to most categories of health care providers. It is possible that providers can improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. Whether these provisions of current law can be sustained is debatable due to substantial uncertainty about the adequacy of future Medicare payment rates. Without fundamental changes in current health care delivery systems, these adjustments would probably not be viable indefinitely. For these reasons, the estimates shown under current law should be used cautiously in evaluating the overall financial obligation created by Medicare and in assessing the financial status of the individual trust fund accounts. However, the effects of some of the law's provisions on Medicare are not known at this time, with the result that the projections are very uncertain, especially in the longer-range future.

As stated previously, the projections in this section are drawn from the annual Medicare Trustees Report, which must be based on current law. In addition, the FASAB rules governing the Statement of Social Insurance also require use of projections based on current law. Accordingly, the permanent payment update reductions are assumed to occur in all future years, as required by the *Affordable Care Act*. In addition, a reduction in Medicare payment rates for physician services of almost 25 percent is assumed to be implemented beginning in 2014 as

required under current law, despite the virtual certainty that Congress will override the reduction, as they have every year since 2003.

As will be discussed in more detail later, the long-range Medicare cost growth assumptions under current law take into consideration the recommendations by the 2010-2011 Technical Review Panel on the *Medicare Trustees Report*. These recommendations were designed to build upon the long-range assumptions used in the 2011 and prior Trustees Reports, but they incorporated a more refined analysis of the factors behind those assumptions, most notably for the increases in the price, volume, and intensity of health care services overall.

In view of the factors described above, it is important to note that the actual future costs for Medicare are likely to exceed those shown by the current-law projections. Therefore, the Medicare Board of Trustees, in their annual report to Congress, reference two alternative scenarios to illustrate where possible the potential understatement of Medicare costs and projection results. At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare Trust Fund projections under hypothetical modifications to current law. No endorsement of the illustrative alternatives by the Trustees, CMS, or the Office of the Actuary should be inferred. Additional information on the hypothetical alternatives to current law is provided in Note 23 in these financial statements, in Appendix C of this years' annual *Medicare Trustees Report*, and in an auxiliary memorandum prepared by the CMS Office of the Actuary at the request of the Board of Trustees.

Printed copies of the Trustees Report and auxiliary memorandum may be obtained from the CMS Office of the Actuary (410-786-6386) or can be downloaded from http://www.cms.hhs.gov/ReportsTrustFunds/.

Actuarial Projections

Long-Range Medicare Cost Growth Assumptions

The assumed long-range rate of growth in annual Medicare expenditures per beneficiary is one of the most critical determinants of the projected cost of Medicare-covered health care services in the more distant future. Starting with the *2001 Medicare Trustees Report*, the assumed average increase in expenditures per beneficiary for the 25th through 75th years of the projection has been based in whole or in part on the growth in per capita GDP plus 1 percentage point.[7] This assumption was recommended by the 2000 Medicare Technical Review Panel and confirmed as reasonable by the 2004 panel. Beginning with the 2006 report, the Trustees adopted a slight refinement of the long-range growth assumption that provided a more gradual transition from current health cost growth rates, which had been roughly 2 to 3 percentage points above the level of GDP growth, to the ultimate assumed level of GDP plus zero percent just after the 75th year and for the indefinite future.[8]

Following enactment of the *Affordable Care Act*, the long-range Medicare cost growth assumptions for the *2010* and *2011 Medicare Trustees Reports* continued to use this same methodology to establish a pre- *Affordable Care Act* "baseline" set of annual growth rates. The Trustees then reduced these growth rates for most categories of

[7] This assumed increase in the expenditures per beneficiary excludes the impacts of the aging of the population and changes in the gender composition of the Medicare population, which are estimated and applied separately.

[8] The year-by-year growth assumptions were based on a simplified economic model and were determined in a way such that the 75-year actuarial balance for the HI Trust Fund was consistent with that generated by the constant "GDP plus 1 percent" assumption.

Medicare expenditures by the 10-year moving average increase in private, non-farm business multifactor productivity, as required under the *Affordable Care Act*.[9]

In December 2011, the 2010-2011 Medicare Technical Review Panel[10] unanimously recommended a new approach that builds on the longstanding "GDP plus 1 percent" assumption while incorporating several key refinements.[11] The methodology involves use of two separate means of establishing long-range growth rates. The first approach is a refinement to the traditional "GDP plus 1 percent" growth assumption, which better accounts for the magnitude of payment rate updates for Medicare (prior to the *Affordable Care Act*) compared to private health insurance and other payers of health care. Under this approach, the rate of growth in Medicare prices prior to the provisions of the *Affordable Care Act*, which was assumed to be the same as the rate of private medical price growth in earlier reports, is now assumed to be 0.4 percent faster. This change results in the long-range pre- *Affordable Care Act* "baseline" cost growth assumption being "GDP plus 1.4 percent." The second approach recommended by the Technical Panel is the "factors contributing to growth" model developed by the Office of the Actuary at CMS as a possible replacement for the existing process.

The Technical Panel did not specify a process for how to establish one set of growth rate assumptions from the two separate and independent techniques. For the 2012 report, the Trustees decided (i) to base the average ultimate growth rate on the updated "GDP plus 1.4 percent" baseline assumption and (ii) to use the "factors contributing to growth" model to create the specific, year-by-year declining growth rates during the last 50 years of the projection.

For the *2013 Medicare Trustees Report*, the Trustees decided to use the factors model as the basis for determining the long-range Medicare cost growth assumption and to apply the "GDP plus" framework as a reasonableness check. The long-range Medicare cost growth assumptions under current law are established in three steps. Based on the factors model, the Trustees (i) create specific, year-by-year declining national health expenditure (NHE) growth rates over the long-range period and derive the growth in the volume and intensity of NHE services; (ii) assume, consistent with Finding III-2 of the Technical Panel's report, that the growth in the volume and intensity of Medicare services prior to the effects of the *Affordable Care Act* is identical to the growth in the volume and intensity of overall NHE services; and (iii) determine the Medicare payment rate updates required by the *Affordable Care Act* and their estimated effects on increases in the volume and intensity of services. For Medicare services for which the *Affordable Care Act* permanently reduces the annual increases in Medicare payment rates by the increase in economy-wide productivity, the Trustees adjust the growth rates in the volume and intensity of services by −0.1 percent annually. This assumption is consistent with Recommendation III-3 of the Technical Panel's report.

[9] "Multifactor productivity" is a measure of real output per combined unit of labor and capital, reflecting the contributions of all factors of production.

[10] The Panel's final report is available at http://aspe.hhs.gov/health/reports/2013/MedicareTech/TechnicalPanelReport2010-2011.pdf.

[11] For convenience, the assumed increase in Medicare expenditures per beneficiary, before consideration of demographic effects, is referred to as the "Medicare cost growth" and is often expressed in relation to the per capita increase in GDP, with the result characterized simply as "GDP plus X percent."

The different provisions for updating payment rates require separate long-range cost growth assumptions for the different categories of providers:

1. All HI, and some SMI Part B (primarily outpatient hospital, home health, and dialysis), services that are updated annually by provider input price increases, less the increase in economy-wide productivity, have on average an ultimate growth rate of 4.3 percent or "GDP plus 0.2 percent." The year-by-year increases for these provider services start at 4.5 percent in 2037, or "GDP plus 0.4 percent," and gradually decline to 3.6 percent in 2087, or "GDP minus 0.5 percent."

2. Certain SMI Part B services—such as durable medical equipment, laboratory tests, care at ambulatory surgical centers, ambulance services, and medical supplies that are updated annually by the Consumer Price Index (CPI) increase, less the increase in productivity—have on average a long-range growth assumption of 3.5 percent or "GDP minus 0.6 percent." The corresponding year-by-year growth rates are 3.6 percent in 2037, or "GDP minus 0.5 percent," declining to 2.8 percent in 2087, or "GDP minus 1.3 percent."

3. Per beneficiary expenditures for services payable under the physician fee schedule are increased at approximately the rate of per capita GDP growth, as required by the sustainable growth rate formula in current law.

4. All other Part B outlays, which constitute an estimated 11.0 percent of total Part B expenditures in 2022, have on average a long-range per beneficiary cost growth rate of 5.1 percent, or "GDP plus 1 percent." The corresponding year-by-year growth rates from the factors model are 5.3 percent in 2037, or "GDP plus 1.2 percent," declining to 4.4 percent by 2087, or "GDP plus 0.3 percent."

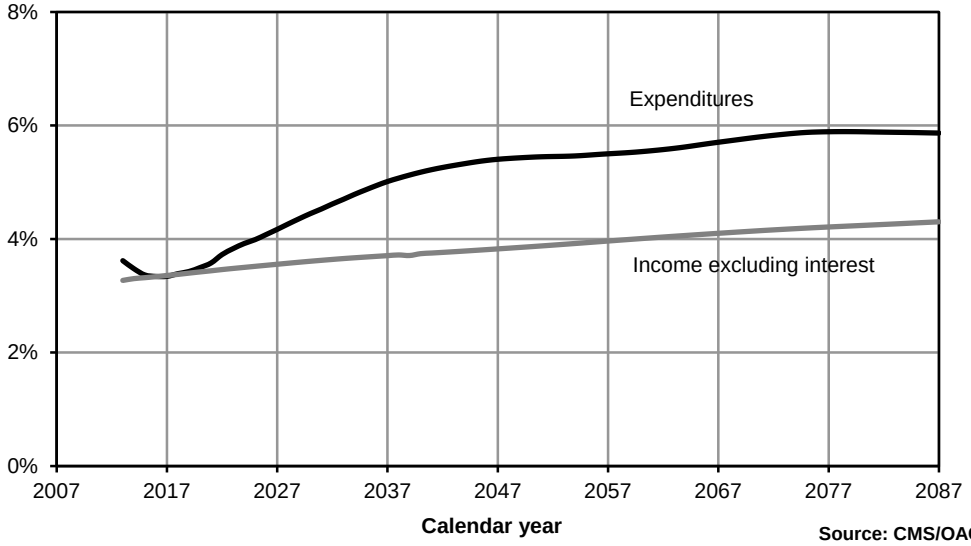
After combining the rates of growth from the four long-range assumptions, the weighted average growth rate for Part B is 4.1 percent per year for the last 50 years of the projection period, or "GDP plus 0 percent," on average. When Parts A, B, and D are combined, the weighted average growth rate for Medicare is 4.3 percent over this same period.

HI Cashflow as a Percentage of Taxable Payroll

Each year, estimates of the financial and actuarial status of the HI Trust Fund are prepared for the next 75 years. It is difficult to meaningfully compare dollar values for different periods without some type of relative scale; therefore income and expenditure amounts are shown relative to the earnings in covered employment that are taxable under HI (referred to as "taxable payroll").

Chart 1 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. The projected long-range HI cost rates shown in this report are lower than those from the 2012 report. The primary reasons for the difference are (i) lower projected spending for most HI service categories—especially for skilled nursing facilities—to reflect lower-than-expected spending in 2012 and other recent data; (ii) lower projected Medicare Advantage program costs that reflect recent data suggesting that certain provisions of the *Affordable Care Act* will reduce growth in these costs by more than was previously projected; and (iii) a refinement in projection methods that reduces assumed per beneficiary cost growth during the transition period between the short-range projections and the long-range projections.

Chart 1—HI Expenditures and Income Excluding Interest as a Percentage of Taxable Payroll 2013 - 2087



Source: CMS/OACT

Since the standard HI payroll tax rates are not scheduled to change in the future under present law, most payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. Under the *Affordable Care Act*, however, high-income workers will pay an additional 0.9 percent of their earnings above $200,000 (for single workers) or $250,000 (for married couples filing joint income tax returns) in 2013 and later. Because these income thresholds are not indexed, over time an increasing proportion of workers will become subject to the additional HI tax rate, and consequently total HI payroll tax revenues will increase steadily as a percentage of taxable payroll. Income from taxation of benefits will also increase as a greater proportion of Social Security beneficiaries become subject to such taxation, since the income thresholds determining taxable benefits are not indexed for price inflation. Thus, as Chart 1 shows, the income rate is expected to gradually increase over current levels.

As indicated in Chart 1, the cost rate will initially decline due to the expected economic recovery, the savings provisions of the *Affordable Care Act*, and the 2 percent reduction in all Medicare expenditures for 2013-2022, as required by the *Budget Control Act of 2011* and amended by the *American Taxpayer Relief Act of 2012*. Subsequently, the cost rate will increase significantly due to retirements of those in the baby boom generation and continuing health services cost growth. The effect of these factors will be largely offset in 2045 and later under current law by the accumulating effect of the reduction in provider price updates, which will reduce annual HI cost growth by an estimated 1.1 percent per year. Under the alternative scenario, if the slower price updates were not feasible in the long range and were phased down during 2020-2034, then the HI cost rate would be 5.2 percent in 2035 and 9.2 percent in 2085. These levels are about 8 percent and 57 percent higher, respectively, than the current-law estimates under the intermediate assumptions.

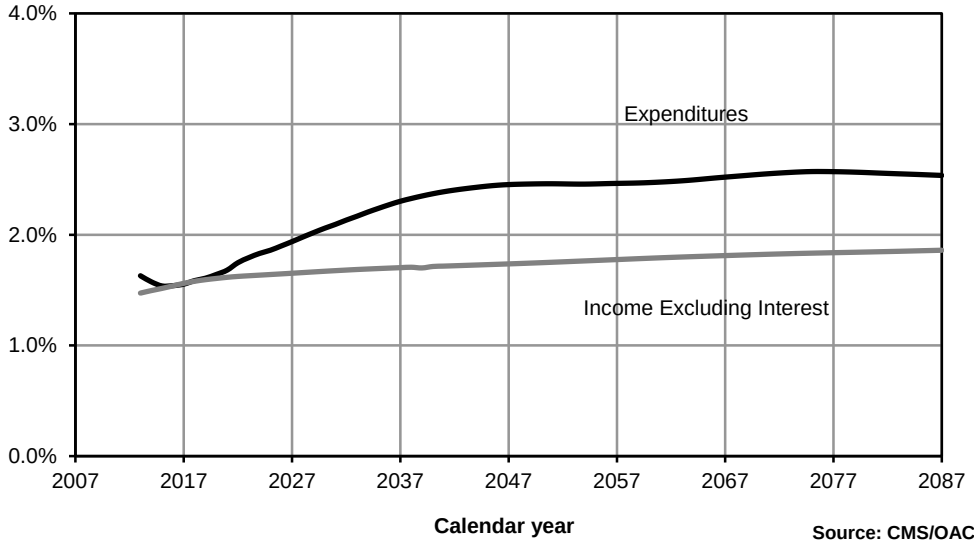
HI and SMI Cashflow as a Percentage of GDP

Expressing Medicare incurred expenditures as a percentage of GDP gives a relative measure of the size of the Medicare program compared to the general economy. The GDP represents the total value of goods and services produced in the United States. This measure provides an idea of the relative financial resources that will be necessary to pay for Medicare services.

HI

Chart 2 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2012, the expenditures were $266.8 billion, which was 1.7 percent of GDP. This percentage is projected to increase steadily through 2046 and then remain fairly level throughout the rest of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative projections,[12] HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 4.0 percent in 2087.

Chart 2—HI Expenditures and Income Excluding Interest as a Percentage of GDP 2013 - 2087



Source: CMS/OACT

[12] At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare Trust Fund projections under hypothetical alternatives to current law, which assumes that (i) the SGR-mandated physician fee schedule payment reductions are replaced with a 0.7-percent annual increase during 2014-2022 and then gradually rise to the per capita increase in health spending in the US overall by 2037; (ii) the *Affordable Care Act* reductions in Medicare payment rates are partially phased out from 2020-2034; and (iii) the Independent Payment Advisory Board requirements are not implemented. A summary of the illustrative alternative projections is contained in appendix V.C. of the *2013 Trustees Report*. No endorsement of the illustrative alternatives to current law by the Trustees, CMS, or the Office of the Actuary should be inferred.

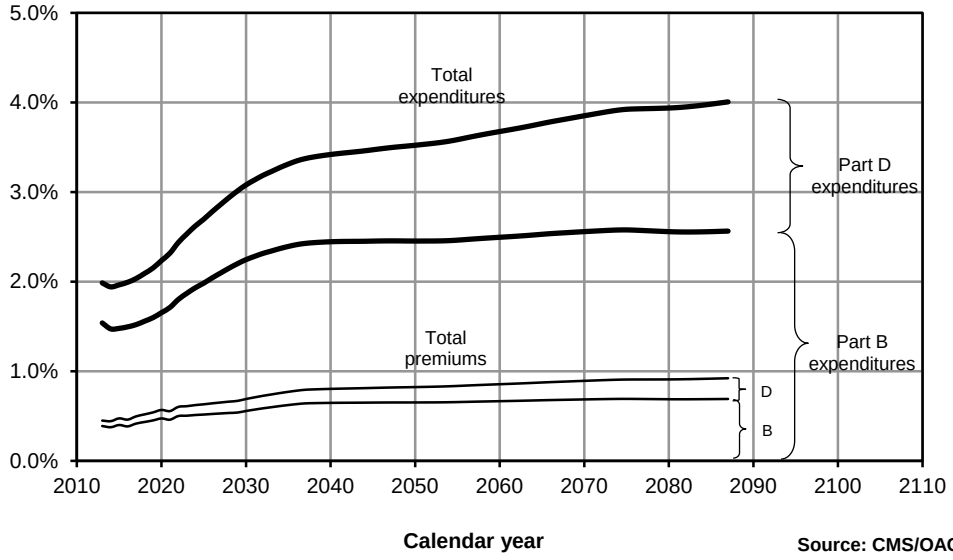
SMI

Because of the Part B and Part D financing mechanism in which income mirrors expenditures, it is not necessary to test for long-range imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and Federal general revenue payments.

Chart 3 shows projected total SMI (Part B and Part D) expenditures and premium income as a percentage of GDP. The growth rates are estimated year by year for the next 10 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 11 to 25 is assumed to grade smoothly into the long-range assumption described previously.

Under the intermediate assumptions, annual SMI expenditures were $307.4 billion, or about 2.0 percent of GDP, in 2012. Then, in about 25 years, they would grow to roughly 3.4 percent of GDP and to 4.0 percent by the end of the projection period. Total SMI expenditures in 2087 would be 4.7 percent of GDP if physician payment rates were set as assumed under the illustrative alternative projections. Such costs would represent 5.7 percent of GDP under the full illustration, including larger payment updates for most other categories of Part B providers.

Chart 3—SMI Expenditures and Premiums as a Percentage of GDP 2013 - 2087



Source: CMS/OACT

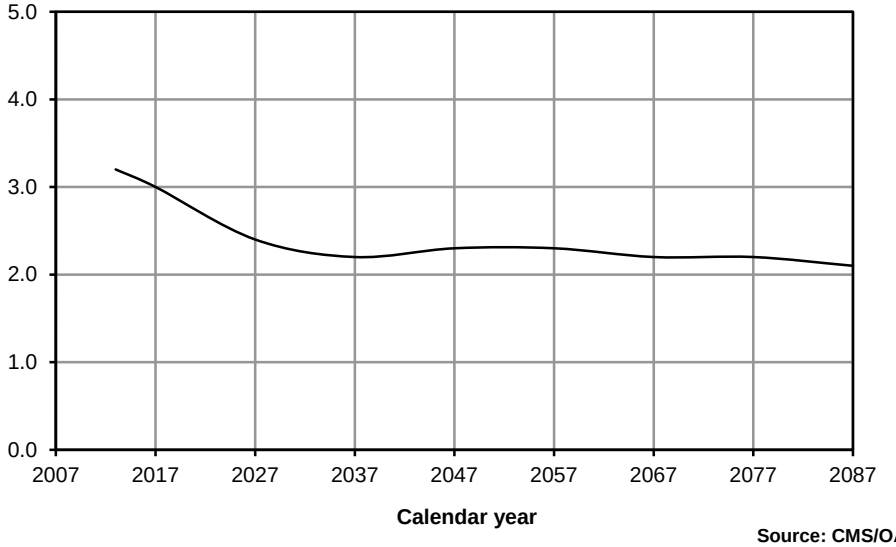
To match the faster growth rates for SMI expenditures under current law, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time. In fact, average per-beneficiary costs for Part B and Part D benefits are projected to increase after 2013 by about 4.4 percent annually. The associated beneficiary premiums—and general revenue financing—would increase by approximately the same rate. The special State payments to the Part D account are set by law at a declining portion of the States' forgone Medicaid expenditures attributable to the Medicare drug benefit. The percentage was 90 percent in 2006, phasing down to 75 percent in 2015 and later. Then, after 2015, the State payments are also expected to increase faster than GDP.

Worker-to-Beneficiary Ratio

HI

Another way to evaluate the long-range outlook of the HI Trust Fund is to examine the projected number of workers per HI beneficiary. Chart 4 illustrates this ratio over the next 75 years. For the most part, current benefits are paid for by current workers. The retirement of the baby boom generation will therefore be financed by the relatively smaller number of persons born after the baby boom. In 2012, every beneficiary had 3.3 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.3 workers per beneficiary. The projected ratio continues to decline until there are just 2.1 workers per beneficiary by 2087.

Chart 4—Number of Covered Workers per HI Beneficiary 2013 - 2087



Source: CMS/OACT

Sensitivity Analysis

In order to make projections regarding the future financial status of the HI and SMI Trust Funds, various assumptions have to be made. First and foremost, the estimates presented here are based on the assumption that both trust funds will continue under present law. In addition, the estimates depend on many economic and demographic assumptions. Because of revisions to these assumptions, due to either changed conditions or updated information, estimates sometimes change substantially compared to those made in prior years. Furthermore, it is important to recognize that actual conditions are very likely to differ from the projections presented here, since the future cannot be anticipated with certainty.

To illustrate the sensitivity of the long-range projections and determine the impact on the HI actuarial present values, six of the key assumptions were varied individually.[13] The assumptions varied are the health care cost factors, real-wage differential, CPI, real-interest rate, fertility rate, and net immigration.[14]

For this analysis, the intermediate economic and demographic assumptions in the *2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* are used as the reference point. Each selected assumption is varied individually to produce three scenarios. All present values are calculated as of January 1, 2013 and are based on estimates of income and expenditures during the 75-year projection period.

Charts 5 through 10 show the present value of the estimated net cashflow for each assumption varied. Generally, under all three scenarios, the present values initially increase, as the effects of the *Affordable Care Act* result in trust fund surpluses, and then decrease until about 2045 when they start to increase (or become less negative) once again. This pattern occurs in part because of the discounting process used for computing present values, which is used to help interpret the net cashflow deficit in terms of today's dollar. In other words, the amount required to cover this deficit, if made available and invested today, begins to decrease at the end of the 75-year period, reflecting the long period of interest accumulation that would occur. The pattern is also affected by the accumulating impact of the lower Medicare price updates over time and the greater proportion of workers who will be subject to the higher HI payroll tax rate, as noted above.

Health Care Cost Factors

Table 1 shows the net present value of cashflow during the 75-year projection period under three alternative assumptions for the annual growth rate in the aggregate cost of providing covered health care services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs, relative to taxable payroll, will be 1 percent slower than the intermediate assumptions, the same as the intermediate assumptions, and 1 percent faster than the intermediate assumptions. In each case, the taxable payroll will be the same as that which was assumed for the intermediate assumptions.

Table 1—Present Value of Estimated HI Income Less Expenditures under Various Health Care Cost Growth Rate Assumptions

Annual cost/payroll relative growth rate	−1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures (in billions)	$1,242	$(4,772)	$(14,352)

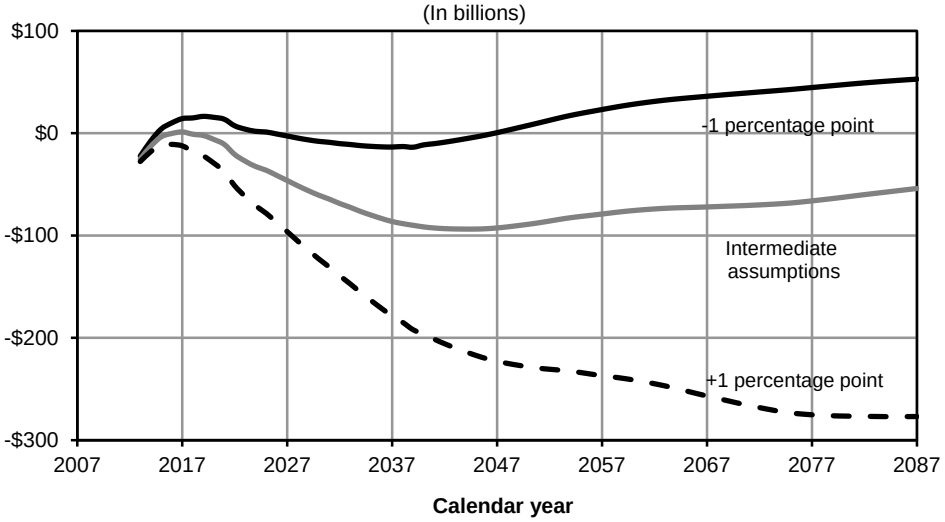
[13] Sensitivity analysis is not done for Parts B or D of the SMI Trust Fund due to the financing mechanism for each account. Any change in assumptions would have a negligible impact on the net cashflow, since the change would affect income and expenditures equally.

[14] The sensitivity of the projected HI net cash flow to variations in future mortality rates is also of interest. At this time, however, relatively little is known about the relationship between improvements in life expectancy and the associated changes in health status and per beneficiary health expenditures. As a result, it is not possible at present to prepare meaningful estimates of the HI mortality sensitivity.

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $6,014 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases substantially, by $9,580 billion.

Chart 5 shows projections of the present value of the estimated net cashflow under the three alternative annual growth rate assumptions presented in Table 1.

Chart 5—Present Value of HI Net Cashflow with Various Health Care Cost Factors 2013 - 2087



Source: CMS/OACT

This assumption has a dramatic impact on projected HI cashflow. The present value of the net cashflow under the ultimate growth rate assumption of 1 percentage point lower than the intermediate assumption actually becomes a surplus and remains positive throughout the entire period, due to the improved financial outlook for the HI Trust Fund as a result of the *Affordable Care Act*. Several factors, such as the utilization of services by beneficiaries or the relative complexity of services provided, can affect costs without affecting tax income. As Chart 5 indicates, the financial status of the HI Trust Fund is extremely sensitive to the relative growth rates for health care service costs.

Real-Wage Differential

Table 2 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.5, 1.1, and 1.7 percentage points.[15] In each case, the assumed ultimate annual increase in the CPI is 2.8 percent, yielding ultimate percentage increases in nominal average annual wages in covered employment of 3.3, 3.9, and 4.5 percent, respectively.

[15] The real-wage differential is the difference between the percentage increases in the average annual wage in covered employment and the average annual CPI.

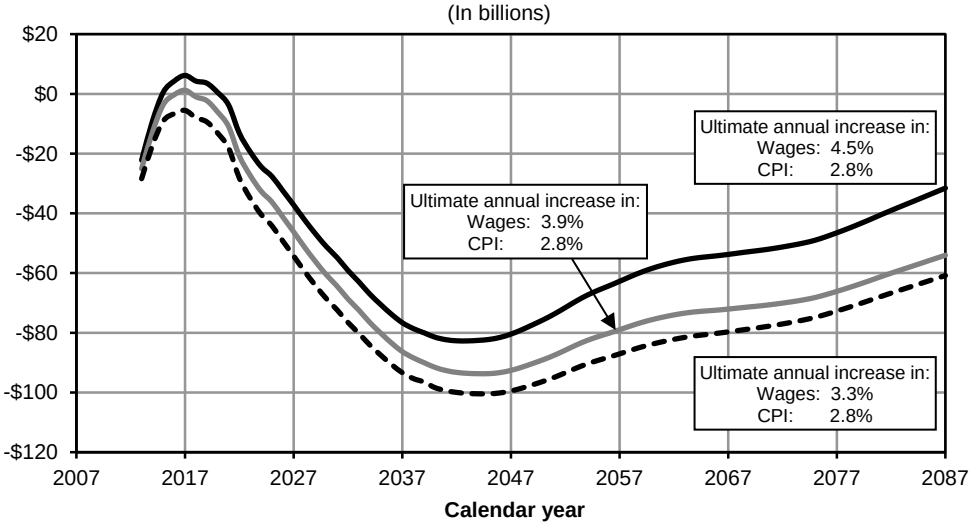
Table 2—Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions

Ultimate percentage increase in wages – CPI	3.3 – 2.8	3.9 – 2.8	4.5 – 2.8
Ultimate percentage increase in real-wage differential	0.5	1.1	1.7
Income minus expenditures (in billions)	$(5,310)	$(4,772)	$(3,753)

As indicated in Table 2, for a half-point increase in the ultimate real-wage differential assumption, the deficit—expressed in present-value dollars—decreases by approximately $850 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about $450 billion.

Chart 6 shows projections of the present value of the estimated net cashflow under the three alternative real-wage differential assumptions presented in Table 2.

Chart 6—Present Value of HI Net Cashflow with Various Real-Wage Assumptions 2013 - 2087



Source: CMS/OACT

As illustrated in Chart 6, faster real-wage growth results in smaller HI cashflow deficits, when expressed in present-value dollars. A higher real-wage differential immediately increases both HI expenditures for health care and wages for all workers. There is a full effect on wages and payroll taxes, but the effect on benefits is only partial, since not all health care costs are wage-related. In practice, faster real-wage growth always improves the financial status of the HI Trust Fund, regardless of whether there is a small or large imbalance between income and expenditures. Also, as noted previously, the closer financial balance for the HI Trust Fund under the *Affordable Care Act* depends critically on the long-range feasibility of the lower Medicare price updates for hospitals and other HI providers. There is a strong likelihood that certain of these changes will not be viable in the long range.

Consumer Price Index

Table 3 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 1.8, 2.8, and 3.8 percent. In each case, the assumed ultimate real-wage differential is 1.1 percent, which yields ultimate percentage increases in average annual wages in covered employment of 2.9, 3.9, and 4.9 percent, respectively.

Table 3—Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions

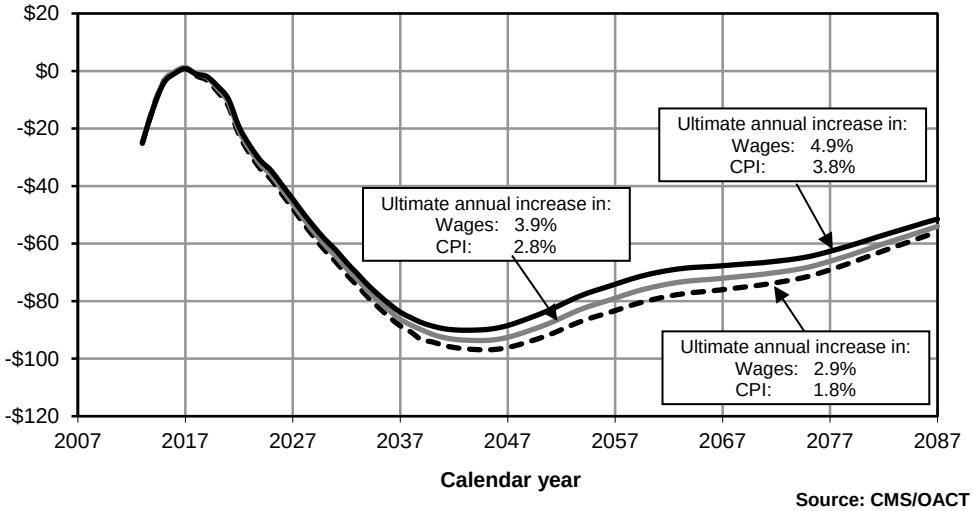
Ultimate percentage increase in wages − CPI	2.9 − 1.8	3.9 − 2.8	4.9 − 3.8
Income minus expenditures (in billions)	$(4,976)	$(4,772)	$(4,548)

Table 3 demonstrates that if the ultimate CPI-increase assumption is 1.8 percent, the deficit increases by $204 billion. On the other hand, if the ultimate CPI-increase assumption is 3.8 percent, the deficit decreases by $224 billion.

Chart 7 shows projections of the present value of net cashflow under the three alternative CPI rate-of-increase assumptions presented in Table 3.

Chart 7—Present Value of HI Net Cashflow with Various CPI-Increase Assumptions 2013 - 2087

(In billions)



Source: CMS/OACT

As Chart 7 indicates, this assumption has a small impact when the cashflow is expressed as present values. The relative insensitivity of the projected present values of HI cashflow to different levels of general inflation occurs because inflation tends to affect both income and costs in a similar manner. In present value terms, a smaller deficit results under high-inflation conditions because the present values of HI expenditures are not significantly different under the various CPI scenarios, but under high-inflation conditions the present value of HI income increases as more people become subject to the additional 0.9-percent HI tax rate required by the *Affordable Care Act* for workers with earnings above $200,000 or $250,000 (for single and joint income-tax filers, respectively). Since the thresholds are not indexed, additional workers become subject to the additional tax more quickly under conditions of faster inflation, and vice versa.

Real-Interest Rate

Table 4 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate annual real-interest assumptions: 2.4, 2.9, and 3.4 percent. In each case, the assumed ultimate annual increase in the CPI is 2.8 percent, which results in ultimate annual yields of 5.2, 5.7, and 6.2 percent, respectively.

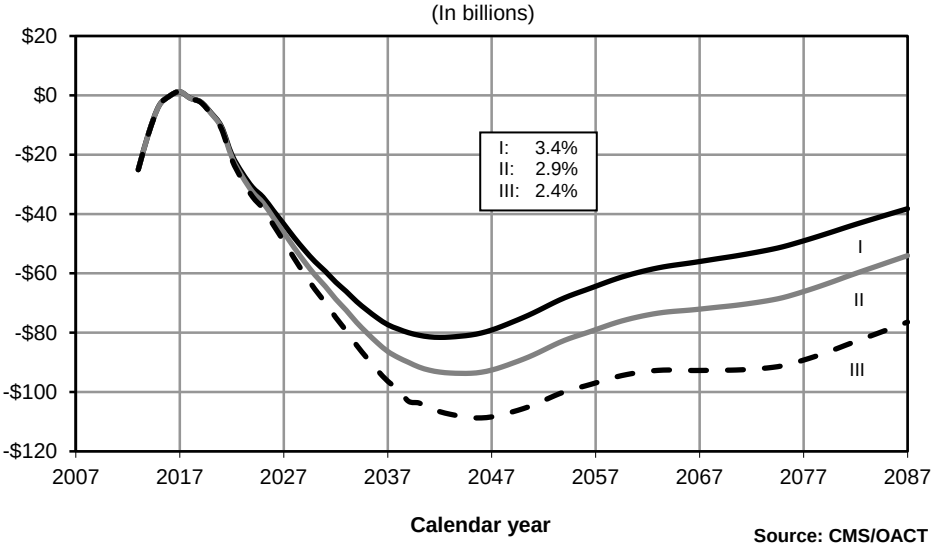
Table 4—Present Value of Estimated HI Income Less Expenditures under Various Real-Interest Assumptions

Ultimate real-interest rate	2.4 percent	2.9 percent	3.4 percent
Income minus expenditures (in billions)	$(5,800)	$(4,772)	$(3,954)

As illustrated in Table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $185 billion.

Chart 8 shows projections of the present value of the estimated net cashflow under the three alternative real-interest assumptions presented in Table 4.

Chart 8—Present Value of HI Net Cashflow with Various Real-Interest Rate Assumptions 2013 - 2087



Source: CMS/OACT

As shown in Chart 8, the projected HI cashflow when expressed in present values is fairly sensitive to the interest assumption. This is not an indication of the actual role that interest plays in HI financing. In actuality, interest finances very little of the cost of the HI Trust Fund because, under the intermediate assumptions, the fund is projected to be relatively low and exhausted by 2026. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), resulting in a smaller overall net present value.

Fertility Rate

Table 5 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.7, 2.0, and 2.3 children per woman.

Table 5—Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

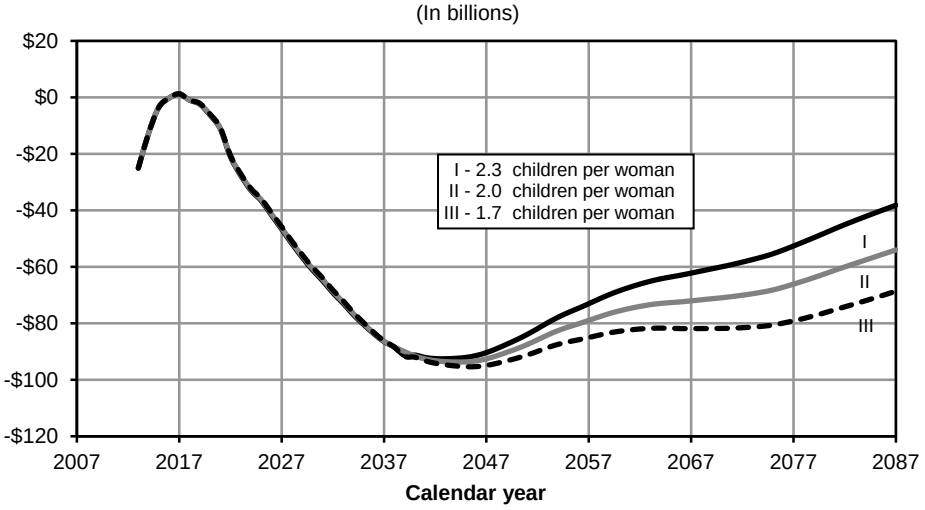
Ultimate fertility rate[1]	1.7	2.0	2.3
Income minus expenditures (in billions)	$(5,159)	$(4,772)	$(4,378)

[1] The total fertility rate for any year is the average number of children who would be born to a woman in her lifetime if she were to experience the birth rates by age observed in, or assumed for, the selected year and if she were to survive the entire childbearing period.

As Table 5 demonstrates, for an increase of 0.3 in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately $390 billion.

Chart 9 shows projections of the present value of the net cashflow under the three alternative fertility rate assumptions presented in Table 5.

Chart 9—Present Value of HI Net Cashflow with Various Ultimate Fertility Rate Assumptions 2013 - 2087



Source: CMS/OACT

As Chart 9 indicates, the fertility rate assumption has a substantial impact on projected HI cashflows. Under the higher fertility rate assumptions, there will be additional workers in the labor force after 20 years, as in past reports, but their impact on future HI taxes will be relatively greater, since many will become subject to the additional HI tax, thereby lowering the deficit proportionately more on a present-value-dollar basis. Under the lower fertility rate assumptions, on the other hand, there will be fewer workers in the workforce with a smaller number subject to the additional tax, in turn raising the HI deficit. It is important to point out that if a longer projection period were used, the impact of a fertility rate change would be more pronounced.

Net Immigration

Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative average annual net immigration assumptions: 800,000 persons, 1,095,000 persons, and 1,400,000 persons per year.

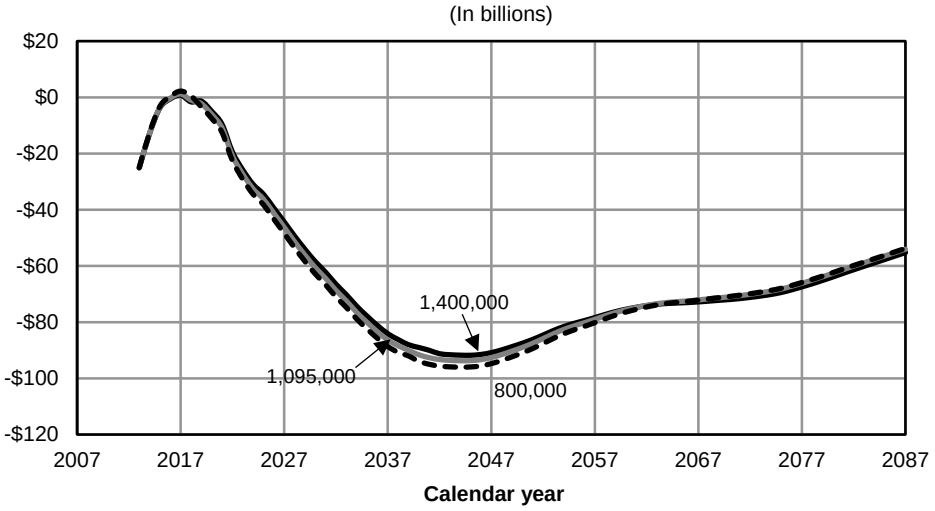
Table 6—Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions

Average annual net immigration	800,000	1,095,000	1,400,000
Income minus expenditures (in billions)	$(4,848)	$(4,772)	$(4,731)

As indicated in Table 6, if the average annual net immigration assumption is 800,000 persons, the deficit—expressed in present-value dollars—increases by $76 billion. Conversely, if the assumption is 1,400,000 persons, the deficit decreases by $41 billion.

Chart 10 shows projections of the present value of net cashflow under the three alternative average annual net immigration assumptions presented in Table 6.

Chart 10—Present Value of HI Net Cashflow with Various Net Immigration Assumptions 2013 - 2087



Source: CMS/OACT

Higher net immigration results in smaller HI cashflow deficits, as illustrated in Chart 10. Since immigration tends to occur most often among people at working ages, who work and pay taxes into the HI system, a change in the net immigration assumption affects revenues from payroll taxes almost immediately. However, the impact on expenditures occurs later as those individuals age and become beneficiaries.

Trust Fund Finances and Sustainability

HI

Under the Medicare Trustees' intermediate assumptions, the estimated depletion date for the HI Trust Fund is 2026, 2 years later than in last year's report. As in past years, the Trustees have determined that the fund is not adequately financed over the next 10 years. HI taxable earnings in 2012 were slightly lower than last year's estimate. The projected rate of growth in these earnings is lower in 2013 and 2014 but then exceeds last year's growth assumptions after 2014. HI expenditures in 2012 were slightly lower than the previous estimate, but after 2014, the projected level grows more rapidly than shown in last year's report because of assumed higher payment updates. HI expenditures have exceeded income annually since 2008, and projected amounts continue doing so through 2014. The Trustees then project slight surpluses in 2015 through 2020 with a return to deficits thereafter until the fund becomes depleted in 2026. The shortfalls can be met with increasing reliance on the redemption of trust fund assets, thereby adding to the draw on the Federal Budget. In the absence of corrective legislation, a depleted HI Trust Fund would initially produce payment delays but would very quickly lead to a curtailment of health care services to beneficiaries. In practice, Congress has never allowed a Medicare or Social Security Trust Fund to become fully depleted.

It is important to note that the improved outlook for the HI Trust Fund, relative to pre- *Affordable Care Act*, depends in part on the feasibility of the provider payment update reductions. There is a significant likelihood, however, that these providers would not be able to reduce their cost growth rates sufficiently during this period to match the slower increases in Medicare payments per service, and in this case they would eventually become unable to continue providing health care services to Medicare beneficiaries. If such a situation occurred, and Congress overrode the payment update reductions, then actual costs would be higher, and the HI Trust Fund would be depleted somewhat sooner.

The HI Trust Fund remains out of financial balance in the long range. Bringing the fund into actuarial balance over the next 75 years under the intermediate assumptions would require significant increases in revenues and/or reductions in benefits. These changes are needed partially as a result of the retirement of the baby boom generation. If the reductions to HI provider price updates could not be continued in the long run, then the actuarial deficit would be much greater.

SMI

Under current law, the SMI Trust Fund will remain adequate, both in the near term and into the indefinite future, because of the automatic financing established for Parts B and D. There is no authority to transfer assets between the Part D and Part B accounts; therefore, it is necessary to evaluate each account's financial adequacy separately.

The financing established for the Part B account for calendar year 2013 is adequate to cover 2013 expected expenditures and to maintain the financial status of the account in 2013 at a satisfactory level. The Part B cost projections are understated as a result of the substantial reductions in physician payments that would be required under current law and are further understated if the reductions in future price updates for most other Part B providers are not viable. Actual future Part B costs will depend on the steps that Congress might choose to take to address these situations.

No financial imbalance is anticipated for the Part D account, since the general revenue subsidy for this benefit is drawn on a daily, as-needed basis. The projected Part D costs shown in this section are lower than previously estimated. The difference is primarily attributable to the further increase of the market penetration of generic drugs, the larger than previously projected impact from patent expiration of several major drugs in 2012, and a lower projected trend for 2013.

The Part B and Part D accounts in the SMI Trust Fund are adequately financed under current law because premium and general revenue income are reset each year to cover expected costs. Such financing, however, would have to increase faster than the economy to cover expected expenditure growth under current law. A critical issue for the SMI program is the impact of the rapid growth of SMI costs, which places steadily increasing demands on beneficiaries and taxpayers.

Medicare Overall

The *Medicare Modernization Act* requires the Board of Trustees to determine whether the difference between Medicare outlays and "dedicated financing sources" is projected to exceed 45 percent of total Medicare outlays within the next 7 fiscal years (2013-2019).[16] This difference is expected to exceed 45 percent of total expenditures in fiscal year 2013, which is the first year of the 7-year test period. Consequently, the Trustees issued a determination of projected "excess general revenue Medicare funding," as required by law. Similar determinations were made in their 2006-2012 annual reports to Congress. With this eighth consecutive finding, another "Medicare funding warning" is triggered this year, indicating that the general revenues provided to Medicare under current law are becoming a substantial proportion of total program costs. This finding requires the President to submit to Congress, within 15 days after the release of the next budget, proposed legislation to respond to the warning. Congress is then required to consider this legislation on an expedited basis. This requirement helps to call attention to Medicare's impact on the Federal Budget. To date, elected officials have not enacted legislation responding to these funding warnings.

The projections shown in this section continue to demonstrate the need for timely and effective action to address the remaining financial challenges facing Medicare—including the projected depletion of the HI Trust Fund, this fund's long-range financial imbalance, and the issue of rapid growth in Medicare expenditures. Furthermore, if the lower prices payable for health services under Medicare cannot be sustained, then these further policy reforms will have to address much larger financial challenges than implied by the current-law projections. In their 2013 annual report to Congress, the Medicare Boards of Trustees emphasized the seriousness of these concerns and urged the nation's policy makers to "work closely together with a sense of urgency to address these challenges." They also stated: "Consideration of such reforms should occur in the near future."

[16]Dedicated Medicare financing sources include HI payroll taxes; income from taxation of Social Security benefits; State transfers for the prescription drug benefit; premiums paid under Parts A, B, and D; fees allocated to Part B related to brand-name prescription drugs; and any gifts received by the Medicare Trust Funds.

In this Section:

- Other Financial Information
- Improper Payments Information Act Report
- Management Report on Final Action
- FY 2013 Top Management and Performance Challenges Identified by OIG
- Department's Response to OIG Top Management Challenges
- Glossary
- Laws, Regulations and Guidance

Other Information

The Other Information (OI) section contains additional financial information including the Schedule of Spending, the Office of Inspector General's (OIG) FY 2013 assessment of management challenges facing the Department, a Management Report on Final Action and the Improper Payments Information Act Report, as well as a glossary and legal regulations relevant to this AFR.

OTHER FINANCIAL INFORMATION

Combining Schedule of Spending by Object Class

As of September 30, 2013
(in Millions)

What Money is Available to Spend?	FY 2013
Total Resources	$ 1,323,724
Less: Amount Available but Not Agreed to be Spent	32,092
Less: Amount Not Available to be Spent	9,596
Total Amounts Agreed to be Spent	$ 1,282,036

How was the Money Spent?	Grants, Subsidies and Contributions	Insurance Claims and Indemnities	Other Contractual Services	Personnel Compensation	Supplies and Materials	Personnel Benefits	Rent, Communications and Utilities	Other	FY 2013
Medicaid	$ 283,398	$ -	$ 72	$ 12	$ 3,422	$ 4	$ 10	$ 2	$ 286,920
Medicare Hospital Insurance	-	266,543	38	-	-	-	-	10,528	277,109
Medicare Supplementary Medical Insurance	-	241,977	44	-	-	-	-	10,412	252,433
Payments to Trust Funds	246,922	-	-	-	-	-	-	780	247,702
Medicare Prescription Drug Benefit (Medicare Part D)	-	69,357	-	-	-	-	-	390	69,747
Temporary Assistance for Needy Families	16,660	-	61	1	-	-	-	-	16,722
State Children's Health Insurance Program	9,472	-	20	-	-	-	33	-	9,525
Children and Families Services	8,928	-	344	118	1	32	17	10	9,450
Foster Care and Adoption Assistance	6,489	-	145	-	-	-	-	-	6,634
Medicare Health Information Technology Incentive	-	6,059	-	-	-	-	-	-	6,059
Indian Health Services	2,494	1	823	964	437	325	39	99	5,182
National Cancer Institute	2,915	-	1,345	386	32	106	10	31	4,825
Child Support Enforcement and Family Support	3,156	-	1,121	-	-	-	-	-	4,277
Allergy and Infectious Diseases	2,381	-	1,504	233	39	66	3	24	4,250
Primary Health Care	3,053	-	164	53	1	17	8	2	3,298
Low Income Home Energy Assistance	3,248	-	7	-	-	-	-	-	3,255
Heart, Lung, and Blood Institute	2,266	-	501	114	17	32	1	13	2,944
Child Care Entitlement to States	2,894	-	40	-	-	-	-	-	2,934
Mental Health	1,972	-	298	75	5	20	2	11	2,383
Affordable Insurance Exchange Grants	2,266	-	31	4	-	1	5	-	2,307
General Medical Sciences	2,142	-	122	21	-	6	-	1	2,292
Public Health and Social Services	291	-	1,160	100	604	25	23	36	2,239
Ryan White HIV/AIDS Program	2,132	-	81	16	-	5	2	2	2,238
Child Care and Development Block Grant	2,182	-	24	-	-	-	-	-	2,206
Social Services Block Grant	2,154	-	14	1	-	-	-	-	2,169
Substance Abuse Treatment	1,937	1	171	5	-	1	-	1	2,116
Diabetes and Digestive and Kidney Diseases	1,478	-	229	85	13	23	1	9	1,838
Pre-existing Condition Insurance Plan	-	-	1,773	1	-	-	2	-	1,776
Health Care Fraud and Abuse	-	-	1,540	36	-	11	10	1	1,598
Neurological Disorders and Stroke	1,238	-	202	63	9	17	1	12	1,542
Aging Services Programs	1,394	-	18	13	-	4	3	-	1,432
Service and Supply Fund	-	-	742	194	53	55	276	22	1,342
Disease Control Research and Training	373	-	473	222	83	70	50	70	1,341
Child Health and Human Development	865	-	292	77	9	21	1	8	1,273
Public Health Preparedness and Response	604	-	164	78	371	26	2	11	1,256
National Institute on Drug Abuse	768	-	234	50	4	14	1	5	1,076
HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases and Tuberculosis Prevention	732	-	137	123	4	43	1	8	1,048
National Institute on Aging	822	-	146	50	9	13	3	5	1,048
Refugee and Entrant Assistance	931	-	62	4	-	1	2	1	1,001
Other Agency Budgetary Accounts	11,582	868	12,757	4,332	363	1,446	539	1,362	33,249
Total Amounts Agreed to be Spent	$ 630,139	$ 584,806	$ 26,899	$ 7,431	$ 5,476	$ 2,384	$ 1,045	$ 23,856	$ 1,282,036
									$ 1,282,036

Who did the Money go to?	FY 2013
Federal	30,608
Non-Federal	1,251,428
Total Amounts Agreed to be Spent	$ 1,282,036

Consolidating Balance Sheet by Budget Function

As of September 30, 2013

(in Millions)

	Education, Training & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals
Assets (Note 2)							
Intragovernmental Assets							
Fund Balance with Treasury (Note 3)	$ 8,807	$ 129,513	$ 9,448	$ 11,424	$ 159,192	$ -	$ 159,192
Investments, Net (Note 4)	-	5,550	276,173	-	281,723	-	281,723
Accounts Receivable, Net (Note 5)	26	1,695	66,027	11	67,759	(64,110)	3,649
Advances (Note 8)	1	39	113	-	153	(50)	103
Total Intragovernmental Assets	$ 8,834	$ 136,797	$ 351,761	$ 11,435	$ 508,827	$ (64,160)	$ 444,667
Accounts Receivable, Net (Note 5)	-	3,714	7,216	3	10,933	-	10,933
Inventory and Related Property, Net (Note 6)	-	8,602	-	-	8,602	-	8,602
General Property, Plant and Equipment, Net (Note 7)	-	5,056	308	-	5,364	-	5,364
Advances (Note 8)	-	34	-	-	34	-	34
Other Assets	-	655	-	-	655	-	655
Total Assets	$ 8,834	$ 154,858	$ 359,285	$ 11,438	$ 534,415	$ (64,160)	$ 470,255
Stewardship Property, Plant and Equipment (Note 1)							
Liabilities (Note 9)							
Intragovernmental Liabilities							
Accounts Payable	$ 5	$ 124	$ 64,410	$ -	$ 64,539	$ (63,974)	$ 565
Other Liabilities (Note 13)	31	1,263	900	1	2,195	(186)	2,009
Total Intragovernmental Liabilities	$ 36	$ 1,387	$ 65,310	$ 1	$ 66,734	$ (64,160)	$ 2,574
Accounts Payable	12	546	104	-	662	-	662
Entitlement Benefits Due and Payable (Note 10)	-	28,663	48,614	-	77,277	-	77,277
Accrued Grant Liability (Note 12)	679	2,577	(17)	710	3,949	-	3,949
Federal Employee and Veterans Benefits (Note 11)	5	11,549	12	-	11,566	-	11,566
Contingencies and Commitments (Note 14)	-	7,600	1,300	-	8,900	-	8,900
Other Liabilities (Note 13)	19	1,301	1,248	13	2,581	-	2,581
Total Liabilities	$ 751	$ 53,623	$ 116,571	$ 724	$ 171,669	$ (64,160)	$ 107,509
Net Position							
Unexpended Appropriations - Funds from dedicated collections (Note 21)	-	(100)	4,569	-	4,469	-	4,469
Unexpended Appropriations - Other funds	8,071	86,954	-	10,703	105,728	-	105,728
Unexpended Appropriations, Total	$ 8,071	$ 86,854	$ 4,569	$ 10,703	$ 110,197	$ -	$ 110,197
Cumulative Results of Operations - Funds from dedicated collections (Note 21)	-	5,851	238,145	-	243,996	-	243,996
Cumulative Results of Operations - Other funds	12	8,530	-	11	8,553	-	8,553
Cumulative Results of Operations, Total	12	14,381	238,145	11	252,549	-	252,549
Total Net Position	$ 8,083	$ 101,235	$ 242,714	$ 10,714	$ 362,746	$ -	$ 362,746
Total Liabilities and Net Position	$ 8,834	$ 154,858	$ 359,285	$ 11,438	$ 534,415	$ (64,160)	$ 470,255

Consolidated Balance Sheet by Operating Division

As of September 30, 2013

(in Millions)

	ACF	ACL	AHRQ	CDC	CMS	FDA	HRSA	IHS	NIH	OS	PSC	SAMHSA	Agency Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals
Assets (Note 2)															
Intragovernmental Assets															
Fund Balance with Treasury (Note 3)	$ 19,589	$ 642	$ 124	$ 6,759	$ 76,609	$ 3,630	$ 7,509	$ 2,082	$ 31,013	$ 7,639	$ 478	$ 3,118	$ 159,192	$ -	$ 159,192
Investments, Net (Note 4)	-	-	-	-	278,270	-	3,428	-	25	-	-	-	281,723	-	281,723
Accounts Receivable, Net (Note 5)	14	23	28	33	3,371	13	17	36	54	142	216	4	3,951	(302)	3,649
Advances (Note 8)	-	1	-	3	114	-	10	-	-	4	1	20	153	(50)	103
Total Intragovernmental Assets	19,603	666	152	6,795	358,364	3,643	10,964	2,118	31,092	7,785	695	3,142	445,019	(352)	444,667
Accounts Receivable, Net (Note 5)	3	-	-	4	10,637	175	6	106	1	-	1	-	10,933	-	10,933
Inventory and Related Property, Net (Note 6)	-	-	-	3,202	-	-	2	7	34	5,353	4	-	8,602	-	8,602
General Property, Plant and Equipment, Net (Note 7)	-	-	-	1,432	369	334	1	1,038	2,090	94	6	-	5,364	-	5,364
Advances (Note 8)	-	-	-	27	-	-	-	-	2	5	-	-	34	-	34
Other Assets	-	-	-	-	407	10	237	1	-	-	-	-	655	-	655
Total Assets	$ 19,606	$ 666	$ 152	$ 11,460	$ 369,777	$ 4,162	$ 11,210	$ 3,270	$ 33,219	$ 13,237	$ 706	$ 3,142	$ 470,607	$ (352)	$ 470,255
Stewardship Property, Plant and Equipment (Note 1)															
Liabilities (Note 9)															
Intragovernmental Liabilities															
Accounts Payable	$ 5	$ 1	$ 2	$ -	$ 655	$ 18	$ 12	$ 4	$ 24	$ 10	$ 2	$ 2	$ 735	$ (170)	$ 565
Other Liabilities (Note 13)	31	-	2	109	1,473	21	15	325	28	38	115	34	2,191	(182)	2,009
Total Intragovernmental Liabilities	36	1	4	109	2,128	39	27	329	52	48	117	36	2,926	(352)	2,574
Accounts Payable	12	-	6	37	147	5	50	26	271	77	22	9	662	-	662
Entitlement Benefits Due and Payable (Note 10)	-	-	-	-	77,277	-	-	-	-	-	-	-	77,277	-	77,277
Accrued Grant Liability (Note 12)	1,289	100	29	375	(424)	(5)	512	22	1,736	157	-	158	3,949	-	3,949
Federal Employee and Veterans Benefits (Note 11)	5	-	-	37	15	32	21	82	67	19	11,276	12	11,566	-	11,566
Contingencies and Commitments (Note 14)	-	-	-	-	7,366	1	533	1,000	-	-	-	-	8,900	-	8,900
Other Liabilities (Note 13)	30	2	15	177	1,354	187	95	267	296	92	50	16	2,581	-	2,581
Total Liabilities	1,372	103	54	735	87,863	259	1,238	1,726	2,422	393	11,465	231	107,861	(352)	107,509
Net Position															
Unexpended Appropriations - Funds from dedicated collections (Note 21)	-	-	-	-	4,569	(100)	-	-	-	-	-	-	4,469	-	4,469
Unexpended Appropriations - Other funds	18,227	547	65	6,245	37,655	(2,920)	6,711	1,157	27,762	7,411	50	2,818	105,728	-	105,728
Unexpended Appropriations, Total	18,227	547	65	6,245	42,224	(3,020)	6,711	1,157	27,762	7,411	50	2,818	110,197	-	110,197
Cumulative Results of Operations - Funds from dedicated collections (Note 21)	-	-	-	49	238,145	2,281	2,925	63	430	-	-	3	243,996	-	243,996
Cumulative Results of Operations - Other funds	7	16	33	4,431	1,545	4,542	336	324	2,605	5,433	(10,809)	90	8,553	-	8,553
Cumulative Results of Operations, Total	7	16	33	4,480	239,690	6,823	3,261	387	3,035	5,433	(10,809)	93	252,549	-	252,549
Total Net Position	18,234	563	98	10,725	281,914	3,803	9,972	1,544	30,797	12,844	(10,759)	2,911	362,746	-	362,746
Total Liabilities and Net Position	$ 19,606	$ 666	$ 152	$ 11,460	$ 369,777	$ 4,162	$ 11,210	$ 3,270	$ 33,219	$ 13,237	$ 706	$ 3,142	$ 470,607	$ (352)	$ 470,255

Net Cost of Top 15 Programs

For the Years Ended September 30, 2013 and 2012
(in Millions)

HHS Program	HHS Net Cost ($) FY 2013	HHS Net Cost ($) FY 2012	Rank by ($) FY 2013	Rank by ($) FY 2012	Budget Function	HHS Responsibility Segment
Medicare	$ 498,576	$ 477,687	1	1	Medicare	CMS
Medicaid	266,624	247,508	2	2	Health	CMS
Research	31,125	32,362	3	3	Health	NIH
Temporary Assistance to Needy Families	18,021	17,131	4	4	Education, Training & Social Services / Income Security	ACF
Children's Health Insurance Program (CHIP)	9,548	9,260	5	5	Health	CMS
Head Start	7,915	7,805	6	6	Education, Training & Social Services / Income Security	ACF
Child Welfare	7,719	7,643	7	7	Education, Training & Social Services / Income Security	ACF
Child Care	5,211	4,982	8	9	Education, Training & Social Services / Income Security	ACF
Affordable Care Act Program	5,047	3,800	9	12	Health	ACL, CDC, CMS, OS & SAMHSA
Immunization and Respiratory Diseases (including Infectious Diseases)*	4,331	5,484	10	8*	Health	CDC
Child Support Enforcement	4,085	3,955	11	10	Education, Training & Social Services / Income Security	ACF
Low-Income Home Energy Assistance	3,495	3,860	12	11	Education, Training & Social Services / Income Security	ACF
Primary Care	3,328	3,411	13	13	Health	HRSA
Clinical Services	2,378	2,402	14	15	Health	IHS
HIV/AIDS Programs	2,203	2,414	15	14	Health	HRSA
Total Top 15 Programs	$ 869,606	$ 829,704				
All Other HHS Programs	26,833	26,001			Various	Various
Total Combined Net Costs	$ 896,439	$ 855,705				
Eliminations	(189)	(158)				
Total Consolidated Net Costs of Operations	$ 896,250	$ 855,547				

**CDC restructured the GPRA programs based on appropriations bills approved by Congress in FY 2012. The Infectious Disease program that was previously presented, is now included in the Immunization and Respiratory Diseases program in FY 2013.*

Supplemental Statement of Net Cost

For The Years Ended September 30, 2013 and 2012
(in Millions)

	2013			
		Inter-Agency Eliminations		
Responsibility Segments	Agency Combined Totals	Costs (-)	Earned/Exchange Revenues (+) *	Consolidated Totals
ACF	$ 50,559	$ (53)	$ 23	$ 50,529
ACL	1,445	(3)	8	1,450
AHRQ	188	(15)	414	587
CDC	10,299	(129)	460	10,630
CMS	779,791	(615)	46	779,222
FDA	1,750	(237)	13	1,526
HRSA	8,847	(217)	36	8,666
IHS	4,441	(156)	165	4,450
NIH	31,125	(897)	214	30,442
OS	3,571	(260)	537	3,848
PSC	1,041	(31)	476	1,486
SAMHSA	3,382	(71)	103	3,414
Net Cost of Operations	$ 896,439	$ (2,684)	$ 2,495	$ 896,250

	2012			
		Inter-Agency Eliminations		
Responsibility Segments	Agency Combined Totals	Costs (-)	Earned/Exchange Revenues (+) *	Consolidated Totals
ACF	$ 49,134	$ (44)	$ 36	$ 49,126
ACL	1,489	(6)	5	1,488
AHRQ	238	(17)	415	636
CDC	9,945	(179)	481	10,247
CMS	737,823	(616)	16	737,223
FDA	2,134	(242)	30	1,922
HRSA	8,782	(223)	49	8,608
IHS	5,766	(209)	173	5,730
NIH	32,362	(945)	128	31,545
OS	3,325	(223)	490	3,592
PSC	1,338	110	521	1,969
SAMHSA	3,369	(66)	158	3,461
Net Cost of Operations	$ 855,705	$ (2,660)	$ 2,502	$ 855,547

**Eliminations for non-exchange revenue are reported in the Consolidated Statement of Changes in Net Position*

Consolidating Statement of Net Cost by Budget Function

For the Year Ended September 30, 2013
(in Millions)

Responsibility Segments	Education, Training, & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra-HHS Eliminations: Cost (-)	Intra-HHS Eliminations: Revenue	Consolidated Totals
ACF	$ 12,214	$ -	$ -	$ 38,345	$ 50,559	$ (53)	$ 23	$ 50,529
ACL	1,445	-	-	-	1,445	(3)	8	1,450
AHRQ	-	188	-	-	188	(15)	414	587
CDC	-	10,299	-	-	10,299	(129)	460	10,630
CMS	-	281,215	498,576	-	779,791	(615)	46	779,222
FDA	-	1,750	-	-	1,750	(237)	13	1,526
HRSA	-	8,847	-	-	8,847	(217)	36	8,666
IHS	-	4,441	-	-	4,441	(156)	165	4,450
NIH	-	31,125	-	-	31,125	(897)	214	30,442
OS	-	3,571	-	-	3,571	(260)	537	3,848
PSC	-	1,041	-	-	1,041	(31)	476	1,486
SAMHSA	-	3,382	-	-	3,382	(71)	103	3,414
Net Cost of Operations	$ 13,659	$ 345,859	$ 498,576	$ 38,345	$ 896,439	$ (2,684)	$ 2,495	$ 896,250

Gross Cost and Exchange Revenue

For the Year Ended September 30, 2013
(in Millions)

Responsibility Segments	Intragovernmental: Gross Cost: Combined	Gross Cost: Eliminations	Gross Cost: Consolidated	Less: Exchange Revenue: Combined	Less: Exchange Revenue: Eliminations	Less: Exchange Revenue: Consolidated	With the Public: Gross Cost	With the Public: Less: Exchange Revenue	Consolidated Net Cost of Operations
ACF	$ 186	$ (53)	$ 133	$ (41)	$ 23	$ (18)	$ 50,433	$ (19)	$ 50,529
ACL	11	(3)	8	(7)	8	1	1,441	-	1,450
AHRQ	43	(15)	28	(414)	414	-	578	(19)	587
CDC	860	(129)	731	(580)	460	(120)	10,040	(21)	10,630
CMS	1,256	(615)	641	(68)	46	(22)	848,326	(69,723)	779,222
FDA	1,101	(237)	864	(34)	13	(21)	2,530	(1,847)	1,526
HRSA	357	(217)	140	(43)	36	(7)	8,580	(47)	8,666
IHS	580	(156)	424	(207)	165	(42)	5,127	(1,059)	4,450
NIH	1,751	(897)	854	(322)	214	(108)	29,837	(141)	30,442
OS	544	(260)	284	(581)	537	(44)	3,616	(8)	3,848
PSC	152	(31)	121	(852)	476	(376)	1,809	(68)	1,486
SAMHSA	114	(71)	43	(121)	103	(18)	3,389	-	3,414
Totals	$ 6,955	$ (2,684)	$ 4,271	$ (3,270)	$ 2,495	$ (775)	$ 965,706	$ (72,952)	$ 896,250

IMPROPER PAYMENTS INFORMATION ACT REPORT

1.0 Overview

The Department of Health and Human Services' (HHS or the Department) Fiscal Year (FY) 2013 *Improper Payments Information Act* Report includes a discussion of the following information, as required by *the Improper Payments Information Act of 2002* (IPIA) as amended by the *Improper Payments Elimination and Recovery Act of 2010* (IPERA) and the *Improper Payments Elimination and Recovery Improvement Act of 2012* (IPERIA), Office of Management and Budget (OMB) Circular A-136, and Appendix C of OMB Circular A-123:

- Program Descriptions (Section 1.10)
- Risk Assessments (Section 2.0)
- Statistical Sampling Process (Section 3.0)
    - Error Rate Presentation (Section 3.10)
- Corrective Action Plans (Section 4.0)
    - Corrective Actions for Grants (Section 4.10)
- Accountability in Reducing and Recovering Improper Payments (Section 5.0)
- Information Systems and Other Infrastructure (Section 6.0)
- Mitigation Efforts Related to Statutory or Regulatory Barriers (Section 7.0)
- Progress and Achievements (Section 8.0)
    - Fiscal Year 2013 Progress (Section 8.10)
    - Fiscal Year 2013 Achievements (Section 8.20)
- Improper Payment Reduction Outlook (Section 9.0)
    - Accompanying Improper Payment Reduction Outlook Notes (Section 9.10)
- Program-Specific Reporting Information (Section 10.0)
    - Medicare Fee-For-Service (FFS) (Parts A and B) (Section 10.10)
    - Medicare Advantage (Part C) (Section 10.20)
    - Medicare Prescription Drug Benefit (Part D) (Section 10.30)
    - Medicaid (Section 10.40)
    - Children's Health Insurance Program (CHIP) (Section 10.50)
    - Temporary Assistance for Needy Families (TANF) (Section 10.60)
    - Foster Care (Section 10.70)
    - Child Care Development Fund (CCDF) (Section 10.80)
- Recovery Auditing Reporting (Section 11.0)

1.10 Program Descriptions

The following is a brief description of the risk-susceptible programs discussed in this report:

1. **Medicare Fee-For-Service (Parts A and B)** - A Federal health insurance program for people age 65 or older, people younger than age 65 with certain disabilities, and people of all ages with End-Stage Renal Disease
2. **Medicare Advantage (Part C)** - A Federal health insurance program that allows beneficiaries to receive their Medicare benefits through a private health plan
3. **Medicare Prescription Drug Benefit (Part D)** - A Federal prescription drug benefit program for Medicare beneficiaries
4. **Medicaid** - A joint Federal/State program, administered by the States, that provides health insurance to certain low income individuals
5. **Children's Health Insurance Program (CHIP)** - A joint Federal/State program, administered by the States, that provides health insurance for qualifying children
6. **Temporary Assistance for Needy Families (TANF)** - A joint Federal/State program, administered by the States, that provides time-limited assistance to needy families with children to promote work, responsibility and self-sufficiency
7. **Foster Care** - A joint Federal/State program, administered by the States, for children who need placement outside their homes in a foster family home or a child care facility.
8. **Child Care Development Fund (CCDF)** - A joint Federal/State program, administered by the States, that provides child care financial assistance to low income working families

2.0 Risk Assessments

In addition to the programs deemed by OMB to be susceptible to significant improper payments, HHS also reviews other programs to determine if they are susceptible to significant improper payments. In FY 2012, HHS incorporated the improper payment risk assessment requirements under IPERA and OMB Circular A-123, Appendix C, into a new risk assessment tool used for multiple purposes. This integrated approach increased efficiency for our programs without compromising the assessment process. HHS continued using the new integrated risk assessment approach in FY 2013 and conducted risk assessments on 32 programs; all 32 programs were determined not to be at-risk for significant improper payments.

3.0 Statistical Sampling Process

Each program's statistical sampling process is discussed in *Section 10: Program-Specific Reporting Information*. Unless otherwise stated in *Section 10*, all programs complied with the IPIA guidance requiring that all estimates be based on the equivalent of a statistically valid random sample of sufficient size to yield an estimate with a 90 percent confidence interval of plus or minus 2.5 percentage points around the estimate of the percentage of erroneous payments. In addition, the seven programs currently reporting error rates used a statistical contractor.

3.10 Error Rate Presentation

OMB Circular A-136 allows agencies to report net error rates in addition to the required gross error rates. Table 1 in *Section 9.0: Improper Payment Reduction Outlook* presents each program's gross and net error rates.

The *gross error rate* is the official program error rate; it is calculated by adding the sample's overpayments and underpayments and dividing by the total dollar value of the sample. The *net error rate* reflects the overall estimated monetary loss to the program; it is calculated by subtracting the sample's underpayments from overpayments and dividing by the total dollar value of the sample.

4.0 Corrective Action Plans

Each program's Corrective Action Plan (CAP) for reducing the estimated rate of improper payments can be found in *Section 10: Program-Specific Reporting Information*. CAPs are used to set aggressive, realistic targets and outline a timetable to achieve scheduled targets. OMB approves all out-year error rate targets. The Department reviews CAPs annually to ensure plans focus on the root causes of the errors, thus making it more likely that targets are met. If targets are not met, HHS will develop new strategies, adjust staffing and other resources, and possibly revise targets.

4.10 Corrective Actions for Grants

In addition to continuing HHS' engagement in the development of government-wide grants circulars, as well as our continuing implementation of HHS regulations and internal policies, the Department has taken the following actions to strengthen the stewardship of grant funds:

- HHS released 11 major internal grants administration policies as part of its update to the Grants Policy Administration Manual (GPAM). These policies covered a wide range of topics including but not limited to: grants closeout, suspension and debarment, grants systems, and grants payments. The updated guidance will facilitate greater financial transparency and accountability, outline consistent grants administration practices, and foster program integrity.
- As part of the GPAM update, HHS launched a departmental effort to utilize subaccounting for HHS' newly awarded grants, and to transition HHS' existing grants that receive new funding to subaccounts. This internal policy change and procedural adjustment will increase financial accountability across the HHS grants community.

5.0 Accountability in Reducing and Recovering Improper Payments

Strengthening program integrity throughout the Department is a top priority of Secretary Sebelius, extending to HHS Senior Executives and program officials at each of our agencies and programs. As evidence of this focus, beginning with senior leadership and cascading down, performance plans contain strategic goals that are related to strengthening program integrity, protecting taxpayer resources, and reducing improper payments. Senior Executives and programs officials are evaluated as part of their semi-annual and annual performance evaluation on their progress toward achieving these goals.

6.0 Information Systems and Other Infrastructure

Section 10: Program-Specific Reporting Information details each program's information systems and other infrastructure.

7.0 Mitigation Efforts Related to Statutory or Regulatory Barriers

Section 10: Program-Specific Reporting Information reports each program's statutory or regulatory barriers, if any, to reduce improper payments.

8.0 Progress and Achievements

8.10 FY 2013 Progress

Since FY 2009, Head Start has reported a consistent decline in its improper payment rate. Head Start reported annual error rates of 0.6 percent in FY 2011 and FY 2012, demonstrating at least two consecutive years of improper payments below the IPIA reporting threshold. Based on Head Start's strong internal controls, monitoring systems, and low reported error rate, OMB approved HHS' request for relief from annual improper payment reporting. In lieu of an annual error rate measurement, HHS will oversee Head Start's performance through existing internal controls and monitoring systems, and incorporate the program into the improper payment risk assessment cycle. In addition, beginning in September 2014, HHS will submit an annual report to OMB that describes Head Start's policies, controls, and corrective actions to prevent and mitigate improper payments in the program, as well as any control deficiencies, risks, and trends that are identified.

8.20 FY 2013 Achievements

8.21 Improving Program Integrity in Medicare and Medicaid

In FY 2013, HHS strengthened its efforts to reduce and recover improper payments in Medicare and Medicaid. While a few of these efforts are highlighted below, more detailed information on the FY 2013 Medicare and Medicaid programs' performance and corrective actions can be found in *Section 10: Program-Specific Reporting Information*. In addition, information on the Medicare and State Medicaid Recovery Auditor Contractor (RAC) programs can be found in *Section 11.0: Recovery Auditing Reporting*.

Affordable Care Act Enrollment Moratorium

Section 6401 of the *Affordable Care Act* added new section 1866(j)(7) to the *Social Security Act* (SSA), which provides HHS with the authority to impose a moratorium on the enrollment of new providers and suppliers to prevent or combat fraud, waste, or abuse in Medicare, Medicaid, or CHIP. On July 30, 2013, HHS launched the first temporary (six month) enrollment moratorium under the *Affordable Care Act* for Miami-area and Chicago-area home health agencies and ground ambulance suppliers in the Houston-area. The focus of these efforts is to prevent and deter fraud, waste, and abuse in problematic services and areas across the country.

Medicare Fraud Prevention System

HHS launched the Fraud Prevention System (FPS) on June 30, 2011, as required by the *Small Business Jobs Act of 2010*. The FPS analyzes all Medicare FFS claims prior to payment using risk-based algorithms developed by HHS and the private sector. HHS uses the FPS to target investigative resources to suspect claims and providers and swiftly impose administrative action when warranted. The system generates alerts in priority order, allowing program integrity analysts to further investigate the most egregious, suspect, or aberrant activity. HHS and its program integrity contractors use the FPS information to stop, prevent, and identify improper payments using a variety of administrative tools and actions, including claim denials, payment suspensions, revocation of Medicare billing privileges, and referrals to law enforcement.

Within the first year of implementing the FPS, HHS took administrative action against providers based solely on FPS leads. Through these actions, HHS saved an estimated $115.4 million in payments, comprised of $31.8 million in estimated actual savings and $83.6 million in estimated projected savings. The FPS also generated leads for 536

new investigations, augmented information for 511 ongoing investigations, and prompted 617 provider interviews and 1,642 beneficiary interviews to verify whether legitimate Medicare services and supplies were provided. HHS continues to take action based on the FPS leads and will report updated information as required by the *Small Business Jobs Act of 2010*.

Medicaid Integrity Program

Under the authority of the *Deficit Reduction Act of 2005* (DRA), HHS' Medicaid Integrity Program has two broad responsibilities:

- To hire contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues.
- To provide effective support and assistance to States in their efforts to combat Medicaid provider fraud, waste, and abuse.

HHS analyzed Medicaid recoveries, which show that since the enactment of the DRA there has been a strong focus on Medicaid integrity. For example, the Medicaid Integrity Program has provided the assistance of Federal staff specializing in program integrity and contractor support to bolster State activities. Based on States' quarterly reports to HHS, this assistance resulted in $1.1 billion in recoveries in FY 2013. HHS is also positioned to provide support to States through funding and technical assistance to implement innovative technology to achieve additional savings.

8.22 Public Assistance Reporting Information System

The Public Assistance Reporting Information System (PARIS) is a Federal/State partnership with all 50 States, the District of Columbia, and Puerto Rico that provides State public assistance agencies detailed information and data to maintain program integrity and detect and deter improper payments in TANF, Medicaid, Workers' Compensation, Child Care, and Supplemental Nutrition Assistance Program (SNAP).

HHS, the Department of Veterans Affairs (VA), and the Department of Defense (DOD) have partnered to advance the PARIS project at no cost to States. The DOD's Manpower Data Center (DMDC) provides computer resources to produce a match file, using Social Security numbers submitted by the States, VA, and DOD as the key match indicator. States verify the matched individual's eligibility and take any necessary action. HHS contributes to this effort by establishing Computer Matching Agreements and coordinating the quarterly matches. PARIS led to reported savings or cost avoidance of approximately $62 million in FY 2013 alone. More information on this partnership can be found at: http://www.acf.hhs.gov/paris.

9.0 Improper Payment Reduction Outlook FY 2012 through FY 2016

The following table displays HHS' IPIA results for the current year (CY) FY 2013, the prior year (PY) FY 2012, and targets for FYs 2014 through 2016. The table includes the following information by year and program: fiscal year outlays, the error rate or future target (IP%), and dollars paid or projected to be paid improperly (IP$). In addition, for the CY, HHS included: the amount of overpayments (CY Overpayments), the amount of underpayments (CY Underpayments), and the net error rate (CY Net IP%) and the corresponding overpayments, when available.

Table 1

Improper Payment Reduction Outlook
FY 2012- FY 2016
(in Millions)

Program or Activity	PY Outlays $	PY IP %	PY IP $	CY Outlays $	CY IP %	CY IP $	CY Over payment $	CY Under payment $	CY Net IP %	CY Net IP $	CY+1 Est. Outlays $	CY+1 IP %	CY+1 IP $	CY+2 Est. Outlays $	CY+2 IP %	CY+2 IP $	CY+3 Est. Outlays $	CY+3 IP %	CY+3 IP $
Medicare FFS	349,673 Note (a)	8.5	29,571	357,397 Note (b)	10.1 Note (1)	36,033	34,609	1,424	9.3	33,185	376,820 Note (c)	9.9	37,305	392,171	9.8	38,433	424,500	9.7	41,177
Medicare Part C	115,183 Note (d)	11.4	13,100	123,696 Note (e)	9.5	11,767	9,313	2,453	5.6	6,860	156,158 Note (f)	9.0	14,054	155,916	8.5	13,253	167,599	8.1	13,576
Medicare Part D	51,140 Note (g)	3.1	1,593	57,056 Note (h)	3.7	2,091	1,741	351	2.4	1,390	72,453 Note (i)	3.6	2,608	81,055	3.5	2,837	92,150	3.4	3,133
Medicaid	271,011 Note (j)	7.1	19,235	246,931 Note (k)	5.8 Note (2)	14,376	13,943	461	5.5	13,495	270,490	5.6	15,147	307,788	5.5	16,928	334,624	5.4	18,070
CHIP	8,629 Note (l)	8.2	704	9,065 Note (m)	7.1 Note (3)	646	635	12	6.9	624	9,763	N/A Note (4)	N/A	9,783	N/A	N/A	10,240	N/A	N/A
TANF	16,538	N/A	N/A	16,521	N/A Note (5)	N/A	N/A	N/A	N/A	N/A	17,058 Note (n)	N/A	N/A	16,848	N/A	N/A	16,817	N/A	N/A
Foster Care	1,294	6.2	80.2	1,326	5.3	70	63	7	4.2	56	1,211 Note (o)	5.1	62	1,049	4.9	51	877	4.7	41
Child Care	5,170	9.4 Note (6)	488	5,188	5.9	306	283	23	5.0	260	5,192 Note (p)	5.0	260	5,195	4.5	234	5,195	4.0	208

Note: For presentation purposes, this table uses rounded numbers. Therefore, some calculations using the figures in the table may not produce the amounts in other cells. For example, the CY Over Payment $ and CY Under Payment $ cells may not add to the CY IP $ cell, and the CY Outlays $ cell times the CY IP % cell may not equal the CY IP $ cell.

Note: The Current Year (CY) CY+1, CY+2 and CY+3 estimated dollars paid improperly (IP$) is calculated based on the target error rate and estimated outlays for each year, respectively. However, it is important to note that the measurement periods for each program vary. Therefore, the future outlay estimates presented may not be the actual amounts against which the error rates will be applied to compute the dollars paid improperly in future years.

9.10 Accompanying Improper Payment Reduction Outlook Notes

a) Medicare FFS PY benefit outlays are from the FY 2012 Medicare FFS Improper Payments Report (based on claims from July 2010 – June 2011).
b) Medicare FFS CY benefit outlays are from the FY 2013 Medicare FFS Improper Payments Report (based on claims from July 2011 – June 2012).
c) Medicare FFS CY+1, CY+2, CY+3 benefit outlays are based on the FY 2014 Midsession Review (Medicare Benefit Outlays current law (CL)).
d) Medicare Part C PY benefit outlays reflect 2010 Part C payments, as reported in the FY 2012 Medicare Part C Payment Error Final Report.
e) Medicare Part C CY benefit outlays reflect 2011 Part C payments, as reported in the FY 2013 Medicare Part C Payment Error Final Report.
f) Medicare Part C CY+1, CY+2, CY+3 benefit outlays are based on the FY 2014 Midsession Review (Medicare Benefit Outlays (CL)).
g) Medicare Part D PY outlays reflect 2010 Part D payments, as reported in the FY 2012 Medicare Part D Payment Error Final Report.
h) Medicare Part D CY outlays reflect 2011 Part D payments, as reported in the FY 2013 Medicare Part D Payment Error Final Report.
i) Medicare Part D CY+1, CY+2, CY+3 benefit outlays are based on the FY 2014 Midsession Review (Medicare Benefit Outlays (CL)).
j) Medicaid PY benefit outlays are from the FY 2012 Medicaid Annual Error Rate Report (based on FY 2011 claims).
k) Medicaid CY (based on FY 2012 expenditures) and CY+1, CY+2, CY+3 benefit outlays ((based on FY 2013 – FY 2015 estimated expenditures) (Medicaid Net Benefit Outlays (CL), excluding CDC Program Vaccine for Children obligations)), are from the FY 2014 Midsession Review.
l) CHIP PY benefit outlays are based on the FY 2012 CHIP Annual Error Rate Report (based on FY 2011 claims).
m) CHIP CY (based on FY 2012 expenditures) and CY+1, CY+2, CY+3 benefit outlays ((based on FY 2013 – FY 2015 estimated expenditures) (CHIP Total Benefit Outlays with CHIPRA Bonus and Health Care Quality Provisions (CL))), are from the FY 2014 Midsession Review.
n) TANF CY+1, CY+2, CY+3 outlays are based on the FY 2014 Midsession Review (TANF total outlays including the Healthy Marriage Promotion and Responsible Fatherhood Grants programs, and excluding the TANF Contingency Fund).
o) Foster Care CY+1, CY+2, CY+3 outlays are based on the FY 2014 Midsession Review, and reflect the Federal share of maintenance payments.
p) Child Care CY+1, CY +2, CY+3 outlays are based on the FY 2014 Midsession Review.

1. Beginning with the FY 2012 AFR, HHS modified the report period by moving it back six months to more accurately measure the improper payment rate in the Medicare FFS program. As a result, the FY 2013 Medicare FFS report period consists of claims from July 1, 2011 through June 30, 2012. In addition, in FY 2012, in consultation with OMB, HHS refined the improper payment methodology to account for the impact of rebilling denied Part A inpatient claims for allowable Part B services when a Part A inpatient hospital claim is denied because the services should have been provided as outpatient services. HHS continued this methodology in FY 2013. This approach is consistent with: (1) Administrative Law Judge (ALJ) and Departmental Appeals Board (DAB) decisions that directed HHS to pay hospitals under Part B for all of the services provided if the Part A inpatient claim was denied, and (2) recent Medicare policy changes that allow rebilling of denied Part A claims under Part B.

HHS calculated an adjustment factor based on a statistical subset of inpatient claims that were in error because the services should have been provided as outpatient. This adjustment factor reflects the difference between what was paid for the inpatient hospital claims under Medicare Part A and what would have been paid had the hospital claim been submitted as an outpatient claim under Medicare Part B. Application of the adjustment factor decreased the overall improper payment rate by 0.6 percentage points to 10.1 percent or $36.0 billion in projected improper payments. Additional information regarding these methodology changes and the adjustment factor can be found on pages 166-167 of HHS' FY 2012 AFR (available at: http://wayback.archive-it.org/3922/20131030171300/http:/www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf).

2. In FY 2013, after consultation with OMB, HHS made two improper payment rate calculation methodology enhancements to improve the accuracy of the Medicaid improper payment rate estimate. These enhancements include: (1) replacing the three-year weighted average national Medicaid improper payment rate with a single-year rolling national Medicaid improper payment rate, and (2) incorporating prior year State-level improper payment rate recalculations.

   In past AFRs, HHS reported a three-year weighted average national Medicaid improper payment rate representing the percentage of expenditures improperly paid over the past three years. The three-year rate was calculated by utilizing a weighted average of the Payment Error Rate Measurement (PERM) cycle error rates from the three most recent years. This methodology was implemented to ensure Medicaid improper payment rate reporting included findings from all States.

   In response to a HHS Office of Inspector General report (OIG report A-06-08-00078, *Oversight and Evaluation of the Fiscal Year 2007 Payment Error Rate Measurement Program*), HHS is now reporting a single-year rolling national Medicaid improper payment rate, a more precise estimate that represents the percentage of expenditures improperly paid during one fiscal year. The single-year rolling rate is calculated by multiplying each State's most recent error rate by that State's expenditures from the fiscal year being reported and dividing by the expenditures for that fiscal year. The single-year rolling rate treats the three most recent PERM cycles as a contiguous sample (as if all States were observed in the fiscal year being reported), which allows HHS to report on findings from all States with improved precision.

   Additionally, past AFRs did not incorporate State-level error rate recalculations that occur after the cycle cut-off date. For the most recent cycle of States measured, these recalculations occur after AFR publication. In response to a Government Accountability Office report (GAO-13-229, *Enhancements Needed for Improper Payments Reporting and Related Corrective Action Monitoring*), State-level error rate recalculations for the previous two cycles measured are now incorporated into the national Medicaid improper payment rate, and will be incorporated in future calculations.

   HHS calculated and is reporting the national Medicaid error rate that is based on measurements that were conducted in FYs 2011, 2012 and 2013. The national Medicaid error component rates are: Medicaid FFS: 3.6 percent; Medicaid managed care: 0.3 percent; and Medicaid eligibility: 3.3 percent. Under the old calculation methodology the FY 2013 national Medicaid error rate would have been 6.1 percent or $15.0 billion instead of the 5.8 percent or $14.4 billion reported in FY 2013 using the new calculation methodology.

3. The two Medicaid improper payment rate calculation methodology enhancements described in *note (2)* also apply to the CHIP improper payment rate estimate with one difference. For FY 2013, only two cycles of States have been measured for CHIP requiring a slightly different approach to the single-year CHIP rolling improper payment rate. For FY 2013, the 34 measured States will be treated as a contiguous sample and projected to the 17 States that have not yet been measured. HHS calculated and is reporting a national CHIP error rate based on measurements that were conducted in FYs 2012 and 2013. The national CHIP error component rates are: CHIP FFS: 5.7 percent; CHIP managed care: 0.2 percent; and CHIP eligibility: 5.1 percent. Under the

old calculation methodology the FY 2013 national CHIP error rate would have been 7.5 percent or $0.7 billion instead of the 7.1 percent or $0.6 billion reported in FY 2013 using the new calculation methodology.

4. The baseline measurement for CHIP, based on the measurement of 50 States and the District of Columbia over a three-year period (FYs 2012 to FY 2014), will be published in the FY 2014 AFR. Therefore, setting out-year target rates for CHIP is not applicable at this time.

5. The TANF program is not reporting an error rate for FY 2013. Statutory limitations prohibit HHS from requiring States to participate in a TANF improper payment measurement.

6. After the publication of the FY 2012 AFR, HHS determined that it had overstated the FY 2012 Child Care improper payment estimate due to incorrect data for a small number of States that was not detected prior to the AFR's publication. HHS implemented corrective actions – including additional data reviews – to prevent this mistake from reoccurring. The FY 2012 improper payment estimate was 9.2 percent or $474 million rather than the published improper payment estimate of 9.4 percent or $488 million. For consistency with the FY 2012 AFR, this table includes the improper payment estimate that was reported in the FY 2012 AFR.

10.0 Program-Specific Reporting Information

10.10 Medicare Fee-for-Service or FFS

10.11 Medicare FFS Statistical Sampling Process

Medicare FFS uses the Comprehensive Error Rate Testing (CERT) program to calculate the improper payment estimate. The CERT program considers any claim paid when it should have been denied or was paid in the wrong amount (including both overpayments and underpayments) to be an improper payment. To meet this objective, a random sample of Medicare FFS claims is reviewed to determine if claims were paid properly under Medicare coverage, coding, and billing rules. If these criteria are not met, the claim is counted as either a total or partial improper payment, depending on the error category. Approximately 54,000 claims were sampled during the FY 2013 report period. The CERT program ensures a statistically valid random sample; therefore, the improper payment rate calculated from this sample reflects all claims processed by the Medicare FFS program during the report period. Additional information on the Medicare FFS improper payment methodology can be found on pages 166-167 of HHS' FY 2012 AFR, available at: http://wayback.archive-it.org/3922/20131030171300/http:/www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf.

The Medicare FFS gross improper payment estimate for FY 2013 is 10.1 percent or $36.0 billion. The FY 2013 net improper payment estimate is 9.3 percent or $33.2 billion.

10.12 Medicare FFS Corrective Action Plans

The primary cause of improper payments is Administrative and Documentation errors (63 percent), in large part due to insufficient documentation. The other cause of improper payments is classified as Authentication and Medical Necessity errors (37 percent), caused by medically unnecessary services, and to a lesser extent, incorrect diagnosis coding.

Data shows that many improper payments resulted from claims paid for services that are clinically appropriate, if provided in less intensive settings. Physicians and DME suppliers contributed substantially to insufficient documentation errors, and hospitals contributed substantially to medical necessity errors. Coding errors were most prevalent in physician services.

HHS developed an Error Rate Reduction Plan (ERRP) that outlines actions the agency will implement to prevent and reduce improper payments for all categories of error. Of particular importance are three corrective actions that HHS believes will have a considerable effect in preventing and reducing improper payments:

- First, HHS is expanding the use of Medicare FFS RACs in the Medicare FFS program. Over the past several years, Medicare FFS RACs have recovered billions of taxpayer dollars by finding improper payments that have already been paid by the Medicare FFS program. HHS now allows the Medicare FFS RACs to review certain types of claims that historically have high amounts of improper payments before they are paid, therefore preventing improper payments from being made in the first place. This demonstration project began for claims processed on or after September 1, 2012. Through this prepayment demonstration, HHS has already saved approximately $22.3 million in improper payments from being made. More information on the Medicare FFS RAC prepayment review demonstration can be found at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/RecoveryAuditPrepaymentReview.html.
- Second, on September 1, 2012, HHS instituted a prior authorization demonstration program in seven States with the expectation of reducing improper payments for power mobility devices. This demonstration project

has already led to a decrease in the expenditures for power mobility devices in the demonstration States as well as in the non-demonstration States. Specifically, based on claims submitted as of September 30, 2013, monthly expenditures for the power mobility devices included in the demonstration States decreased from $20 million in September 2012 to $9 million in August 2013, and from $12 million to $4 million in the non-demonstration States for the same time period. Prior authorization reviews are being performed timely, industry feedback has been positive, and HHS has received no complaints from beneficiaries. HHS continues to closely monitor and evaluate the effectiveness of the demonstration and plans to analyze demonstration data to assist in the investigation and prosecution of fraud. More information on the power mobility device prior authorization demonstration can be found at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Prior-Authorization-of-PMDs-Demonstration-Status-Update-.html.

- Third, HHS implemented two major policies pertaining to inpatient hospital claims that are expected to reduce improper payments:
    - HHS issued an interim measure, Centers for Medicare & Medicaid Services (CMS) Ruling 1455–R (78 FR 16614, issued on March 13, 2013), which ended the demonstration project that allowed hospital participants to bill for inpatient Part B claims when their Part A claim was denied as not reasonable and necessary, and expanded this concept for all hospitals. Proposed Rule 1455-P (78 PR 16632, issued on March 13, 2013), as finalized in 1599-F (78 FR 50495, issued on August 2, 2013), permitted inpatient Part B billing within one year from the date of service. The final measure 1599-F became effective, and Ruling 1455-R became inapplicable, on October 1, 2013.
    - Final measure 1599-F (78 FR 50495) also clarified and modified HHS policy regarding when an inpatient admission is generally appropriate for payment under Medicare Part A and how Medicare review contractors will assess hospital inpatient claims for payment purposes.

In addition to these three major efforts and the ongoing corrective actions reported on pages 167-169 of HHS' FY 2012 AFR, HHS has implemented additional efforts to reduce improper payments in the Medicare FFS program as outlined below.

Corrective Actions: Administrative and Documentation Errors

- HHS continues to build the Healthcare Fraud Prevention Partnership (HFPP), a public-private partnership to improve detection and prevention of health care fraud, waste, and abuse. Public and private partners, including Federal and State partners, private payers, associations, and law enforcement exchange data and successful anti-fraud practices within the HFPP, helping to prevent and detect fraud across sectors.
- HHS, in close collaboration with its Regional Offices, holds program integrity education events for physicians and other providers. These events, typically held in medical schools or hospitals, offer continuing medical education credits (CME) through local provider organizations. As part of its broader outreach activities, HHS created educational materials tailored specifically for physicians, industry stakeholders, and beneficiaries. These materials include fact sheets, guidance documents, frequently asked questions, and CME through Medscape, a company that offers free online news and education for providers. HHS also engaged in direct outreach through live events and speaking engagements.
- HHS requires its Medicare review contractors to focus their medical review efforts on identifying documentation errors in certain error prone claim types, such as home health, hospital outpatient, skilled nursing facility (SNF), and nonhospital-based hospice claims.

Corrective Actions: Authentication and Medical Necessity Errors

- HHS contracted with a Supplemental Medical Review/Specialty Contractor to perform medical reviews focused on vulnerabilities identified by HHS internal data analysis, the CERT program, professional organizations, and Federal oversight agencies. The contractor evaluates medical records and related

documents to determine whether claims were billed in compliance with Medicare coverage, coding, payment, and billing rules.

- HHS implemented the Medicare Part B Outpatient Therapy Cap Exceptions Process, which mandates manual medical review on claims when the beneficiary exceeds the annual $3,700 therapy threshold. On April 1, 2013, the Medicare FFS RAC program began prepayment manual medical review on therapy claims above the threshold in 11 demonstration States. In the remaining States, the Medicare FFS RAC program conducted post-payment manual medical reviews on therapy claims above the threshold.
- HHS continues to allow Medicare Administrative Contractors (MACs) and RACs to review more claim types than in previous years, while closely monitoring the decisions made by these contractors. The MACs' medical review resulted in a projected savings of $5.6 billion in FY 2013.
- HHS continues to develop and issue Comparative Billing Reports (CBRs) to help non-hospital providers analyze their coding and billing practices for specific procedures or services. CBRs are proactive statements that enable providers to examine their billing patterns compared to their peers in the State and nation.

10.13 Medicare FFS Improper Payment Recovery

The actual overpayments identified in the FY 2013 Medicare FFS Improper Payments Report were $40,000,013. The identified overpayments are to be recovered by the Medicare contractors via standard payment recovery methods. As of the report publication date, Medicare contractors reported collecting $33,196,339 or 83 percent of the actual overpayment dollars identified in the report.

10.14 Medicare FFS Information Systems and Other Infrastructure

HHS has the information systems and other infrastructure it needs to reduce improper Medicare FFS payments to the targeted levels. HHS' systems have the ability to identify developing and continuing aberrant billing patterns based upon a comparison of local payment rates with national rates. The systems at both the Medicare contractor level and the HHS level are tied together by a high-speed secure network that allows rapid transmission of large data sets between systems. No other systems or infrastructure are needed at this time.

10.15 Medicare FFS Statutory or Regulatory Barriers That Could Limit Corrective Actions

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

10.16 Medicare FFS Best Practices

The CERT program has incorporated the following best practices to ensure the highest degree of efficiency:

- HHS provides multiple resources to educate providers and suppliers about the CERT program, including several websites, a toll-free customer service telephone line, and on-line reference materials.
- HHS holds weekly calls with all CERT contractors and MACs to facilitate communication, solve problems, and improve the CERT process.
- CERT collaborates with other review contractor entities, such as the MACs and Medicare FFS RACs, to clarify unclear policies, in an effort to ensure review consistency.
- HHS provides interim improper payment rate data to the MACs to help them focus on problematic areas and identify emerging vulnerabilities.

In addition, HHS continues to improve the Medicare FFS improper payment rate measurement program to ensure that providers and suppliers submit the required documentation. Such improvements include:

- HHS coordinates provider outreach and education task forces. These task forces consist of MAC medical review professionals who meet regularly to develop strategies addressing provider education in areas prone

to improper payments. The task forces hold open door forums to discuss documentation requirements and answer provider and supplier questions, and distribute informational articles as needed to improve documentation and to educate providers on Medicare policies. The articles are maintained online on the Medicare Learning Network (MLN) and can be accessed by the public at the MLN website: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html?redirect=/mlngeninfo.

- HHS conducts ongoing education to inform providers and suppliers about the importance of submitting thorough and complete documentation. This education involves national training sessions, individual meetings with providers or suppliers with high improper payment rates, presentations at industry association meetings, and the dissemination of educational materials.
- HHS revises medical record request letters, as needed, to clarify the components of the medical record required for CERT review. The letter serves as a checklist for the provider or supplier to ensure their record submission is complete. Follow-up medical record request letters have also been developed to explain the missing documentation that needs to be submitted.
- When a supplier is contacted for documentation, HHS notifies the ordering provider that they may be contacted by the supplier in order to provide supporting documentation. In addition to this notification, HHS contacts third party providers to request documentation when the billing provider indicates that a portion of the medical record is possessed by a third party. For example, a third party provider may be a physician who orders a power wheelchair from a supplier that submits the claim.
- HHS regularly examines the reasons for errors and makes efforts to collect medical documentation that support the submitted claim, such as through additional phone calls requesting the specific documentation that is missing.

10.20 Medicare Advantage or Part C

10.21 Part C Medicare Advantage Statistical Sampling Process

The FY 2013 Medicare Part C gross improper payment estimate, based on 2011 payments is 9.5 percent or $11.8 billion. The FY 2013 net improper payment estimate is 5.6 percent or $6.9 billion.

The Part C methodology estimates errors resulting from incorrect beneficiary risk scores. The primary component of a beneficiary's risk score is based on clinical diagnoses submitted by plans. If the diagnoses submitted to HHS are not supported by medical records, the risk scores will be inaccurate and result in payment errors. The Part C estimate is based on medical record reviews conducted under HHS' annual Risk Adjustment Data Validation (RADV) process, where unsupported diagnoses are identified and corrected risk scores are calculated.

The FY 2013 methodology consists of the following steps:

- Selection of a stratified random sample of beneficiaries for whom a risk adjusted payment was made in CY 2011, where the strata are high, medium, and low risk scores,
- Medical record review of the diagnoses submitted by plans for the sampled beneficiaries,
- Calculation of beneficiary-level payment error for the sample, and
- Extrapolation of the sample payment error to the population subject to risk adjustment, resulting in a Part C gross payment error amount.

As disclosed in the FY 2012 AFR, due to significant improvements in the Medicare Advantage Prescription Drug (MARx) Payment Error (MPE) component estimate, the MPE was not included in the FY 2013 Part C error rate calculation per OMB approval, and will not be included in future measurements.

10.22 Medicare Advantage Corrective Action Plans

The root cause (100 percent) of FY 2013 Medicare Part C improper payments resulted from Administrative and Documentation errors due to insufficient documentation to support diagnoses submitted by the plans.

HHS has implemented three key initiatives as part of its corrective action plan to address errors in the Part C program. The three initiatives are as follows:

- *Contract-Level Audits*: HHS has proceeded with the RADV contract-level audits to recover overpayments. RADV verifies, through medical record review, the accuracy of enrollee diagnoses submitted by Medicare Advantage (MA) organizations for risk adjusted payment. RADV audits are HHS' primary corrective action to recoup improper payments. HHS expects that payment recovery will have a sentinel effect on the quality of risk adjustment data submitted by plans for payment. HHS expects to conduct RADV audits for approximately 30 MA contracts annually. RADV audits of payment year 2011, expected to begin in FY 2014, will be the first HHS reviews to conduct payment recovery based on extrapolated estimates.
- *Medicare Advantage Organization Guidance and Training*: HHS conducts national training sessions for MA organizations that provide comprehensive assistance for submitting accurate risk adjustment data. In addition, HHS has identified risk adjustment diagnoses that are more likely to be associated with payment error. HHS will continue to analyze diagnoses to determine high-error diagnoses and use these findings to conduct outreach, education, and provide guidance to MA organizations.

  Furthermore, HHS implemented a process to assist plans' submission of medical record documentation. To assist plans and reduce administrative error, HHS extended the medical record submission timeframe and provided outreach to plans during the National Risk Adjustment payment error data validation process. HHS also provides preliminary results to the MA plans and feedback on the validity of submitted records to ensure they are suitable for the Part C error estimate reviews.
- *Physician Outreach*: HHS enhances physician understanding of HHS payment procedures for MA organizations and the payment methodology impact on physicians. This outreach seeks to improve physicians' medical record documentation practices to support risk adjustment diagnoses.

10.23 Medicare Advantage Program Improper Payment Recovery

The Part C error estimate is based on a national sample of beneficiaries across all MA plans. Since this type of sample design does not allow for collection at the MA plan level, no payment recovery had been initiated until FY 2012, when HHS recovered approximately $3.4 million for the first five plans involved in the 2007 RADV audits (the pilot audits) (Note: The FY 2012 Medicare Part C RADV audit amount recovered was amended from $3.5 million, as reported in the FY 2012 AFR, to $3.4 million, due to a reporting discrepancy that was identified after the AFR was published). In FY 2013, HHS continued payment recovery for plans under the 2007 RADV audits and recovered approximately $5 million.

10.24 Medicare Advantage Information Systems and Other Infrastructure

HHS has the information systems and other infrastructure needed to reduce improper Part C payments. HHS uses the following internal Medicare systems to make and validate the Part C payments: the Medicare Beneficiary Database, the Risk Adjustment System, the Health Plan Management System, and the MARx payment system. No other systems or infrastructure are needed at this time.

10.25 Medicare Advantage Statutory or Regulatory Barriers that could limit Corrective Actions

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

10.26 Medicare Advantage Program Best Practices

HHS has taken several steps to ensure payment accuracy in the Part C program, including the corrective actions that were outlined earlier in *Section 10.22*.

10.30 Medicare Prescription Drug Benefit or Part D

10.31 Medicare Prescription Drug Statistical Sampling Process

The Medicare Part D gross improper payment estimate for FY 2013 is 3.7 percent or $2.1 billion. The FY 2013 net improper payment estimate is 2.4 percent or $1.4 billion.

The FY 2013 Part D Composite Payment Error Rate combines four component payment error measures:

- Payment Error Related to Low Income Subsidy Status (PELS),
- Payment Error Related to Medicaid Status (PEMS),
- Payment Error Related to Prescription Drug Event Data Validation (PEPV), and
- Payment Error Related to Direct and Indirect Remuneration (PEDIR).

Combining these four component measures poses complex technical and statistical challenges in calculating a confidence interval for the composite rate. As a result, HHS calculated the precision level for each component independently, and each component meets OMB precision requirements.

The FY 2013 national Part D improper payment rate for each component is:

- *PELS*: 0.2 percent
- *PEMS*: 0.4 percent
- *PEPV*: 2.8 percent
- *PEDIR*: 0.3 percent

The methodology for calculating the PELS, PEMS, PEPV, and PEDIR rates was not altered from FY 2012. A description of the methodology may be found on pages 173-175 of HHS' FY 2012 AFR. In addition, as disclosed in the FY 2012 AFR, due to significant improvements in the MPE component estimate, the MPE component was not included in the FY 2013 Part D calculation per OMB approval, and will not be included in future measurements.

10.32 Medicare Prescription Drug Corrective Action Plan

The root cause of all FY 2013 Part D improper payments (100 percent) is Administrative and Documentation errors. HHS conducted the following corrective actions to address errors in the respective Part D component measures:

- HHS analyzed the PELS error estimate to further understand the PELS population and identify additional steps that can be taken to address errors. In addition, HHS provided guidance to Part D sponsors to update beneficiary LIS status prior to reconciliation.
- The Medicaid corrective actions identified in *Section 10.42* will assist in reducing the PEMS error estimate, as this component is driven by the Payment Error Rate Measurement (PERM) program findings.
- HHS continued national training sessions for Medicare Part D plans. Training provides comprehensive information on all aspects of Part D payment and data submission requirements, including sessions focusing on improvements in prescription drug event (PDE) record submission, which is reflected in the PEPV error rate estimate.

- To assist plans with improved DIR reporting in the future, HHS required plans to submit DIR amounts by National Drug Code (NDC).

10.33 Medicare Prescription Drug Benefit Improper Payment Recovery

HHS conducted the following improper payment recovery activities in FY 2013 for each error rate component:

- *PELS Component*: Further investigation must be done to better determine how to conduct payment recovery.
- *PEMS Component*: Application of the national Medicaid active case eligibility error rate to Part D payments does not allow HHS to identify which dual eligible beneficiaries actually had incorrect Medicaid status. Thus, it is not possible to identify beneficiary-level payments that HHS could recover.
- *PEPV Component*: The FY 2013 PDE validation is based on a national sample of PDEs and the imputation of these results onto the Part D population; therefore, payment errors cannot be linked to specific beneficiaries for payment recovery purposes.
- *PEDIR Component*: The original data used to develop the FY 2013 error rate was based on 2010 audits. Plans submit updates to their reported DIR amounts on a flow basis. HHS will, therefore, address payment recovery through the 2010 Part D reconciliation.

10.34 Medicare Prescription Drug Benefit Information Systems and Other Infrastructure

HHS has the information systems and other infrastructure needed to reduce improper Medicare Part D payments. HHS uses the following internal Medicare systems to make and validate the Part D payments: the Medicare Beneficiary Database, the Risk Adjustment System, the Health Plan Management System, the MARx payment system, and the Integrated Data Repository. No other systems or infrastructure are needed at this time.

10.35 Medicare Prescription Drug Benefit Statutory or Regulatory Barriers that could limit Corrective Actions

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

10.36 Medicare Prescription Drug Benefit Program Best Practices

In addition to the corrective actions outlined in *Section 10.32*, HHS has taken steps to ensure payment accuracy in the Medicare Part D program, including: (1) contacting plans before and during the PEPV data collection and validation process, which provides an open forum for improving instructions for data submission, and (2) extending the data collection period, which increased response rates.

10.40 Medicaid

10.41 Medicaid Statistical Sampling Process

The national FY 2013 Medicaid error rate is based on measurements conducted in FYs 2011, 2012, and 2013. Medicaid improper payments are estimated on a Federal fiscal year basis and measure three component error rates: FFS, managed care, and eligibility. HHS, through its use of Federal contractors, measures the FFS and managed care components and States perform the eligibility component measurement.

The PERM program uses a 17 State three-year rotation for measuring Medicaid improper payments. For information on how HHS grouped States into each of the three cycles, please see pages 177-179 of HHS' FY 2012 AFR.

FFS and Managed Care Component

States submit quarterly adjudicated claims data from which a randomly selected sample of FFS claims and managed care payments are drawn each quarter. Each selected FFS claim is subjected to a medical and data

processing review. Managed care payments are subject only to a data processing review. The FFS sample size was between 260 and 968 claims per State and the managed care sample size was between 240 and 280 payments per State. For FY 2013, the sample sizes were based on each State's historical FFS and managed care improper payment rate data. When a State's FFS component or managed care component accounted for less than two percent of the State's total Medicaid expenditures, the State's FFS and managed care claims were combined into one component for sampling and measurement purposes. This consolidation occurred in five of the 17 States in this year's cycle.

Eligibility Component

States conducted an eligibility review on a randomly selected sample of between 144 and 972 active cases and between 132 and 420 negative cases. The difference in sample sizes is based on the State's historical eligibility improper payment rate data.

Active cases contain information on a beneficiary who is enrolled in the program in the month that eligibility is reviewed. Negative cases contain information on an individual who applied for benefits and was denied, or whose program benefits were terminated based on the State agency's eligibility determination in the month that eligibility is reviewed.

HHS calculated two error rates for active cases, the payment error rate and the case error rate.

- The *payment error rate* is calculated using the weighted dollar value of payments made for services provided to beneficiaries who were ineligible for the program or received a service that was not included in the beneficiary's benefit package divided by the weighted dollar value of claims for the sample of beneficiaries each month (i.e., weighted dollars in error over total weighted dollars in the sample). HHS combines the State reported eligibility component payment error rates to develop a national eligibility error rate for Medicaid.
- The *case error rate* is calculated by dividing the projected number of ineligible beneficiaries by the projected total number of beneficiaries. HHS calculates only a case error rate for negative cases, because no payments were made.

In August 2013, HHS released guidance announcing temporary changes to future PERM eligibility reviews, in light of changes to the way States adjudicate eligibility for Medicaid and CHIP starting in 2014. These changes will impact Medicaid and CHIP improper payment rates reported starting with the FY 2015 AFR.

Calculations and Findings

The national Medicaid program improper payment rate represents the combination of each State's Medicaid FFS, managed care, and eligibility improper payment rates. In addition, individual State improper payment rate components are combined to calculate the national improper payment rates for each component. National component improper payment rates and the Medicaid program improper payment rate are weighted by State size, so that a State with a $10 billion program "counts" 10 times more toward the national rate than a State with a $1 billion program. A small correction factor ensures that Medicaid eligibility improper payments do not get "double counted."

In FY 2013, HHS made two improper payment rate methodology enhancements to improve the accuracy of the Medicaid improper payment rate estimate:

- Single-year Rolling Rate: HHS replaced the three-year weighted average national Medicaid improper payment rate with a single-year rolling national Medicaid improper payment rate.

- Error Rate Recalculations: HHS incorporated prior year State-level improper payment rate recalculations. Seven State-level FFS error rates were recalculated subsequent to FY 2012 reporting and are incorporated into FY 2013 improper payment rate reporting.

See *Section 9.10: Accompanying Improper Payment Reduction Outlook Notes, note (2)* for detailed information on the two improper payment rate calculation methodology enhancements.

The national Medicaid gross improper payment estimate for FY 2013 is 5.8 percent or $14.4 billion. The FY 2013 net improper payment estimate is 5.5 percent or $13.5 billion.

The FY 2013 national Medicaid improper payment rate for each component is:

- *Medicaid FFS*: 3.6 percent
- *Medicaid managed care*: 0.3 percent
- *Medicaid eligibility*: 3.3 percent

Within the Medicaid eligibility improper payment rate, the active case improper payment rate is 2.9 percent and the negative case improper payment rate is 4.2 percent.

Under the old calculation methodology the FY 2013 national Medicaid error rate would have been 6.1 percent or $15.0 billion instead of the 5.8 percent or $14.4 billion reported in FY 2013 using the new calculation methodology enhancements.

10.42 Medicaid Corrective Action Plans

States reviewed for the FY 2013 AFR measurement were the same States reviewed in FY 2010. The re-measurement of these States reflects the impact of effective corrective action plans implemented after the last measurement. The improper payment rate for these States dropped from 9.0 percent in FY 2010 to 5.7 percent in FY 2013, causing a decrease in the FY 2013 national Medicaid error rate. The eligibility component reported the greatest improvement, dropping from 7.6 percent to 3.3 percent.

Overall, the largest cause of the FY 2013 improper payments (by dollar amount) was Verification errors (46 percent), which were mostly caused by cases reviewed for eligibility that were either not eligible or their eligibility status could not be determined, and system pricing errors. The second largest cause of improper payments was Administrative and Documentation errors (35 percent), which were mostly due to insufficient documentation. The remaining improper payments were attributed to Authentication and Medical Necessity errors (19 percent), and were mostly due to diagnosis coding errors.

HHS works closely with all States to develop State-specific Corrective Action Plans (CAPs). All States are responsible for implementing, monitoring, and evaluating the effectiveness of their CAPs. HHS received CAPs from all States whose Medicaid programs were previously measured, and all States measured in FY 2013 are in the process of developing their CAPs for submission to HHS. When developing the CAPs, States focus their efforts on the major causes of improper payments where the State can clearly identify patterns. In addition, States also take steps to reduce errors identified during the measurement.

Because much of the Medicaid FFS improper payment rate in the past was due to missing or insufficient documentation, the majority of State CAPs focused on provider communication and education. These methods included holding provider training sessions and meetings with provider associations; issuing provider notices, bulletins, newsletters, alerts, and surveys; implementing improvements and clarifications to written State policies emphasizing documentation requirements; and performing more provider audits. State CAPs also target eligibility

errors through the leveraging of technology and available databases to obtain eligibility verification information without client contact; providing caseworker training, particularly in areas determined by the PERM review to be error-prone; and providing additional eligibility policy resources through a consolidated manual and web-based training.

In addition to the development, execution, and evaluation of the State-specific CAPs and the ongoing corrective actions reported on pages 179 – 181 of HHS' FY 2012 AFR, HHS has implemented additional efforts to lower improper payments rates:

- HHS began "mini-PERM audits" with two States. Mini-PERM audits are voluntary State-specific improper payment reviews, intended to assist States in identifying and eliminating improper payments during years States are not measured under PERM. These reviews assist States in developing targeted CAPs to decrease Medicaid improper payments.
- As of September 30, 2013, 45 States and the District of Columbia have implemented Medicaid RAC programs to identify and recover overpayments and identify underpayments made for services in their Medicaid programs. The remaining five States have HHS-approved exceptions.
- HHS created a process to allow States to share information on terminated providers and to view information on Medicare providers and suppliers with revoked billing privileges.
- HHS formed a State systems workgroup (that includes representatives from HHS and State staff) to address individual State system problems that may cause payment errors. More information on this effort can be found in *Section 10.44: Medicaid Information Systems and Other Infrastructure*.

10.43 Medicaid Program Improper Payment Recovery

HHS identified $1,516,184; $1,633,991; and $153,188 in Medicaid overpayments eligible for recovery for FYs 2011, 2012 and 2013, respectively. The decrease in Medicaid overpayments eligible for recovery in FY 2013 compared to FYs 2011 and FY 2012 was due to: (1) a decrease in the dollar value of overpayments that were identified in the sample, and (2) the exclusion of overpayments due to eligibility errors because PERM does not recover overpayments for the eligibility component. In addition, the amount of Medicaid overpayments eligible for recovery for FYs 2011 and 2012 was amended from information previously reported in HHS' FY 2012 AFR to also exclude overpayments due to eligibility errors.

HHS works closely with States to recover overpayments identified from the FFS and managed care claims sampled and reviewed. The recoveries of Medicaid improper payments are governed by Section 1903(d)(2) of the SSA and related regulations at 42 CFR Part 433, Subpart F under which States must return the Federal share of overpayments. Section 6506 of the *Affordable Care Act* amended section 1903(d)(2) to allow States up to one year from the date of discovery of an overpayment for Medicaid services to recover, or to attempt to recover, such overpayment before making an adjustment to refund the Federal share of the overpayment.

10.44 Medicaid Information Systems and Other Infrastructure

Since Medicaid payments occur at the State level, information systems and other infrastructure needed to reduce Medicaid improper payments would need to be implemented at the State level. PERM faced many challenges with State payment systems that had paper only and aggregate claims, changes in information systems at the State level during the course of the measurement cycle, and a wide variation of system designs and capabilities. HHS has encouraged and supported States in their efforts to modernize and improve State Medicaid Management Information Systems (MMIS), which will produce greater efficiencies in the PERM measurement and strengthen program integrity. The State systems workgroup meets regularly to identify and discuss vulnerabilities and the

impact on the measurement of improper payments. In addition, HHS developed a methodology to measure aggregate claims that have been incorporated into the PERM processes.

HHS developed a comprehensive plan to modernize the Medicaid and CHIP data systems. The primary goal of this plan is to leverage technologies to create an authoritative and comprehensive Medicaid and CHIP data structure so that HHS can provide more effective oversight of its programs. The plan will also result in a reduction of State burden and the availability of more robust data for the PERM program.

HHS is also developing the Transformed Medicaid Statistical Information System (T-MSIS). T-MSIS will facilitate State submission of timely claims data to HHS, expand the MSIS dataset, and allow HHS to review the completeness and quality of State MSIS submittals in real-time. HHS will use this data for the Medicaid improper payment measurement and to satisfy other HHS requirements. Through the use of T-MSIS, HHS will not only acquire higher quality data, but will also reduce State data requests. States will move to T-MSIS on a rolling basis with the goal of having all States submitting data monthly by July 1, 2014.

10.45 Medicaid Statutory or Regulatory Barriers that could limit Corrective Actions

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

10.46 Medicaid Program Best Practices

Based on lessons learned through previous PERM cycles and in an effort to address challenges faced by the States, HHS continues the pre-cycle phase of the PERM measurement. The pre-cycle phase occurs prior to a State's first data submission, and allows HHS to disseminate information on changes in the program and to conduct individual orientation and education sessions with the States. In addition to the ongoing measures reported on pages 182 - 183 of HHS' FY 2012 AFR, HHS incorporated the following efforts into the Medicaid measurement process:

- HHS issued State-specific error rate targets. State-level goals for reducing improper payments provide a foundation for meeting national Medicaid improper payment targets. Collaboration between HHS and the States is vital to achieve national and State-specific targets.
- HHS issued updated CAP development guidance for States and improved protocols for HHS' review of State CAPs. These improvements ensure that State CAPs fully address errors and reduce improper payments.
- HHS continues to offer training, technical assistance, and support to State Medicaid program officials through the Medicaid Integrity Institute (MII). Between FYs 2008 and 2013, the MII provided training to over 4,000 State employees and officials from 50 States, the District of Columbia, and Puerto Rico.

10.50 Children's Health Insurance Program or CHIP

10.51 CHIP Statistical Sampling Process

HHS calculated and reports the national CHIP improper payment rate based on measurements conducted in FYs 2012 and 2013. CHIP improper payments are estimated on a Federal fiscal year basis and measure three component error rates: FFS, managed care, and eligibility. HHS, through its use of Federal contractors, measures the FFS and managed care components and States perform the eligibility component measurement.

CHIP utilizes the same State sampling process as Medicaid. HHS determined that CHIP can be measured in the same States selected for Medicaid review each fiscal year with a high probability that the CHIP improper payment rate will meet the IPIA required confidence and precision levels. Since CHIP and Medicaid will be measured in the same States each year, each State will be measured for CHIP once every three years. For information on how HHS grouped States into each of the three cycles, please see pages 177-179 of HHS' FY 2012 AFR.

FFS and Managed Care Component

States submit quarterly adjudicated claims data from which a randomly selected sample of FFS claims and managed care payments are drawn each quarter. Each selected FFS claim is subjected to a medical and data processing review. Managed care payments are subject only to a data processing review. The average FFS sample size was 520 claims per State and the average managed care sample size was 280 payments per State.

Under Section 601 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), beginning in FY 2012 States could elect to accept or reject their previously reported CHIP improper payment rate. If a State elected to accept their previous CHIP improper payment rate, the State would utilize a State-specific sample size based on that rate. Since no historical improper payment rate data was available for States reviewed in FY 2013, State-specific samples were not utilized during this measurement cycle.

When a FFS component or managed care component for a State accounted for less than two percent of the State's total CHIP expenditures, the State's FFS and managed care claims were combined into one component for sampling and measurement purposes. This consolidation occurred for claims in three States.

Eligibility Component

States conducted an eligibility review on a randomly selected sample of 504 active cases and 204 negative cases. Since no historical eligibility improper payment rate data was available for States reviewed in FY 2013, State-specific sample sizes were not utilized during this measurement cycle.

HHS calculated two error rates for active cases, the payment error rate and the case error rate. The methodologies for these calculations are the same as those applied to Medicaid. Please see *Section 10.41* for further explanation of active and negative cases. In addition, the temporary changes to future PERM eligibility reviews that are discussed in *Section 10.41* also apply to the CHIP measurement.

Calculations and Findings

All payment error rate calculations for the CHIP program (the FFS component, managed care component, eligibility component, and national CHIP error rate) are based on the ratio of estimated dollars of improper payments to the estimated dollars of total payments. Individual State improper payment rate components are combined to calculate the national component improper payment rates. The national CHIP improper payment rate is calculated by combining the individual State improper payment rates. National component improper payment rates and the CHIP improper payment rate are weighted by State size, so that a State with a $1 billion program "counts" 5 times more toward the national rate than a State with a $200 million program. The national CHIP improper payment rate represents the combination of FFS, managed care, and eligibility improper payment rates. A small correction factor ensures that CHIP eligibility improper payments do not get "double counted."

The two Medicaid improper payment rate methodology enhancements described in *Section 10.41* also apply to the CHIP improper payment rate estimate with one difference. For FY 2013, only two cycles of States have been measured for CHIP requiring a slightly different approach to the single-year CHIP rolling improper payment rate until all three cycles of States are measured in FY 2014. For FY 2013, the 34 measured States will be treated as a contiguous sample and projected to the 17 States that have not yet been measured. Only two State-level FFS error rates were recalculated subsequent to FY 2012 reporting and are incorporated into FY 2013 improper payment rate reporting. See *Section 9.10: Accompanying Improper Payment Reduction Outlook Notes, notes (2) and (3)* for detailed information on the two improper payment rate methodology enhancements.

The national CHIP improper payment estimate for FY 2013 is 7.1 percent or $646 million. The FY 2013 net improper payment estimate is 6.9 percent or $624 million.

The FY 2013 national CHIP improper payment rate for each component is:

- *CHIP FFS* – 5.7 percent
- *CHIP managed care* – 0.2 percent
- *CHIP eligibility* – 5.1 percent

Within the CHIP eligibility error rate, the active case error rate is 7.2 percent and the negative case error rate is 3.7 percent.

Under the old calculation methodology the FY 2013 national CHIP error rate would have been 7.5 percent or $0.7 billion instead of the 7.1 percent or $0.6 billion reported in FY 2013 using the new calculation methodology enhancements.

10.52 CHIP Corrective Action Plans

HHS actively works with States to develop CAPs to address errors. HHS' experience is that improper payments are typically higher in the early years of improper payment measurement programs because the process is new. HHS expects CHIP improper payments to decrease as States refine their outreach and documentation efforts. Overall, the majority of the FY 2013 improper payments (by dollar amount) were a result of Verification errors (50 percent), which were mostly caused by cases reviewed for eligibility that were not eligible. The second largest cause of improper payments was Authentication and Medical Necessity errors (29 percent), which were mostly due to policy violations. The third leading cause of errors was Administrative and Documentation errors (21 percent), which were mostly due to insufficient and no documentation errors.

HHS works closely with all States to develop State-specific CAPs. All States are responsible for implementing, monitoring and evaluating the effectiveness of their CAPs. HHS received CAPs from all States whose CHIP programs were measured and reported in FY 2012, and all States that measured in FY 2013 are in the process of developing their CAPs for submission to HHS. When developing the CAPs, States focus their efforts on the major causes of improper payments where the State can clearly identify patterns. In addition, States take steps to reduce errors identified during the measurement.

Because much of the CHIP FFS improper payment rate has been due to missing or insufficient documentation, the majority of State CAPs focused on strengthening provider communication and education. These methods included enhancing provider training, presentations, newsletters, notices, bulletins, and provider broadcasts; conducting outreach to public providers; and performing more provider audits. For eligibility errors, State corrective actions included clarifying written State policies, particularly documentation requirements; launching a more advanced and improved electronic client eligibility system; providing refresher training for eligibility staff, particularly in areas determined by the PERM review to be error-prone; and producing informational broadcasts regarding error information and changes to eligibility policy and procedures. In addition to the development, execution, and evaluation of the State-specific CAPs, HHS has also made significant efforts to lower improper payments rates:

- HHS began "mini-PERM audits" with three States. Mini-PERM audits are voluntary, State-specific improper payment reviews, intended to assist States in identifying and eliminating improper payments during years States are not measured under PERM. These reviews assist States in developing targeted CAPs to decrease CHIP improper payments.
- HHS created a process to allow States to share information on terminated providers and to view information on Medicare providers and suppliers with revoked billing privileges.

- HHS continues provider outreach efforts, provider open forum calls, PERM+ data submission option implementation, aggregate payments methodology implementation, national best practice calls, post-CAP meetings, and State system workgroup meetings as discussed on pages 180-181, of HHS' FY 2012 AFR.

10.53 CHIP Program Improper Payment Recovery

HHS identified $355,399 and $172,482 in CHIP overpayments eligible for recovery for FYs 2012 and 2013 respectively. The decrease in CHIP overpayments eligible for recovery in FY 2013 compared to FY 2012 was due to: (1) a decrease in the dollar value of overpayments that were identified in the sample, and (2) exclusion of overpayments due to eligibility errors because PERM does not recover overpayments for the eligibility component. In addition, the amount of CHIP overpayments eligible for recovery for FY 2012 was amended from information previously reported in HHS' FY 2012 AFR to also exclude overpayments due to eligibility errors.

HHS works closely with States to recover overpayments identified from the FFS and managed care claims sampled and reviewed. Recoveries of CHIP improper payments are governed by Section 2105(e) of the SSA and related regulations at 42 CFR Part 457, Subpart B under which States must return the Federal share of overpayments. States reimburse HHS for the Federal share on the CHIP CMS-21 expenditure report. Section 2105(c)(6)(B) of the SSA incorporated the overpayment requirements of Section 1903(d)(2) for CHIP. Section 6506 of the *Affordable Care Act* amended section 1903(d)(2) to allow States up to one year from the date of discovery of an overpayment for services to recover, or to attempt to recover, such overpayment before making an adjustment to refund the Federal share of the overpayment.

10.54 CHIP Information Systems and Other Infrastructure

Since CHIP payments occur at the State level, information systems and other infrastructure needed to reduce CHIP improper payments would need to be implemented at the State level. Please refer to *Section 10.44: Medicaid Information Systems and Other Infrastructure* for information on HHS- and State-led efforts to modernize information and data systems at the national and State level.

10.55 CHIP Statutory or Regulatory Barriers that Could Limit Corrective Actions

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

10.56 CHIP Best Practices

Based on lessons learned through previous PERM cycles and in an effort to address challenges faced by the States, HHS continues the pre-cycle aspect of the PERM measurement. The pre-cycle phase occurs prior to a State's first data submission, and allows HHS to disseminate information on changes in the program and to conduct individual orientation and education sessions with the States. In addition to the Medicaid Program Best Practices outlined in *Section 10.46*, the following measures have been incorporated into the CHIP measurement process:

- States are educated on the PERM process through HHS-initiated cycle calls and website activity.
- HHS designated a cycle manager as the lead for a fiscal year measurement and the main point of contact at HHS for that year.
- HHS utilized dashboards, a compilation of the contractors' and States' work, to monitor the progress of the measurement. The dashboards enable HHS to monitor problems in the measurement early and provide assistance to resolve issues that could delay the measurement process.
- HHS used monthly all-contractor meetings to facilitate communication and problem solving between HHS and its contractors to improve the PERM process.
- For States having difficulty providing complete data, HHS has provided onsite technical assistance.

10.60 Temporary Assistance for Needy Families or TANF

10.61 TANF Statistical Sampling Process

Statutory limitations prohibit HHS from requiring States to participate in a TANF improper payment measurement. As a result, the TANF program is not reporting an error rate for FY 2013.

10.62 TANF Corrective Action Plans

Since TANF is a State-administered program, corrective actions that could help reduce improper payments would have to be implemented at the State level. The TANF statute prohibits HHS from requiring State TANF agencies to implement and report on corrective actions. Despite the limitations, HHS has taken the following actions to assist States in reducing improper payments:

- HHS is working with States to analyze Single Audit findings related to TANF and to implement corrective actions to address these findings.
- HHS performed a detailed risk assessment of the TANF program. As part of this process, HHS identified potential programmatic risks at the Federal level and is working to mitigate these programmatic risks.
- HHS awarded two TANF Program Integrity Innovation Grants to State human service agencies with funding from OMB's Partnership Fund for Program Integrity Innovation. The grantees will conduct pilot projects that are designed to reduce improper payments and improve administrative efficiency in their TANF programs. Lessons learned from the pilots will be used to improve internal efficiency and provide guidance to other State human service agencies looking to improve TANF program integrity.
- HHS released guidance to State human service agencies, in a question and answer format, related to appropriate use of TANF program funds.

10.63 TANF Improper Payments Recovery

Statutory limitations prohibit HHS from requiring States to participate in a TANF improper payment measurement. As a result, HHS is not reporting an error rate or any results from improper payment recoveries for FY 2013.

10.64 TANF Information Systems and Other Infrastructure

Information systems and other infrastructure needed to reduce TANF improper payments would need to be implemented at the State level. States utilize PARIS, the National Directory of New Hires (NDNH), and the Income and Eligibility Verification System (IEVS) to minimize improper payments. No other systems or infrastructure are needed at this time.

10.65 TANF Statutory or Regulatory Barriers

Statutory limitations prohibit HHS from requiring States to participate in a TANF improper payment measurement.

10.66 TANF Program Best Practices

HHS encourages States to stress the importance of payment accuracy for TANF cases and seriously consider measures that will reduce the incidence of erroneous payments. Actions that may prove beneficial include, but are not limited to:

- Conduct local office quality control reviews for eligibility and payment processes at both the initial intake and redetermination stages of the case, and perform periodic "checks" of case records, paying particular attention to documentation such as a current application and facts supporting income, household composition, participation in work activities, and cooperation with child support enforcement.

- Develop and maintain a reminder system for critical follow-up actions on cases such as responding to reports of non-cooperation with child support, IEVS "hits", redeterminations of eligibility, or failure to fulfill work requirements.

- Remind TANF recipients periodically of their responsibility to accurately report income, resources, and other changes in family circumstances to the local TANF agency on a timely basis; to use NDNH information to verify the eligibility of adult TANF recipients residing in the State; and to modify benefits or close the case if the individual is not eligible for assistance.

- Conduct training on investigative interviewing techniques for intake workers and case managers.

- Establish and monitor internal procedures to ensure that TANF payments are adjusted on a timely basis when family circumstances change and affect case eligibility or the amount of payment, and establish a process for the collection of TANF overpayments from the applicable recipients.

10.70 Foster Care

10.71 Foster Care Statistical Sampling Process

There were no changes to the statistical sampling process for *Title IV-E* Foster Care in FY 2013. The Foster Care improper payment estimate is calculated each year using data collected in the most recent Foster Care Eligibility Review for each State. Under the regulatory review promulgated at *45 CFR 1356.71*, Foster Care Eligibility Reviews are conducted systematically in each State every three years. Each regulatory review identifies the number of error cases and amount of payment errors, as determined from the review of a sample drawn from the State's overall *Title IV-E* Foster Care caseload for its six-month Period Under Review (PUR). The sample is a random sample drawn from the universe of cases having at least one *Title IV-E* Foster Care maintenance payment during the PUR. Since each State is reviewed every three years, each year's data incorporates new review data for about one-third of the States. For a more detailed description of the Foster Care improper payments statistical sampling and estimation methodology, please see pages 189-190 of HHS' FY 2012 AFR.

The Foster Care gross improper payment estimate for FY 2013 is 5.3 percent or $69.7 million. The FY 2013 net improper payment rate is 4.2 percent or $56.0 million.

10.72 Foster Care Corrective Action Plans

All payment errors (100 percent) in the *Title IV-E* Foster Care Program are Administrative and Documentation errors due to incorrect case classification and payment processing by State agencies. The Foster Care program designs corrective action plans to help States address these payment errors that contribute most to *Title IV-E* improper payments.

Corrective actions have decreased the overall number of payment errors and altered the composition of identified payments errors. For example, following years of work with State Court Improvement Programs and outreach to heighten judicial awareness, judiciary-related errors, once the most prevalent error type, are now among the least common.

HHS continues to monitor review results and analyze the types of payment errors in the Foster Care program to target corrective action planning. In FY 2013, the most common payment errors included:

- Underpayments (29 percent of errors),
- Ineligible payments (e.g., therapy or unallowable transportation costs) (11 percent of errors),
- Family not eligible for the Aid to Families with Dependent Children program at time of removal (8 percent of errors),

- Duplicate or excessive maintenance payments to providers (8 percent of errors),
- Provider not licensed or approved (7 percent of errors), and
- Provider criminal records check not completed (6 percent of errors).

Together these six items continue, as in past years, to account for nearly 70 percent of Foster Care payment errors; however, the overall frequency of all types of payment errors in the composite Foster Care sample decreased by 9 percent from FY 2012 to FY 2013. In addition, although underpayments represent nearly one-third of all errors in terms of frequency, the dollar amount of the underpayments decreased, as the underpayment rate improved from 0.7 percent in FY 2012 to 0.5 percent in FY 2013.

In FY 2013, HHS undertook the following key actions to reduce improper payments:

- Program leadership convened meetings with Federal Regional Office staff to share information about the Foster Care program's improper payment estimates and to highlight the importance of achieving HHS' performance goals.
- The National Team Leader for the *Title IV-E* Foster Care Eligibility Reviews conducted training at all ten Regional Offices on current Foster Care eligibility requirements and guidance on identifying improper payments. This in-depth training enhanced Federal staff's knowledge of program requirements, allowing them to better work with States to improve performance.

In addition, HHS continued the following ongoing corrective actions:

- HHS conducts onsite and post-site review activities to validate the accuracy of State claims for reimbursement of payments made on behalf of children and their Foster Care providers. Specific feedback is provided onsite to the State agency to positively affect proper and efficient program administration and implementation. Furthermore, HHS issues a comprehensive final report that presents findings of the review to the State agency. The final report serves as the basis for the development of a Program Improvement Plan (PIP) for States that exceed the error threshold.
- HHS requires non-compliant States (those that exceed the error threshold) to develop and execute State-specific PIPs that link corrective actions to the root cause of payment errors. The PIP identifies the specific action steps necessary to target and correct error root causes. To ensure the timely error correction, each action strategy is required to have a projected completion within one year from the date HHS approved the PIP. PIPs are a proven and effective strategy, as reflected in the decrease of the national *Title IV-E* error rate since FY 2004.
- HHS provides training and technical assistance to States to develop and implement program improvement strategies, even when States are not required to develop a PIP. The intent of this assistance is to help States expand organizational capacity and promote more effective program operations.
- HHS conducts secondary reviews, as applicable, and takes appropriate disallowances consistent with the review findings, including an extrapolated disallowance if the State is found not in substantial compliance. These additional disallowances, in conjunction with the development and implementation of the PIP, serve as a strong incentive to States to improve compliance.

10.73 Foster Care Improper Payment Recovery

As a result of conducting Foster Care eligibility reviews in 18 States during the 12-month period between July 2012 and June 2013, HHS recovered over $1.1 million in *Title IV-E* improper payments. The recovered funds are comprised of $627,686 in disallowed maintenance payments and $459,781 in disallowed administrative payments.

Improper payment recovery occurs through *post-payment review*, through both eligibility reviews as well as audit reviews. The Foster Care program does not systematically track cost recovery through OIG reviews or Single Audit reports; rather, the program obtains this information from HHS reports generated as part of the audit clearance process. Specifically, the program identifies and tabulates audit findings where the audit has been closed and a recommended cost recovery has been sustained for the *Title IV-E* Foster Care program. These recovery amounts are in addition to the amounts identified through the eligibility reviews and are presumed to be recovered in the fiscal year when the audit is closed. Recoveries of improper payments through audits may include *Title IV-E* Foster Care maintenance assistance payments, administration, training, and automated systems development costs. See *Section 11.0* for further information on payment recovery.

10.74 Foster Care Information Systems and Other Infrastructure

HHS uses the Adoption and Foster Care Analysis and Reporting System for the regulatory reviews. Utilization of this system reduces the burden on States to draw their own samples, promotes uniformity in sample selection, and employs the database in a practical and beneficial manner. Since Foster Care payments occur at the State level, information systems and other infrastructure needed to reduce Foster Care improper payments would need to be implemented at the State level. No other systems or infrastructure are needed at this time.

10.75 Foster Care Statutory or Regulatory Barriers

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

10.76 Foster Care Best Practices

Since the inception of its improper payment reporting, HHS has maintained a diligent focus on improper payment identification and reduction efforts in the Foster Care program. Refinements to the error rate methodology have included steps to ensure systematic examination and consideration of underpayments in eligibility reviews and modifying data retention practices to permit shifting from case-based extrapolation to dollar-based extrapolation.

Concurrent with these efforts to continually refine its identification and reporting of improper payments, HHS works with State child welfare agencies to improve administrative procedures for tracking and documenting eligibility. HHS also works with the judiciary to support adherence to requirements for timely and thoroughly documented case hearings and court orders. These efforts have yielded reductions in eligibility errors and improper payments, as well as the recovery of $17.9 million in improper payments.

In addition to the ongoing efforts to address improper payments as outlined above, the Foster Care program continues to lay the groundwork for a new methodology to review administrative payments (i.e., Administrative Cost Review or ACR). In FY 2013, HHS issued final reports for two FY 2012 pilot tests of the ACR methodology and transmitted the results to State agency leadership for their consideration. Recommendations focused on improving allocation and assignment of administrative costs to *Title IV-E* Foster Care. HHS has compiled all ACR pilot results (nine reviews conducted between FY 2007 and FY 2012), and HHS is currently analyzing these results to determine how best to utilize the ACR process in the future.

10.80 Child Care or CCDF

10.81 Child Care Statistical Sampling Process

There were no changes to the statistical sampling process in FY 2013. For the CCDF improper payments statistical sampling methodology, please see: http://www.acf.hhs.gov/sites/default/files/occ/data_final_0.pdf.

The CCDF methodology distinguishes between authorizations for payment and actual payments made to providers. Therefore, the amount of improper authorizations for payment identified during the review process does not

represent actual improper payments. In general, the amount of payments is lower, computed to be on average about 17 percent lower.

The CCDF gross improper authorizations for payment estimate for FY 2013 is 5.9 percent or $306 million. The FY 2013 net improper payment estimate is 5.0 percent or $260 million.

10.82 Child Care Corrective Action Plans

Administrative and Documentation errors account for an estimated 51 percent of errors identified in the CCDF Improper Authorizations review process. Errors were primarily due to missing or insufficient documentation. The most frequently cited errors due to missing or insufficient documentation include:

- Insufficient documentation of earned income, unearned income, and income deductions,
- Insufficient documentation of the hours of care needed,
- Missing or incomplete documentation about the work, or educational or training activity of the head of household, and
- Missing case records.

Verification errors represent approximately 49 percent of errors found in the reviews. Verification errors occur when there is a lack of information to verify portions of the case record. These errors consist of the failure to apply policy correctly, including:

- Income calculation errors (inability to determine income calculation method, or use of an incorrect monthly conversion factor),
- Incorrect computation of the hours of care needed,
- Inclusion or exclusion of income,
- Co-pay calculation errors, including incorrect use of the fee schedule,
- Failure to process reported changes, and
- Data errors.

HHS and States have established corrective actions targeting both error types. States' efforts include:

- *Performing ongoing case record reviews:* Eight of 17 States measured in FY 2013 conducted reviews or re-reviews of cases to monitor error-prone policy areas and review supporting documentation to ensure correct policy application.
- *Developing comprehensive training plans:* Twelve of 17 States measured in FY 2013 developed aggressive training plans that included policy clarifications, calculation tools, and checklists for supervisors and workers to ensure accuracy in eligibility processing and the targeting of specific errors, such as income calculation, co-payment, and fee schedules.
- *Enhancing automated systems:* Ten of 17 States measured in FY 2013 implemented automation changes to track attendance, issue caseworker alerts for action items, produce monitoring reports, and generate computer edits.
- *Performing ongoing program monitoring*: Eight of 17 States measured in FY 2013 created performance improvement plans, performance expectations, and targeted corrective actions for managers to include in their monitoring procedures.

HHS' corrective actions include:

- Providing technical assistance through on-site visits, webinars, interactive online meetings, conference calls, and written documents. These were specifically designed to help States focus on staff training, eligibility determination policies and procedures, documentation requirements, routine case reviews, and overall program administration.
- Providing States with an opportunity for peer-to-peer sharing of both error causes and program improvements, in an effort to reduce and/or eliminate improper payments. States were able to share information with each other during Regional calls with State Administrators, at Regional and National meetings, and through conference calls.
- Implementing the technical assistance tool "Grantee Internal Control Self-Assessment Instrument" with States with high error rates to help them assess their internal control system, identify areas of risk, develop mitigation strategies, and receive technical assistance as they implement corrections. Seven of the States measured during FY 2013 were visited by HHS representatives to help complete the self-assessment between their previous review and this review.

10.83 Child Care Program Improper Payment Recovery

The cumulative FY 2013 CCDF improper overauthorizations for payments amount is $505,094. The overall error estimate is comprised of three review cycles: FYs 2011, 2012, and 2013. The improper overauthorizations for payments are as follows for each cycle: Year One States (reported in FY 2011) - $155,883, Year Two States (reported in FY 2012) - $146,914, and Year Three States (reported in FY 2013) - $202,297. (Note: After the publication of HHS' FY 2012 AFR, HHS determined that it had provided incorrect totals for the improper overauthorizations identified in previous reviews. The figure for Year 1 States' (reported in FY 2011) estimated improper overauthorizations was previously reported as $159,012, but the correct figure is $155,883.)

The FY 2013 review cycle represents the second time that Year Three States have conducted the error rate measurement. Compared to FY 2010, the last time this cycle of States was measured, the improper overauthorizations for payment amount declined by $193,932 (from $396,229 to $202,297). (Note: After the publication of HHS' FY 2012 AFR, HHS determined that it had provided incorrect totals for the improper overauthorizations identified in previous reviews. The figure for the Year 3 States' (reported in FY 2010) estimated improper overauthorizations was previously reported as $384,748, but the correct figure is $396,229.)

Overall, States estimate that they will recover 16 percent of the $505,094 identified as overauthorizations during the complete review cycle. Year Three States expect to recover an estimated 21 percent, or $42,117, of the $202,297 in overauthorizations for payment identified during the review. The current review methodology only requests that States provide an estimate for projected recoveries identified from the sampled cases. Requesting information regarding actual collections would violate the *Paperwork Reduction Act.* The planned revision, effective in FY 2014, to measure payments instead of authorizations for payment, will require grantees to provide information on both the estimate they expect to recover in the future and any funds recovered from prior reviews.

10.84 Child Care Program Information Systems and Other Infrastructure

Since CCDF payments occur at the State level, information systems and other infrastructure needed to reduce CCDF improper payments would need to be implemented at the State level. In addition to the efforts outlined on page 198 of HHS' FY 2012 AFR, States reported a range of improvements to information systems including:

- Incorporating the Federal case review worksheet or a facsimile in the automated eligibility system, and,
- Providing eligibility staffs with access to eligibility systems for other programs like TANF and SNAP.

10.85 Child Care Program Statutory or Regulatory Barriers

No statutory or regulatory barriers that would limit corrective actions have been identified at this time.

10.86 Child Care Program Best Practices

The "best practices" or "lessons learned" most frequently cited by the Year Three States, based on their experiences in two review cycles, include the following:

- *Centralized case-record reading*: This practice supported the re-review process through consistent policy interpretation, error definition, and copying record materials; regular reviewer meetings to discuss issues; and the management of operational costs.
- *Starting the planning process early:* All phases of the measurement process took longer than States expected. Starting the process earlier allowed time to react to the unexpected, such as sampling problems or delays, review-team issues, or record-reading problems.
- *Ongoing case-record reviews:* Several Year Three States continued or began to incorporate case record reviews into ongoing monitoring processes to improve practices and reduce errors. Results from these reviews informed training needs, policy and procedure revisions, and increased productivity and accuracy.

11.0 Recovery Auditing Reporting

From FY 2004 to FY 2006, HHS awarded a contingency fee contract to a recovery auditing firm to review $24 billon in contract payments made from FY 2002 to FY 2005. During that review, the recovery auditors found the HHS payment systems to be without major program integrity issues. The auditors identified approximately $1.6 million in potential recoveries and HHS recovered $74,401. We have not sought a contractor to attempt to recover funds beyond FY 2005 because our efforts to date have produced such small recoveries.

More recently, HHS created a risk-based strategy to implement the recovery auditing provisions of *IPERA*. Specifically, HHS is focusing initially on implementing recovery audit programs in Medicare and Medicaid, which accounted for 85 percent of HHS' outlays in FY 2013. In addition, HHS is also exploring implementing recovery audit programs in a cost-effective manner for additional programs, which account for the remaining HHS' outlays. In the meantime, we are making substantial progress in recovering improper payments in Medicare and Medicaid, as described below.

Medicare FFS RACs

Section 302 of the *Tax Relief and Health Care Act of 2006* required HHS to implement the Medicare FFS RAC program in all 50 States no later than January 1, 2010. In FY 2013, the Medicare FFS RAC program demanded approximately $4.2 billion and recovered $3.7 billion in overpayments by the end of the fiscal year. The difference in the amount of improper payments identified compared to the amount of improper payments recovered was due to several factors, including: extended repayment plans; bankruptcies; investigations by the HHS Office of Inspector General, the Department of Justice, or Zone Program Integrity Contractors; and provider or supplier appeals of overpayment determinations. During FY 2013, the Medicare FFS RACs focused their reviews on short hospital stays and claims for durable medical equipment. HHS continues to monitor and make continuous improvements to the Medicare FFS RAC program activities.

In addition to using the Medicare FFS RACs to identify overpayments, HHS also uses Medicare FFS RAC findings to prevent future improper payments. For example, in FY 2013, HHS released four Provider Compliance Newsletters that provided detailed information on 30 findings identified by the Medicare FFS RACs. Based on these findings, HHS also implemented local and/or national system edits to automatically prevent improper payments.

More information on the Medicare FFS RAC program can be found at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/.

Medicare Part C and Part D RACs

Section 6411(b) of the *Affordable Care Act* expanded the RAC program to Medicare Parts C and D. Procurement activities for the Part C RAC are ongoing and an award is expected in FY 2014.

The Part D RAC program became fully operational in FY 2012, and is currently reviewing prescription drug claims for calendar years 2008 through 2011. Since its launch, the Part D RAC identified overpayments made as a result of prescriptions written by excluded providers or filled at excluded pharmacies. In FY 2013, approximately $1.8 million in overpayments were recouped from plans as a result of overpayments that were identified during FY 2012 (but that were not recovered that year). Similarly, at the end of FY 2013, HHS sent notification letters for additional overpayments totaling approximately $3.4 million to plans. For those plans that do not appeal, overpayment recoupment will begin in FY 2014 and will be reported in the FY 2014 AFR.

In FY 2014, the Part D RAC will review excluded providers, duplicate payments, and Direct and Indirect Remuneration (which includes discounts, rebates, cash discounts, and other types of benefits). In the future, the Part D RAC may expand its reviews.

More information on the Medicare Part C and Part D RAC programs can be found at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/.html.

State Medicaid RACs

Section 6411(a) of the *Affordable Care Act* required each State to establish State Medicaid RAC programs by submitting a State plan amendment, which attests that its program meets the statutory requirements by December 31, 2010. States were required to implement RAC programs by January 1, 2012; thus, FY 2013 is the first full Federal fiscal year of reporting State Medicaid RAC recoveries. As States continue to implement their State Medicaid RAC programs, State Medicaid RAC Federal-share recoveries reported by States increased from $57.6 million in FY 2012 to $74.5 million in FY 2013. States have increased the total Federal and State share combined amount of Medicaid RAC recoveries from $95.6 million in FY 2012 to $124.3 million in FY 2013.

HHS regulations align the State Medicaid RAC requirements to existing Medicare FFS RAC program requirements, where feasible, and provide each State the flexibility to tailor its RAC program where appropriate. As of September 30, 2013, 45 States and the District of Columbia have implemented Medicaid RAC programs. The remaining 5 States have time-limited HHS-approved exemptions.

HHS provides guidance to States as each State implements its Medicaid RAC program. In September 2012, HHS launched a tool to encourage transparency and monitoring called the State Medicaid RACs At-A-Glance website. This tool can be found at: http://w2.dehpg.net/RACSS/Map.aspx. The website contains State-reported information on each State's Medicaid RAC program, the name of each RAC vendor and Medical Director, and contact information for the State Program Integrity Director.

Recovery Auditing Reporting Tables

OMB Circular A-136 requires agencies to provide detailed information on their recovery audit programs, as well as other efforts related to the recapture of improper payments. Some of our programs have results to report in this area and those results are included in the following tables. If a program is not listed on a certain table, it is because they do not yet have results in that area.

Table 2
Payment Recapture Audit Reporting
FY 2013
(in Millions)

Type of Payment	Amount Subject to Review for CY Reporting	Actual Amount Reviewed and Reported (CY)	Amount Identified for Recovery (CY)	Amount Recovered (CY)	% of Amount Recovered out of Amount Identified (CY)	Amount Outstanding (CY)	% of Amount Outstanding out of Amount Identified (CY)	Amount Determined Not to be Collectable (CY)	% of Amount Determined Not to be Collectable out of Amount Identified (CY)	Amounts Identified for Recovery (PYs)	Amounts Recovered (PYs)	Cumulative Amounts Identified for Recovery (CY + PYs)	Cumulative Amounts Recovered (CY + PYs)	Cumulative Amounts Outstanding (CY+PYs)	Cumulative Amounts Determined Not to be Collectable (CY+PYs)
Medicare FFS Recovery Auditors	N/A	N/A	$4,234.9	$3,650.9 Note 1	86%	$584.0	14%	N/A	N/A	$3,731.1 Note 2	$3,164.2 Note 2	$7,966.0	$6,815.1	$1,150.9	N/A
Medicare Part C Recovery Auditors	N/A Note 3	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medicare Part D Recovery Auditors	N/A	N/A	$3.4 Note 4	$1.8 Note 5	53%	$1.6	47%	N/A	N/A	$1.8 Note 6	N/A	$5.2	$1.8	$3.4	N/A
State Medicaid Recovery Auditors	N/A	N/A	N/A Note 7	$74.5	N/A	N/A	N/A	N/A	N/A	N/A	$57.6 Note 8	N/A	$132.1	N/A	N/A
HHS Contracts	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$1.6 Note 9	$0.074	$1.6 Note 9	$0.074	N/A	N/A

Notes:

1. The Medicare FFS recovery auditors Amount Recovered (CY) column is the amount recovered in FY 2013, regardless of the year the overpayment was identified
2. The Medicare FFS recovery auditors Prior Year (PYs) columns reflect recovery audit information reported in the FY 2010, FY 2011, and FY 2012 AFRs.
3. HHS expects to award a contract for a Medicare Part C RAC program in FY 2014. Accordingly, HHS is not reporting Medicare Part C RAC results in the FY 2013 AFR.
4. The Medicare Part D recovery auditor Amount Identified for Recovery (CY) column reflects the amount HHS identified in the notification of improper payment letters issued to plans in FY 2013.
5. The Medicare Part D recovery auditor Amount Recovered (CY) column reflects the amount recovered in FY 2013, regardless of the year the overpayment was identified.
6. The Medicare Part D recovery auditor identified $1.8 million in overpayments in FY 2012. HHS did not report that amount in the FY 2012 AFR, but has included the totals in the FY 2013 AFR.
7. The State Medicaid recovery auditors are only required to report the amount of recoveries, and no other information like the amount of improper payments identified, amount of improper payments outstanding, or how the States use the recovered funds. The State Medicaid recovery auditors Amount Recovered (CY) and Amounts Recovered (PYs) columns represent the Federal-share of the State recoveries.
8. The State Medicaid recovery auditors Amounts Recovered (PYs) column was not reported in Table 3 of the FY 2012 AFR since HHS did not have a full year of results to report at the time. HHS has included FY 2012 and FY 2013 information in the FY 2013 AFR since the Department is reporting full year results for FY 2013.
9. The HHS Contracts Amounts Identified for Recovery (PYs) and Cumulative Amounts Identified for Recovery (CY + PYs) columns were amended from $1.5 million, as reported in the FY 2012 AFR, to $1.6 million. As noted in Table 2 and Section 110, HHS recovered approximately $74,401 out of $1.6 million identified by the recovery auditors. The remaining funds are not included in Table 2 for reasons including, but not limited to, they were collected through other mechanisms and do not fit in the reporting columns.

Table 3

Payment Recapture Audit Targets

FY 2013

(in Millions)

Type of Payment	CY Amount Identified	CY Amount Recovered	CY Recovery Rate (Amount Recovered / Amount Identified)	CY + 1 Recovery Rate Target	CY + 2 Recovery Rate Target	CY + 3 Recovery Rate Target
Medicare FFS Recovery Auditors	$4,234.9	$3,650.9	86%	85%	85%	85%
Medicare Part D Recovery Auditors	$3.4	$1.8	53%	85%	85%	85%

Note: The State Medicaid recovery auditors are not included in this table since States do not report information to HHS that would allow the Department to calculate the amount of overpayments identified, the recovery rate, or the recovery rate targets.

Table 4

Aging of Outstanding Overpayments

FY 2013[1]

(in Millions)

Type of Payment	CY Amount Outstanding (0 – 6 months)	CY Amount Outstanding (6 months to 1 year)	CY Amount Outstanding (over 1 year)
Medicare FFS Recovery Auditors	$1,004.2 Note 2 & Note 3	$210.4	N/A
Medicare Part D Recovery Auditors	N/A Note 4	N/A	N/A

Notes:

1. The State Medicaid recovery auditors are not included in this table since States do not report information to HHS that would allow the Department to calculate the amount of overpayments that are currently outstanding.
2. The amount of outstanding Medicare FFS recovery auditors overpayments identified in this table ($1,214.6 million) does not match the amount outstanding identified in Table 3 because this table includes information from FY 2013 only whereas Table 3 includes information on recoveries from multiple years.
3. Under the Medicare FFS recovery auditors program, recovery of identified overpayments cannot begin until the overpayment is at least 41 days old. Therefore, the CY Amount Outstanding (0-6 months) includes identified overpayments that HHS cannot begin collecting.
4. Recoupments of FY 2013 overpayments will not begin on the Medicare Part D recovery auditors' overpayments until the appeals process is complete. The appeals process is ongoing, but is expected to be completed by the 3rd quarter of FY 2014.

Table 5

Disposition of Recaptured Funds

FY 2013[1]

(in Millions)

Type of Payment	Agency Expenses to Administer the Program	Payment Recapture Auditor Fees	Financial Management Improvement Activities	Original Purpose	Office of Inspector General	Returned to Treasury
Medicare FFS Recovery Auditors	$152.4	$301.7	N/A	$3,094.4 Note 2	N/A	N/A
Medicare Part D Recovery Auditors	N/A	$0.2	N/A	$1.6 Note 3	N/A	N/A

Notes:

1. The State Medicaid recovery auditors are not included in this table since States do not report information to HHS on how the recoveries are used.
2. For the Medicare FFS recovery auditors program, funds included under the "Original Purpose" column were returned to the Medicare Trust Funds after taking into consideration agency expenses to administer the program and recovery auditors contingency fees (amounts are listed above) and underpayments to providers ($102.4 million).
3. For the Medicare Part D recovery auditors program, funds included under the "Original Purpose" column were returned to the Medicare Trust Funds.

Table 6

Overpayments Recaptured Outside of Payment Recapture Audits
FY 2013

(in Millions)

Agency Source	Amount Identified (CY)	Amount Recovered (CY)	Amount Identified (PYs)	Amount Recovered (PYs)	Cumulative Amount Identified (CY+PYs)	Cumulative Amount Recovered (CY+PYs)
Medicare FFS Error Rate Measurement	$40.0	$33.2	$30.9	$25.5 Note 1	$70.9	$58.7
Medicare Contractors	$14,204.6 Note 2	$12,559.2 Note 2	$24,882.9 Note 3	$19,487.1 Note 3	$39,087.5	$32,046.3
Medicare Part C Note 4	$0	$0	$1.7	$0	$1.7	$0
Medicare Part D Note 4	$0	$0	$0.2	$0	$0.2	$0
Medicare Part C RADV Audits	$5.0	$5.0	$3.4 Note 5	$3.4 Note 5	$8.4	$8.4
Medicaid Error Rate Measurement	$0.2	$0.7	$3.5 Note 6	$1.3	$3.7	$2.0
CHIP Error Rate Measurement	$0.2	$0.2	$0.3 Note 6	$0.01	$0.5	$0.21
Medicaid Integrity Contractors-Federal Share-FMAP rates	$14.1 Note 7	$2.6	$8.0	$1.8	$22.2 Note 7	$4.4
Foster Care Eligibility Reviews = Post-Payment Reviews	$1.1	$1.1	$16.8	$16.8	$17.9	$17.9
Foster Care OIG Reviews	$4.0	$0.2	$203.1 Note 8	$102.7	$207.1 Note 8	$102.9
Foster Care Single Audits	$0.5	$0.2	$34.4	$33.2	$34.9	$33.4
Child Care-Single Audit	$2.0	$2.5	$4.9	$3.3	$6.9	$5.8
Child Care-Error Rate Measurement	$0.2	$0	$0.7 Note 9	$0	$0.9	$0
Head Start- OIG Reviews	$1.9	$0	$5.1 Note 10	$5.1 Note 10	$7.0	$5.1
Head Start- Single Audits	$1.8	$0.8	$2.1	$3.5	$3.9	$4.3

Notes:

1. The Medicare FFS Error Rate Measurement's Amount Recovered (PYs) amount of $27.2 million that was reported in the FY 2012 AFR was amended $25.5 million to exclude amounts that were later overturned on appeal.
2. This total reflects amounts reported by the Medicare FFS Contractors excluding the amounts reported for the Medicare FFS recovery auditors program, which are reported in Table 3, and the Medicare FFS Error Rate Measurement program, which are reported separately in Table 7.
3. This total reflects amounts reported by the Medicare FFS Contractors excluding the amounts reported for the Medicare FFS recovery auditors program, which are reported in Table 3, and the Medicare FFS Error Rate Measurement program, which are reported separately in Table 7. In addition, the Amount Identified (PYs) and Amount Recovered (PYs) amounts that were reported in the FYs 2011 and 2012 AFR were amended to remove amounts associated with the Medicare FFS Error Rate Measurement program and to reflect revisions made after the FY 2012 AFR publication date. The Amount Identified (PYs) information was changed from $24,913.9 million to $24,882.9 million, and the Amount Recovered (PYs) information was changed from $19,513.0 million to $19,487.1 million.
4. These amounts represent money owed to HHS by health plans that terminated their Part C or Part D contracts.
5. The Medicare Part C RADV Audits Amount Identified (PYs) and Amount Recovered (PYs) columns were amended from $3.5 million, as reported in the FY 2012 AFR, to $3.4 million.
6. For the Medicaid and CHIP error rate measurements, the Amount Identified (PYs) information that was reported in the FY 2012 AFR was amended to exclude improper payments that were due to eligibility errors, which HHS and States are unable to recover. The Medicaid error rate measurement's Amount Identified (PYs) was amended from $4.3 million to $3.5 million, while the CHIP error rate measurement's Amount Identified (PYs) amount was amended from $0.5 million to $0.3 million.
7. For Medicaid, the Medicaid Integrity Contractors (MICs) identified total overpayments which include both the Federal and State shares. For the Amount Identified (CY) column, HHS has reported the actual Federal share across audits. For the Amount Identified (PYs) column, HHS applied FY 2012 State FMAP rates to estimate the Federal share of overpayments, although not all overpayments identified were based on FY 2012 paid claims. Lastly, adding the $14.1 million figure in the Amount Identified (CY) cell and the $8.0 million figure in the Amount Identified (PYs) cells produces $22.1 million, not the $22.2 million figure in the Cumulative Amount Identified (CY + PYs) cell, due to using rounded numbers in the table for presentation purposes.
8. The Foster Care OIG Reviews information that was published in the FY 2012 AFR contained $217.8 million in the Amount Identified (PYs) and Cumulative Amount Identified (CY+PY) columns. Theses prior year totals were amended to reflect the issuance in FY 2013 of revised sustained amounts associated with previously sustained audit report recommended disallowances (four from FY 2010 and one from FY 2011). The net impact of these changes reduced the totals for the Amounts Identified (PYs) and the Cumulative Amounts Identified (CY + PYs) columns by approximately $14.8 million.
9. The Child Care Error Rate Measurement information reflects overpayments that are identified through the statistical sampling process. The information reported represents the amount that is subject to disallowance. For the Child Care Error Rate Measurement Amount Recovered (CY) information, States are required to recover child care payments that are the result of fraud and have discretion as to whether to recover misspent funds that were not the result of fraud, such as in cases of administrative error.
10. In FY 2012 the amount reported for the Amount Identified (CY) and Amount Recovered (CY) columns was $0.3 million. However, this total did not reflect an additional $4.8 million that was also identified through OIG reviews and subsequently recovered. Therefore, the amount reported in FY 2013 as Amount Identified (PYs) and Amount Recovered (PYs) columns were amended to reflect the true total of $5.1 million.

MANAGEMENT REPORT ON FINAL ACTION

October 1, 2012 – September 30, 2013

Background

The Inspector General Act Amendments of 1988 require departments and agencies to report to Congress on the actions they have taken and the amount of funds recovered or saved in response to OIG audit recommendations. This annual management report provides the status of OIG A-133 audit reports (reports) in the Department and summarizes the results of actions taken to implement OIG audit recommendations during the reporting period. As part of the U.S. Chief Financial Officer Council's Streamlining Effort of FY 1996, the Management Report on Final Action has been incorporated in the AFR.

Four Key Elements to the HHS Audit Resolution and Follow-Up Process

1. HHS OPDIVs have a lead responsibility for implementation and follow-up on OIG and independent auditor recommendations;
2. The Assistant Secretary for Financial Resources establishes policy and monitors HHS OPDIVs' compliance with audit follow-up requirements;
3. The audit resolution process indicates the ability to appeal disallowances administratively under such programs as Head Start, Foster Care and Medicaid pursuant to the Departmental Grant Appeals Board's regulations in 45 C.F.R. Part 16; and
4. If necessary, the Conflict Resolution Council resolves conflicts between the HHS OPDIVs and OIG.

Status of Audits in the Department

In general, HHS OPDIVs have followed up on OIG recommendations effectively and within regulatory time limits. HHS Agencies usually reach a management decision within the 6-month period that is prescribed by the *Inspector General Act Amendments of 1988* and OMB Circular A-50, *Audit Follow-up*. For the most part, they also complete their final actions on reports, including collecting disallowed costs and carrying out corrective action plans, within a reasonable amount of time. However, the Department continues to monitor this area to improve procedures and ensure compliance with corrective action plans.

Departmental Conflict Resolution

In the event that HHS OPDIVs and OIG staff cannot resolve differences on specific report recommendations, a conflict resolution mechanism is available. During FY 2013, there were no disagreements requiring the convening of the Conflict Resolution Council.

Final Action Tables and Departmental Findings

Table 1, Management Action on Costs Disallowed in OIG Reports, presents costs that HHS challenged because a grantee had violated a law, regulation, grant term or condition.

- In FY 2013, HHS initiated Recovery Action, through collection, offset or other means, on 334 reports for a total of $767,400,888.

- In FY 2013, HHS completed Recovery Action, through collection, offset or other means, on 300 reports for a total of $553,507,193.

E. As of September 30, 2013, HHS identified 228 reports with outstanding balances over one year old totaling $2,019,398,540 . Forty-three percent of these accounts receivable are currently being pursued for collection. These accounts receivable are owed by state and local governments (132), hospital and medical related organizations (54), non-profit organizations (21), Indian tribes (19) and educational institutions (2). A detailed list of reports over one year old with outstanding balances to be collected can be found at: http://www.hhs.gov/asfr/of/finpollibrary/financialpolicies.html - Audit Guidance.

TABLE 1

Management Action on Costs Disallowed in OIG Reports

As of September 30, 2013

	Number	Disallowed Costs
A. Reports for which final action had not been taken by the commencement of the reporting period. See Note 1.	303	$ 2,357,574,840
B. Reports on which management decisions were made during the reporting period. See Note 2.	334	767,400,888
Subtotal (A + B)	**637**	**$ 3,124,975,728**
C. Reports for which final action was taken during the reporting period:		
i. The dollar value of disallowed costs that was recovered through collection, offset, property in lieu of cash, or otherwise.	300	553,507,193
ii. The dollar value of disallowed costs that were written off by management.	4	2,886,847
Subtotal (i + ii)	**304**	**$ 556,394,040**
D. Reports for which no final action has been taken by the end of the reporting period. See Note 3.	333	$ 2,568,581,688

Notes:

1. Includes adjustments of amended disallowance and disallowance excluded from the previous reporting period.
2. Represents the amount of management concurrence with the OIG's recommendations. For this fiscal year, the OIG's reconciliation with the HHS Agencies showed a variance that represents only timing differences between the OIG's and the OPDIVs' records.
3. In addition to current unresolved reports, this figure includes reports over one year old with outstanding balances totaling $2,019,398,540 (e.g., audits under current collection schedule or audits under administrative or judicial appeal).

Table 2, Management Action on OIG Reports with Recommendations that Funds Be Put to Better Use, appears below. "Funds to be put to better use" relates to those costs associated with cost avoidances, budget savings, etc. identified by the OIG.

- In FY 2013, HHS initiated action on $821,434,473 in OIG recommendations to put funds to better use.
- In FY 2013, HHS completed action on $149,503,974 in OIG recommendations to put funds to better use.

TABLE 2

Management Action on OIG Reports with Recommendations that Funds Be Put to Better Use

As of September 30, 2013

	Number	Disallowed Costs
A. Reports for which final action had not been taken by the commencement of the reporting period. See Note 1.	7	$ 439,029,967
B. Reports on which management decisions were made during the reporting period.	30	821,434,473
Subtotal (A + B)	**37**	**$ 1,260,464,440**
C. Reports for which final action was taken during the reporting period:		
i. The dollar value of recommendations that were actually completed based on management action or legislative action.	24	149,503,974
ii. The dollar value of recommendations that management has subsequently concluded should not or could not be implemented or completed.		
Subtotal (i + ii)	**24**	**$ 149,503,974**
D. Reports for which no final action has been taken by the end of the reporting period.	13	$ 1,110,960,466

Notes:

1. Includes adjustments of amended disallowance and disallowance excluded from the previous reporting period.

FY 2013 TOP MANAGEMENT AND PERFORMANCE CHALLENGES IDENTIFIED BY OFFICE OF INSPECTOR GENERAL (OIG)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

TO: The Secretary — December 12, 2013

Through: DS _____
COS _____
ES _____

FROM: Inspector General

SUBJECT: Top Management and Performance Challenges Facing the Department of Health and Human Services in Fiscal Year 2013

This memorandum transmits the Office of Inspector General's (OIG) list of top management and performance challenges facing the Department of Health and Human Services (the Department). The *Reports Consolidation Act of 2000*, Public Law 106-531, requires OIG to identify these management challenges, assess the Department's progress in addressing each challenge, and submit this statement to the Department annually.

The OIG's top management and performance challenges for fiscal year 2013 are:

1) Overseeing the Health Insurance Marketplaces
2) Transitioning to Value-Based Payments for Heath Care
3) Ensuring Appropriate Use of Prescription Drugs in Medicare and Medicaid
4) Protecting the Integrity of an Expanding Medicaid Program
5) Fighting Fraud and Waste in Medicare Parts A and B
6) Preventing Improper Payments and Fraud in Medicare Advantage
7) Ensuring Quality of Care in Nursing Facilities and Home- and Community-based Settings
8) Effectively Using Data and Technology to Protect Program Integrity
9) Protecting HHS Grants and Contract Funds from Fraud, Waste, and Abuse
10) Ensuring the Safety of Food, Drugs and Medical Devices

OIG looks forward to continuing to work with the Department to identify and implement strategies to protect the integrity of the Department's programs and the well-being of the beneficiaries of these programs. If you have any questions or comments, please contact me, or your staff may contact Erin Bliss, Director of External Affairs, at (202) 205-9523 or Erin.Bliss@oig.hhs.gov.

/Daniel R. Levinson/

Daniel R. Levinson

Management Challenge 1: Overseeing the Health Insurance Marketplaces

Why This Is a Challenge

The Health Insurance Marketplaces (Marketplaces), also known as the Health Insurance Exchanges, add a substantial new dimension to the Department's program landscape.

The Marketplaces include State, Federal, and Partnership Marketplaces, each of which must implement and successfully operate a complex set of program requirements. Individuals use the Marketplaces to get information about their health insurance options, be assessed for eligibility (for, among other things, qualified health plans, premium tax credits, and cost sharing reductions), and enroll in the health plan of their choice. Sufficient enrollment, including enrollment of relatively healthy individuals, is essential for producing a stable and effective insurance market.

The Department faces significant challenges in several key areas, including eligibility systems, payment accuracy, contractor oversight, and data security and consumer protection. Coordination among Federal and State agencies, private insurers, and contractors is necessary to achieve program objectives and poses an additional challenge to the Department.

Eligibility Systems. The Federally Facilitated Marketplace (FFM) operates via the Department's healthcare.gov website. Healthcare.gov also serves as a gateway for consumers to reach State-run Marketplaces. The Department has acknowledged that it faces significant, well-publicized challenges in ensuring that healthcare.gov operates successfully. These reported challenges include hardware and software issues. The Department must ensure that healthcare.gov verifies consumers' personal information; accurately determines eligibility for Marketplace insurance, tax credits, and cost-sharing subsidies; operates effectively and easily for consumers; and transmits complete, accurate, and timely information to insurers regarding enrollees. The Marketplaces must also successfully facilitate Medicaid enrollment for those who qualify (see Challenge 4, Protecting the Integrity of an Expanding Medicaid Program).

CMS operates and oversees the Data Services Hub (Hub), which allows for exchange of data between the Marketplaces and Government databases to verify applicant eligibility, in coordination with partners at the Social Security Administration, Internal Revenue Service (IRS), Department of Homeland Security, Department of Justice (DOJ), and the States.

The Department must also be attentive to State Marketplace operations to ensure States' compliance with requirements, including requirements for making eligibility determinations and for transmitting accurate and timely data used for purposes of Federal payments, such as determinations related to subsidies.

Contractor Oversight. Contractors have played, and will continue to play, a vital role in building, maintaining, and fixing the systems that underpin the FFM. Early reports reflected that these systems, as constructed, did not function as they were intended. The Department must ensure, to the greatest extent possible, that the Government obtains specified products and services from its various contractors on time and within budget. The Department faces a challenge to ensure proper management of, and payment under, the various contracts entered into for implementation and operation of the FFM, including the Hub. This challenge is heightened by, among other things, the large number of contracts and the need to coordinate work across multiple contractors. For general information on challenges associated with contract administration, see Management Challenge 9.

Payment Accuracy. Ensuring accurate payments related to the Marketplaces also poses a substantial management challenge. The Department needs to implement financial management and payment systems to ensure accurate and timely payments to insurers of advance premium tax credits, cost-sharing subsidies, and premium stabilization payments. These payments involve complex calculations and offsets, adjustments, and reconciliations, which pose challenges for making accurate payments. Monitoring and accounting for these payments can also be challenging. In addition, some payments will rely on information obtained from private insurers. The Centers for Medicare & Medicaid Services (CMS) will need to work closely with insurers to ensure that information is timely, complete, and accurate. Given the amount of Federal funds involved, the Department should undertake a thorough risk assessment and, where appropriate, develop error rates to measure the integrity of program payments.

Security. Effective operation of the Marketplaces requires rapid, accurate, and secure integration of data from numerous Federal and State sources and individuals who use the Marketplaces. It requires means for real-time communication among many Federal and State systems on a large scale. Because these systems handle consumers' sensitive personal information, security of data and systems is paramount. Where the Department offers consumers alternate pathways for enrollment that do not require consumers to use healthcare.gov, such as submitting paper applications or using a call center, the Department also must ensure that those pathways incorporate effective security and eligibility safeguards and work well for consumers and insurers.

Another key responsibility is educating consumers about the Marketplaces and how to use them. It is also important to educate consumers about protecting themselves from fraud schemes, such as identity theft, since criminals often take advantage of new programs. Potential fraud schemes include identity thieves posing as legitimate assisters offering to help individuals purchase insurance in exchange for money or personal identifying information; imposters misleading Medicare beneficiaries into falsely believing they need to purchase new insurance; and sham websites that appear to be legitimate. The Department must also ensure that navigators, agents and brokers, and other assisters are qualified and properly trained to help consumers and provide reliable information.

Progress in Addressing the Challenge

On December 1, 2013, the Administration reported significant improvement in the operations of healthcare.gov. The report identified improvement on several system performance metrics, including response time, error rate, system stability, and number of concurrent users.

With respect to the Hub, CMS obtained its necessary security authorization on September 6, 2013. OIG had reviewed CMS's implementation of security controls for the Hub from March through June 2013. CMS has reported that all key steps that remained at the time of our review have since been completed.

CMS has issued regulations and guidance regarding numerous aspects of the Marketplaces and the related subsidies and premium stabilization programs. This includes a final rule on program integrity provisions for the Marketplaces and related programs intended to safeguard Federal funds and protect consumers. In addition to these regulations, CMS reports providing technical assistance and other support to States regarding Marketplace implementation.

The Department and Office of Inspector General (OIG) are working closely with Government partners, including the Federal Trade Commission (FTC), DOJ, and State Attorneys General, among others, to prevent and respond to consumer fraud in connection with the Marketplaces. OIG and the Department have conducted consumer education and outreach on how to protect oneself against fraud and identity theft. The FTC and States have primary jurisdiction for responding to consumer fraud allegations, and OIG has updated the OIG fraud hotline to seamlessly route consumer fraud complaints to the FTC, as well as routing consumer inquiries about the Marketplaces to CMS.

What Needs To Be Done

The Department must continue to upgrade and improve healthcare.gov, including both the front-facing consumer functions, as well as the back-end administrative and financial management functions. The Department also must ensure that alternate pathways for enrollment operate with integrity and that consumers' personal information is secure. The Department must ensure that issuers and consumers receive accurate enrollment and subsidy information and that systems for paying insurers operate with sound safeguards and internal controls. States and consumers must receive accurate information about potential Medicaid enrollment. Vigilant monitoring and testing of the Marketplaces and rapid mitigation of identified vulnerabilities are essential.

The Department must address challenges in the short run to facilitate the ongoing open enrollment for 2014, when most people will be required to have health insurance. In addition, where the Department uses temporary mechanisms for the current enrollment period, the Department must develop permanent solutions that ensure the smooth and successful operation of the Marketplaces for special enrollment periods, the 2015 open enrollment period that is scheduled to start on November 15, 2014, and beyond. Moreover, the Department must address full implementation of the online SHOP Exchange.

The Department must also complete its development and implementation of financial management and payment systems and ensure that payments to insurers, which are scheduled to begin in January 2014, are accurate. While in the near-term the Department faces immediate challenges related to healthcare.gov operations, eligibility verification, payment accuracy, contracting, and security of data, the Department will face continuing challenges as the program evolves over time. The Department will need to adjust its management and oversight approaches accordingly to ensure that problems are prioritized and addressed. As with other new programs, the Department must monitor for known fraud, waste, and abuse risks and detect emerging new risks to protect the Federal investment in health care reform. If fraud schemes are identified, the Department must respond quickly and effectively.

Further, the Department must continue to coordinate closely with States and with other Federal agencies to monitor the operations and security of the Marketplaces and to implement the subsidies and other programs that begin on January 1, 2014. OIG will monitor the implementation and operations of the Marketplaces and plans to conduct oversight work initially focused on core risk areas, such as eligibility systems, payment accuracy, IT security, and contracting. In particular, OIG will conduct an audit of safeguards to prevent the submission of fraudulent or inaccurate information pursuant to the mandate at Public Law 113-46, Section 1001(c). OIG is coordinating closely with its oversight partners at GAO, other IGs (such as the Treasury IG for Tax Administration), and State auditors to develop complementary work and maximize the Government's limited oversight resources.

Key OIG Resource

- OIG testimony on security controls for the data services hub, September 2013

Management Challenge 2: Transitioning to Value-Based Payments for Heath Care

Why This Is a Challenge

To secure the future of the public health care programs, the Department must be vigilant in reducing waste and increasing value in health care. The Institute of Medicine (IOM) estimated that 20-30% of U.S. Health Spending (public and private) in 2009—roughly $750 billion – was wasted. Other estimates suggest similar levels of waste. Waste in health care programs is a multi-dimensional problem. The IOM report identified six major areas of waste: unnecessary services, inefficient delivery of care, excess administrative costs, inflated prices, prevention failures, and fraud. OIG work has identified waste in these areas; see also Management Challenges 3, 4, 5, 6, and 7 for more discussion on issues specific to prescription drugs, Medicaid, Medicare Parts A & B, Medicare Advantage (MA) and quality of care.

There is widespread agreement among experts that the incentives created by paying for health care based on the volume of items or services furnished, generally known as a fee-for-service system, contributes to waste in health care by encouraging unnecessary utilization and fragmented, poor quality care. Moreover, poor quality care harms beneficiaries and can result in additional costs; for example, OIG found that adverse events (i.e., patient harm caused by care) for hospitalized Medicare beneficiaries cost over $4 billion in one year. For these and other reasons, the Department is transitioning to value-based payments in Medicare and Medicaid intended to produce higher quality care at lower costs, in part by rewarding high-quality care, penalizing low -quality care, or enhancing care coordination. These models include, for example, value-based payments for hospitals, penalties for hospital readmissions, pay-for-performance systems, shared savings programs, gainsharing, care coordination payments, and bundled payments. These new models hold promise for improving health care delivery and efficiency; at the same time, they present long-standing and new program-integrity challenges.

Aligning Incentives. In a complex health care system, designing payment mechanisms that encourage desired goals (e.g., quality outcomes and cost efficiencies) while avoiding incentives that lead to unintended and undesirable outcomes (e.g., overutilization or stinting on care) is a key challenge. This is a particular challenge for models that use the traditional fee-for-service payment structure alongside, or in addition to, value-based payments, such as the Medicare Shared Savings Program, which includes both fee-for-service payments and shared savings payments. When considering such hybrid payment methodologies, it is important to carefully assess: (1) the financial incentives that arise from each payment component, (2) new or different financial incentives that might arise from their combination, and (3) the potential fraud, waste, and abuse risk areas corresponding to the multiple types of payment. Longstanding program and enforcement experience illustrates that how Medicare and Medicaid pay for services influences the types of misconduct that arise. For example, fee-for-service payments raise the risk of overutilization and payment for unnecessary services; some risk-based or bundled payments may reduce overutilization risks, but increase risks of underutilization or stinting on care. For models that are untested for the Department and for providers under Medicare and Medicaid, it can be challenging to anticipate and account for all of the potential impacts – both benefits and risks – of significant changes in payment methodology.

An additional challenge arises because certain initiatives could raise costs in one part of a program but lead to greater savings elsewhere. For example, greater investments in chronic disease management could improve patients' overall health and reduce the need for expensive emergency care. Similarly, effective care coordination across multiple programs – such as for individuals eligible for both Medicare and Medicaid -- is important not only because of the potential for better patient care, but also because costs may increase for one program but decrease under another. For example, increased use of personal care services (covered by Medicaid) may increase Medicaid and therefore States' costs while saving money for Medicare and the Federal Government by reducing or avoiding hospitalizations. The Department needs to be mindful of these incentives when structuring cross-cutting care coordination initiatives.

Program Design and Integrity. Designing, implementing, and overseeing many new and sometimes complex payment models and demonstrations, combined with the complexity and scope of the Medicare and Medicaid programs and evolving health care landscape, poses significant management and program integrity challenges. Designing payments and programs with incentives in mind is essential, but it is only one facet. The Department must track and coordinate new models to ensure effective administration and must be alert to issues that impact more than one program, such as provider participation and beneficiary alignment. The Department must continually review the underlying market and provider practice assumptions, including those related to quality, on which payment structures and the resulting payments are based. The Department must be alert to new program integrity risks that may emerge as a result of changing financial incentives and deploy appropriate program integrity tools to prevent and detect fraud, waste, and abuse.

Getting value-based payment structures and rates right can be difficult. OIG work has illustrated the challenges in structuring accurate bundled payments, which cover related services and/or products or an episode of care. For example, OIG found that Medicare's bundled payment for global surgery fees, which provides one fee for the surgery and related pre- and post-surgical care, has not been adjusted to reflect evolving physician practices. As a result, the payment model assumes more services than are typically provided, resulting in inflated payments. Examples of other design and rate setting challenges include ensuring that payment bundles avoid creating incentives and opportunities to furnish and bill for services outside the bundle to increase payments, that providers participating in multiple incentive payment programs are not receiving duplicative incentive payments, and that payment mechanisms encompassing services furnished across multiple provider settings work properly and reimburse correctly.

Integrity of Information. When payments are linked to quality, outcomes, or performance, the Department must ensure the reliability of underlying data. Many value-based payment mechanisms rely on complex data, electronic health information, and sophisticated quality and performance measures. To ensure reliable results, data must be accurate, complete, and timely. Measures must be appropriate and meaningful. Outcomes must be correctly assessed to ensure correct payment. When quality or performance is determined on the basis of Medicare or Medicaid claims billed, ensuring accurate and reliable claims information – and detecting improper claims -- is also critical.

In addition, the data CMS provides to the industry must be accurate. For example, programs such as the Pioneer Accountable Care Organization (ACO) Model, the Medicare Shared Savings Program (MSSP), and the Medicare fee for service (FFS) Physician Feedback Program call for CMS to provide performance or clinical data to providers so they can use it to improve the care they furnish. To be effective, the data must be correct, the metrics meaningful, and the information usable.

In sum, the linkage between quality, performance, and payment presents new challenges for administering Medicare and Medicaid payment systems.

Progress in Addressing the Challenge

The Department is continuing to implement value-based payment programs and develop new demonstration programs. CMS recently reported positive initial results from the first year of the Pioneer ACO program – all ACOs achieved quality goals, and 13 ACOs generated a total savings of $87.6 million, of which $33 million was returned to the Medicare Trust Fund. In 2013, CMS began implementing the Bundled Payment for Care Improvement (BPCI) Initiative, which includes four models testing different payment mechanisms that include quality and accountability measurements. CMS continues to develop, implement, and test new value-based payment structures.

The Department has taken steps to foster integrity in these new programs, as illustrated by the regulations for the MSSP and Participation Agreements for the BPCI Initiative, which incorporate various safeguards intended to mitigate potential vulnerabilities. It is too early to assess the outcomes of these program integrity efforts, but CMS's attention to, and integration of, safeguards into the design of the MSSP and BPCI Initiative demonstrate a focus on program integrity that should be replicated in all programs.

CMS has reported that it is developing management and tracking systems and procedures to support new value-based payment structures and other new models. CMS also reports that it has established internal review processes to promote the use of effective measurement strategies, to coordinate across components regarding quality measurement, and to identify areas where beneficiaries are impacted by more than one value-based payment initiative. CMS also provides technical assistance to participants in new models.

What Needs to be Done

The Department should continue to prioritize the effective transition to value-based payment mechanisms and the development and refinement of quality, outcomes, and performance metrics. Data systems supporting programs that link payment to quality and value must be scrutinized for timeliness, accuracy, and completeness. The Department should continue to develop and maintain internal controls to ensure effective coordination among value-based payment programs and to avoid duplicative payments and operational inefficiencies. The Department must scrutinize bundled payments, shared savings programs, and other value-based payments to ensure that payment methodologies are appropriate, payments are calculated accurately, and that performance-based incentives are aligned with beneficial outcomes for Medicare, Medicaid, and patients. CMS should also continue its efforts to provide technical assistance to participants in its demonstration and other value-based programs.

CMS should continue to strengthen its program integrity tools and apply them as needed to ensure integrity in new models. In overseeing new models, the Department should monitor financial incentives to ensure that they achieve quality and efficiency goals and do not result in undesirable outcomes. The Department's oversight is critical and must consider the full range of potential risks. For example, shared savings or bundled payments may pose a heightened risk of stinting or underutilization compared to traditional fee-for-service payments, for which the larger risk may be provision of unnecessary care or overly expensive care. Models that incorporate both types of payments may raise both types of risks or different risks. CMS must continue to assess emerging fraud, waste, and abuse risks in new models and, as necessary, develop and implement new tools to detect and prevent them. Moreover, the Department should continue to monitor cost, quality, utilization, outcomes, and experience of care and to disseminate lessons learned to improve new programs.

As demonstration programs continue to unfold, the Department should carefully monitor for successes and benefits that can be scaled and replicated, as well as for potential problems -- including inefficiencies, misaligned incentives, or abuses. The Department must rigorously evaluate results of demonstration programs and other new value-based purchasing payment mechanisms. As with any innovation and experimentation, missteps may occur; it is critical that the Department address missteps effectively and take appropriate actions to prevent their recurrence.

Management Challenge 3: Ensuring Appropriate Use of Prescription Drugs in Medicare and Medicaid

Why This Is a Challenge

Ensuring the appropriate use of prescription drugs by Medicare and Medicaid beneficiaries is vital for financial reasons as well as patient safety and quality of care. In 2012, Medicare Part D provided prescription drug coverage to more than 37 million beneficiaries at a cost of almost $67 billion. In 2010, Medicaid provided prescription drug coverage to 28 million beneficiaries at a cost of $19 billion. The following are concerns about appropriate prescribing and dispensing of drugs as well as deficiencies in the safeguards intended to protect beneficiaries and the programs from drug overutilization, fraud, and abuse.

Prescription Drug Diversion and Abuse. The Centers for Disease Control and Prevention (CDC) has characterized prescription drug abuse as an epidemic, and in 2010, overdose of prescription painkillers was one of the leading causes of accidental death in the United States. Prescription drug abuse is a serious and growing problem for Medicare Part D and Medicaid – OIG's investigations of abuses in this area have increased dramatically over the past 5 years. Prescription drug diversion is a complex crime that involves many co-conspirators, ranging from simple street traffickers to complex criminal enterprises of health care professionals, pharmacies, and even patients. Fraud schemes bill Medicare and Medicaid for services and drugs that are unnecessary or never provided, resulting in patient harm and financial loss to the program.

Prescription drug fraud and diversion often involve controlled drugs but can also include billing for unnecessary non-controlled prescriptions. For example, an OIG investigation led to the conviction of a pharmacist who owned 26 pharmacies and used an elaborate web of physicians, pharmacists, and patient recruiters to fraudulently bill Part D and Medicaid. This pharmacist paid kickbacks, bribes, and other inducements to physicians to write unnecessary prescriptions for controlled drugs and expensive non-controlled drugs. The physicians directed their patients to fill their prescriptions at 1 of the 26 pharmacies, which then billed Medicare and Medicaid for unnecessary controlled substances it dispensed to the beneficiaries and for expensive non-controlled drugs that it did not dispense.

Prescriber Qualifications. As a basic safeguard, prescription drugs must be prescribed in accordance with State law by an appropriate medical professional to qualify for Part D reimbursement. This safeguard is not operating as effectively as it should; Medicare Part D inappropriately paid $5.4 million in 2009 for 72,552 prescriptions written by unauthorized prescribers, such as massage therapists, veterinarians, and athletic trainers. Medicare should never pay for drugs ordered by unauthorized individuals.

Questionable Prescribing and Billing Patterns. OIG has identified questionable prescribing by hundreds of general-care physicians. Some 736 physicians demonstrated extreme patterns of prescribing relative to their peers with respect to: number of drugs prescribed per beneficiary; number of pharmacies filling their prescriptions; percentages of expensive brand-name drugs; or percentages of Schedule II drugs like morphine and oxycodone, which are more susceptible to abuse. In total, Medicare paid $352 million for Part D drugs ordered by questionable prescribers in 2009.

In addition, OIG uncovered questionable billing patterns by 2,637 retail pharmacies nationwide with billing patterns far outside the norm. These pharmacies billed extremely high numbers of drugs per beneficiary or per prescriber or billed extremely high percentages of Schedule II or III drugs, brand-name drugs, or refills relative to other pharmacies. In 2009, Medicare paid these pharmacies a total of $5.6 billion. It is important to note that while these practices are not necessarily fraudulent they raise flags that warrant further attention.

Schedule II Refills. Federal law requires an original prescription each time a Schedule II drug is dispensed; nonetheless, OIG found that Medicare Part D inappropriately paid $25 million for Schedule II drugs billed as refills in 2009. Part D plan sponsors should not have paid for Schedule II refills. Paying for refills of these addictive drugs raises public health concerns and may contribute to the diverting of controlled substances. Three-quarters of Part D plan sponsors paid for these refills, indicating that many do not have adequate controls in place.

Atypical Antipsychotic Drug Use In Nursing Homes. OIG has raised concerns about overmedication of Medicare nursing home residents, particularly the use of atypical antipsychotic drugs for beneficiaries with dementia. More than 20 percent of claims for atypical antipsychotic drugs for Medicare patients in nursing homes indicated a failure to satisfy Federal standards that protect nursing home residents from unnecessary drug use. OIG also found that nursing homes generally were not meeting all requirements for assessments and care plans for residents receiving antipsychotics.

Ineffective Oversight of Part D Utilization. Part D plan sponsors and CMS's Medicare Drug Integrity Contractor (MEDIC) are key lines of defense in identifying and addressing drug overutilization, fraud, and abuse. However, OIG found evidence that oversight is inconsistent across sponsors and may be lacking overall. Some plan sponsors did not identify any potential fraud, waste, and abuse incidents; most potential fraud, waste, and abuse incidents were associated with only a small number of plan sponsors. In addition, the MEDIC has not fully utilized data analytics to identify potential fraud, waste, and abuse.

Progress In Addressing the Challenge

CMS has taken steps to strengthen oversight of appropriate drug utilization in Medicare Part D. For example, CMS responded to a prior OIG recommendation by requiring that all Part D claims submitted to CMS include a valid National Provider Identifier for the prescriber – this safeguard is one step toward ensuring and monitoring appropriate prescribing. Plan sponsors are required to maintain compliance programs to help detect, prevent and correct fraud, waste, and abuse. CMS also provided guidance and educational outreach to sponsors and providers about the overutilization of prescription drugs, including support for State Prescription Drug Monitoring Programs. Moreover, CMS has increased monitoring of prescribers through the Part D Recovery Audit Contractors (RACs), which identify and recover Part D improper payments. CMS has also reported providing information and guidance to sponsors about high risk pharmacies and prescribers to combat prescription drug diversion. In addition, CMS has reported taking steps to redirect the MEDIC to focus more acutely on proactive data analysis.

CMS has also described its efforts to curb overprescribing by developing metrics at the beneficiary level that trigger follow-up actions. If a beneficiary's drug use exceeds certain clinical standards, this triggers a review of the beneficiary's medical management by his/her physician(s). If this review does not substantiate a clinical need for the high utilization, the Part D plan will implement prior authorization reviews for that beneficiary's claims.

In March 2012, CMS launched the National Partnership to Improve Dementia Care (the Partnership), aimed at improving behavioral health and safeguarding nursing home residents from unnecessary antipsychotic drug use. The Partnership set a goal to reduce antipsychotic drug use in nursing homes by 15 percent by the end of 2012, and CMS reported a national drop in antipsychotic use of 11.4 percent by the second quarter of 2013. CMS also provided guidance and training in May 2013 to assist surveyors in determining whether nursing homes are meeting minimum standards of care governing antipsychotic drug use.

What Needs To Be Done

In addition to the steps described above, CMS must take further action to ensure that each claim for a prescription contains both a valid identifier and authorized prescriber. Additionally, CMS should ensure that the MEDIC routinely analyzes billing data to detect pharmacies and providers with extreme billing patterns. CMS should also require that sponsors identify and refer potential fraud, waste, and abuse to CMS for further review. CMS must

also better ensure that Part D plans do not pay for prohibited refills of Schedule II drugs. In addition, CMS needs to implement its plans described to OIG to develop predictive models and utilize data analytics that will target aberrant billing patterns in the future.

OIG remains concerned that some instances of atypical antipsychotic drug use by nursing home residents may not represent the best clinical care for the patients; in addition, inappropriate Part D payments for some of these prescriptions may persist. CMS should facilitate access to information, like diagnosis codes, that are necessary to ensure appropriate care and accurate coverage and reimbursement determinations.

Key OIG Resources

- Testimony of Deputy Inspectors General on Curbing Prescription Drug Abuse in Medicare. June 24, 2013
- Medicare Atypical Antipsychotic Drug Claims For Elderly Nursing Home Residents. May 2011

Management Challenge 4: Protecting the Integrity of an Expanding Medicaid Program

Why This Is a Challenge

In 2014, States have the option to expand Medicaid eligibility to qualifying adults earning up to 133 percent of the Federal poverty level. In addition to the challenges in implementing this expansion, increases in the Medicaid population and spending also heighten the urgency of addressing the program integrity challenges that Medicaid already faces. These include reducing waste associated with excessive payment rates, avoiding or recovering Medicaid improper payments and payments for which a third party is liable, and preventing fraud, waste, and abuse in Medicaid managed care programs. (Other key challenges for Medicaid are addressed elsewhere – prescription drug abuse in Management Challenge 3; vulnerabilities in nursing homes and home- and community-based settings in Challenge 7; and limitations in the national Medicaid database in Challenge 8.)

Expansion of Medicaid Eligibility. For individuals who are "newly eligible" under the Affordable Care Act (ACA) expanded income limits, the Federal Government will pay the full costs of their care through 2016; after which the Federal share gradually falls to 90 percent by 2020 and continues at 90 percent thereafter. For other Medicaid beneficiaries, the Federal Government will continue to share costs with States according to its standard Federal Medical Assistance Percentage (FMAP), which ranges by State from 50 to 74 percent. These eligibility expansions are expected to increase the number of Medicaid beneficiaries and Federal spending on Medicaid significantly. Many individuals eligible for Medicaid will use the ACA created Marketplaces to enroll in Medicaid and thus the Marketplaces must effectively facilitate that enrollment (see Challenge 1, Overseeing the Health Insurance Marketplaces.)

Challenges involve the implementation of this expansion and the financial and internal controls needed to ensure that the Federal Government pays the appropriate share of costs for each beneficiary depending on the criteria under which he or she qualified for coverage. It may be challenging to apply Medicaid eligibility requirements accurately, and to the extent that States miscategorize beneficiaries, the financial implications for the Federal and State financial shares could be significant.

Problems Identifying and Recovering Improper Payments. OIG found that CMS Federal Medicaid Integrity Contractors (MIC) had limited success identifying Medicaid overpayments. Review MICs initially identified over 113,000 providers with potential overpayments of $282 million, but after performing audits, the Audit MICs found actual overpayments to only 25 of these providers, totaling less than $300,000. Likewise, 80 percent of the audits that OIG reviewed either did not find an overpayment or were unlikely to find overpayments. OIG found similarly limited results for Medicaid from the Medicare-Medicaid Data Match program (Medi-Medi Program). Of the total

$46.2 million in expenditures recouped through the program during 2007 and 2008, more than three-quarters – $34.9 million – was recouped for Medicare.

OIG has also found that longstanding challenges persist in recovering payments from third parties. Millions of Medicaid beneficiaries have additional health insurance through third-party sources. If beneficiaries have another insurance source, it should pay before Medicaid does, up to the extent of its liability. However, since 2001, States have consistently reported challenges in getting third parties to provide complete coverage information and to process or pay claims. As a result, as of 2011, $4 billion in claims remained at risk of not being recovered.

Program Integrity in Managed Care Programs. As of 2011, almost three-quarters of all Medicaid beneficiaries were enrolled in some type of managed care system. The private plans and Medicaid share financial risk; fraud, waste, and abuse by health care providers or beneficiaries drive up costs for both the plans and Medicaid. Fraud or abuse by the managed care plan (e.g., manipulating its bids) can further increase Medicaid costs.

CMS's guidelines identify six areas of fraud, waste, and abuse in Medicaid managed care: (1) managed care contract procurement, (2) marketing and enrollment, (3) underutilization of services, (4) claims submission and billing procedures, (5) fee-for-service payments within managed care, and (6) embezzlement and theft. OIG found that the predominant concerns of both States and plans were provider fraud – billing for services that were not provided, medically unnecessary, or upcoded – and beneficiary fraud including prescription drug abuse.

Excessive Payments to Public Providers. OIG has raised long-standing concerns about States' Medicaid payment rates to public providers. For example, we found that in 2009, New York Medicaid paid $2.27 billion ($1.13 billion Federal share) to 15 State-run developmental centers. New York's payments to these centers were not based on actual costs. If New York had used actual costs in its rate-setting, Medicaid reimbursements to the developmental centers could have been up to $1.41 billion lower that year, saving the Federal Government up to $701 million.

In some cases, the excess Medicaid payments are returned to the State and not retained by the facilities to provide care to Medicaid beneficiaries. In essence, this can serve as a mechanism for States to use Federal Medicaid funds to subsidize non-Medicaid costs.

Progress In Addressing the Challenge

CMS has reported that it is working to promote program integrity with respect to the Medicaid expansion by providing tools and technical assistance to the States, developing new procedures and practices for ensuring eligibility verification and payment accuracy, and training State staff on reporting and accounting for expenditures associated with newly eligible individuals.

CMS has also reported actions to improve the MIC and Medi-Medi programs consistent with OIG recommendations, such as assigning more Medicaid audits through the collaborative process, which showed greater success than the traditional process. This progress includes assigning 516 collaborative audits in 32 States as of August 2013. CMS is also reconfiguring its approach to Medicaid program integrity contractors, including letting the Review MIC contracts expire. In the future, CMS expects to develop a Unified Program Integrity Contractor model in which program integrity contractors will cover Medicare and Medicaid.

In addition, CMS stated that it will continue working with States and third parties to address problems identified by States with identification and collection from liable third parties. CMS also stated that it will review existing authorities to identify options for increased enforcement to deal with uncooperative third parties.

In 2011, OIG reported that States and managed care plans were taking important steps to protect against fraud, waste, and abuse. These included providing program integrity training to managed care plans' staffs and to providers in their networks. States conduct desk reviews of managed care plans' compliance plans, and many States also conducted onsite reviews. States also reported requiring managed care plans to disclose ownership and control information. CMS is working to update guidelines to States on program integrity in Medicaid managed care settings.

Finally, CMS is continuing to work with New York to revise its methodology for Medicaid payments to State-run developmental centers to better align them with costs. In addition, CMS issued guidance on Medicaid upper payment limits and is requiring all States to demonstrate annually the upper payment liability to the Federal Government for services that are subject to these limits.

What Needs To Be Done

CMS should continue its efforts to develop robust oversight for the Medicaid expansion. CMS must be vigilant in addressing program integrity risks associated with the expansion, including monitoring States' compliance with eligibility requirements and FMAP expenditures.

CMS should continue to build on its progress addressing MIC and Medi-Medi performance in identifying Medicaid overpayments. In particular, CMS should expand its use of collaborative audits to ensure that all States and the District of Columbia are actively engaged with the MICs in the identification and auditing of providers.

CMS should work with States to explore options to strengthen enforcement of third party liability. CMS could facilitate a conversation with States about additional enforcement authorities at the State and Federal levels.

Given that concerns about identifying fraud and abuse remained among States and plans, particularly with respect to provider and beneficiary fraud, CMS should update guidance to States to reflect these concerns. CMS should work with States to ensure that contracts with managed care organizations contain adequate provisions for the identification and referral of potential fraud cases.

OIG recommends that Medicaid payments to public providers be limited to the costs of providing services. In 2008, CMS issued a final rule that, among other things, would limit Medicaid payments to public providers to their costs of providing care, but the rule was ultimately vacated by Federal District Court. CMS should issue new regulations to prevent excessive payments to public providers.

Key OIG Resources

- Office of Inspector General testimony on Medicaid overpayments to public providers. September 20, 2012
- Office of Inspector General testimony on Medicaid contractors. June 14 2012
- Medicaid Third-Party Liability Savings Increased, But Challenges Remain. January 2013
- Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards. December 2011

Management Challenge 5: Fighting Fraud and Waste in Medicare Parts A & B

Why This is a Challenge

While all fraud is waste, not all waste is fraud. Waste is inefficiency that may be, for example, a medically unnecessary service, inefficient delivery of care, inflated prices, excess administrative costs, or prevention failures, and as such, addressing it is a multi-dimensional problem. (For challenges related to maximizing value in health care, see Management Challenge 2.) The Department must take necessary steps to address improper payments and payment inefficiencies that waste Medicare dollars and divert finite resources away from beneficiary care and services. In fiscal year (FY) 2013, CMS reported an error rate of 10.1 percent for Medicare Fee-for-Service. This exceeds the 10-percent threshold set by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and is an increase from FY 2012.

Waste. OIG work has spotlighted various types of waste in Medicare Parts A and B:

- *Hospital Billing Errors:* Our reviews of hospital's billing compliance have consistently found inappropriate claims for inpatient and outpatient services. Some of the most common problems include billing for short inpatient stays that should have been billed as outpatient or outpatient-with-observation services, transfers to other hospitals or post-acute care, incorrect diagnosis codes that result in higher payments, same-day discharges and readmissions, billing separately for services that should be bundled into the inpatient bill, and unreported credits from medical device manufacturers.
- *Improper Payments to Skilled Nursing Facilities (SNFs):* SNFs billed one-quarter of all claims in error in FY 2009, resulting in $1.5 billion in inappropriate Medicare payments. The majority of the claims in error were upcoded, i.e., the SNF reported a higher level of therapy than was provided, resulting in an inflated payment. In other cases, a SNF provided a higher level of therapy than the Medicare patient needed or could benefit from.
- *Misaligned Payment Rates:* OIG compared Medicare payments for 20 high-volume/high-expenditure lab tests to payments by State Medicaid and Federal Employees Health Benefit plans and found that Medicare paid between 18 and 30 percent more than other payers. Medicare could have saved up to $901 million in 2011 if it had paid providers at the lowest established rate in each geographic area. In another example, Medicare's bundled payments for global surgery fees have not always been adjusted to reflect evolving physician practices; in certain instances, the OIG has found that fewer services are provided than assumed in Medicare's payment model. Revising the payment methodology to more closely reflect the services typically provided in medical care today could result in more efficient provision of surgical services.

RACs are one important tool that CMS uses to identify and recover improper payments. In FYs 2010 and 2011, RACs identified errors in half of all claims they reviewed, resulting in improper payments totaling more than $1 billion. CMS took corrective actions to address the majority of vulnerabilities identified by the RACs in FYs 2010 and 2011. However, CMS may not be taking full advantage of this tool, as it did not evaluate the effectiveness of its corrective actions therefore, significant improper payments continue. In addition, CMS's RAC performance evaluations did not include metrics to evaluate compliance with all contract requirements.

Fraud. Fraud is one significant cause of waste in Medicare, resulting in funds being paid for services or products that were not rendered, were not medically necessary, or did not meet quality standards. Curbing fraud is vital to conserving scarce health care resources and protecting beneficiaries, and the Department must continue to direct all necessary resources toward fraud prevention, detection, and remediation. Adding to this challenge, fraud is a crime of deception, and perpetrators design their schemes to make claims appear legitimate.

Fraud schemes shift over time, but certain Medicare services have been consistent targets. OIG work has consistently raised concerns about fraud in Medicare Parts A & B. For example, OIG investigations continue to uncover durable medical equipment (DME) suppliers, home health agencies, community mental health centers, ambulance operators, and outpatient therapy providers that are defrauding the Medicare program. In national assessments, OIG has identified questionable billing patterns by home health agencies and community mental health centers and is conducting similar analysis of questionable billing by ambulance providers.

CMS's contractors play a key role in fighting Medicare fraud. However, there are indications that CMS is not realizing the full potential of this oversight tool. In 2011, OIG found that four of the Zone Program Integrity Contractors (ZPICs) did not identify any vulnerabilities related to home health, despite this being a source of numerous fraud investigations and convictions at that time, and the ZPICs varied substantially in their efforts to detect and deter fraud. Medicare also inappropriately paid some home health agencies with suspended or revoked billing privileges. In another review, we found that only one of nine Medicare Administrative Contractors (MACs) performed activities to detect and deter fraud by community mental health centers (another provider type known to have high risk for fraud) in 2010; most of these activities were part of a CMS-led special project. Other contractors performed minimal activities to detect and deter fraudulent billing by community mental health centers, despite having jurisdiction over fraud-prone areas. Additionally, Medicare paid community mental health centers that did not comply with its requirements after their revocations were effective and while their revocations were being processed.

Progress in Addressing the Challenge

The Department has made progress in its fight against fraud in Medicare Parts A & B. The Health Care Fraud Prevention and Enforcement Action Team (HEAT) operations, including the Medicare Fraud Strike Force teams, have demonstrated reductions in claims submitted to Medicare and payments made by Medicare for Part A & B services susceptible to fraud, including DME suppliers, home health agencies, and community mental health centers. Medicare Fraud Strike Force operations also have taken down ambulance and outpatient therapy fraud schemes. Significantly, CMS for the first time used the provider enrollment moratoria authority granted by the ACA. CMS instituted 6-month moratoria on the enrollment of new home health agencies in the Miami and Chicago areas, and ambulance suppliers in the Houston area. CMS continues to use its payment suspension authority to stop payments to certain providers and suppliers suspected of fraud. Another of CMS's major tools in fraud prevention is the Fraud Prevention System – this is discussed in Management Challenge 8.

CMS reported that it has improved its performance metrics for the ZPICs for all contracts that take effect in FY 2014. According to CMS, these new metrics will evaluate the contractors' performance in critical program integrity areas, including the accuracy and timeliness of implementing payment suspensions and revocations. CMS also reported efforts to improve coordination between RACs and ZPICs. It added to the RAC Statement of Work a requirement to meet with the ZPICs at least quarterly to discuss potential fraud referrals and trends they are seeing in the applicable jurisdictions.

The Department has also made progress in combatting waste in Medicare Parts A & B. CMS issued a final rule to implement its Hospital Readmissions Reduction Program, effective October 1, 2012, under which Medicare payments may be reduced to applicable hospitals with high patient readmission rates. In that same final rule, CMS also expanded its list of existing hospital-acquired conditions with some updated billing codes and added two new conditions to this list. CMS also issued a final rule in August 2013 that modifies and clarifies review and payment rules regarding inpatient hospital admissions and services under Parts A & B, which it expects will lower improper payments in this problem area.

In addition, the Department continues to implement the Competitive Bidding Program for DME, which holds promise for addressing prior OIG findings that Medicare paid significantly more than market prices for many types of DME. Regarding global surgery fees, CMS indicated that it will continue to work in conjunction with the American Medical Association Relative Value Update Committee and relevant specialty societies to identify potentially mis-valued services. CMS annually reviews hundreds of codes, many of which are codes with global surgery periods. CMS also continues to monitor hospice claims at each MAC through inclusion of hospice as part of their medical review strategies for the year.

What Needs to be Done

Fraud in Medicare Parts A & B remains a major challenge, and experience shows that schemes migrate among provider and supplier types as well as geographically. The Department must improve its use of data and program integrity tools to address shifting fraud schemes. For example, CMS should consider instituting additional temporary enrollment moratoria for certain types of providers in geographic areas at significant risk for fraud. Also, CMS should implement the surety bond requirement for home health agencies, and CMS should consider increasing surety bond amounts above $50,000 for those home health agencies with high overall Medicare payment amounts.

CMS should continue to build on its progress in addressing program integrity contractor performance and oversight challenges, including developing additional performance evaluation metrics, particularly for high-risk providers such as home health agencies and community mental health centers in fraud-prone areas. CMS also should facilitate increased collaboration between RACs and program integrity contractors and provide training to RACs to help them refer potential fraud, as appropriate.

More needs to be done to reduce improper payments. For instance, CMS should increase and expand reviews of claims by SNFs and follow up with SNFs that billed in error. CMS should also address payment inefficiencies, such as adjusting bundled payments for surgery fees, and should seek legislative fixes where necessary, for example, by seeking legislative authority to reduce Medicare payments for lab tests.

Key OIG Resources

- Example of one of numerous hospital audits (North Shore Medical Center). March 2013
- OIG Spotlight on "Bad Bargains" (payment misalignments). August 2013
- OIG Spotlight on Skilled Nursing Facilities. February 2013
- Summary of Medicare Fraud Strike Force cases and accomplishments in OIG's Semiannual Report to Congress, April 2013. (See pages 35-36)
- Selected OIG reports on CMS contractors – RAC oversight and actions to address improper payments, August 2013; ZPICs' and MACs' oversight of home health. December 2012
- OIG report on questionable billing by community mental health centers. August 2012

Management Challenge 6: Preventing Improper Payments and Fraud in Medicare Advantage

Why This is a Challenge

Improper payments to MA plans pose a significant vulnerability for CMS and cost taxpayers billions of dollars. In FY 2013, the Department reported an error rate of 9.5 percent for MA, corresponding to an estimate of almost $11.8 billion in improper payments (consisting of about $9.3 billion in overpayments and about $2.6 billion in underpayments). The MA error rate measures errors related to risk-adjustment payments.

In general, Medicare makes capitated payments to MA organizations to deliver a specified set of health care benefits to qualified beneficiaries. MA organizations submit bids to CMS related to their expected costs for the upcoming year to calculate a standard monthly payment rate per beneficiary. This standard rate is then risk-adjusted (increased or decreased) based on the health characteristics of individual enrolled beneficiaries; i.e., Medicare will make higher monthly payments on behalf of sicker beneficiaries. To calculate risk-adjustment payments, MA organizations submit beneficiaries' clinical diagnoses to CMS. If a diagnosis submitted is not supported by the beneficiary's medical record, the risk-adjustment will be inaccurate and result in payment errors.

OIG has audited risk-adjustment payments to MA organizations. In OIG audits of six MA organizations' risk data from payment year 2007, we identified approximately $650 million in aggregate extrapolated overpayments to these plans because the medical records did not support the reported diagnosis.

Improper payments by MA organizations to providers (including those resulting from provider fraud) also raise concerns. These improper payments are not measured or reported in the MA error rate because CMS does not reimburse MA organizations on a claim-by-claim basis. However, such improper payments raise costs for MA organizations, and in turn, raise costs for Medicare and beneficiaries.

MA organizations share risk with the Government and have incentives to detect and prevent fraud; however, not all MA organizations have done so effectively. OIG found wide variability across MA organizations in their identification and reporting of fraud and abuse incidents (ranging from 1 incident to 1.1 million incidents). In addition, not all MA organizations took appropriate steps to respond to suspected fraud incidents.

Further, OIG found that from 2010 to 2011, CMS's contractor charged with oversight of MA program integrity (known as the MEDIC) produced limited results and faced significant barriers to effectively safeguarding this program. For example, lack of a centralized MA data repository hindered the MEDIC's ability to identify and investigate MA fraud and abuse. The MEDIC also lacked administrative authority to recommend recoupment of payments associated with inappropriate services.

Progress In Addressing the Challenge

CMS's reported error rate for MA decreased from 11.4 percent for FY 2012 to 9.5 percent for FY 2013. CMS described changes to its process for measuring MA payment errors in FY 2013 intended to ensure that the error rate reflects MA organizations' submissions of inaccurate diagnoses and not "false positives" associated with the procedures for submitting medical record documentation. These changes included extending the time allotted for MA organizations to submit medical records, providing interim feedback on the validity of those records, and providing preliminary coding results to MA organizations.

CMS has reported that it is implementing three initiatives to reduce the errors in risk-adjustment data and resulting improper payments. One is by contracting for audits of risk-adjustment data to verify the accuracy of plan-reported diagnoses through medical record review and recouping improper payments identified by these audits. CMS launched these audits in November 2013 and plans to audit about 30 MA contracts per year. The second is conducting training for MA organizations about accurate diagnosis reporting, including identifying the

diagnoses most often resulting in errors. The third is educating physicians to improve their medical record documentation in support of patient diagnoses.

Building on a model for identifying and collecting overpayments for Medicare Parts A & B, the ACA required CMS to develop a RAC program for MA. CMS is working to implement this requirement.

CMS has updated its reporting requirements for the MEDIC to better oversee its performance in safeguarding MA program integrity. CMS has reported that the MEDIC has access to a new data source, which facilitates analysis of a large volume of data and increases data storage capacity. CMS expects that this will help the MEDIC perform proactive analyses targeting MA fraud and abuse in the future.

What Needs to Be Done

CMS needs to ensure that MA organizations submit accurate beneficiary diagnoses for setting risk-adjustment payments and recoup overpayments that were based on inaccurate data reported by plans. It should continue to monitor the effectiveness of its initiatives aimed at this goal and take additional steps if error rates remain high.

CMS should also develop administrative mechanisms to recover or otherwise remedy overpayments that MA organizations have made to providers so that these do not increase costs for Medicare. Implementation of the RAC program in MA may provide such an opportunity.

CMS should work with MA organizations to ensure that they implement effective programs to detect, correct, and prevent fraud, waste, and abuse, as required in their compliance plans. In addition, CMS should require MA organizations to report suspected fraud incidents to the CMS and/or the MEDIC for further review and potential referral to law enforcement. CMS should also develop a centralized repository of MA data, and provide access to that repository to the MEDIC, to facilitate more effective program oversight. CMS should continue working to ensure that the MEDIC successfully carries out proactive data analyses targeting MA fraud and abuse, as planned.

Key OIG Resources

- OIG audit of risk adjustment data (Excellus Health Plan, one of six audits). October 2012
- OIG report on MEDIC integrity activities in Parts C & D. January 2013
- OIG report on MA organizations' identification of fraud and abuse. February 2012

Management Challenge 7: Ensuring Quality of Care in Nursing Facilities and Home- and Community-Based Settings

Why This Is a Challenge

As the median age of Americans continues to age and as more Americans live with chronic medical conditions, the Department faces challenges in ensuring that beneficiaries who require nursing facility services receive high quality care. It is also critical to ensure that appropriate home- and community-based care is available, allowing beneficiaries whose needs and preferences are better served by remaining in their own homes or other community-based settings to avoid institutionalization. Nursing facility and home- and community-based services are important for individuals' well-being and can often prevent the need for acute inpatient hospitalizations. OIG work has uncovered various problems with nursing home care, including inadequate staffing, failure to provide adequate nutrition and hydration, inadequate wound care resulting in pressure wounds (bedsores), inappropriate medication practices, failure to develop adequate care plans, and excessive therapy services that are medically unnecessary or even harmful to beneficiaries.

Medicaid is a major payer of personal care services, spending more than $12 billion annually. The Department is committed to ensuring that Medicaid beneficiaries enjoy adequate home- and community- based care options and as such, expenditures for personal care services may be expected to increase. Many Medicaid programs support beneficiary-directed models for the delivery of personal care services. While these systems offer certain advantages for promoting patient choice and preferences, OIG investigators have found such systems particularly vulnerable to fraud and abuse.

Progress in Addressing the Challenge

The Department has taken steps to improve quality of nursing home and home- and community-based care. For example, the Department has initiated a review of the requirements for nursing homes to participate in the Medicare and Medicaid programs. This review promises to emphasize patient-centered care, quality improvement, and preventable rehospitalization. The Department has long recognized problems with patients cycling between nursing homes and acute care hospitals. As part of the Partnership for Patients Initiative, the Department specifically committed $300 million towards a Community-Based Care Transition Program to improve patient outcomes following hospital discharge. The Department has launched the National Nursing Home Quality Care Collaborative that proposes to identify best practices from high performing facilities and promote dissemination and replication of those practices to improve care. Increased involvement of Quality Improvement Organizations also offers potential improvement in quality of nursing home care. Through its Nursing Home Compare initiative, the Department also attempts to disseminate information about nursing home quality that may help inform beneficiaries and their families when selecting facilities. In 2013, CMS also released guidance that strengthens nursing home requirements in areas such as: the use of unnecessary medication, access and visitation, handling linens and infection control, and the provision of basic life support services for residents.

OIG continues to pursue enforcement actions against nursing homes that render substandard care. CMS and OIG continue to work closely with law enforcement partners at the Department of Justice and through the Federal Elder Justice Interagency Working Group to promote better care for elderly persons and to prosecute providers that subject them to abuse or neglect. Additionally, State Medicaid Fraud Control Units (MFCUs), which receive oversight and funding from OIG, devote substantial resources to the investigation and prosecution of patient abuse and neglect in both Medicaid-funded facilities and board and care facilities. The President's FY 2014 Budget includes a legislative proposal to expand MFCU jurisdiction to review patient abuse and neglect in home- and-community based settings, as well.

The decision to force a nursing home to shut down or stop serving Federal health care program beneficiaries is never taken lightly, as the experience of being transferred may be traumatic to displaced beneficiaries and locating nearby facilities to adequately serve them can be challenging. Therefore, OIG invests substantial efforts in helping facilities improve. OIG has developed an innovative quality-oriented corporate integrity agreement process to work with facilities so they may properly serve beneficiaries. OIG has placed more than 750 nursing homes under corporate integrity agreements that include quality-monitoring provisions designed to ensure that beneficiaries receive the care they deserve.

Ensuring high quality home- and community-based services, enabling beneficiaries to avoid institutionalization, relies heavily on appropriate personal care services. In another promising initiative, the Department funded the National Direct Service Workforce Resource Center to develop the Road Map of Core Competencies for the Direct Service Workforce. A planned component of this initiative is to develop nationally validated core competencies for personal care service providers and reduce State variation. As OIG has previously noted, developing the standards will be a good first step, but getting States to adopt them may require more forceful action from the Department.

What Needs To Be Done

The Department should continue to prioritize quality of nursing home and home- and community-based care. OIG has offered recommendations that can assist the Department in this mission. For example, OIG suggested enhancements to nursing home oversight to ensure that Medicare does not pay nursing homes to overmedicate or otherwise inappropriately medicate beneficiaries (See Challenge 3 for more information). The Department should also continue denying payments for services of such low quality that they are virtually worthless and work with OIG to exclude providers that have rendered grossly substandard care, thereby preventing additional harm to vulnerable beneficiaries.

The Department should ensure integrity of Medicaid-funded personal care services by establishing minimum Federal qualification standards for providers, improving CMS's and States' ability to monitor billing and care quality, and issuing operational guidance for claims documentation, beneficiary assessments, plans of care, and supervision of attendants. The Department should also issue guidance to States regarding adequate prepayment controls and help States access data necessary to identify overpayments. CMS should continue developing and then implement its comprehensive action plan, including the input it gathered from the roundtable it held in April 2013 to consider feasible and effective practices for improving program integrity in personal care services.

Key OIG Resources

- Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement. November 2012
- OIG Spotlight on Skilled Nursing Facilities. February 2013
- Example of Fraudulent Substandard Care: press release on nursing home operator health care fraud sentencing. August 2012

Management Challenge 8: Effectively Using Data and Technology to Protect Program Integrity

Why This is a Challenge

The Department compiles an enormous amount of data related to Federal health insurance programs, public health and human services, and the beneficiaries whom they serve. It continues to face challenges in effectively using these data to detect and prevent improper payments and to ensure consumer and patient safety and quality of care. It also faces challenges to protect the privacy and security of the data it collects and maintains.

Improving the Effectiveness of Medicaid Data. Federal Medicaid payments are expected to increase an average of 8 percent each year from 2013 through 2023, according to recent Congressional Budget Office estimates. As Medicaid expands, it is imperative that CMS have a functional, national Medicaid database so that CMS may monitor Medicaid payments and services. OIG work has found that the current national Medicaid data are not complete, accurate, or timely and that additional data are needed to conduct national Medicaid program integrity activities. OIG has recommended several actions for improvement, including that CMS establish a deadline for when national Medicaid data of sufficient completeness and quality will be available and ensure that States submit required data. CMS has attempted to improve the access and quality of Medicaid data, most recently through the Transformed Medicaid Statistical Information System (T-MSIS) initiative. Although implementation is still early, analysis completed in January 2013 showed that T-MSIS has made limited progress in addressing Medicaid data concerns. (For additional information on challenges related to Medicaid, see Challenge 4).

Demonstrating Impact from the Fraud Prevention System (FPS). As the Department continues to implement predictive analytics technologies to help identify fraudulent claims before they are paid, it must produce reliable information demonstrating the effectiveness of these technologies. The Small Business Jobs Act of 2010 required CMS to use predictive analytics to identify and prevent the payment of improper claims in the Medicare fee-for-service program. In response, CMS implemented the FPS in 2011 and now uses the predictive analytics program to identify potential health care fraud, waste, and abuse. However, after its first year of implementation, challenges remain in demonstrating the FPS's impact. OIG found that some reporting requirements were not met and that its methodology for calculating estimates on savings, recoveries, and return on investment included some invalid assumptions that may have affected the accuracy of those amounts.

Ensuring HHS Data and Systems Are Secure. All information collected, processed, transmitted, stored, or disseminated by HHS agencies, their contractors, States, and hospitals must be adequately protected pursuant to the Privacy Act, Office of Management and Budget (OMB) guidelines, and other authorities. OIG has identified vulnerabilities in a variety of information systems controls, including implementation of directives and guidance on information security controls, access controls, and configuration management controls, which may lead to unauthorized access to and disclosure of sensitive information or disruption of critical operations and limit the ability to ensure the confidentiality, integrity, and availability of critical information and systems. As discussed in Challenge 1, the Department also faces challenges in the development of systems for and effective operation of the Marketplaces, which require rapid, accurate, and secure integration of data from numerous Federal and State sources and individuals who use the Marketplaces.

Protecting Information Contained in Electronic Health Records (EHR) and Guarding Against Fraud. With the enactment of the Recovery Act and the HITECH Act, the Department has played a leading role in the nationwide adoption of EHRs and other health IT. These innovations offer opportunities for improved patient care and more efficient practice management. However, as the volume of electronically-stored medical information grows, protecting the privacy, security, and integrity of EHRs has become more critical. Data security breaches and

medical identity theft are growing concerns, with thousands of cases reported each year.[17] The Department faces challenges as it maximizes implementation of promising health IT while maintaining the privacy and security of sensitive health information.

Experts in health information technology caution that use of EHRs can make it easier to commit fraud. In the Department's efforts to promote EHR adoption, it focused largely on developing criteria, defining meaningful use, and administering incentive payments. It has given less attention to the risks EHRs may pose to program integrity. Certain features, such as cut-and-paste and auto-fill templates may be used to mask true authorship of the medical record and distort information to inflate health care claims. An examination of hospitals that received Medicare incentive payments as of March 2012 revealed that while nearly all hospitals had recommended audit functions in place, they may not be using them to their full extent. For example, nearly half of hospitals reported being able to turn off audit logs, and few hospitals report using audit logs to identify potentially fraudulent or abusive practices.

Progress in Addressing the Challenge

CMS has taken action to improve its data and technology capabilities. Beginning in 2012, CMS partnered with 12 volunteer States on the planning and development of T-MSIS. OIG found that the 12 States had made some progress in implementing T-MSIS. CMS stated that all States are expected to participate in T-MSIS by the end of 2013 and to demonstrate operational readiness to submit timely T-MSIS data by July 1, 2014. CMS issued a letter to State Medicaid Directors in August 2013 that included a deadline for when all States are expected to demonstrate operational readiness to submit T-MSIS files, transition to T-MSIS, and submit timely T-MSIS data. CMS also reports that it has added terms and conditions to various Medicaid funding mechanisms to provide incentive for States to report timely, complete and accurate data. CMS created a set of tools to help States prepare to submit T-MSIS data, including establishing a CMS liaison for States and the creation of a T-MSIS State collaboration workgroup.

In implementing FPS in July 2011, CMS met legislative timeline requirements and implemented the largest scale predictive analytics program used to identify potential health care fraud, waste, and abuse ever developed. With regard to demonstrating the impact of FPS, CMS has shown leadership by coordinating and leveraging relationships with public and private entities to discern best practices for measuring the impact of program integrity activities. CMS has also continued to take steps to refine its methodologies for calculating cost savings from costs avoided due to FPS.

Some HHS agencies, States, and hospitals have made progress in addressing recommendations made by OIG in audits of information security systems. However, CMS continues to have significant deficiencies in its planning, implementation, and execution of its overall information security directives and guidance; and implementing controls to prevent unauthorized access to sensitive information.

Through its EHR adoption incentive programs regulations and its EHR certification criteria regulations, HHS has addressed privacy and security matters in limited ways. The Office of the National Coordinator for Health IT (ONC), which coordinates the adoption, implementation, and exchange of EHRs, awarded a contract to develop

[17] CMS tracks nearly 300,000 compromised Medicare-beneficiary numbers. The Office for Civil Rights has received more than 77,000 complaints regarding breaches of health information privacy and completed more than 27,000 investigations, which have resulted in more than 18,000 corrective actions.

recommendations to enhance data protection; increase data validity, accuracy, and integrity; and strengthen fraud protection in EHR technology; however, the Department did not directly address all recommended safeguards through certification criteria and meaningful use requirements. CMS has acknowledged the potential for EHRs to be used to commit fraud and intends to develop guidelines to ensure appropriate use of the copy/paste feature in EHRs. Additionally, CMS audits providers who received EHR incentive payments to gauge the accuracy of, among other things, attestations that risk analyses designed to protect electronic health information were conducted. If the Department takes steps to that ensure meaningful use requirements include necessary safeguards, these audits may be a helpful oversight tool.

What Needs To Be Done

CMS and the 12 volunteer States participating in T-MSIS have made some progress, particularly toward planning for T-MSIS implementation. However, early implementation outcomes raised questions about the completeness and accuracy of T-MSIS data upon national implementation. CMS should continue to work with States to ensure the submission of complete, accurate, and timely data. It should also establish a deadline for when T-MSIS data will be available for use. If States fail to begin submitting T-MSIS data by the implementation deadline, CMS should use its statutory enforcement mechanisms or seek legislative authority to employ alternative tools to compel State participation.

To ensure effective operations during the planned expansion and enhancement of FPS over the next few years, CMS will need to address FPS's reporting and measurement vulnerabilities. OIG will continue monitoring the FPS and analyze future modifications or refinements to it.

The Department, States, and hospitals should continue improving systems controls to help ensure that system assets are protected from unauthorized usage and that only authorized personnel are granted access to data and programs.

The Department should continue to focus on oversight and enforcement of privacy and security protections to ensure that sensitive data are protected. It should also do more to ensure that EHRs contain safeguards and that providers use these safeguards to protect against health care fraud involving electronic systems. The Department should also provide additional guidance on information technology security standards and best practices that the health care industry should adopt for EHRs.

Key OIG Resources

- Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology. December 2013
- Early Outcomes Show Limited Progress for the T-MSIS. September 2013
- The Department and CMS Financial Statement Reports *which can be found on the HHS website after December 16, 2013*. Fiscal Year 2013
- Security Gaps May Threaten Electronic Health Records. June 2011
- Protect Yourself Against Medical Identity Theft.
- CMS Response to Breaches and Medical Identity Theft. October 2012
- OIG report on implementation predictive analytics. September 2012

Management Challenge 9: Protecting HHS Grants and Contract Funds from Fraud, Waste, and Abuse

Why This Is a Challenge

HHS is the largest grant-making organization in the Federal Government, and its funding of health and human services programs touches the lives of almost all Americans. In FY 2012, the Department awarded over 81,000 grants totaling approximately $347 billion. Of these, approximately 80,000 grants totaling approximately $90 billion were for programs other than Medicare or Medicaid. According to HHS's Tracking Accountability in Government Grants System, in FY 2013, HHS issued over 20,000 new awards totaling over $272 million. These grants include those added to the HHS grant portfolio by the ACA and the Recovery Act, thus expanding the oversight responsibilities of grant managers and project officers.

HHS is also the third largest contracting agency in the Federal Government; in FY 2013, HHS awarded over $19 billion in contracts across all program areas. Under ACA, contractors have played, and will continue to play, a vital role in building, maintaining, and fixing the computer systems that underpin the implementation of Marketplaces and the Data Hub. HHS faces a challenge to ensure proper management and oversight of these contracts. (See Challenge 1 for more information on ACA contractor management and oversight.) Additionally, several HHS Operating Divisions (OPDIVs) funded Small Business Innovation Research (SBIR) and Small Business Technology Transfer (STTR) grants and contracts. In calendar year 2012, HHS spent $755 million for grants and contracts in these programs. In contracts alone, HHS awarded $13 million in SBIR contracts and $463,000 in STTR contracts in FY 2013. HHS is the second largest payer under the SBIR and STTR programs (the Department of Defense is the first).

The size and scope of departmental awards make their operating effectiveness crucial to the success of programs designed to improve the health and well-being of the public. Yet OIG has noted weaknesses in the oversight of grantees, as demonstrated by late or absent financial and related reports, insufficient documentation on progress toward meeting program goals, and failure to ensure that grantees obtain required annual financial audits.

At the grantee level, a common problem uncovered by our reviews is that grantees lack robust financial management systems. Some grantees cannot even account for specific grants on a grant-by-grant basis. Without this basic ability, grantees cannot account for costs associated with specific grant awards. Accountability suffers as a result. Collectively, when combined with frequent significant findings of unallowable expenses, these conditions suggest the need for more purposeful oversight and consistency in oversight processes.

Additionally, OMB is in the process of finalizing extensive revisions to the grants management circulars and associated cost principles for Federal grant awards, which will result in implementation challenges for the Department, including changes to HHS regulations and potential adjustments to some grant oversight practices.

With respect to contracts, OIG raised concerns about HHS's use of appropriations to fund contracts as well as its efforts to monitor contractor performance. OIG audits of NIH contracts revealed instances of improper funding in 11 of 18 contracts. Follow-up audit work is underway to assess the effectiveness of the remedial actions outlined by the Department in its 2011 report of Antideficiency Act violations.

OIG has also identified weaknesses in contracting processes and contract management. An audit of CDC contracts revealed that CDC failed to meet Government requirements for contractor performance assessments. Failure to conduct these assessments and make contractor evaluations available through the Federal Awardee Performance and Integrity Information System (FAPIIS) deprives CDC's and other agencies' contracting officers of valuable performance information that should be used in determining whether a contractor is responsible and should receive another Federal award. During FY 2013 the Department focused on contractor performance assessments

and posting performance information in the FAPIIS, resulting in an overall improvement from 7.91% (baseline FY 2009 – FY 2012) to 14.88% (FY 2009 – FY 2013).

With respect to misconduct involving grants or contracts, HHS faces various challenges pursuing criminal, civil or administrative actions. While HHS has established a suspension and debarment program, in FY 2013, the implementation of this tool to impose suspensions and debarments remains limited. HHS faces the challenge of educating its grant and contract officers on these administrative remedies and encouraging their use.

Progress in Addressing the Challenge

HHS is strengthening its program integrity efforts by working with its OPDIVs and Staff Divisions (STAFFDIVs) to implement a uniform risk management approach. The Department has established a Program Integrity Coordinating Council to look across programs for common challenges and solutions. Additionally, HHS has actively participated in the Government-wide grants reform guidance project, and is in the process of updating its own internal grants administration manual to foster greater program integrity, accountability, and transparency throughout the grants lifecycle.

With respect to systemic contract funding problems, the Department continues to provide its contracting workforce with an online reference tool for contract funding, formation, and appropriations law compliance. The Department conducts appropriations law compliance reviews of all contract actions exceeding $5 million or $10 million, depending on the type of requirement reviewed and the awarding OPDIV or STAFFDIV. HHS has also revised its contract funding guidance to more accurately describe appropriations law and policy; these revisions incorporated best practices and lessons learned. All Heads of Contracting Activities have developed guidance for their contracting workforce on contractor performance evaluation.

With respect to grant and contract misconduct, the Department has participated in training related to fraud, waste and abuse in the grant and contract area. OIG, a member of the President's Financial Fraud Enforcement Task Force Grant Fraud Subcommittee, collaborated to produce guidance to be used by all Federal agencies as a framework for grant training to reduce grant fraud risk and has offered to assist the Department in developing training specific to HHS OPDIVs.

In outreach efforts, OIG provided fraud, waste, and abuse training to SBIR/STTR program staff in multiple OPDIVs and to staff at CMS's Center for Medicare and Medicaid Innovation. OIG created an Intranet Web Page for HHS OPDIV officials to use to refer allegations of fraud or to submit questions about fraud to OIG.

With respect to suspension and debarment, the Suspension and Debarment Official (SDO) and her staff continue to have monthly coordination meetings with OIG, the Office of Research Integrity and the Office of the General Counsel. The SDO is also developing procedures and tools to assist HHS grants and contracts officials.

What Needs To Be Done

Sustained focus by the Department is needed to address vulnerabilities in its grant programs and contract administration. With respect to grant oversight, OPDIVs need continued vigilance in monitoring grant resources stemming from the ACA, the Recovery Act, and other grant programs. Implementation of planned program integrity initiatives, such as evaluating and mitigating risks, identifying and addressing cross-cutting issues, resolving grantee audit findings, and sharing best practices across the Department will better position HHS to integrate program integrity into all aspects of its operations and culture.

OIG is continuing to examine grants management practices across the Department. For example, OIG is reviewing the extent to which OPDIVs mitigate grantee risks and share information about high risk grantees. We are also reviewing OPDIVs' oversight of the SBIR program as it pertains to ensuring grantee compliance with program eligibility requirements.

With respect to contract funding, the Department has advised that it is focused on preventing new violations and that it is taking legally appropriate actions to ensure that there are no further violations of the Antideficiency Act among ongoing contracts. OIG continues to recommend that the Department correct the improper funding of contracts that resulted in appropriations violations and continue to ensure that appropriate officials attend mandated training, that future contracts are funded properly, and that policy guidance is consistently followed.

The Department and OIG should continue to provide training on identifying and pursuing misconduct in HHS grants and contracts. The Department also needs to continue to refine its Suspension and Debarment Procedures, including streamlining the referral and decision process, setting up a department-wide tracking system, training officials throughout the Department on suspension and debarment, and decreasing the processing time of suspension and debarment referrals.

Key OIG Resources

- OIG Spotlight on Grants Management and Oversight. February 2013
- OIG review of CDC's contract monitoring. July 2013

Management Challenge 10: Ensuring the Safety of Food, Drugs and Medical Devices

Why This Is a Challenge

The Department, through the Food and Drug Administration (FDA), is responsible for protecting public health by ensuring the safety, efficacy, and security of drugs, medical devices, biologicals, and much of our Nation's food supply. The Department must ensure that once a drug, biologic, or device has been approved for use, it is marketed appropriately. During a food emergency, the Department is also responsible for finding the contamination source and overseeing the removal by manufacturers of these products from the market. However, OIG work has revealed weaknesses in FDA's ability to adequately oversee the safety of drugs, biologics, medical devices, and food. These challenges include:

Limited oversight of drug safety. A fall 2012 nationwide meningitis outbreak caused by contaminated injections raised major concerns about the use of drugs supplied by compounding pharmacies. OIG reviewed hospitals' use of compounded drugs and found that in 2012, 92 percent of hospitals used compounded sterile preparations (CSPs). Additionally, we found that 56 percent of hospitals made changes or planned to make changes to CSP sourcing practices in response to the fall 2012 meningitis outbreak. In recent congressional hearings about vulnerabilities in the oversight of compounding pharmacies, FDA has raised concerns that its enforcement authority might not be sufficient to take action against inappropriate compounding practices.

Similarly, OIG's review of Risk Evaluation and Mitigation Strategies (REMS) raised concerns about FDA's monitoring of the risks associated with drugs that have known or potential risks that may outweigh the drugs' benefits. REMS are enforceable, structured plans to manage specific risks associated with these drugs. We found that nearly half of sponsor assessments for the REMS we reviewed did not include all information requested in FDA assessment plans. Moreover, FDA does not have the authority to take enforcement actions against drug sponsors that do not include all information requested in FDA assessment plans.

Inadequate food facility and dietary supplement manufacturer recordkeeping. In the past, OIG have found that food facilities' failure to comply with FDA's recordkeeping requirements impedes the Department's ability to ensure the safety of the Nation's food supply. OIG found that 59 percent of selected food facilities did not comply with FDA's recordkeeping requirements. In recent reviews of manufacturers of dietary supplements, OIG found that 28 percent of contacted companies failed to register with FDA as required. Of the companies that did register, 72 percent failed to provide the complete and accurate information required in the registry.

Potentially misleading claims made by manufacturers of dietary supplements. The Government Accountability Office (GAO) and public interest groups have raised concerns about a specific type of claim called a structure/function claim that manufacturers may use on dietary supplement labels. Manufacturers have used these claims to promote health benefits of their products. Stakeholders have urged FDA to strengthen oversight of these claims because they are potentially misleading and may lack scientific support. Manufacturers must have competent and reliable scientific evidence to show that claims are truthful and not misleading, but they do not have to submit the substantiation to FDA, and FDA has only voluntary standards for it. A manufacturer must notify FDA when it uses structure/function claims. OIG found that substantiation documents for the supplements reviewed were inconsistent with FDA guidance on competent and reliable scientific evidence. OIG also found that FDA could not readily determine whether manufacturers had submitted the required notification for their claims. These results raise questions about the extent to which structure/function claims are truthful and not misleading.

Ensuring Compliance With Marketing Requirements. Manufacturers of drugs, biologicals, and medical devices gain approval for sale of their products for specific uses once FDA determines that the products are safe and effective for those uses. Once approved for sale, qualified medical providers may prescribe them for any uses on the basis of their medical judgment. However, manufacturers are prohibited from promoting products for uses for which FDA has not specifically approved them (known as off-label uses). OIG, in conjunction with its law enforcement partners, including FDA's Office of Criminal Investigations, has investigated many instances in which manufacturers illegally promoted products for off-label uses. Off-label promotion can undermine the system intended to ensure that drugs are safe and effective and can put patients at risk. Additionally, this illegal off-label promotion may lead to fraudulent claims for payment submitted to Federal health care programs, including Medicare and Medicaid. FDA faces ongoing challenges in adequately monitoring and preventing illegal off-label promotional activities.

Progress in Addressing the Challenge

Since September 2009, FDA has required food facilities to report to a new registry all instances when there is a reasonable probability that a food might cause serious adverse health consequences and to investigate the causes of any adulteration reported if the adulteration may have originated with the food facility. The Food Safety Modernization Act (FSMA), signed into law in January 2011, provides FDA important new authorities to better protect the Nation’s food supply. OIG will continue to oversee the Department’s management of food safety issues and FSMA implementation.

The Food and Drug Administration Safety and Innovation Act (FDASIA), enacted in July 2012, expands the FDA’s authorities and strengthens its ability to safeguard public health by authorizing the collection of user fees to fund reviews of drugs and devices; promoting innovation to expedite the development and review of certain new drugs; increasing stakeholder involvement in FDA decision making; and enhancing the safety of the drug supply chain. FDA has established a 3-year plan to implement these provisions, and the agency’s progress is updated monthly on a website.

OIG is continuing to work with law enforcement partners to investigate and prosecute drug and device manufacturers that engage in illegal activity. This year, as in past years, the Government entered several settlements with drug and device manufacturers relating to alleged off-label promotion. For example, in December

2012, Amgen Inc. agreed to pay a total of $762 million to resolve allegations of off-label promotion and other improper conduct. Amgen pled guilty to misdemeanor misbranding charges, entered a civil settlement agreement, and entered a comprehensive corporate integrity agreement with OIG to resolve its criminal, civil, and administrative liability for the improper conduct. In July 2013, TranS1, a medical device manufacturer, agreed to pay $6 million to resolve allegations under the False Claims Act that it caused false claims to be submitted to Medicare and Medicaid by, among other things, promoting its medical device for uses not approved or cleared by the FDA.

FDA has made progress in addressing OIG recommendations. For example, as a result of OIG's identifying vulnerabilities in FDA's oversight of regulatory decisions, FDA implemented new operating procedures for resolving scientific disagreements. However, other concerns raised by our office, such as weaknesses in ensuring the adequate monitoring of adverse-event reporting for medical devices and the accuracy of FDA's National Drug Code Directory, remain unaddressed.

What Needs To Be Done

The Department and FDA will need to continue issuing the rules and guidance documents necessary to fully implement the various provisions in FDASIA. In addition, FDA will need to continue its efforts to fully implement FSMA to better protect the Nation's food supply. FSMA addresses many of OIG's recommendations; however, we continue to recommend that FDA vigorously use its new authorities to remedy identified weaknesses in its inspections and recall procedures. FDA should also ensure that States properly conduct contracted food facility inspections. The Department also needs to focus on eliminating off-label promotion to protect patients and HHS health care programs.

Key OIG Resources

- OIG reports on food facility safety inspections (December 2011), structure/function claims by dietary supplements (October 2012), Risk Evaluation and Mitigation Strategies for drug safety (February 2013), and hospital outsourcing of high-risk compounded drugs (April 2013)
- DOJ press release: resolution with Amgen, Inc. settlement. December 19, 2012
- DOJ press release: resolution with TranS1, INC. July 3, 2013

DEPARTMENT'S RESPONSE TO OIG TOP MANAGEMENT CHALLENGES

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

To: Daniel R. Levinson, Inspector General

From: Ellen G. Murray, Assistant Secretary for Financial Resources and Chief Financial Officer

Subject: FY 2013 Top Management and Performance Challenges Identified by the Office of Inspector General (OIG)

On December 12, 2013, the Department received the OIG's report, *Fiscal Year 2013 Top Management and Performance Challenges Identified by Office of Inspector General*. The report, which is published annually in the Department of Health and Human Services (HHS) Agency Financial Report (AFR), provides an OIG assessment of major Agency management and performance challenges during the most recent fiscal year that pose significant risks related to waste, fraud, error, or mismanagement. This memorandum is in response to the OIG's Report.

We concur with OIG's findings concerning HHS top management and performance challenges, which include Transitioning to Value-Based Payments for Heath Care; Overseeing the Health Insurance Marketplaces; Ensuring Appropriate Use of Prescription Drugs in Medicare and Medicaid; Protecting the Integrity of an Expanding Medicaid Program; Fighting Fraud and Waste in Medicare Parts A & B; Preventing Improper Payments and Fraud in Medicare Advantage; Ensuring Quality of Care in Nursing Facilities and Home- and Community-based Settings; Effectively Using Data and Technology to Protect Program Integrity; Protecting HHS Grants and Contract Funds from Fraud, Waste, and Abuse; and Ensuring the Safety of Food, Drugs and Medical Devices. Our management is committed to working toward resolving these challenges and looks forward to continued collaboration with OIG to improve the health and well-being of the American people through these efforts.

We appreciate the cooperation and work conducted by OIG in helping us to continue to address the Department's major management and performance challenges. Many thanks to you and your staff for your continued commitment in helping us improve our management environment.

/Ellen G. Murray/

Ellen G. Murray
Assistant Secretary for Financial Resources and
Chief Financial Officer
December 16, 2013

GLOSSARY

ACRONYM	DESCRIPTION
AA	Associate of Arts
ACA	Affordable Care Act
ACF	Administration for Children and Families
ACL	Administration for Community Living
ACO	Accountable Care Organization
ACR	Administrative Cost Review
AFR	Agency Financial Report
AHRQ	Agency for Healthcare Research and Quality
AICPA	American Institute of Certified Public Accountants
AIDD	Administration for Intellectual and Development Disabilities
AIDS	Acquired Immune Deficiency Syndrome
ALJ	Administrative Law Judge
AoA	Administration on Aging
ARRA	American Recovery and Reinvestment Act of 2009
ASA	Office of the Assistant Secretary for Administration
ASC	Ambulatory Surgical Center
ASFR	Office of the Assistant Secretary for Financial Resources
ASL	Office of the Assistant Secretary for Legislation
ASPA	Office of the Assistant Secretary for Public Affairs
ASPE	Office of the Assistant Secretary for Planning and Evaluation
ASPR	Office of the Assistant Secretary for Preparedness and Response
ATSDR	Agency for Toxic Substances and Disease Registry
BA	Bachelor of Arts
BHPr	Bureau of Health Professions
BPCI	Bundled Payment Care Improvement
CAP	Corrective Action Plan
CAUTI	Catheter-Associated Urinary Tract Infections
CBO	Congressional Budget Office
CBRs	Comparative Billing Reports
CCDF	Child Care Development Fund
CFBNP	Center for Faith-Based and Neighborhood Partnerships
CDC	Centers for Disease Control and Prevention
CERT	Comprehensive Error Rate Testing
CFBNP	Center for Faith-Based and Neighborhood Partnerships
CFO	Chief Financial Officer
CFRS	Consolidated Financial Reporting System
CHIP	Children's Health Insurance Program
CHIPRA	*Children's Health Insurance Program Reauthorization Act of 2009*
CIO	Chief Information Officer
CISO	Chief Information Security Officer
CLABSI	Central Line-associated Bloodstream Infections

ACRONYM	DESCRIPTION
CLASS	Community Living Assistance Services and Support
CME	Continuing Medical Education Credits
CMMI	Center for Medicare and Medicaid Innovation
CMP	Civil Monetary Penalties
CMS	Centers for Medicare and Medicaid Services
CO-OP	Consumer Operated and Oriented Plan
COLA	Cost of Living Adjustment
COTS	Commercial Off the Shelf
CPI	Consumer Price Index
CPIM	Consumer Price Index-Medical
CRADA	Cooperative Research and Development Agreement
CSPs	Compounded Sterile Preparations
CSRS	Civil Service Retirement System
CUSP	Comprehensive Unit-based Safety Program
CY	Current Year
DAB	Departmental Appeals Board
DHS	Department of Homeland Security
DIR	Direct and Indirect Remuneration
DMDC	DOD's Manpower Date Center
DME	Durable Medical Equipment
DOD	Department of Defense
DOJ	Department of Justice
DOL	Department of Labor
DRA	Deficit Reduction Act of 2005

ACRONYM	DESCRIPTION
ERRP	Early Retiree Reinsurance Program
EHR	Electronic Health Records
ESRD	End-Stage Renal Disease
FAPIIS	Federal Awardee Performance and Integrity Information System
FASAB	Federal Accounting Standards Advisory Board
FBIS	Financial Business Intelligence System
FBWT	Fund Balance with Treasury
FCA	False Claims Act
FCRA	Federal Credit Reform Act
FDA	Food and Drug Administration
FECA	Federal Employees' Compensation Act
FERS	Federal Employees' Retirement System
FETP	Field Epidemiology Training Program
FFM	Federally Facilitated Marketplace
FFMIA	*Federal Financial Management Improvement Act of 1996*
FFS	Fee-for-Service
FICA	Federal Insurance Contributions Act
FIFO	First-in/first-out
FISMA	*Federal Information Security Management Act of 2002*
FMFIA	*Federal Managers' Financial Integrity Act of 1982*
FPS	Fraud Prevention System
FSMA	Food Safety Modernization Act
FMAP	Federal Medical Assistance Percentage

ACRONYM	DESCRIPTION
FTC	Federal Trade Commission
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	Government Accountability Office
GDP	Gross Domestic Product
GMRA	*Government Management Reform Act of 1994*
GPAM	Grants Policy Administration Manual
GPRA	*Government Performance and Results Act of 1993*
GSA	General Services Administration
GTEx	Genotype-Tissue Expression
HAIs	Healthcare-Associated Infections
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HEW	Department of Health, Education and Welfare (now HHS)
HFPP	Healthcare Fraud Prevention Partnership
HHS	Department of Health and Human Services
HI	Hospital Insurance
HIGLAS	Healthcare Integrated General Ledger Accounting System
HIPAA	*Health Insurance Portability and Accountability Act of 1996*
HITECH	Health Information Technology for Economic and Clinical Health Act
HIV	Human Immunodeficiency Virus
HPSA	Health Professional Shortage Areas
HRSA	Health Resources and Services Administration

ACRONYM	DESCRIPTION
H5N1	Avian Influenza
IBNR	Incurred But Not Reported
IEA	Office of Intergovernmental and External Affairs
IEVS	Income Eligibility Verification System
IG	Inspector General
IHS	Indian Health Service
IP	Improper Payments
IPERA	*Improper Payments Elimination and Recovery Act of 2010*
IPERIA	*Improper Payments Elimination and Recovery Improvement Act of 2013*
IPIA	*Improper Payments Information Act of 2002*
IRS	Internal Revenue Service
IT	Information Technology
LIS	Low-Income Subsidy
LLP	Limited Liability Partnership
LPR	Legal Permanent Resident
MA	Medicare Advantage or Part C
MACs	Medicare Administrative Contractors
MARx	Medicare Advantage Prescription Drug
MD&A	Management's Discussion and Analysis
MEDIC	Medicare Drug Integrity Contractors
MFCUs	Medicaid Fraud Control Units
MIC	Medical Integrity Contractors
MII	Medicaid Integrity Institute
MLN	Medicare Learning Network

ACRONYM	DESCRIPTION
MMA	*Medicare Prescription Drug, Improvement and Modernization Act of 2003*
MMIS	Medicaid Management Information Systems
MPD	Medicare Prescription Drug or Part D
MPE	MARx Payment Error
MSIS	Medicaid Statistical Information Systems
MSP	Medicare Secondary Payer
MSSP	Medicare Shared Saving Program
N/A	Not Applicable
NBS	NIH Business Systems
NDC	National Drug Code
NDNH	National Directory of New Hires
NHSC	National Health Service Corps
NHSN	National Healthcare Safety Network
NIH	National Institutes of Health
OAA	Title III Older Americans Act
OACT	Office of the Actuary
OASDI	Old-Age Survivors and Disability Insurance
OASH	Office of the Assistant Secretary for Health
OCR	Office for Civil Rights
OGA	Office of Global Affairs
OGC	Office of the General Counsel
OI	Other Information
OIG	Office of Inspector General
OMB	Office of Management and Budget
OMHA	Office of Medicare Hearings and Appeals
ONC	Office of the National Coordinator for Health Information Technology
OPD	Orphan Products Development
OPDIV	Operating Division
OS	Office of the Secretary
PARIS	Public Assistance Reporting Information System
PCMH	Patient Centered Medical Home
PDE	Prescription Drug Event
PEDIR	Payment Error related to Direct and Indirect Remuneration
PELS	Payment Error related to Low-Income Subsidy Status
PEMS	Payment Error related to Medicaid Status
PEPV	Prescription Drug Event Data Validation
PERM	Payment Error Rate Measurement
PHS	Public Health Service
PII	Program Integrity Initiative
PIP	Program Improvement Plan
P.L.	Public Law
PNS	Projects of National Significance
PP&E	Property, Plant and Equipment
PRRB	Provider Reimbursement Review Board
PSC	Program Support Center
PUR	Period Under Review
PY	Prior Year
QIO	Quality Improvement Organization

ACRONYM	DESCRIPTION
QRIS	Quality Rating and Improvement Systems
RAC	Recovery Audit Contractor
RADV	Risk Adjustment Data Validation
REMS	Risk Evaluation and Mitigation Strategies
RDS	Retiree Drug Subsidy
RMFOB	Risk Management and Financial Oversight Board
RSI	Required Supplementary Information
RSSI	Required Supplementary Stewardship Information
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIR	Small Business Innovation Research
SBR	Statement of Budgetary Resources
SCSIA	Statement of Changes in Social Insurance Amounts
SDO	Suspension and Debarment Official
SE	Salmonella Enteritidis
SECA	*Self Employment Contribution Act of 1954*
SF	Standard Form
SFFAS	Statement of Federal Financial Accounting Standards
SGR	Sustainable Growth Rate
SHOP	Small Business Health Options Program

ACRONYM	DESCRIPTION
SIR	Standardized Infection Ratios
SMI	Supplementary Medical Insurance
SNAP	Supplemental Nutrition Assistance Program
SNF	Skilled Nursing Facility
SNS	Strategic National Stockpile
SOSI	Statement of Social Insurance
SSA	Social Security Administration
SSF	Service and Supply Funds
STAFFDIV	Staff Division
STTR	Small Business Technology Transfer
TANF	Temporary Assistance for Needy Families
T-MSIS	Transformed Medical Shared Saving Program
Treasury	Department of the Treasury
UFMS	Unified Financial Management System
U.S.	United States
U.S.C	U.S. Code
USDA	U.S. Department of Agriculture
USSGL	U.S. Standard General Ledger
VA	Department of Veterans Affairs
VFC	Vaccines for Children
VICP	Vaccine Injury Compensation Program
ZPIC	Zone Program Integrity Contractor

LAWS, REGULATIONS AND GUIDANCE

LONG TITLE *(each title is linked to an official government source)*	**AVAILABLE AT:**	**SHORT TITLE**
Office of Management and Budget		OMB
Public Law		P.L.
United States Code		U.S.C.
Accountability of Tax Dollars Act of 2002	http://www.gpo.gov/fdsys/pkg/PLAW-107publ289/pdf/PLAW-107publ289.pdf	*P.L. 107-289*
Affordable Care Act of 2010	http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf http://www.gpo.gov/fdsys/pkg/PLAW-111publ152/pdf/PLAW-111publ152.pdf	*P.L. 111-148* *and* *P.L. 111-152*
American Recovery and Reinvestment Act of 2009 (ARRA or Recovery Act)	http://www.gpo.gov/fdsys/pkg/PLAW-111publ5/pdf/PLAW-111publ5.pdf	*P.L. 111-5*
Anti-Deficiency Act (§ 1341, 1342, 1349-1351 and 1511-1519)	http://uscode.house.gov/view.xhtml?path=/prelim@title31/subtitle2/chapter13&edition=prelim	*31 U.S.C. Ch 13*
Audit Follow-Up	http://www.whitehouse.gov/omb/circulars_a050/	*OMB Circular A-50*
Budget Control Act of 2011	http://www.gpo.gov/fdsys/pkg/PLAW-112publ25/pdf/PLAW-112publ25.pdf	*P.L. 112-25*
Cash Management Improvement Act of 1990, as amended	http://www.fms.treas.gov/cmia/statute.html	*P.L. 102-589*
Chief Financial Officer (CFO) Act of 1990	http://govinfo.library.unt.edu/npr/library/misc/cfo.html	*P.L. 101-576*
Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)	https://www.cms.gov/HealthInsReformforConsume/Downloads/CHIPRA.pdf	*P.L. 111-3*
Clinger-Cohen Act of 1996	http://www.gpo.gov/fdsys/pkg/PLAW-104publ106/pdf/PLAW-104publ106.pdf	*P.L. 104-106*
Community Living Assistance Services and Support (CLASS) Act	http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf	*P.L. 111-148, § 8001*
Computer Security Act of 1987	https://www.govtrack.us/congress/bills/100/hr145/text	*P.L. 100-235*
Debt Collection Improvement Act of 1996	http://www.dol.gov/ocfo/media/regs/DCIA.pdf	*P.L. 104–134*
Department of Defense and Full-Year Continuing Appropriations Act of 2011	http://www.govtrack.us/congress/bills/112/hr1473/text	*P.L. 112-10*
Department of Education Organization Act of 1979	http://history.nih.gov/research/downloads/PL96-88.pdf	*P.L. 96-88*

Economy Act	http://www.loc.gov/rr/frd/Military_Law/pdf/FLD_2013_Ch6.pdf	*31 U.S.C. Ch 15 § 1535*
Federal Credit Reform Act of 1990 (FCRA)	http://www.fms.treas.gov/ussgl/creditreform/fcratoc.html	*P.L. 101-508 § 500*
Federal Employees' Compensation Act of 1916 (FECA)	http://www.dol.gov/owcp/dfec/regs/statutes/feca.htm	*5 U.S.C. 751*
Federal Financial Assistance Management Improvement Act of 1999	http://www.gpo.gov/fdsys/pkg/PLAW-106publ107/pdf/PLAW-106publ107.pdf	*P.L. 106-107*
Federal Financial Management Improvement Act of 1996 (FFMIA)	http://www.gpo.gov/fdsys/pkg/PLAW-104publ208/pdf/PLAW-104publ208.pdf	*P.L. 104-208*
Federal Information Security Management Act of 2002 (FISMA - Title III of the E-Government Act of 2002)	http://www.gpo.gov/fdsys/pkg/PLAW-107publ347/pdf/PLAW-107publ347.pdf	*P.L. 107-347*
Federal Insurance Contributions Act (FICA)	http://www.gpo.gov/fdsys/granule/USCODE-2011-title26/USCODE-2011-title26-subtitleC-chap21/content-detail.html	*26 U.S.C. Ch 21*
Federal Managers' Financial Integrity Act of 1982	http://www.whitehouse.gov/omb/financial_fmfia1982	*P.L. 97-255*
Federal Records Act of 1950	http://uscode.house.gov/view.xhtml?req=%22federal+records+act+of+1950%22&f=treesort&fq=true&num=2&hl=true&edition=prelim&granuleId=USC-prelim-title44-section3603	*44 U.S.C. Ch 31 § 3101*
Financial Management Systems	http://www.whitehouse.gov/sites/default/files/omb/assets/omb/circulars/a127/a127.html	*OMB Circular A-127*
Financial Reporting Requirements	http://www.whitehouse.gov/sites/default/files/omb/assets/omb/circulars/a136/a136_revised_2012.pdf	OMB Circular A-136
Food, Drug, Cosmetic Act	http://library.clerk.house.gov/reference-files/PPL_Title21_FoodDrugCosmeticAct.pdf	*P.L. 59-384*
Freedom of Information Act of 1974	http://uscode.house.gov/view.xhtml?req=freedom+of+information+act&f=treesort&fq=true&num=1&hl=true&edition=prelim&granuleId=USC-prelim-title5-section552	*P.L. 93-502 or 5 U.S.C. Ch 5 §552*
Government Management Reform Act of 1994	http://www.gpo.gov/fdsys/pkg/BILLS-103s2170enr/pdf/BILLS-103s2170enr.pdf	*P.L. 103-356*
Government Paperwork Elimination Act of 1998	http://www.gpo.gov/fdsys/pkg/PLAW-105publ277/pdf/PLAW-105publ277.pdf	*P.L. 105-277 § 1701*
Government Performance and Results Act of 1993	http://www.whitehouse.gov/omb/mgmt-gpra/gplaw2m	*P.L. 103-62*
Government Performance and Results Modernization Act of 2010	http://www.gpo.gov/fdsys/pkg/PLAW-111publ352/pdf/PLAW-111publ352.pdf	*P.L. 111-352*
Health Care and Education	http://www.gpo.gov/fdsys/pkg/PLAW-	*P.L. 111-152*

Reconciliation Act of 2010	111publ152/pdf/PLAW-111publ152.pdf	
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	http://library.clerk.house.gov/reference-files/PPL_HIPAA_HealthInsurancePortabilityAccountabilityAct_1996.pdf	*P.L. 104-191*
Healthy-Hunger Free Kids Act	http://www.gpo.gov/fdsys/pkg/PLAW-111publ296/pdf/PLAW-111publ296.pdf	*P.L. 111-296*
Improper Payments Elimination and Recovery Act (IPERA) of 2010	http://www.gpo.gov/fdsys/pkg/PLAW-111publ204/pdf/PLAW-111publ204.pdf	*P.L. 111-204*
Improper Payments Information Act of 2002	http://www.gpo.gov/fdsys/pkg/PLAW-107publ300/pdf/PLAW-107publ300.pdf	*P.L. 107-300*
Inspector General Act Amendments of 1988	http://uscodebeta.house.gov/view.xhtml;jsessionid=627131C92BBAA4188DA1AC4484416C65?req=granuleid%3AUSC-prelim-title44-chapter39&saved=%7CZ3JhbnVsZWlkOlVTQy1wcmVsaW0tdGl0bGU0NC1zZWN0aW9uMzkwMQ%3D%3D%7C%7C%7C0%7Cfalse%7Cprelim&edition=prelim	*P.L. 100-504 or 44 U.S.C. Ch 39*
Internal Revenue Service Restructuring and Reform Act of 1998	http://www.gpo.gov/fdsys/pkg/PLAW-105publ206/html/PLAW-105publ206.htm	*P.L. 105-206*
Management of Federal Information Resources	http://www.whitehouse.gov/omb/circulars_a130	*OMB Circular A-130*
Management of Federal Information Resources	http://www.whitehouse.gov/sites/default/files/omb/assets/omb/circulars/a127/a127.html	*OMB Circular A-127*
Management's Responsibility for Internal Control	http://www.whitehouse.gov/sites/default/files/omb/assets/omb/circulars/a123/a123_rev.pdf	*OMB Circular A-123*
Medicare Prescription Drug, Improvement and Modernization Act of 2003 (a.k.a. Medicare Modernization Act, or MMA)	http://www.gpo.gov/fdsys/pkg/PLAW-108publ173/pdf/PLAW-108publ173.pdf	*P.L. 108-173*
Middle Class Tax Relief and Job Creation Act of 2012	http://www.gpo.gov/fdsys/pkg/PLAW-112publ96/pdf/PLAW-112publ96.pdf	*P.L. 112-96*
Omnibus Reconciliation Act of 1993	http://www.gpo.gov/fdsys/pkg/BILLS-103hr2264enr/pdf/BILLS-103hr2264enr.pdf	*P.L. 103-66*
Orphan Drug Act, as amended	http://history.nih.gov/research/downloads/PL97-414.pdf	*P.L. 97-414*
Paperwork Reduction Reauthorization Act of 1995	http://www.gpo.gov/fdsys/pkg/PLAW-104publ13/pdf/PLAW-104publ13.pdf	*P.L. 104-13*
Patient Protection and Affordable Care Act of 2010	http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf	*P.L. 111-148*
Preparation, Submission and Execution of the Budget	http://www.whitehouse.gov/sites/default/files/omb/assets/a11_current_year/a_11_2011.pdf	*OMB Circular A-11*
Privacy Act of 1974	http://dpclo.defense.gov/privacy/documents/pa1974.pdf	*P.L. 93-579*

Prompt Payment Act Amended as of 1998	http://uscode.house.gov/view.xhtml?hl=false&edition=prelim&req=granuleid%3AUSC-prelim-title31-chapter39&f=treesort&num=0&saved=%7CKHRpdGxlOjMxIGNoYXB0ZXI6MzkgZWRpdGlvbjpwcmVsaW0pIE9SIChncmFudWxlaWQ6VVNDLXByZWxpbS10aXRsZTMxLWNoYXB0ZXIzOSk%3D%7CdHJlZXNvcnQ%3D%7C%7C0%7Cfalse%7Cprelim	*P.L. 100-496 or 31 U.S.C. Ch 39*
Public Health Service Act	http://www.ssa.gov/OP_Home/comp2/F078-410.html	*P.L. 78-410 or 42 U.S.C. Ch 6A*
Rehabilitation Act Amendments of 1998 (Workforce Investment Act)	http://www.gpo.gov/fdsys/pkg/PLAW-106publ246/pdf/PLAW-106publ246.pdf	*P.L. 106-246 §2403*
Reports Consolidation Act of 2000	http://www.dol.gov/ocfo/media/regs/RCA.pdf	*P.L. 106-531*
Sarbanes Oxley Act of 2002	http://www.gpo.gov/fdsys/pkg/PLAW-107publ204/pdf/PLAW-107publ204.pdf	*P.L. 107-204*
Self Employment Contributions Act (SECA) of 1954 (§1401 through §1403)	http://uscodebeta.house.gov/view.xhtml?req=%22self+employment+contributions+act%22&f=treesort&fq=true&num=0&hl=true&edition=prelim&granuleId=USC-prelim-title26-section1403	*26 U.S.C. Ch 2*
Small Business Jobs Act of 2010	http://www.gpo.gov/fdsys/pkg/PLAW-111publ240/pdf/PLAW-111publ240.pdf	*P.L. 111-240*
Small Business Jobs Act of 2010, U.S. Small Business Administration Initiatives	http://www.sba.gov/content/small-business-jobs-act-2010	*P.L. 111-240*
Social Security Act of 1935, as amended	http://library.clerk.house.gov/reference-files/PPL_SocialSecurity.pdf	*P.L. 74-271*
Tax Increase Prevention and Reconciliation Act of 2005	http://www.gpo.gov/fdsys/pkg/BILLS-109hr4297enr/pdf/BILLS-109hr4297enr.pdf	*P.L. 109-222*
Temporary Payroll Tax Cut Continuation Act of 2011	http://www.gpo.gov/fdsys/pkg/PLAW-112publ78/pdf/PLAW-112publ78.pdf	*P.L. 112-78*
Native American $1 Coin Act	http://www.gpo.gov/fdsys/pkg/PLAW-110publ82/pdf/PLAW-110publ82.pdf	*P.L. 110-82*

DEPARTMENT OF HEALTH AND HUMAN SERVICES

200 Independence Ave, S.W. ● Washington, DC 20201

877.696.6775 ● www.hhs.gov