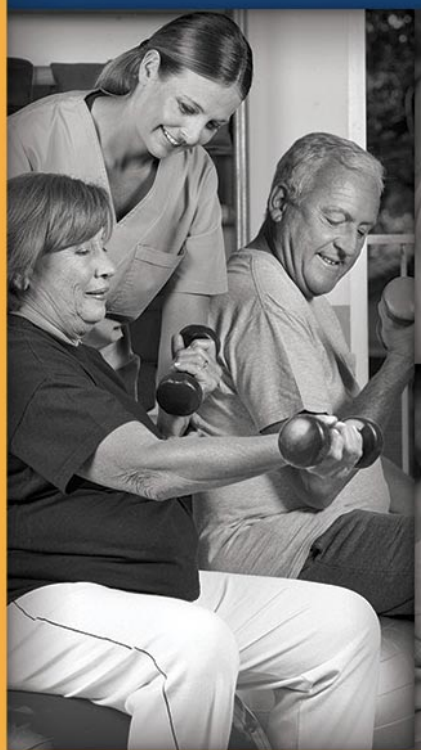
IT WAS ONCE SAID THAT
THE MORAL TEST OF GOVERNMENT
IS HOW THAT GOVERNMENT TREATS
THOSE WHO ARE IN THE DAWN OF LIFE,
THE CHILDREN; THOSE WHO ARE IN
THE TWILIGHT OF LIFE, THE ELDERLY;
AND THOSE WHO ARE IN
THE SHADOWS OF LIFE, THE SICK,
THE NEEDY AND THE HANDICAPPED.

HUBERT H. HUMPHREY



HHS AGENCY FINANCIAL REPORT

FY 2014

U.S. Department of Health and Human Services

ADMINISTRATION FOR CHILDREN & FAMILIES

ACL

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

FDA

HRSA

AHRQ

NIH
National Institutes of Health

INDIAN HEALTH SERVICE · PHS · 1955 ·

Substance Abuse and Mental Health Services Administration
SAMHSA

PSC

ATSDR
AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

One Department, One Mission, One HHS!

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MESSAGE FROM THE SECRETARY

Sylvia M. Burwell

Mission/Introduction

The mission of the U.S. Department of Health and Human Services (HHS) is to ensure every American has access to the building blocks of healthy and productive lives. At HHS, we believe in building bridges, relationships, and strong teams with the talent and focus necessary to deliver results. We believe in managing well, in transparency, and in delivering impact on behalf of the people we serve.

I'm pleased to present HHS's Fiscal Year (FY) 2014 Agency Financial Report (AFR). The report illustrates how we manage our resources, highlights our major accomplishments, and outlines our plans to address the challenges we face. At HHS, we're dedicated to meeting the high standards of government reporting and accountability. This year, for the first time, the Department received the Association of Government Accountants' *Certificate of Excellence in Accountability Reporting* for our FY 2013 AFR, and we're committed to upholding these standards of excellence in the future.

Financial Management

As responsible stewards of the public resources that the American taxpayers and the Congress entrust to us, we practice fiscal responsibility and transparency. One of the best tools to assess our financial information is our departmental financial statement audit. This year, we obtained an unmodified (clean) opinion on the Consolidated Balance Sheet, Statement of Net Cost, Statement of Changes in Net Position, and the Combined Statement of Budgetary Resources. Based on our internal assessments and the auditor's report, I believe that our financial and performance data are reliable and complete. For the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts, the auditors disclaimed providing an opinion. The disclaimer was primarily due to the uncertainties surrounding provisions of the *Affordable Care Act* and the impact of potential changes in law that would impact underlying assumptions of financial projections. These statements were developed based upon current law using information from the *2014 Medicare Trustees Report*, as required by standards issued by the Federal Accounting Standards Advisory Board. The Financial Section of this report includes more detailed information.

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 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. Management continues efforts to improve our financial reports and systems. The Management's Discussion and Analysis section of this report includes further details.

HHS Building Progress

Delivery System Reform

Over the last four years, the *Affordable Care Act* rolled out comprehensive health insurance reform. When you consider the law through the lens of access, affordability, and quality, the evidence reflects that the *Affordable Care Act* is working. Examples of the impact over the past four years include:

- ***Access.*** The number of uninsured adults decreased by 10.3 million adults since 2013. More than 7.3 million people signed up for Marketplace plans, paid their premiums, and accessed quality, affordable

coverage. Another 8.7 million enrolled in Medicaid or CHIP since the beginning of Open Enrollment (as of August 2014) – an increase of 15 percent compared to average monthly signups before October 1, 2013. Three million Americans under the age of 26 gained coverage under their parent's plans.

- ***Affordability.*** 70 percent of Americans with Marketplace insurance plans feel they can now afford care if they get sick, and a majority say their premiums are easy to afford. Across the board, health care price inflation is at the lowest level in 50 years.
- ***Quality.*** Americans are pleased by the quality of care they're receiving. In one recent survey, more than 3 in 4 newly insured consumers expressed satisfaction with their coverage. And from 2012 to 2013, there were 150,000 fewer unnecessary hospital readmissions.

We will continue to improve, and have been challenged by the Office of Inspector General in our FY 2014 Top Management Challenges to do so. We are committed to making progress and we will work with the American people across all sectors. We have a four-part strategy moving forward:

- Improving access and affordability through the Marketplace. In order to make sure that Americans continue to access affordable choices, we have to get HealthCare.gov right. We are prioritizing the most important items and areas to improve, giving ourselves the appropriate amount of time for testing, and focusing on security.
- Improving quality for patients and spending every dollar wisely. We are changing incentives to move from a volume-based to a more impact-based system. We are investing in tools that expand our capacity to change. We are improving the flow of information, so doctors can spend more time with patients and less time doing paperwork, and so they can coordinate more effectively with one another.
- We are expanding access by expanding Medicaid. We are working to bring more states into the fold on Medicaid expansion.
- We are partnering with organizations across the country to help consumers understand how to use their existing and new coverage, including the role of prevention and wellness.

Unaccompanied Children

The growth in unaccompanied children over the last three years has risen from an estimated 6,600 children in FY 2011 to 58,000 children in FY 2014. The influx of unaccompanied children across our border is the result of complex human tragedies. Although there are no easy answers to this issue, I am confident that we can work together to care for the unaccompanied children in a way that honors the values of the American people while at the same time enforcing the law and dissuading children from undertaking this dangerous journey. HHS has a role in providing care to these children and we seek to minimize the time they initially spend in U.S. Customs and Border Protection (CBP) custody. To do this, HHS is pursuing two key strategies: (1) reducing the amount of time that children remain in our care before being placed with a sponsor (typically a parent or other relative) who can care for them safely and appropriately while their immigration case is processed; and (2) expanding our shelter capacity, both in standard shelters and temporary shelters for use during an influx. Additionally, in May and early June, HHS established temporary emergency shelters on three military bases to help relieve the backlog of children in CBP custody at the border. The Administration for Children and Families (ACF) provides grant funding to organizations to operate standard shelters around the country to care for these children until they can be placed with an appropriate sponsor, while awaiting immigration proceedings. We have made progress in both areas, though significant work remains. Americans can be proud of the work carried out through partnerships between government entities, the military, and communities.

Global Health Security

A consequence of a more interconnected world is the increasing opportunities for human, animal, and zoonotic diseases to emerge and spread globally. The thousands of lives lost to Ebola are a tragic and solemn reminder of

why global health security must remain a top priority. Through global partnerships and a strong whole-of-government U.S. response, we will bring the epidemic under control. The HHS contribution includes the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the Food and Drug Administration (FDA), the Office of the Assistant Secretary for Preparedness and Response (ASPR), and the Office of Global Affairs (OGA). Efforts include:

- CDC is working to make sure health care providers, public health workers, and others in this country enlist in extra precautions to ensure protocols are being met. CDC is also working abroad and at home to coordinate our national response. In the most impacted countries, CDC is helping to establish and equip emergency operations infrastructure and train local staff, including surveillance, contact tracing, health education, and testing of Ebola cases. CDC is partnering with ministries of health and humanitarian groups in affected countries, the United Nations, the World Health Organization, and U.S. agencies and hospitals across the country.
- NIH is working to develop an Ebola vaccine and recently began clinical trials using an expedited process. NIH is also aiding the efforts of private sector and university researchers pursuing the development of Ebola vaccines.
- FDA expedited the review of investigational New Drug Applications to speed along the process of relevant medical products in development, and also authorized a diagnostic test developed by the Department of Defense to detect the Ebola virus.
- ASPR is working with foreign governments, non-government organizations and industry partners to support expediting the development of Ebola drugs and vaccines.
- OGA is helping coordinate our current response to the World Health Organization effort.

Delivering Impact to Meet Our Challenges

The HHS Inspector General identified 10 performance challenges that present opportunities for improvement. These challenges range from overseeing the Health Insurance Marketplace, safeguarding privacy and data security, to protecting HHS grants and contract funds from fraud, waste and abuse. Greater detail of how HHS is addressing these challenges can be found in the Other Information Section under *FY 2014 Top Management and Performance Challenges Identified by the Office of Inspector General.*

The hardworking Americans who rely on our Department as they look to obtain the building blocks of healthy and productive lives are our "bosses." We believe in managing well. We believe in transparency and we believe in impact – impact for the American people. We're here to fight for affordability, access and quality. When we tackle a problem at HHS, I make sure that we set out a very clear definition of impact from the beginning: *What do we hope to accomplish and who do we hope to accomplish it for?*

I appreciate the talent of our employees and the relationships we have built with our state, local and nonprofit partners. None of our accomplishments would be possible without them. We will continue to build and strengthen relationships with anyone and everyone who shares our passion for impact and progress while helping Americans obtain the building blocks of healthy and productive lives.

/Sylvia M. Burwell/

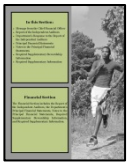
Sylvia M. Burwell
Secretary
November 13, 2014

ABOUT THE AGENCY FINANCIAL REPORT

The Department of Health and Human Services (HHS or the Department) Fiscal Year (FY) 2014 *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 October 1, 2013, through September 30, 2014. 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 2014. It also discusses HHS's compliance with legal and regulatory requirements, a summary of audit and management assurances and gives a brief look ahead to FY 2015.



Financial Section

The Financial Section includes the Report of the Independent Auditors, the Department's Principal Financial Statements, Notes to the Principal Financial Statements, Required Supplementary Stewardship Information, and Required Supplementary Information.

Other Information

The Other Information section contains additional financial information including the Schedule of Spending, the Office of Inspector General's FY 2014 assessment of management challenges facing the Department, a Management Report on Final Action and the Improper Payments Information Act Report, as well as appendices to this AFR.

The Department has chosen to produce an AFR and *Annual Performance Report and Performance Plan*. In February 2015, additional reports that will be available on the Department's website (http://www.hhs.gov/budget) include:

1. FY 2014 *HHS Summary of Performance and Financial Information*
2. FY 2016 *Annual Performance Report and Performance Plan*
3. FY 2016 *Congressional Budget Justification*

Certificate of Excellence in Accountability Reporting

In May 2014, HHS received the Certificate of Excellence in Accountability Reporting (CEAR) from the Association of Government Accountants (AGA) for its FY 2013 Agency Financial Report. The CEAR Program was established by the AGA, in conjunction with the Chief Financial Officers Council, to further performance and accountability reporting. Receiving the CEAR Award represents a significant accomplishment for a federal agency. FY 2013 marks the first year the Department received this prestigious award.

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In this Section:

- About the Department of Health and Human Services
- Performance Goals, Objectives, and Results
- Systems, Legal Compliance, and Internal Controls
- Management Assurances
- Looking Ahead to FY 2015
- Analysis of Financial Statements and Stewardship Information

Management Discussion and Analysis

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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, providing essential human services, and promoting economic and social well-being for individuals, families, and communities, including seniors and individuals with disabilities. HHS represents almost a quarter of all federal outlays and administers more grant dollars than all other federal agencies combined. HHS's Medicare program is the nation's largest health insurer, handling more than one billion claims per year. Medicare and Medicaid together provide health care insurance for one in four Americans.

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 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 11 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. 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. ACF programs aim to empower families and individuals to increase their economic independence and productivity, and encourage strong, healthy, supportive communities that have a positive impact on quality of life and the development of children. 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.

Women participating in an exercise program at an ACL senior center in Portsmouth, VA.

The Agency for Healthcare Research and Quality's (AHRQ) mission is to conduct 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. This mission is supported by focusing on 1) improving health care quality, 2) making health care safer, 3) increasing accessibility, and 4) improving health care affordability, efficiency, and cost transparency. For more information, please visit: http://www.ahrq.gov.

The Agency for Toxic Substance and Disease Registry (ATSDR) is charged with the prevention of exposure to toxic substances and the prevention of the adverse health effects and diminished quality of life associated with exposure to hazardous substances from waste sites, unplanned releases, and other sources of pollution present in the environment. For more information, please visit: http://www.atsdr.cdc.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. CDC works to protect America from health, safety and security threats, both foreign and domestic. Whether diseases start at home or abroad, are chronic or acute, curable or preventable, human error or deliberate attack, CDC fights disease and supports communities and citizens to do the same. For more information, please visit: http://www.cdc.gov.

The Centers for Medicare and Medicaid Services (CMS) administers public insurance programs that serve as the primary sources of health care coverage for seniors and a large population of medically vulnerable individuals. CMS 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 is also responsible for helping to implement many provisions of the *Affordable Care Act*, such as the establishment of the Consumer Operated and Oriented Plan (CO-OP). This plan fosters the creation of qualified non-profit health insurance issuers to offer competitive health plans in the individual and small group markets. For more information, please visit: http://www.cms.gov.

In an FDA laboratory, chemist Patrick Gray, Ph.D., prepares rice-based food samples for an analysis that will determine if arsenic is present and, if so, how much.

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 more effective, safer, and more affordable and by helping the public get the accurate, science-based information they need to use medicines and foods to maintain and improve their health. FDA also has responsibility for regulating the manufacturing, marketing, and distribution of tobacco products to protect the public health and to reduce tobacco use by minors.

Finally, FDA plays a significant role in the nation's counterterrorism capability. FDA fulfills this responsibility by ensuring the security of the food supply and by fostering development of medical products to respond to deliberate and naturally emerging public health threats. For more information, please visit: http://www.fda.gov.

The Health Resources and Services Administration (HRSA) is responsible for improving access to health care by strengthening the health care workforce, building healthy communities and achieving health equity. HRSA's programs provide health care to people who are geographically isolated, economically or medically vulnerable. For more information, please visit: http://www.hrsa.gov.

Let's Move! in Indian Country (coordinated by IHS) works to prevent childhood obesity in American Indian and Alaska Native children.

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. IHS is the principal federal health care provider and health advocate for the Indian people, with the goal of raising Indian health status to the highest possible level. 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/.

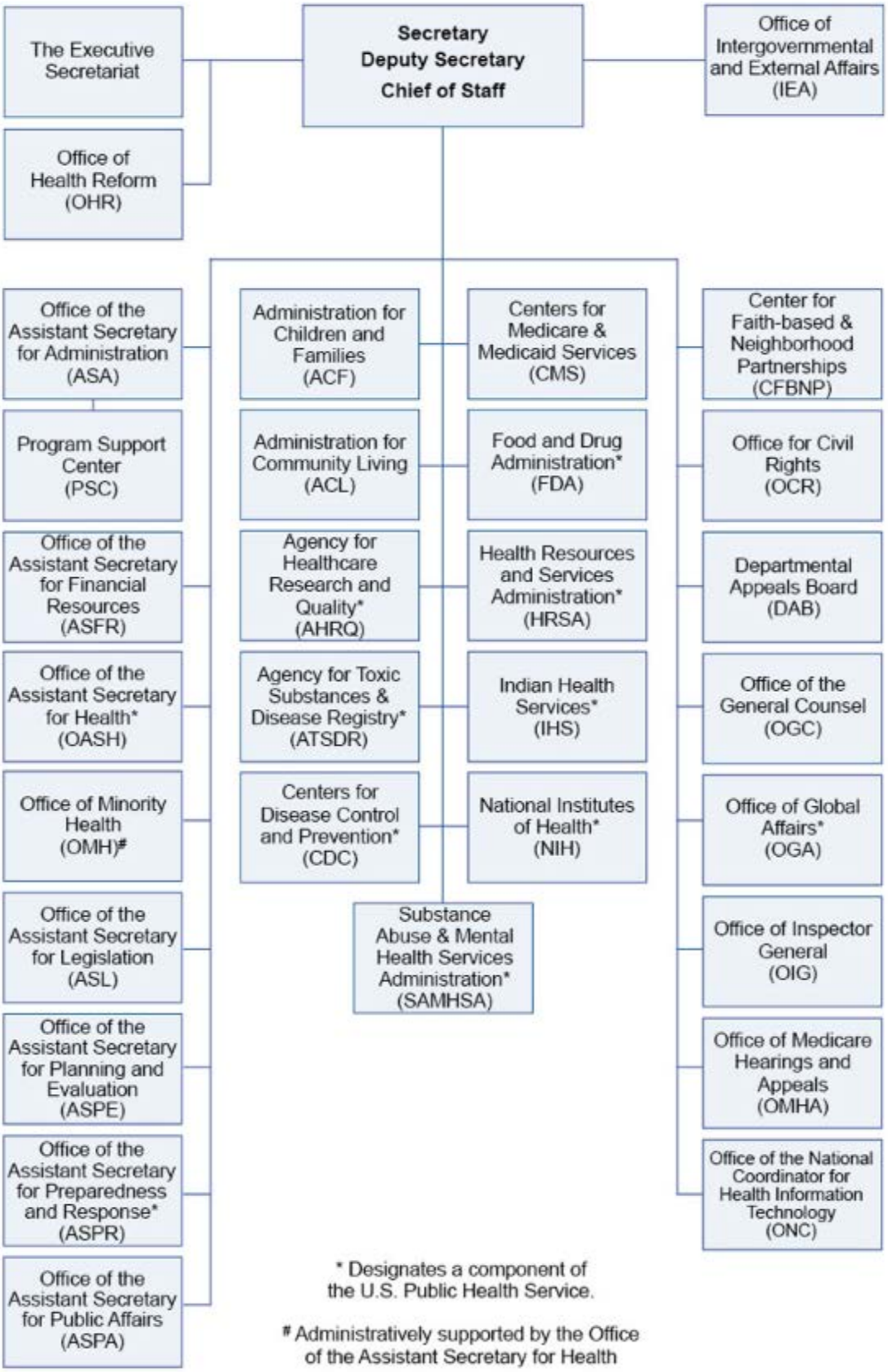
The National Institutes of Health (NIH) seeks fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability. For more information, please visit: http://www.nih.gov.

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 behavioral health practice in communities, and both primary and specialty care settings. For more information, please visit: http://www.samhsa.gov.

The Office of the Secretary (OS), with the Secretary, leads HHS and its 11 OpDivs 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. The StaffDivs are:

- Immediate Office of the Secretary (IOS) http://www.hhs.gov/about/foa/osleadership
    - The Executive Secretariat
    - Office of Health Reform (OHR)
- Office of the Assistant Secretary for Administration (ASA) http://www.hhs.gov/asa
    - Program Support Center (PSC) http://www.hhs.gov/asa/psc
- 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 Minority Health (OMH) http://minorityhealth.hhs.gov
- Office of the National Coordinator for Health Information Technology (ONC) http://www.healthit.gov/newsroom/about-onc

On the next page, 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/about/foa.


The Executive Secretariat
Secretary
Deputy Secretary
Chief of Staff
Office of Intergovernmental and External Affairs (IEA)
Office of Health Reform (OHR)
Office of the Assistant Secretary for Administration (ASA)
Program Support Center (PSC)
Office of the Assistant Secretary for Financial Resources (ASFR)
Office of the Assistant Secretary for Health* (OASH)
Office of Minority Health (OMH)#
Office of the Assistant Secretary for Legislation (ASL)
Office of the Assistant Secretary for Planning and Evaluation (ASPE)
Office of the Assistant Secretary for Preparedness and Response* (ASPR)
Office of the Assistant Secretary for Public Affairs (ASPA)
Administration for Children and Families (ACF)
Administration for Community Living (ACL)
Agency for Healthcare Research and Quality* (AHRQ)
Agency for Toxic Substances & Disease Registry* (ATSDR)
Centers for Disease Control and Prevention* (CDC)
Substance Abuse & Mental Health Services Administration* (SAMHSA)
Centers for Medicare & Medicaid Services (CMS)
Food and Drug Administration* (FDA)
Health Resources and Services Administration* (HRSA)
Indian Health Services* (IHS)
National Institutes of Health* (NIH)
Center for Faith-based & Neighborhood Partnerships (CFBNP)
Office for Civil Rights (OCR)
Departmental Appeals Board (DAB)
Office of the General Counsel (OGC)
Office of Global Affairs* (OGA)
Office of Inspector General (OIG)
Office of Medicare Hearings and Appeals (OMHA)
Office of the National Coordinator for Health Information Technology (ONC)
* Designates a component of the U.S. Public Health Service.
# Administratively supported by the Office of the Assistant Secretary for Health

PERFORMANCE GOALS, OBJECTIVES, AND RESULTS

Health and Human Services Performance Results

HHS continues to improve its performance management processes in alignment with the *Government Performance and Results Modernization Act*. HHS executes Priority Goals through collaboration across the Department leading to improvements in each goal. Additionally, the knowledge gained in these collaborations and during our data-driven reviews has supported the development of our Priority Goals. HHS performance initiatives, including Priority Goals, continue to influence plans and policies as demonstrated in the Department's Strategic Plan which guides our future efforts.

HHS also continues to engage with individuals across the federal performance management community to implement best practice and refine our processes. These refinements and lessons learned have also influenced future plans and are represented in the FY 2014 - FY 2015 Priority Goals which HHS has developed. The most recent data and completed accomplishments as well as future actions on Priority Goals can also be found at http://www.performance.gov. The site provides information on what measures and milestones HHS uses to track progress toward these goals.

In addition to the HHS Strategic Goals and the HHS Priority Goals, HHS reported data on 135 key performance measures in their FY 2015 *HHS Annual Performance Report and Performance Plan*. These measures represent important issue areas being addressed by the health care and human services communities. These measures present a powerful tool in improving HHS operations and help to advance an effective, efficient and productive government. HHS regularly collects and analyzes performance data to inform decisions. While HHS does not yet have FY 2014 data available for all measures due to the lag associated with data collection and reporting, HHS's Operating and Staff Divisions constantly strive to find lower-cost ways to achieve positive impacts, in addition to sustaining and fostering the replication of effective and efficient government programs.

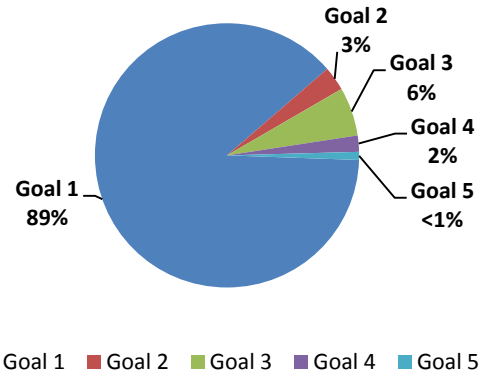
Looking Back at FY 2013 Performance

It is helpful to look at how HHS invests resources toward fulfilling the Department's mission through its strategic goals. In FY 2013, HHS focused on 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 Health and Human Services Infrastructure and Workforce

As shown in the FY 2013 *HHS Summary of Performance and Financial Information,* the chart on the next page provides the breakdown of the HHS FY 2013 budget by strategic goal. Although HHS funding here is broken down into strategic goals, many of the programs in HHS are crosscutting in nature and support a number of strategic goals.

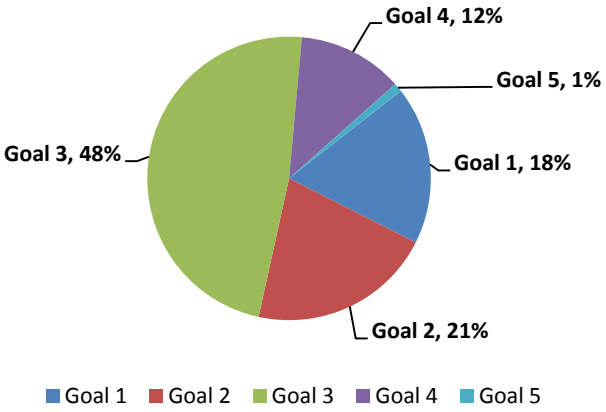
Total FY 2013 HHS Budget



The total resources available to spend in FY 2013 were $1.3 trillion. The majority of the Department's funding was primarily associated with Goal 1 because of the large amount of money invested in delivering quality care and services through Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). For FY 2013, of the five strategic goals, 89 percent was spent on Goal 1, 3 percent on Goal 2, 6 percent on Goal 3, 2 percent on Goal 4, and less than 1 percent on Goal 5.

The chart below demonstrates the HHS FY 2013 budget spent $386 billion after subtracting the costs of Medicare, Medicaid, and CHIP. Of the five strategic goals excluding Medicare, Medicaid, and CHIP, 18 percent was spent on Goal 1, 21 percent on Goal 2, 48 percent on Goal 3, 12 percent on Goal 4, and 1 percent on Goal 5.

FY 2013 HHS Budget Excluding Medicare, Medicaid CHIP



Similar information on FY 2014 strategic goals resource allocation will be published in the FY 2014 *HHS Summary of Performance and Financial Information,* available in February 2015 on the Department's website (http://www.hhs.gov/budget). A detailed breakdown of FY 2014 spending by HHS activity and budget function is available now in the Other Information section of this report.

Performance Management Process Milestones

In FY 2014, HHS released a new strategic plan outlining how the Department will emphasize program performance to support the Department's mission of protecting the health of all Americans, providing essential human services, and promoting economic and social well-being for individuals, families, and communities, including seniors, and individuals with disabilities. These efforts are shown through the successes of the near-term 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 four 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. Ensure efficiency, transparency, accountability, and effectiveness of HHS programs

The table below lists alphabetically the primary OpDivs that contribute to each Strategic Goal.

1. Strengthen Health Care
Administration for Community Living (ACL) Agency for Healthcare Research and Quality (AHRQ) Centers for Disease Control and Prevention (CDC) Centers for Medicare and Medicaid Services (CMS) Food and Drug Administration (FDA) Health Resources and Services Administration (HRSA) Indian Health Services (IHS) National Institutes of Health (NIH) Substance Abuse and Mental Health Services Administration (SAMHSA)
2. Advance Scientific Knowledge and Innovation
Administration for Children and Families (ACF) Administration for Community Living (ACL) Agency for Healthcare Research and Quality (AHRQ) Centers for Disease Control and Prevention (CDC) Food and Drug Administration (FDA) National Institutes of Health (NIH) Substance Abuse and Mental Health Services Administration (SAMHSA)
3. Advance the Health, Safety and Well-being of the American People
Administration for Children and Families (ACF) Administration for Community Living (ACL) Agency for Healthcare Research and Quality (AHRQ) Centers for Medicare and Medicaid Services (CMS) Centers for Disease Control and Prevention (CDC) Food and Drug Administration (FDA) Health Resources and Services Administration (HRSA) Indian Health Services (IHS) National Institutes of Health (NIH) Substance Abuse and Mental Health Services Administration (SAMHSA)
4. Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs
Every Operating Division has responsibility within this goal.

With collaboration from stakeholders throughout the Department, HHS is pursuing five Priority Goals for FY 2014-2015, which contribute toward the achievement of our Strategic Goals. These efforts have supported significant improvements in near-term outcomes and advanced progress toward longer-term, outcome-focused strategic objectives. These Priority Goals include efforts to:

1. Improve patient safety
2. Improve health care through meaningful use of Health Information Technology
3. Improve the quality of early childhood education
4. Reduce cigarette smoking
5. Reduce food-borne illness in the population

Performance Results

The performance results in this section represent key measures and performance highlights demonstrating progress toward each HHS Strategic Goal. In February 2015, additional performance measures and trends are available in related reports on the Department's website (http://www.hhs.gov/budget). These reports include:

- FY 2014 *HHS Summary of Performance and Financial Information*
- FY 2016 *Annual Performance Report and Performance Plan*
- FY 2016 *Congressional Budget Justification*

The accomplishments and performance trends below, including progress on HHS Priority Goals, underscore HHS's dedication to sustained performance improvement, and emphasis on working to meet the Department's four Strategic Goals. Targets presented within the graphs 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 and marked with an asterisk (*) 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 the lag associated with data collection requirements. The target is displayed to show planned progress, with results expected in FY 2015.

Strategic Goal One: Strengthen Health Care

National Cancer Institute's Bradford Wood, M.D., and Peter Pinto, M.D., perform a prostate biopsy at the NIH Clinical Center in Bethesda, Maryland. (Photo Credit Rhoda Bear)

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's efforts in patient safety as well as health care quality are reflected in the improve patient safety Priority Goal (http://www.performance.gov/content/improve-patient-safety), 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. During the FY 2012-2013 Priority Goal period, HHS efforts focused on two of these infections: central line-associated bloodstream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI). Despite the continual CLABSI reductions seen throughout the 2012-2013 Priority Goal period,

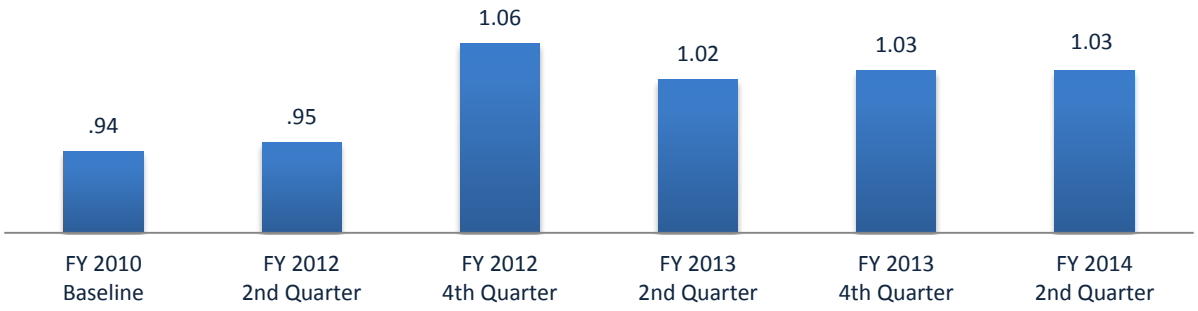
HHS fell short of the final target, which was a 25 percent reduction in CLABSI or a final standard infection ratio (SIR) of 0.51. Although CLABSI reduction was not retained in the FY 2014-2015 Priority Goal, this effort is closely monitored and will continue to be publicly reported elsewhere by HHS. The reduction of CAUTI in hospitals is now the singular focus of the FY 2014-2015 Priority Goal.

Leveraging the combined programmatic efforts within HHS, including AHRQ, CDC, CMS and OASH, the Improve Patient Safety Priority Goal is working to reduce CAUTI by 10 percent in hospitals nationwide by the end of FY 2015. This is measured over the FY 2013 SIR of 1.03. The final SIR of the previous Priority Goal period (1.03) was higher than the 2010 baseline (.94). Although the SIR increased, knowledge gained during this period has led to better data tracking and monitoring as well as new approaches in the Intensive Care Units (ICUs) based on identified potential barriers. Lessons learned were also used to focus HHS efforts, including targeting the hospitals with the highest excess number of CAUTIs.

A doctor at the National Cancer Institute's Center for Cancer Research, under NIH, reviews brain images in the dosimetry planning of radiation therapy for brain tumors. (Photo by Rhoda Bear)

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

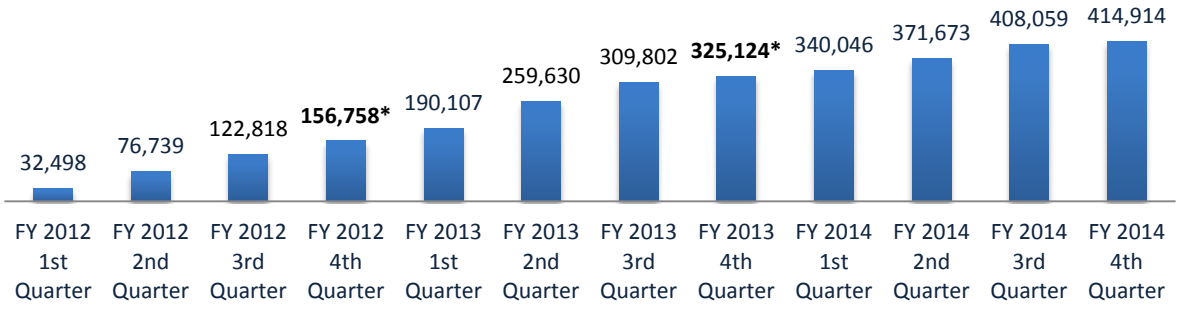
Standardized Infection Ratio of Catheter-Associated Urinary Tract Infections
HHS Priority Goal- Improve Patient Safety
(result met or exceeded target)*



At the heart of HHS's strategy to strengthen and modernize health care is the use of 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. The nation's health information technology infrastructure enables the flow of information to power these critical efforts that can help facilitate the types of fundamental changes in access and health care delivery proposed in the *Affordable Care Act*. 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. The improvement of health care through meaningful use of health information technology (http://www.performance.gov/content/improve-health-care-through-meaningful-use-health-information-technology) continues as a Priority Goal for the FY 2014-2015 period, with a goal of 425,000 incentive payments by the end of 2015. HHS will also begin tracking participating hospitals and professionals that are eligible to attest to Medicare and Medicaid EHR Incentive Program Stage 2 meaningful use milestones and will report this data beginning in 2015. Providers must demonstrate Stage 1

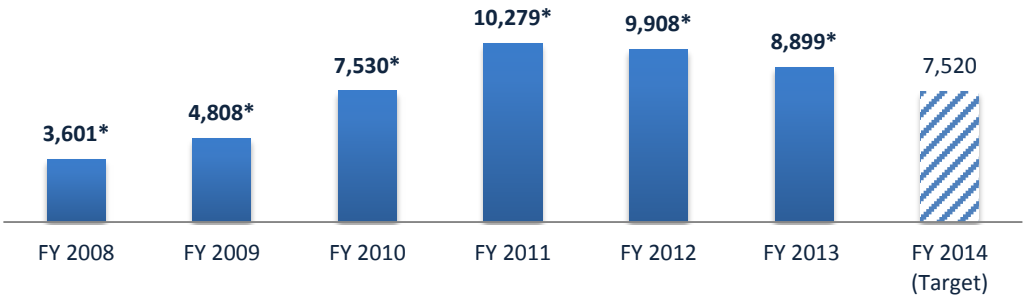
meaningful use before attesting to Stage 2. Please note that while information has been available quarterly, targets have generally been set on an annual basis.

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 met or exceeded target)*



The National Health Service Corps (NHSC) addresses the nationwide shortage of health care providers 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. More than 45,000 primary care medical, dental, mental, and behavioral health professionals have served in the NHSC since its inception. The 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. In FY 2013, the NHSC field strength was 8,899. The annual field strength is dependent upon funding levels and programmatic policy decisions that allocate funding between the scholarship and loan repayment programs. NHSC loan repayors are immediately counted in the annual field strength, while NHSC scholars are not counted until completion of training. The FY 2015 President's budget request includes *Affordable Care Act*, discretionary, and new mandatory funding to substantially grow the NHSC field strength to expand access to primary care services in underserved communities and vulnerable populations in high need urban and rural communities across the country.

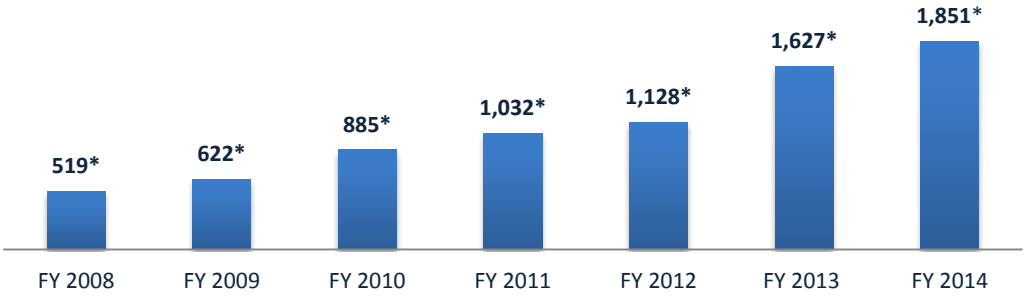
Field Strength of the NHSC, as Measured by the Number of Providers Fulfilling Active Service Obligations in Exchange for Scholarship and Loan Repayment Agreements
(result met or exceeded target)*



As an indicator of the number of health care organizations using AHRQ-supported tools to improve patient safety, AHRQ relies in part on the Hospital Survey of Patient Safety (HSOPS). Some organizations that use the survey voluntarily submit their data to a comparative database for aggregation. In 2013, data from 653 hospitals, 934 medical offices, and 40 nursing homes were available in the database. It is anticipated that as many as 1,750 organizations will have submitted information to the HSOPS comparative database by 2015. Interest in other

AHRQ tools and resources has also remained strong, as evidenced by on-going participation in informational webinars, electronic downloads, and orders placed for various products.

Number of Users of Research Using AHRQ-Supported Research Tools to Improve Patient Safety Culture
(result met or exceeded target)*



Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers who come together voluntarily to provide coordinated high quality care to the Medicare patients. This coordinated care helps ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors. Leveraging the innovative model of ACOs is a key part of promoting health care cost savings through the *Affordable Care Act*. While data collection on a number of ACO-related measures began only in 2013, early results are encouraging. The number of Medicare beneficiaries who have been aligned with ACOs in FY 2014 was 5,652,270, exceeding the target by over 50,000. The number of physicians participating in an ACO in FY 2014 was 163,549, exceeding the target by over 30,000.

Strategic Goal Two: Advance Scientific Knowledge and Innovation

NIH supported researchers are developing a powered robotic prosthesis that senses a person's next move and provides powered assistance to achieve a more natural gait.

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.

AHRQ's Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) is an evidence-based teamwork system used to improve communication and teamwork skills among health care professionals as a way to improve patient safety. The system, developed jointly by the Department of Defense (DOD) and AHRQ, has spread to all 50 states, now reaching an estimated 30 percent of U.S. hospitals, including small critical access hospitals. Over 8,000 master trainers have received TeamSTEPPS training through AHRQ and DOD. These master trainers, on average, have trained an additional 50 front line health care professionals for an estimated national grand total of over 350,000.

The use and dissemination of data is a priority for the Department. ASPR is using big data and technology, specifically geographic information systems, to enhance the ability to link, visualize, and analyze the multi-dimensional realities of disasters and translate that data into actionable information at the state, local, and

community level. FDA has launched openFDA, an initiative designed to spur innovation, advance regulatory science and empower decision-making by providing software developers, researchers, consumers, and health professionals easy access to high-value FDA public data. The initial pilot will cover datasets defined into three broad focus areas: Adverse Events, Product Recalls, and Product Labeling.

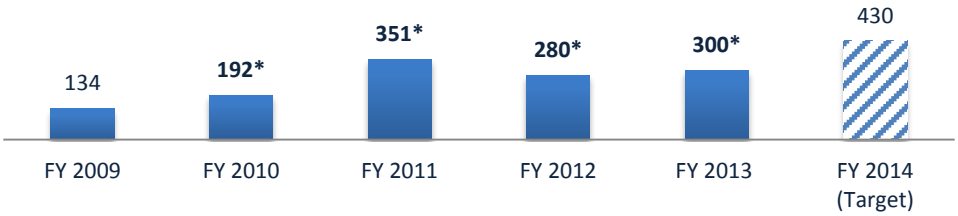
SAMHSA launched two mobile apps in FY2014 to provide information resources and tools regarding two key behavioral health issues – disaster response and bullying prevention. In February 2014, SAMHSA launched the Behavioral Health Disaster Response mobile app to support first responders in times of natural or man-made disasters. This app enables first responders to access and share behavioral health resources, with those most in need, during and after deployment. In August of 2014, SAMHSA also launched the KnowBullying app. This app helps parents and caregivers engage in meaningful conversations with their children about bullying. It includes strategies for different age groups to prevent bullying. Parents and caregivers also learn about warning signs and to recognize if their child is engaging in bullying, being bullied, or witnessing bullying. The apps are tagged to allow SAMHSA to see screens/pages visitors view, clicks on outbound links, device type and other traditional web metrics. Within seven months of launch, the Disaster mobile app has been downloaded over 8,250 times. Within two months of launch, the KnowBullying app has been downloaded almost 5,000 times.

A father and son handle 3D-printed virus models at the NIH 2014 USA Science & Engineering Festival.

Three new research awards (totaling up to $19.4 million over five years) will address the growing proportion of the U.S. population that has multiple chronic medical conditions. These milestone-driven, phased awards are funded through NIH's Health Care Systems (HCS) Research Collaboratory, which engages health care systems as research partners in conducting large-scale clinical studies. It is estimated that 3 in 4 adults over age 65 and 1 in 15 children suffer from two or more chronic medical conditions--such as diabetes mellitus, chronic kidney disease, hypertension, and chronic pain. As patients develop more chronic conditions, they are likely to use more health care services and suffer negative outcomes, such as unnecessary hospitalizations, adverse drug reactions, declining functional status, and mortality. Health care systems, which include health maintenance organizations and other large integrated care settings, serve large populations of patients. Through these new collaborative research projects, NIH is better able to conduct large-scale and cost-effective clinical research on multiple chronic conditions within the settings where patients are already receiving their care.

Since 1980, CDC has developed international Field Epidemiology Training Programs (FETPs) serving 94 countries that have graduated over 3,100 epidemiologists. 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. In FY 2013, FETP graduates and residents led 345 outbreak investigations, and CDC's Global Disease Detection Centers responded to 268 disease outbreaks. On average, over 80 percent of FETP graduates work within their Ministry of Health after graduation and many assume key leadership positions, such as the National Director of Tuberculosis program and National Director of Chronic Disease program in the Dominican Republic. In FY 2013, CDC met its target of bringing on 300 new FETP residents to increase global health ministries' ability to detect and respond to outbreaks.

Capacity of Epidemiology and Laboratory within Global Health Ministries through FETP
As measured by the Number of New Residents
(result met or exceeded target)*

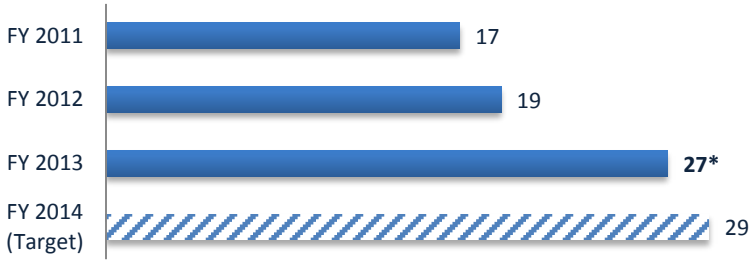


Strategic Goal Three: Advance the Health, Safety, and Well-Being of the American People

HHS strives 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.

The improve the quality of early childhood education Priority Goal (http://www.performance.gov/content/improve-quality-early-childhood-education) calls for actions to improve the quality of programs for children of low-income families, namely Head Start and Child Care. 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 HHS, in coordination with the Department of Education. QRIS is a mechanism used 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 the end of FY 2013, 27 states had a QRIS that met high-quality benchmarks, exceeding the goal of 25 states. States made several changes to their QRIS, such as opening eligibility to family child care providers, expanding from a pilot program to statewide, and implementing new consumer education efforts.

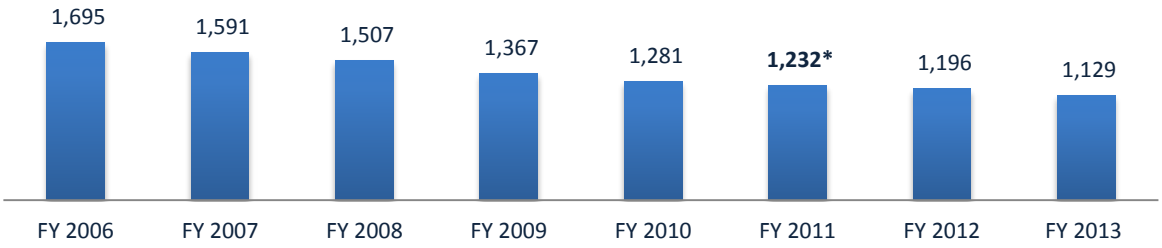
Number of States Implementing QRIS that are Meeting the QRIS High-Quality Benchmarks
HHS Priority Goal- Improve the Quality of Early Childhood Education
(result met or exceeded target)*



Smoking and secondhand smoke kill an estimated 480,000 people in the U.S. each year. For every smoker who dies from a smoking-attributable disease, another 30 live with a serious smoking-related disease. Smoking costs the U.S. $133 billion in medical costs and $156 billion in lost productivity each year. While smoking among adults in the U.S. has decreased significantly from a decade ago, the decline in adult smoking rates has slowed, concurrent with reductions in state investments in tobacco control programs. In addition, the coordinated efforts

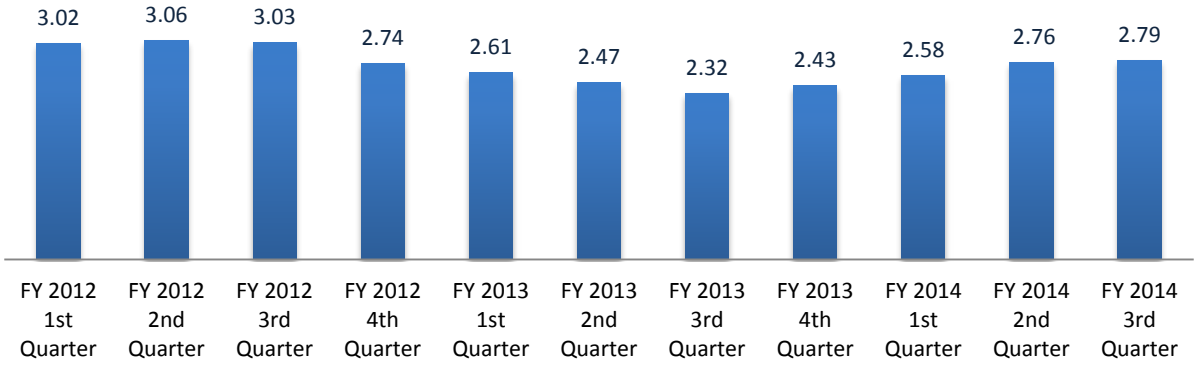
of the Priority Goal to reduce tobacco use (http://www.performance.gov/content/reduce-combustible-tobacco-use) have resulted in reductions in adult cigarette consumption, based on FY 2013 results (reported in June 2014). In the 2014-2015 iteration of this Priority Goal, HHS is focused on a new measure of smoking-- annual per capita adult combustible tobacco consumption in the U.S. This new measure focuses on all combustibles, not just cigarettes, as a way to ascertain broader trends in tobacco use among adults. Data on this new measure will be available following FY 2014. The data represented below captures the most recent results from the measure used during the previous FY 2012-2013 Priority Goal period.

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



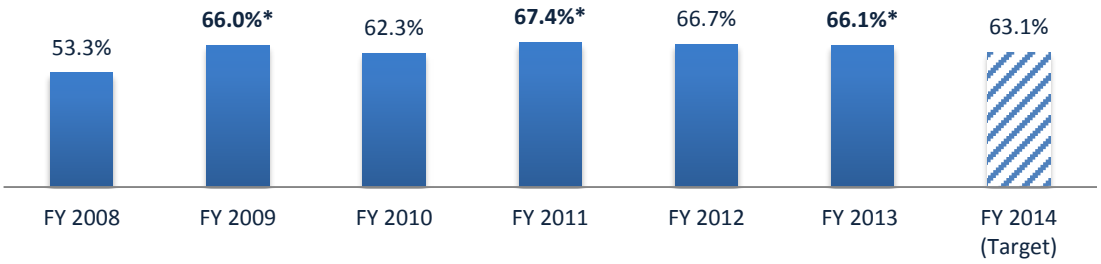
Salmonella is the leading known cause of bacterial foodborne illness and death in the U.S. Each year in the U.S., Salmonella causes an estimated 1.2 million illnesses and between 400 and 500 deaths. Salmonella serotype enteritidis (SE), a subtype of Salmonella, is now the most common type of salmonella in the U.S. and accounts for approximately 20 percent of all salmonella cases in humans, and reducing its prevalence is an HHS Priority Goal to reduce foodborne illness in the population (http://www.performance.gov/content/reduce-foodborne-illness-population). 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 estimated that, for 2007-2009, 40 percent of domestically-acquired, foodborne SE illnesses were from eating shell eggs and 28 percent of total SE illnesses (foodborne, non-foodborne, and international travel-associated) were from shell eggs. CDC completed an evaluation of a "food product" model to estimate annual change in percentage of SE illnesses from shell eggs, but determined that necessary data about contamination of shell eggs was not available. CDC concluded that this model could not be used unless new sources of egg data were obtained. Therefore, as of January 2014, CDC began collecting exposure data from persons with SE infection in FoodNet sites, a network that conducts surveillance for infections diagnosed by laboratory testing of samples from patients. CDC will conduct a preliminary evaluation of this data to assess its quality and determine its usefulness in updating CDC's exposure model for estimating the proportion of total SE illnesses attributable to shell eggs during 2014-2015.

Rate of Salmonella Enteritidis Illness in the Population
HHS Priority Goal- Reduce Food-Borne Illness in the Population
(result met or exceeded target)*



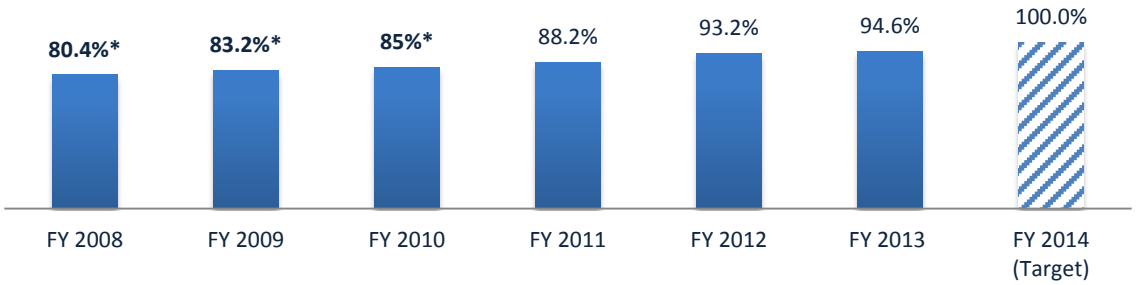
One of SAMHSA's goals in its Strategic Initiative on Recovery Support is to ensure that permanent housing and supportive services are available for individuals with mental and substance use disorders. A way to meet this goal is to ensure that the most vulnerable individuals who experience chronic homelessness 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 health, from the consumer's perception of his or her recent functioning. Following the initial 13 percentage point increase from FY 2008 to FY 2009, the percentage has consistently remained over 60 percent since, and FY 2013 progress supports continued sustained performance. A lack of funding due to sequestration and other budget restrictions led to no new grants being awarded in FY 2012, which impacted trends in this area.

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



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 2014), 94.6 percent of Head Start teachers (42,527 out of 44,973) had an AA degree or higher, missing the target of 100 percent but improving significantly since 2008. Additionally, 66 percent of Head Start teachers have a BA degree or higher, which far exceeds the statutory requirement of 50 percent.

Percentage of Head Start Teachers with AA, BA, Advanced Degree, or Other Degree in a Field Related to Early Childhood Education
(result met or exceeded target)*



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 relatives 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. Nearly 90 percent of respondents reported that the services helped them to be a better caregiver, and nearly three quarters report feeling less stressed due to the services.

Strategic Goal Four: Ensure Efficiency, Transparency, Accountability, and Effectiveness 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's 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 dollars. The primary cause of improper payments is Documentation and Administrative Errors, in large part due to insufficient documentation. Other notable causes include Authentication and Medical Necessity Errors, caused by medically unnecessary services, and to a lesser extent, incorrect diagnosis coding. Between FY 2009 and FY 2012, the improper payment rate consistently improved. Data from FY 2013 indicates an increase in this improper payment rate and efforts are currently in progress to investigate and resolve the drivers causing this increase.

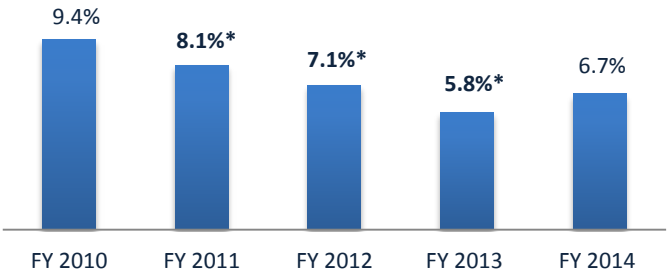
The HHS Office for Civil Rights (OCR) in action at the Oakland Pride weekend in Oakland, California.

For Medicaid, the Payment Error Rate Measurement (PERM) program uses a 17 state three-year rotation for measuring improper payments, so the FY 2014 rate is based on measurements conducted in FYs 2012, 2013, and 2014. To reduce the national Medicaid error rates, states are required to develop and submit corrective action

plans targeting root causes of error. The current FY 2014 error rate is 6.7 percent. Additional information is available in Section III - Improper Payments Infrormation Act Report.

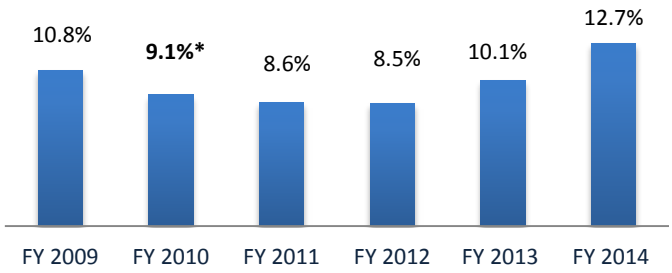
Estimate of the Payment Error Rate in the Medicaid Program

(result met or exceeded target)*

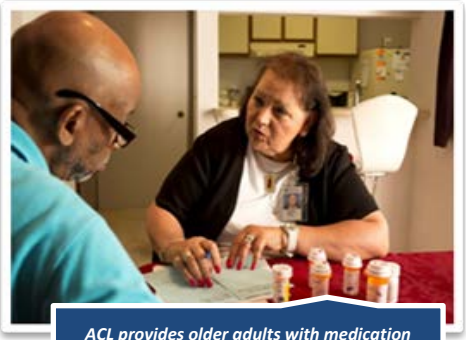


Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program

(result met or exceeded target)*



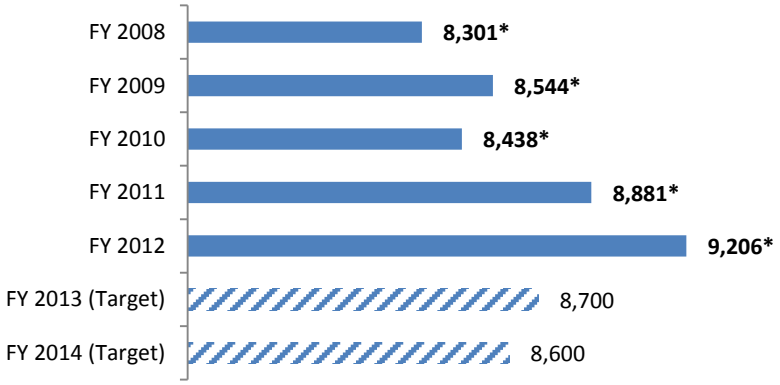
A foundation of ACL's program success is access to Home and Community-based Services. In FY 2012, the Aging Services Network served 9,206 clients per million dollars of *Older Americans Act* funding exceeding the target of 8,600. Performance has largely trended upward and performance targets have been consistently achieved. This reflects the success of ongoing initiatives to improve program management and expand options for home and community-based care. Aging and Disability Resource Centers (ADRCs), along with increased commitments and partnerships at the state and local levels, have all had positive impacts on program efficiency. Between FY 2007 and FY 2012 performance has improved by 10.5 percent, without the benefit of adjustment for inflation. The targeted number of clients served is expected to be maintained or slightly increased between FY 2013 and FY 2016.



ACL provides older adults with medication management assistance.

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 met or exceeded target)*

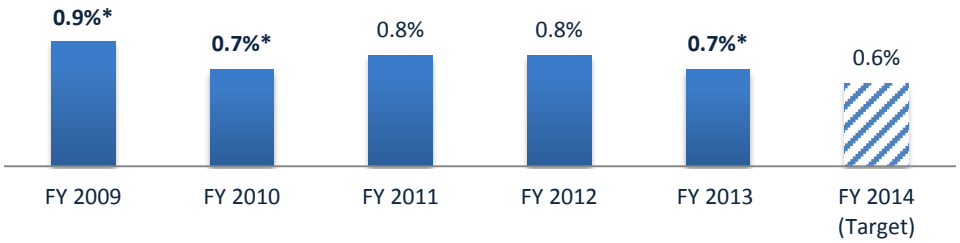


ACF's Head Start program works to ensure that the maximum number of children are served and that federal funds are used appropriately and efficiently by measuring under-enrollment across programs. Since Head Start grantees range in size from super-grantees with multiple delegate agencies serving up to 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. An un-enrolled space or vacancy in Head Start is defined as a funded space that is vacant for over 30 days.

The most recent data available indicate that, during the FY 2012-2013 program year, Head Start grantees had, on average, not enrolled 0.7 percent of the children they were funded to serve, continuing steady improvement in this area. Further improvements are expected in FY 2014 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 met or exceeded target)*



Cross-Agency Priority Goals

HHS contributes to Cross-Agency Priority Goals with other federal agencies. For example, the Department contributes significantly to the mission-related Science, Technology, Engineering and Mathematics (STEM) and Service Members and Veterans Mental Health Cross-Agency Priority Goals. We are also maximizing federal spending through participation in the Shared Services, and Benchmark and Improve Mission-Support Operations efficiency goals. For more information on HHS's contributions to Cross-Agency Priority Goals and progress, refer to http://www.performance.gov/cap-goals-list.

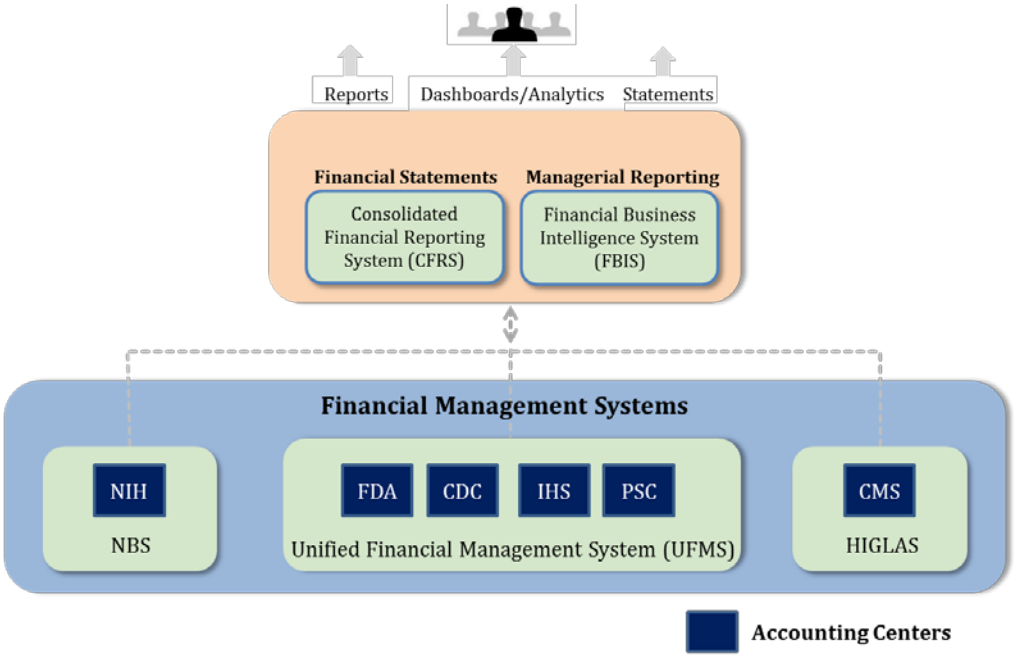
SYSTEMS, LEGAL COMPLIANCE, AND INTERNAL CONTROLS

Systems

Current Financial 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 is depicted in the image below:

HHS Financial Management System Environment



The HHS Financial Management System Environment and its major components are described below.

The financial management systems component (shown above in the Financial Management Systems layer), consists of three financial management 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. 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. The specific systems are shown below:

- Unified Financial Management System (UFMS) supports HHS's health care delivery mission and is responsible for its regulatory functions. It is an integrated financial management system with four standardized accounting centers (one for each of the OpDivs shown above, with the PSC supporting five OpDivs and the OS). UFMS, along with the Healthcare Integrated General Ledger Accounting System (HIGLAS) and the National Institutes of Health Business System (NBS) (described below), provides the accounting and financial backbone for managing the Department's $1.4 trillion in budgetary resources.

- HIGLAS at CMS serves the Medicare Administrative Contractors (MACs) that process medical payments; supports accounting for Medicaid and Children's Health Insurance Program (CHIP) grants; generates the CMS Financial Statements; and handles all vendor payments, payables, and receivables.
- NBS fosters NIH's mission through the provision of business transaction capabilities that enable the NIH scientific community and supporting organizations to acquire needed assets, goods and services. It serves 27 separate research institutes and centers supporting health research, an integral part of the HHS mission.

The reporting systems component of HHS Financial Management System Environment (shown in the Reporting Systems layer of the diagram at the top of this section) consists of two reporting solutions: Consolidated Financial Reporting System (CFRS) and Financial Business Intelligence System (FBIS). These reporting systems accept data from the financial management systems and facilitate reconciliation, financial analysis and reporting, as well as management reporting. These reporting systems are described in more detail below:

- CFRS enables HHS to systematically consolidate information from the three financial management systems. It generates the HHS-wide consolidated financial statements and other managerial reports on a consistent, timely, and reliable basis and meets regulatory reporting requirements.
- FBIS gathers information from the three financial management systems into a business intelligence platform for integrated, timely, and accurate reporting and analysis. HHS is implementing FBIS in phases, with the third phase rolled out during the fourth quarter of FY 2014. FBIS delivers actionable data to all levels of the user community. HHS leadership primarily accesses this data using executive dashboards and scorecards for strategic decision making, whereas others rely on operational reports, alerts, ad hoc queries, and drill-down capabilities for making tactical decisions and 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 HHS's Financial Management System Environment are to consistently strengthen internal controls, to maintain data integrity, increase data transparency, and to report reliable financial information on a timely basis. In addition, it is an HHS priority to ensure continual systems improvement by addressing identified weaknesses through improved management oversight of the 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 of 1990*
- *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 directives related to these laws*

Financial Systems Strategy, Opportunities and Challenges

In line with the goals described above and anticipating the need to meet new regulatory and reporting demands, HHS is in the process of executing a Department-wide financial systems improvement strategy that it developed in FY 2012 for both the Financial Systems Improvement Program (FSIP) and Financial Business Intelligence Program (FBIP).

The most critical component of this multi-year initiative addresses the need to upgrade the three financial management systems as part of FSIP, since the software vendor will end its support for the software version HHS is currently operating in December 2015. In early 2014, HHS initiated the effort to upgrade these systems in order to maintain a secure and reliable systems environment, while also protecting its investment. As part of the upgrade effort, which we expect to complete in FY 2016, HHS will also implement data standards that will improve fiscal transparency and accountability, enhance the accuracy of financial reporting, and reduce the need for burdensome and manual reconciliations across the Department. Another key component of FSIP is the pursuit of sharing initiatives, such as the standardization of accounting treatment across systems, the transitioning of the financial management systems environment to a Cloud infrastructure design, and the use of shared acquisition contracts. Concurrently with FSIP, HHS plans to continue executing FBIP in phases to expand the use of business intelligence, with the goals of further enhancing financial management information and reporting, as well as facilitating effective decision making.

To support both FSIP and FBIP, HHS has created a strong governance foundation in FY 2014. HHS established a Financial Governance Board (FGB) to address at an enterprise level the financial management areas of common concern among the OpDivs, including financial policies and procedures, financial data, and system technologies. In addition, the FGB provides executive-level oversight of financial management-related areas and promotes collaboration among stakeholders from the different disciplines within the financial management environment.

As it executes both programs, HHS is prepared to address the challenges that are inherent in programs of this scale, including those listed below:

- Finding the right resources as part of an effective strategic workforce planning effort – The successful completion of FSIP and FBIP hinges to a large degree on having the resources with the necessary skills and experience working on the project. For the upgrade of our financial management systems, HHS has sought internal resources as subject matter experts where possible, because they would be most familiar with HHS's business processes and unique requirements. Although program leadership has been successful to date finding a sufficient number of high-quality, internal resources, challenges are certain to arise in the future as additional needs surface and/or as resources currently on the project return to their previous roles.
- Acquiring a steady flow of long term funding to ensure successful completion of new programs – Although currently focused on the upgrade of our financial management systems, FSIP's roadmap envisions other important projects that, together with FBIP, would move HHS towards a state of operational excellence. These multi-year initiatives will require funding through FY 2018. Any interruption of the required funding could adversely affect HHS's ability to fully achieve the benefits that these programs offer.
- Complying with mandates from Congress and central agencies with diminishing resources – HHS is subject to many mandates from Congress and central agencies (e.g. Treasury and OMB) that impact our financial management systems. These mandates, such as the recent *Digital Accountability and Transparency Act of 2014* (DATA Act), require that HHS initiate new projects to research their requirements, devise appropriate solutions for meeting the requirements and then implement the solutions. In many cases, these solutions have both significant system and non-system impacts. The cost to maintain currency with,

and respond to, the current and future mandates is significant. HHS, like other agencies, faces the challenge of seeking funding for these efforts in a fiscal landscape where each is asked to do more with diminishing resources.

Legal Compliance

Anti-Deficiency Act (ADA)

The *Anti-Deficiency Act* prohibits federal employees from obligating in excess of an appropriation, or before funds are available, or from accepting voluntary services. As required by the *Anti-Deficiency Act*, HHS notifies all appropriate authorities of any ADA violations. HHS notifications may be found at http://www.gao.gov/legal/lawresources/antideficiencyrpts.html.

HHS management has taken and continues to take necessary steps to prevent future violations. With respect to two 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.

Digital Accountability and Transparency Act of 2014 (DATA Act)

The recently-passed DATA Act expands the *Federal Funding Accountability and Transparency Act of 2006* to increase accountability and transparency in federal spending, making federal expenditure information more accessible to the public. It directs the federal government to use government-wide data standards for developing and publishing reports, and to make more information, including award-related data, available on the USASpending.gov website. The standards and website allow stakeholders to track federal spending more effectively. Among other goals, the DATA Act aims to improve the quality of the information on USASpending.gov, as verified through regular audits of the posted data, and to streamline and simplify reporting requirements through clear data standards. Additionally, the DATA Act accelerated the referral of delinquent debt owed to the federal government to Treasury's administrative offset program after 120 days of delinquency.

HHS is preparing now for implementation of the DATA Act starting in 2015. We reduced our delinquent debt referral window from 180 days to 120 days, and we established processes to audit the information on the USASpending.gov website. Furthermore, HHS is in the midst of revamping our accounting treatment manual to facilitate data standards throughout the Department.

Improper Payments Information Act (IPIA) of 2002, Improper Payments Elimination and Recovery Act (IPERA) of 2010 and the Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012

An improper payment occurs when federal funds go to the wrong recipient, the recipient receives an incorrect amount of funds, or the recipient uses the funds in an improper manner. *The Improper Payments Information Act* (IPIA) of 2002, as amended by the Improper *Payments Elimination and Recovery Act* (IPERA) of 2010 and the *Improper Payments Elimination and Recovery Improvement Act* (IPERIA) of 2012, requires federal agencies to review their programs and activities, identify programs that may be susceptible to significant improper payments, perform testing of programs considered high risk, and develop and implement corrective action plans for high risk programs. HHS is striving to better detect and prevent improper payments through close review of our programs and activities using sound risk models, statistical estimates and internal controls.

Patient Protection and Affordable Care Act (Affordable Care Act)

The *Affordable Care Act* is monumental legislation that implements comprehensive health care reform over the next several years to make quality health care more affordable and accessible. The *Affordable Care Act* includes provisions for a patient's bill of rights, a Health Insurance Marketplace, tax credits for low-income Americans, and expansion of the Medicaid program, helping to provide access to affordable health insurance options for all Americans.

The *Affordable Care Act* also aims to reduce health care fraud, waste and abuse by toughening the sentences for perpetrators of fraud; employing enhanced screening procedures; improving the monitoring of providers; and using predictive modeling technology to target suspect behaviors. These efforts have enabled the government to recover over $19.2 billion in related improper payments over the last five years.

A key aspect of the *Affordable Care Act* allows eligible Americans to receive a premium tax credit when purchasing their health insurance coverage through the Health Insurance Marketplace. The amount of the credit can be paid in advance directly to the consumer's health insurer. Consumers then claim the premium tax credit on their federal tax returns, reconciling the credit allowed with any advance payments made throughout the tax year. HHS coordinates closely with the Internal Revenue Service (IRS) on this process.

HHS has already implemented many provisions of the *Affordable Care Act*. For more information about implementation of the many *Affordable Care Act* provisions, visit the "Key Features" page at http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html.

Federal Managers' Financial Integrity Act (FMFIA) and Federal Financial Management Improvement Act (FFMIA)

The *Federal Managers' Financial Integrity Act* (FMFIA) requires federal agencies to annually evaluate and assert on the effectiveness and efficiency of their internal control and financial management systems. Agency heads must annually provide a statement on whether there is reasonable assurance that the agency's internal controls are achieving their intended objectives and the agency's financial management systems conform to government-wide requirements. Section 2 of FMFIA outlines compliance with internal control requirements, while Section 4 dictates conformance with systems requirements. Additionally, agencies must report on any material weaknesses identified and provide a plan and schedule for correcting the weaknesses.

The *Federal Financial Management Improvement Act* (FFMIA) requires federal agency heads to assess the conformance of their financial management information systems to mandated requirements. FFMIA expanded upon FMFIA by requiring that agencies implement and maintain financial management systems that substantially comply with federal financial management systems requirements, applicable federal accounting standards and the U.S. Standard General Ledger at the transaction level. Guidance for determining compliance with FFMIA is provided in OMB Circular A-123, Appendix D, *Compliance with the FFMIA of 1996*.

HHS is fully focused on the requirements of FMFIA and FFMIA through its internal control program and annual risk-based assessment cycle. Based on thorough, ongoing internal assessments and FY 2014 audit findings, HHS provides a qualified statement of reasonable assurance that controls are operating effectively and financial systems conform to federal requirements. We are actively engaged with our OpDivs to correct the identified weakness. More information on the internal control program and the HHS Statement of Assurance follows.

Internal Control

FMFIA requires agency heads to regularly evaluate and report on the internal control and financial systems that protect the integrity of federal programs. This evaluation aims to provide reasonable assurance that internal controls are achieving the objectives of effective and efficient operations, reliable financial reporting, and compliance with applicable laws and regulations. The safeguarding of assets is a subset of these objectives. HHS has performed rigorous evaluations of its internal controls in compliance with OMB Circular A-123*, Management's Responsibility for Internal Control,* since FY 2006.

HHS management is directly responsible for establishing and maintaining effective internal controls in its respective areas of responsibility. As part of this responsibility, management regularly evaluates internal controls and HHS executive leadership provides annual assurance statements reporting on the effectiveness of internal controls at meeting objectives. The HHS Risk Management and Financial Oversight Board (RMFOB) evaluates all senior management assurances and provides a recommended Department assurance to the Secretary for consideration. The Secretary's annual Statement of Assurance is included on the following page.

HHS aims to strengthen its internal control assessment and reporting process to be more effective at identifying key risks, developing effective risk responses, and implementing timely corrective actions. The HHS FY 2014 OMB Circular A-123 assessment and the financial statement audit reported one material weakness in information system controls and security, which also constitutes a non-conformance under Section 4 of FMFIA. Additionally, HHS recognizes one material noncompliance with IPIA regarding Error Rate Measurement. These material deficiencies were also reported in FY 2013.

Maintaining integrity and accountability in all programs and operations is critical to HHS's mission and demonstrates responsible stewardship over assets and resources. It also promotes responsible leadership, ensures the effective delivery of high quality services to the American people and maximizes desired program outcomes.

MANAGEMENT ASSURANCES

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 Office of Management and Budget (OMB) Circular A-123, *Management's Responsibility for Internal Control*. These objectives are to ensure (1) effective and efficient operations; (2) compliance with applicable laws and regulations; and (3) reliable financial reporting. The safeguarding of assets is a subset of these objectives.

As required by OMB Circular A-123, 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 under Section 2 of FMFIA, 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 OMB Circular A-123, Appendix A. The assessment identified one material weakness in internal control over financial reporting related 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, 2014, 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. The assessment identified one material weakness in internal control over the effectiveness and efficiency of operations under Section 2 of FMFIA related to the Department's Information System Controls and Security, which also constitutes a non-conformance under Section 4 of FMFIA. The assessment also identified one material noncompliance with IPIA related to error rate measurement. Other than these exceptions, the Department provides reasonable assurance that internal control over operations and compliance with applicable laws and regulations was operating effectively as of September 30, 2014, and no other material weaknesses were found in the design or execution of the internal control over operations and compliance.

Federal Financial Management Improvement Act of 1996

The *Federal Financial Management Improvement Act of 1996* (FFMIA) requires agencies to implement and maintain financial management systems that substantially comply with Federal Financial Management System Requirements, Federal accounting standards, and the United States Standard General Ledger at the transaction level. HHS conducted its assessment of financial management systems for compliance with FFMIA in accordance with OMB Circular A-123, Appendix D. The results of this evaluation identified one material noncompliance, which constitutes a non-conformance under Section 4 of FMFIA, relating to the Department's Information System Controls and Security. Other than this exception, the Department substantially complies with FFMIA as of September 30, 2014.

/Sylvia M. Burwell/

Sylvia M. Burwell
Secretary
November 13, 2014

Summary of Material Weaknesses

Control Areas	FMFIA Section 2			FMFIA Section 4
	Financial Reporting (As of 6/30/2014)	Operations (As of 9/30/2014)	Compliance (As of 9/30/2014)	System Conformance (As of 9/30/2014)
1. Information System Controls and Security	**1**	**1**	0	**1**
2. Error Rate Measurement	0	0	**1**	0

1. Information System Controls and Security

HHS acknowledges an internal control weakness related to information system security, including general and application controls in our financial management systems, and other information system security weaknesses identified through the annual *Federal Information Security Management Act* (FISMA) review. Although no one financial management system had a material weakness, the pervasive nature of the deficiencies across the organization leads management to conclude that these deficiencies in aggregate warrant classification as a material weakness under Section 2 of FMFIA and a non-conformance under Section 4 of FMFIA. While the Department has made progress in the remediation of this material deficiency, our information systems are not yet in substantial compliance with the *Federal Financial Management Improvement Act* (FFMIA) *of 1996* and its associated regulatory guidelines.

2. Error Rate Measurement

HHS did not identify any material weaknesses in our internal controls over compliance with applicable laws and regulations; however, HHS recognizes a process limitation relating to the Temporary Assistance for Needy Families (TANF) program that results in one material noncompliance with IPIA. The TANF program is not reporting an error rate, as required by IPIA, for Fiscal Year (FY) 2014 as statutory limitations currently prohibit HHS from requiring states to participate in reporting a TANF improper payment measurement.

Summary of Corrective Action Plans for Material Deficiencies

1. Information System Controls and Security

The range of challenges resulting in HHS's Information System Controls and Security material weakness and system non-conformance will require additional work beyond FY 2014 to address. In FY 2015, we will continue our efforts to remediate this IT material weakness by coordinating 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's 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 RMFOB 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 due to current statutory limitations. When legislation is considered to reauthorize TANF, HHS plans to encourage Congress to consider statutory modifications that would allow for a reliable error rate measurement.

For summary information related to HHS internal control, refer to the tables on the financial statement audit material weakness findings and related management assurances in the Other Information section.

LOOKING AHEAD TO 2015

HHS is the United States Government's principal agency for protecting the health of all Americans, providing essential human services, and promoting economic and social well-being for individuals, families, and communities, including seniors and individuals with disabilities. Guided by the *HHS Strategic Plan*, 2015 will be crucial in supporting continuing Health Insurance Marketplace operations as well as many other efforts in a number of exciting and challenging areas.

IHS Ribbon cutting ceremony celebrating the opening of the new Samuel Simmonds Memorial Hospital in Barrow, Alaska.

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, supports informed decision making and increases health insurance coverage for low-income populations, partly through the expansion of Medicaid eligibility and the advent of the Health Insurance Marketplace, which launched on October 1, 2013. More than 7.3 million people signed up for Marketplace plans, paid their premiums, and accessed quality, affordable coverage. Another 8.7 million enrolled in Medicaid or CHIP since the beginning of Open Enrollment (as of August 2014) – an increase of 15 percent compared to average monthly signups before October 1, 2013. Beginning in January 2015, a new provision enacted in the *Affordable Care Act* will increasingly tie Medicare physician payments to the quality and efficiency of care they provide through the application of the Value-based Payment Modifier. As this modifier is phased in, physicians who provide higher value care will receive higher payments than those who provide lower value care.

Efforts continue to emphasize 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.

NIH's lab technician pipetting substrate at the Biopharmaceutical Development Laboratory at the National Cancer Institute's Frederick National Laboratory for Cancer Research in Frederick, Maryland.

Advance Scientific Knowledge and Innovation

HHS is working to advance scientific knowledge and innovation to prevent, diagnose, 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 for the prevention and treatment of substance use and abuse, research Alzheimer's disease and related dementias, as well as human immunodeficiency virus (HIV), and reverse the national epidemic of obesity and diabetes. Research will also address health disparities, multiple chronic conditions, and cardiovascular disease, critical health priorities facing America. HHS is also sparking innovation in various ways, including the NIH's "Follow

that Cell" challenge. NIH is challenging science innovators to compete for prizes totaling up to $500,000, by developing new ways to track the health status of a single cell in complex tissue over time. This could lead to a tool that would, for example, monitor a cell in the process of becoming cancerous, detect changes due to a disease-causing virus, or track how a cell responds to treatment.

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

HHS's focus will continue aligning 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.

A mother and daughter outside an accessible home provided by ACL funded Georgia Developmental Disability Council's Universal Home Design project.

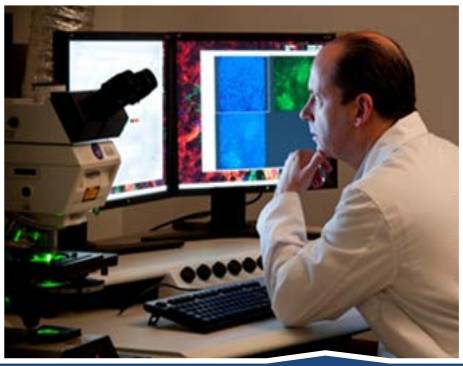
Global health security is an area in which HHS plays a crucial role. Through the Biomedical Advanced Research and Development Authority (BARDA) the Department provides an integrated, systematic approach to the advanced development and purchase of the necessary vaccines, drugs, therapies, and diagnostic tools. Beyond developing, manufacturing, and storing medical countermeasures for chemical, radiological, biological, and nuclear threats, pandemic influenza, and emerging infectious threats, BARDA, along with HHS and industry partners, is also working to provide new options to treat antibiotic-resistant infections. The Department will also continue its effort to promote global well-being and health diplomacy, as well as creating a nimble system better able to respond to unanticipated demands.

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. Health at all ages is a priority for the Department. 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, such as improving access to care, treatment, and services for children and youth exposed to traumatic events. 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. Community living for older adults and people with disabilities will continue to be an area of focus as the U.S. population over the age of 65 is projected to increase by 29 percent between 2012 and 2020.

NIH's senior investigator works with a student investigator in the NIAID Laboratory of Malaria and Vector Research.

Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs

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 towards its goal of improved health and well-being among Americans. Specifically, HHS will continue its evaluation efforts, including program integrity reviews that ensure compliance with federal program integrity regulations 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.



Robert Fariss, Ph.D., chief of the Biological Imaging Core at the National Eye Institute (NEI) under NIH, examines tissue samples illuminated under a laser scanning microscope.

One area identified to ensure effective and efficient services are provided is recruiting, developing, retaining, and supporting a skilled and diverse workforce. Supporting this, the Department is making it a priority to fill STEMM (Scientific, Technical, Engineering, Mathematics, and Medicine) positions. This effort strengthens agency strategic workforce management architecture and capability for mission critical occupations.

ANALYSIS OF FINANCIAL STATEMENTS AND STEWARDSHIP INFORMATION

The Principal Financial Statements (statements) have been prepared to report the financial position, results of operations, and budgetary resources of the HHS, as required by the *Chief Financial Officers Act.* The statements are the Consolidated Balance Sheet, Statement of Changes in Net Position, Statement of Net Cost, and Combined Statement of Budgetary Resources. In addition, HHS is also responsible for producing the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts. The format presentations are in accordance with the OMB Circular A-136. The statements found in the Financial Section of this report present our financial condition as of September 30, 2014 and 2013.

The statements are prepared in conformity with U.S. generally accepted accounting principles (GAAP) established by the Federal Accounting Standards Advisory Board (FASAB), and audited by the independent accounting firm of Ernst & Young LLP, under the direction of our Inspector General. 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 Consolidated Balance Sheet presents resources owned or managed by HHS (assets), amounts owed by HHS that will require payments from resources or future resources (liabilities), and the residual amounts retained by HHS comprising the difference (net position). The table, on the next page, summarizes trend information concerning components of our financial condition as of September 30 each year.

Another presentation of our financial picture is our Consolidated Statement of Net Cost, also found in the Financial Section, with further detailed presentations located 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)

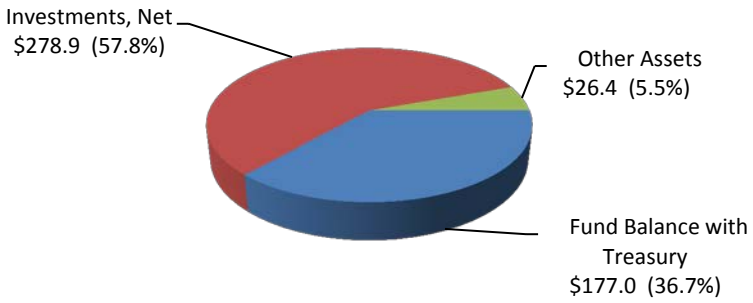
	2010	2011	2012	2013	2014	$ Change (2013-14)	% Change (2013-14)
Fund Balance with Treasury	$ 182.2	$ 166.9	$ 197.3	$ 159.2	$ 177.0	$ 17.8	11.2
Investments, Net	359.9	325.4	306.4	281.7	278.9	(2.8)	(1.0)
Other Assets	21.6	40.6	27.0	29.3	26.4	(2.9)	(9.9)
Total Assets	$ 563.7	$ 532.9	$ 530.7	$ 470.2	$ 482.3	$ 12.1	2.6
Accounts Payable	$ 1.6	$ 1.2	$ 1.1	$ 1.2	$ 1.0	$ (0.2)	(16.7)
Entitlement Benefits Due and Payable	72.7	80.9	72.5	77.3	91.0	13.7	17.7
Accrued Grant Liability	4.2	4.5	3.7	3.9	3.3	(0.6)	(15.4)
Federal Employee and Veterans' Benefits	10.0	10.2	11.0	11.6	12.0	0.4	3.4
Other Liabilities	10.7	8.1	11.2	13.5	16.8	3.3	24.4
Total Liabilities	$ 99.2	$ 104.9	$ 99.5	$ 107.5	$ 124.1	$ 16.6	15.4
Net Position	$ 464.5	$ 428.0	$ 431.2	$ 362.7	$ 358.2	$ (4.5)	(1.2)
Total Liabilities & Net Position	$ 563.7	$ 532.9	$ 530.7	$ 470.2	$ 482.3	$ 12.1	2.6

Assets: What Do We Own and Manage?

Assets represent the value of what we own and manage. Our total assets were $482.3 billion on September 30, 2014. This amount represents an increase of $12.1 billion (2.6 percent) over last year's assets. The increase in assets is primarily attributable to an increase in CMS's Fund Balance with Treasury (FBwT) of $15.7 billion related to increased appropriations for Payments to Trust Fund and Medicaid. This increase in FBwT was offset by a decrease in CMS's Investments of $2.9 billion and a decrease in HHS's Other Assets of $2.9 billion. The decrease in Investments is primarily attributable to a decrease in the Medicare Hospital Insurance (HI) Trust Fund investments.

Figure 1: FY 2014 Assets by Type

(in Billions)



Medicare Trust Funds are classified as Dedicated Collections in the financial statements and reported separately in many of the financial statements and notes. Medicare Trust Fund holdings that are not needed to meet current expenditures are invested in interest-bearing U.S. Treasury securities and reported on the Balance Sheet as Investments, Net. This year the payments from the Medicare HI Trust Fund exceeded revenue collected from

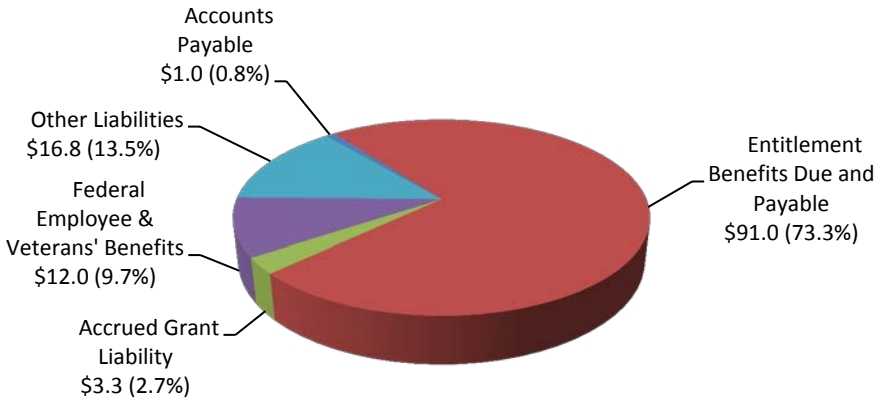
Federal Insurance Contributions Act (FICA) and *Self Employment Contributions Act* (SECA) withholding taxes; therefore, CMS's Trust Fund investments decreased by $2.9 billion.

Securities held by the Medicare Trust Fund are debts to the U.S. Government. While the Federal Government does not set aside assets to pay future benefits associated with Medicare, the Medicare Investments shown on the Balance Sheet present accounting balances of amounts that have been collected and not yet expended as benefit payments. Although FICA and SECA revenue are beginning to grow following the national recession, the HI investments continue to decrease as expenses exceed revenues.

Liabilities: What Do We Owe?

Our liabilities, or amounts that we owe from past transactions or events, were $124.1 billion on September 30, 2014. This represents an increase of $16.6 billion (15.4 percent) more than the FY 2013 liabilities, primarily due to Entitlement Benefits Due and Payable and Other Liabilities. Entitlement Benefits Due and Payable increased by $13.7 billion (17.7 percent) from FY 2013, due to the Medicare, and the *Affordable Care Act* expanding eligibility for Medicaid programs. This represents 73.3 percent and 71.9 percent of our total liabilities in FY 2014 and FY 2013, respectively. Additionally, Other Liabilities increased by $3.3 billion (24.4 percent) from FY 2013, primarily due to contingencies related to the Medicaid audit and program disallowances and reimbursements of State Plan Amendments.

Figure 2: FY 2014 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 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 $4.5 billion (1.2 percent), from $362.7 billion in FY 2013 to $358.2 billion in FY 2014. The $358.2

billion includes $243.8 billion for funds from dedicated collections (compared to $248.5 billion in FY 2013) and $114.4 billion for FY 2014 for all other funds (compared to the FY 2013 ending balance of $114.2 billion).

The FY 2014 decrease of $4.5 billion includes a decrease of $16.4 billion in funds from dedicated collections cumulative results of operation, and $1.5 billion in Cumulative Results of Operations for all other funds. The decrease was offset by an increase of $11.7 billion in funds from dedicated collections Unexpended Appropriations and, $1.7 billion in Unexpended Appropriations 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.

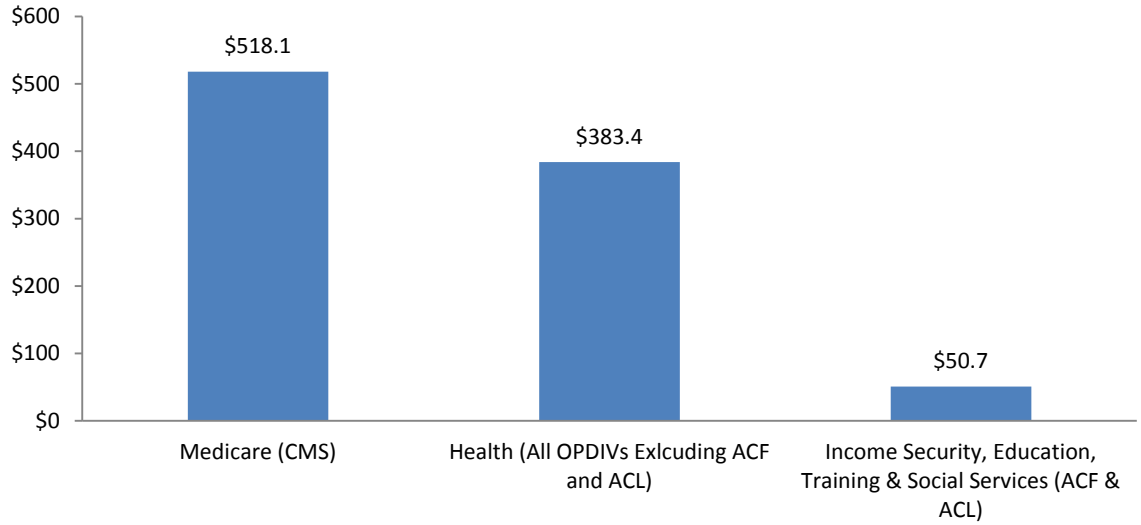
Net Cost of Operations: What Are Our Sources and Uses of Funds?

Our Consolidated 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 Consolidated Net Cost of Operations for the year ended September 30, 2014, totaled $952.0 billion.

Figure 3 depicts our FY 2014 Combined Net Cost of Operations by major budget function and significant components. 94.7 percent of our annual net costs relate to Medicare ($518.1 billion) and the Health budget function ($383.4 billion) which includes Medicaid. During FY 2014, the Medicare budget function experienced growth of $19.5 billion (3.9 percent) and Health increased $37.5 billion (10.8 percent).

The growth in the Medicare budget function is primarily attributable to benefit expense increases in Supplementary Medical Insurance (SMI) of $17.4 billion and HI of $5.3 billion, offset by SMI premium increases (decrease to net cost) of $3.5 billion.

Figure 3: FY 2014 Combined Net Cost of Operations by Budget Function
(in Billions)



The FY 2014 Consolidated Net Cost of Operations represents an increase of $55.7 billion (6.2 percent) over FY 2013. Approximately 87.9 percent of Net Cost of Operations ($837.2 billion) relates to Medicare, Medicaid, CHIP and other health programs managed by CMS. The Table, on the next page, depicts our Consolidated Net Cost of Operations by major responsibility segment for the last five years.

Consolidated Net Cost of Operations
(in Billions)

	2010	2011	2012	2013	2014	$ Change (2013-14)	% Change (2013-14)
Responsibility Segments:							
CMS Gross Cost	$ 789.7	$ 817.4	$ 802.3	$ 848.9	$ 910.5	$ 61.6	7.3
CMS Exchange Revenue	(60.7)	(63.7)	(65.1)	(69.7)	(73.3)	(3.6)	5.2
CMS Net Cost of Operations	$ 729.0	$ 753.7	$ 737.2	$ 779.2	$ 837.2	$ 58.0	7.4
Other Segments:							
Other Segments Gross Cost	$ 130.9	$ 128.2	$ 121.5	$ 121.0	$ 120.5	$ (0.5)	(0.4)
Other Segments Exchange Revenue	(3.2)	(3.8)	(3.2)	(3.9)	(5.7)	(1.8)	46.2
Other Segments Net Cost of Operations	$ 127.7	$ 124.4	$ 118.3	$ 117.1	$ 114.8	$ (2.3)	(2.0)
Net Cost of Operations	$ 856.7	$ 878.1	$ 855.5	$ 896.3	$ 952.0	$ 55.7	6.2

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 2014 total resources were $1.4 trillion, representing an increase of $88.5 billion (6.7 percent) over FY 2013. FY 2014 total obligations of $1.4 trillion increased by $92.3 billion (7.2 percent) compared to FY 2013. Our year-end resources were $37.9 billion, of which $8.5 billion are not yet available for expenditure as of September 30, 2014. Total net outlays (cash disbursed for HHS's obligations) of $937.4 billion increased by $49.2 billion (5.5 percent) from FY 2013 net outlays of $888.2 billion.

Statement of Social Insurance

The Statement of Social Insurance 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 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 are not included in the Consolidated Balance Sheet, Statements of Net Cost and Changes in Net Position, or Combined Statement of Budgetary Resources.

Actuarial present values are computed under the intermediate set of assumptions specified in the *Annual Report of the Medicare Board of Trustees*. As noted in the Trustees Report, the basis for the Part B projections has changed since last year (for more information, see footnotes 20 and 21).

The Statement of Social Insurance 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;

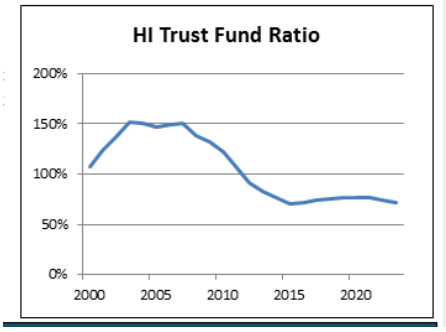
- The present value of future income to be received from or on behalf of current participants who have not yet attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income less future cost for the closed group, which represents all 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 $(4.8) trillion, determined as of January 1, 2013, to $(3.8) trillion, determined as of January 1, 2014.

Including the combined HI and SMI Trust Fund assets increases the present value, as of January 1, 2014, of future cash flow for all current and future participants to $(3.5) trillion for the 75-year valuation period. The comparable closed group of participants, including the combined HI and SMI Trust Fund assets, is $(8.8) trillion.

Hospital Insurance 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 124.0 percent at the beginning of FY 2010 to 77.0 percent at the beginning of FY 2014.



Trust Fund Ratio[1]
Beginning of Fiscal Year

	2010	2011	2012	2013	2014
HI	124.0%	107.0%	95.0%	86.0%	77.0%

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 2014 Trustees Report indicate that the HI Trust Fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the 2014 Trustees Report, the HI Trust Fund ratio is estimated to continue to decline

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

through 2015 and remain at approximately that level through 2023. From the end of 2013 to the end of 2023, assets are expected to increase, from $205.0 billion to $320.0 billion.

Long-Term Financing

The short-range outlook for the HI Trust Fund is somewhat better than projected last year, and the estimated depletion is 4 years later. After 2023, the trust fund ratio starts to decline quickly until the fund is depleted in 2030. HI financing is not projected to be sustainable over the long term with the tax rates and expenditure levels projected. Program cost is expected to exceed total income in 2014, and thereafter, income is projected to exceed costs for several years before falling below it in 2022 and later. 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 85.0 percent of projected expenditures after the HI Trust Fund exhaustion in 2030, declining to 75.0 percent of projected expenditures in 2045, and to stabilize at about this level thereafter.

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 3.2 in 2013 to about 2.1 by 2088. 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 $3.6 trillion, which is 0.8 percent of taxable payroll over the same period.

Significant uncertainty surrounds the estimates for the Statement of Social Insurance. 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 FASAB.

Supplementary Medical Insurance 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, and their program benefits are quite different in nature.

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 generally included an indefinite authority provision allowing for amounts to be transferred to the Part D account on an as-needed basis. This provision allows previously apportioned amounts to change without additional Congressional action if those amounts are later determined to be insufficient. Consequently, once an appropriation with this provision has been made, no deficit will occur in the Part D account, and no contingency fund will be necessary to cover deficits.

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 $(24.7) 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 2013, SMI expenditures were 1.92 percent of GDP. By 2088, SMI expenditures are projected to grow to 4.54 percent of the GDP.

The following table presents key amounts from our basic financial statements for fiscal year 2012 through 2014.

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

	2014	2013	2012
Net Position (end of fiscal year)			
Assets	$ 380.0	$ 370.2	$ 424.8
Less Total Liabilities	104.7	88.3	80.5
Net Position (assets net of liabilities)	$ 275.3	$ 281.9	$ 344.3
Change in Net Position (end of fiscal year)			
Net Costs	$ 837.8	$ 779.8	$ 737.8
Total Financing Sources	820.4	756.1	710.8
Change in Net Position	$ (17.4)	$ (23.7)	$ (27.0)
Statement of Social Insurances (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 evaluation	$ (3,823.0)	$ (4,772.0)	$ (5,581.0)
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), prior year evaluation	(4,772.0)	(5,581.0)	(3,252.0)
Change in present value	$ 949.0	$ 809.0	$ (2,329.0)

Statement of Changes in Social Insurance Amounts

The Statement of Changes in Social Insurance Amount 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, 2014, would have decreased by $239.0 billion due to advancing the valuation date by one year and including the additional year 2088, and by $139.0 billion due to the change in demographic assumptions. However, changes in the projection base, economic and health care assumptions, and legislation changes increased the present value of future cash flows by $447.0 billion, $772.0 billion, and $108.0 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

[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.

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 2014 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.

Limitation of the Principal Financial Statements

The principal financial statements have been prepared to report our financial position and results of operations, pursuant to the requirements of 31 U.S.C. 3515(b). While the financial statements have been prepared from our books and records in accordance with GAAP for federal entities and the formats prescribed by OMB, the statements are in addition to the financial reports used to monitor and control budgetary resources that 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 that provides resources to do so.

The Required Supplementary Information section is unique to federal financial reporting. This section is required under OMB Circular A-136*, Financial Reporting Requirements*, and is unaudited.

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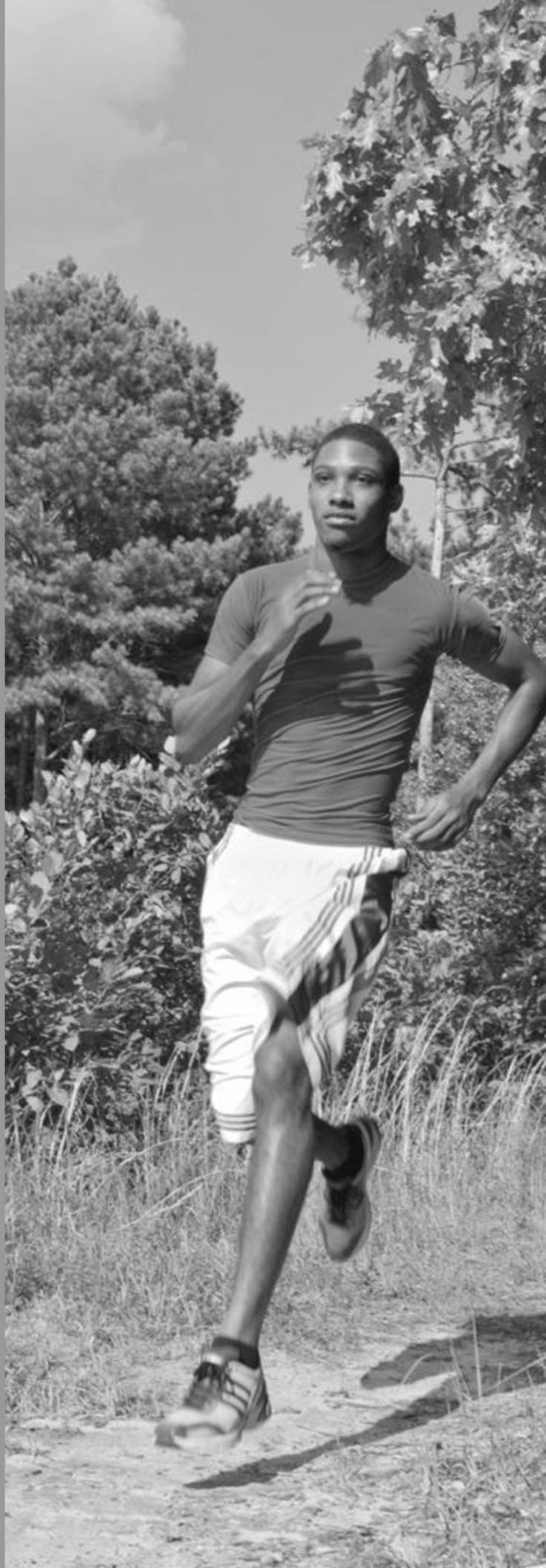
In this Section:

- 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 Report of the Independent Auditors, the Department's Principal Financial Statements, Notes to the Principal Financial Statements, Required Supplementary Stewardship Information, and Required Supplementary Information.



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* (AFR) represents our accountability report for FY 2014. We will issue the FY 2014 *HHS Summary of Performance and Financial Information*, and the FY 2016 *Annual Performance Report and Congressional Budget Justification* in February 2015.

Through collaboration, our Chief Financial Officer (CFO) community manages financial accountability, transparency, compliance, and risk across the Department by prioritizing resources to drive results. We are committed to using taxpayer resources wisely to carry out the Department's mission. This year, for the first time, the Department received the prestigious *Certificate of Excellence in Accountability Reporting* awarded by the Association of Government Accountants for our FY 2013 AFR.

We are dedicated to upholding these standards of excellence. During 2014, we continued to carry out our role as public stewards and worked together collaboratively to confront the challenges we faced. We have addressed the planned time frames for correcting audit weaknesses and non-compliances in the Other Information section. Other examples of our commitment to these standards of excellence include:

- Continued working together as a CFO community to improve Department-wide financial reporting and systems, with the overall goal to consistently strengthen internal control, maintain data integrity, increase data transparency, and report reliable information on a timely basis.
- Initiated the upgrade of our financial systems to maintain a secure and reliable system environment, with completion expected in FY 2016. We also expanded the use of business intelligence to further enhance the availability and analysis of financial management information to facilitate effective decision making.
- Pursued sharing initiatives using a phased approach, such as the standardization of accounting treatment across systems. Standardization is an important step to substantially comply with federal financial management system requirements, applicable federal accounting standards and the U.S. Government Standard General Ledger at the transaction level as required by the *Federal Financial Management Improvement Act*.
- Strengthened our governance foundation by establishing the Financial Governance Board (FGB) to address, at an enterprise level, financial management areas of common concern across HHS. In addition, the FGB promotes collaboration among stakeholders from the different mission support disciplines such as grants, acquisitions, human resources, information technology, and our shared service provider.

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. For the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts, the auditors disclaimed providing an opinion. The disclaimer was primarily due to the uncertainties surrounding provisions of the *Affordable Care Act* and the impact of potential changes in law that would impact underlying assumptions of financial projections. These statements were developed based upon current law using information from the *2014 Medicare Trustees Report*, as required by standards issued by the Federal Accounting Standards Advisory Board. Please refer to the Report of the Independent Auditors, Principal Financial Statements, and Notes to the Principal Financial Statements, in this section 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
November 13, 2014

REPORT OF THE INDEPENDENT AUDITORS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

TO: The Secretary
Through: DS _____
COS _____
ES _____

FROM: Inspector General Daniel R. Levinson

DATE: November 13, 2014

SUBJECT: OIG Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2014 (A-17-14-00001)

This memorandum transmits the independent auditors' reports on the Department of Health and Human Services (HHS) fiscal year (FY) 2014 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, 2014 and 2013, 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, 2014, 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 *Government Auditing Standards*, issued by the Comptroller General of the United States; and 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 2014 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 20 to the

financial statements, with respect to the estimates for the Centers for Medicare & Medicaid Services (CMS) social insurance program as of January 1, 2014 and 2013, CMS management has assumed, in the projections of the program, that the various cost-reduction measures will occur as the Patient Protection and Affordable Care Act (P.L. No. 111-148) (ACA) requires. The Medicare Board of Trustees, in its annual report to Congress, indicated, "While the ACA has been successful in reducing many Medicare expenditures to date, there is a strong possibility that certain of these changes will not be viable in the long range." It further showed the potential impact of this uncertainty in illustrative alternative scenarios and projections intended to provide additional context for the actuarial estimates regarding the long-term sustainability of the social insurance program. The width of the range of the social insurance liability estimates in the various scenarios is significant. As a result, Ernst & Young was unable to obtain sufficient audit evidence for the particular amounts presented in the statements of social insurance as of January 1, 2014, 2013, 2012, 2011, and 2010 and the related statements of changes in social insurance amounts for the periods ended January 1, 2014 and 2013. Ernst & Young was not able and did not express an opinion on the financial condition of the HHS social insurance program and related changes in the social insurance program for the specified periods.

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*, 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 HHS had continued to make strides to improve controls that support the information technology infrastructure and financial system applications. HHS operating divisions continued to address and implement the existing governance, financial processes and practices, and system tools needed to enhance controls over application information security and contingency planning. HHS established standard operating procedures and practices to facilitate the improvement of entitywide governance and security assessment and authorization documentation. HHS also continued to establish system-level contingency plans and backup policies and procedures to reduce redundancy and improve availability of infrastructure that supports financial application systems. As in previous fiscal years, Ernst & Young indicated a focused effort is still needed to 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, configuration management, and access to HHS financial systems. The deficiencies identified represent a material weakness in internal control.

- *Financial Reporting Systems, Analyses, and Oversight*—During the FY 2014 audit, Ernst & Young noted further progress as HHS continued to improve current and implement new financial management processes. HHS has started to automate more manual journal entries, upgrade various financial systems, develop new guidance and policies, improve infrastructure, and take other actions to address longstanding financial reporting issues. While progress continued, the audit identified internal control deficiencies in financial systems and processes for producing financial statements,

including a lack of integrated financial management systems and insufficient analysis of certain accounts. Ernst & Young continued to note HHS did not consistently perform controls to ensure differences were properly identified, researched, and resolved in a timely manner and account balances were complete and accurate. Ernst & Young concluded additional improvements in the financial reporting systems and processes are required. These deficiencies collectively constitute a significant deficiency in internal control.

Ernst & Young identified several instances of noncompliance with laws and other matters. During FY 2014, HHS was not in full compliance with the requirements of the Improper Payments Information Act of 2002 (P.L. No. 107-300) (IPIA), as amended, and section 6411 of ACA related to the implementation of recovery activities for the Medicare Advantage program. HHS reported improper payment error rates for its high-risk programs except for Temporary Assistance for Needy Families (TANF). HHS believes it does not have the authority under the Social Security Act to compel the States to report error rates for TANF. One program, Medicare Fee-for-Service, reported an error rate of over 10 percent, a violation of IPIA. Two other programs, Medicaid and Foster Care, also reported error rates that increased from the error rates reported in FY 2013, another violation of IPIA. We will be communicating further details on agency compliance with improper payment reporting as required by the IPIA later in FY 2015. In addition, HHS's management determined that it may have one potential violation with certain provisions of the Anti-Deficiency Act (P.L. No. 101-508) related to conference spending by the Administration for Children and Families in FY 2014 and FY 2015. On the basis of the material weakness reported over Financial Information Management Systems and the significant deficiency reported over Financial Reporting Systems, Analysis, and Oversight, Ernst & Young concluded HHS also did not comply with the Federal Financial Management Improvement Act of 1996 (P.L No.104-208).

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 2014 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-17-14-00001.

Attachment

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

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

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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, 2014 and 2013, and the related consolidated statements of net cost and changes in net position, and the combined statements of budgetary resources for the fiscal years then ended, and the related notes to the financial statements. We were engaged to audit the statements of social insurance as of January 1, 2014, 2013, 2012, 2011, and 2010, the related statements of changes in social insurance amounts for the periods ended January 1, 2014 and 2013, 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, 2014, 2013, 2012, 2011, and 2010, the related statements of changes in social insurance amounts for the periods ended January 1, 2014 and 2013, and the related notes to these financial statements, we conducted our audits in accordance with auditing standards generally accepted in the United States, and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget (OMB) Bulletin No. 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, 2014 and 2013, and the related consolidated statements of net cost and changes in net position, and the combined statements of budgetary resources for the fiscal years then ended, and the related notes to 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 20 to the financial statements, the statement of social insurance presents the actuarial present value of the HHS' 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, 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 (Affordable Care Act).

As further described in Note 21 to the financial statements, with respect to the estimates for the HHS social insurance program presented as of January 1, 2014, 2013, 2012, 2011, and 2010, management has assumed in the projections of the program that the various cost-reduction measures will occur as the Affordable Care Act requires. Management 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. The range of the social insurance liability estimates in the scenarios is significant. As described in Note 21, the ability of health care providers to sustain these price reductions will be challenging, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these

services. If the health sector cannot transition to more efficient models of care delivery and achieve productivity increases commensurate with economy-wide productivity, actual future costs for Medicare could exceed those shown in the projections. 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, 2014, 2013, 2012, 2011, and 2010, and the related statements of changes in social insurance amounts for the periods ended January 1, 2014 and 2013.

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, 2014, 2013, 2012, 2011, and 2010, and the related changes in the social insurance program for the periods ended January 1, 2014 and 2013.

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, 2014 and 2013, and its net cost, changes in net position, and budgetary resources for the years then ended, in conformity with U.S. generally accepted accounting principles.

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, which considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our 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 November 13, 2014, 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/

November 13, 2014

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

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

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial 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, 2014, 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, 2014, and the related statement of changes in social insurance amounts for the period ended January 1, 2014, and have issued our report thereon dated November 13, 2014. 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, 2014, and the related statement of changes in social insurance amounts for the period ended January 1, 2014.

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

HHS continued to make strides during fiscal year (FY) 2014 to improve the controls within its supporting information technology (IT) infrastructure and financial application systems. We noted attention among 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.

- Continued to enhance its standard operating procedures and practices to facilitate the improvement of entity-wide governance and security management/security assessment and authorization documentation.

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

- Updated and implemented service level agreements (SLAs) with key third-party providers and respective backup policies and procedures that align to the COOP and in order to strengthen availability of the supporting IT infrastructure and financial application systems.

- Strengthened the HHS' security program management practices through the implementation of program-wide governance, security authorization activities, and plan of actions and milestones (POA&M) management through the use of the Risk Management Framework Portal (RMFP).

A focused effort is still necessary to remediate the long-outstanding deficiencies in Access Controls, Configuration Management, and Segregation of Duties (SoD) 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 National Institutes of Health (NIH) Business System (NBS). Specifically, management informed us of policy improvements around SoD to include addressing weaknesses around SoD and user recertification weaknesses at the OpDiv level as well as strengthening the configuration management processes. However, the remaining un-remediated deficiencies continue to constitute a material weakness in internal control. These deficiencies fall into the following categories:

- Access Controls – which consist of:
  - Inconsistently maintaining user access reviews, which monitor access, anomalies and findings
  - Ineffective review of super users/end user access, as users are reviewing their own access, and reviews are not performed in a timely manner
- Configuration Management – which consists of:
  - Excessive access for system administrators providing them the ability to develop changes and also migrate those changes into the production environment
  - System Administration access within the production environment as well as development access (SoD issue as well)
  - Lack of automated mechanisms to support change management activities
  - Inability to verify that unauthorized changes were not made to the production environment that did not go through the change approval and management process; additionally, there is a lack of proactive monitoring of changes in support of those reviews
- Segregation of Duties – efforts necessary include:
  - Completely implementing role-based security
  - Establishment of least privileged access considerations for all users
  - Performance of a one-time clean-up activities for roles in conflict, and continued sustainment of SoD principles moving forward

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 – Access assignments were excessive for UFMS, GrantSolutions (GS), NBS, Information for Management, Planning, Analysis, and Coordination (IMPACII), Health and Human Services Consolidated Acquisitions Solution (HCAS), Grants Administration Tracking and Evaluation System (GATES), and Enterprise Human Resources & Payroll (EHRP) systems and did not document and implement adequate SoD. Process Owners have not completely identified SoD 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. Centers for Medicare and Medicaid Services (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 SoD. We found several deficiencies that may result in a potential lack of SoD at both the Medicare fee-for-service contractors and across the enterprise.

- Configuration Management (CM) – CM processes for NBS, HCAS, GATES, GS, UFMS, and EHRP were insufficient to ensure only properly authorized changes were implemented into production systems. For UFMS, we found that system administrators have access to the production environment as well as development access giving them the capability to migrate code. We also found that GATES baseline configuration is not documented for the application and database levels. We also noted CMS did not fully document waivers to change management policies when those waivers involved contractors.

- 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 was not documented. GATES and GS do not have formal documented procedures for conducting the Grants Management Review Board (GMRB) report reviews, explicitly giving guidance for what and how to perform the review, as well as what documents should be retained to support the reviews. Also, approximately 10% of EHRP active users have not been reviewed by HR managers to ensure that only authorized users have access to the application. At CMS, several vulnerabilities in system configurations, program coding, input validation, and incident response procedures were observed for the Medicare fee-for-service network.

- 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 FY 2014 FISMA assessment, we performed our procedures at the following OPDIVs: (1) Indian Health Service (IHS), (2) U.S. Food and Drug Administration, (3) NIH, (4) CMS, and (5) the HHS Office of the Secretary. Our procedures identified the following deficiencies identified across the OPDIVs reviewed:

  – Continuous Monitoring – We noted that the implementation and reporting capabilities with respect to continuous monitoring are being refined. However, the Department does not currently have a consistent and effective continuous monitoring program. Such a program should identify and reconcile both user access and identification of physical IT devices on the network. We noted that the implementation and reporting capabilities with respect to continuous monitoring are being refined.

  – Patch Management – The Department does not have an effective process for timely implementation of critical system patches. We noted inconsistencies in processes as well as deficiencies with asset identification and asset management.

  – Identity and Access Management – The Department needs to standardize identification and access management procedures to provision, recertify, and de-provision user accounts.

  – Remote Access Management – 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 virtual private network (VPN) user account maintenance.

  – Plan of Action and Milestones – The Department's 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

HHS should continue the focus achieved in FY 2014 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 is documented in an organizationally specified timely manner (industry best practice is within 10 business days.)
  - 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.
  - Develop and implement a process and procedures for physical inventory identification as well as reconciliation of physical IT assets to those devices on the network
  - 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 SoD 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 release into the production environment. Management should periodically review the list of changes made in the production environment and confirm that the changes made have gone through the formal change management process and that only authorized changes were implemented into the production environment.

– For UFMS, management should enforce SoD within the change management process and review the access of all personnel (including administrators) who access development libraries and production libraries for appropriateness based on the principle of least privilege.

– For GATES and GS, management should update policies and procedures to include guidance for how to perform the GMRB report reviews, what to review, and what documents should be retained to support the review.

– For EHRP, the review of all active accounts, including system accounts, should be conducted on a consistent basis so that only authorized users have access to the application.

We have performed a separate financial statement audit of CMS for FY 2014 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 were informed that a handful of HHS 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 2014, our audit identified further progress as HHS continued to implement new processes, automate manual entries, upgrade (or plan for the upgrade) of its various systems, relocate certain shared service center processes, develop new guidance and policies, improve communication, improve its infrastructure by planning for the consolidation and relocation of HHS offices, hire new experienced personnel, and provide training to address significant long-standing issues. 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 discussed above and related processes continued to be developed throughout FY 2014 and will require additional refinements in FY 2015 and beyond. Within the context of the approximately $900 billion in departmental net outlays, the ultimate resolution of our specific 2014 findings were not material to the financial statements taken as a whole. However, these matters are indicative of systemic issues that should continue to be resolved.

Lack of Integrated Financial Management System

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. Over the past 18 years, HHS has continued its efforts to overcome certain issues that have affected its ability to become compliant with the FFMIA, including the following long-standing issues, for which HHS and the audit have identified and reported in the past:

- The recording of billions of dollars in manual journal entries to ensure balances within financial systems are correct

- Departures from requirements specified in OMB A-123 Appendix D, *Management's Responsibility for Internal Control in Federal Agencies*, and OMB A-130, *Management of Federal Information Resources*, related to access and change management controls within financial systems, as discussed above

- The use of surveys or data calls to the OPDIVs or to the specified program to obtain information for specified requests

- The lack of sufficient integration within the various financial systems which are not complemented with sufficient manual preventative and detective-type controls, including CMS' durable medical equipment (DME) Medicare Administrative Contractors (MACs) who have not fully implemented CMS' HIGLAS and the NIH Business System which 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

- Inconsistencies across the various accounting centers and financial systems on how accounting transactions are captured and which standard general ledger accounts are utilized, including intragovernmental and intergovernmental transactions

Resource limitations and other priorities have consistently been identified as the causes for delays in upgrading certain system and financial internal control processes limiting HHS' ability to comply with requirements under FFMIA.

With the passage of new laws, including the Digital Accountability and Transparency Act (the Data Act), and the continued implementation of Treasury requirements, including the continued implementation of the Government-wide Treasury Account Symbol Adjusted Trial Balance

System (GTAS) and other treasury endeavors, HHS has taken an aggressive approach in addressing its compliance with the FFMIA Act. During FY 2014, the Department has moved forward in its planning and initial implementation to upgrade its financial systems, expected to be completed by FY 2016; initiated the updating and implementation of the Department-wide accounting treatment manual (effective in FY 2016) to enable the collection of consistent financial data and consistency in the processing of financial activity among its accounting centers; prioritized and centralized additional resources in addressing certain issues related to controls within its financial information management systems; and continued to automate the manual journal entry processes required to ensure financial data is accurate.

As it continues its pursuit in resolving these long-standing issues, HHS needs to be vigilant in developing, maintaining, and implementing consistent policies and procedures, monitoring the implementation of its upgrades, providing extensive training throughout the Department to ensure consistent application, and developing a monitoring program to ensure continued compliance.

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 that differences were properly identified, researched, and resolved in a timely manner and that account balances were complete and accurate. We identified 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

As deficiencies exist in financial systems, management compensates 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 may 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 that need enhanced periodic reconciliation and analysis:

- *Departmental Review of OPDIV Financial Statements and Other Financial Activity* – Although the Department performs periodic reviews of OPDIV financial activity related to required financial reporting or external inquiry, we noted that limited routine communication from OPDIVs to notify the Department of newly adopted, unique and/or complex financial management activity for purposes that may impact the

Department's required financial reporting was not taking place on a routine basis. Progress was noted during our review of the financial statements whereby differences had been reduced by a significant level through the Department's review. However, for CMS, we noted that full communication of significant or complex activities had not taken place with the Department. Since CMS makes up over 80% of the Department's financial statements, the Department should have an opportunity to review CMS financial statements and discuss treatment of significant transactions prior to external release. Reporting matters should be communicated in advance and on a regular basis because of the uniqueness and complexity of the operations at CMS. Open communication will improve and align the reporting between CMS and the Department to ensure consistent reporting.

- *Intra- and Inter-governmental Transactions* – HHS processes more than $1.5 billion annually in intergovernmental and HHS transactions annually. During FY 2014, certain controls related to intra-HHS transactions within the OPDIVs were not working sufficiently to identify errors in a timely fashion. Intra-HHS transactions are those transactions between HHS OPDIVs that require elimination to ensure the HHS financial statements are fairly stated. For example, we identified one interagency agreement between the NIH and the Program Support Center whereby a charge of $5.9 million was recorded against the incorrect interagency agreement due to the inappropriate reference included on the Intra-Governmental Payment and Collection (IPAC) documentation. Further, due to the incorrect reference on the IPAC and it not being identified in a timely manner, an additional $4.6 million IPAC was charged and could not be recorded, as the obligation was not sufficient to cover the difference. As a result, $1.2 million remained in suspense for approximately a year as the research of the difference had not taken place at the point we selected the sample for our audit. Once identified, the Program Support Center (PSC) and the National Institute of Health (NIH) performed analysis and determined that the incorrect reference and subsequent posting had occurred. Based on discussions with NIH and PSC personnel, we believe there were several causes for the untimely resolution of the posting, including the following: insufficient communications between NIH's Office of Finance, its Institutes and the PSC; NIH's process for researching interagency agreements and related activities; NIH's untimely research of transactions included in its fund balance with Treasury suspense account; and the need for further information/documentation on IPAC charges, specifically appropriate interagency agreement numbers, modifications, and potentially purchase order numbers.

  Additionally, in certain cases, HHS has not properly classified Trading Partners and failed to report intergovernmental transactions, using the appropriate USSGL account number as prescribed by the Treasury Financial Manual. In addition, a formal process has not been consistently applied between the Trading Partners to settle and report transactions. This issue is apparent at the intragovernmental and intra-HHS levels. At the intra-HHS reporting level, the Consolidated Financial Reporting System (CFRS)

has reported unresolved intra-HHS differences from each reciprocal category of nearly $150 million. This activity has been identified as "Federal" within HHS, but the Trading Partners have not resolved the differences.

- *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 2014.

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 that sufficient knowledge of financial management systems/processes or consistency and adequacy of internal control exist. For example, HHS management indicated that, while certain policies within its procedural manuals have been drafted awaiting final approval, including sections within its accounting treatment manual, others continue to be on a listing waiting to be updated. Full implementation of the updated accounting treatment manual is not expected until FY 2016. 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.

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 November 10, 2014. 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 business partner risk management, 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 a recommendation that 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.

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 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), AT Section 801, *Reporting on Controls at a Service Organization* (AT 801), 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 where actions are required in the following circumstances: (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 but are not investigated as to why they are returned; (3) the claims outstanding greater than one year – periodic review, track, or monitor those aged claims other than those identified as bankruptcy, fraud, or abuse; and (4) the provider records – reconcile, review, or monitor provider records and provider eligibility status on a periodic basis to verify that all changes were timely and accurately and completely processed.

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 move forward in its planning and implementation to upgrade its financial systems; prioritize and centralize additional resources in addressing certain issues related to controls within its financial information management systems; and continue to automate the manual journal entry processes required to ensure financial data is accurate.

- Continue to update and implement the Department-wide accounting treatment manual and other guidance to enable the collection of consistent financial data and consistency in the processing of financial activity among its accounting centers and headquarters. As policies and procedures are developed, training should be developed and delivered across all OPDIVs to determine consistent application of the new policies. Additionally, ongoing monitoring processes should be enhanced to ensure appropriateness and consistency over the long-term and continued compliance.

- Develop increased communication protocols with all OPDIVs, especially CMS, to enhance notification and awareness of newly adopted, unique and/or complex financial management activity for purposes that may impact the Department's required financial reporting.

- Strengthen controls surrounding the property, plant, and equipment and related processes to ensure that documentation is maintained and that balances are accurate and supportable.

- Continue to focus on the area of intra- and intergovernmental transactions to ensure partner codes are identifiable with the transaction and that trading partners are accounting for transactions consistently. HHS should also develop policies and procedures to be implemented across HHS regarding the use of interagency agreements – both within HHS and with other agencies. The policies should identify required IPAC information, which may include agreement or modification numbers, transaction account symbols, and, to the extent possible, purchase order numbers. Once developed, HHS should provide Department-wide training to ensure consistency in interpretation of the policies in accounting for interagency and intraagency activity. It should also discuss processes to utilize when differences between trading parties exist. Further, HHS should enhance its communication processes to ensure interagency agreements are recorded correctly with differences being resolved on a timely basis. This may entail sharing of information, periodic meetings, or use of an independent group – such as headquarters or Treasury to mediate differences. Finally,

to the extent that differences may be recorded in a fund balance with Treasury suspense account, HHS should develop and monitor processes to ensure suspense account transactions are cleared properly on a timely basis.

- Establish a policy individual or group to analyze the accounting and reporting of unique, newly implemented, non-routine, or significant transactions; enhance the financial reporting process; and address or identify transactions that required cross-functional input. Enhancement of this process may assist to develop, document, and validate the new critical accounting matters that are identified or implemented during the year and improve the timeliness and completeness of the white papers. In addition, prepare the required presentations and disclosures to ensure adequate time for analysis and feedback from key stakeholders.

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.

STATUS OF PRIOR-YEAR FINDINGS

In the reports on the results of the FY 2013 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	• Segregation of Duties • Change Management • Access Controls • FISMA Compliance	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; however, certain issues identified require continued focus. Additionally, issues related to intragovernmental and intergovernmental transactions were identified. Modified Repeat Condition

HHS' Response to Findings

HHS' response to the findings identified in our audit and examination are included in its letter dated November 13, 2014, 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/

November 13, 2014

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

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

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and the Office of Management and Budget (OMB) Bulletin No. 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, 2014, 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, 2014, and the related statement of changes in social insurance amounts for the period ended January 1, 2014, and have issued our report thereon dated November 13, 2014. 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, 2014, and the related statement of changes in social insurance amounts for the period ended January 1, 2014.

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 (FY) 2014, HHS' management determined that it may have potential violations of the Anti-Deficiency Act (P.L. 101-508 and OMB Circular A-11) related to FY 2014 and FY 2015 obligation of funds for conference spending at the Administration for Children and Families.

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. For example, 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). HHS indicated that it is unable to compel states to collect the necessary information required to conduct an improper payment measurement for TANF due to Section 411 of the Social Security Act, which specifies the data elements that HHS may require states to report, and Section 417 of the same Act, which 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. Additionally, the Medicare Fee-for-Service program error rate exceeded 10%. Also, 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. HHS indicated it remains committed to implementing this provision of the Affordable Care Act, and anticipates awarding a Medicare Part C Recovery Audit Contractor contract in 2015.

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:

- During fiscal year 2014, thousands of manual journal vouchers were required to be recorded in Unified Financial Management System (UFMS)/National Institute of Health (NIH) Business System (NBS) to post certain types of transactions not currently configured correctly within UFMS and for the purpose of ensuring that balances within financial systems are correct to enable the development of periodic financial statements.

- Although progress was noted, reviews of general and application controls over financial management systems identified certain departures from requirements specified in OMB A-130, *Management of Federal Information Resources*, and OMB A-123 Appendix D, *Management's Responsibility for Internal Control in Federal Agencies*. 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.

- The lack of sufficient integration within the various financial systems which are not complemented with sufficient manual preventative and detective type controls, including CMS' durable medical equipment (DME) Medicare Administrative Contractors (MACs) who have not fully implemented CMS' HIGLAS and the NBS which 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.

- Inconsistencies across the various accounting centers and financial systems on how accounting transactions are captured and which standard general ledger accounts are utilized, including intragovernmental and intergovernmental transactions.

* * * * *

HHS' Response to Findings

Our Report on Internal Control dated November 13, 2014, 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 November 13, 2014. We did not audit management's comments, and accordingly, we express no opinion on them. Additionally, HHS is updating its Department-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/

November 13, 2014

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 2014 Financial Statement Audit

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

We appreciate the opportunity to comment on the draft reports you provided. We generally concur with the findings identified in the Report on Internal Control. The final reports will be included in our FY 2014 Agency Financial Report. In response to your reports, we will prepare corrective action plans to address the identified findings with particular focus on the reported material weakness, as described below.

The size and complexity of our information technology environment pose significant challenges to resolving the deficiencies across our multiple financial management systems. While we have addressed deficiencies and risks as they arise, a more strategic overall approach to strengthening controls and security over our financial systems environment is needed. To accomplish this, the Department's Chief Financial Officer and Chief Information Officer communities are working together to develop a corrective action plan with milestones for addressing the identified financial systems material weakness in a sustainable manner. We are also working closely with your office and EY to identify and prioritize key risks, and to track our progress. HHS is dedicating additional resources to significantly lower the risk in our financial systems in 2015.

Our stakeholders are committed to implementing this strategic approach and the Department's Risk Management and Financial Oversight Board will oversee this effort.

We look forward to continued collaboration with the OIG to improve our stewardship of taxpayer funds.

/Ellen G. Murray/

Ellen G. Murray
Assistant Secretary for Financial Resources and
Chief Financial Officer
November 13, 2014

PRINCIPAL FINANCIAL STATEMENTS

U.S. Department of Health and Human Services

Consolidated Balance Sheet

As of September 30, 2014 and 2013

(in Millions)

	2014	2013
Assets (Note 2)		
Intragovernmental Assets		
Fund Balance with Treasury (Note 3)	$ 176,958	$ 159,192
Investments, Net (Note 4)	278,900	281,723
Accounts Receivable, Net (Note 5)	919	3,649
Other Assets (Note 8)	95	103
Total Intragovernmental Assets	456,872	444,667
Accounts Receivable, Net (Note 5)	10,159	10,933
Inventory and Related Property, Net (Note 6)	8,606	8,602
General Property, Plant and Equipment, Net (Note 7)	5,868	5,364
Other Assets (Note 8)	810	689
Total Assets	$ 482,315	$ 470,255
Stewardship Property Plant and Equipment (Note 1)		
Liabilities (Note 9)		
Intragovernmental Liabilities		
Accounts Payable	$ 401	$ 565
Other Liabilities (Note 13)	3,022	2,009
Total Intragovernmental Liabilities	3,423	2,574
Accounts Payable	555	662
Entitlement Benefits Due and Payable (Note 10)	91,037	77,277
Accrued Grant Liability (Note 12)	3,314	3,949
Federal Employee and Veterans' Benefits (Note 11)	11,979	11,566
Contingencies and Commitments (Note 14)	11,332	8,900
Other Liabilities (Note 13)	2,501	2,581
Total Liabilities	124,141	107,509
Net Position		
Unexpended Appropriations - Funds from Dedicated Collections (Note 19)	16,215	4,469
Unexpended Appropriations - All Other funds	107,427	105,728
Cumulative Results of Operations - Funds from Dedicated Collections (Note 19)	227,551	243,996
Cumulative Results of Operations - All Other funds	6,981	8,553
Total Funds from Dedicated Collections	243,766	248,465
Total All Other Funds	114,408	114,281
Total Net Position	358,174	362,746
Total Liabilities and Net Position	$ 482,315	$ 470,255

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, 2014 and 2013
(in Millions)

	2014	2013
Responsibility Segments		
Centers for Medicare & Medicaid Services (CMS)		
Gross Cost	$ 910,511	$ 848,967
Exchange Revenue (Note 15)	(73,276)	(69,745)
CMS Net Cost of Operations	837,235	779,222
Other Segments:		
Administration for Children and Families (ACF)	49,283	50,566
Administration for Community Living (ACL)	1,485	1,449
Agency for Healthcare Research and Quality (AHRQ)	386	606
Centers for Disease Control and Prevention (CDC)	10,336	10,771
Food and Drug Administration (FDA)	3,833	3,394
Health Resources and Services Administration (HRSA)	8,817	8,720
Indian Health Service (IHS)	6,339	5,551
National Institutes of Health (NIH)	30,676	30,691
Office of the Secretary (OS)	4,209	3,900
Program Support Center (PSC)	1,784	1,636
Substance Abuse and Mental Health Services Administration (SAMHSA)	3,275	3,432
Other Segments Gross Cost of Operations before Actuarial Gains and Losses	$ 120,423	$ 120,716
Actuarial (Gains) and Losses Commissioned Corp Retirement and Medical Plan (Note 11)	82	230
Other Segments Gross Cost of Operations after Actuarial Gains and Losses	$ 120,505	$ 120,946
Exchange Revenue (Note 15)	(5,758)	(3,918)
Other Segments Net Cost of Operations	114,747	117,028
Net Cost of Operations (Note 15)	$ 951,982	$ 896,250

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, 2014
(in Millions)

	2014			
	Funds From Dedicated Collections	All Other Funds	Eliminations	Consolidated Total
Cumulative Results of Operations:				
Beginning Balances	$ 243,996	$ 8,553	$ -	$ 252,549
Budgetary Financing Sources:				
Other Adjustments (Recessions, etc.) (+/-)	-	(573)	-	(573)
Appropriations Used	260,360	432,855	-	693,215
Non-exchange Revenue				
Non-exchange Revenue - Tax Revenue	227,822	-	-	227,822
Non-exchange Revenue - Investment Revenue	11,360	3	-	11,363
Non-exchange Revenue - Other	3,826	-	-	3,826
Donations and Forfeitures of Cash and Cash Equivalents	63	-	-	63
Transfers-in/out without Reimbursement	(3,389)	2,083	-	(1,306)
Other (+/-)	-	-	-	-
Other Financing Sources (Non-Exchange):				
Donations and Forfeitures of Property	-	53	-	53
Transfers-in/out Without Reimbursement (+/-)	(4)	(1)	-	(5)
Imputed Financing	37	711	(194)	554
Other (+/-)	-	(1,047)	-	(1,047)
Total Financing Sources	500,075	434,084	(194)	933,965
Net Cost of Operations (+/-)	516,520	435,656	(194)	951,982
Net Change	(16,445)	(1,572)	-	(18,017)
Cumulative Results of Operations:	$ 227,551	$ 6,981	$ -	$ 234,532
Unexpended Appropriations:				
Beginning Balances	$ 4,469	$ 105,728	$ -	$ 110,197
Budgetary Financing Sources:				
Appropriations Received	273,772	458,633	-	732,405
Appropriations Transferred in/out	-	(4)	-	(4)
Other Adjustments	(1,666)	(24,075)	-	(25,741)
Appropriations Used	(260,360)	(432,855)	-	(693,215)
Total Budgetary Financing Sources	11,746	1,699	-	13,445
Total Unexpended Appropriations	16,215	107,427	-	123,642
Net Position	$ 243,766	$ 114,408	$ -	$ 358,174

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
Combined Statement of Budgetary Resources
For the Years Ended September 30, 2014 and 2013
(in Millions)

	2014		2013	
	Budgetary	Non-Budgetary Credit Reform Financing Account	Budgetary	Non-Budgetary Credit Reform Financing Account
Budgetary Resources:				
Unobligated Balance, Brought Forward, Oct 1	$ 41,577	$ 111	$ 80,780	$ 3,175
Recoveries of Prior Year Unpaid Obligations	26,083	-	24,598	-
Other Changes in Unobligated Balance	(719)	(62)	(1,221)	(1)
Unobligated Balance from Prior Year Budget Authority, Net	66,941	49	104,157	3,174
Appropriations (Discretionary and Mandatory)	1,320,180	(4)	1,193,733	-
Borrowing Authority (Discretionary and Mandatory)	-	237	-	(2,064)
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	24,658	198	25,409	(685)
Total Budgetary Resources	$ 1,411,779	$ 480	$ 1,323,299	$ 425
Status of Budgetary Resources:				
Obligations Incurred (Note 18)	$ 1,373,901	$ 477	$ 1,281,722	$ 314
Unobligated Balance, End of Year:				
Apportioned	29,384	-	29,993	40
Exempt from Apportionment	39	-	2,059	-
Unapportioned	8,455	3	9,525	71
Total Unobligated Balance, End of Year	37,878	3	41,577	111
Total Budgetary Resources	$ 1,411,779	$ 480	$ 1,323,299	$ 425
Change in Obligated Balance:				
Unpaid Obligations:				
Unpaid Obligations, Brought Forward, Oct 1	$ 188,654	$ 1,248	$ 180,754	$ 1,602
Obligations Incurred (Note 18)	1,373,901	477	1,281,722	314
Outlays (Gross)	(1,320,306)	(727)	(1,249,330)	(668)
Actual Transfers, unpaid obligations	-	-	106	-
Recoveries of Prior Year Unpaid Obligations	(26,083)	-	(24,598)	-
Unpaid Obligations, End of Year	$ 216,166	$ 998	$ 188,654	$ 1,248
Uncollected Payments:				
Uncollected Customer Payments from Federal Sources, Brought Forward, Oct 1	$ (11,018)	$ (536)	$ (10,103)	$ (1,587)
Adjustment to Uncollected Payments, Federal Sources	-	-	-	-
Change in Uncollected Customer Payments from Federal Sources	(820)	106	(915)	1,051
Uncollected Payments from Federal Sources, End of Year	$ (11,838)	$ (430)	$ (11,018)	$ (536)
Memorandum (non-add) Entries:				
Obligated Balance, Start of Year	$ 177,636	$ 712	$ 170,651	$ 15
Obligated Balance, End of Year	$ 204,328	$ 568	$ 177,636	$ 712
Budget Authority and Outlays, Net:				
Budget Authority, Gross (Discretionary and Mandatory)	$ 1,344,838	$ 431	$ 1,219,142	$ (2,749)
Actual Offsetting Collections (Discretionary and Mandatory)	(23,687)	(315)	(24,812)	(366)
Change in Uncollected Customer Payments from Federal Sources (Discretionary and Mandatory)	(820)	106	(915)	1,051
Budget Authority, Net (Discretionary and Mandatory)	$ 1,320,331	$ 222	$ 1,193,415	$ (2,064)
Outlays, Gross (Discretionary and Mandatory)	$ 1,320,306	$ 727	$ 1,249,330	$ 668
Actual Offsetting Collections (Discretionary and Mandatory)	(23,687)	(315)	(24,812)	(366)
Outlays, Net (Discretionary and Mandatory)	1,296,619	412	1,224,518	302
Distributed Offsetting Receipts	(359,650)	-	(336,655)	-
Agency Outlays, Net (Discretionary and Mandatory)	$ 936,969	$ 412	$ 887,863	$ 302

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 (Unaudited)

75-Year Projection as of January 1, 2014 and Prior Base Years

(in Billions)

	Estimates from Prior Years				
	2014	2013	2012	2011	2010
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 20 and 21)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 8,398	$ 8,147	$ 7,929	$ 7,581	$ 7,216
SMI Part B	17,127	15,227	14,431	13,595	12,688
SMI Part D	5,928	5,871	5,866	6,438	6,355
Have attained eligibility age (age 65 or over)					
HI	332	301	302	262	248
SMI Part B	2,873	2,620	2,395	2,122	1,972
SMI Part D	775	722	694	695	646
Those expected to become participants					
HI	7,812	7,744	7,367	7,260	6,944
SMI Part B	4,311	3,530	3,333	3,223	3,077
SMI Part D	2,609	2,617	2,568	2,817	2,714
All current and future participants					
HI	16,542	16,192	15,598	15,104	14,408
SMI Part B	24,311	21,377	20,159	18,940	17,737
SMI Part D	9,312	9,211	9,128	9,950	9,715
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 20 and 21)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 14,117	$ 14,629	$ 14,919	$ 12,887	$ 12,032
SMI Part B	17,003	15,075	14,303	13,489	12,587
SMI Part D	5,928	5,871	5,866	6,438	6,355
Have attained eligibility age (age 65 and over)					
HI	3,484	3,422	3,369	2,923	2,648
SMI Part B	3,171	2,887	2,646	2,343	2,166
SMI Part D	775	722	694	695	646
Those expected to become participants					
HI	2,764	2,913	2,891	2,546	2,411
SMI Part B	4,137	3,415	3,211	3,108	2,984
SMI Part D	2,609	2,617	2,568	2,817	2,714
All current and future participants:					
HI	20,365	20,963	21,179	18,356	17,090
SMI Part B	24,311	21,377	20,159	18,940	17,737
SMI Part D	9,312	9,211	9,128	9,950	9,715
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 20 and 21)					
HI	$ (3,823)	$ (4,772)	$ (5,581)	$ (3,252)	$ (2,683)
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 20 and 21)					
HI	$ (3,823)	$ (4,772)	$ (5,581)	$ (3,252)	$ (2,683)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Trust Fund assets at start of period					
HI	205	220	244	272	304
SMI Part B	74	66	80	71	76
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 20 and 21)					
HI	$ (3,618)	$ (4,551)	$ (5,337)	$ (2,980)	$ (2,378)
SMI Part B	74	66	80	71	76
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) (Unaudited)

75-Year Projection as of January 1, 2014 and Prior Base Years

(in Billions)

	Estimates from Prior Years				
	2014	2013	2012	2011	2010
Medicare 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)	$ 3,980	$ 3,643	$ 3,391	$ 3,079	$ 2,866
Expenditures	7,430	7,031	6,709	5,961	5,459
Income less expenditures	(3,450)	(3,388)	(3,319)	(2,882)	(2,593)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	31,453	29,244	28,227	27,615	26,259
Expenditures	37,048	35,574	35,088	32,814	30,974
Income less expenditures	(5,595)	(6,330)	(6,861)	(5,199)	(4,715)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(9,045)	(9,718)	(10,180)	(8,081)	(7,308)
Combined Medicare Trust Fund assets at start of period	280	288	325	344	381
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	(8,764)	(9,430)	(9,855)	(7,737)	(6,927)
Future Participants:					
Actuarial present value for the 75-year projection period:					
Income (excluding interest)	14,732	13,891	13,268	13,300	12,735
Expenditures	9,510	8,945	8,669	8,471	8,109
Income less expenditures	5,222	4,946	4,599	4,829	4,626
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(3,823)	(4,772)	(5,581)	(3,252)	(2,683)
Combined Medicare Trust Fund assets at start of period	280	288	325	344	381
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$ (3,542)	$ (4,484)	$ (5,256)	$ (2,908)	$ (2,302)

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 January 1, 2014

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 22)					
As of January 1, 2013	$ 46,779	$ 51,550	$ (4,772)	$ 288	$ (4,484)
Reasons for change					
Change in the valuation period	1,962	2,201	(239)	(19)	(258)
Change in projection base	(98)	(545)	447	12	458
Changes in the demographic assumptions	180	318	(139)	-	(139)
Changes in economic and health care assumptions	1,293	521	772	-	772
Changes in law	50	(57)	108	-	108
Net changes	3,387	2,438	949	(7)	942
As of January 1, 2014	$ 50,166	$ 53,988	$ (3,823)	$ 280	$ (3,542)
HI - Part A (Note 22)					
As of January 1, 2013	$ 16,192	$ 20,963	$ (4,772)	$ 220	$ (4,551)
Reasons for change					
Change in the valuation period	619	858	(239)	(22)	(261)
Change in projection base	123	(323)	447	7	454
Changes in the demographic assumptions	(45)	93	(139)	-	(139)
Changes in economic and health care assumptions	(346)	(1,118)	772	-	772
Changes in law	-	(108)	108	-	108
Net changes	350	(598)	949	(15)	934
As of January 1, 2014	$ 16,542	$ 20,365	$ (3,823)	$ 205	$ (3,618)
SMI - Part B (Note 22)					
As of January 1, 2013	$ 21,377	$ 21,377	$ -	$ 66	$ 66
Reasons for change					
Change in the valuation period	894	894	-	3	3
Change in projection base	(391)	(391)	-	4	4
Changes in the demographic assumptions	(203)	(203)	-	-	-
Changes in economic and health care assumptions	2,638	2,638	-	-	-
Changes in law	(2)	(2)	-	-	-
Net changes	2,935	2,935	-	8	8
As of January 1, 2014	$ 24,311	$ 24,311	$ -	$ 74	$ 74
SMI - Part D (Note 22)					
As of January 1, 2013	$ 9,211	$ 9,211	$ -	$ 1	$ 1
Reasons for change					
Change in the valuation period	450	450	-	-	-
Change in projection base	170	170	-	-	-
Changes in the demographic assumptions	428	428	-	-	-
Changes in economic and health care assumptions	(999)	(999)	-	-	-
Changes in law	53	53	-	-	-
Net changes	102	102	-	-	-
As of January 1, 2014	$ 9,312	$ 9,312	$ -	$ 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 (Continued) (Unaudited)

For the Two Year Period Ending January 1, 2014

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 22)					
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 22)					
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 22)					
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 22)					
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.

NOTES TO THE PRINCIPAL FINANCIAL STATEMENTS

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 11 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:

- Administration for Children and Families (ACF)
- Administration for Community Living (ACL)
- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC) and Agency for Toxic Substances and Disease Registry (ATSDR)
- Centers for Medicare and Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- National Institutes of Health (NIH)
- Office of the Secretary (OS) – excluding the Program Support Center
- Program Support Center (PSC)
- 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's financial records 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. All financial activity related to these allocation transfers is reported in the financial statements of the parent entity, from which the underlying legislative authority, appropriations and budget apportionments are derived.

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.

Under the *Affordable Care Act*, HHS has established a child relationship with the Internal Revenue Service of the Department of Treasury for the payment of the advance premium tax credits and cost-sharing reductions to insurance providers. No financial activity is included in HHS's financial statements.

HHS also receives allocation transfers, as the child, from the Department of Agriculture, Justice and State. HHS allocates funds, as the parent, to the Bureau of Indian Affairs of the Department of Interior and Department of Treasury.

E. Reclassifications and Adjustments

Certain FY 2013 balances have been reclassified to conform to FY 2014 financial statement presentations. The effects are immaterial.

F. Funds from Dedicated Collections

Generally, funds from dedicated collections are financed by specifically identified revenues, provided to the government by non-federal sources, often supplemented by other financing sources, which remain available over time. Dedicated collections must meet the following criteria:

1. 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;
2. Explicit authority for the fund 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
3. A requirement to account for and report on the receipt, use and retention of the revenues and/or other financing sources that distinguishes the dedicated collections from the Federal Government's general revenues.

HHS's 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 IRS, 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 Prescription Drug Benefit – Part D. The program 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 Fee-for-Service (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 two programs with borrowing authority: the CMS Consumer Operated and Oriented Plan (CO-OP) Loan Program and the Health Center Loan Program.

1. **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.
2. **Loan Guarantees.** HHS administers guaranteed loans under the Health Center Loan Program. Loans receivable represent defaulted guaranteed loans which have been paid to lenders and also include interest due to HHS on the defaulted loans. The liability for loan guarantees is valued at the present value of the cash outflows from HHS less the present value of related inflows.

HHS reports loans in accordance with the *Federal Credit Reform Act*. Budgetary related activity is reported separately within the Combined Statement of Budgetary Resources.

As of June 30, 2014, the assets and liabilities of the Health Education Assistance Loan (HEAL) program were transferred to the Department of Education under section 525 of Division H of the *Consolidated Appropriations Act*, 2014 (Public Law 113-76).

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's 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's 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 United States, 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. 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 IRS 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 Securities 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's 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 (SSF) 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.

HHS has commitments under various operating leases with private entities and General Services Administration (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.

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's 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's 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's 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. 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.

U. Entitlement Benefits Due and Payable

Entitlement Benefits Due and Payable represents a liability for Medicare, Medicaid and CHIP 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 and CHIP

The Medicaid and Children's Health Insurance Program (CHIP) 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.

V. 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.

W. 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.

HHS has no material obligations related to cancelled appropriations for which we have a contractual commitment for payment or for contractual arrangements which many require future financial obligations.

X. Statement of Social Insurance

The Statement of Social Insurance 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 Statement of Social Insurance actuarial projections are drawn from the *Social Security and Medicare Trustees Reports for 2014*. 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.

Y. *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.

The *Affordable Care Act* contains the most significant changes to health care coverage since the passing of the *Social Security Act*. The *Affordable Care Act* provided funding for the establishment by CMS of a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. It also allowed for the establishment of a Center for Consumer Information and Insurance Oversight (CCIIO). The programs under CCIIO

include: Affordable Insurance Marketplaces (the "Marketplace") and the CO-OP program. A brief description of these programs and their impact on the financial statement is presented below.

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, 2014, HHS awarded about $5.1 billion in cumulative Marketplace grants to states, including Establishment grants to 37 states and the District of Columbia. All Marketplaces launched open enrollment on October 1, 2013.

To help make health insurance more affordable to consumers, HHS makes payments of advance premium tax credits (APTC) and cost-sharing reductions (CSR) to health insurance issuers on behalf of consumers who are eligible for financial assistance. APTC and CSR payments (which are included in the Internal Revenue Service financial statements; see Note 1) are a critical component of the Marketplace, and $30 billion has been allocated for these payments. In addition to these payments on behalf of consumers, HHS collects Marketplace user fees from issuers participating in the Federally-facilitated Marketplace (FFM).

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. CO-OP Program loans have been awarded in 24 states.

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

	2014	2013
Non-Entity Intragovernmental Assets		
Fund Balance with Treasury	$ 8	$ -
Accounts Receivable	-	11
Total Non-Entity Intragovernmental Assets	8	11
Accounts Receivable With the Public	20	30
Total Non-Entity Assets	28	41
Total Entity Assets	482,287	470,214
Total Assets	$ 482,315	$ 470,255

Note 3. Fund Balance with Treasury (in Millions)

Fund Balance with Treasury	2014	2013
Trust Funds	$ 19,551	$ 9,916
Revolving Funds	1,275	1,263
Appropriated Funds	155,736	147,547
Other Funds	396	466
Total	$ 176,958	$ 159,192

Status of Fund Balance with Treasury		
Unobligated Balance		
Available	$ 29,423	$ 32,092
Unavailable	8,458	9,596
Obligated Balance not yet Disbursed	204,896	178,348
Non-Budgetary Fund Balance with Treasury	(65,819)	(60,844)
Total	$ 176,958	$ 159,192

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 $12.4 billion and $13.0 billion as of September 30, 2014 and 2013, respectively. The restricted amount is primarily for the *Affordable Care Act* programs, CHIP, CMS Program Management, State Grants and Demonstrations and the Recovery Act Health Information Technology Program. In FY 2014, HHS received $21.6 billion in apportioned under the *Affordable Care Act*, of which $8.3 billion is restricted for future use.

The Non-Budgetary FBwT negative balances reported for September 30, 2014 and 2013 are primarily due to CMS Medicare Trust Funds temporarily precluded from obligation.

Note 4. Investments, Net (in Millions)

2014	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 270,598	$ -	$ 2,688	$ 273,286	$ 273,286
Non-Marketable: Market-Based	5,779	(193)	28	5,614	5,614
Total, Intragovernmental	$ 276,377	$ (193)	$ 2,716	$ 278,900	$ 278,900

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

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, 2016 through June 30, 2029, with interest rates ranging from 2.25 percent to 5.625 percent. Medicare Non-Marketable: Par Value Certificates of Indebtedness mature on June 30, 2015, with an interest rate of 2.125 percent to 2.375 percent.

Securities held by the Vaccine Injury Compensation Trust Fund (funds from dedicated collections) will mature through fiscal year 2020. The Market-Based Notes paid from 1.0 percent to 4.125 percent during October 1, 2013 to September 30, 2014 and 1.0 percent to 4.125 percent during October 1, 2012 to September 30, 2013. The Market-Based Bonds pay 9.125 percent through FY 2018.

The Market-Based Securities held in the NIH gift funds during the fiscal year ended September 30, 2014, yielded from 0.015 percent to 0.095 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, 2014, 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)

2014	Accounts Receivable Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Net HHS Receivables
Intragovernmental					
Entity	$ 919	$ -	$ 919	$ -	$ 919
Non-Entity	-	-	-	-	-
Total, Intragovernmental	$ 919	$ -	$ 919	$ -	$ 919
With the Public					
Entity					
Medicare	$ 7,881	$ -	$ 7,881	$ (1,649)	$ 6,232
Other	5,558	7	5,565	(1,658)	3,907
Non-Entity	-	40	40	(20)	20
Total With the Public	$ 13,439	$ 47	$ 13,486	$ (3,327)	$ 10,159

2013	Accounts Receivable Principal	Interest 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	4,582	13	4,595	(908)	3,687
Non-Entity	52	2	54	(24)	30
Total With the Public	$ 13,445	$ 15	$ 13,460	$ (2,527)	$ 10,933

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

	2014	2013
Inventory Held for Current Sale, Net	$ 8	$ 8
Operating Materials and Supplies Held for Use	120	113
Stockpile Materials Held for Emergency or Contingency	8,478	8,481
Inventory and Related Property, Net	$ 8,606	$ 8,602

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

			2014		
	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	$ 53	$ -	$ 53
Construction in Progress	-	-	549	-	549
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	6,122	(2,615)	3,507
Equipment	Straight Line	3-20 Yrs	1,858	(1,149)	709
Internal Use Software	Straight Line	7-10 Yrs	1,827	(860)	967
Assets Under Capital Lease	Straight Line	1-30 Yrs	119	(55)	64
Leasehold Improvements	Straight Line	*Life of Lease	51	(32)	19
Totals			$ 10,579	$ (4,711)	$ 5,868

			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	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

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

Note 8. Other Assets (in Millions)

	2014	2013
Intragovernmental		
Advances to Other Federal Entities	$ 95	$ 103
With the Public		
Other Prepayments & Deferred Charges	21	33
Direct Loan	769	644
Other	20	12
Total With the Public	$ 810	$ 689

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

	2014	2013
Intragovernmental		
Accrued Payroll and Benefits	$ 60	$ 63
Other	748	174
Total Intragovernmental	$ 808	$ 237
Federal Employee and Veterans' Benefits (Note 11)	11,979	11,566
Accrued Payroll and Benefits	620	603
Contingencies and Commitments (Note 14)	11,332	8,900
Other	152	165
Total Liabilities Not Covered by Budgetary Resources	$ 24,891	$ 21,471
Total Liabilities Covered by Budgetary Resources	99,250	86,038
Total Liabilities	$ 124,141	$ 107,509

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

	2014	2013
Medicare FFS	$ 41,311	$ 38,729
Medicare Advantage/Prescription Drug Program	16,280	9,885
Medicaid	32,275	27,588
CHIP	923	693
Other	248	382
Totals	$ 91,037	$ 77,277

Entitlement Benefits Due and Payable represents a liability for Medicare FFS, Medicare Advantage and the Prescription Drug Program, Medicaid, and CHIP owed to the public for medical services/claims IBNR as of the end of the reporting period.

The Medicare FFS benefits payable liability is primarily an actuarial liability which represents (a) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment, (b) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (c) checks that have been issued by the Medicare contractors in payment of a claim and

that have not yet been cashed by payees, (d) periodic interim payments for services rendered in the current fiscal year but paid in the subsequent fiscal year, and (e) an estimate of retroactive settlements of cost reports. The September 30, 2014 and 2013 estimate also includes amounts which may be due/owed to providers for previous years' disputed cost report adjustments for disproportionate share hospitals and teaching hospitals as well as amounts which may be due/owed to hospitals for adjusted prospective payments.

The Medicare Advantage and Prescription Drug program liability represents amounts owed to plans after the completion of the Prescription Drug payment reconciliation and estimates relating to risk and other payment related adjustments including the estimate for the first nine months of calendar year 2014. In addition, it includes an estimate of payments to plan sponsors of retiree prescription drug coverage incurred but not yet paid as of September 30, 2014.

The Medicaid and CHIP estimates represent the net federal share of expenses that have been incurred by the states but not yet reported to CMS.

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

	2014	2013
With the Public		
Liabilities Not Covered by Budgetary Resources		
PHS Commissioned Corp Pension Liability	$ 11,154	$ 10,712
PHS Commissioned Corp Post-retirement Health Benefits	537	561
Workers' Compensation Benefits (Actuarial FECA Liability)	288	293
Total, Federal Employee and Veterans' Benefits	$ 11,979	$ 11,566

Public Health Service (PHS) Commissioned Corps

HHS administers the PHS Commissioned Corps Retirement System for 6,760 active duty officers and 6,466 retiree annuitants and survivors. As of September 30, 2014, the actuarial accrued liability for the retirement benefit plan was $11.2 billion and $0.5 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, 2014 and 2013, were:

	2014	2013
Interest on federal securities	4.65 percent	4.68 percent
Annual basic pay scale increase	2.93 percent	2.90 percent
Annual inflation	2.43 percent	2.40 percent

The following shows key valuation results as of September 30, 2014 and 2013, 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, 2014 and actuarial assumptions. The September 30, 2014 valuation includes an increase in liabilities of $418 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.

	2014	2013
Beginning Liability Balance	$ 11,273	$ 10,734
Expense		
Normal Cost	274	263
Interest on the liability balance	517	491
Actuarial (Gain)/Loss		
From experience	(63)	(18)
From assumption changes		
Change in discount rate assumption	2	282
Change in inflation/salary increase assumption	44	(29)
Change in Others	99	(5)
Net Actuarial (Gain)/Loss	82	230
Total expense	$ 873	$ 984
Less amounts paid	(455)	(445)
Ending Liability Balance	$ 11,691	$ 11,273

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 2014, 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 2014, projected annual payments were discounted to present value based on OMB's interest rate assumptions which were interpolated to reflect the average duration in year for income payments and medical payments. In FY 2013 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, 2014 and 2013 appear below.

	2014	2013
Wage Benefits	3.455% in Year 1 3.455% in Year 2 and thereafter	2.727% in Year 1 3.127% in Year 2 and thereafter
Medical Benefits	2.855% in Year 1 2.855% in Year 2 and thereafter	2.334% in Year 1 2.860% 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
2014	N/A	N/A
2015	1.73%	2.93%
2016	2.17%	3.76%
2017	2.13%	3.86%
2018	2.23%	3.90%
2019	2.30%	3.90%

Note 12. Accrued Grant Liability (in Millions)

	2014	2013
Estimated Accrual for Amounts Due to Grantees	$ 21,641	$ 22,410
Offsetting Grant Advances	(18,327)	(18,461)
Net Accrued Grant Liability	$ 3,314	$ 3,949

Note 13. Other Liabilities (in Millions)

	2014		2013	
	Intra-governmental	With the Public	Intra-governmental	With the Public
Accrued Payroll & Benefits	$ 109	$ 918	$ 101	$ 983
Advances from Others	339	106	360	98
Deferred Revenue	-	483	-	445
Custodial Liabilities	934	15	930	18
Legal Liabilities (Note 14)	707	-	106	-
Other	933	979	512	1,037
Total Other Liabilities	$ 3,022	$ 2,501	$ 2,009	$ 2,581

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 and State Plan Amendments

The Medicaid amount of $8.5 billion ($6.1 billion in FY 2013) consists of Medicaid audit and program disallowances of $2.9 billion ($3.0 billion in FY 2013) and of $5.6 billion ($3.1 billion in FY 2013) 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 9,311 cases (7,124 in FY 2013) remaining on appeal as of September 30, 2014. In FY 2014, a total of 4,400 new cases were filed (3,907 in FY 2013) and 12 cases were reopened (9 in FY 2013). The PRRB rendered decisions on 73 cases in FY 2014 (210 in FY 2013); and 2,152 additional cases (1,623 in FY 2013) 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.

Note 15. Revenue (in Millions)

2014 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	$ 158	$ 7,059	$ 1,052	$ 87	$ 8,356	$ (2,935)	$ 5,421
Exchange Revenue	(53)	(3,555)	(16)	(12)	(3,636)	2,741	(895)
Net Cost, *Intragovernmental*	105	3,504	1,036	75	4,720	(194)	4,526
With the Public							
Gross Cost	13,025	385,456	589,581	37,583	1,025,645	-	1,025,645
Exchange Revenue	-	(5,607)	(72,551)	(31)	(78,189)	-	(78,189)
Net Cost, *With the Public*	13,025	379,849	517,030	37,552	947,456	-	947,456
Total Gross Cost	13,183	392,515	590,633	37,670	1,034,001	(2,935)	1,031,066
Total Exchange Revenue	(53)	(9,162)	(72,567)	(43)	(81,825)	2,741	(79,084)
Total Net Cost of Operations	$ 13,130	$ 383,353	$ 518,066	$ 37,627	$ 952,176	$ (194)	$ 951,982

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

Exchange Revenue

HHS recognizes its revenue from exchange transactions when goods and services are provided. Total exchange revenue was $79.1 billion and $73.7 billion through September 30, 2014 and 2013, respectively. HHS's 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 16. Legal Arrangements Affecting Use of Unobligated Balances

The unobligated balances at year end on the 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 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 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 $225.0 billion as of September 30, 2014, ($245.0 billion in FY 2013) are included in Investments on the Balance Sheets.

Note 17. 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 2014, has not been published, therefore, no comparisons can be made between FY 2014 amounts presented in the Statement of Budgetary Resources with amounts reported in the Actual column of the *President's Budget*. The FY 2016 *President's Budget* is expected to be released in February 2015 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 2013 column on the Statement of Budgetary Resources to the actual amounts for FY 2013 from the Appendix in the FY 2015 *President's Budget* for budgetary resources, obligations incurred, offsetting receipts and net outlays (gross outlays less offsetting collections) as presented below.

2013	Budgetary Resources	Obligations Incurred	Distributed Offsetting Receipts	Net Outlays (Gross Outlays less Offsetting Collections)
Statement of Budgetary Resources	$ 1,323,724	$ 1,282,036	$ 336,655	$ 1,224,820
Expired Accounts	(8,985)	39	-	-
Other	(561)	29	372	(131)
Budget of the U.S. Government	$ 1,314,178	$ 1,282,104	$ 337,027	$ 1,224,689

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 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 includes an adjustments made to reclassify recoveries. In addition, sequestration was not reported in the HHS Statement of Budgetary Resources for the Federal Hospital Insurance Trust Fund but was included in the *President's Budget*.

The Other differences in the offsetting receipts consist primarily of adjustments made by NIH 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 General Fund Proprietary Receipts and Intra-Departmental Delegation of Authority (IDDA) in the Combined Statement of Budgetary Resources.

Lastly, the Other differences in the net outlays include outlays reported on the HHS's 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 18. Apportionment Categories of Obligations Incurred and Undelivered Orders (in Millions)

	2014		
	Direct	Reimbursable	Total
Category A (Distributed by Quarter)	$ 94,625	$ 8,084	$ 102,709
Category B (Restricted and Distributed by Activity)	628,534	3,004	631,538
Exempt from Apportionment	640,113	18	640,131
Total Obligations Incurred	$ 1,363,272	$ 11,106	$ 1,374,378

	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

Obligations incurred consist of expended authority and the change in undelivered orders. OMB has exempted CMS from the 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 $117.0 billion of budgetary resources obligated for undelivered orders as of September 30, 2014 and $93.3 billion as of September 30, 2013.

Note 19. 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 on the next page. 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 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 funds from dedicated collections financial statement balances are shown below.

	2014		
Consolidated Balance Sheet as of September 30	Medicare	Other	Total
Fund Balance with Treasury	$ 19,189	$ 3,581	$ 22,770
Investments	273,286	3,513	276,799
Other Assets	7,225	221	7,446
Total Assets	$ 299,700	$ 7,315	$ 307,015
Entitlement Benefits Due and Payable	$ 57,591	$ -	$ 57,591
Other Liabilities	4,999	659	5,658
Total Liabilities	$ 62,590	$ 659	$ 63,249
Unexpended Appropriations	16,315	(100)	16,215
Cumulative Results of Operations	220,795	6,756	227,551
Total Liabilities and Net Position	$ 299,700	$ 7,315	$ 307,015
Consolidated Statement of Net Cost for the Period Ended September 30			
Gross Program Costs	$ 590,633	$ 1,109	$ 591,742
Less: Exchange Revenues	72,567	2,655	75,222
Net Cost of Operations	$ 518,066	$ (1,546)	$ 516,520
Consolidated Statement of Changes in Net Position for the Period Ended September 30			
Net Position Beginning of Period	$ 242,714	$ 5,751	$ 248,465
Non-Exchange Revenue	242,701	307	243,008
Other Financing Sources	269,761	(948)	268,813
Net Cost of Operations	(518,066)	1,546	(516,520)
Change in Net Position	$ (5,604)	$ 905	$ (4,699)
Net Position End of Period	$ 237,110	$ 6,656	$ 243,766

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

Note 20. Statement of Social Insurance (Unaudited)

The Statement of Social Insurance presents, for the 75-year projection period, the present values of the income and expenditures of the HI and SMI trust funds for both the open group and closed group of participants. The open group consists of 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. The closed group comprises only current participants—those who attain age 15 or older in the first year of the projection period.

Actuarial present values are computed under the intermediate set of assumptions specified *Annual Report of the Medicare Board of Trustees*. These assumptions represent the Trustees' reasonable 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.

As noted in the Trustees Report, the basis for the Part B projections has changed since last year. The scheduled reductions under the sustainable growth rate (SGR) formula for updating the physician fee schedule have been

overridden by lawmakers each year beginning with 2003. Current law requires CMS to implement a reduction in Medicare payment rates for physician services of an estimated 20.8 percent in April 2015. However, it is a virtual certainty that lawmakers will override this reduction as they have for every year starting with 2003. For this reason, the income, expenditures, and assets for Part B reflect the Trustees' *projected baseline* scenario, which includes an override of the provisions of the SGR and an assumed annual increase in the physician fee schedule equal to the average SGR override over the 10-year period ending with March 31, 2015.

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 July 28, 2014 but also reflect the nearly certain override of the physician fee reductions scheduled under current law. 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 Statement of Social Insurance 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 Statement of Social Insurance 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 Statement of Social Insurance also presents the net present values of future net cash flows, which are calculated by subtracting the actuarial present value of estimated future expenditures from the actuarial present value of estimated 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 Statement of Social Insurance also sets forth the same calculation for the closed group of participants. The closed group 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 estimated future income over estimated 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 estimated 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 inherently uncertain factors and by the application of future payment updates. Consequently, Medicare's actual cost over time, especially for periods as long as 75 years, cannot be predicted with certainty and could differ materially from the projections shown in the Statement of Social Insurance. Moreover, these differences could affect the long-term sustainability of this social insurance program.

To develop 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 Trustees' projected baseline scenario. 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 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 following table includes the most significant underlying assumptions used in the projections of Medicare spending displayed in this section. The assumptions underlying the 2014 Statement of Social Insurance actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2014. 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 below 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 2014

					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]
2014	1.91	1,345,000	779.8	2.18	3.78	1.61	3.1	−2.9	3.4	0.2	0.3
2020	2.06	1,350,000	730.2	1.42	4.12	2.70	2.6	4.0	5.6	6.3	2.7
2030	2.03	1,160,000	667.6	1.24	3.94	2.70	2.1	4.5	5.1	5.3	2.9
2040	2.00	1,105,000	614.6	1.15	3.85	2.70	2.2	5.2	4.9	5.2	2.9
2050	2.00	1,085,000	568.1	1.11	3.81	2.70	2.1	4.1	4.5	5.0	2.9
2060	2.00	1,070,000	527.1	1.10	3.80	2.70	2.1	3.8	4.3	4.7	2.9
2070	2.00	1,065,000	490.8	1.09	3.79	2.70	2.1	4.0	4.2	4.6	2.9
2080	2.00	1,060,000	458.4	1.13	3.83	2.70	2.1	3.8	4.1	4.4	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 4 years, based on the intermediate assumptions of the respective Medicare Trustees Reports, are summarized in Table 2 below.

Table 2: Significant Ultimate Assumptions Used for the Statement of Social Insurance, FY 2014-2010

					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 2014	2.0	1,060,000	458.4	1.13	3.83	2.7	2.1	3.8	4.1	4.4	2.9
FY 2013	2.0	1,055,000	419.8	1.13	3.93	2.8	2.1	3.8	3.8	4.5	2.9
FY 2012	2.0	1,030,000	446.0	1.12	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

[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.

Note 21. Alternative SOSI Projections (Unaudited)

As mentioned previously, the Statement of Social Insurance projections reflect a projected baseline scenario, which includes an override of the SGR formula for updating physician payment rates. This scenario also assumes that the various cost-reduction measures—the most important of which are the reductions in the annual payment rate updates for most categories of Medicare providers by the growth in economy-wide multifactor productivity—will occur as the *Affordable Care Act* requires. The Board of Trustees believes that this outcome is achievable if health care providers are able to realize productivity improvements at a faster rate than experienced historically. The ability of health care providers to sustain these price reductions will be challenging, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time.

Absent an unprecedented change in health care delivery systems and payment mechanisms, the prices paid by Medicare for health services will fall increasingly short of the costs of providing these services. By the end of the long-range projection period, Medicare prices for many services would be less than half of their level without consideration of the productivity price reductions. Before such an outcome would occur, lawmakers would likely intervene to prevent the withdrawal of providers from the Medicare market and the severe problems with beneficiary access to care that would result. Overriding the productivity adjustments, as lawmakers have done

repeatedly in the case of physician payment rates, would lead to substantially higher costs for Medicare in the long range than those projected in this report.

To help illustrate and quantify the potential magnitude of the cost understatement, the Trustees asked the Office of the Actuary at CMS to prepare an illustrative Medicare trust fund projection under a hypothetical alternative that assumes that, starting in 2020, the economy-wide productivity adjustments gradually phase down to 0.4 percent.[4] This alternative was developed for illustrative purposes only; the calculations have not been audited; no endorsement of the policies underlying the illustrative alternative 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 under Medicare and of the broad range of uncertainty associated with such impacts.

The table below contains a comparison of the Medicare 75-year present values of estimated future income and estimated future expenditures under the projected baseline with those under current law—including the almost 21-percent scheduled reduction in physician payment rates under the SGR formula—and the illustrative alternative scenario.

Medicare Present Values

(in Billions)

	Projected baseline (Unaudited)	Current law (Unaudited)	Alternative scenario[1, 2] (Unaudited)
Income			
Part A	$16,542	$16,542	$16,550
Part B	24,311	21,847	27,286
Part D	9,312	9,327	9,440
Expenditures			
Part A	20,365	20,396	24,848
Part B	24,311	21,847	27,286
Part D	9,312	9,327	9,440
Income less expenditures			
Part A	(3,823)	(3,854)	(8,297)
Part B	0	0	0
Part D	0	0	0

[1]These amounts are not presented in the 2014 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 both from the projected baseline emphasized throughout the 2014 Trustees Report and from current law. No endorsement of the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred.

As expected, the projected baseline and current-law projections differ most markedly for Part B, since the physician fee reductions do not affect Part A and Part D directly.[5] The present values of estimated future income and expenditures under current law are roughly 10 percent lower than under the projected baseline projections.

[4]The Trustees have used this approach since 2007 to address concerns with the SGR provision. Starting with the 2010 annual report, following enactment of the *Affordable Care Act*, the illustrative alternative projections have included changes to the productivity adjustments.
[5]The differences between the projected baseline and current law for Parts A and D are the result of (1) changes in the operations of the Independent Payment Advisory Board (IPAB) due to modifications in the Part B projections; and (2) slight changes to the discount rates.

The difference between the projected baseline and illustrative alternative projections is substantial for Parts A and B. All Part A fee-for-service providers and roughly half of Part B fee-for-service providers are affected by the productivity adjustments, so the projected baseline and current-law projections reflect an estimated 1.1-percent reduction in annual cost growth each year. If the productivity adjustments were gradually phased out, as illustrated under the alternative scenario, the estimated present value of Part A and Part B expenditures would be higher than the projected baseline projections by roughly 22 percent and 12 percent, respectively. As indicated above, the present value of Part A income is basically unaffected under the alternative scenario; and the present value of Part B income is also 12 percent higher under the illustrative alternative scenario, since income is set each year to mirror expenditures.

The Part D values are similar under each projection because the services are not affected 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 amounts due to changes to the productivity adjustments depends on what specific changes might be legislated and whether Congress would pass further provisions to help offset such costs. As noted, these examples reflect only hypothetical changes to provider payment rates.

Note 22. Statement of Changes in Social Insurance Amounts (Unaudited)

The Statement of Changes in Social Insurance Amounts reconciles the change (between the current valuation and the prior valuation) in the (1) present value of estimated future income (excluding interest) for current and future participants; (2) present value of estimated future expenditures for current and future participants; (3) present value of estimated future noninterest income less estimated 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 estimated future noninterest income less estimated 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 in Social Insurance Amounts shows the reconciliation from the period beginning on January 1, 2013 to the period beginning on January 1, 2014, and the reconciliation from the period beginning on January 1, 2012 to the period beginning on January 1, 2013. 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 future expenditures has the same effect on estimated total future income, and vice versa. Therefore, any change has no impact on the estimated future net cashflow. In order to enhance the presentation, the changes in the present values of estimated future income and estimated future expenditures are presented separately.

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

- change in the valuation period,
- change in projection base,
- changes in the demographic assumptions,
- changes in economic and health care assumptions, and
- 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 20 summarizes these assumptions for the current year.

Period beginning on January 1, 2013 and ending January 1, 2014

Present values as of January 1, 2013 are calculated using interest rates from the intermediate assumptions of the 2013 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2014. 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 2013 Trustees Report. Since interest rates are economic assumptions, the estimates of the present values of changes in economic and health care assumptions are presented using the interest rates under the intermediate assumptions of the 2014 Trustees Report.

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 and health care assumptions are presented using the interest rates under the intermediate assumptions of the 2013 Trustees Report.

Change in the Valuation Period

Period beginning on January 1, 2013 and ending January 1, 2014

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2013-87) to the current valuation period (2014-88) 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 2013 and replaces it with a much larger negative net cashflow for 2088. The present value of estimated 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 2013-87 to 2014-88. 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 2013 are realized. The change in valuation period decreased the level of assets in the combined Medicare Trust Funds.

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 estimated 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.

Change in Projection Base

Period beginning on January 1, 2013 and ending January 1, 2014

Actual income and expenditures in 2013 were different than what was anticipated when the 2013 Trustees Report projections were prepared. Part A income was slightly higher 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 higher on an incurred basis than prior estimates. The net impact of the Part A, B, and D projection base changes is an increase in the estimated future net cashflow. Actual experience of the Medicare Trust Funds between January 1, 2013 and January 1, 2014 is incorporated in the current valuation and is slightly more than projected in the prior valuation.

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 estimated 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.

Changes in the Demographic Assumptions

Period beginning on January 1, 2013 and ending January 1, 2014

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 SSA.

The ultimate demographic assumptions for the current valuation (beginning on January 1, 2014) 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.

- Preliminary birth rate data for 2012 indicated lower birth rates 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.

There was one change in demographic methodology:

The modeling of the other immigrant population was divided into three distinct groups for the current valuation: (1) those with temporary legal status; (2) those never authorized to be in the country; and (3) those who had temporary legal status previously but are no longer authorized to be in the country.

These changes slightly lowered overall Medicare enrollment for the current valuation period resulting in a decrease in the estimated future net cashflow, and had a very minor impact on the present value of estimated income and estimated expenditures for Part A, Part B, and Part D.

A further assumption change was made that resulted in higher Part D enrollment for the current valuation period. The participation rate represents the percentage of beneficiaries assumed to enroll in a Part D plan out of all eligible and, in prior years, was assumed to stay relatively constant at the same rate as the recent historical period. However, since actual participation has consistently been higher than expected, it was decided to increase the participation rate by 1 percent per year for the first 3 years of the projection period, before leveling out. This results in an assumed 62.4 percent participation rate, prior to adjustments for beneficiaries who have retiree drug subsidy coverage and those who are assumed to drop out because they are required to pay an income-related premium, for 2017 and later, which is higher than the 57.2 percent that was assumed for all years in the prior valuation period. This assumption change resulted in an increase in the present value of estimated future income and estimated future expenditures for Part D, and had no impact on the Part A and Part B present values.

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 OASDI and are prepared by the Office of the Chief Actuary at 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 1.0 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 estimated 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 estimated future expenditures, and also estimated future income because of the financing mechanism in place for both.

Changes in Economic and Health Care Assumptions

Period beginning on January 1, 2013 and ending January 1, 2014

The economic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

For the current valuation (beginning on January 1, 2014), there was one change to the ultimate economic assumptions:

The ultimate annual rate of change in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) is assumed to be 2.7 percent per year in the current valuation period, compared to 2.8 percent per year in the previous valuation period. Lowering the ultimate average annual increase in the CPI-W makes it more comparable to recent historical annual increases.

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

The ratio of average taxable earnings to the average wage index is lower by 1.9 percent in 2012 and 1.5 percent in 2013, compared to the previous valuation period.

There were two main changes in the economic methodology:

- Projected labor force participation rates for the older population are slightly lower for the current valuation in order to better reflect the difference in participation rates between never-married and married populations and the projected improvement in life expectancy.
- Different earnings levels are assigned to the three distinct groups of the other immigrant population supplied by demography. (This change decreased the present value of future cashflows by about the same amount as the related change in the demography methodology increased the present value of future cashflows.)

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

- The projections emphasized in the 2014 Medicare Trustees Report were changed to reflect the projected baseline scenario. This scenario assumes that the physician payment updates required under the current-law sustainable growth rate formula will be permanently overridden by lawmakers. The use of these projections increases the present value of estimated future expenditures, compared to the current law projections, for Part B by roughly 11 percent, and for total Medicare by about 5 percent.
- Utilization rate assumptions for inpatient hospital services were decreased.
- Case mix increase assumptions for skilled nursing facilities and home health agencies were decreased.
- Market basket differential for skilled nursing facilities was lowered.
- Higher assumed enrollment in Medicare Advantage plans where benefits are more costly.
- Higher increases in productivity rates, resulting in lower payment updates.
- The methodology used to transition from the short-range projections to the long-range projections was refined, resulting in smaller increases during this transition period.
- Lower projected prescription drug trend rates.
- Higher assumed rebates from drug manufacturers.

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

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 OASDI and are prepared by the Office of the Chief Actuary at the 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 estimated future net cashflow for total Medicare. For Part A, these changes resulted in a decrease to the present value of estimated future expenditures and income, with an overall slight increase in the estimated future net cashflow. For Part B, these changes increased the present value of estimated future expenditures (and also income). On the other hand, the above-mentioned changes lowered the present value of estimated future expenditures (and also income) for Part D.

Changes in Law

Period beginning on January 1, 2013 and ending January 1, 2014
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 estimated future income, expenditures, and net cashflow. The Continuing Appropriations Resolution of 2014 included several provisions that had an impact on the Medicare program, including a 0.5 percent physician payment update for January through March of 2014, extension of the Medicare sequester to FY 2022 and 2023, and payment reform for long-term care hospitals. Further, sections 1 and 3 of Public Law 113-82 included a further extension of the Medicare sequester to FY 2024. Lastly, the Protecting Access to Medicare Act of 2014 extended the 0.5 percent physician update through December 2014, enacted a 0 percent update for January through March of 2015, improved payment policy for clinical diagnostic lab tests, made revisions to the end-stage renal disease (ESRD) prospective payment system and physician fee schedule, and realigned the Medicare sequester in FY 2024. Overall these provisions resulted in an increase in the

estimated future net cashflow for total Medicare. For Part A, these changes resulted in an increase to the present value of estimated future expenditures, with an overall increase in the estimated future net cashflow. For Part B, these changes lowered the present value of estimated future expenditures (and also income) only very slightly. For Part D, the above-mentioned changes increased the present value of estimated future expenditures (and also income) also very slightly.

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 0 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 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 estimated future expenditures and increases the present value of Part D estimated future 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 estimated future expenditures.

Note 23. Reconciliation of Net Cost of Operations (Proprietary) to Budget (in Millions)

	2014	2013
Resources Used to Finance Activities:		
Budgetary Resources Obligated		
Obligations Incurred	$ 1,374,378	$ 1,282,036
Spending Authority from Offsetting Collections and Recoveries	(50,799)	(49,640)
Obligations Net of Offsetting Collections and Recoveries	1,323,579	1,232,396
Distributed Offsetting Receipts	(359,650)	(336,655)
Net Obligations	$ 963,929	$ 895,741
Other Resources		
Net Non-Budgetary Resources Used to Finance Activities	(445)	58
Total Resources Used to Finance Activities	$ 963,484	$ 895,799
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	$ 21,765	$ (3,623)
Resources That Fund Expenses Recognized in Prior Periods	33	54
Budgetary Offsetting Collections and Receipts That Do Not Affect Net Cost of Operations	(6,715)	(1,202)
Resources That Finance the Acquisition of Assets or Liquidations of Liabilities	1,389	1,314
Other Resources or Adjustments to Net Obligated Resources That Do Not Affect Net Cost of Operations	3,114	7,089
Total Resources Used to Finance Items Not Part of the Net Cost of Operations	19,586	3,632
Total Resources Used to Finance the Net Cost of Operations	$ 943,898	$ 892,167
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	$ 3,399	$ 2,495
Components Not Requiring or Generating Resources	4,685	1,588
Total Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period	8,084	4,083
Net Cost of Operations	$ 951,982	$ 896,250

REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

Investment in Human Capital (in Millions)

For the Year Ended September 30, 2014

Responsibility Segment Program	2014	2013	2012	2011	2010
Administration for Children and Families					
Administration for Intellectual and Developmental Disabilities	$ -	$ 6	$ 6	$ 11	$ 9
Administration for Community Living					
Administration for Intellectual and Developmental Disabilities	8	-	-	-	-
Health Resources and Services Administration					
Scholarships Loan Repayments and Loans	660	766	705	761	691
National Institutes of Health					
Research Training and Career Development	1,541	1,621	1,858	1,920	1,915
Totals	$ 2,209	$ 2,393	$ 2,569	$ 2,692	$ 2,615

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. The following operating divisions conduct education and training programs under this category:

Administration for Children and Families

While previously administered by the ACF, the Administration for Intellectual and Developmental Disabilities (AIDD) program was transferred to ACL as part of a 2012 reorganization. Funding for this and other AIDD programs is no longer reported by ACF and is administered solely by ACL as of FY 2014.

Administration for Community Living

Projects of National Significance (PNS) grants are awarded to public and 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. Under AIDD, as of September 30, 2014, 27 grants have been awarded for FY 2014. Grants awarded total $7.5 million as of September 30, 2014.

Health Resources and Services Administration

Under Clinician Recruitment and Service, the National Health Service Corps (NHSC) is a network of 9,200 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 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, 2014

Responsibility Segments	Basic	Applied	Develop-mental	2014 Total	2013	2012	2011	2010	Grand Total
ACF	$ -	$ 3	$ -	$ 3	$ 1	$ 2	$ 7	$ 9	$ 22
AHRQ	-	250	-	250	372	401	333	263	1,619
CDC	60	306	28	394	457	408	457	465	2,181
FDA	96	-	7	103	94	80	58	48	383
NIH	16,631	11,088	-	27,719	29,328	30,681	32,902	31,342	151,972
Totals	$ 16,787	$ 11,647	$ 35	$ 28,469	$ 30,252	$ 31,572	$ 33,757	$ 32,127	$ 156,177

The research and development programs in HHS include the following:

Administration for Children and Families (ACF)

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)

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 (CDC)

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)

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 U.S.).

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 (NIH)

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)

For the Year Ended September 30, 2014

Budgetary Resources:	CMS Medicare HI	CMS Medicare SMI	CMS Medicaid	Other Agency Budgetary Accounts[1]	Agency Combined Budgetary Totals	Non-Budgetary Credit Reform Financing Account
Unobligated Balance, Brought Forward, Oct 1	$ -	$ -	$ 2,282	$ 39,295	$ 41,577	$ 111
Recoveries of Prior Year Unpaid Obligations	777	2	21,569	3,735	26,083	-
Other Changes in Unobligated Balance	-	-	12	(731)	(719)	(62)
Unobligated Balance from Prior Year Budget Authority, Net	777	2	23,863	42,299	66,941	49
Appropriations (Discretionary and Mandatory)	278,190	264,039	302,282	475,669	1,320,180	(4)
Borrowing Authority (Discretionary and Mandatory)	-	-	-	-	-	237
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	5	18	693	23,942	24,658	198
Total Budgetary Resources	$ 278,972	$ 264,059	$ 326,838	$ 541,910	$ 1,411,779	$ 480
Status of Budgetary Resources:						
Obligations Incurred	$ 278,972	$ 264,059	$ 325,463	$ 505,407	$ 1,373,901	$ 477
Unobligated Balances, End of Year:						
Apportioned	-	-	1,309	28,075	29,384	-
Exempt from Apportionment	-	-	-	39	39	-
Unapportioned	-	-	66	8,389	8,455	3
Total Unobligated Balance, End of Year	-	-	1,375	36,503	37,878	3
Total Status of Budgetary Resources	$ 278,972	$ 264,059	$ 326,838	$ 541,910	$ 1,411,779	$ 480
Change in Obligated Balance:						
Unpaid Obligation:						
Unpaid Obligations, Brought Forward, Oct 1	$ 25,103	$ 24,691	$ 29,877	$ 108,983	$ 188,654	$ 1,248
Obligation Incurred	278,972	264,059	325,463	505,407	1,373,901	477
Outlays (Gross)	(273,796)	(265,932)	(298,365)	(482,213)	(1,320,306)	(727)
Actual Transfers, unpaid obligations (net)	-	-	-	-	-	-
Recoveries of Prior Year Unpaid Obligations	(777)	(2)	(21,569)	(3,735)	(26,083)	-
Unpaid Obligations, End of Year	$ 29,502	$ 22,816	$ 35,406	$ 128,442	$ 216,166	$ 998
Uncollected Payments:						
Uncollected Customer Payments from Federal Sources, Brought Forward, Oct 1	$ -	$ -	$ -	$ (11,018)	$ (11,018)	$ (536)
Adjustment to Uncollected Payments, Federal Sources	-	-	-	-	-	-
Change in Uncollected Customer Payments from Federal Sources	-	-	-	(820)	(820)	106
Uncollected Payments from Federal Sources, End of Year	$ -	$ -	$ -	$ (11,838)	$ (11,838)	$ (430)
Memorandum (non-add) Entries:						
Obligated Balance, Start of Year	$ 25,103	$ 24,691	$ 29,877	$ 97,965	$ 177,636	$ 712
Obligated Balance, End of Year	$ 29,502	$ 22,816	$ 35,406	$ 116,604	$ 204,328	$ 568

[1] "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 gross 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[1]	Agency Combined Budgetary Totals	Non-Budgetary Credit Reform Financing Account
Budget Authority and Outlays, Net:						
Budget Authority, Gross (Discretionary and Mandatory)	$ 278,195	$ 264,057	$ 302,975	$ 499,611	$ 1,344,838	$ 431
Actual Offsetting Collections (Discretionary and Mandatory)	(5)	(18)	(693)	(22,971)	(23,687)	(315)
Change in Uncollected Customer Payments from Federal Sources (Discretionary and Mandatory)	-	-	-	(820)	(820)	106
Budget Authority, Net (Discretionary and Mandatory)	$ 278,190	$ 264,039	$ 302,282	$ 475,820	$ 1,320,331	$ 222
Outlays, Gross (Discretionary and Mandatory)	$ 273,796	$ 265,932	$ 298,365	$ 482,213	$ 1,320,306	$ 727
Actual Offsetting Collections (Discretionary and Mandatory)	(5)	(18)	(693)	(22,971)	(23,687)	(315)
Outlays, Net (Discretionary and Mandatory)	273,791	265,914	297,672	459,242	1,296,619	412
Distributed Offsetting Receipts	(31,770)	(326,854)	-	(1,026)	(359,650)	-
Agency Outlays, Net (Discretionary and Mandatory)	$ 242,021	$ (60,940)	$ 297,672	$ 458,216	$ 936,969	$ 412

Summary of Other Agency Budgetary Accounts

	Budgetary Resources	Status of Budgetary Resources	Net Outlays
ACF	$ 53,746	$ 53,746	$ 48,672
ACL	1,730	1,730	1,463
AHRQ	423	423	42
CDC	12,058	12,058	10,110
CMS	405,532	405,532	345,628
FDA	5,391	5,391	2,052
HRSA	9,764	9,764	8,960
IHS	6,837	6,837	4,512
NIH	35,092	35,092	29,231
OS	5,827	5,827	3,775
PSC	1,759	1,759	578
SAMHSA	3,751	3,751	3,193
Totals	$ 541,910	$ 541,910	$ 458,216

[1] "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 gross 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, 2014 and 2013

The Federal Accounting Standards Advisory Board (FASAB) issued SFFAS Number 40, *Definitional Changes to Deferred Maintenance and Repairs; Amending Statement of Federal Financial Accounting Standards 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.

		Estimated Cost to Return to Acceptable Condition (in Millions)	
Category of Asset	Condition	2014	2013
General PP&E			
Buildings	1-5	$ 1,876	$ 2,249
Equipment	3-4	12	12
Other Structures	1-5	13	13
Total		$ 1,901	$ 2,274

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 PP&E 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, 2014

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 [capitalized] 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, 2014, 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 2014 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, 2014.

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 presented in accordance with the requirements of the 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 *2014 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 reflect an exception to current law with regard to the sustainable growth rate (SGR) formula for physician fee schedule payment under Part B. Current law requires CMS to implement a reduction in Medicare payment rates for physician services of almost 21 percent in April 2015. However, it is a virtual certainty that lawmakers will override this reduction as they have every year beginning with 2003. For this reason, the income, expenditures, and assets for Part B shown throughout the report reflect a *projected baseline*, which includes an override of the provisions of the SGR and an assumed annual increase in the physician fee schedule equal to the average SGR override over the 10-year period ending with March 31, 2015. The projections do not represent either a policy recommendation or a prediction of legislative outcomes.

Incorporated in these projections is the sequestration of non-salary Medicare expenditures as required by the following laws: 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*; the Continuing Appropriations Resolution, 2014 (Public Law 113-67, enacted on December 26, 2013); Sections 1 and 3 of Public Law 113-82, enacted on February 15, 2014; and the Protecting Access to Medicare Act of 2014 (Public Law 113-93, enacted on April 1, 2014). The sequestration reduces benefit payments by 2 percent from April 1, 2013 through March 31, 2023, by 2.9 percent from April 1, 2023 through September 30, 2023, by 1.1 percent from October 1, 2023 through March 31, 2024, and by 4 percent from April 1, 2024 through September 30, 2024. Due to sequestration, non-salary administrative expenses are reduced by an estimated 5 percent from March 1, 2013 through September 30, 2024.

These projections 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. Without fundamental changes in current health care delivery systems, these adjustments would probably not be viable indefinitely. 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. 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.

In view of the factors described above, it is important to note that Medicare's actual future costs are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time. The current-law cost projections reflect the scheduled SGR reductions to physicians' payment rates and the *Affordable Care Act*-mandated reductions in other Medicare payment rates. Because the physician payment reduction required by current law has been overridden for 12 consecutive years, the Medicare Board of Trustees decided for the 2014 Medicare Trustees Report to emphasize projections under a projected baseline, as mentioned previously. In addition, the Trustees reference in their report an illustrative alternative scenario, which incorporates the override of SGR physician payment rates included in the projected baseline and a partial phase-out of the *Affordable Care Act* reductions in Medicare payment rates, as well as an assumed legislative override of the cost-saving actions of the Independent Payment Advisory Board. The difference between the illustrative alternative and the projected baseline projections demonstrates that the long-range costs could be substantially higher than those shown throughout much of the 2014 report if the *Affordable Care Act*'s cost reduction measures prove ineffectual or are scaled back.

Additional information on the projected baseline, current-law, and illustrative alternative projections is provided in Note 21 in these financial statements, in appendix V.C of this year's 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 based on statutory price updates (except for physician fee schedule services) and assumptions for volume and intensity growth derived from a "factors contributing to growth" model, which, developed by the Office of the Actuary at CMS, decomposes the major drivers of historical and projected health spending growth into distinct factors. Additionally, the Trustees assume that the Medicare payment rate updates that reflect an economy-wide productivity adjustment will reduce volume and intensity growth slightly below the assumption from the factors model for affected Medicare services. The Trustees' methodology is consistent with the recommendations by the 2010-2011 Technical Review Panel on the Medicare Trustees Report,[6] which incorporated a more refined analysis of the factors behind those assumptions. The Trustees plan to continue to direct research into the factors approach and will consider additional refinements and improvements in forthcoming reports.

In December 2011, the Technical Panel unanimously recommended a new approach that builds off of the longstanding GDP plus 1 percent assumption while incorporating several key refinements.[7] Specifically, the Panel recommended two separate means of establishing long-range growth rates:

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

[7] For convenience, the increase in Medicare expenditures per beneficiary, before consideration of demographic impacts, is referred to as the Medicare cost growth rate. Similarly, these growth rate assumptions are described relative to the per capita increase in GDP and characterized simply as GDP plus X percent.

- The first approach is a refinement to the traditional GDP plus 1 percent growth assumption that better accounts for the level of payment rate updates for Medicare (prior to the effects of the *Affordable Care Act*) compared to private health insurance and other payers of health care in the U.S. This refinement results in an increase in the long-range pre-*Affordable Care Act*
- Baseline cost growth assumption for Medicare to GDP plus 1.4 percent. (The corresponding assumed average growth rate for all national health expenditures continues to be GDP plus 1 percent.)
- The second approach recommended by the Technical Panel is the factors model developed by the Office of the Actuary at CMS as a possible replacement for the existing process. This model builds upon the key considerations used in establishing the earlier GDP plus 1 percent assumption, together with subsequent refinements in the analysis of growth factors, additional years of data on national health expenditures available since the 2000 Medicare Technical Review Panel's deliberations, and use of projected trends in the model's key factors. The model is based on economic research that decomposes health spending growth into its major drivers—income growth, relative medical price inflation, insurance coverage, and a residual factor that primarily reflects the impact of technological development.[8]

The Trustees (i) used the statutory price updates and the volume and intensity assumptions from the factors model to derive the year-by-year Medicare cost growth assumptions for the last 50 years of the projection period and (ii) checked the ultimate Medicare cost growth assumptions derived from this approach for reasonableness by comparing them to results produced by an average "GDP plus" approach.

For some time, the Trustees have assumed that it is reasonable to expect over the long range that the drivers of health spending will be similar for the overall health sector and for the Medicare program. This view was affirmed by the 2010-2011 Medicare Technical Review Panel, which recommended use of the same long-range assumptions for the increase in the volume and intensity of health care services for the total health sector and for Medicare. Therefore, the overall health sector long-range cost growth assumptions for volume and intensity are used as the starting point for developing the Medicare-specific assumptions under current law.

Prior to the *Affordable Care Act*, Medicare payment rates for most non-physician provider categories were updated annually by the increase in providers' input prices for the market basket of employee wages and benefits, facility costs, medical supplies, energy and utility costs, professional liability insurance, and other inputs needed to produce the health care goods and services. To the extent that health care providers can improve their productivity each year, their net costs of production (other things being equal) will increase more slowly than their input prices—but the Medicare payment rate updates prior to the *Affordable Care Act* were not adjusted for potential productivity gains. Accordingly, Medicare costs per beneficiary would have increased somewhat faster than for the health sector overall.[9] The *Affordable Care Act* requires that many of these Medicare payment updates be reduced by the 10-year moving average increase in private, nonfarm business multifactor productivity, which the Trustees assume will be 1.1 percent per year over the long range. The different statutory provisions for updating payment rates require the development of separate long-range Medicare cost growth assumptions for three categories of health care providers:

(i) *All HI, and some SMI Part B, services that are updated annually by provider input price increases less the increase in economy-wide productivity.*

[8]Smith, Sheila, Newhouse, Joseph P., and Freeland, Mark S. "Income, Insurance, and Technology: Why Does Health Spending Outpace Economic Growth?" *Health Affairs,* 28, no. 5 (2009): 1276-1284.

[9]Historically, lawmakers frequently reduced the payment updates below the increase in providers' input prices in an effort to slow Medicare cost growth or to offset unwarranted changes in claims coding practices. Prior to the *Affordable Care Act*, the law did not specify any such adjustments after 2009.

HI services are inpatient hospital, skilled nursing facility, home health, and hospice. The primary Part B services affected are outpatient hospital, home health, and dialysis. Under the Trustees' intermediate economic assumptions, the year-by-year increases for these provider services start at 4.4 percent in 2038, or GDP plus 0.4 percent, declining gradually to 3.5 percent in 2088, or GDP minus 0.5 percent. On average, the ultimate cost growth rate for these provider services is 4.2 percent, or GDP plus 0.2 percent.

(ii) *Certain SMI Part B services that are updated annually by the CPI increase less the increase in productivity.*

Such services include durable medical equipment, care at ambulatory surgical centers, ambulance services, and medical supplies. The Trustees assume the per beneficiary year-by-year rates to be 3.6 percent in 2038, or GDP minus 0.4 percent, declining to 2.7 percent in 2088, or GDP minus 1.3 percent. On average, the total assumed rate of growth for these services is 3.4 percent, which equates to GDP minus 0.6 percent.

(iii) *All other Medicare services, for which payments are established based on market processes, such as prescription drugs provided through Part D and the remaining Part B services, including physician payments.*[10]

These Part B outlays constitute an estimated 50 percent of total Part B expenditures in 2023 and consist mostly of payments for physician services, laboratory tests, physician-administered drugs, and small facility services. Medicare payments to Part D plans are based on a competitive-bidding process and are not affected by the productivity adjustments. Similarly, payments for the other Part B services are based on market factors.[11] The long-range per beneficiary cost growth rate for Part D and these Part B services is assumed to equal the increase in per capita national health expenditures as determined from the factors model. The corresponding year-by-year growth rates for these services are 5.2 percent in 2038, or GDP plus 1.2 percent, declining to 4.3 percent by 2088, or GDP plus 0.3 percent. On average, the rate of growth for these services is 5.0 percent, or GDP plus 1 percent.

In addition, these long-range cost growth rates must be modified to reflect demographic impacts. For example, beneficiaries at ages 80 and above use Part A skilled nursing and home health services much more frequently than do younger beneficiaries. As the beneficiary population ages, Part A costs will grow at a faster rate due to increased use of these services. In contrast, the incidence of prescription drug use is more evenly distributed by age, and an increase in the average age of Part D enrollees has significantly less of an effect on Part D costs.

After combining the rates of growth from the three long-range assumptions, the weighted average growth rate for Part B is 4.6 percent per year for the last 50 years of the projection period, or GDP plus 0.6 percent, on average. When Parts A, B, and D are combined, the weighted average growth rate is 4.5 percent over this same time period or GDP plus 0.5 percent, while the growth rate in 2088 is 3.8 percent or GDP minus 0.2 percent.

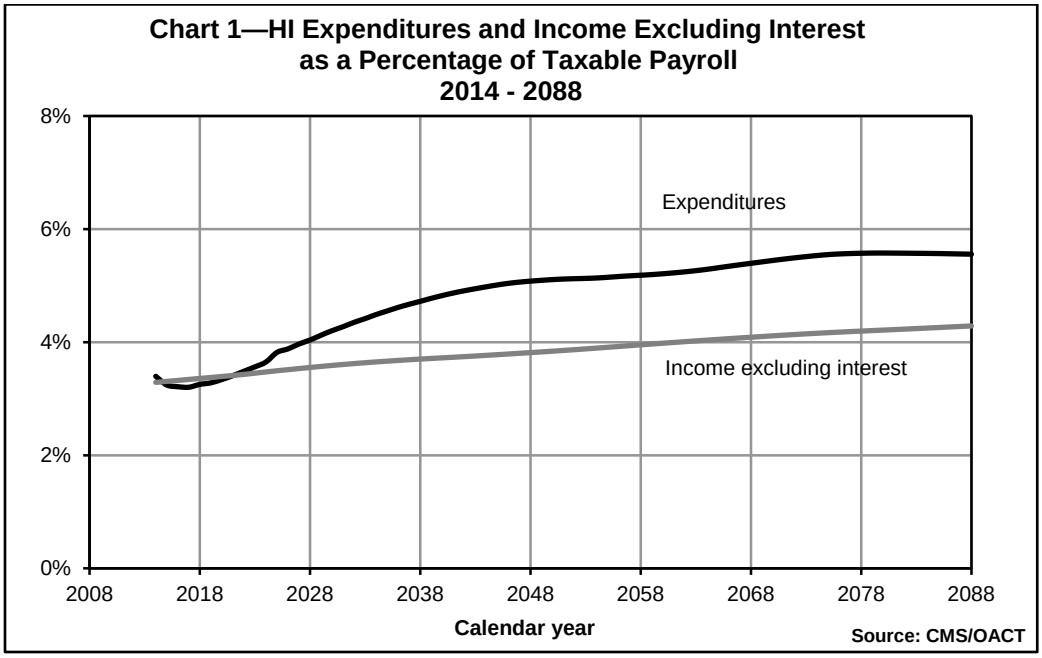
[10] In the long range under the projected baseline, physician services are assumed to increase at the rate equal to the per capita increase in health spending in the U.S. overall.

[11] For example, physician-administered Part B drugs are reimbursed at the level of the average sales price in the market plus 6 percent.

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 the 2014 report are lower than those from the 2013 report. The primary reasons for the difference are lower-than-expected recent spending and revised utilization assumptions.



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 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 continuation of the economic recovery, the savings provisions of the *Affordable Care Act*, and the sequestration of Medicare expenditures for 2013-2024. Subsequently, the cost rate will increase significantly due to retirements of those in the baby boom generation and partly due to health services cost growth. The effect of these factors will be somewhat offset 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 illustrative alternative scenario, if the slower price updates were not

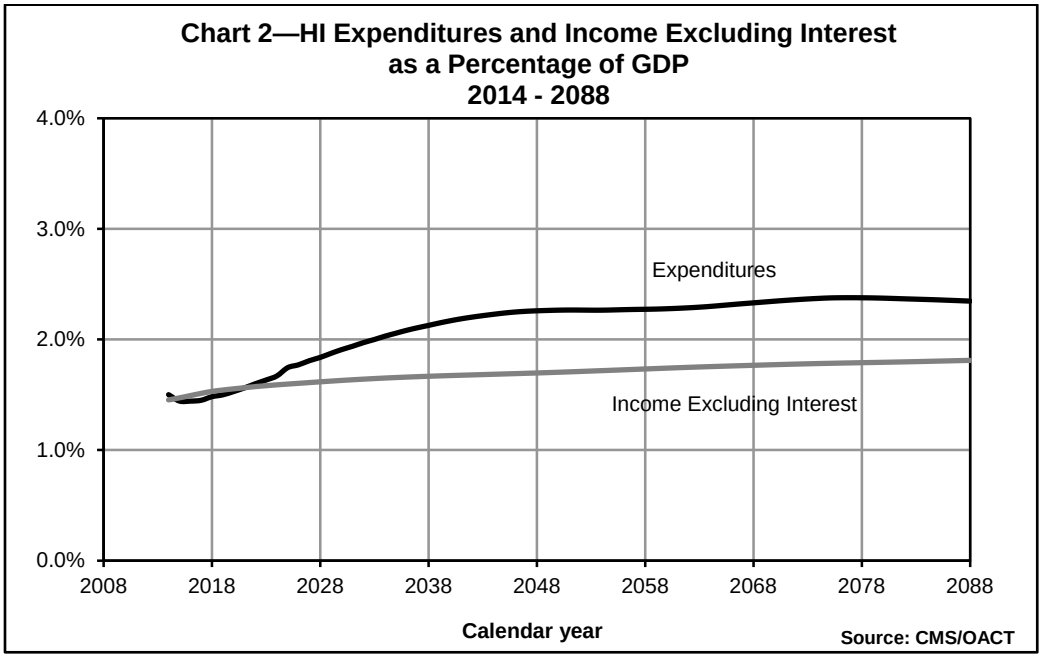
feasible in the long range and were phased down during 2020-2034, then the HI cost rate would be 4.9 percent in 2035 and 8.8 percent in 2085. These levels are about 8 percent and 57 percent higher, respectively, than the projected baseline estimates under the intermediate assumptions.

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 2013, the expenditures were $266.2 billion, which was 1.6 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 scenario, HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 3.8 percent in 2088.

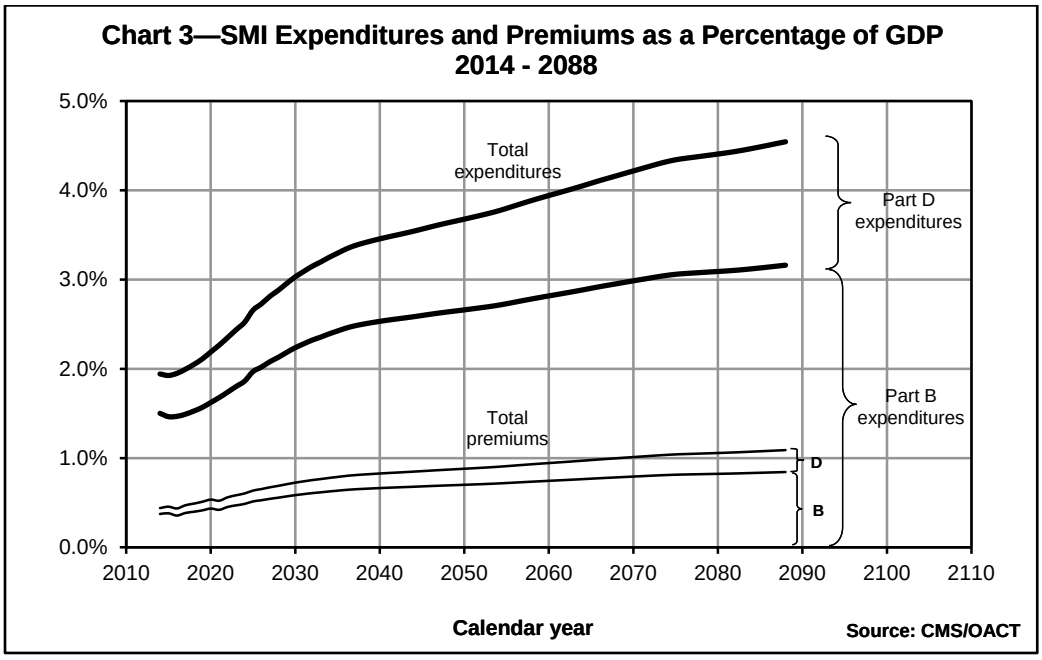


SMI

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.

In 2013, SMI expenditures were $316.7 billion, or about 1.9 percent of GDP. Under the projected baseline, they would grow to roughly 3.4 percent of GDP in about 25 years and to more than 4.5 percent by the end of the projection period. (Total SMI expenditures in 2088 would be 4.0 percent of GDP if physician payment rates were set as assumed under the current-law projections. Such costs would represent more than 4.6 percent of GDP under the illustrative alternative, which includes larger payment updates for most non-physician categories of Part B providers.)

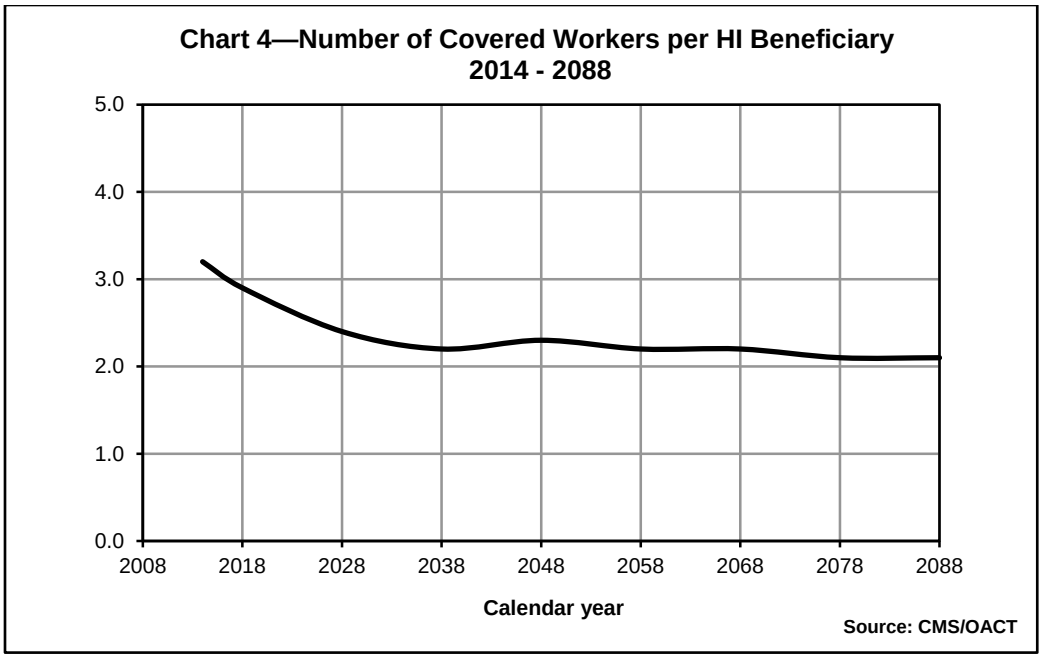


To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time. In fact, average per beneficiary costs for Part B and Part D benefits are projected to increase after 2014 by about 4.6 percent annually. 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 workers pay for current benefits. The relatively smaller number of persons born after the baby boom will therefore finance the retirement of the baby boom generation. In 2013, every beneficiary had 3.2 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 2088.



Sensitivity Analysis

To prepare 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.[12] The assumptions varied are the health care cost factors, real-wage differential, CPI, real-interest rate, fertility rate, and net immigration.[13]

For this analysis, the intermediate economic and demographic assumptions in the *2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund*s 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, 2014 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 2047 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

[12] 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.

[13] 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.

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

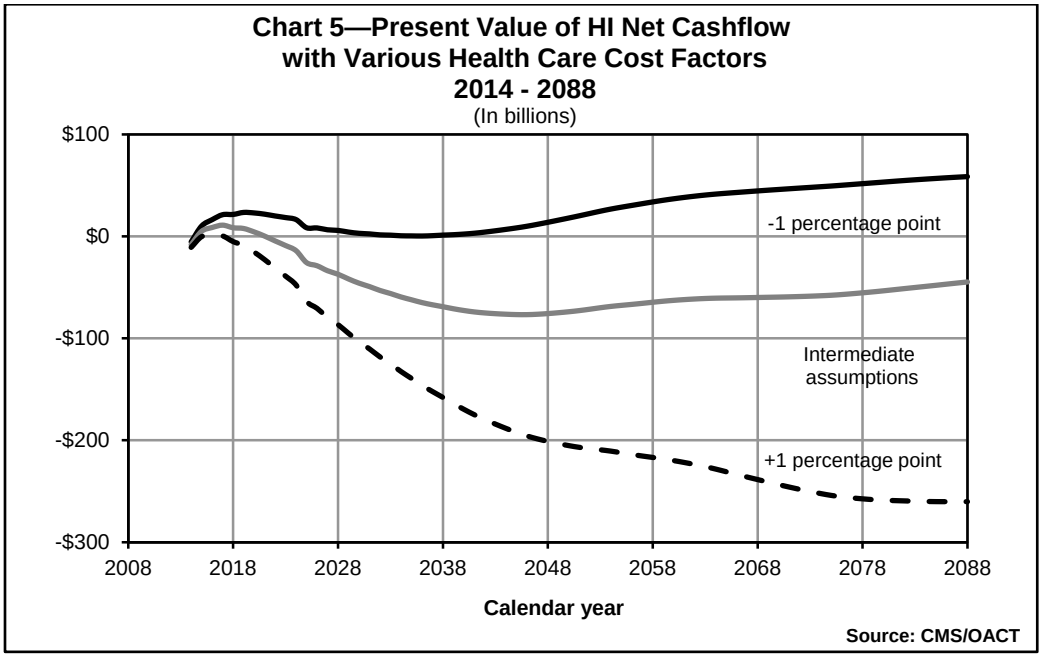
Table 1 shows the net present value of cashflow during the 75-year projection period under three alternative assumptions for the annual growth rate in the aggregate cost of providing covered health care services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs, 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)	$1,996	$(3,823)	$(13,090)

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $5,819 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 $9,267 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.



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 1.8 percentage points.[14] In each case, the assumed ultimate annual increase in the CPI is 2.7 percent, yielding ultimate percentage increases in nominal average annual wages in covered employment of 3.2, 3.8, and 4.5 percent, respectively.

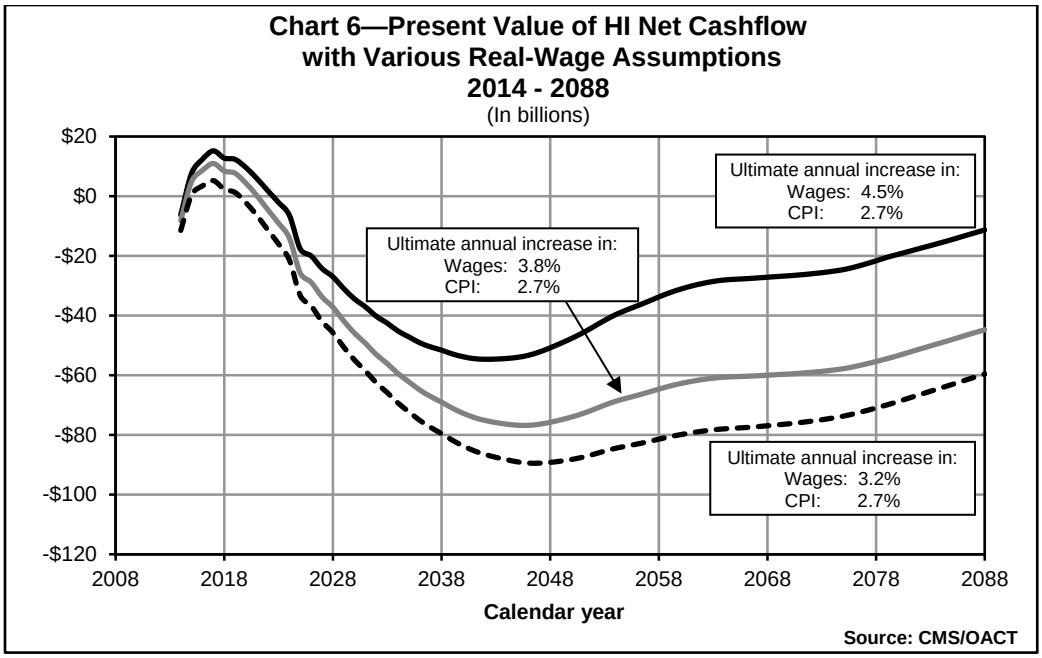
Table 2—Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions

Ultimate percentage increase in wages – CPI	3.2 – 2.7	3.8 – 2.7	4.5 – 2.7
Ultimate percentage increase in real-wage differential	0.5	1.1	1.8
Income minus expenditures (in billions)	$(4,777)	$(3,823)	$(2,101)

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 $1,230 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about $795 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.

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



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

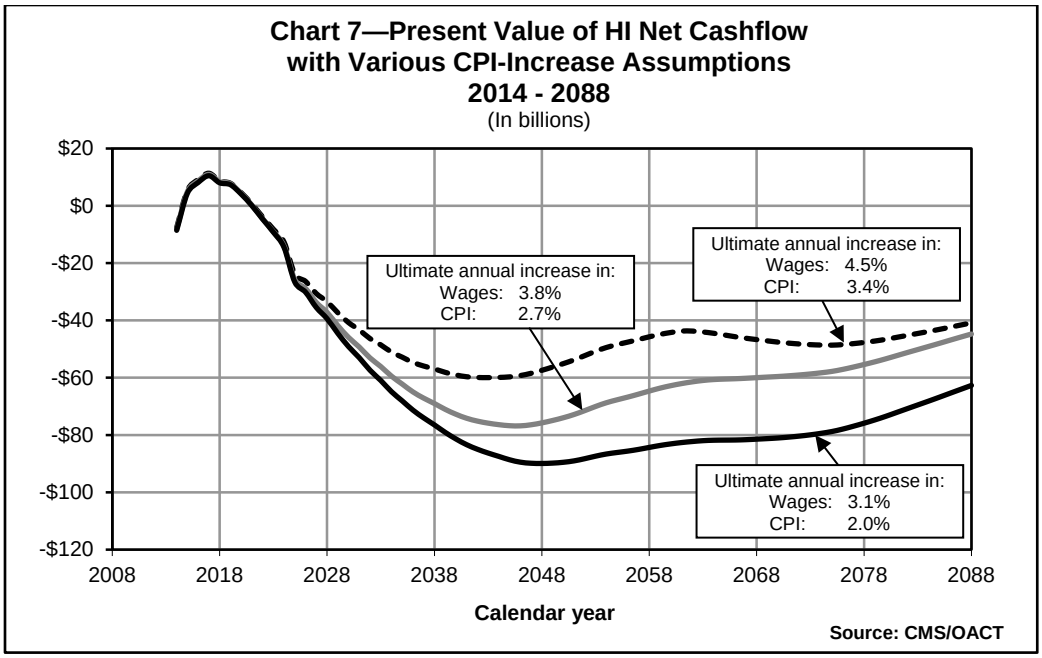
Table 3 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 3.4, 2.7, and 2.0 percent. In each case, the assumed ultimate real-wage differential is 1.1 percent, which yields ultimate percentage increases in average annual wages in covered employment of 4.5, 3.8, and 3.1 percent, respectively.

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

Ultimate percentage increase in wages – CPI	4.5 – 3.4	3.8 – 2.7	3.1 – 2.0
Income minus expenditures (in billions)	$(3,055)	$(3,823)	$(4,780)

Table 3 demonstrates that if the ultimate CPI-increase assumption is 3.4 percent, the deficit decreases by $767 billion. On the other hand, if the ultimate CPI-increase assumption is 2.0 percent, the deficit increases by $957 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.



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

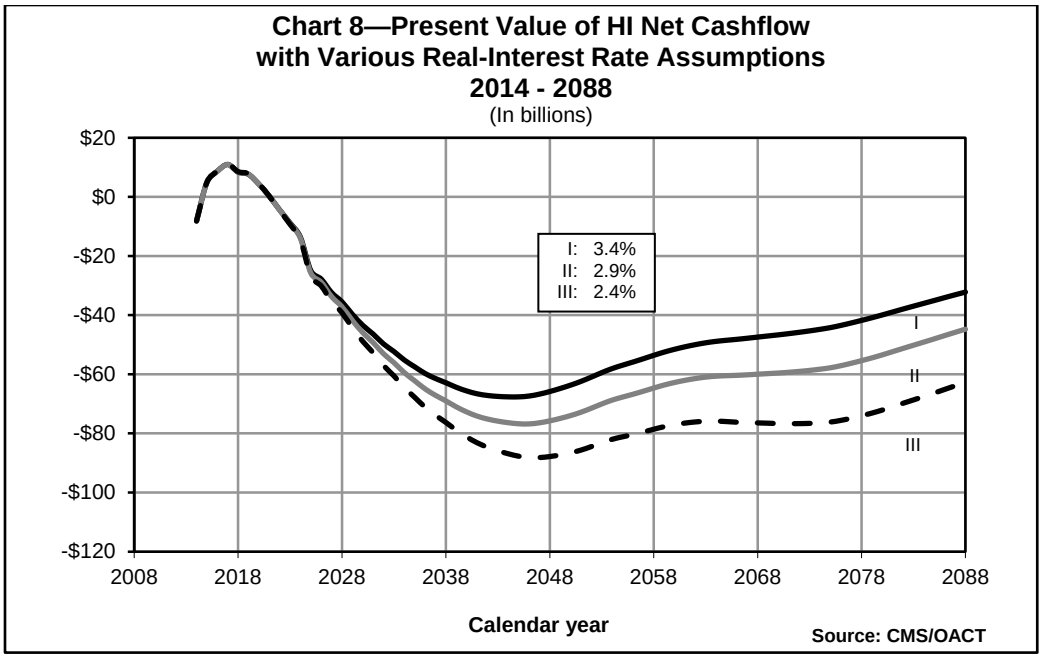
Table 4 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate annual real-interest assumptions: 2.4, 2.9, and 3.4 percent. In each case, the assumed ultimate annual increase in the CPI is 2.7 percent, which results in ultimate annual yields of 5.1, 5.6, and 6.1 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)	$(4,626)	$(3,823)	$(3,204)

As illustrated in Table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $140 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.



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 2030. 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.

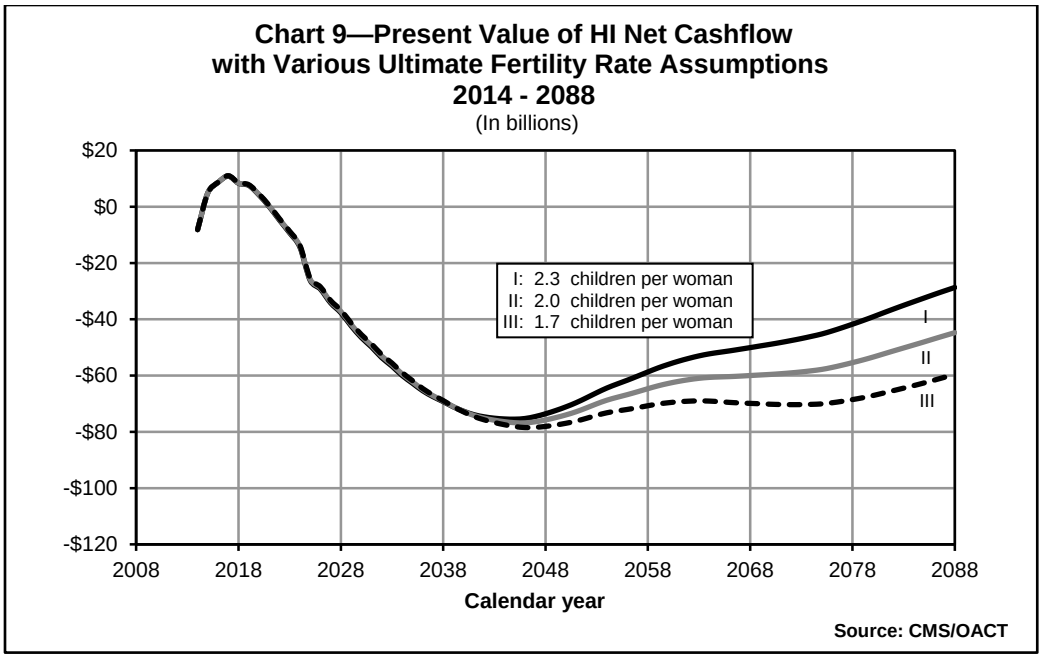
Table 5—Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

Ultimate fertility rate[1]	1.7	2.0	2.3
Income minus expenditures (in billions)	$(4,211)	$(3,823)	$(3,426)

[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.



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, 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

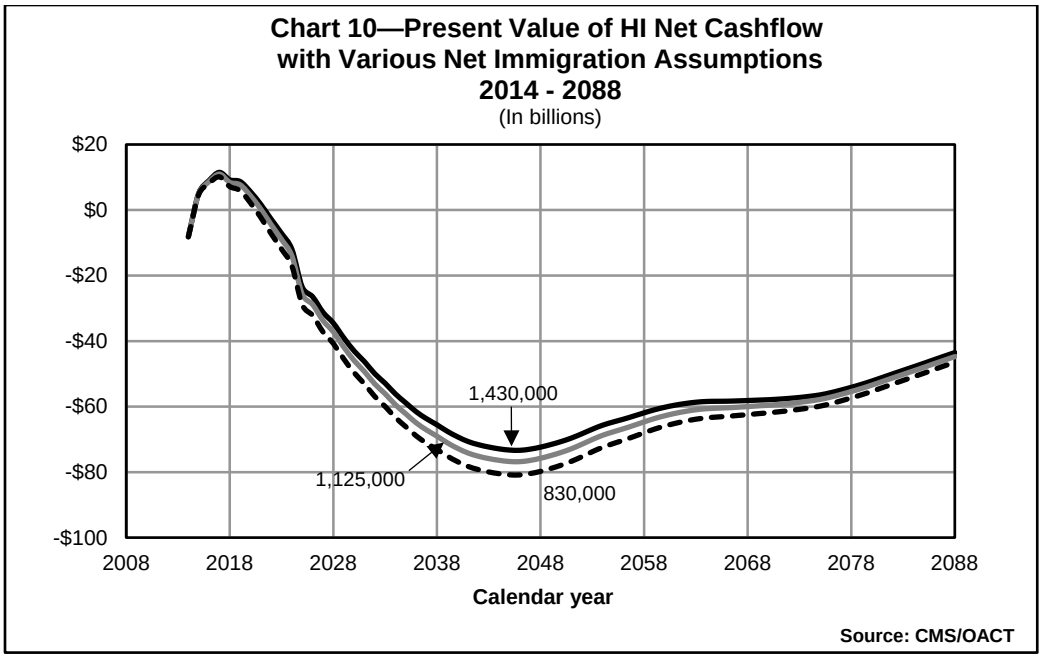
Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative average annual net immigration assumptions: 830,000 persons, 1,125,000 persons, and 1,430,000 persons per year.

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

Average annual net immigration	830,000	1,125,000	1,430,000
Income minus expenditures (in billions)	$(4,039)	$(3,823)	$(3,654)

As indicated in Table 6, if the average annual net immigration assumption is 830,000 persons, the deficit—expressed in present-value dollars—increases by $216 billion. Conversely, if the assumption is 1,430,000 persons, the deficit decreases by about $168.5 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.



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 2030, 4 years later than in the 2013 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 2013 were slightly higher than last year's estimate; after 2013, however, projections of earnings throughout the period are lower mostly due to lower assumptions for the GDP deflator and real GDP. HI expenditures in 2013 were significantly lower than the previous estimate, and through 2016 the projected level grows more slowly than shown in last year's report largely due to reductions in utilization assumptions, reflecting recent trends. HI expenditures have exceeded income annually since 2008 and are projected to continue doing so through 2014. The Trustees project slight surpluses in 2015-2022, with a return to deficits thereafter until the fund becomes depleted in 2030. 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. To date, 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

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 2014 is adequate to cover 2014 expected expenditures and to maintain the financial status of the account in 2014 at a satisfactory level. 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 a lower projected drug cost trend, and higher drug rebates, consistent with recent experience.

The Part B and Part D accounts in the SMI Trust Fund are adequately financed 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. 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[15] is projected to exceed 45 percent of total Medicare outlays under current law within the next 7 fiscal years (2014-2020). If this level is attained within the 7-year timeframe, Federal law requires a determination of projected excess general revenue Medicare funding. For the 2014 Medicare Trustees Report, this difference is not expected to exceed 45 percent of total expenditures in fiscal years 2014-2020 (the first 7 years of the projection), and therefore, the Trustees are not issuing this determination.

The projections shown in this section continue to demonstrate the need for timely and effective action to address Medicare's remaining financial challenges—including the projected depletion of the HI Trust Fund, this fund's long-range financial imbalance, and the rapid growth in Medicare expenditures. Furthermore, if the growth in Medicare costs is comparable to growth under the illustrative alternative, then these further policy reforms will have to address much larger financial challenges than those assumed under the projected baseline scenario. In their 2014 annual report to Congress, the Medicare Board 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 not be delayed."

[15] 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
- Management Report on Final Action
- Summary of Financial Statement Audit
- Summary of Management Assurances
- FY 2014 Top Management and Performance Challenges Identified by the OIG
- Department's Response to OIG Top Management Challenges
- Appendices

Other Information

The Other Information section contains additional financial information including the Schedule of Spending, the Office of Inspector General's FY 2014 assessment of management challenges facing the Department, a Management Report on Final Action and the Improper Payments Information Act Report, as well as acronyms and appendices to this AFR.

OTHER FINANCIAL INFORMATION

Schedule of Spending

The Schedule of Spending presents an overview of how departments or agencies are spending (i.e. obligating) money. The Schedule of Spending presents total budgetary resources and total obligations incurred for the reporting entity. The data used to populate this schedule is the same underlying data used to populate the Combined Statement of Budgetary Resources. Simplified terms are used to improve the public's understanding of the budgetary accounting terminology used in the Statement of Budgetary Resources.

What Money is Available to Spend? This section presents resources that were available to spend as reported in the Statement of Budgetary Resources. Total Resources refers to total budgetary resources as described in the Statement of Budgetary Resources and represents amounts approved for spending by law. Amounts Not Agreed to be Spent represents amounts that HHS was allowed to spend but did not take action to spend by the end of the fiscal year. Amounts Not Available to Spend represents amounts that HHS was not approved to spend during the current fiscal year. Total Amounts Agreed to be Spent represents spending actions taken by HHS—including contracts, orders, grants, or other legally binding agreements of the Federal Government—to pay for goods or services. This line total agrees to the Obligations Incurred line in the Statement of Budgetary Resources.

Who did the Money Go To? This section identifies the recipient of the money, by federal and non-federal entities. Amounts in this section reflect "amounts agreed to be spent" and agree to the Obligations Incurred line on the Statement of Budgetary Resources.

How was the Money Spent/Issued? This section presents services or items that were purchased, categorized by Treasury Symbol. Those Treasury Symbols that have a material impact on the Statement of Budgetary Resources are presented separately. Other Treasury Symbols, such as Child Support Enforcement and Family Support, Child Care Entitlement to States, Affordable Insurance Exchange Grants, and Child Care and Development Block Grant, are summarized under Other Spending.

Combining Schedule of Spending

As of September 30, 2014 and 2013

(in Millions)

	FY 2014	FY 2013
Total Resources	$ 1,412,259	$ 1,323,724
Less Amount Available but Not Agreed to be Spent	29,423	32,092
Less Amount Not Available to be Spent	8,458	9,596
	$ 1,374,378	$ 1,282,036
Federal	$ 10,954	$ 30,608
Non-Federal	1,363,424	1,251,428
	$ 1,374,378	$ 1,282,036

Combining Schedule of Spending

As of September 30, 2014 and 2013

(in Millions)

	FY 2014	FY 2013
How was the Money Spent/Issued?		
Medicaid	$ 329,020	$ 286,920
Grants, Subsidies, and Contributions	325,548	283,398
Supplies and Materials	3,357	3,422
Other Contractual Services	96	72
Other	19	28
Medicare Hospital Insurance	278,971	277,109
Insurance Claims and Indemnities	272,336	266,543
Other	6,635	10,566
Payments to Trust Funds	276,792	247,702
Grants, Subsidies, and Contributions	243,361	246,922
Other	33,431	780
Medicare Supplementary Medical Insurance	264,059	252,433
Insurance Claims and Indemnities	258,024	241,977
Other Contractual Services	53	44
Other	5,982	10,412
Medicare Prescription Drug Benefit (Medicare Part D)	71,581	69,747
Insurance Claims and Indemnities	71,581	69,357
Other	-	390
Temporary Assistance for Needy Families	16,759	16,722
Grants, Subsidies, and Contributions	16,702	16,660
Other Contractual Services	57	62
State Children's Health Insurance Program	10,112	9,525
Grants, Subsidies, and Contributions	10,054	9,472
Other Contractual Services	21	20
Other	37	33
Children and Families Services	9,894	9,450
Grants, Subsidies, and Contributions	9,455	8,928
Other Contractual Services	280	344
Other	159	178
Medicare Health Information Technology Incentive	6,809	6,059
Insurance Claims and Indemnities	6,809	6,059
Foster Care and Adoption Assistance	7,428	6,634
Grants, Subsidies, and Contributions	7,393	6,489
Other Contractual Services	35	145
Indian Health Services	5,429	5,182
Grants, Subsidies, and Contributions	2,756	2,494
Personnel Compensation	971	964
Other Contractual Services	813	823
Other	889	901
Low Income Home Energy Assistance	3,401	3,255
Grants, Subsidies, and Contributions	3,375	3,248
Other Contractual Services	26	7
Primary Health Care	3,929	3,298
Grants, Subsidies, and Contributions	3,652	3,053
Other Contractual Services	199	164
Other	78	81
Allergy and Infectious Diseases	4,457	4,250
Grants, Subsidies, and Contributions	2,744	2,381
Other Contractual Services	1,336	1,504
Other	377	365
National Cancer Institue	4,997	4,825
Grants, Subsidies, and Contributions	2,981	2,915
Other Contractual Services	1,424	1,345
Other	592	565
Other Spending	80,740	78,925
Grants, Subsidies, and Contributions	44,447	44,179
Other Contractual Services	23,939	22,332
Insurance Claims and Indemnities	716	869
Other	11,638	11,545
Total Amounts Agreed to be Spent	$ 1,374,378	$ 1,282,036

Consolidating Balance Sheet by Budget Function

As of September 30, 2014

(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)	$ 9,648	$ 135,554	$ 19,189	$ 12,567	$ 176,958	$ -	$ 176,958
Investments, Net (Note 4)	-	5,614	273,286	-	278,900	-	278,900
Accounts Receivable, Net (Note 5)	84	1,538	65,810	-	67,432	(66,513)	919
Other Assets (Note 8)	-	203	25	-	228	(133)	95
Total Intragovernmental Assets	9,732	142,909	358,310	12,567	523,518	(66,646)	456,872
Accounts Receivable, Net (Note 5)	-	3,925	6,232	2	10,159	-	10,159
Inventory and Related Property, Net (Note 6)	-	8,606	-	-	8,606	-	8,606
General Property, Plant and Equipment, Net (Note 7)	-	5,561	307	-	5,868	-	5,868
Other Assets (Note 8)	-	809	1	-	810	-	810
Total Assets	$ 9,732	$ 161,810	$ 364,850	$ 12,569	$ 548,961	$ (66,646)	$ 482,315
Stewardship Property, Plant & Equipment (Note 1)							
Liabilities (Note 9)							
Intragovernmental Liabilities							
Accounts Payable	$ 25	$ 218	$ 66,621	$ 9	$ 66,873	$ (66,472)	$ 401
Other Liabilities (Note 13)	18	2,260	918	-	3,196	(174)	3,022
Total Intragovernmental Liabilities	43	2,478	67,539	9	70,069	(66,646)	3,423
Accounts Payable	10	439	104	2	555	-	555
Entitlement Benefits Due and Payable (Note 10)	-	33,446	57,591	-	91,037	-	91,037
Accrued Grant Liability (Note 12)	686	2,149	(47)	526	3,314	-	3,314
Federal Employee and Veterans Benefits (Note 11)	5	11,963	11	-	11,979	-	11,979
Contingencies and Commitments (Note 14)	-	10,032	1,300	-	11,332	-	11,332
Other Liabilities (Note 13)	15	1,234	1,242	10	2,501	-	2,501
Total Liabilities	759	61,741	127,740	547	190,787	(66,646)	124,141
Net Position							
Unexpended Appropriations - Funds from Dedicated Collections (Note 19)	-	(100)	16,315	-	16,215	-	16,215
Unexpended Appropriations - All Other funds	8,912	86,505	-	12,010	107,427	-	107,427
Cumulative Results of Operations - Funds from Dedicated Collections (Note 19)	-	6,756	220,795	-	227,551	-	227,551
Cumulative Results of Operations - All Other funds	61	6,908	-	12	6,981	-	6,981
Total Funds from Dedicated Collections	-	6,656	237,110	-	243,766	-	243,766
Total All Other Funds	8,973	93,413	-	12,022	114,408	-	114,408
Total Net Position	8,973	100,069	237,110	12,022	358,174	-	358,174
Total Liabilities and Net Position	$ 9,732	$ 161,810	$ 364,850	$ 12,569	$ 548,961	$ (66,646)	$ 482,315

Consolidating Statement of Net Cost by Budget Function

For the Year Ended September 30, 2014

(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	$ 11,650	$ -	$ -	$ 37,627	$ 49,277	$ (78)	$ 32	$ 49,231
ACL	1,480	-	-	-	1,480	(7)	12	1,485
AHRQ	-	30	-	-	30	(13)	369	386
CDC	-	10,034	-	-	10,034	(247)	371	10,158
CMS	-	319,698	518,066	-	837,764	(544)	15	837,235
FDA	-	2,168	-	-	2,168	(275)	16	1,909
HRSA	-	9,057	-	-	9,057	(316)	32	8,773
IHS	-	5,141	-	-	5,141	(161)	201	5,181
NIH	-	29,260	-	-	29,260	(696)	241	28,805
OS	-	3,826	-	-	3,826	(493)	764	4,097
PSC	-	966	-	-	966	(32)	543	1,477
SAMHSA	-	3,173	-	-	3,173	(73)	145	3,245
Net Cost of Operations	$ 13,130	$ 383,353	$ 518,066	$ 37,627	$ 952,176	$ (2,935)	$ 2,741	$ 951,982

Gross Cost and Exchange Revenue

For the Year Ended September 30, 2014

(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	$ 229	$ (78)	$ 151	$ (53)	$ 32	$ (21)	$ 49,132	$ (31)	$ 49,231
ACL	16	(7)	9	(12)	12	-	1,476	-	1,485
AHRQ	33	(13)	20	(369)	369	-	366	-	386
CDC	865	(247)	618	(522)	371	(151)	9,718	(27)	10,158
CMS	1,344	(544)	800	(30)	15	(15)	909,711	(73,261)	837,235
FDA	1,221	(275)	946	(29)	16	(13)	2,887	(1,911)	1,909
HRSA	406	(316)	90	(32)	32	-	8,727	(44)	8,773
IHS	1,172	(161)	1,011	(264)	201	(63)	5,328	(1,095)	5,181
NIH	1,938	(696)	1,242	(356)	241	(115)	29,434	(1,756)	28,805
OS	820	(493)	327	(868)	764	(104)	3,882	(8)	4,097
PSC	187	(32)	155	(926)	543	(383)	1,761	(56)	1,477
SAMHSA	125	(73)	52	(175)	145	(30)	3,223	-	3,245
Totals	$ 8,356	$ (2,935)	$ 5,421	$ (3,636)	$ 2,741	$ (895)	$ 1,025,645	$ (78,189)	$ 951,982

Freeze the Footprint

For the Year Ended September 30, 2014

Freeze the Footprint Baseline Comparison (in Square Footage)

	FY 2012 Baseline	FY 2013 Year End	+/- Change
Total Leased	13,603,974	13,438,256	(165,718)
Total Owned	6,112,229	6,486,379	374,150
Total	19,716,203	19,924,635	208,432

Reporting of O&M Costs - Owned and Direct Lease Buildings (in Millions)

	FY 2012 Baseline	FY 2013 Year End	+/- Change
Operation and Maintenance Costs	$ 83.3	$ 85.0	$ 1.7

Consistent with Section 3 of the OMB Memorandum - 12-12, *Promoting Efficient Spending to Support Agency Operations* and OMB Management Procedures Memorandum 2013-02, the "Freeze the Footprint" policy implementing guidance, all *CFO Act* departments and agencies shall not increase the total square footage of their domestic office and warehouse inventory compared to the FY 2012 baseline. Compared to the FY 2012 Baseline, the HHS inventory of office and warehouse space increased by 208,432 square feet in FY 2013, an overall increase of 1 percent. This is consistent with our projections in the September 2013 HHS Freeze the Footprint Plan. Because of known projects currently underway, HHS continues to project that it will be the end of FY 2016 when we can meet the FY 2012 Baseline. HHS will accomplish this through aggressively pursuing space and cost savings in office and warehouse space, through implementation of the HHS 170 useable square feet per person utilization rate policy for office space and through targeted consolidation projects for both office and warehouse space.

IMPROPER PAYMENTS INFORMATION ACT REPORT

1.0 Overview

The Department of Health and Human Services' FY 2014 *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), OMB Circular A-136, and Appendix C of OMB Circular A-123:

- Program Descriptions (Section 1.10)
- Risk Assessments (Section 2.0)
  - *Affordable Care Act* Risk Assessment (Section 2.10)
- 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 2014 Progress (Section 8.10)
  - Fiscal Year 2014 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)
- The Do Not Pay Initiative (Section 12.0)
- Superstorm Sandy Reporting Information (Section 13.0)
  - Head Start (Section 13.10)
  - Social Services Block Grant (SSBG) (Section 13.20)
  - Family Violence Prevention and Services (Section 13.30)
  - Assistant Secretary for Preparedness and Response (ASPR) Research (Section 13.40)
  - Centers for Disease Control and Prevention (CDC) Research (Section 13.50)
  - Substance Abuse and Mental Health Services Administration (SAMHSA) (Section 13.60)
  - National Institutes of Health (NIH) Research (Section 13.70)

1.10 Program Descriptions

The following is a brief description of the risk-susceptible programs discussed in this report.

OMB Determined Risk-Susceptible Programs

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

Superstorm Sandy Risk-Susceptible Programs:

9. **Head Start -** A federal program that provides comprehensive developmental services for America's low-income, preschool children ages three to five and their families
10. **Social Services Block Grant (SSBG)** – A joint federal/state program, administered by the states, which supports programs that allow communities to achieve or maintain economic self-sufficiency to prevent, reduce or eliminate dependency on social services
11. **Family Violence Prevention and Services (FVPS)** – A federal funding stream dedicated to the support of emergency shelters and related assistance for victims of domestic violence and their children
12. **Assistant Secretary for Prevention and Response (ASPR) Research** – A federal initiative to build a strong scientific research dataset and to support research that will aid in the response to, and recovery from, Superstorm Sandy
13. **Centers for Disease Control and Prevention (CDC) Research –** A federal effort to improve and enhance the emergency preparedness system to protect life and property from disasters
14. **Substance Abuse and Mental Health Administration (SAMHSA) –** A joint federal/state initiative to provide continued and enhanced mental health and substance abuse treatment to the affected parties in affected states
15. **National Institutes of Health (NIH) Research –** A federal initiative to restore investment in biomedical research and infrastructure that was severely damaged or destroyed by Superstorm Sandy

2.0 Risk Assessments

In addition to the programs deemed by OMB to be susceptible to significant improper payments and those required to be measured under the *Superstorm Sandy Disaster Relief Appropriations Act* (Disaster Relief Act), 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 this integrated risk assessment approach in FY 2014 and all of the programs that were reviewed under this integrated approach were determined not to be at-risk for significant improper payments.

2.10 *Affordable Care Act* Risk Assessment

The Department of Health and Human Services and the Department of the Treasury each have responsibilities for ensuring payment accuracy in the Marketplaces and related programs created under the *Affordable Care Act*. In fiscal year 2015, both Departments will begin to perform comprehensive risk assessments to determine areas that might affect payment accuracy. Performing comprehensive risk assessments is critical to establishing an effective program for achieving payment accuracy in future years. The status of these risk assessments will be reported in the fiscal year 2015 AFR. In the interim, both Departments have established internal controls to provide for effective program operations, reliable financial reporting, and compliance with laws and regulations.

3.0 Statistical Sampling Process

Each program's statistical sampling process is discussed in *Section 10: Program-Specific Reporting Information* or *Section 13.0: Superstorm Sandy Information*. Unless otherwise stated in *Section 10 or Section 13*, 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 determined by OMB to be susceptible to significant improper payments are currently using a statistical contractor to calculate improper payment estimates.

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 at-risk program's gross and net error rates. In addition, Table 8 in *Section 13.0: Superstorm Sandy Information* presents gross and net error rates for each of the Divisions that received Superstorm Sandy funding.

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 10.0: Program-Specific Reporting Information* or *Section 13.0: Superstorm Sandy 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's 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 worked with the programs to create subaccounts for newly awarded grants, and to transition HHS's existing grants that receive new funding to subaccounts. Previously, grantees with multiple grants "pooled" the grants into a single account. Almost all programs have ceased pooling grants and moved to subaccounts, and the remaining programs will be transitioned by the end of FY 2015. This internal policy change and the procedural adjustments will increase our financial accountability across the HHS grants community because subaccounts provide greater transparency and enhance efforts to close out grants in a timely fashion.
- HHS developed implementing guidance for OMB's "Uniform Administrative Requirements, Cost Principles, and Audit Requirement for Federal Awards" guidance, which streamlined and superseded requirements from previous OMB circulars. The regulations, both government-wide and HHS-specific, will be effective December 26, 2014. The regulations and reform activities will standardize the Department's grants activities, increasing transparency and accountability on the part of recipients and sub-recipients.
- HHS continued updating our internal grants policies in light of the government-wide grants reform effort. The updated guidance will facilitate greater financial transparency and accountability, outline consistent grants administration practices, and foster program integrity.

5.0 Accountability in Reducing and Recovering Improper Payments

Strengthening program integrity throughout the organization is a top Departmental priority, 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 10.0: Program-Specific Reporting Information details each program's information systems and other infrastructure.

7.0 Mitigation Efforts Related to Statutory or Regulatory Barriers

Section 10.0: 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 2014 Progress

As reported in the FY 2013 AFR, based on Head Start's strong internal controls, monitoring systems, and low reported error rate, OMB approved HHS's request for relief from annual improper payment reporting for Head Start. In lieu of an annual error rate measurement, HHS provided oversight through Head Start's existing internal controls and monitoring systems, and is annually reporting to OMB on its internal controls. In September 2014, HHS submitted its first report to OMB describing Head Start's policies, controls, and corrective actions to preventing and mitigating improper payments in the program, as well as any control deficiencies, risks, and trends. In the report to OMB, Head Start provided data showing that no new control deficiencies, risks or trends were identified in FY 2014, and that Head Start continued to implement and establish control mechanisms to monitor grantee performance.

8.20 FY 2014 Achievements

8.21 Improving Program Integrity in Medicare and Medicaid

In FY 2014, 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 2014 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 Provider Enrollment Moratorium

Section 6401 of the *Affordable Care Act* added new Section 1866(j)(7) to the *Social Security Act*, 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 (HHAs) and ground ambulance suppliers in the Houston-area. On January 30, 2014, HHS extended the original moratoria for these locations and expanded the enrollment moratoria to include HHAs in the Ft. Lauderdale; Detroit; and Dallas areas. HHS also expanded the moratoria for ground ambulance suppliers into the Philadelphia-area. All of these moratoria actions were extended an additional six months with the latest notice effective July 30, 2014. The focus of these efforts is to prevent and deter fraud, waste, and abuse in problematic services and areas across the country while ensuring beneficiary access to care.

Fraud Prevention System

HHS launched the Fraud Prevention System (FPS) on June 30, 2011, as required by the *Small Business Jobs Act of 2010* (SBJA). 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 imposes 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.

During the second implementation year of the FPS, defined in the SBJA as October 1, 2012 through September 30, 2013, HHS took administrative action against 938 providers resulting in an estimated $210.7 million in identified

savings. These savings are almost double the amount identified during the first implementation year and also resulted in more than a 5 to 1 return on investment. The FPS generated leads for 469 new investigations, and augmented information for 348 ongoing investigations. Information on these and other actions initiated through the FPS can be found in the second year FPS Report to Congress, available at: http://www.stopmedicarefraud.gov/fraud-rtc06242014.pdf. HHS continues to take action based on the FPS leads and will report updated information in the third year FPS Report to Congress in FY 2015 as required by the SBJA.

National Benefit Integrity (NBI) MEDIC

The National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC) is tasked to perform data analysis to proactively fight fraud, waste, and abuse (FWA) in the Medicare Part C and D programs. The MEDIC identifies improper payments as a result of data analysis and assists HHS with recovering the improper payments. In FY 2013, the MEDIC conducted four projects related to the identification of improper payments. As a result of the MEDIC's analysis, in FY 2014 HHS recovered $63 million from Part D sponsors that corrected Prescription Drug Event (PDE) records.

Medicaid Integrity Program

Under the authority of Section 1936 of the *Social Security Act* as amended by the *Deficit Reduction Act of 2005* (DRA), HHS's 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 there has been a strong focus on Medicaid integrity since the enactment of the DRA. 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 $944.4 million in total collections in FY 2014. The DRA also required HHS to establish a Comprehensive Medicaid Integrity Plan to guide the Medicaid Integrity Program's development and operations. HHS's most recent Comprehensive Medicaid Integrity Plan for FYs 2014—2018 is available at http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/cmip2014.pdf.

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) partnered to advance the PARIS project at no cost to states. The DOD's Defense 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 executing Computer Matching Agreements and coordinating the quarterly matches. Since its establishment, PARIS has strengthened program administration among its programs and state public assistance agencies. For instance, three states reported that PARIS led to reported savings or cost avoidance of approximately $93.4 million in FY 2014 alone. More information on this effective partnership can be found at: http://www.acf.hhs.gov/paris.

9.0 Improper Payment Reduction Outlook FY 2013 through FY 2017

The following table displays HHS's IPIA results for the current year (CY) FY 2014, the prior year (PY) FY 2013, and targets for FYs 2015 through 2017. 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$). In addition, for the CY, HHS included: the amount of overpayments (CY Overpayments), the amount of underpayments (CY Underpayments), and the net error rate (CY Net IP%) and the corresponding overpayments (CY net IP$), when available.

Table 1

Improper Payment Reduction Outlook

FY 2013- FY 2017

(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	357,397 Note (a)	10.1	36,033	360,173 Note (b)	12.7 Note (1)	45,754	44,214	1,540	11.8	42,673	380,772 Note (c)	12.5	47,597	396,314	11.5	45,576	416,378	8.5	35,392
Medicare Part C	123,696 Note (d)	9.5	11,767	135,513 Note (e)	9.0	12,229	8,098	4,131	2.9	3,967	161,965 Note (f)	8.5	13,767	180,486	8.1	14,619	180,761	8.1	14,642
Medicare Part D	57,056 Note (g)	3.7	2,091	58,493 Note (h)	3.3	1,931	1,549	382	2.0	1,168	77,172 Note (i)	3.5	2,701	95,840	3.4	3,259	94,935	3.3	3,133
Medicaid	246,931 Note (j)	5.8	14,376	261,613 Note (k)	6.7 Note (2)	17,492	16,783	733	6.1	16,072	305,937	6.7	20,498	328,593	6.4	21,030	351,493	6.2	21,793
CHIP	9,065 Note (l)	7.1 Note (3)	646	9,469 Note (m)	6.5 Note (4)	612	603	10	6.3	594	11,486	6.5	747	12,711	6.4	814	12,609	6.2	782
TANF	16,521 Note (n)	N/A	N/A	16,327 Note (o)	N/A Note (5)	N/A	N/A	N/A	N/A	N/A	17,305	N/A	N/A	16,797	N/A	N/A	16,736	N/A	N/A
Foster Care	1,326 Note (p)	5.3	70	1,198 Note (q)	5.5	66.2	62.5	3.7	4.9	58.8	1,049	5.3	55.6	868	5.1	44.3	878	4.9	43.0
Child Care	5,188 Note (r)	5.9	306	5,239 Note (s)	5.7	299	274	25	4.8	250	5,278	5.6	296	5,326	5.4	288	5,311	5.2	276

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 outlays are from the FY 2013 Medicare FFS Improper Payments Report (based on claims from July 2011 – June 2012).
b) Medicare FFS CY outlays are from the FY 2014 Medicare FFS Improper Payments Report (based on claims from July 2012 – June 2013).
c) Medicare FFS CY+1, CY+2, CY+3 outlays are based on the FY 2015 Midsession Review (Medicare Benefit Outlays current law (CL)).
d) Medicare Part C PY outlays reflect 2011 Part C payments, as reported in the FY 2013 Medicare Part C Payment Error Final Report.
e) Medicare Part C CY outlays reflect 2012 Part C payments, as reported in the FY 2014 Medicare Part C Payment Error Final Report.
f) Medicare Part C CY+1, CY+2, CY+3 outlays are based on the FY 2015 Midsession Review (Medicare Benefit Outlays (CL)).
g) Medicare Part D PY outlays reflect 2011 Part D payments, as reported in the FY 2013 Medicare Part D Payment Error Final Report.
h) Medicare Part D CY outlays reflect 2012 Part D payments, as reported in the FY 2014 Medicare Part D Payment Error Final Report.
i) Medicare Part D CY+1, CY+2, CY+3 outlays are based on the FY 2015 Midsession Review (Medicare Benefit Outlays (CL)).
j) Medicaid PY outlays (based on FY 2012 expenditures) are from the FY 2014 Midsession Review and exclude CDC Vaccine for Children program funding.
k) Medicaid CY (based on FY 2013 expenditures) and CY+1, CY+2, CY+3 outlays (Medicaid - Outlays (CL) exclude CDC Vaccine for Children program funding), are from the FY 2015 Midsession Review.
l) CHIP PY outlays (based on FY 2012 expenditures) are from the FY 2014 Midsession Review.
m) CHIP CY (based on FY 2013 expenditures) and CY+1, CY+2, CY+3 outlays (CHIP Total Benefit Outlays with CHIPRA Bonus and Health Care Quality Provisions (CL)), are from the FY 2015 Midsession Review.
n) TANF PY outlays amount is based - on the FY 2014 Midsession Review.
o) TANF CY, and CY+1, CY+2, CY+3 outlays are based on the FY 2015 Midsession Review (TANF total outlays including the Healthy Marriage Promotion and Responsible Fatherhood Grants programs, and excluding the TANF Contingency Fund).
p) Foster Care PY outlays are based on the FY 2014 Midsession Review, and reflect the federal share of maintenance payments.
q) Foster Care CY, and CY+1, CY+2, CY+3 outlays are based on the FY 2015 Midsession Review, and reflect the federal share of maintenance payments.
r) Child Care PY outlays are based on the FY 2014 Midsession Review.
s) Child Care CY, and CY+1, CY +2, CY+3 outlays are based on the FY 2015 Midsession Review.

1. Beginning in FY 2012, in consultation with OMB, HHS refined the improper payment methodology to account for the impact of rebilling denied Part A inpatient hospital claims for allowable Part B services when a Part A inpatient hospital claim is denied because the services (i.e. improper payments due to inpatient status reviews) should have been provided as outpatient services. HHS continued this methodology in FY 2013 and FY 2014. 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 properly submitted as an outpatient claim under Medicare Part B. Application of the adjustment factor decreased the overall improper payment rate by 0.9 percentage points to 12.7 percent or $45.8 billion in projected improper payments. Additional information regarding the adjustment factor can be found on pages 166-167 of HHS's FY 2012 AFR (available at: http://wayback.archive-it.org/3922/20131030171234/http:/www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf).

On August 29, 2014, HHS announced that, to more quickly reduce the volume of inpatient status claims currently pending in the appeals process, HHS is offering an administrative agreement to any hospital willing to withdraw their pending appeals in exchange for timely partial payment (68 percent of the net allowable amount). The settlement is intended to ease the administrative burden for all parties. Any claims in the sample that are included in a settlement will still be considered improper for the measurement.

2. HHS calculated and is reporting the national Medicaid error rate based on measurements that were conducted in FYs 2012, 2013 and 2014. The national Medicaid error component rates are: Medicaid FFS: 5.1 percent; Medicaid managed care: 0.2 percent; and Medicaid eligibility: 3.1 percent.
3. Information presented in the CHIP prior year (PY) columns represents measurement results from the 34 states reviewed in 2012 and FY 2013.
4. HHS calculated and is reporting the first baseline measurement for CHIP based on the measurement of 50 states and the District of Columbia over a three-year period (FYs 2012, 2013 and 2014). The national CHIP error component rates are: CHIP FFS: 6.2 percent; CHIP managed care: 0.2 percent; and CHIP eligibility: 4.2 percent.
5. The TANF program is not reporting an error rate for FY 2014. Statutory limitations prohibit HHS from requiring states to participate in a TANF improper payment measurement. Please see *Section 10.60* for additional information on statutory limitations to establishing a TANF improper payment measurement.

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 stratified 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 50,544 claims were sampled during the FY 2014 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 page 165 of HHS's FY 2013 AFR, available at: http://www.hhs.gov/budget/fy2013/fy2013-other-information.pdf.

The Medicare FFS gross improper payment estimate for FY 2014 is 12.7 percent or $45.8 billion. The FY 2014 net improper payment estimate is 11.8 percent or $42.7 billion.

The factors contributing to improper payments are complex and vary from year to year.

The primary causes of improper payments are insufficient documentation and medical necessity errors. Insufficient documentation was particularly prevalent for home health claims. The improper payment rate for home health claims increased from 17.3 percent in FY 2013 to 51.4 percent in FY 2014 due to the implementation of documentation requirements to support the medical necessity of the services.

Another reason for the increase is attributed to medical necessity errors for inpatient hospital claims, particularly short stays determined to not be medically necessary in an inpatient setting (i.e., services should have been billed as outpatient).

10.12 Medicare FFS Corrective Action Plan

The primary cause of improper payments is Administrative and Documentation errors (67 percent), in large part due to insufficient documentation. The other cause of improper payments is classified as Authentication and Medical Necessity errors (33 percent), caused by medically unnecessary services, and to a lesser extent, incorrect coding errors. HHS strives to reduce improper payments in the Medicare FFS program. Improper payment data garnered from the CERT program and other sources is used to reduce or eliminate improper payments through various corrective actions. Each year, HHS outlines actions the agency will implement to prevent and reduce improper payments for all categories of error. While some corrective actions have been implemented, others are in the early stages of implementation. HHS believes these focused corrective actions will have a larger impact over time as they become integrated into business operations.

Of particular importance are four corrective actions that HHS believes will have a considerable effect in preventing and reducing improper payments:

- First, HHS issued a final rule, Centers for Medicare & Medicaid Services (CMS) CMS-1611-F (79-FR 66031, issued on November 6, 2014) to update Medicare's Home Health Prospective Payment System payment rates and wage index for calendar year 2015. This final rule also included three changes to the face-to-face requirements for episodes beginning on or after January 1, 2015. Since implementation of the face-to-face requirements in April 2011, HHS observed that the provider community had difficulty complying with the documentation requirements and these errors have increased the improper payment rate. HHS believes clarifying the face-to-face requirements will lead to a decrease in these errors and improve provider compliance with regulatory requirements, while continuing to strengthen the integrity of the Medicare program.
- Second, HHS implemented two major policies in CMS 1599-F (78 FR 50495, issued on August 2, 2013 and effective on October 1, 2013) pertaining to inpatient hospital claims that are expected to reduce improper payments:
    - HHS allowed all hospital participants to rebill, under Part B, denied Part A inpatient claims within one year from the service date when the service should have been billed as outpatient.
    - HHS clarified and modified the policy regarding when an inpatient admission is generally appropriate for payment under Medicare Part A.
- Third, HHS is expanding the use of prior authorization in the Medicare FFS program for durable medical equipment prosthetics orthotics and supplies (DMEPOS) items in two areas:
    - 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 led to a decrease in the expenditures for power mobility devices in both the demonstration and non-demonstration states. Specifically, based on claims submitted as of September 17, 2014, monthly expenditures for the power mobility devices included in the demonstration project decreased from $20 million in September 2012 to $5 million in March 2014 in the non-demonstration states; and from $12 million to $2 million in the demonstration states. Prior authorization reviews are being performed timely, industry feedback has been positive, and HHS has received no complaints from beneficiaries. HHS is leveraging this success by extending the demonstration to an additional 12 states (Arizona, Georgia, Indiana, Kentucky, Louisiana, Maryland, Missouri, New Jersey, Ohio, Pennsylvania, Tennessee, and Washington) effective October 1, 2014, bringing the total number of states participating in the demonstration to 19.

- HHS also proposed to establish a prior authorization process for certain DMEPOS items that are frequently subject to unnecessary utilization. Through a proposed rule, HHS has solicited public comments on this prior authorization process, as well as criteria for establishing a list of durable medical items that are frequently subject to unnecessary utilization.

- Fourth, in FY 2015 HHS will further test whether prior authorization in Medicare FFS reduces expenditures while maintaining or improving quality of care by launching two demonstration projects to test prior authorization for certain non-emergent services. HHS will implement a prior authorization demonstration program for: 1) non-emergent hyperbaric oxygen therapy in Illinois, Michigan, and New Jersey; and 2) repetitive, scheduled non-emergent ambulance transport in New Jersey, Pennsylvania, and South Carolina. Using a prior authorization process will ensure services are provided in compliance with applicable Medicare coverage, coding, and payment rules before services are rendered and claims are paid.

In addition to these four major efforts and the ongoing corrective actions reported on pages 165- 167 of HHS's FY 2013 AFR (http://www.hhs.gov/budget/fy2013/fy2013-other-information.pdf), HHS has implemented additional efforts in specific areas to reduce improper payments in the Medicare FFS program as outlined below.

Corrective Actions: Administrative and Documentation Errors

- Due to the volume of claims processed by Medicare each day and the significant cost associated with conducting medical review of an individual claim, HHS relies on automated edits to identify many inappropriate claims. HHS designed its systems to detect anomalies on the face of the claims, and through these efforts, we are paying the claims correctly as they are submitted nearly 100 percent of the time. For example, HHS uses the National Correct Coding Initiative (NCCI) to stop claims that never should be paid. This program prevents payments for services such as a hysterectomy for a man or a prostate exam for a woman. The use of the NCCI edits saved the Medicare program $530 million in FY 2013.
- The *Affordable Care Act* required HHS to revalidate all 1.5 million existing Medicare suppliers and providers under new risk-based screening requirements. Since March 25, 2011, more than 930,000 providers and suppliers have been reviewed under the new screening requirements. Since the implementation of these requirements, HHS has revoked 20,219 providers' and suppliers' ability to bill the Medicare program as a result of felony convictions, practice locations that were determined to be non-operational at the address HHS had on file, or non-compliance with HHS rules, such as licensure requirements.
- 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 anti-fraud practices within the HFPP, helping to prevent and detect fraud across sectors.

- HHS and its contractors develop medical review strategies using the improper payment data to ensure the areas of highest risk and exposure are targeted. HHS requires its Medicare review contractors to focus on identifying and preventing improper payments due to documentation errors in certain error prone claim types, such as home health, hospital outpatient, and skilled nursing facility (SNF) 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. In FY 2014 this contractor performed post payment reviews on five home health claims from every HHA, specifically to identify the presence of an adequate face-to-face encounter. The contractor also reviewed physician claims for the more expensive level 4 and 5 evaluation and management services. The results of these reviews are used by HHS and providers to improve billing accuracy.
- HHS continues to allow review contractors to review more claim types than in previous years, while closely monitoring the decisions made by these contractors. In February 2014, HHS announced a number of changes to the Medicare FFS Recovery Auditing Contractor (RAC) program that will take effect with the new contract awards as a result of stakeholder feedback. HHS believes that these improvements will result in a more effective and efficient program, including improved accuracy, less provider burden, and more program transparency.
- HHS issues 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 across the nation.
- HHS published CMS-6010-F, "Medicare and Medicaid Programs: Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements and Changes in Provider Agreements" (77 FR 25283), on April 27, 2012. For Medicare, effective January 6, 2014, this rule requires physicians and other professionals who order and certify certain covered items and services for Medicare beneficiaries to be a Medicare participating provider. These items and services include the following: home health, clinical laboratory, imaging and DMEPOS. Finally, it establishes document retention and access to documentation requirements for providers and suppliers that order and certify certain items and services for Medicare beneficiaries.

10.13 Medicare FFS Improper Payment Recovery

The actual overpayments identified by the CERT program during the FY 2014 report period were $53,725,898. The identified overpayments are recovered by the Medicare Administrative Contractors (MACs) via standard payment recovery methods. As of the report publication date, MACs reported collecting $44,243,005 or 82 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's 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. In addition, HHS continuously reviews opportunities for centralizing the development and implementation of automated edits based on national coverage determinations, medically unlikely units

billed, and other relevant parameters to prevent improper payments on a prepayment basis. No other systems or infrastructure are needed at this time.

10.15 Medicare FFS Statutory or Regulatory Barriers That Could Limit Corrective Actions

HHS has identified a statutory barrier that could limit Medicare FFS' corrective actions: current law limits HHS authority to conduct prior authorization on services that account for a large portion of the overall improper payments. Section 1834(a)(15) of the *Social Security Act* authorizes the Secretary to develop and periodically update a list of DMEPOS determined, on the basis of prior payment experience, to be subject to unnecessary utilization and to develop a prior authorization process for these items. However, current law does not allow for prior authorization of any other claim types or services. As a result, the FY 2015 President's Budget proposed amending Section 1893 of the *Social Security Act* to give the Secretary the discretion to select items or services for prior authorization without rulemaking where the items or services involve high cost, high utilization, patient risk, and/or high improper payment rates.

10.16 Medicare FFS Best Practices

HHS has incorporated the following best practices to ensure the highest degree of efficiency:

- HHS made significant progress in identifying fraud with the opening of the CMS Program Integrity Command Center in 2012. The Command Center is focused on driving innovation and improvement in reducing fraud and improper payments by providing a collaborative environment for multi-disciplinary teams to develop consistent approaches for investigation and action.
- HHS works with state Medicaid data in the Medicare-Medicaid Data Match program (Medi-Medi program). HHS designed the program to collaborate with participating state Medicaid agencies on billing trends across the Medicare and Medicaid programs. HHS analyzes matched data to identify potential fraud, waste, and abuse patterns. Analysis performed in the Medi-Medi program can reveal trends that are not evident in each program's claims data alone, making the program an important tool in identifying and preventing fraud and improper payments.
- HHS conducts re-reviews of certain claims that have been medically reviewed by the MACs to ensure accurate decisions are being made and that Medicare policies are being applied consistently across the program.
- 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 provider education strategies and materials addressing 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 what missing documentation needs to be submitted.
- When a supplier is contacted for documentation, the CERT program notifies the ordering provider that they may be contacted by the supplier in order to provide supporting documentation. In addition to this notification, the CERT program 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 hospital that possesses the record for professional services provided by a billing physician while the beneficiary was hospitalized.

10.20 Medicare Advantage or Part C

10.21 Part C Medicare Advantage Statistical Sampling Process

The FY 2014 Medicare Part C gross improper payment estimate is 9.0 percent or $12.2 billion. The FY 2014 net improper payment estimate is 2.9 percent or $4.0 billion. The primary factor that drove the program's decrease from the prior year's reported error estimate was more accurate diagnoses submitted by Medicare Advantage (MA) organizations for payment.

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's annual Risk Adjustment Data Validation (RADV) process, where unsupported diagnoses are identified and corrected risk scores are calculated.

The FY 2014 methodology consists of the following steps:

- Selection of a stratified random sample of beneficiaries for whom a risk adjusted payment was made in calendar year 2012, 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.

10.22 Medicare Advantage Corrective Action Plans

The root cause (100 percent) of FY 2014 Medicare Part C improper payments resulted from Administrative and Documentation errors due to insufficient documentation to support diagnoses submitted by the MA organizations.

HHS has implemented two key corrective actions to address the Part C improper payment rate: contract-level audits and new regulatory provisions.

- *Contract-Level Audits*: HHS is proceeding with the RADV contract-level audits to recover overpayments. RADV verifies, through medical record review, the accuracy of enrollee diagnoses submitted by MA

organizations for risk adjusted payment. RADV audits are HHS's 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, which began in FY 2014, will be the first HHS reviews to recoup funds based on extrapolated estimates.

- *New Regulatory Provisions*: In CMS-4159-F, "Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program" (79 FR 100), HHS codified the *Affordable Care Act* requirement that MA organizations must report and return overpayments that they identify. In CMS-1613-FC, "The Calendar Year 2015 OPPS/ASC Proposed Rule" (79 FR 134), HHS also established a payment recovery and appeal mechanism to be applied when HHS identifies erroneous payment data submitted by an MA organization.

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). Payment recovery for the pilot audits has been completed and totaled $13.8 million ($5.4 million was recovered in FY 2014, $5.0 million in FY 2013, and $3.4 million in FY 2012). In addition, HHS began the 2011 RADV audits in FY 2014, and expects payment recovery of audited plans to begin in FY 2016.

10.24 Medicare Advantage Information Systems and Other Infrastructure

HHS has the information systems and other infrastructure needed to reduce improper Medicare Part C payments. HHS uses the following internal Medicare systems to make and validate the Medicare 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 2014 is 3.3 percent or $1.9 billion. The FY 2014 net improper payment estimate is 2.0 percent or $1.2 billion. The primary factor that drove the program's decrease from the prior year's reported error estimate was a decrease in each component measure. This improvement was driven, in part, by a reduction in the eligibility component of the FY 2012 Payment Error Rate Measurement (PERM) Medicaid eligibility component error rate and a change in the Part D benefit design that has reduced government liability for some claims.

The FY 2014 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 2014 national Part D improper payment rate for each component is:

- *PELS*: 0.11 percent
- *PEMS*: 0.26 percent
- *PEPV*: 2.76 percent
- *PEDIR*: 0.11 percent

The methodology for calculating the PELS, PEMS, PEPV, and PEDIR rates was not altered from previous years. A description of the methodology may be found on pages 173-175 of HHS's FY 2012 AFR (http://wayback.archive-it.org/3922/20131030171300/http:/www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf).

10.32 Medicare Prescription Drug Corrective Action Plan

The root cause of all FY 2014 Part D improper payments (100 percent) is Administrative and Documentation errors. HHS conducted the following corrective actions to address errors:

- *Training:* HHS will continue its national training sessions for Part D sponsors on Part D payment and data submission.
- *Outreach:* Formal outreach to plan sponsors will continue for invalid/incomplete documentation, including errors due to missing provider signatures on Long Term Care medication orders.
- *New Regulatory Provisions:* HHS codified the *Affordable Care Act* requirement that Part D sponsors must report and return overpayments that they identify. HHS also established a payment recovery and appeal mechanism to be applied when HHS identifies erroneous payment data submitted by a Part D sponsor (See *Section 10.22* for more information on the rules).

10.33 Medicare Prescription Drug Benefit Improper Payment Recovery

HHS conducted the following improper payment recovery activities in FY 2014 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 2014 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 data used to develop the FY 2014 error rate was based on 2012 audits. Plans submit updates to their reported DIR amounts throughout the year. HHS will, therefore, address payment recovery through the 2012 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 2014 Medicaid improper payment rate is based on measurements conducted in FYs 2012, 2013, and 2014. 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's FY 2012 AFR (http://wayback.archive-it.org/3922/20131030171300/http:/www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf).

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 966 claims per state and the managed care sample size was between 231 and 286 payments per state. 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 seven states.

Eligibility Component

States conducted an eligibility review on a randomly selected sample of between 144 and 972 active cases and between 132 and 792 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 projected 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 projected dollar value of claims for the sample of beneficiaries each month (i.e., projected dollars in error over total projected dollars). 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 under the *Affordable Care Act* that started in January 2014. These changes will impact Medicaid and CHIP improper payment rates and associated reporting 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." Additionally, HHS incorporates state-level error rate recalculations for the states measured in FY 2012 and FY 2013 into the national Medicaid improper payment rate. Two state-level FFS error rates were recalculated subsequent to FY 2013 reporting and are incorporated into FY 2014 improper payment rate reporting.

The national Medicaid gross improper payment estimate for FY 2014 is 6.7 percent or $17.5 billion. The FY 2014 net improper payment estimate is 6.1 percent or $16.1 billion. This rate increased from prior years due to an increase in the FFS component, as discussed in *Section 10.42.* Both the eligibility and managed care components of the rate decrease from the prior year estimate.

The FY 2014 national Medicaid improper payment rate for each component is:

- *Medicaid FFS*: 5.1 percent
- *Medicaid managed care*: 0.2 percent
- *Medicaid eligibility*: 3.1 percent

Within the Medicaid eligibility case error rate, the active case error rate is 2.8 percent and the negative case error rate is 4.8 percent.

10.42 Medicaid Corrective Action Plans

States reviewed for the FY 2014 AFR measurement were the same states reviewed in FY 2011.

The improper payment rate for these states increased from 6.7 percent in FY 2011 to 8.2 percent in FY 2014, causing an increase in the FY 2014 national Medicaid error rate. The FFS component reported the greatest increase, rising from 3.6 percent to 8.8 percent. However, the eligibility component reported a decrease, dropping from 4.0 percent to 2.3 percent, and the managed care component dropped from 0.5 percent to 0.1 percent.

Overall, the largest reason for the FY 2014 improper payments (by dollar amount) was Verification errors (80 percent), which were mostly caused by errors related to state claims processing systems not being fully compliant with new requirements. These new requirements include: all referring or ordering providers must be enrolled in Medicaid, states must screen providers under a risk-based screening process prior to enrollment, and attending providers must include their National Provider Identifier (NPI) on all electronically filed institutional claims. While these requirements will ultimately strengthen Medicaid's integrity, they require systems changes that many states have not fully implemented. The second largest cause of improper payments was Authentication and Medical Necessity errors (11 percent), which were mostly due to provider billing errors. The remaining improper payments were attributed to Administrative and Documentation errors (10 percent), and were mostly due to insufficient documentation 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, with assistance and oversight from HHS. HHS received CAPs from all states whose Medicaid programs were previously measured, and all states measured in FY 2014 are developing 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.

Since the Medicaid FFS improper payment rate was primarily driven by state systems having difficulty complying with new requirements, State CAPs will focus on systems changes to reduce these errors. Methods will include implementing new claims processing edits, converting to a more sophisticated claims processing system, and implementing a new provider enrollment process to make it easier for referring providers to enroll in the program. Because much of the Medicaid FFS improper payment rate in the past was due to missing or insufficient documentation, State CAPs have also focused on provider communication and education to reduce errors related to these categories. 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 to identify areas of vulnerability and target solutions. 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; 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 173-174 of HHS's FY 2013 AFR (http://www.hhs.gov/budget/fy2013/fy2013-other-information.pdf), HHS has implemented additional efforts to lower improper payments rates:

- HHS completed a "mini-PERM audit" in one state and continued a mini-PERM audit in one state. 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, 2014, 47 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 three states have HHS-approved exceptions.
- HHS made available via a website (http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html) a variety of educational tool kits which include videos, fact sheets, and checklists that were made specifically for providers and beneficiaries. These educational resources are intended to educate providers, beneficiaries, and other stakeholders in promoting best practices and awareness of Medicaid fraud, waste and abuse.
- HHS worked with the National Association of Medicaid Directors (NAMD) to establish an executive workgroup to focus on strengthening financial management and program integrity within the Medicaid program. That workgroup has met regularly and has made substantial progress in expanding state access to Medicare and HHS data for program integrity purposes.

10.43 Medicaid Program Improper Payment Recovery

Through the PERM program, HHS identified $1,570,419; $152,968; and $631,595 in Medicaid overpayments eligible for recovery for FYs 2012, 2013 and 2014, respectively. The decrease in Medicaid overpayments eligible for recovery in FY 2013 compared to FY 2012 was due to a decrease in the dollar value of overpayments that were identified in the sample. In addition, the amount of Medicaid overpayments eligible for recovery for FYs 2012 and 2013 was amended from information previously reported in HHS's FY 2013 AFR to reflect changes made during state-level error rate recalculations.

HHS works closely with states to recover overpayments identified from the FFS and managed care claims sampled and reviewed. Recoveries of Medicaid improper payments are governed by Section 1903(d)(2) of the *Social Security Act* and related regulations at 42 CFR Part 433, Subpart F under which states must return the federal share of overpayments. States reimburse HHS for the federal share of overpayments on the Medicaid CMS-64 expenditure report. 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. In addition to errors caused by state systems non-compliance with new requirements, 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. In addition, HHS has approved enhanced federal funding for five states to implement predictive analytics technologies that are integrated with State MMIS. The state systems workgroup (composed of HHS and state staff representatives) meets regularly to identify and discuss system vulnerabilities and the impact on the measurement of improper payments. HHS also developed a methodology to measure aggregate claims and this has 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 from MSIS to T-MSIS on a rolling basis with the goal of having all states submitting data in the T-MSIS file format in 2015.

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 page 175 of HHS's FY 2013 AFR (http://www.hhs.gov/budget/fy2013/fy2013-other-information.pdf) HHS incorporated the following efforts into the Medicaid measurement process:

- HHS continues to offer training, technical assistance, and support to state Medicaid program integrity officials through the Medicaid Integrity Institute (MII). Between FYs 2008 and 2014, the MII provided training to state employees and officials from 50 states, the District of Columbia, and Puerto Rico through over 5,100 enrollments in 114 courses and 8 workgroups at no cost to the states.
- HHS developed a PERM Standard Operating Procedure to provide consistent direction and instruction to state Medicaid and CHIP agencies regarding responsibilities during a PERM cycle. During periods of high staff turnover within the states, this document will prevent delays or issues in complying with the PERM program by providing detailed instructions to new staff.
- HHS issues quarterly PERM Newsletters to keep all states up-to-date on important information regarding the PERM program.
- HHS hosts http://www.medicaid.gov/ as a one-stop-shop for federal policy, guidance, data, and program information about Medicaid and CHIP.
- HHS continues the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and reduce improper coding which may result in improper payments of Medicaid claims.

10.50 Children's Health Insurance Program or CHIP

10.51 CHIP Statistical Sampling Process

The national FY 2014 CHIP improper payment rate is based on measurements conducted in FYs 2012, 2013, and 2014. This is the first year that HHS is reporting a CHIP baseline improper payment rate. 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 175-177 of HHS's FY 2013 AFR (http://www.hhs.gov/budget/fy2013/fy2013-other-information.pdf).

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 states reviewed in FY 2012 accepted their previous CHIP improper payment rates and no historical improper payment rate data was available for states reviewed in FY 2013 or FY 2014, no state-specific sample sizes were utilized.

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 the majority of states, state-specific sample sizes were not utilized during this three-year measurement cycle except for one state measured in FY 2012. The state had a state-specific sample size of 360 active cases and 156 negative cases based on their FY 2009 eligibility improper payment rate data.

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

The national CHIP improper payment rate represents the combination of each state's FFS, managed care, and eligibility improper payment rates. In addition, individual state improper payment rate components are combined to calculate the national component 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. A small correction factor ensures that CHIP eligibility improper payments do not get "double counted." Additionally, HHS incorporates state-level error rate recalculations for the states measured in FY 2012 and FY 2013 into the national CHIP improper payment rate. Two state-level FFS error rates were recalculated subsequent to FY 2013 reporting and are incorporated into FY 2014 improper payment rate reporting.

The national CHIP gross improper payment estimate for FY 2014 is 6.5 percent or $612 million. The FY 2014 net improper payment estimate is 6.3 percent or $594 million. This is the first baseline improper payment rate for

CHIP reflecting the measurement of all states. Comparing the baseline rate to the prior year's reported error estimate does not necessarily reflect a reduction in improper payments because this year HHS has incorporated the final cycle of states measurements into the estimate.

The FY 2014 national CHIP improper payment rate for each component is:

- *CHIP FFS* – 6.2 percent
- *CHIP managed care* – 0.2 percent
- *CHIP eligibility* – 4.2 percent

Within the CHIP eligibility error rate, the active case error rate is 4.8 percent and the negative case error rate is 2.8 percent.

10.52 CHIP Corrective Action Plans

HHS's experience is that improper payment rates 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 2014 improper payments (by dollar amount) were a result of Verification errors (70 percent), which were mostly caused by errors related to state claims processing systems. The second largest cause of improper payments was Administrative and Documentation errors (15 percent), which were mostly due to insufficient and no documentation errors. The third leading cause of errors was Authentication and Medical Necessity errors (15 percent), which were mostly due to policy violations and providers billing the wrong number of units.

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, with assistance and oversight from HHS. HHS received CAPs from all states whose CHIP programs were previously measured, and all states measured in FY 2014 are developing 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.

Since the CHIP FFS improper payment rate was primarily driven by state's systems having difficulty complying with new requirements, state CAPs will focus on systems changes to reduce these errors. Methods include: implementing new claims processing edits, converting to a more sophisticated claims processing system, and implementing a new provider enrollment process to make it easier for referring providers to enroll in the program. Because missing or insufficient documentation is also a contributor to the CHIP improper payment rate, the state CAPs also focused on strengthening provider communication and education to reduce errors related to these categories. These methods included enhancing provider training, presentations, newsletters, notices, bulletins, and provider broadcasts; conducting outreach to public providers; and performing more provider audits to identify areas of vulnerability and target solutions. For eligibility errors, state corrective actions included clarifying written state policies; launching a more advanced and improved electronic client eligibility system; providing refresher training for eligibility staff; and producing informational broadcasts regarding changes to eligibility policy and procedures.

In addition to the development, execution, and evaluation of the state-specific CAPs, HHS completed a "mini-PERM audit" with two states and continued a mini-PERM audit with one state. 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.

10.53 CHIP Program Improper Payment Recovery

HHS identified $384,994; $161,764; and $691,352 in CHIP overpayments eligible for recovery for FYs 2012, 2013, and 2014 respectively. In addition, the amount of CHIP overpayments eligible for recovery for FYs 2012 and 2013 was amended from information previously reported in HHS's FY 2013 AFR to reflect changes made during state-level error rate recalculations.

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 2105(c)(6)(B) and Section 2105(e) of the *Social Security Act* 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 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 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 178 of HHS's FY 2013 AFR (http://www.hhs.gov/budget/fy2013/fy2013-other-information.pdf), HHS incorporated the following efforts into the CHIP measurement process:

- HHS developed a PERM Standard Operating Procedure to provide consistent direction and instruction to State Medicaid and CHIP agencies regarding responsibilities during a PERM cycle. During periods of high staff turnover within the states, this document will prevent delays or issues in complying with the PERM program by providing detailed instructions to new staff.
- HHS issues quarterly PERM Newsletters to keep all states up-to-date on important information regarding the PERM program.
- HHS hosts http://www.medicaid.gov/ as a one-stop-shop for federal policy, guidance, data, and program information about Medicaid and CHIP.

10.60 Temporary Assistance for Needy Families of 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 2014.

10.62 TANF Corrective Action Plans

Due to TANF being 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 material non-compliance 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 is monitoring a TANF Program Integrity Innovation Grant funded from OMB's Partnership Fund for Program Integrity Innovation. The state human service agency grantee is conducting a pilot project designed to reduce improper payments and improve administrative efficiency in the state's TANF program. Lessons learned from the pilot will be used to improve internal efficiency and provide guidance to other state human service agencies looking to improve TANF program integrity.
- HHS is implementing revisions to the TANF financial reporting form, which will require states to provide more accurate information about the ways states are using their TANF block grants and meeting their Maintenance-of-Effort obligations. The changes will take effect in FY 2015 and include a revised and expanded list of spending categories as well as a change to the accounting method to more accurately track actual expenditures that occur in a fiscal year.
- In February 2014, HHS published a Notice of Proposed Rulemaking regarding State Reporting on Policies and Practices to Prevent the Use of TANF Funds in Electronic Benefit Transfer Transactions in Specified Locations. The proposed regulations would require states, subject to penalty, to maintain policies and practices that prevent TANF funded assistance from being used in any electronic benefit transfer transaction in specified locations. The locations, specified in the *Middle Class Tax Relief and Job Creation Act of 2012*, are: liquor stores; any casino, gambling casino, or gaming establishment; and any retail establishment that provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment. HHS anticipates that the final regulation will be published in FY 2015.

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 2014.

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", eligibility redeterminations, 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 2014. 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's FY 2012 AFR (http://wayback.archive-it.org/3922/20131030171300/http:/www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf).

The Foster Care gross improper payment estimate for FY 2014 is 5.5 percent or $66.2 million. The FY 2014 net improper payment rate is 4.9 percent or $58.8 million. The primary factor that drove the program's increase from the prior year's calculated error rate estimate was the performance of three large states that were reviewed in this cycle. Two of these large states reported two to three percent increases in their error rate estimates, and the third state maintained an error rate above 10 percent.

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 CAPs 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 2014, the most common payment errors included:

- Underpayments (27 percent of errors),
- Provider not licensed or approved (10 percent of errors),
- Ineligible payments (e.g., therapy or unallowable transportation costs) (9 percent of errors),
- No safety documentation for institutional caregiver staff (9 percent of errors),
- Provider criminal records check not completed (8 percent of errors), and
- Family not eligible for the Aid to Families with Dependent Children program at time of removal (8 percent of errors).

Together these six items account for 70 percent of Foster Care payment errors. Although underpayments represent just over one-quarter of all errors in terms of frequency, the dollar amount of the underpayments continued to decrease in 2014 as the underpayment rate improved from 0.5 percent in FY 2013 to 0.3 percent in FY 2014.

In FY 2014, HHS undertook the following key action to reduce improper payments:

- Based on discussions with individual states on review preparation and compliance results, HHS is working with states to emphasize and develop strategies for continuous program improvement with an emphasis on: viewing the quality assurance process as an ongoing, systematic process that is not limited to review preparations or results; and developing sound program improvements that support systemic change and sustain the improvement effort.

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, and each action strategy is required to have a projected completion within one year from the date HHS approved the plan. 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 15 states during the 12-month period between July 2013 and June 2014, HHS recovered over $1.4 million in Title IV-E improper payments. The recovered funds are comprised of $994,710 in disallowed maintenance payments and $449,595 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 $19.4 million in improper payments for the FY 2004 through FY 2014 reporting periods.

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). HHS has compiled the results of nine pilot tests of the ACR methodology conducted between FY 2007 and FY 2012, and is continuing to assess the feasibility of using the ACR process in the future.

10.80 Child Care or CCDF

10.81 Child Care Statistical Sampling Process

The methodology for measuring improper payments uses a case-record review process to determine if child care subsidies were properly paid for services provided to eligible families. The methodology focuses on improper payments made, and enables states to determine the types of errors and their sources. For the CCDF improper payments methodology, please see http://www.acf.hhs.gov/programs/occ/resource/program-integrity-and-accountability-improper-payments-error-rate-review.

Data reported in the previous two review cycles, based on the original implementation of the CCDF error rate methodology, measured improper authorizations for payment. After an evaluation of the review process, HHS determined that "improper authorizations for payment" was not a sufficient proxy for "improper payment." In pilot tests, substantial variances between authorizations and payments emerged, with authorizations estimated to be as much as 20 percent higher. Thus, HHS revised the methodology, enabling states to assess accuracy in payments made as a result of child care eligibility determinations, rather than authorizations for services that may or may not have actually been paid.

This review cycle, using the revised methodology, incorporates the following changes to the error rate methodology: (a) drawing samples from a universe of paid cases instead of cases with an authorization for payment, (b) measuring improper payments instead of improper authorizations for payment, and (c) requiring states with error rates exceeding ten percent to submit a CAP. The error rate methodology and reporting requirements continue to focus on administrative errors associated with client eligibility, consistent with the focus of the initial methodology.

The CCDF gross improper payment estimate for FY 2014 is 5.7 percent or $299 million. The FY 2014 net improper payment estimate is 4.8 percent or $250 million. The primary factor that drove the program's decrease from the prior year's reported error estimate was tates implementing steps to improve programs and reduce errors, including revising policies, expanding staff training, and enhancing information systems.

10.82 Child Care Corrective Action Plans

Verification errors represent approximately 70 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 (12 states),
- Unit of care authorized (7 states),
- Provider payment (6 states), and
- Application or redetermination forms (3 states).

Administrative and Documentation errors account for an estimated 30 percent of errors identified in the CCDF improper payment review process. Errors were primarily due to missing or insufficient documentation. The most frequently cited errors due to missing or insufficient documentation include:

- Paystubs or income verification (10 states),
- Need for care (such as work or school schedules) (7 states), and
- Application or redetermination forms (3 states).

HHS and states have established corrective actions targeting both error types. States reporting in FY 2014 plan the following actions:

- Training and technical assistance: Providing technical assistance for eligibility staff on error-prone issues; clarifications of policy; or Information Technology (IT) systems training (14 states).
- Ongoing quality assurance reviews: Performing ongoing audits and reviews, and implementing CAPs for eligibility agencies with high error rates (6 states).
- Policy revisions: Reviewing and possibly revising program policy and procedures, either based on the current error review or after conferring with eligibility agencies (6 states).
- Information Technology (IT) systems: Enhancing IT systems to reduce errors; for example, implementing additional rules or warnings when questionable data is entered (5 states).

HHS's corrective actions have been consistent over time and assist states in reducing their error rates. This ongoing work includes the following activities:

- Providing technical assistance to states around policy and procedure changes that will streamline processes and reduce errors.
- Delivering technical assistance to states regarding updating or developing IT systems that will improve practices and reduce errors.
- Providing individual reporting cohort training on the methodology that allows states to learn best practices from each other as they conduct the reviews.
- Starting training early to allow states time to learn the methodology and implement in real time.

10.83 Child Care Program Improper Payment Recovery

Under the revised methodology effective in FY 2014, grantees provide information on both the estimate they expect to recover from the current review and any funds recovered from prior reviews. CCDF regulations only require states to recover misspent funds due to fraud. States have discretion whether to recover misspent funds for other reasons. All misspent funds are subject to disallowance.

The cumulative FY 2014 CCDF improper overpayment amount is $399,947. The overall improper payment estimate is comprised of three review cycles: FYs 2012, 2013, and 2014. The improper payments are as follows for each cycle:

- Year One States (reported in FY 2014) - $50,736,
- Year Two States (reported in FY 2012) - $146,914, and
- Year Three States (reported in FY 2013) - $202,297.

The estimates for the Year Two and Year Three States are based on the previous methodology, which measured improper authorizations for payment. The figures will reflect actual improper payments once the Year Two and Year Three States complete a review under the revised methodology in FYs 2015 and 2016, respectively.

The FY 2014 review cycle represents the third time that Year One States have conducted the error rate measurement. In FY 2011, the last time this cycle of states was measured, they reported an improper

overauthorization amount of $155,883, and they anticipated recovering 7.4 percent, or $11,576, of this total. States reported actual recoveries of 5.8 percent, or $9,043, of the $155,883 overauthorization amount.

Under the revised methodology implemented in FY 2014, the Year One States reported improper payments of $50,736 in FY 2014, and they anticipate recovering 23 percent, or $11,807, of these improper payments. Reports submitted in FY 2017 will address any amounts recovered based on the FY 2014 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 in prior HHS AFRs, states reported a range of other improvements to information systems including:

- Automating copay determinations,
- Building additional functions for payment management and tracking,
- Strengthening capabilities to assist in the recovery of improper payments, and
- Enhancing system supports for staff who audit providers.

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

In addition to those best practices cited in prior reports, Year One States also reported:

- Updating review tools: Some states developed an electronic customized Record Review Worksheet, which helped reviewers be more consistent and thorough in their reviews (5 states).
- Clarifying policy and rules: Rules and policy that were found to be challenging during the previous cycle were clarified or updated, assisting both eligibility and review staff (4 states).
- Ongoing communication of review findings: Through regular meetings, eligibility and review staff discussed case findings and addressed concerns that could result in errors (4 states).
- Conducting secondary reviews: Secondary and tertiary-level reviews contributed to accuracy and promoted accountability for review staff (3 states).
- Upgrading IT systems: Electronic record storage and case document imaging upgrades allowed for faster reviews (2 states).

HHS best practices included:

- Revised the error rate methodology to increase precision in the error rate measurement.
- Continued implementing the Grantee Internal Controls Self-Assessment as an important mechanism to help states identify areas of strength and risk, as well as strategies to improve their programs and reduce errors.
- Continued to provide opportunities for peer-to-peer sharing to enhance learning and shared understanding about best practices in program implementation across the country.

11.0 Recovery Auditing Reporting

HHS developed a risk-based strategy to implement the recovery auditing provisions of *IPERA*. Specifically, HHS is focusing on implementing recovery audit programs in Medicare and Medicaid, which accounted for 85 percent of HHS's outlays in FY 2014. We are making substantial progress in recovering improper payments in Medicare and Medicaid, and, most importantly implementing corrective actions to prevent improper payments, 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 2014, the Medicare FFS RAC program demanded approximately $1.9 billion and recovered $2.4 billion in overpayments by the end of the fiscal year. The amount of improper payments identified was lower than the amount of improper payments recovered primarily due to the cessation in RAC activities under the old Medicare FFS RAC contracts and a delay in awarding new Medicare FFS RAC contracts. This resulted in fewer reviews and less identified improper payments than in previous years. Meanwhile, amounts that were identified in previous years continued to be collected. During FY 2014, the majority of Medicare FFS RACs collections were from inpatient hospital claims and outpatient therapy services. 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 2014, HHS released four Provider Compliance Newsletters that provided detailed information on 19 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/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program.

Medicare Secondary Payer RACs

The Medicare Secondary Payer (MSP) RAC began full recovery operations at the end of FY 2013 and operates as the MSP Commercial Repayment Center ("CRC"). The CRC reviews HHS information regarding beneficiaries that had or have primary coverage through an employer-sponsored Group Health Plan (GHP). When that information is incomplete, Medicare FFS may mistakenly pay for services as the primary payer. The CRC recovers these mistaken payments from the entity that had primary payment responsibility (typically the employer or other plan sponsor, insurer, or claims processing administrator). The debtors for these MSP debts do not have formal appeal rights, but do have the opportunity to dispute the debt through the established "defense" process. In FY 2014, the CRC demanded approximately $234.2 million and collected $59.3 million in mistaken payments.

In FY 2015, the CRC will introduce a new, secure web-based tool designed to provide employers, insurers, and third-party administrators a way to electronically manage their GHP recovery activities. This tool is designed to improve customer service, increase efficiency, and ultimately increase recoveries for the program. More information on the CRC can be found at: http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Group-Health-Plan-Recovery/Group-Health-Plan-Recovery.html.

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. As part of the procurement process to secure a Medicare Part C RAC, HHS posted a Request for Quote (RFQ) in June 2014; however, no responses were received as a result of that solicitation. HHS continues its implementation efforts and anticipates awarding a Part C RAC contract in 2015.

The Part D RAC program became fully operational in FY 2012, and is currently reviewing prescription drug claims for calendar years 2008 through 2012. Since its launch, the Part D RAC identified overpayments made as a result of prescriptions written by excluded or unauthorized providers or filled at excluded pharmacies. At the end of FY 2013, HHS sent notification letters for overpayments totaling approximately $3.4 million to plans. As a result, approximately $2.7 million was recovered in FY 2014, with the remaining amount overturned on appeal. Additionally, $5.3 million in overpayments were identified in FY 2014, and recoupment is expected in FY 2015.

In FY 2015, the Part D RAC will review unauthorized prescribers, Drug Enforcement Agency (DEA) schedule drug refill errors, and duplicate payments. 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 states to submit assurances by December 31, 2010 that their programs meet the statutory requirements to establish State Medicaid RAC programs. States were required to implement RAC programs by January 1, 2012, so federal FY 2012 reporting encompassed nine months of results. FY 2014 was the second 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 totaled $55.1 million in FY 2014. State Medicaid RAC federal-share recoveries include overpayments collected, adjusted, or refunded to HHS, as reported by states on the CMS-64.

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, 2014, 47 states and the District of Columbia have implemented Medicaid RAC programs. The remaining three 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 auditing 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 2014
(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) Note 2	% 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	$1,894.1 Note 3	$2,394.8	126%	$0 Note 3	0% Note 3	N/A	N/A	$7,966.0 Note 4	$6,815.1 Note 4	$9,860.0	$9,210.0	$1,150.9	N/A
Medicare Secondary Payer Recovery Auditor	N/A	N/A	$234.2 Note 5	$59.3 Note 6	25%	$174.9	75%	N/A	N/A	N/A	N/A	$234.2 Note 7	$59.3 Note 7	$174.9	N/A
Medicare Part C Recovery Auditors	N/A Note 8	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	$5.3	$2.7	51%	$2.6	49%	N/A	N/A	$5.2	$1.8	$10.4	$4.5	$6.0	N/A
State Medicaid Recovery Auditors	N/A	N/A	N/A Note 9	$55.1	N/A	N/A	N/A	N/A	N/A	N/A	$132.1	N/A	$187.1	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	$0.074	$1.6	$0.074	N/A	N/A

Notes:

1. 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 Amount Recovered (CY) and Amount Recovered (PYs) cells may not add to the Cumulative Amount Recovered (CY + PYs) cell.
2. The amount reported in the Amount Recovered (CY) column is the amount recovered in FY 2014, regardless of the year the overpayment was identified.
3. The transition process for new Medicare FFS recovery auditors began in FY 2014. As a result, fewer reviews were conducted which led to a smaller amount identified for recovery (CY). The smaller amount identified for recovery creates a negative number for the Amount Outstanding (CY) and % of Amount Outstanding out of the Amount Identified (CY) cells, thus HHS entered zeroes in these cells.
4. The Medicare FFS recovery auditors Prior Year (PYs) columns reflect recovery audit information reported in the FYs 2010 - 2013 AFRs.
5. The Medicare Secondary Payer recovery auditor Amount Identified for Recovery (CY) column is the amount of mistaken payments identified from when the program became fully operational in FY 2014.
6. The Medicare Secondary Payer recovery auditor maintains all debts established under prior MSP recovery programs; consequently, the reported collections is the amount recovered in FY 2014, regardless of the year the mistaken payment was identified.

7. Cumulative amounts reflect FY 2014 totals, as the MSP recovery auditor only commenced full recovery operations in the second quarter of FY 2014
8. HHS expects to award a contract for a Medicare Part C RAC program in FY 2015. Accordingly, HHS is not reporting Medicare Part C RAC results in the FY 2014 AFR.
9. For State Medicaid recovery auditor programs, states are only required to report the amount of recoveries on the CMS-64, and not 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 as of the publication date of the Agency Financial Report.

Table 3
Payment Recapture Audit Targets
FY 2014[1]
(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	$1,894.1 Note 2	$2,394.8 Note 2	126%	85%	85%	85%
Medicare Secondary Payer Recovery Auditor	$234.2	$59.3	25%	85%	85%	85%
Medicare Part D Recovery Auditors	$5.3	$2.7	51%	85%	85%	85%

Notes:
1. The State Medicaid recovery auditors are not included in this table since states do not report information to HHS on recovery rate targets.
2. For the Medicare FFS recovery auditors, the amount of improper payments identified was lower than the amount of improper payments recovered primarily due to the cessation in recovery auditor activities under the old Medicare FFS recovery auditor contracts and a delay in awarding new contracts. This resulted in fewer reviews and less identified improper payments than in previous years. Meanwhile, amounts that were identified in previous years continued to be collected.

Table 4
Aging of Outstanding Overpayments
FY 2014[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	$90.9 Note 2 & Note 3	$223.3	0
Medicare Secondary Payer Recovery Auditor Note 4	$146.9 Note 2	$41.1	0
Medicare Part D Recovery Auditors	N/A Note 5	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 aging of overpayment amounts that are currently outstanding.

2. The amount of outstanding Medicare FFS and Medicare Secondary Payer recovery auditors overpayments identified in this table does not match the amount outstanding identified in Table 2 because this table includes information from FY 2014 only whereas Table 2 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. The Medicare Secondary Payer recovery auditor maintains debts established under prior MSP recovery programs; consequently, collections exclusively related to mistaken payments identified by the MSP recovery auditor does not directly correlate to the amount outstanding.
5. Recoupments of FY 2014 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 during FY 2015.

Table 5
Disposition of Recaptured Funds
FY 2014[1,2]
(in Millions)

Type of Payment	Agency Expenses to Administer the Program	Payment Recapture Auditor Fees	Financial Management Improvement Activities	Original Purpose[3]	Office of Inspector General	Returned to Treasury
Medicare FFS Recovery Auditors	$186.3	$274.6	N/A	$1,760.9	N/A	N/A
Medicare Secondary Payer Recovery Auditor	$0.3	$8.4	N/A	$50.6	N/A	N/A
Medicare Part D Recovery Auditors	N/A	$0.7	N/A	$1.9	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 state portion of recoveries are used. The federal share of recoveries is returned to the Treasury.
2. For presentation purposes, this table uses rounded numbers. Therefore, some calculations using the figures in the table may not produce the amounts in other tables. For example, adding the Medicare FFS Recovery Auditors cells does not add to the Amount Recovered (CY) cell in Table 2.
3. 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 auditor contingency fees. In addition, the Medicare FFS Recovery Auditors "Original Purpose" cell also takes into consideration underpayments to providers that were identified and corrected ($173.1 million).

Table 6
Overpayments Recaptured Outside of Payment Recapture Audits
FY 2014
(in Millions)[1]

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	$53.7	$44.2	$70.9	$58.7	$124.6	$102.9
Medicare Contractors Note 2	$12,980.1	$10,793.3	$39,087.5	$32,046.3	$52,067.6	$42,839.6
Medicare Part C	$0	$0	$1.7	$0	$1.7	$0
Medicare Part D	$0	$0	$0.2	$0	$0.2	$0
Medicare Part C RADV Audits	$5.4	$5.4	$8.4	$8.4	$13.8	$13.8
Medicaid Error Rate Measurement	$0.6	$0.3	$3.6 Note 3	$2.0	$4.2	$2.3
CHIP Error Rate Measurement	$0.7	$0.1	$0.5 Note 3	$0.2	$1.2	$0.3
Medicaid Integrity Contractors-Federal Share-FMAP rates	$15.7 Note 4	$5.9	$22.2 Note 4	$4.4	$37.9 Note 4	$10.3
Foster Care Eligibility Reviews = Post-Payment Reviews	$1.4	$1.4	$17.9	$17.9	$19.4	$19.4
Foster Care OIG Reviews	$58.3	$0.8	$207.1	$102.9	$265.4	$103.7
Foster Care Single Audits	$22.1	$28.2	$34.9	$33.4	$57.0	$61.6
Child Care Single Audits	$0	$0.5	$6.9	$5.8	$6.9	$6.2
Child Care-Error Rate Measurement Note 5	$0.05	$0.009	$0.9	$0.00	$1.0	$0.009
Head Start- OIG Reviews	$8.1	$0.5	$7.0	$5.1	$15.1	$5.6
Head Start- Single Audits	$1.6	$0.2	$3.9	$4.3	$5.5	$4.5

Notes:

1. 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 Amount Recovered (CY) and Amount Recovered (PYs) cells may not add to the Cumulative Amount Recovered (CY + PYs) cell.
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 this table.
3. For the Medicaid measurements, the Amount Identified (PYs) information that was reported in the FY 2013 AFR was amended to reflect changes made during state-level error rate recalculations. The Medicaid error rate measurement's Amount Identified (PYs) was amended from $3.7 million to $3.6 million. For the CHIP measurement, the Amount Identified (PYs) information that was reported in the FY 2013 AFR was also amended to reflect changes

made during state-level error rate recalculations as discussed in *Section 10.53.* However, due to rounding the small changes did not affect reporting in this table.

4. For Medicaid, the Medicaid Integrity Contractors (MICs) identified total overpayments which include both the federal and state shares. For the Amount Identified (CY) column and the FY 2013 data included in the Amount Identified (PYs) column, HHS has reported the actual federal share across audits. For data prior to FY 2013 included in 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.
5. 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. This is the first year that recovery amounts are being reported for the CCDF program. Therefore, no prior year recovery amounts are indicated.

12.0 Do Not Pay Initiative

In June 2010, the President issued a Memorandum on Enhancing Payment Accuracy Through a "Do Not Pay List", which underscored that:

> "While identifying and recapturing improper payments is important, prevention of payments before they occur should be the first priority in protecting taxpayer resources from waste, fraud, and abuse. In those cases where data available to agencies clearly shows that a potential recipient of a Federal payment is ineligible for it, subsequent payment to that recipient is unacceptable. We must ensure that such payments are not made."

So as "to ensure that only eligible recipients receive Government benefits or payments," the President directed the establishment of a "single point of entry" through which agencies would access relevant data - in a network of databases to be collectively known as the "Do Not Pay List"- before determining eligibility for a benefit, grant or contract award, or other federal funding. Subsequently, the "Do Not Pay List" was codified by IPERIA, which included a requirement for agencies to check relevant databases prior to making an award or payment. The Presidential memorandum and IPERIA identified the following databases to include in the Do Not Pay portal: the Social Security Administration's Death Master File (DMF), the HHS OIG's List of Excluded Individuals & Entities (LEIE), the General Service Administration's System for Award Management (SAM) exclusion records (also referred to as the Excluded Party List System), the Department of the Treasury's Debt Check, the Department of Housing and Urban Development's Credit Alert Interactive Voice Response System (CAIVRS), and the Social Security Administration's Prisoner Update Processing System (PUPS). Treasury's "Do Not Pay" website - http://www.donotpay.treas.gov/index.htm - includes information on currently available and pending data sources in the DNP portal.

Since the Presidential memorandum was issued, and IPERIA was enacted, HHS has worked diligently to implement the "Do Not Pay" (DNP) initiative. In addition, after OMB released OMB Memorandum M-13-20, 'Protecting Privacy While Reducing Improper Payments with the Do Not Pay Initiative', HHS was one of the first agencies to establish a Computer Matching Agreement (CMA) with the Department of the Treasury under the DNP initiative in FY 2014. The CMA will allow HHS to match electronic files against restricted content (such as Social Security Number, Date of Birth, or Taxpayer Identification Number) in some of the data sources, simultaneously reducing the time to complete the matches while also producing more accurate results. In addition, several of our Divisions are now using DNP to check for recipients or potential recipients' eligibility and to prevent improper payments from being made.

In addition, Treasury-disbursed payments are matched against the DMF and the excluded parties elements of SAM in the DNP portal to identify improper payments on a monthly basis. While the Department has had several "hits" over the past year as part of these monthly matches, the number of confirmed matches is very low, as shown below in Table 7.

Table 7

Implementation of the Do Not Pay Initiative to Prevent Improper Payment

FY 2014[1]

	Number (#) of payments reviewed for improper payments	Dollars ($) of payments reviewed for improper payments	Number (#) of payments stopped[2]	Dollars ($) of payments stopped[2]	Number (#) of improper payments reviewed and not stopped[2]	Dollars ($) of improper payments reviewed and not stopped[2]
HHS's Treasury Disbursed Payments Matched Against the GSA SAM Excluded Parties List Elements	820,536[3]	$191.0 billion	N/A	N/A	9	$6,991
HHS's Treasury Disbursed Payments Matched Against the Death Master File	818,349[3]	$190.9 billion	N/A	N/A	5	$14,507

Notes:

1. In FY 2014, DNP matches were performed two months after payments were made. Therefore, data reported in this table covers data on monthly payment file matches that were available at the time of the report (October 2013 to June 2014).
2. All matches performed in FY 2014 were conducted on a post-payment basis. Therefore, HHS did not have the opportunity to stop the payments before the payment was made. Rather, HHS analyzed post-payment information to determine if any potential improper payments were made that should be recovered.
3. The number of payments reviewed for improper payments that were screened against the SAM Excluded Parties Elements and the DMF differ because some payments did not contain a name or a tax identification number in a format that could be matched against the DMF, and, therefore were excluded from the match.

13.0 Superstorm Sandy Information

Superstorm Sandy was a major hurricane that struck the United States' eastern seaboard on October 29, 2012 and caused extensive damage from Florida to Maine, with New Jersey and New York sustaining the most damage. Sandy was the second costliest hurricane in United States' history, causing $68 billion worth of damage, draining state funds and stretching limited resources.

In response to this disaster, Congress passed the *Disaster Relief Appropriations Act* (Disaster Relief Act), which was signed into law on January 29, 2013 to bring relief and funding to those areas most affected. The Disaster Relief Act provided $50.5 billion in aid for Sandy disaster victims and their communities. HHS received $747 million, allocated among multiple programs across five Divisions: the Administration for Children and Families (ACF), the Assistant Secretary for Preparedness and Response (ASPR), the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Institutes of Health (NIH). Because funding of this type and magnitude often carries additional risk, the Disaster Relief Act states that all federal programs or activities receiving funds are automatically considered susceptible to significant improper payments, regardless of any previous improper payment risk assessment results, and are required to calculate and report an improper payment estimate. Accordingly, HHS developed methodologies to estimate improper payments in the programs that received Disaster Relief Act funding.

Table 8 describes the FY 2014 improper payment results for the programs that received Disaster Relief Act funding, and additional information on the methodologies, results, and corrective actions can be found on subsequent pages. Because FY 2014 is the first year that the Superstorm Sandy measurements were conducted, the table does

not include prior year results. In addition, because the measurements will only be conducted until the funding runs out, out-year reduction targets were not established. Accordingly, Table 8 displays results for the current year FY 2014 outlays (CY Outlays $), the error rate (CY IP%), and dollars paid or projected to be paid improperly (CY IP$); the amount of overpayments (CY Overpayments $); the amount of underpayments (CY Underpayments $); and the net error rate (CY Net IP%) and the corresponding amount of net improper payments (CY Net IP$), when available.

Table 8

Improper Payment Reporting for Superstorm Sandy Programs

FY 2014

Program Name or Operating Division	CY Outlays $	CY IP %[1]	CY IP $	CY Over payment $	CY Under payment $	CY Net IP %	CY Net IP $
ACF Head Start	3,926,931	0	0	0	0	0	0
ACF Social Services Block Grant	67,032,147	13.5	9,036,535	7,773,626	1,262,909	9.7	6,510,717
ACF Family Violence Prevention and Services	137,215	4.4	6,013	6,013	0	4.4	6,013
ASPR Research[2]	0	0	0	0	0	0	0
CDC Research	1,823,383	0	0	0	0	0	0
SAMHSA	415,329	12.7	52,735	52,735	0	12.7	52,735
NIH Research	32,047,237	0.002	741	741	0	0.002	741

Notes:

1. As part of the improper payment measurement development process, each Division establishes a 12-month time period that will be reported in the annual AFR.
2. ASPR Research's FY 2014 measurement period is based on the previous FY. ASPR Research will report $0 in CY outlays since they awarded grants late in FY 2013 and their grantees did not begin expending funds until FY 2014.

13.10 Head Start

13.11 Head Start Statistical Sampling Process and Results

Head Start received approximately $95 million in Disaster Relief Act funding to provide services, training and oversight, and construction assistance to affected grantees. Every grantee who spends Superstorm Sandy funds receives an erroneous payments onsite monitoring visit in the quarter following the quarter when funds are spent, or as soon thereafter as possible. Sandy transactions for each quarter are reviewed using a standard onsite monitoring tool to identify potential and actual erroneous payments. The onsite tool gathers information about project status, procurement activities, adequacy of contracts, duplication of funding, cost allocation, *Davis-Bacon Act*, cost principles, and period of availability. Payments are identified as actual erroneous payments if not fully remediated within 30 days of the monitoring visit (e.g., grantee locates missing invoice to demonstrate adequate source documentation within 30 days of the visit).

HHS used a risk-based sampling process to determine the number of grantee transactions to review. Specifically, HHS established three risk levels of transactions (high, medium, and low risk) based on input from general HHS monitoring activities, regional office experience with Sandy grantees, and subject matter experts assigned to the Sandy Head Start grants. Grantees with high-risk transactions have more transactions reviewed than grantees with low-risk transactions. Sampling is based on the highest risk class of any transaction during the previous quarter. For example, a grantee with mostly high-risk expenditures and a few low-risk expenditures will be sampled at the high-risk rate.

The FY 2014 review period consisted of transactions between August 29, 2013 (when HHS awarded its first Head Start Superstorm Sandy grants) and June 30, 2014, and future review periods will be from July 1 to June 30. During the FY 2014 review period, grantees expended $3,926,931 in Head Start Disaster Relief Act funds.

The Head Start gross and net improper payment estimate for FY 2014 is 0 percent or $0 million.

13.12 Head Start Root Causes and Corrective Action Plans

Since no improper or erroneous payments were identified during the FY 2014 review, no root causes of actual improper payments are known. In general, however, HHS believes that Administrative and Documentation errors have the greatest potential for generating improper or erroneous payments in the program. To prevent these errors from occurring in the future, the importance of maintaining adequate source documentation, including demonstrating compliance with the *Davis-Bacon Act*, has been consistently emphasized in HHS training and technical assistance and ongoing program and grants support of Superstorm Sandy grantees.

13.13 Head Start Improper Payment Recovery

No recoveries will be attempted as no improper payments were reported.

13.20 Social Services Block Grant (SSBG)

13.21 SSBG Statistical Sampling Process and Results

SSBG received $474.5 million in Disaster Relief Act funding to assist individuals and communities impacted by Superstorm Sandy. HHS developed a two-fold improper payment methodology to review SSBG Disaster Relief Act funds in Connecticut, New Jersey, and New York (the three states' allocations represent 99 percent of all SSBG Disaster Relief Act funding). The two approaches are: 1) a case record review and 2) a vendor payment review. The case record review uses specific eligibility criteria to review payments or benefits provided to or on behalf of individuals, families or households. The vendor payment review examines individual payments made to service vendors, and assesses if the vendors provided adequate documentation (e.g., applications or authorizations) necessary to be eligible for these payments.

In FY 2014, HHS implemented a risk-based measurement approach and only reviewed case records in New Jersey, where the vast majority of the SSBG Disaster Relief Act expenditures occurred during the FY 2014 review period (July 1, 2013 to June 30, 2014). In FY 2014, HHS reviewed payments made in nine of New Jersey's service areas, which included individual or household services such as housing assistance, direct child care assistance, behavioral health services, and accessibility repairs for people with disabilities. Using a sampling universe of New Jersey's cases served in the FY 2014 review period, HHS randomly selected 383 case records for review. For the FY 2015 review period (July 1, 2014 to June 30, 2015), HHS will complete case record reviews and vendor payment reviews for Connecticut, New York and New Jersey. HHS will consolidate the findings, describe the amounts and types of errors, and compute a national SSBG Disaster Relief Act funds error rate that will be published in the FY 2015 AFR.

The SSBG gross improper payment estimate for FY 2014 is 13.5 percent or $9 million. The FY 2014 net improper payment estimate is 9.7 percent or $6.5 million.

13.22 SSBG Root Causes and Corrective Action Plans

Of the 383 reviewed cases, 90 cases had an improper payment. All of the improper payment errors (100 percent) were Administrative and Documentation errors identified in payment processing or recipient eligibility.

The payment processing errors included: (1) missing or insufficient documentation confirming a client's service needs; (2) missing or insufficient documentation properly recording a payment made for a corresponding need; or (3) incorrect payment amounts for a client's documented needs (i.e., a payment amount did not equal the amount billed). The recipient eligibility errors included missing or insufficient documentation establishing: (1) a client's age requirements for service (i.e., 18 years or older); (2) a client's citizenship requirements for service (i.e., U.S. citizen or legal resident); or (3) that the applicant's primary residence was affected by Superstorm Sandy.

HHS shared the error findings with New Jersey so the state can identify strategies to monitor and provide oversight to the most error prone providers. In response to the error findings and to prevent future improper payments, New Jersey is developing a plan that includes: (1) monitoring its sub-awardees and (2) periodic reporting of the review findings and monitoring plan implementation.

13.23 SSBG Improper Payment Recovery

Of the total amount of $278,643 in improper payments identified in the sample, $239,701 are overpayments. New Jersey is completing additional actions before determining how many overpayments will be recovered. New Jersey will base the recovery estimate on those cases where there are core eligibility errors, and the benefit should not have been paid. As an example, there were cases where applicants misrepresented their eligibility for housing assistance services, or members of a household received benefits after their household benefit limit had been met. These types of improper payments are recoverable. On the other hand, for cases where the eligibility or payment documentation was missing from the case record at the time of the review, but was subsequently located or resubmitted by the recipient after the measurement review was completed, the payment would not be recovered. New Jersey will report an estimate of the amount subject to recovery in the state's corrective action plan.

13.30 Family Violence Prevention and Services (FVPS)

13.31 FVPS Statistical Sampling Process and Results

The ACF Family and Youth Services Bureau's Division of Family Violence Prevention and Services (FVPS) received $2 million in Disaster Relief Act funding to prevent domestic violence in affected states. This funding is used for multiple purposes. HHS identified the area of financial alternative housing assistance as most susceptible to improper payments, therefore, these are the payments that will be measured. Alternative housing assistance benefits are paid directly to third parties on behalf of an individual recipient by the New Jersey Department of Children and Families and the New York State Office of Children and Family Services.

HHS determined that each state grantee would sample 45 percent of its financial alternative housing payments during each review period to generate a statistically valid estimate. If the number of payments in any review period is less than 110, then 100 percent of the payments will be reviewed. Due to the low number of payments made during the first review period (July 1, 2013 to June 30, 2014), FVPS reviewed all 169 payments (139 were related to New Jersey's grants and 30 were from New York's grant).

FVPS' gross and net improper payment estimate for FY 2014 is 4.4 percent or $6,013.

13.32 FVPS Root Causes and Corrective Action Plans

Of the 169 payments that were reviewed, HHS determined 11 payments were in error. All 11 of the improper payments were overpayments by the New Jersey Department of Children and Families' subawardees due to Administrative and Documentation errors (100 percent); specifically, subawardees' failure to correctly classify ineligible or unallowable expenses. For example, two programs had unallowable expenses (purchases of household goods) due to misinterpretation of allowable expenses for "basic, essential items."

To reduce future improper payments, FVPS' corrective actions are to: (1) share the improper payment findings with New Jersey, (2) provide further technical assistance and clarification on allowable versus unallowable expenses, and (3) release a Frequently Asked Questions guidance document in early FY 2015 to further assist grantees in reducing unallowable expenditures. In addition, New Jersey will also identify internal corrective actions to prevent errors.

13.33 FVPS Improper Payment Recovery

It is estimated that all $6,013 of the identified overpayments will be recovered by New Jersey and will be reused by the state.

13.40 Assistant Secretary for Preparedness and Response Research (ASPR Research)

13.41 ASPR Research Statistical Sampling Process and Results

ASPR received approximately $11.9 million in Disaster Relief Act funding to evaluate preparedness and response activities in the affected states. ASPR's Superstorm Sandy improper payment methodology will be conducted in two stages. The first stage, for FY 2014 reporting, reviewed the eligibility of grantees that received funding in FY 2013. The second stage of the methodology will be implemented for FY 2015 and FY 2016 reporting, and will calculate an unallowable spending error rate (e.g., unallowable expenses, lack of documentation) based on a review of each grantee's expenditures during the review period. The sample for the FY 2015 reporting period will consist of expenditures made during FY 2014 (October 1, 2013 to September 30, 2014), and the sample for the FY 2016 reporting period will consist of expenditures made during FY 2015 (October 1, 2014 to September 30, 2015).

Based on a sample size of 9 grants awarded in FY 2013, no ineligible applications or awards were identified.

13.42 ASPR Research Root Causes and Corrective Action Plans

HHS has taken a number of steps to monitor and prevent improper payments from occurring in the ASPR Research program in the future. These actions include:

- Leveraging the FY 2014 OMB Circular A-123 activities, and the Department's effort to fully incorporate internal controls requirements for the Disaster Relief Act into the *Federal Managers Financial Integrity Act* (FMFIA)/A-123 assessment process, ASPR developed a Superstorm Sandy Disaster Relief Act Internal Control Plan and proactively tested controls associated with eligibility criteria.
- Requiring awardees to submit quarterly programmatic and financial reports within the Funding Opportunity Announcement (FOA) and Notice of Award (NoA) terms and conditions. The programmatic report is reviewed by the assigned Government Project Officer, while the financial report is reviewed by the Grants Management Specialist (GMS) and compared to draw downs in the payment management

system. HHS will maintain a copy of the reports in the official grant files for each Disaster Relief Act awardee. Awardees who fail to submit the reports may face disciplinary actions.

- Listing the requirements to fully expend funds within 24 months in the terms and conditions of the award. The final Federal Financial Report (FFR) lists the date of last obligation and expenditure for the award. ASPR will monitor the quarterly cash reports submitted to HHS to ensure grantees are on track to expend funding.
- Separately tracking, flagging, and expediting closeout procedures for Disaster Relief Act grantees and ensuring that all funds not expended (obligated and outlaid) by the end of the 24th month after award are recaptured. Approvals of extensions cannot be granted without obtaining OMB approval.

13.43 ASPR Research Improper Payment Recovery

No recoveries are necessary because only grantee eligibility was reviewed, and no ineligible grantees were identified.

13.50 Centers for Disease Control and Prevention Research (CDC Research)

13.51 CDC Research Statistical Sampling Process and Results

CDC received approximately $8.2 million under the Disaster Relief Act to perform environmental health studies and provide public health support. The CDC's NoA required awardees to include additional documentation to support the line items on the Federal Financial Report (FFR). This additional documentation includes grantees internally generated reports or extracts of expenses. Under its methodology, CDC reviewed these documents to identify improper payments due to causes including: 1) unallowable costs; 2) unallocable costs; and 3) goods and/or services not received. The FY 2014 sampling methodology included quarterly reviews of draw down activity and transactions from September 30, 2013 (when the grants were first awarded) through June 30, 2014 for each grantee that spent Disaster Relief Act funding (subsequent reporting period will measure transactions made between July 1 and June 30), covering 238 transactions representing approximately $1.8 million in outlays.

The CDC Research gross and net improper payment estimate for FY 2014 is 0 percent or $0 million.

13.52 CDC Research Root Causes and Corrective Action Plans

Although HHS did not identify any improper payments in the CDC Research program in FY 2014, HHS established internal controls to prevent future improper payments from occurring. Specifically, HHS developed a Risk Mitigation Plan for the CDC Research program that outlines steps to prevent improper payments in the Superstorm Sandy funding.

13.53 CDC Research Improper Payment Recovery

No recoveries will be attempted as no improper payments were identified.

13.60 Substance Abuse and Mental Health Services Administration (SAMHSA)

13.61 SAMHSA Statistical Sampling Process and Results

SAMHSA received $10 million under the Disaster Relief Act. SAMHSA awarded $6.2 million to four programs and returned approximately $3.8 million because fewer organizations applied for the funding and applications received were for amounts significantly less than expected. The four funded programs are: 1) Behavioral Health

Treatment, 2) Disaster Distress Helpline, 3) Resiliency Training for Educators, and 4) Medication Assisted Treatment of Opioid Addiction Restoration.

For FY 2014, SAMHSA's program universe subject to sampling consisted of four grants awarded to New York State ($798,339), New York City ($2,947,786), New Jersey ($329,120), and Link2Health ($2,100,000) for the four funded programs listed above. Between July 1, 2013 and June 30, 2014, SAMHSA outlaid $415,329 across 18 transactions. Due to the small number of transactions, SAMHSA reviewed all outlays for payment accuracy (e.g., examining grant expenditures and related documentation to ensure the expenditures were appropriate and accurate) and used the results to calculate the total improper payments for the program.

SAMHSA's gross and net improper payment estimate for FY 2014 is 12.7 percent or $52,735.

13.62 SAMHSA Root Causes and Corrective Action Plans

SAMHSA's improper payments identified during the review period were due to Administrative and Documentation errors (100 percent). Of the total gross improper payments of $52,735, $42,985 of the improper payments were due to errors in the calculation of direct and indirect expenses, and the remaining $9,750 were related to outlays that were incorrectly classified to a Disaster Relief Act program grant.

SAMHSA's improper payment results were discussed with each grantee and the grantees concurred with the findings. Efforts to reduce future improper payments include: (1) improving grantee processes for ensuring adequate supporting documentation is maintained, (2) ongoing examinations by SAMHSA GMSs of documentation supporting grantee draw downs, and (3) developing and disseminating additional guidance to grantees to govern the conditions under which draw downs can be made and the supporting evidence that should be maintained.

13.63 SAMHSA Improper Payment Recovery

SAMHSA has corrected the entire $52,735 in improper payments. The $42,985 in improper payments due to errors in the calculation of direct and indirect expenses were recovered through a check submitted by the grantee and the remaining $9,750 was reclassified from the Disaster Relief Act program grant to the correct grant in the payment management system.

13.70 National Institutes of Health Research (NIH Research)

13.71 NIH Research Statistical Sampling Process and Results

NIH received $148.7 million in funds under the Disaster Relief Act to support recovery efforts at eligible impacted universities and research institutions. These funds will restore NIH's investment in biomedical research and infrastructure that was severely damaged or destroyed by Superstorm Sandy.

Due to the variable grant expenditure amounts, NIH implemented a stratified random sampling process, with the sampling frame being divided into mutually exclusive groups or "strata" based on expenditure amount. Each sampling period consists of six months. NIH selects a random sample of expenditures from the grantees quarterly reports for the respective two quarters. The sampling unit is the total quarterly expenditures for a single award, while the sampling frame is the collection of all reports filed containing expenditures during the sampling period. NIH uses a random number generator to assign random numbers to each quarterly expenditure report. The list of expenditure reports is sorted by stratum and random number, and the appropriate number of items from each stratum is reviewed. NIH's methodology examines two areas for improper payments: (1) ensuring funds are used for an allowable program use and (2) grantee eligibility. For each grant in the sample, NIH requests detailed

expenditure data and appropriate background documentation from the grantee to determine allowability. NIH also confirms grantees' continued eligibility to receive Disaster Relief Act funding in accordance with HHS requirements.

Under its methodology, NIH completed two rounds of improper payment reviews for FY 2014 covering 12-months of expenditures in two semi-annual sampling periods: July 1, 2013 to December 31, 2013 and January 1, 2014 to June 30, 2014. For this sampling period, NIH reviewed 332 expenditure reports representing 166 grant awards, and identified one improper payment of $352.

The NIH Research gross and net improper payment estimate for FY 2014 is .002 percent or $741.

13.72 NIH Research Root Causes and Corrective Action Plans

The root cause for the one improper payment identified for the review period was Administrative and Documentation Errors (100 percent). Since the grantee was unable to provide supporting documentation for this cost, NIH was unable to determine if the cost was allowable.

NIH will implement the following corrective actions for the grantee with the improper payment:

- NIH will perform an accounting system review to identify potential weaknesses in the grantee's accounting system.
- NIH will recover unallowable costs.
- NIH will counsel the grantee on the federal requirements for documenting charges to grant awards.
- NIH will include the grantee in all future improper payment testing if they report additional expenditures.

13.73 NIH Research Improper Payment Recovery

It is estimated that NIH will recover all $352 identified as an improper payment from the grantee.

MANAGEMENT REPORT ON FINAL ACTION

October 1, 2013-September 30, 2014

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-initiated and OMB Circular 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 includes 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 the 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*. Final action for single audits occurs when non-monetary and/or monetary compliance actions are completed. Achieving final action can require more than a year if the findings are complex or the grantee does not have the resources to take corrective action. 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 2014, 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 2014, HHS initiated Recovery Action, through collection, offset or other means, on 314 reports for a total of $840,372,969.
- In FY 2014, HHS completed Recovery Action, through collection, offset or other means, on 284 reports for a total of $550,478,597.

- As of September 30, 2014, HHS identified 245 reports with outstanding balances over one year old totaling $2,001,618,350[16]. Six percent of these accounts receivable are currently being pursued for collection. These accounts receivable are owed by state and local governments (128), hospital and medical related organizations (22), non-profit organizations (78), Indian tribes (15) 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.

TABLE 1
Management Action on Costs Disallowed in OIG Reports
As of September 30, 2014

	Number	Disallowed Costs
A. Reports for which final action had not been taken by the commencement of the reporting period.[1]	336	$ 2,214,401,414
B. Reports on which management decisions were made during the reporting period.[2]	314	840,372,969
Subtotal (A + B)	**650**	**$ 3,054,774,383**
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.	284	550,478,597
ii. The dollar value of disallowed costs that were written off by management.	15	8,144,846
Subtotal (i + ii)	**299**	**$ 558,623,443**
D. Reports for which no final action has been taken by the end of the reporting period.[3]	351	$ 2,496,150,940

Notes:

1. Includes adjustments of amended disallowance and disallowance excluded from the previous reporting period (FY 2013 ending balance of $2,568,581,688 less adjustments of $354,180,274).
2. Represents the amount of management concurrence with the OIG's recommendations. For this fiscal year, the OIG's reconciliation with the HHS OpDivs 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 $2,001,618,350 (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 2014, HHS initiated action on $724,841,230 in OIG recommendations to put funds to better use.
- In FY 2014, HHS completed action on $11,081,763 in OIG recommendations to put funds to better use.

[16] This amount is included in Table 1, Item D (see Note 3 of the table).

TABLE 2
Management Action on OIG Reports
with Recommendations that Funds Be Put to Better Use

As of September 30, 2014

	Number	Disallowed Costs
A. Reports for which final action had not been taken by the commencement of the reporting period.	11	$ 1,110,960,466
B. Reports on which management decisions were made during the reporting period.	16	724,841,230
Subtotal (A + B)	**27**	**$ 1,835,801,696**
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.	9	11,081,763
ii. The dollar value of recommendations that management has subsequently concluded should not or could not be implemented or completed.	-	-
Subtotal (i + ii)	**9**	**$ 11,081,763**
D. Reports for which no final action has been taken by the end of the reporting period.	18	$ 1,824,719,933

SUMMARY OF FINANCIAL STATEMENT AUDIT

As mentioned earlier in the MD&A section, management annually presents an assurance statement on the effectiveness of internal control. The following two tables present summary information related to the material weakness identified during the audit, as well as conformance with FMFIA and compliance with FFMIA.

TABLE 1

Audit Opinion			Unmodified 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***	**-**	**-**	**-**	***1***

***Definition of Terms – Tables 1 and 2**

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

New: The total number of material weaknesses that have been identified during the current 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 Balance: The agency's year-end balance.

***Reference**: OMB Circular A-136, *Financial Reporting Requirements*, September 18, 2014, page 151

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	***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 Measurement	*1*	-	-	-	-	*1*
Total Material Weaknesses	***2***	**-**	**-**	**-**	**-**	***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***	**-**	**-**	**-**	**-**	***1***

Compliance with Section 803(a) of the *Federal Financial Management Improvement Act* (FFMIA)		
	Agency	**Auditor**
1. System Requirements	Lack of substantial compliance noted	Lack of substantial compliance noted
2. Accounting Standards	No lack of substantial compliance noted	No lack of substantial compliance noted
3. USSGL at Transaction Level	Lack of substantial compliance noted	Lack of substantial compliance noted

FISCAL YEAR 2014 TOP MANAGEMENT AND PERFORMANCE CHALLENGES IDENTIFIED BY THE OFFICE OF INSPECTOR GENERAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

TO: The Secretary

FROM: Inspector General

SUBJECT: Top Management and Performance Challenges Facing the Department of Health and Human Services in Fiscal Year 2014

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 (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 2014 are:

1) Implementing, Operating, and Overseeing the Health Insurance Marketplaces
2) Ensuring Appropriate Use of Prescription Drugs in Medicare and Medicaid
3) Protecting an Expanding Medicaid Program from Fraud, Waste, and Abuse
4) Fighting Waste and Fraud and Promoting Value in Medicare Parts A and B
5) Ensuring Quality in Nursing Home, Hospice, and Home- and Community-Based Care
6) The Meaningful and Secure Exchange and Use of Electronic Health Information
7) Effectively Operating Public Health and Human Services Programs To Best Serve Program Beneficiaries
8) Ensuring Effective Financial and Administrative Management
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 Lisa Re, Acting Director of External Affairs, at (202) 205-9213 or Lisa.Re@oig.hhs.gov.

/Daniel R. Levinson/

Daniel R. Levinson

Management Challenge 1: Implementing, Operating, and Overseeing the Health Insurance Marketplaces

Why This Is a Challenge

The new Health Insurance Marketplaces, also known as Health Insurance Exchanges, (Marketplaces) are critical components of the health insurance market reforms enacted through the *Affordable Care Act*. In 2014, The Centers for Medicare & Medicaid Services (CMS) operated Marketplace functions on behalf of 36 states. Implementation, operation, and oversight of the Marketplaces were among the most significant challenges for the Department of Health and Human Services (Department or HHS) in fiscal year (FY) 2014 and will continue to present a top management and performance challenge in FY 2015, http://oig.hhs.gov/reports-and-publications/top-challenges/2013/.

In 2015, CMS and the Health Insurance Marketplaces face new and ongoing challenges including, for example, ensuring accurate eligibility determinations; processing enrollments, re-enrollments, and qualifying life change events; and communicating timely and accurate information to health insurance issuers (issuers) and consumers. Marketplaces must also facilitate Medicaid enrollment for those who qualify. In coordination with states, CMS will implement premium-stabilization programs. To carry out these complex Marketplace functions, the Department must ensure effective communication and coordination between and among all internal and external parties with Marketplace responsibilities, including within HHS and with contractors, issuers, and partners in state and federal government. Effective coordination with, and timely provision of accurate data to, the Internal Revenue Service (IRS) will be particularly important for sound administration of the premium tax credit program. In addition, CMS will need to be attentive to state Marketplace operations to ensure state compliance with requirements, including transmitting accurate and timely data used for federal payments. Key focus areas for the federal and state Marketplaces should include:

Payments. Ensuring sound expenditure of taxpayer funds for intended purposes poses a substantial management challenge, especially given the use of manual systems. The Department must implement financial management and payment systems that produce accurate and timely payments to issuers of advance payment of premium tax credits, cost-sharing reduction amounts, and premium-stabilization payments. In addition, CMS must validate information received from issuers to ensure that it is timely, complete, and accurate for payment purposes. Given the substantial federal funds involved, the Department should undertake a thorough risk assessment and, where appropriate, develop error rates to measure the integrity of program payments.

Eligibility. Ensuring accurate eligibility determinations is critical. Recent Office of Inspector General (OIG) work addressing eligibility verification systems during the first open enrollment period found that not all internal controls at reviewed Marketplaces were effective and that Marketplaces were unable to resolve most inconsistencies between applicants' self-reported information and data obtained by the Marketplaces from other sources. Moreover, for the second open enrollment period, Marketplaces must add functionality for processing re-enrollments. Effective internal controls and timely and accurate resolution of inconsistencies are, and will continue to be, critical to ensure that eligible consumers receive appropriate benefits and that ineligible individuals are not enrolled.

Management and Administration. Following the October 1, 2013, launch of the Marketplaces, the Department acknowledged the need for improved management and oversight, including clear leadership, disciplined operations, and better communication across the Department. Challenges include selecting capable contractors and providing appropriate oversight to ensure successful operation of the federal Marketplace, including both public-facing and administrative systems. The Department must ensure, to the greatest extent possible, that the Government obtains specified products and services from its contractors on time and within budget. In addition,

problematic operations at some state Marketplaces have prompted questions regarding the use of Federal establishment grant funds, and the Department must ensure that these grants have been properly managed. (For general information about challenges associated with grants management and contract administration, see Management Challenge 9.)

Security. Protecting and ensuring the confidentiality and integrity of consumers' sensitive personal information and Marketplace information systems is paramount. Effective operation of the Marketplaces requires rapid, accurate, and secure integration of data from numerous federal and state sources, issuers, and consumers. It also requires an established large-scale means of communication among many federal and state systems. The Department must vigilantly guard against intrusions and continuously assess and improve the security of Marketplace related systems, including, among others, the Data Services Hub. OIG work found that selected Marketplaces generally protected personally identifiable information, but could improve some information security controls. The Department also must ensure that non-automated systems used to process consumer enrollment information, such as the call center and paper application processes, incorporate effective security measures.

Progress in Addressing the Challenge

Since October 1, 2013, the Department has reported improvement in the operations of the federal Marketplace, as well as substantial enrollment figures. Key progress reported by CMS includes:

- changes to CMS's management of the federal Marketplace, including closer oversight by CMS leadership, designation of a systems integrator, use of cross-functional teams, and procurement of a new contractor for federal Marketplace construction and maintenance;
- establishment of (1) an interim process for resolving data inconsistencies pending automated functionality, (2) an interim process for paying issuers that are owed financial assistance payments pending automated functionality, and (3) functionality for reporting life change events;
- an improved application on a redesigned HealthCare.gov intended to streamline the eligibility process and improve the consumer experience;
- actions taken to address OIG recommendations to improve information technology (IT) security; and
- screening of call center representatives and focused training on protecting sensitive information.

CMS also reported regular communications with the IRS to validate payment information and the provision of technical and other support to the state Marketplaces.

What Needs To Be Done

The Department must continue to improve the federal Marketplace, including the public-facing consumer functions, as well as the back-end administrative and financial management functions. The Department must ensure that alternate pathways for enrollment operate with integrity and that consumers' personal information is secure. The Department must operate a well-run second open enrollment period for individuals and small businesses, employing lessons learned, taking all steps practicable to avoid problems that marred the first open enrollment period and rapidly and effectively addressing any problems that arise. Vigilant monitoring and testing and rapid mitigation of identified vulnerabilities are essential. In addition, attention must be paid to sound operation of financial assistance and premium-stabilization programs. The Department must ensure that consumers and issuers receive accurate Marketplace information, including information relevant for tax purposes, such as Form 1095A tax forms.

As with other new programs, the Department must continue to work with its partners to develop program integrity measures and processes. It must monitor for and address fraud, waste, and abuse risks to protect the federal investment in health care reform. If fraud schemes are identified, the Department must respond quickly

and effectively, working jointly with partners at the federal and state level to ensure program integrity and hold those involved accountable. Further, the Department must continue to coordinate closely with states and others in federal government to monitor the operations and security of the Marketplaces and to implement Marketplace programs.

Key OIG Resources

- OIG Testimony, "Failure To Verify: Concerns Regarding PPACA's Eligibility System," July 2014, http://oig.hhs.gov/testimony/docs/2014/Daly_Greenleaf_testimony_07162014.pdf
- OIG Report, *Marketplaces Generally Protected Personally Identifiable Information but Could Improve Certain Information Security Controls*, September 2014, http://oig.hhs.gov/oas/reports/region1/181430011.asp
- OIG Report, *Not All Internal Controls Implemented by the Federal, California, and Connecticut Marketplaces Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements*, June 2014, http://oig.hhs.gov/oas/reports/region9/91401000.asp
- OIG Report, *Marketplaces Faced Early Challenges Resolving Inconsistencies with Applicant Data*, June 2014, http://oig.hhs.gov/oei/reports/oei-01-14-00180.pdf
- OIG Report, *An Overview of 60 Contracts That Contributed to the Development and Operation of the Federal Marketplace*, August 2014, http://oig.hhs.gov/oei/reports/oei-03-14-00231.asp
- OIG 2015 Work Plan, http://oig.hhs.gov/reports-and-publications/archives/workplan/2015/FY15-Work-Plan.pdf

Management Challenge 2: Ensuring Appropriate Use of Prescription Drugs in Medicare and Medicaid

Why This Is a Challenge

CMS provides prescription drug coverage for 37.4 million Medicare beneficiaries through Part D and 59.4 million Medicaid beneficiaries. In 2012, combined Part D and Medicaid prescription drug expenditures totaled over $93 billion. Medicare Part D alone accounted for $66.9 billion of those expenditures. Maintaining the integrity of these two programs is critical to ensuring patient safety; safeguarding the quality of care; protecting the programs from fraud, waste, and abuse; and protecting taxpayer dollars.

OIG has extensively examined ongoing monitoring and oversight of the programs and the effectiveness of controls designed to ensure appropriate payment and patient safety. In both the Medicare Part D and Medicaid programs, OIG has uncovered improper and potentially harmful prescribing practices, pharmacies billing for drugs not dispensed, and diversion of prescription drugs.

Questionable Utilization and Billing Patterns. A 2014 OIG report examining questionable utilization patterns for HIV drugs by beneficiaries revealed claims on behalf of many beneficiaries with no indication of HIV in their Medicare histories, claims for excessive doses or supplies of HIV drugs, claims for HIV drugs from a high number of pharmacies or prescribers, or claims for contraindicated drugs. These patterns may indicate that beneficiaries are receiving inappropriate prescription drugs and selling them illegally, pharmacies are billing for drugs that beneficiaries never received, or that beneficiaries' Medicare identification numbers were stolen. Medicare paid $32 million for HIV drugs for beneficiaries with questionable utilization patterns in 2012.

Additional health care fraud schemes have involved providers submitting fraudulent claims to Medicare for deceased beneficiaries. A 2013 report revealed that, in 2011, Part D inappropriately paid more than $1 million for prescription drugs for 5,101 deceased beneficiaries, including some beneficiaries who had died in 2009.

Drug Diversion and Abuse of Controlled Substances. The diversion and abuse of prescription drugs is an ongoing problem. Drug diversion is the transfer of legitimate prescription drugs for unlawful purposes. Controlled substances, such as opiate pain relievers, are potentially so dangerous that they require restrictions on their manufacture, possession, or use. The Centers for Disease Control and Prevention (CDC) characterizes prescription drug abuse as an epidemic, reaching virtually all demographics and geographic locations. As abuses of these drugs have increased over the past five years, OIG has also increased its investigations of abuses in this area, many of which involve harm to individual beneficiaries. Diversion of these drugs may also result in profound public harm. In one noteworthy example, an OIG investigation found that a health care worker infected with Hepatitis C diverted a controlled prescription drug from a hospital for his own personal use. In an attempt to remain undetected, the worker inserted saline solution into the vials to replace the diverted drugs. Because the worker used his contaminated syringes to switch the fluids, several patients treated from these vials contracted the infectious disease.

Drug Diversion and Abuse of Non-Controlled Substances. A rapidly growing trend is the illegal billing and diversion of non-controlled medications (e.g., anti-psychotics), which presents a substantial financial vulnerability to federal health care programs. Many cases involve pharmacies billing federal programs for expensive brand-name medications that were never dispensed. Other common cases involve Medicare or Medicaid beneficiaries combining prescribed drugs with opioids to create an enhanced euphoria; such drugs are called "potentiators." Some HIV drugs are examples of non-controlled substances that can be used as potentiators.

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 an OIG recommendation that it strengthen the Medicare Drug Integrity Contractor's (MEDIC) monitoring of pharmacies and its ability to identify pharmacies with questionable billing patterns and develop pharmacy risk scores. In June 2013, CMS and the MEDIC developed pharmacy risk scores and released a list of "high risk" pharmacies to Part D plans. CMS instructed Part D plans to use the risk score information in conjunction with their own data analysis to combat fraud, waste, and abuse. CMS suggested that plans use the list of high risk pharmacies to target pharmacies for audits and further review.

Moreover, OIG recommended that CMS require Part D sponsors to verify that prescribers have the authority to prescribe drugs. Beginning June 1, 2015, physicians and eligible professionals must be enrolled in Medicare to prescribe Part D drugs. In addition, to identify the prescribing physician or eligible professional, CMS will require that a pharmacy claim for a Part D drug contain the National Provider Identifier. This will enable CMS, Part D plans, and the MEDIC to verify that prescribers have the authority to prescribe Part D drugs before the claims are paid.

What Needs To Be Done

In addition to taking the steps described above, CMS must increase Part D plan sponsors' abilities to limit questionable utilization of drugs, particularly drugs that are vulnerable to diversion and recreational abuse. For example, CMS should expand sponsors' drug utilization review programs and use of beneficiary-specific controls. CMS should also restrict certain beneficiaries with questionable utilization patterns to a limited number of pharmacies or prescribers.

Additionally, CMS should improve existing safeguards to prevent improper payments in Part D. CMS needs to ensure that the MEDIC routinely analyzes billing data to detect pharmacies and providers with questionable billing patterns, including billing for deceased beneficiaries.

Key OIG Resources

- OIG Report, *Part D Beneficiaries with Questionable Utilization Patterns for HIV Drugs*, August 2014, http://oig.hhs.gov/oei/reports/oei-02-11-00170.pdf
- OIG Testimony, "Medicare Program Integrity: Screening Out Errors, Fraud, and Abuse," June 2014, https://oig.hhs.gov/testimony/docs/2014/cantrell_testimony_06252014.pdf
- OIG Report, *Medicare Payments Made on Behalf of Deceased Beneficiaries*, October 2013, http://oig.hhs.gov/oei/reports/oei-04-12-00130.pdf

Management Challenge 3: Protecting an Expanding Medicaid Program From Fraud, Waste, and Abuse

Why This Is a Challenge

Protecting the integrity of Medicaid takes on heightened urgency as the program continues to grow in spending and in the number of people it serves. As of October 2014, 27 states and the District of Columbia (28 states) are expanding Medicaid coverage to include qualifying adults earning up to 133 percent of the federal poverty level, pursuant to *Affordable Care Act* and Medicaid waivers. Further, states that have not expanded eligibility have seen increases in Medicaid enrollment. In addition to facing the challenges in implementing expanded eligibility in the 28 states, Medicaid programs face long-standing program integrity challenges. These include improving the effectiveness of Medicaid data; preventing and addressing fraud, waste, and abuse, including avoiding or recovering Medicaid improper payments; ensuring access to care in Medicaid managed care programs; and curbing state Medicaid policies that inflate federal costs. (See Management Challenge 5 for more information on Medicaid issues related to nursing homes and benefits provided in home- and community-based settings.)

Expansion of Medicaid Eligibility. As of August 2014, CMS reported that enrollment in Medicaid and the Children's Health Insurance Program (CHIP) had increased by 8.7 million people since individuals became eligible to apply under the *Affordable Care Act's* expanded eligibility criteria in October 2013. For individuals in expansion states who are "newly eligible" under the *Affordable Care Act's* expanded income limits, the Federal Government will pay the full costs of medical assistance through 2016, after which the federal share gradually falls to 90 percent by 2020 and continues at 90 percent thereafter. For Medicaid beneficiaries who are not "newly eligible," the Federal Government will continue to share costs with states according to its standard Federal Medical Assistance Percentage (FMAP), which currently ranges by state from 50 to 74 percent. Updating eligibility systems and ensuring appropriate eligibility determinations and FMAP designations for each beneficiary present implementation challenges.

Improving the Effectiveness of Medicaid Data. As Medicaid expands, implementing a functional, national Medicaid database is essential to effective oversight of Medicaid payments and services. OIG continues to find that the existing national Medicaid data are not complete, accurate, or timely and that additional data are needed to conduct national Medicaid program integrity activities. CMS has attempted to improve the access and quality of Medicaid data, most recently through the Transformed Medicaid Statistical Information System (T-MSIS) initiative. OIG found that as of January 2013, CMS and 12 volunteer states had made some progress in implementing T-MSIS; however, early T-MSIS implementation outcomes raised questions about the completeness and accuracy of T-MSIS data upon national implementation.

Identifying and Recovering Improper Payments. In 2013, CMS reported that Medicaid's improper payment rate was 5.8 percent. The projected federal share of the $24.9 billion improper payments was $14.4 billion; almost 97 percent of these improper payments were overpayments. Payments made on behalf of individuals who should not have been enrolled in the program were the main source of error. CMS is developing a Unified Program Integrity Contractor model in which program integrity work at the federal level will be consolidated so that each contractor

will conduct Medicare, Medicaid, and Medicare-Medicaid Data Match (Medi-Medi Program) work within designated geographic areas; CMS expects to implement this strategy starting in FY 2015. OIG has found that CMS's national Medicaid integrity programs—Medicaid Audit Program and Medi-Medi Program—have had limited success identifying Medicaid overpayments and potential fraud. (See Management Challenge 8 for more information on error rate measurement and reporting.)

Program Integrity and Beneficiary Access in Managed Care Programs. CMS reports that, 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 from fraud, waste, and abuse by health care providers or beneficiaries. Such fraud, waste, and abuse drives 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. In a 2011 report, OIG work revealed that the predominant concerns of both states and plans were provider fraud—billing for services that were not provided, were medically unnecessary, or were upcoded—and beneficiary fraud, including prescription drug abuse.

Ensuring that beneficiaries enrolled in managed care plans have sufficient access to providers and services is paramount. OIG has found that standards for access to care vary widely across states. For example, standards range from requiring 1 primary care provider for every 100 enrollees to 1 primary care provider for every 2,500 enrollees. States do not commonly use "direct tests," such as making calls to providers, to identify whether plans are meeting access-to-care-standards. Further, CMS provides limited oversight of state access standards.

State Policies That Inflate Federal Costs. OIG has raised long-standing concerns, as noted in our Compendium of Priority Recommendations, about states' Medicaid policies that result in the Federal Government's paying a greater share of Medicaid costs than the FMAP percentages would dictate. Medicaid permits states to provide enhanced payments that qualify for federal reimbursement to non-state-owned government providers, such as county or local publicly owned nursing facilities and hospitals. But some states have required such facilities to transfer the funds to the states to be put to other uses, leaving the facilities underfunded. Misalignment of costs and payments at certain state-operated facilities can also inflate federal costs; for example, in New York, Medicaid payments to state-run developmental centers exceeded actual costs by more than $1 billion during New York's State FY 2009. In another example, Pennsylvania used a state tax on Medicaid managed care plans to draw down almost $1 billion in federal funds over a three-year period.

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 determination and payment accuracy, and training state staff on reporting and accounting for expenditures associated with newly eligible individuals.

CMS has taken action to improve its data and technology capabilities with respect to Medicaid program integrity. Beginning in July 2014, all states were expected to demonstrate operational readiness to submit T-MSIS files to CMS. As of October 2014, CMS stated that over 38 states are engaged in testing with CMS regarding the transfer of their T-MSIS files. CMS stated that it will continue to monitor, evaluate, and improve the quality and consistency of T-MSIS data submissions.

CMS has also reported actions to improve the Medicaid Audit Program and the Medi-Medi Program consistent with OIG recommendations, such as assigning more Medicaid audits through a collaborative process, which showed greater success than the traditional process. 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.

In a June 2014 status update to OIG, CMS indicated that it is working with states to protect against fraud, waste, and abuse in managed care. Specifically, CMS is working to update guidelines to states on program integrity in Medicaid managed care. In addition, CMS indicated that it will advise states to work with their managed care entities to identify and implement effective strategies for verifying billed services in managed care settings. CMS also agreed with OIG's recommendations to strengthen oversight of managed care access standards, and it described plans to provide guidance and technical assistance to states.

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. CMS has approved a State Plan Amendment, issued a disallowance letter to New York for $1.25 billion for 2010-2011, and plans to review two subsequent fiscal years. Finally, CMS has 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. In addition, CMS recently issued a State Health Officials letter on the treatment of health-care-related taxes and their effect on federal matching funding, following OIG's audit work in Pennsylvania.

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 work with states to ensure the submission of complete, accurate, and timely T-MSIS data. If states fail to submit timely T-MSIS data, CMS should use its statutory enforcement mechanisms or seek legislative authority to employ alternative tools to compel state participation.

CMS should continue to build on its progress addressing Medicaid Integrity Contractors (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 identifying and auditing providers.

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. CMS should also implement its plans to work with states to ensure adequate access to care for Medicaid beneficiaries enrolled in managed care plans.

OIG has long recommended that Medicaid payments to public providers be based on 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.

Key OIG Resources

- OIG Report, *State Standards for Access to Care in Medicaid Managed Care*, September 2014, http://oig.hhs.gov/oei/reports/oei-02-11-00320.asp
- OIG *Compendium of Priority Recommendations*, March 2014, http://oig.hhs.gov/reports-and-publications/compendium/files/compendium2014.pdf
- OIG Testimony, "Examining the Federal Government's Failure to Curb Wasteful State Medicaid Financing Schemes," July 29, 2014, http://oversight.house.gov/wp-content/uploads/2014/07/Hagg-HHS-OIG-Final.pdf
- OIG Report, *Early Outcomes Show Limited Progress for the T-MSIS*, September 2013, https://oig.hhs.gov/oei/reports/oei-05-12-00610.asp

- OIG Testimony, "Saving Taxpayer Dollars by Curbing Waste and Fraud in Medicaid," June 14 2012, http://oig.hhs.gov/testimony/docs/2012/Maxwell_testimony_06142012.pdf
- OIG Testimony, "Examining the Administration's Failure to Prevent and End Medicaid Overpayments," September 20, 2012, https://oig.hhs.gov/testimony/docs/2012/Hagg_testimony_09202012.pdf
- OIG Report, *Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards*, December 2011, https://oig.hhs.gov/oei/reports/oei-01-09-00550.asp

Management Challenge 4: Fighting Waste and Fraud and Promoting Value in Medicare Parts A and B

Why This Is a Challenge

To secure the future of health care for Medicare beneficiaries, the Department must be vigilant in reducing wasteful spending and promoting better health outcomes at lower costs. The Institute of Medicine estimated that 30 percent of U.S. health spending (public and private) in 2009—roughly $750 billion—was wasted.[17]

Waste in health care programs is a multi-dimensional problem. Key areas of focus for reducing waste in Medicare Parts A and B include reducing improper payments, fighting fraud, fostering economical payment policies, and transitioning from volume to value in health care. HHS faces challenges—and opportunities—in each of these areas.

Reducing Improper Payments. CMS reported an error rate of 10.1 percent for Medicare fee for service (Parts A and B), corresponding to an estimated $36 billion in improper payments in FY 2013. This measure includes payments for unnecessary services, billing or coding errors, and payments for claims that did not meet documentation or other Medicare coverage requirements. Medicare's pending transition to a new system of diagnosis codes, the ICD-10, may bring implementation challenges or potential increases in improper billing as providers transition to the new codes. (See Management Challenge 8 for more information on error rate measurement and reporting.)

Challenges affect every stage of the payment process, from making the initial payment accurately to adjudicating overpayment recoveries. OIG has documented high Medicare improper payment rates for various services, including home health services and evaluation and management services. OIG audits of hospitals have uncovered and sought to remedy improper billing and payments for a myriad of issues, such as incorrect billing for transfers to post-acute care and inaccurate patient diagnosis codes. Accurate billing by hospitals for short inpatient stays versus outpatient observations has been an area of considerable challenge and concern for the Department, hospitals, and beneficiaries.

CMS relies on contractors for most of these crucial functions; however, OIG has identified deficiencies in contractor performance and in CMS's oversight of contractors that process Medicare claims and that audit and recover overpayments. Finally, the Department is facing significant challenges in adjudicating provider appeals of Medicare overpayment recoveries, including (1) a substantial backlog of appeals at the administrative law judge (ALJ) level (third level of appeals), (2) inconsistent determinations among the ALJs and between the ALJs and Qualified Independent Contractors (second level of appeals), and (3) insufficient CMS participation in the appellate process.

Preventing and Responding to Fraud. Curbing fraud is vital to conserving scarce health care resources and protecting beneficiaries. Fraud schemes shift over time, but certain Medicare services have been consistent targets. For example, OIG investigations continue to uncover fraud schemes and questionable billing patterns by durable medical equipment (DME) suppliers, home health agencies, community mental health centers, clinical

[17] Institute of Medicine, "Best Care at Lower Cost: The Path to Continuously Learning Health Care in America," September 6, 2012.

laboratories, ambulance transportation suppliers, and outpatient therapy providers. CMS's contractors play a key role in fighting Medicare fraud. However, CMS is not realizing the full potential of this oversight tool. For example, OIG found that CMS contractors' program integrity efforts were limited with respect to home health and community mental health services, even though these services are known as fraud risk areas.

Fostering Economical Payment Policies. As a result of certain payment policies that OIG has identified, Medicare pays significantly different amounts for the same services for similar patients in different settings. For example, Medicare pays significantly more for services performed in an outpatient hospital department than for the same services performed in an ambulatory surgical center (ASC). While not all patients can safely receive services in an ASC, for low-risk patients that do not need hospital-level care at an outpatient hospital department, Medicare could save billions of dollars by paying for their services at ASC rates. In another example, Medicare generally reduces payments to hospitals for patients with early discharges to post-acute care, such as care provided in a skilled nursing facility, to avoid overlapping payments for the hospital care and the post-acute care. However, Medicare does not reduce hospital payments if a patient's early discharge is to hospice care.

Transitioning From Volume- to Value-Based Payment. Experts generally agree that the incentives created by paying for health care on the basis of the volume of items or services furnished, as in Medicare's fee-for-service program, contribute to waste by encouraging unnecessary utilization and fragmented, poor quality care. HHS is transitioning to value-based payments in Medicare, which are intended to produce better quality of care at lower costs by rewarding high-quality care, penalizing low-quality care, or enhancing care coordination. Models involve, for example: accountable care organizations (ACOs), value-based payments for hospitals, penalties for hospital readmissions, pay-for-performance systems, shared savings programs, gainsharing, care coordination payments, and bundled payments.

Designing bundled payment methodologies that reimburse for items and services across separate provider settings will pose additional challenges. Many value-based payment mechanisms rely on complex data, electronic health information, and sophisticated quality and performance measures. To be effective, the data must be correct and timely, the metrics meaningful, and the information usable.

Progress in Addressing the Challenge

Overall, the Department has implemented many of OIG's recommendations for combating waste and fraud in Medicare, resulting in cost savings, improved program operations, and enhanced protections for beneficiaries. In FY 2013, OIG audits and investigations resulted in expected recoveries of $5.8 billion in stolen or misspent funds across Department programs. In addition, OIG reported estimated savings of more than $19 billion resulting from legislative and regulatory actions supported by OIG recommendations. The Health Care Fraud and Abuse Control Program (a joint program of the Department, CMS, OIG, and the Department of Justice (DOJ) to fight waste, fraud, and abuse in Medicare and Medicaid) returned more than $8 for every $1 invested. Medicare Fraud Strike Forces, led by OIG and DOJ, have demonstrated success in investigating and prosecuting fraud and shutting down criminal networks.

CMS has taken actions intended to improve the integrity and accuracy of billing for numerous types of services. For example, CMS implemented (1) a provision of the *Affordable Care Act* that practitioners who certify Medicare patients as eligible for home health services must document their face-to-face encounters with those patients and (2) a demonstration project that requires prior authorization for scooters and power wheelchairs in seven states with high incidences of fraud and improper payments for these items. CMS is working with home health service providers and practitioners to improve the low initial rates of compliance with this requirement. CMS continues to work to address hospital billing for short inpatient stays and outpatient observation stays, which has significant impacts on Medicare spending, beneficiary cost-sharing, and hospital revenue.

OIG has also noted reductions in Medicare billing and payments for certain services and geographic areas with known fraud risks. For example, following high-intensity law enforcement activities and administrative actions by CMS, billing and payments for home health services and community mental health services declined significantly in fraud hot spots. CMS has also instituted temporary moratoria on the enrollment of new home health agencies in the Miami, Chicago, Fort Lauderdale, Detroit, Dallas, and Houston areas and ambulance transportation suppliers in the Houston and Greater Philadelphia areas. Additionally, CMS continues to develop its Fraud Prevention System (FPS). OIG certified CMS's reported $54 million in actual savings and $210 million in unadjusted savings resulting from year 2 of the FPS, representing a positive return on investment of $1.34 for every $1.

CMS has reported improvements to its oversight and measurement of its contractors' performance and its follow-up on improper payment vulnerabilities that contractors identify. The Department also continues to focus on resolving the backlog of Medicare appeals by providers.

CMS has implemented and is administering ACO programs, value-based purchasing programs, the Bundled Payment for Care Improvement initiative, the Health Care Innovation Awards program, the State Innovation Model program, and others. In September 2014, CMS reported first performance year results for the Medicare Shared Savings Program (MSSP) showing that 53 MSSP ACOs earned shared savings payments of more than $300 million and held spending $652 million below their targets; in total, the Medicare Trust Fund will save approximately $345 million.

What Needs To Be Done

Despite progress in key areas, further actions are needed to protect Medicare from waste and fraud. CMS needs to better ensure that Medicare makes accurate and appropriate payments. When Medicare improper payments occur, CMS needs to identify and recover them in a timely manner. CMS must also implement safeguards, as needed, to prevent recurrence. CMS relies on contractors for most of these crucial functions; therefore, ensuring effective contractor performance is essential. Finally, the Medicare appeals system needs fundamental changes to resolve issues about improper payments efficiently, effectively, and fairly. OIG has recommended numerous actions to advance these outcomes.

With respect to promoting value in Medicare, 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. CMS should continue to strengthen its program integrity tools and apply them as needed to ensure integrity in new models. 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. As with any innovation and experimentation, missteps may occur; it is critical that the Department take effective and appropriate actions to address such missteps and prevent their recurrence.

Key OIG Resources

- OIG Testimony, "Medicare Program Integrity: Screening Out Errors, Fraud, and Abuse," June 2014, https://oig.hhs.gov/testimony/docs/2014/cantrell_testimony_06252014.pdf
- OIG Testimony, "Medicare Mismanagement: Oversight of the Federal Government Efforts to Recapture Misspent Funds," May 2014, http://oig.hhs.gov/testimony/docs/2014/Ritchie_testimony_05202014.pdf
- OIG *Compendium of Priority Recommendations*, March 2014, http://oig.hhs.gov/reports-and-publications/compendium/files/compendium2014.pdf

Management Challenge 5: Ensuring Quality in Nursing Home, Hospice, and Home- and Community-Based Care

Why This Is a Challenge

As the median age of Americans continues to rise and as more Americans live with chronic medical conditions, the Department faces challenges in ensuring that beneficiaries who require nursing home, hospice, or home- and community-based services (HCBS) receive high quality care. It is critical that these services be available, allowing beneficiaries to receive the care they need in the setting that best serves their needs and preferences. High quality nursing home and HCBS programs are important for the continued well-being of people who need ongoing assistance with daily living, as well as those who need additional help recuperating from hospital stays or other acute care. Hospice care provides comfort for terminally ill beneficiaries by reducing pain and addressing physical and other needs. High quality nursing home, hospice, and HCBS personal care services can often prevent the need for disruptive and costly hospitalizations.

OIG continues to identify various problems with nursing home and hospice care. For example, in reports on nursing homes, OIG raised concerns about the frequency of preventable adverse events due to substandard care, the extent to which nursing homes comply with federal regulations for reporting abuse and neglect, and the lack of monitoring of nursing homes' resident hospitalization rates. With respect to hospice care, OIG has raised concerns about insufficient monitoring of hospice service use, as well as inadequate oversight of hospice certification surveys and hospice-worker licensure requirements.

It is critical to ensure effective oversight of HCBS programs and Medicaid-paid personal care services. HCBS programs are important, in part, because they allow beneficiaries whose needs and preferences are better served by remaining in their own homes or other community-based settings to avoid or delay institutionalization. These programs offer many advantages for promoting beneficiary choice and preferences, but OIG efforts have revealed persistent payment, compliance, and quality vulnerabilities.

Progress in Addressing the Challenge

The Department continues to take steps to improve the quality of nursing home, hospice, and HCBS programs. Through its Web site and in various outreach strategies, CMS is providing guidance to nursing homes on how to meet newly expanded quality assessment and performance improvement (QAPI) activities required under the *Affordable Care Act*. Adding to this effort is a recent proposed rule that outlines actions CMS intends to take to remove obsolete or unnecessary provisions affecting nursing homes' ability to carry out these and other requirements. CMS also published rules strengthening nursing home requirements in areas such as emergency preparedness, dementia care, and infection control.

The Department has also taken steps to improve the quality of services beneficiaries receive in hospice settings and from HCBS programs. To improve hospice care, CMS proposed rules that would update the hospice quality reporting program and reform hospice payment methodologies. For HCBS programs, CMS finalized rules covering minimum quality expectations for providers, new administrative flexibilities for states running HCBS programs, requirements for person-centered planning in these services, and enforcement actions CMS can take against HCBS programs out of compliance with requirements. The Department also entered into a contract with the National Quality Forum to begin work on the development of a national quality measure set for HCBS.

OIG continues to pursue enforcement actions against nursing homes, hospices, and HCBS providers that render substandard care. CMS and OIG work closely with law enforcement partners at DOJ and through the federal Elder Justice Interagency Working Group to promote better care for older adults and to prosecute providers committing 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 abuse and neglect in Medicaid-funded facilities, such as nursing homes and board-and-care homes.

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 is 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 nursing home providers so they may better serve beneficiaries. OIG has placed nearly 40 nursing home companies (covering more than 750 facilities) under corporate integrity agreements that include quality-monitoring provisions designed to ensure that beneficiaries receive the care they deserve.

What Needs To Be Done

The Department should continue to prioritize quality of nursing home, hospice, and HCBS. OIG has offered recommendations to assist the Department in this mission. For example, OIG recommended that the Department monitor how often nursing home residents are hospitalized and develop resources that can be used to help nursing home staff reduce the incidence of adverse events in nursing homes. OIG has also recommended that the Department seek to link payments for services to meeting quality-of-care requirements and work with OIG to hold providers that have rendered substandard care accountable, thereby preventing additional harm to vulnerable beneficiaries. Further, the Department should promulgate the regulations mandated under section 6102 of the *Affordable Care Act* concerning compliance and ethics programs for nursing homes. Such regulations could assist nursing homes in preventing and detecting fraud, waste, and abuse and promoting quality of care.

Recently, Congress passed two laws that gave the Department new tools to improve the quality of care in nursing homes and other post-acute care providers. The *Protecting Access to Medicare Act of 2014* (PAMA) establishes a value-based payment program for nursing homes under which incentive payments will be made to high performing providers. The *Improving Medicare Post-Acute Care Transformation Act of 2014* (IMPACT) includes new reporting requirements for nursing homes and other post-acute care providers, including standardized admission and discharge patient assessments. IMPACT also includes requirements that hospice programs be surveyed at least once every 36 months and that oversight entities perform chart reviews, in some cases, of hospice episodes longer than 180 days. The Department should use these tools to improve the care people receive in these settings.

Lastly, the Department should ensure the 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 personal care attendants. The Department should also issue guidance to states regarding adequate prepayment controls and help states access data necessary to identify overpayments.

Key OIG Resources

- OIG Report, *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*, February 2014, http://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf
- OIG Portfolio, *Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement*, November 2012, http://oig.hhs.gov/reports-and-publications/portfolio/portfolio-12-12-01.pdf

Management Challenge 6: The Meaningful and Secure Exchange and Use of Electronic Health Information

Why This Is a Challenge

The American health care system increasingly relies on health information technology (health IT) and the electronic exchange and use of health information. Health IT, including electronic health records (EHRs), offers opportunities for improved patient care, more efficient practice management, and improved overall public health. The *Health Information Technology for Economic and Clinical Health Act of 2009* (HITECH) provided for Medicare and Medicaid incentive payments to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) for adopting, implementing, upgrading, or demonstrating meaningful use of EHRs and established a variety of grant programs to encourage widespread adoption of EHRs. HITECH also included requirements for public reporting of breaches of unsecured protected health information. Although participation in the Medicare and Medicaid EHR Incentive Programs is high and has led to widespread adoption among eligible providers, significant challenges exist with respect to overseeing the EHR Incentive Programs, achieving interoperability of EHRs, and keeping sensitive health information secure. Additionally, as the Department works to link payments with care quality, health outcomes, or performance as part of health care delivery system reforms, it will need to ensure that EHR and other health information data are accurate and reliable and are protected from misuse. (For more information on linking health care payments to value, see Management Challenge 4.)

Medicare and Medicaid EHR Incentive Programs. As of September 2014, the EHR Incentive Programs have paid out $25.4 billion in incentive payments. Although program interest has been high among those eligible, recent data suggest that not all those currently participating will continue in the programs. If the number of program participants were to decrease, fewer eligible professionals, eligible hospitals, and CAHs would progress to Stage 2 meaningful use, which includes a focus on health information exchange. For example, a recent Office of the National Coordinator for Health Information Technology (ONC) report, http://dashboard.healthit.gov/quickstats/pages/FIG-Medicare-Professionals-Stage-One-Meaningful-Use-Attestation-Cohort-2011.php, shows that a substantial number of the first cohort of participants may be dropping out of the Medicare EHR Incentive Program. Of those that received a payment in 2011, 16 percent did not return for 2012. Further, 19 percent of participants dropped out of the Medicare EHR Incentive Program in 2013.

Challenges in program oversight also leave the EHR Incentive Programs vulnerable to inappropriate payments to participants that do not meet program requirements. OIG work has demonstrated vulnerabilities in oversight controls for EHR incentive payments, as well as the accuracy of EHR incentive payment calculations. OIG also found that CMS and states did not implement strong prepayment controls and relied primarily on postpayment audits of high-risk participants to confirm that payments were appropriate. Additionally, OIG found that CMS and states lacked adequate data to verify participants' self-reported attestations about their eligibility and meaningful use of EHRs. ONC requires EHRs to generate audit reports for some, but not all, meaningful use measures; this requirement may create some oversight obstacles for CMS to verify payment during postpayment audits.

An OIG audit of Medicaid EHR incentive payment accuracy in Louisiana found that the state did not always pay Medicaid EHR incentive payments, in accordance with federal and state requirements. OIG found incorrect incentive payments including both overpayments and underpayments, totaling $4.4 million.

Interoperability. Those who adopt health IT must be able to use their systems to exchange and meaningfully use health information in order to achieve the broader policy objectives and cost savings to the health care system. Health information is still not commonly exchanged between groups of health care providers that use different EHR products. For example, most Health Resources and Services Administration (HRSA) health centers had the capability to capture data, but few were able to meet the Stage 1 meaningful use standard for sharing data. As of

September 2014, only 93 hospitals and 2,282 doctors had successfully progressed to Stage 2 meaningful use, which includes functionalities related to exchanging data, including for transitions of care between inpatient, outpatient, and postacute care providers. This may mean that patients' electronic health information is not shared across organizational, vendor, and geographic boundaries. A June 2014 study, http://jamia.bmj.com/content/21/6/1060.full.pdf+html?sid=30b4ae26-1916-4b0d-ac5a-0afd31e2cc95, published in the Journal of the American Medical Informatics Association found that customized health history documents in certified EHRs lead to errors in transmissions between EHR systems, often necessitating manual data entry—a counterproductive outcome. Sharing of data may be impeded by several factors, including costs to establish the capability to share data, complex federal and state privacy and security rules, and system variation.

Further, many health care delivery system reform initiatives envision providers, suppliers, and others coming together in new or enhanced ways to better coordinate patient care and increase efficiency. These reform initiatives include the Medicare Shared Savings Program, the Pioneer ACO Model, and the Bundled Payments for Care Improvement initiative, among others. To improve care coordination and meet performance goals, many participants in these and other reform initiatives will share data across settings and use data received from outside their own systems. A lack of data exchange and incompatibility across systems presents challenges to achieving the benefits promised by EHRs and other health IT and could undermine the goals of some reform initiatives. Data created, maintained, or transmitted using EHRs or other health IT are used to ensure correct Medicare and Medicaid payments, including value-based payments. Participants in some of these payment initiatives also receive Departmental data for their use in improving the care they furnish. Those data similarly must be accessible and accurate.

Protecting Sensitive Information. Safeguarding privacy and data security is, and should remain, a top priority in health IT adoption and health data exchange, storage, and use efforts. Health care data breaches can have serious consequences, including medical identity theft, misdiagnoses, delays in treatment, and mistreatment of illness. Following HITECH's enhancements of breach notification requirements, HHS's database of major breach reports affecting 500 people or more has tracked nearly 950 incidents affecting the personal information of about 30.1 million people. OIG consistently finds gaps in adherence to security standards set by the *Health Insurance Portability and Accountability Act* and the National Institute of Standards and Technology. During our audits of hospitals and covered entities, we identified weaknesses that included inadequacies in access controls, patch management, encryption of data, and Web site security vulnerabilities. Such weaknesses could result in unauthorized access to sensitive health information.

Safeguarding EHRs From Fraud. Some of the beneficial characteristics of EHRs, including efficiency and ease of storage and access, may also make them tools for fraud. OIG work in examining fraud safeguards in EHRs found that protections designed to improve validity, accuracy, and integrity in EHRs were not being used to their full extent. Only about one-quarter of hospitals have policies regarding the use of copy-paste, a feature that could be used inappropriately to add documentation to a patient's record to support a fraudulent bill for services that were never provided. Deleting or disabling audit logs could make it harder to prevent and detect fraud. Furthermore, CMS and its program integrity contractors have done little to update their practices to address EHR vulnerabilities.

Progress in Addressing the Challenge

The Department has made great strides in developing a foundational health IT infrastructure by making inroads with EHR adoption, establishing privacy and security guidance and standards, and offering services to support health information exchanges (HIE) and interoperability. As of September 2014, 95 percent of eligible hospitals and CAHs and 92 percent of physicians and other eligible professionals have registered to participate in the EHR Incentive Programs, amounting to more than 500,000 eligible professionals, eligible hospitals, and CAHs.

With respect to oversight of the EHR Incentive Programs, CMS has audited Medicare 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. CMS also reports that it began conducting pre-payment audits in 2013. If the Department continues to takes steps to ensure that meaningful use requirements include necessary safeguards, these audits will be a helpful oversight and enforcement tool.

ONC has issued a document entitled "Connecting Health and Care for the Nation: A 10-Year Vision to Achieve an Interoperable Health IT Infrastructure" (10-Year Vision Paper), http://healthit.gov/sites/default/files/ONC10yearInteroperabilityConceptPaper.pdf, which describes future efforts to expand the sharing of information for health beyond EHRs and identifies privacy and security protections for health information as a building block for a nationwide interoperable health information infrastructure.

What Needs To Be Done

The 10-Year Vision Paper states that, "[b]y 2024, individuals, care providers, communities, and researchers should have an array of interoperable health IT products and services that allow the health care system to continuously learn and advance the goal of improved health care." The desired "learning health system" should, according to the 10-Year Vision Paper, also enable lower costs, improved population health, and other benefits. To fully realize the value of an over $24 billion investment, the Department must do more to ensure that systems are interoperable in order to realize these goals.

As the Department progresses through the development and implementation of meaningful use stages, it should continue to consider feedback from stakeholders to ensure that adopted policies advance the Nation towards the Department's stated goals, while appropriately reflecting the changing health IT landscape. Guidance and technical assistance should be issued to address adoption, meaningful use, and interoperability barriers and program integrity safeguards. It is also essential that privacy, security, and fraud prevention remain at the forefront of the Department's, ONC's, and CMS's health IT efforts.

Finally, given the magnitude of the investment in EHRs and other health IT programs, it will become increasingly important to demonstrate and measure the extent to which EHRs and health IT have actually achieved the Department's goals, which include improved health care and lower costs. Ongoing OIG work is examining the accuracy of Medicare and Medicaid EHR incentive payments for the first stage of meaningful use and attempting to determine whether Medicaid safeguards prevent improper payments. Future work may examine health IT interoperability across providers, across HHS, and between providers and patients, as well as examine outcomes from health IT investments.

Key OIG Resources

- OIG Reports on EHR Incentive Program Oversight, January 2014, http://oig.hhs.gov/oei/reports/oei-09-11-00380.pdf; August 2014, http://oig.hhs.gov/oas/reports/region6/61200041.pdf; November 2012, http://oig.hhs.gov/oei/reports/oei-05-11-00250.pdf; July 2011, http://oig.hhs.gov/oei/reports/oei-05-10-00080.pdf; December 2013, http://oig.hhs.gov/oei/reports/oei-01-11-00570.pdf
- OIG Report, *Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology*, December 2013, http://oig.hhs.gov/oei/reports/oei-01-11-00570.pdf
- OIG Report, *CMS and Its Contractors Have Adopted Few Program Integrity Practices To Address Vulnerabilities in EHRs*, January 2014, http://oig.hhs.gov/oei/reports/oei-01-11-00571.pdf
- OIG Report, *The Office of the National Coordinator for Health Information Technology's Oversight of the Testing and Certification of Electronic Health Records*, August 2014, http://oig.hhs.gov/oas/reports/region6/61100063.pdf

Management Challenge 7: Effectively Operating Public Health and Human Services Programs To Best Serve Program Beneficiaries

Why This Is a Challenge

The Department funds and operates public health and human services programs that promote health and economic and social well-being. These include, among others, programs to prevent, track, and treat acute and chronic diseases; respond to natural and man-made disasters; and protect, care for, and educate children. Many of these programs target vulnerable populations. Effective management of these programs is essential to ensure that they achieve their goals and best serve the programs' intended beneficiaries. Key challenges include (1) ensuring effective preparedness and response to current and future public health emergencies, (2) protecting the health and safety of America's vulnerable populations, and (3) ensuring access for intended beneficiaries and delivery of quality services such that beneficiaries' needs are met.

Public Health Preparedness and Emergency Response. Recent natural disasters, such as Hurricane Sandy, and disease outbreaks, such as the Ebola virus outbreak, highlight the importance of an agile public health infrastructure that can rapidly and capably respond to emergencies at home and abroad. The ability to effectively communicate and coordinate with federal, state, local, tribal, and private entities, as well as with international partners, is critical. OIG's recent review of hospitals' experiences during Hurricane Sandy revealed that the vast majority of hospitals in affected areas reported substantial challenges, including infrastructure breakdown and communication failures. The recurrence of similar problems as experienced during prior disasters highlights the need to apply knowledge gained from past experience to anticipate and prepare for new problems going forward.

The Department is also responsible for ensuring that select agents (e.g., anthrax and smallpox), which have the potential to pose a severe threat to human, animal, or plant health, are handled safely and stored securely. Earlier work by OIG identified security vulnerabilities at many Department research facilities, and recent testimony and news accounts attest to continuing problems with how these agents are inventoried and handled.

Access to and Quality of Services. To achieve program goals, the Department must ensure that qualified beneficiaries have access to high quality services. OIG work has uncovered situations in which beneficiaries could not access key services and situations in which beneficiaries received substandard services. For example, OIG found that many HRSA-funded health centers, which provide primary care for millions of patients, failed to fully adopt CDC-endorsed practices for routine HIV testing that are recommended to help combat spread of the virus. In another example, OIG found that vaccines intended for use in the Vaccines for Children (VFC) program had expired or had been improperly stored in ways that could compromise their safety or efficacy. Additional challenges arise in ensuring that children in foster care receive required health screenings.

Protecting Vulnerable Populations. OIG work has revealed potential threats to the health and safety of children served by the Child Care and Development Fund (CCDF) program of the Administration for Children and Families. CCDF provides financial assistance for child care, each month serving approximately 1.45 million children from low income families. OIG work identified vulnerabilities in states' standards for and monitoring of child care providers and suggested efforts the Department should undertake to better serve this vulnerable population.

Since first assuming responsibility for unaccompanied children in 2003, the Office of Refugee Resettlement (ORR) has cared for more than 100,000 such children, through the end of FY 2013. This year, the number of unaccompanied children arriving in the United States without lawful immigration status has dramatically increased. In 2014, the Department estimates that the total number of such unaccompanied children will reach nearly 60,000, more than double the number from the prior year. ORR faces substantial demands in adequately caring for this influx of children in an environment of heightened public and media scrutiny.

Progress in Addressing the Challenge

The Department reports that it has made progress in improving physical security and employee training related to secure storage and safe handling of select agents; however issues related to inventory control in HHS laboratories remain.

CMS is developing more comprehensive emergency preparedness requirements for Medicare providers and suppliers. The Department is currently undertaking several initiatives, including a technical assistance center, to support collaboration among federal, state, and community entities in disaster response. Similarly, in response to OIG's recommendations, the Department has established new training materials for its grantees and providers to ensure that VFC vaccines are stored according to requirements.

What Needs To Be Done

The Department must effectively deploy its resources and expertise to combat communicable diseases, such as Ebola. The Department should continue to promote federal, state, tribal, and community collaboration in major disasters and public health exigencies. While it may not be possible to predict when and where disasters will strike, the Department should prepare for a range of potential emergency scenarios and be ready to rapidly and effectively respond. Similarly, the Department must plan for, and meaningfully assist health care providers in planning for, a range of public health emergencies. Additionally, improvements in adoption and interoperability of health IT can facilitate medical care for displaced patients or patients with communicable diseases by ensuring continuity of access to health records. (For additional discussion on issues related to the secure exchange of health care information, see Management Challenge 6.)

The Department should also fully implement OIG recommendations to ensure that HRSA-funded health centers follow CDC recommendations regarding routine HIV testing to prevent disease transmission. Improved program operation will better serve beneficiaries and help prevent future public health emergencies.

Given the recent unprecedented surge in unaccompanied children, the Department must be prepared to meet future demand for services for additional children. OIG continues to recommend that the Department establish a memorandum of understanding with the Department of Homeland Security to clearly delineate the roles and responsibilities of each Department and facilitate gathering and exchange of information regarding unaccompanied children.

The Department should also fully implement OIG recommendations regarding CCDF to ensure compliance with state requirements related to the health and safety of children, implementation of controls for determining eligibility for receiving assistance payments, and ensuring that states implement better controls for regulating and monitoring childcare providers. OIG has also recommended strengthened health and safety requirements and use of provider background checks to reduce health and safety risks to children served by the programs.

The Department will need to take swift action to significantly improve its inventory control policies and procedures for select agents in light of recent news reports identifying significant issues with inventory controls, which the Department has confirmed.

Key OIG Resources

- OIG Report, *Hospital Emergency Preparedness and Response During Superstorm Sandy*, November 2014, http://oig.hhs.gov/oei/reports/oei-06-13-00260.asp
- OIG Testimony, "The Foundation for Success: Strengthening the Child Care and Development Block Grant Program," March 25, 2014, http://oig.hhs.gov/testimony/docs/2014/jarmon-testimony-0314.pdf
- OIG Report, *HIV Testing in HRSA-Funded Health Center Sites*, November 2013, http://oig.hhs.gov/oei/reports/oei-06-10-00290.asp

- OIG Report, *Vaccines for Children: Vulnerabilities in Vaccine Management*, April 2012, http://oig.hhs.gov/oei/reports/oei-04-10-00430.asp
- OIG Report, *Division of Unaccompanied Children's Services: Efforts To Serve Children*, March 2008, http://oig.hhs.gov/oei/reports/oei-07-06-00290.pdf

Management Challenge 8: Ensuring Effective Financial and Administrative Management

Why This Is a Challenge

The Department manages health care insurance, public health, social services, and research programs designed to enhance the health, safety, and well-being of all Americans. Responsible stewardship of these programs is vital. Underpinning such stewardship should be a financial management and administrative infrastructure that employs appropriate internal controls to minimize risk to the programs and safeguard resources.

Financial statement audits. Financial statement audit results provide an important assessment of financial management challenges an agency faces. For FY 2013, independent auditor Ernst & Young identified a material weakness in the Department's financial management systems related to IT security and a significant deficiency in its financial reporting systems, analyses, and oversight. Specifically, Ernst & Young recommended that the Department bolster IT security in its financial management systems and take steps to improve internal control deficiencies that impact HHS's ability to report accurate financial information on a timely basis.

The financial statement audit also revealed challenges the Department continues to face in addressing violations of certain provisions of the *Anti-Deficiency Act*. These violations highlight weaknesses in an agency's control over budgetary resources. Prior OIG audits of National Institutes of Health contracts revealed instances of improper funding in 11 of 18 contracts reviewed. Follow-up work is underway to assess the effectiveness of the remedial actions outlined by the Department in its 2011 report of *Anti-Deficiency Act* violations.

Improper payments. Improper payments cost federal programs billions of dollars annually. For FY 2013, the Department reported improper payments totaling almost $50 billion in the Medicare program and $65 billion overall. Pursuant to the *Improper Payments Information Act of 2002* (IPIA), as amended, federal agencies are required to provide uniform, annual reporting on improper payments and their efforts to reduce them. Inspectors General are required to report annually to Congress and The President regarding agency compliance with IPIA. Although the Department met many requirements of the IPIA in FY 2013, it did not fully comply. The greatest challenges in this area are to report on all programs deemed susceptible to significant improper payments and minimize improper payments to acceptable levels. The Department has not published an improper payment estimate and other required information for the Temporary Assistance for Needy Families (TANF) program. For the Medicare fee-for-service program, the Department reported an improper payment rate that exceeded 10 percent of program outlays in FY 2013.

Administrative Oversight. Careful coordination of Departmental staff, contract staff, grantees, and other partners is essential to achieve mission objectives in accordance with federal, departmental, and agency requirements. Many grantees receive multiple awards from HHS. The discontinuation of the Department-wide Alert List in 2007 may pose challenges for awarding agencies to share concerns with one another regarding grantees' abilities to handle federal funds. Moreover, OIG found that only one of four agencies within HHS that awarded Small Business Innovation Research (SBIR) funds checked for duplicative funding within the Department, and none of the four completed a required check for duplicative awards across other federal agencies. OIG is currently evaluating the extent to which HHS programs maintain and share information about grantees vulnerable to fraud, waste, and abuse. (For more information on specific issues associated with grantee and contractor oversight and effectiveness, see Challenge 9.)

Progress in Addressing the Challenge

The Department has been taking steps to address outstanding financial management challenges. Most significantly, to help address a number of shortcomings, it has scheduled an upgrade of its accounting systems, which the Department expects to complete in 2016, to alleviate internal control deficiencies it has reported in the financial statement audits.

With respect to *Anti-Deficiency Act* violations related 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 certain thresholds, depending on the type of requirement reviewed and the awarding Operating Division (OpDiv) or Staff Division (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. Further, in its FY 2013 *Agency Financial Report*, the Department stated that it released a major update to its internal grants policies, featuring enhanced guidance on grants closeout, suspension and debarment, grants systems, and grants payments.

With regard to improper payments, the Head Start program had reported a consistently low improper payment rate which has been below the mandated threshold for reporting, and Office of Management and Budget (OMB) granted the Department relief from reporting annual error rate estimates in FY 2013. Further, between FY 2012 and FY 2013, the Department reduced the improper payment rate for Medicare Advantage from 11.4 percent to 9.5 percent, for Medicaid from 7.1 percent to 5.8 percent, for the Child Care and Development Fund from 9.4 percent to 5.9 percent, and for the Foster Care program from 6.2 percent to 5.3 percent.

HHS is drafting regulations to implement OMB's new Uniform Guidance: Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, commonly referred to as the Uniform Guidance. The Uniform Guidance consolidates eight federal regulations into a single guide to ease administrative burdens and strengthens oversight of federal awards to reduce the risk of fraud, waste, and abuse.

What Needs To Be Done

To ensure better financial management across all program areas, the Department should resolve weaknesses identified across all financial management systems currently in operation, as recommended by internal and external auditors. To bring the Department into full compliance with the IPIA, it should continue to reduce error rates in all programs via appropriate corrective action plans. However, full compliance would also require the Department to publish an improper payment estimate for the TANF program. To do this for TANF, the Department reports it needs legislative changes to require states to report information necessary to calculate and report improper payment estimates for TANF. The Department should actively seek such legislative changes. CMS should work to improve its oversight of corrective action plans to ensure their relevance to contractors' error measurement.

Grant-making agencies, including HHS, are scheduled to implement OMB's new Uniform Guidance by the end of calendar year 2014. In accordance with the new guidance, the Department will need to implement robust new processes, including enhancements to processing the Single Audit reports. OIG will monitor the Department's implementation of these new processes and future reform efforts. OIG will also continue to examine existing administrative controls and grants management practices across the Department.

The Department should continue to leverage technology to further prevent improper payments and ensure responsible program stewardship. The Department should also continue to expand its education efforts for providers, grantees, staff, contractors, and other partners. Implementation of planned program integrity efforts, such as evaluating and mitigating risks, identifying and addressing cross-cutting issues, resolving reported grantee

audit findings, and sharing best practices across HHS, will help the Department integrate program integrity into all aspects of its operations and culture and fortify the financial and administrative infrastructure.

Key OIG Resource

- OIG Report, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2013, April 2014, https://oig.hhs.gov/oas/reports/other/171452000.asp
- OIG Report, Medicare Claims Administration Contractors' Error Rate Reduction Plans, January 2014, http://oig.hhs.gov/oei/reports/oei-09-12-00090.asp

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; over 79,000 grants totaling $389 billion were awarded in FY 2014. That amount comprised $47 billion in discretionary awards and the remaining amount in formula/block grant and entitlement awards.

HHS is also the third largest contracting agency in the Federal Government. In FY 2013, HHS awarded over $20 billion in contracts across all program areas. The Government Accountability Office (GAO) and OIG both have identified weaknesses in HHS contracting processes and contract management throughout the Department. Oversight is a particular concern. An OIG audit of CDC contracts revealed poor execution of required contractor performance assessments by HHS. A recent GAO report, http://www.gao.gov/products/GAO-14-694, identified ineffective contract planning and management as one cause of the problematic rollout of HealthCare.gov. In addition, recent OIG work identified the large number of contractors responsible for aspects of the federal Marketplace and requiring appropriate oversight and management. Under the *Affordable Care Act*, contractors have a vital role in building, maintaining, and fixing the systems that underpin the federal Marketplace. HHS faces a challenge to ensure proper management and oversight of these and other contracts. (See Management Challenge 1 for more information on management and oversight of the Marketplaces.)

The size and scope of departmental awards make vigilant oversight by the Department 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.

A common problem uncovered by our reviews at the grantee level is that grantees have lacked robust financial management systems. Many grantees still do not account for specific costs on a grant-by-grant basis, making it difficult to reliably monitor and account for costs associated with specific grant awards. When combined with frequent findings of significant unallowable expenses, these conditions support the need for more purposeful and consistent oversight.

HHS is the second largest payer under the SBIR and Small Business Technology Transfer (STTR) programs. HHS awarded $13 million in SBIR contracts and $463,000 in STTR contracts in FY 2013. OIG has noted two significant issues with the programs: inconsistent collection of information needed to evaluate commercial success and failures to check for duplicative funding within the Department and across other agencies. (See Management Challenge 8 for more information on administrative oversight of HHS grants and contracts.)

Progress in Addressing the Challenge

HHS has strengthened its program integrity efforts by working with OpDivs and StaffDivs to implement a uniform risk management approach that encompasses developing strategies, plans, and metrics. The Department has established a Program Integrity Coordinating Council, which identifies common program challenges and explores solutions.

The Department has sponsored training for HHS grant and contracting officials to aid them in identifying potential fraud, waste, and abuse, including encouraging contractors to self-report contract fraud and overpayments. Training has also taken place on best practices for investigating fraud in HHS grants and contracts.

The Department has made progress in its Suspension and Debarment program by conducting training, finalizing the HHS Suspension and Debarment Guidance and accompanying Desk Reference, creating a Department-wide referral tracking system, and working with the Office of the General Counsel to streamline the referral review process. The total number of suspension and debarment referrals according to the Office of Recipient Integrity Coordination (ORIC) has increased from 22 in FY 2012 to 42 in FY 2013, and the total number of actions taken by the Suspension and Debarment Officer (SDO) has increased from 0 suspensions or debarments in FY 2012 to 8 debarments and 8 suspensions in FY 2013. The Department is on track to increase the number of suspensions and debarments in FY 2014.

What Needs To Be Done

Sustained focus by the Department is needed to address vulnerabilities in its grant programs and contract administration. For instance, although the Department designed internal controls with features specified by OMB Memorandum M-13-07, this effort must be followed by diligent monitoring to ensure that qualified individuals have access to grants and that recipients use the funds according to the award terms and in a manner consistent with the *Disaster Relief Appropriations Act of 2013*.

HHS could improve federal contracting by aligning more closely with the Office of Federal Procurement Policy (OFPP) strategy of improving contractor source selection decisions. A key part of OFPP's strategy is contractor performance monitoring. HHS has improved its rate of monitoring from 10 percent to 24 percent in the last two years. However, according to a recent GAO report, http://www.gao.gov/products/GAO-14-707, that rate is less than half the FY 2014 government-wide rate of 49 percent.

OpDivs must be vigilant in monitoring grant resources and take appropriate actions, including: implementing planned program integrity efforts, such as evaluating and mitigating risks and identifying and addressing cross-cutting issues; resolving grantee audit findings; and sharing best practices across the Department to better position HHS to integrate program integrity into all aspects of its operations and culture.

Training on identifying and pursuing misconduct in HHS grants and contracts should continue. HHS contract and grant officers should more actively coordinate with, and refer potential grant and contract fraud to, OIG for investigation. The Department needs to implement a program to actively pursue fraud under the *Program Fraud Civil Remedies Act* (PFCRA). The Department also needs to continue to refine its suspension and debarment procedures by further streamlining the referral and decision process, continuing to provide training and decreasing the processing time of referrals. Although HHS has begun to take suspension and debarment actions largely in response to conviction-based actions, OpDivs, StaffDivs, OIG, and the SDO need to make effective use of fact-based debarments and suspensions.

Key OIG Resources

- OIG Hurricane Sandy Grants and Contracts Training Videos, http://oig.hhs.gov/newsroom/podcasts/2014/sandy/
- OIG Report, *The Department of Health and Human Services Designed Its Internal Controls Over Hurricane Sandy Disaster Relief To Include Elements Specified by the Office of Management and Budget*, July 2014, http://oig.hhs.gov/oas/reports/region2/21302010.asp
- OIG Report, *Vulnerabilities in the HHS Small Business Innovation Research Program*, April 2014, http://oig.hhs.gov/oei/reports/oei-04-11-00530.asp

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, biologics, dietary supplements, tobacco, 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 conducts effective post-market monitoring. During a food emergency, the Department is responsible for finding the contamination source and overseeing the removal 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. It has also revealed failures by industry participants to follow processes designed to ensure the safety and efficacy of food, drugs, biologics, and medical devices. These high risk areas include:

Drug Compounding. A fall 2012 nationwide fungal meningitis outbreak associated with contaminated compounded sterile drug injections raised major concerns about the quality of drugs supplied by compounders and FDA's ability to effectively oversee these entities. 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 2012 outbreak. After the meningitis outbreak, in November 2013, President Obama signed the *Drug Quality and Security Act* (DQSA), Public Law 113-54. Among other things, the DQSA added a new section to the *Federal Food, Drug, and Cosmetic Act*, section 503B, that provides a new pathway for entities called "outsourcing facilities" to legally compound human drugs. FDA also continues to identify serious deviations from acceptable practices for the production of compounded sterile drugs, as evidenced by the lists of inspectional observations issued to compounders at the conclusion of FDA inspections; the numerous recalls of compounded drugs because of contamination or lack of sterility assurance; and the warning letters issued to compounders addressing, in part, unsanitary conditions at their facilities. Implementation of the DQSA poses new challenges for the Department.

Imported Drugs. Medications imported from foreign or unlicensed suppliers may be unapproved by FDA and may be ineligible for reimbursement by Medicare, Medicaid, and other federal health care programs. Such drugs may also be counterfeit, contaminated, ineffective, and/or unsafe. FDA's Office of Criminal Investigations (OCI), OIG, and our law enforcement partners have investigated many instances in which physician practices, drug distributors, and suppliers have imported such drugs. Among other consequences, importation of such drugs can lead to patient safety issues, the submission of improper claims to federal health care programs, and the circumvention of FDA drug approval and facility inspection processes.

Food Safety. Protecting the American public from food-borne illness, such as those caused by salmonella and E. coli, is an ongoing challenge. In the past, OIG has found that food facilities' failures to comply with FDA's requirements impede the Department's ability to ensure the safety of the Nation's food supply. 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 authorities to better protect the Nation's food supply. However, implementing these authorities could prove difficult given the broad preventive controls framework envisioned in FSAM, including establishing the new import oversight program and the training needed to ready both FDA and the states to conduct preventive control inspections.

Marketing Requirements. Manufacturers of drugs, biologics, 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 use 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 OCI, 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. (See Management Challenge 2 for more information on drug diversion and appropriate use of prescription drugs in Medicare and Medicaid.)

FDA faces ongoing concerns regarding dietary supplements and the structure/function claims made by manufacturers. Structure/function claims describe the role of a dietary supplement in the structure and function of human bodies, but the claims may not explicitly or implicitly claim to prevent, treat, mitigate, cure, or diagnose a disease. Manufacturers must have competent and reliable scientific evidence to show that dietary supplement 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. 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.

Progress in Addressing the Challenge

To address risks associated with imported drugs, FDA has engaged in both outreach and enforcement actions. FDA has undertaken significant efforts to warn consumers, medical practitioners, and others about the risks associated with buying drugs from foreign sources. In addition, FDA has continued to work with OIG and other law enforcement partners to investigate and prosecute individuals and businesses (e.g., physicians and drug suppliers) that import unapproved drugs. In July 2013, three physicians previously associated with McLeod Cancer and Blood Center entered into civil settlement agreements and agreed to pay more than $4.25 million to resolve allegations that they purchased misbranded, unapproved chemotherapy drugs from foreign sources; used the drugs to treat their Medicare, Medicaid, and other patients; and billed federal health care programs for the drugs. Dr. William Kincaid, the managing partner, pled guilty to receiving misbranded drugs with intent to defraud and mislead. Dr. Kincaid was sentenced to 2 years in prison and was excluded from participating in federal health care programs for 10 years.

With regard to drug compounding, FDA increased inspection and enforcement efforts, while developing the regulatory framework to implement the DQSA. In FY 2014, FDA conducted over 85 inspections of compounding pharmacies and outsourcing facilities and issued 29 warning letters. FDA's inspection and enforcement efforts are continuing. In addition, since the DQSA was enacted in November, 2013, FDA issued numerous policy documents to implement both section 503A (concerning pharmacy compounding) as well as the new section 503B (concerning outsourcing facilities) and continues to work on additional rules and guidance. 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. In response to OIG recommendations regarding oversight of dietary supplements, FDA stated that it is considering whether to seek explicit statutory authority to review substantiation for structure/function claims beyond its pre-existing authorities.

What Needs To Be Done

The Department and FDA will need to continue issuing rules and guidance documents to fully implement the various provisions in the July 2012 *Food and Drug Administration Safety and Innovation Act* (FDASIA) and in DQSA. FDA will need to continue to conduct inspections of compounding pharmacies and pursue regulatory action, as needed to protect public health, when deficiencies are identified. 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 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 continue its efforts to eliminate off-label promotion and reduce the importation of unapproved drugs from foreign sources to protect patients and HHS health care programs. Moreover, the Department and FDA will need to continue implementing the provisions under the 2009 *Family Smoking Prevention and Tobacco Control Act* to protect public health.

Key OIG Resources

- OIG Report, *High-Risk Compounded Sterile Preparations and Outsourcing by Hospitals That Use Them*, April 2013, https://oig.hhs.gov/oei/reports/oei-01-13-00150.asp
- OIG Report, *Dietary Supplements: Structure/Function Claims Fail To Meet Federal Requirements*, October 2012, http://oig.hhs.gov/oei/reports/oei-01-11-00210.asp
- OIG Report, *Vulnerabilities in FDA's Oversight of State Food Facility Inspections*, December 2011, http://oig.hhs.gov/oei/reports/oei-02-09-00430.asp
- DOJ press release, sentencing of William Kincaid, M.D., June 11, 2013, http://www.justice.gov/usao/tne/news/2013/June/061113%20Kincaid%20Sentencing%20Misbranded%20Drugs.html#top

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: William V. Corr, Deputy Secretary

Subject: FY 2014 Top Management and Performance Challenges Identified by the Office of Inspector General (OIG)

Thank you for your memorandum "Top Management and Performance Challenges Facing the Department of Health and Human Services in Fiscal Year 2014" issued November 12, 2014. We remain committed to enhancing the financial and operational effectiveness of HHS and appreciate OIG's role in the effort.

We concur with OIG's findings concerning HHS. We appreciate the cooperation and work conducted by OIG to help us address the Department's major management and performance challenges. Our management is committed to resolving these challenges to help us achieve our mission of improving the health and well-being of the American people.

Many thanks to you and your staff for your continued commitment in helping us improve our management environment. We look forward to working with you to further address these challenges.

/William V. Corr/

William V. Corr
Deputy Secretary
November 13, 2014

APPENDIX A: ACRONYMS

ACRONYM	DEFINITION
3D	Three-dimensional
AA	Associate of Arts
ACF	Administration for Children and Families
ACL	Administration for Community Living
ACO	Accountable Care Organization
ACR	Administrative Cost Review
ADA	*Anti-Deficiency Act*
ADRCs	Aging and Disability Resource Centers
AFR	Agency Financial Report
AGA	Association of Government Accountants
AHRQ	Agency for Healthcare Research and Quality
AICPA	American Institute of Certified Public Accountants
AIDD	Administration for Intellectual and Development Disabilities
ALJ	Administrative Law Judge
AOA	Administration on Aging
APP	Application
APTC	Advance premium tax credits
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
BARDA	Biomedical Advanced Research and Development Authority
BHPR	Bureau of Health Professions
CAHs	Critical Access Hospitals
CAIVRS	Urban Development's Credit Alert Interactive Voice Response System
CAP(s)	Corrective Action Plan(s)
CAUTI	Catheter-Associated Urinary Tract Infections
CBRs	Comparative Billing Reports
CCDF	Child Care Development Fund
CCIIO	Center for Consumer Information and Insurance Oversight
CDC	Centers for Disease Control and Prevention
CERT	Comprehensive Error Rate Testing
CEAR	*Certificate of Excellence in Accountability Reporting*
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
CL	Current Law
CLABSI	Central Line-associated Bloodstream Infections
CMA	Computer Matching Agreement
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
CPI-W	Consumer Price Index for Urban Wage Earners and Clerical Workers
CPIM	Consumer Price Index-Medical
CRADA	Cooperative Research and Development Agreement

ACRONYM	DEFINITION
CRC	Commercial Repayment Center
CSPs	Compounded Sterile Preparations
CSR	Cost-sharing reductions
CSRS	Civil Service Retirement System
CUSP	Comprehensive Unit-Based Safety Program
CY	Current Year
DAB	Departmental Appeals Board
DATA Act	*Digital Accountability and Transparency Act of 2014*
DEA	Drug Enforcement Agency
DHS	Department of Homeland Security
DIR	Direct and Indirect Remuneration
DMDC	DOD's Manpower Date Center
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment Prosthetics Orthotics and Supplies
DNP	Do Not Pay
DOD	Department of Defense
DOJ	Department of Justice
DOL	Department of Labor
DRA	*Deficit Reduction Act of 2005*
DQSA	*Drug Quality and Security Act*
EHR	Electronic Health Records
ESRD	End-Stage Renal Disease
FASAB	Federal Accounting Standards Advisory Board
FBIS	Financial Business Intelligence System
FBIP	Financial Business Intelligence Program
FBwT	Fund Balance with Treasury
FDA	Food and Drug Administration
FDASIA	*Food and Drug Administration Safety and Innovation Act*
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*
FFR	Federal Financial Report
FFS	Fee-for-Service
FGB	Financial Governance Board
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*
FOA	Funding Opportunity Announcement
FPS	Fraud Prevention System
FR	Final Rule
FSMA	*Food Safety Modernization Act*
FMAP	Federal Medical Assistance Percentage
FSIP	Financial Systems Improvement Program
FVPS	Family Violence Prevention and Services
FWA	Fraud, waste, and abuse
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	Government Accountability Office
GDP	Gross Domestic Product
GHP	Group Health Plan
GMRA	*Government Management Reform Act of 1994*
GMS	Grants Management Specialist
GSA	General Services Administration
HAIs	Healthcare-Associated Infections
HCBS	Home-and community-based- services
HCS	Health Care System
HEAL	Health Education Assistance Loan
HEW	Department of Health, Education and Welfare (now HHS)
HFPP	Healthcare Fraud Prevention Partnership

ACRONYM	DEFINITION
HHAs	Home Health Agencies
HHS	Department of Health and Human Services
HI	Hospital Insurance
HIE	Health Information Exchange
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
HRSA	Health Resources and Services Administration
HSOPS	Hospital Survey of Patient Safety
H5N1	Avian Influenza
IBNR	Incurred But Not Reported
ICUs	Intensive Care Units
IDDA	Intra-Departmental Delegation of Authority
IEA	Office of Intergovernmental and External Affairs
IEVS	Income Eligibility Verification System
IG	Inspector General
IHS	Indian Health Service
IMPACT	*Improving Medicare Post-Acute Care Transformation Act of 2014*
IOS	Immediate Office of the Secretary
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
LEIE	List of Excluded Individuals & Entities
LLP	Limited Liability Partnership
LPR	Legal Permanent Resident
J&J	Johnson & Johnson
MA	Medicare Advantage or Part C
MACS	Medicare Administrative Contractors
MARX	Medicare Advantage Prescription Drug
M.D.	Medical Doctor
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
MMA	*Medicare Prescription Drug, Improvement and Modernization Act of 2003*
MMIS	Medicaid Management Information Systems
MSIS	Medicaid Statistical Information Systems
MSP	Medicare Secondary Payer
MSSP	Medicare Shared Saving Program
NAMD	National Association of Medicaid Directors
NBI	National Benefit Integrity
NBS	NIH Business Systems
NCCI	National Correct Coding Initiative
NEI	National Eye Institute
NDNH	National Directory of New Hires
NHSC	National Health Service Corps
NHSN	National Healthcare Safety Network
NIH	National Institutes of Health
NOA	Notice of Award
NPI	National Provider Identifier
OACT	Office of the Actuary
OASDI	Old-Age Survivors and Disability Insurance
OASH	Office of the Assistant Secretary for Health
OCI	Office of Criminal Investigations
OCR	Office for Civil Rights

ACRONYM	DEFINITION
OFPP	Office of Federal Procurement Policy
OGA	Office of Global Affairs
OGC	Office of the General Counsel
OHR	Office of Health Reform
OI	Other Information
OIG	Office of Inspector General
OMB	Office of Management and Budget
OMH	Office of Minority Health
OMHA	Office of Medicare Hearings and Appeals
ONC	Office of the National Coordinator for Health Information Technology
OPD	Orphan Products Development
OpDiv	Operating Division
ORR	Office of Refugee Resettlement
OS	Office of the Secretary
PAMA	*Protecting Access to Medicare Act of 2014*
PARIS	Public Assistance Reporting Information System
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
PFCRA	Program Fraud Civil Remedies Act
PHD	Doctor of Philosophy
PHS	Public Health Service
PIP	Program Improvement Plan
PNS	Projects of National Significance
PP&E	Property, Plant and Equipment
PRRB	Provider Reimbursement Review Board
PSC	Program Support Center
PUPS	Social Security Administration's Prisoner Update Processing System
PUR	Period Under Review
PY	Prior Year
QAPI	Quality Assessment and Performance Improvement
QIO	Quality Improvement Organization
QRIS	Quality Rating and Improvement Systems
RAC	Recovery Auditor Contractor
RADV	Risk Adjustment Data Validation
RFQ	Request for Quote
RMFOB	Risk Management and Financial Oversight Board
RSI	Required Supplementary Information
SAM	General Service Administration's System for Award Management
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIR	Small Business Innovation Research
SBJA	*Small Business Jobs Act of 2010*
SDO	Suspension and Debarment Officer
SE	Salmonella Enteritidis
SECA	*Self Employment Contribution Act of 1954*
SF	Standard Form
SFFAS	Statement of Federal Financial Accounting Standards
SGR	Sustainable Growth Rate
SIR	Standard 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
SSBG	Social Service Block Grant
SSF	Service and Supply Fund
StaffDiv	Staff Division
STEM	Science, Technology, Engineering and Mathematics
STEMM	Science, Technology, Engineering, Mathematics, and

ACRONYM	DEFINITION
	Medicine
STTR	Small Business Technology Transfer
TANF	Temporary Assistance for Needy Families
TeamSTEPPS	Team Strategies and Tolls to Enhance Performance and Patient Safety
T-MSIS	Transformed Medical Shared Information 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

APPENDIX B: CONNECT WITH HHS

Secretary Burwell gives remarks at the Pan American Health Organization Directing Council, September 29, 2014.

Thank you for your interest in the HHS FY 2014 *Agency Financial Report*. Electronic copies of this report and related budgetary reports are available through HHS's website at http://www.hhs.gov/budget.

We would like to hear from you about our FY 2014 *Agency Financial Report*. Did we present information in a way you could use? What did you like best and least about our report? How can we improve our report in the future?

You can send written comments to:

U.S. Department of Health and Human Services
Office of Finance/OFPR
Mail Stop 549D
200 Independence Avenue, S.W.
Washington, DC 20201

Or, if you prefer, e-mail your comments to hhsafr@hhs.gov.

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