

MANAGEMENT'S
DISCUSSION & ANALYSIS

SECTION 1

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About the Department of Health and Human Services

Our Mission

The mission of the United States (U.S.) Department of Health and Human Services (HHS or the Department) 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.

Who We Are

HHS is the U.S. Government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. HHS accomplishes its mission through programs and initiatives that cover a wide spectrum of activities, serving and protecting Americans at every stage of life.

HHS is responsible for more than 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 1 in 3 Americans.

What We Do

HHS works closely with state, local, tribal governments, state or county agencies, private sector grantees, tribes, tribal organizations, and Urban Indian organizations that provide many HHS-funded services at the local level. The HHS Office of the Secretary and the 11 Operating Divisions (OpDivs), including 8 Public Health Service and 3 human service agencies of HHS administer more than 300 programs covering a wide spectrum of activities. While HHS is a domestic agency working to protect and promote the health and well-being of the American people, the interconnectedness of our world requires that HHS engage globally to fulfill its mission. In addition, Staff Divisions (StaffDivs) provide leadership, direction, and policy guidance to the Department.

Did you know?

Between February 2014 and November 2016, the Food and Drug Administration's (FDA) award-winning "[The Real Cost](#)" campaign prevented up to 587,000 youths ages 11-19 from trying cigarettes. This smoking prevention campaign educates more than 10 million at-risk youth in the U.S. about the harmful effects tobacco. FDA's [Youth Tobacco Prevention Plan](#) will expand "The Real Cost" campaign to help teens understand the risks of e-cigarettes. To learn more about the real cost of tobacco, smoking, and vaping, visit TheRealCost.BeTobaccoFree.hhs.gov.





HHS, through its programs and partnerships:

- Provides health care coverage to more than 100 million people through Medicare, Medicaid, and the Children's Health Insurance Program (CHIP);
- Promotes patient safety and health care quality in health care settings and by health care providers by assuring the safety, effectiveness, quality, and security of foods, drugs, biologics, and medical devices;
- Conducts health, social science, and medical research while creating hundreds of thousands of jobs for scientists in universities and research institutions in every state across America and around the globe;
- Leverages health information technology (IT) to improve the quality of care and to use data to drive innovative solutions to health care, public health, and human services challenges;
- Improves maternal and infant health; promotes the safety, well-being, and healthy development of children and youth; and supports young people's successful transition to adulthood;
- Supports wellness efforts across the life span, from protecting mental health, to preventing risky behaviors such as tobacco use and substance abuse, to promoting better nutrition and physical activity;
- Prevents and manages the impacts of infectious diseases and chronic diseases and conditions, including the top causes of disease, disability, and death;
- Serves as a responsible steward of the public's investments; and
- Prepares and protects Americans by providing comprehensive responses to health, safety, and security threats, both foreign and domestic, natural or man-made.

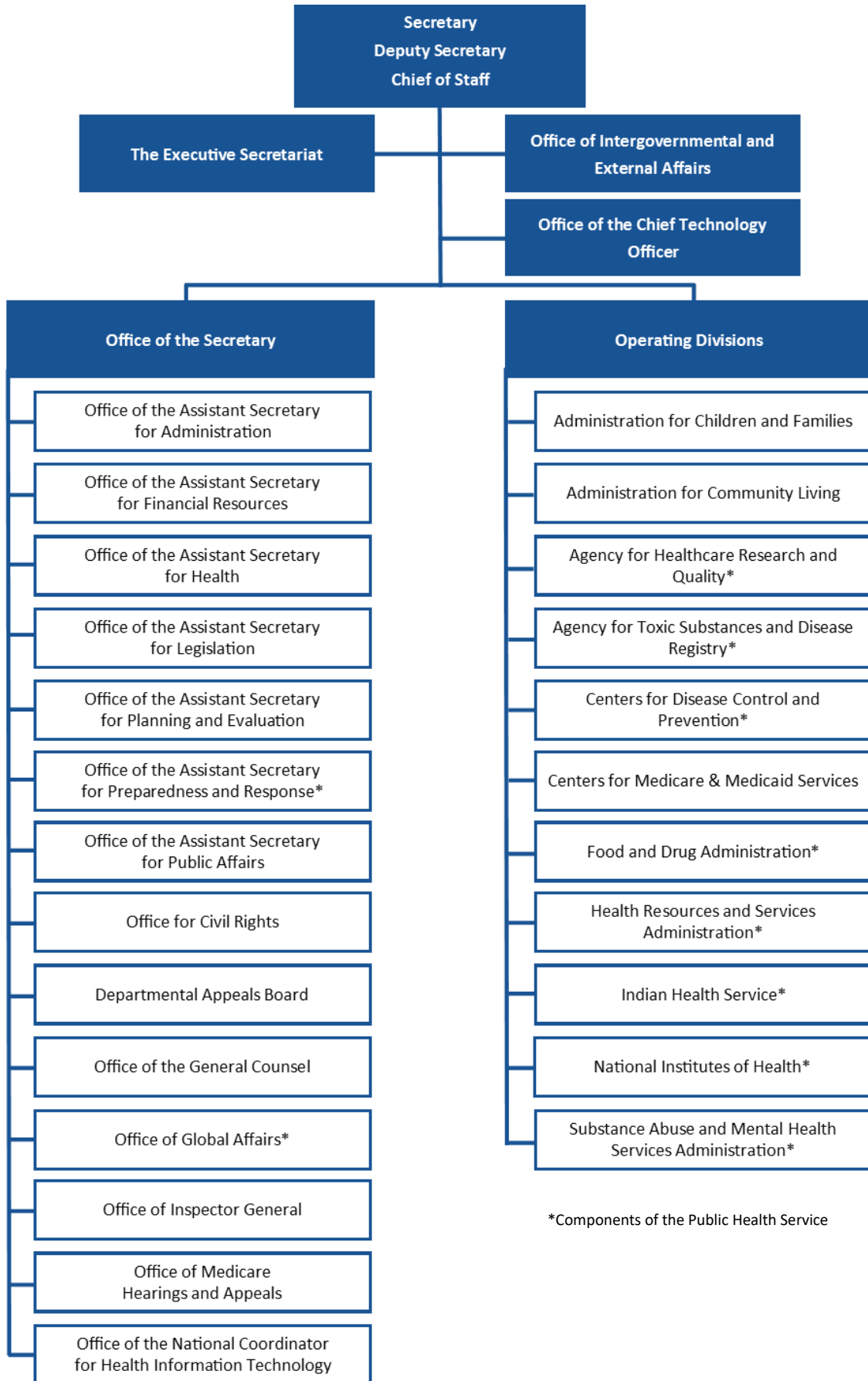
Did you know?



Serious difficulty seeing is the fifth most common form of disability among adults with disabilities in the U.S. The Centers for Disease Control and Prevention supports 19 state disability and health programs and 2 National Centers on Health Promotion for People with Disabilities, all of which promote healthy lifestyles and improving quality of life for people with disabilities. To learn more, visit [Centers for Disease Control and Prevention.gov](https://www.cdc.gov).

Organizational Structure

HHS's organizational structure is designed to accomplish its mission and provide a framework for sound business operations and management controls. The Office of the Secretary, with the Secretary, provides the overarching vision and strategic direction for the Department, and leads HHS and its OpDivs to provide a wide range of services and benefits to the American people. The HHS organizational chart is presented on the next page. For additional information, refer to the [HHS website](https://www.hhs.gov).





Each OpDiv contributes to our mission and vision as follows:

ADMINISTRATION FOR CHILDREN AND FAMILIES (ACF)

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. Visit [ACF](#) for more information.



ADMINISTRATION FOR COMMUNITY LIVING (ACL)

ACL was created around the fundamental principle that all people, regardless of age or disability, should be able to live independently, and fully participate in their communities. By advocating across the federal government for older adults, people with disabilities, and families and caregivers; funding services and supports primarily provided by networks of community-based organizations; and investing in training, education, research, and innovation, ACL helps make this principle a reality for millions of Americans. Visit [ACL](#) for more information.



AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

AHRQ produces evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and works within HHS and with other partners to make sure that evidence is understood and used. This mission is supported by focusing on: (1) investing in research on the nation's health delivery system that goes beyond the "what" of health care to understand "how" to make health care safer and improve quality; (2) creating materials to teach and train health care systems and professionals to put the results of research into practice; and (3) generating measures and data used by providers and policymakers. Visit [AHRQ](#) for more information.



AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY (ATSDR)

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. Visit [ATSDR](#) for more information.



CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

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 curable or preventable, due to human error or deliberate attack, CDC fights diseases and supports communities and citizens to do the same. Visit [CDC](#) for more information.





CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

CMS administers Medicare, Medicaid, CHIP, and the Health Insurance Exchanges, which together provide health care coverage for more than 100 million people. 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. Visit [CMS](https://www.cms.gov) for more information.



Did you know?

Medicare is composed of different parts that cover specific services.

Medicare Part A (Hospital Insurance)

Part A covers inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to get these benefits. Most people do not pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working.

Medicare Part B (Medical Insurance)

Part B covers doctors' services and outpatient care. It also covers some other medical services that Part A does not cover, such as services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary. Most people pay a premium for Part B.

Medicare Fee-for-Service

Often referred to as the "Original Medicare," Medicare Fee-for-Service (FFS) is a federal health insurance program that provides Medicare Part A and Medicare Part B to eligible citizens.

Medicare Part C (Medicare Advantage)

Medicare pays a fixed amount to approved private companies to offer Part C Medicare Advantage Plans. Part C provides the same coverage benefits as Part A and Part B, and may offer Part D coverage or other extra coverage options (e.g., vision, hearing, dental and/or health and wellness programs). Private Medicare Advantage companies must follow requirements set by Medicare; however, Part C plans can have varying amounts of out-of-pocket costs or qualification rules based on the coverage provider.

Medicare Part D (Prescription Drug Coverage)

Medicare prescription drug coverage is available to everyone with Medicare. To get Medicare prescription drug coverage, people must join a prescription drug plan approved by Medicare. Most people pay a monthly premium for Part D.

Visit [Medicare.gov](https://www.Medicare.gov) to find more information.





FOOD AND DRUG ADMINISTRATION (FDA)

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 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 it needs to use medicines and foods to maintain and improve their health. FDA is also responsible 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. Visit [FDA](#) for more information.



HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

HRSA programs provide health care to people who are geographically isolated, economically, or medically vulnerable. This includes people living with HIV/AIDS, pregnant women, mothers, and their families, and those otherwise unable to access high-quality health care. HRSA also supports access to health care in rural areas, the training of health professionals, the distribution of providers to areas where they are needed most, and improvements in health care delivery. In addition, HRSA oversees organ, bone marrow, and cord blood donation. It compensates individuals harmed by vaccination, and maintains databases that flag providers with a record of health care malpractice, waste, fraud, and abuse for federal, state, and local use. Visit [HRSA](#) for more information.



INDIAN HEALTH SERVICE (IHS)

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 mission of raising the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. IHS provides a comprehensive health service delivery system for approximately 2.6 million American Indians and Alaska Natives who belong to 573 federally recognized tribes in 37 states. Visit [IHS](#) for more information.



NATIONAL INSTITUTES OF HEALTH (NIH)

NIH is the primary agency of the U.S. Government responsible for biomedical and public health research. NIH provides leadership and direction to programs designed to improve the health of the nation by seeking 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. Visit [NIH](#) for more information.



SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

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, in both primary and specialty care settings. Visit [SAMHSA](#) for more information.





The following StaffDivs report directly to the Secretary, managing programs and supporting the OpDivs in carrying out the Department's mission. The primary goal of the Department's StaffDivs is to provide leadership, direction, and policy guidance to the Department. The StaffDivs are:

IMMEDIATE OFFICE OF THE SECRETARY (IOS)

IOS oversees the Secretary's operations and coordinates the Secretary's work.

- The Executive Secretariat (ES)

ES manages the Department's policy review and decision-making processes, coordinating the development, clearance, and submission of all policy documents for the Deputy Secretary and Secretary's review and approval.

- Office of Intergovernmental and External Affairs (IEA)

IEA represents both the government and external perspective in federal policymaking and clarifies the federal perspective to government officials and external parties.

- Office of the Chief Technology Officer (CTO)

CTO harnesses the power of data, technology, and innovation to create a more modern and effective government that works to improve the health of our nation.

OFFICE OF THE ASSISTANT SECRETARY FOR ADMINISTRATION (ASA)

ASA provides leadership for HHS departmental management, including human resource policy and departmental operations. The Program Support Center (PSC), a component of ASA, is a shared services organization dedicated to providing support services to help its customers achieve mission-oriented results.

OFFICE OF THE ASSISTANT SECRETARY FOR FINANCIAL RESOURCES (ASFR)

ASFR provides advice and guidance to the Secretary on budget, financial management, acquisition policy and support, grants management, and small business programs. It also directs and coordinates these activities throughout the Department.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH (OASH)

OASH advises on the nation's public health and oversees HHS's U.S. Public Health Service for the Secretary.

OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION (ASL)

ASL provides advice on legislation and facilitates communication between the Department and Congress.

OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION (ASPE)

ASPE advises on policy development and contributes to policy coordination, legislation development, strategic planning, policy research, evaluation, and economic analysis.





OFFICE OF THE ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE (ASPR)

The mission of ASPR is to save lives and protect Americans from 21st century health security threats. ASPR leads the nation's medical and public health preparedness for, response to, and recovery from disasters and public health emergencies. ASPR collaborates with hospitals, healthcare coalitions, biotech firms, community members, state, local, tribal, and territorial governments, and other partners across the country to improve readiness and response capabilities.

OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC AFFAIRS (ASPA)

ASPA provides centralized leadership and guidance on public affairs for HHS's StaffDivs, OpDivs, and regional offices. ASPA also administers the *Freedom of Information and Privacy Act*.

OFFICE FOR CIVIL RIGHTS (OCR)

OCR enforces federal laws that prohibit discrimination on the basis of race, color, national origin, disability, sex, age, religion, or conscience by health care and human services providers that receive funds from HHS as well as the federal laws and regulations governing the privacy and security of health information and the rights of individuals with respect to their health information.

DEPARTMENTAL APPEALS BOARD (DAB)

DAB provides impartial review of disputed legal decisions involving HHS.

OFFICE OF THE GENERAL COUNSEL (OGC)

OGC provides quality representation and legal advice on a wide range of highly visible national issues.

OFFICE OF GLOBAL AFFAIRS (OGA)

OGA provides leadership and expertise in global health diplomacy and policy to protect the health and well-being of Americans.

OFFICE OF INSPECTOR GENERAL (OIG)

OIG protects the integrity of HHS programs as well as the health and welfare of the program participants.

OFFICE OF MEDICARE HEARINGS AND APPEALS (OMHA)

OMHA administers nationwide hearings for the Medicare program.

OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY (ONC)

ONC provides counsel for the development and implementation of a national health IT framework.

For more information regarding our organization, visit [our website](#).

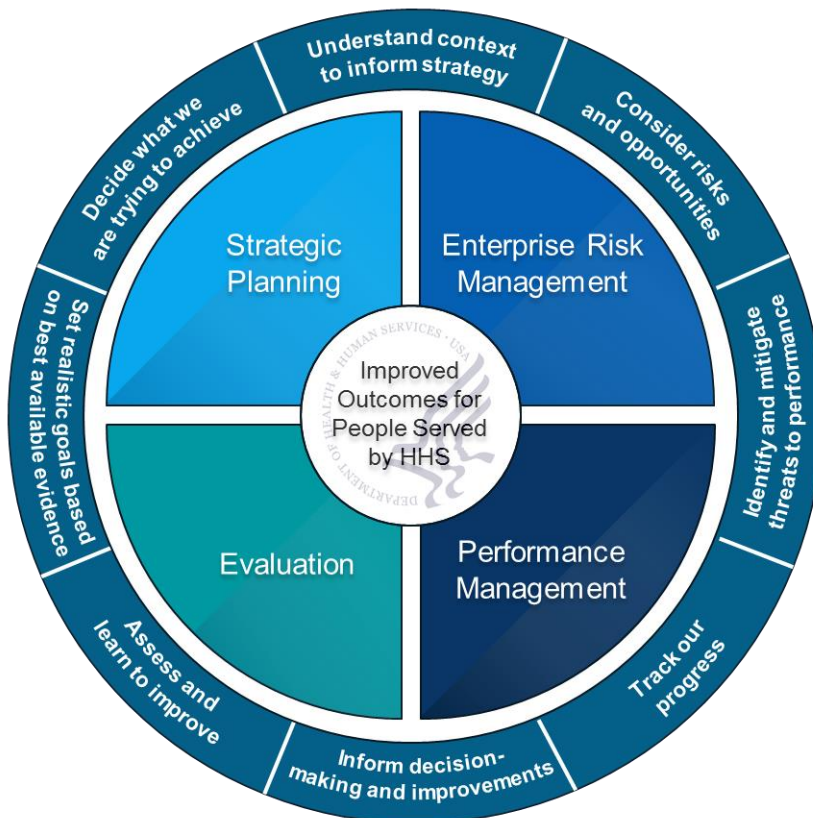
Performance Goals, Objectives, and Results

Overview of Strategic and Agency Priority Goals

The *Government Performance and Results Act Modernization Act of 2010* (GPRAMA) requires agencies to update their strategic plans every 4 years. The [HHS Fiscal Year \(FY\) 2018—2022 Strategic Plan](#) identifies the Department’s mission and its strategic goals and objectives. Each of the Department’s OpDivs and StaffDivs contributes to the development of the [Strategic Plan](#). HHS tracks progress on each strategic objective through performance goals, which HHS reports annually in the [HHS Annual Performance Plan and Report](#). In addition, HHS engages in a variety of efforts to support the Secretary’s Agency Priority Goals (APGs), the President’s Management Agenda (PMA), and the government-wide Cross-Agency Priority (CAP) Goals.

Within HHS, Strategic Planning, Enterprise Risk Management, Performance Management, and Evaluations work closely together to strategically manage their overlapping activities and deliverables. Figure 1 below illustrates HHS’s approach to strategic management, which works to integrate planning, performance, enterprise risk management, and evaluation processes to support HHS programs. The following pages provide more information about the HHS strategic goals and objectives for FY 2018—2022.

Figure 1: Strategic Management at HHS





Strategic Goals

The [HHS Strategic Plan FY 2018–2022](#) is comprised of five strategic goals, representing input from all HHS OpDivs and StaffDivs, as well as over 13,000 public comments. HHS aligns its focus, strategies, and activities to achieve these strategic goals and objectives. The Department’s five strategic goals are:

1. Reform, Strengthen, and Modernize the Nation’s Healthcare System
2. Protect the Health of Americans Where They Live, Learn, Work, and Play
3. Strengthen the Economic and Social Well-Being of Americans Across the Lifespan
4. Foster Sound, Sustained Advances in the Sciences
5. Promote Effective and Efficient Management and Stewardship

Strategic Goal 1: Reform, Strengthen, and Modernize the Nation’s Healthcare System

For a nation to thrive, the population must be physically and mentally healthy. To improve the nation’s health, the Department is working with its public and private partners to enhance the quality of health care, while making it more affordable and accessible. Improving access to health care goes beyond affordability. HHS is working to overcome access issues, which exacerbate health problems, increase costs, and prevent better health outcomes. The Department is also making investments to strengthen and expand the health care workforce. This Strategic Goal seeks to improve health care outcomes for all people across the lifespan, including the unborn, children, youth, adults, and older adults across diverse health care settings.

STRATEGIC GOAL 1
STRATEGIC OBJECTIVES

- 1.1: Promote affordable healthcare, while balancing spending on premiums, deductibles, and out-of-pocket costs
- 1.2: Expand safe, high-quality healthcare options, and encourage innovation and competition
- 1.3: Improve Americans’ access to healthcare and expand choices of care and service options
- 1.4: Strengthen and expand the healthcare workforce to meet America’s diverse needs

STRATEGIC GOAL 2
STRATEGIC OBJECTIVES

- 2.1: Empower people to make informed choices for healthier living
- 2.2: Prevent, treat, and control communicable diseases and chronic conditions
- 2.3: Reduce the impact of mental and substance use disorders through prevention, early intervention, treatment, and recovery support
- 2.4: Prepare for and respond to public health emergencies

Strategic Goal 2: Protect the Health of Americans Where They Live, Learn, Work, and Play

HHS aims to protect and improve the health of Americans by promoting health and wellness knowledge, preparing for fatal outbreaks or natural disasters, and improving accessibility to health care. HHS programs help Americans take control of their health. Healthy living involves more than avoiding risky behavior and disease; health and wellness improves with healthy eating, regular physical activity, preventive care, and positive relationships. Mental illness and substance abuse create health risks and place a heavy burden on affected individuals and their families. HHS invests in programs focused on prevention, screening, and early detection of these risks, including those related to opioid misuse. HHS also focuses on environmental health and reducing the burden caused by disease and other conditions.

Strategic Goal 3: Strengthen the Economic and Social Well-Being of Americans Across the Lifespan

A core component of the HHS mission commits to improving the well-being of Americans, which includes those individuals and populations who are at high risk of social and economic challenges. Overall wellness goes beyond physical health: it entails positive social and economic development. HHS focuses on fostering environments where individuals and families can be socially and economically independent. A strong family can lead to many positive outcomes for the health, social, and economic status of both adults and children. HHS focuses on fostering environments where individuals and families can be socially and economically independent.

STRATEGIC GOAL 3 STRATEGIC OBJECTIVES

- 3.1: Encourage self-sufficiency and personal responsibility, and eliminate barriers to economic opportunity
- 3.2: Safeguard the public against preventable injuries and violence or their results
- 3.3: Support strong families and healthy marriage, and prepare children and youth for healthy, productive lives
- 3.4: Maximize the independence, well-being, and health of older adults, people with disabilities, and their families and caregivers

STRATEGIC GOAL 4 STRATEGIC OBJECTIVES

- 4.1: Improve surveillance, epidemiology, and laboratory services
- 4.2: Expand the capacity of the scientific workforce and infrastructure to support innovative research
- 4.3: Advance basic science knowledge and conduct applied prevention and treatment research to improve health and development
- 4.4: Leverage translational research, dissemination and implementation science, and evaluation investments to support adoption of evidence-informed practices

Strategic Goal 4: Foster Sound, Sustained Advances in the Sciences

HHS's success is contingent on scientific advances and discovery. Scientific investments through foundations, charities, private industry, and government entities strive to unlock mysteries that improve health and well-being; reduce death, disease, and disability; and extend and improve quality of life. These types of decisions rely on data acquired through surveillance, epidemiology, and laboratory services. Achievements in science tie to the other strategic goals, such as protecting Americans from disease outbreaks or reaching advances in public health care. Success in this domain starts with a high caliber workforce devoted to achieving award-winning breakthroughs. HHS aims to expand the capacity of the research workforce, equipping them with the tools to make discoveries of the future. To be effective, HHS must share, adopt, and implement scientific discoveries with fidelity. The Department is working to promote evidence-informed practices that improve health and human service fields.





Strategic Goal 5: Promote Effective and Efficient Management and Stewardship

HHS promotes sound stewardship for the financial resources the American taxpayers and Congress entrust to the Department through cultivation of top talent, development of robust and responsive information management systems, and the creation of a safe and secure environment for human, digital, and physical assets. Efforts such as *ReImagine HHS* improve the efficiency and accountability of the Department. *ReImagine HHS* is the Department's robust reform and transformation effort with goals to streamline processes, reduce burden, and realize cost savings. As the nation's largest grant-awarding agency, HHS is responsible for more than a quarter of federal outlays and administers more grant dollars than all other federal agencies combined. HHS prioritizes the integrity of expenditures by maintaining effective risk and internal controls for payments, grants, contracts, and other financial transactions, and by developing a financial management workforce with the expertise to comply with legislative mandates and requirements.

STRATEGIC GOAL 5
STRATEGIC OBJECTIVES

- 5.1: Ensure responsible financial management
- 5.2: Manage human capital to achieve the HHS mission
- 5.3: Optimize information technology investments to improve process efficiency and enable innovation to advance program mission goals
- 5.4: Protect the safety and integrity of our human, physical, and digital assets

Agency Priority Goals

APGs are a set of ambitious but realistic performance objectives that the Department expects to achieve within a 24-month period. APG results rely on strong agency implementation and do not require new legislation or additional funding. General areas of focus for APGs include customer service, efficiencies, and advances in progress toward longer-term, outcome-focused strategic goals and objectives. The FY 2018 – 2019 APGs are:

- Increase capacity to prevent health threats originating abroad from impacting the United States;
- Reduce opioid-related morbidity and mortality;
- Increase combined data analysis of disparate datasets in order to achieve better insights; and
- Improve treatment for individuals with Serious Mental Illness.

For more information on HHS's APGs, visit [Performance.gov](https://www.performance.gov). HHS performance initiatives continue to influence plans and policies identified in the [Strategic Plan](#).

Cross-Agency Priority Goals

CAP Goals are government-wide goals defined by the PMA and identified in Figure 2. The PMA provides a long-term vision for modernizing the federal government in key areas that will improve the ability of agencies to deliver mission outcomes, provide excellent service, and effectively steward taxpayer dollars on behalf of the American people. CAP Goals drive the implementation of the PMA. These goals provide accountability for results and utilize concrete, measurable performance indicators to track progress.

HHS aligns its management and business process improvement efforts to support CAP Goals. Senior accountable officials within the Department facilitate oversight and ensure effective progress toward goal achievement. HHS shares a government-wide leadership role on several CAP Goals, including “Results-Oriented Accountability for Grants”, “Sharing Quality Services”, and “Getting Payments Right.” For more information on HHS performance and contributions to the PMA and CAP Goals, visit [Performance.gov](https://www.performance.gov).

Figure 2: PMA CAP Goals



* Source: President's Management Agenda on [Performance.gov](https://www.performance.gov)

Performance Management

Performance goals and measures are powerful tools to advance an effective, efficient, and productive government. HHS regularly collects and analyzes performance data to inform decisions, gauge meaningful progress toward objectives, and identify more cost-efficient ways to achieve results. Responding to opportunities afforded by GPRAMA, HHS continues to institute significant performance management improvements that include:

- Developing, analyzing, reporting, and managing APGs, and conducting quarterly performance reviews between HHS OpDiv/StaffDivs and HHS leadership to monitor progress toward achieving key performance objectives;
- Conducting the Strategic Reviews process to support decision-making and performance improvement across the Department;
- Overseeing and aligning Strategic Planning, Budgeting, Enterprise Risk Management, and Performance Management activities within the Department;
- Fostering a network of OpDiv/StaffDiv Performance Officers who support, coordinate, and implement performance management efforts across HHS; and
- Sharing best practices in performance management at HHS through webinars and other media.



Data Quality

HHS follows GPRAMA guidelines for reporting data quality. For all measures that appear in APG reporting or in the [HHS Strategic Plan](#), HHS publicly reports:

- Processes used to verify and validate measured values;
- Sources for the data;
- Confirmation that the data meets the level of accuracy required for its intended use;
- Any limitations to the data at the required level of accuracy; and
- How the agency will compensate for such limitations if needed to reach the required level of accuracy.

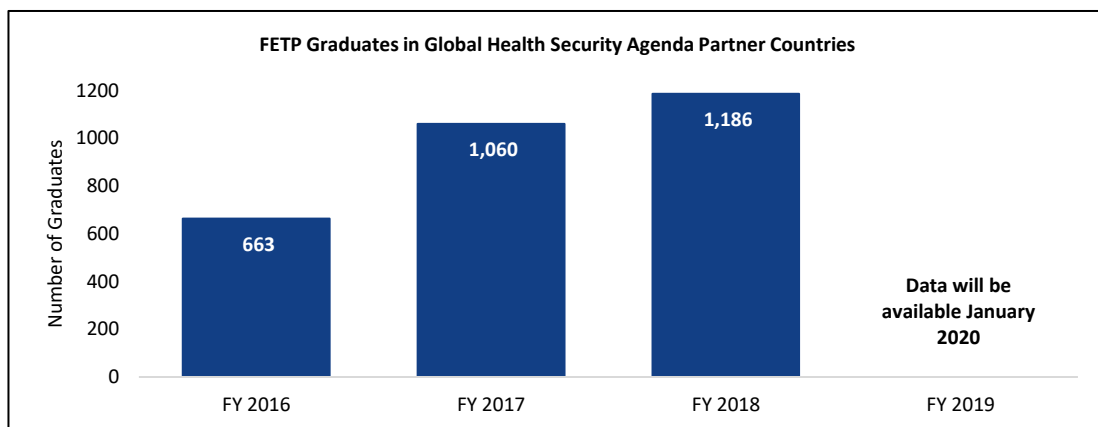
Each agency within HHS is responsible for certifying that these data undergo a thorough quality assurance process and provides to the Performance Improvement Officer a signed letter of attestation. Data quality information for the APG-related measures mentioned below can be found online at [Performance.gov](#). Data source and validation information on other data analyses, such as improper payment measures discussed in the “Other Information” section, can be found at [HHS Budget and Performance](#).

Performance Results

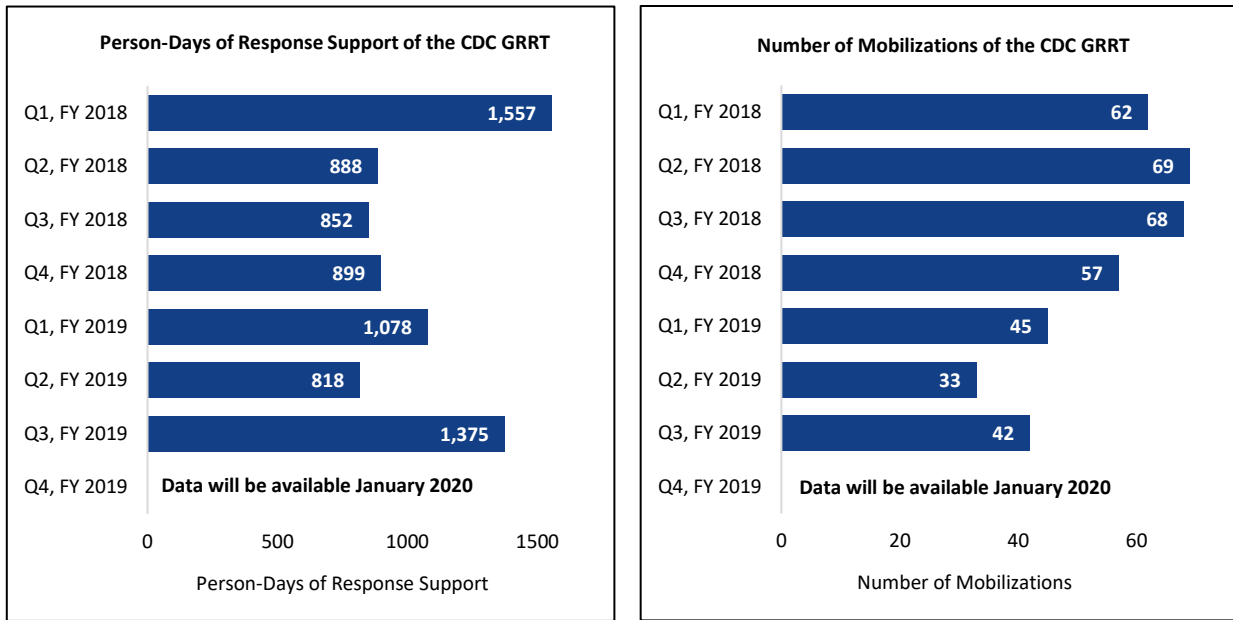
In FY 2019, HHS monitored over 900 performance measures to manage departmental programs and activities, and to improve the efficiency and effectiveness of these programs. For this report, HHS chose to highlight the achievements in three APGs: Health Security, Reducing Opioid Morbidity and Mortality, and Serious Mental Illness. For more detailed information on HHS’s APG accomplishments, refer to the HHS page on [Performance.gov](#).

Health Security. Infectious diseases originating abroad can quickly and unpredictably spread to the U.S. HHS works with partner countries to improve their capacities to prevent, detect, and respond to health threats at their points of origin. For this APG, HHS has focused on building capacity in 17 partner countries. HHS’s International Field Epidemiology Training Programs (FETP), are a key resource for strengthening countries’ capacities for surveillance, epidemiology, and outbreak response. HHS has implemented FETP in over 70 countries, which include the 17 partner countries identified for the Health Security APG.

FETP programs provide on-the-job training to build critical skills for effectively conducting infectious disease surveillance at the local level. Graduates are trained disease detectives with the skills to collect, analyze, and quickly interpret disease information to save lives. FETP graduates assist their countries in transitioning from U.S.-led global health investments to long-term host country ownership of the methods for detection and prevention.



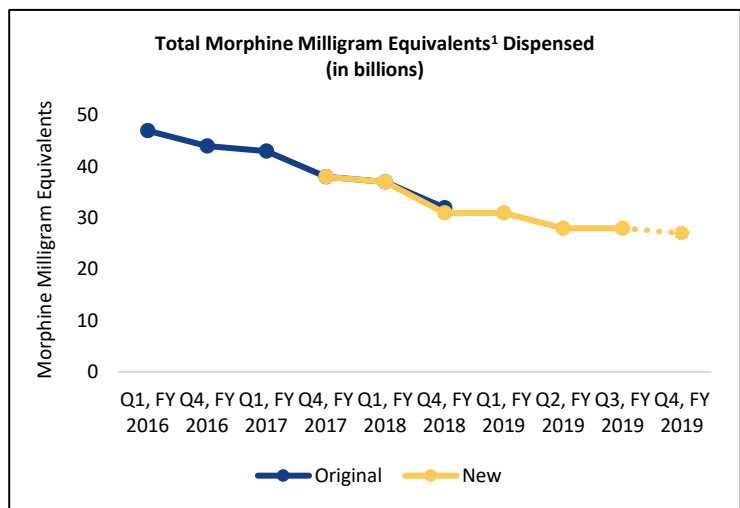
HHS maintains the capability to rapidly provide personnel and operational resources for health threats in its partner countries. For example, HHS's Global Rapid Response Team (GRRT) is a highly trained workforce ready to deploy on short notice anywhere in the world. GRRT provides emergency response staff, and employs and deploys field-based leaders, scientific experts, and support for response management and operations. The data presented capture the impact of U.S.-supported activities. HHS will report how much progress each partner country made from FY 2018—2019 on [Performance.gov](https://www.performance.gov).



Reducing Opioid Morbidity and Mortality. Opioid misuse and overdose present a nationwide public health challenge. Death by drug overdose is the leading cause of injury death in the U.S. Overdose deaths involving heroin have increased significantly in recent years. There were 6.5 times more heroin overdose deaths in 2017 than in 2007. The surge of fentanyl use has been the main driver in increasing synthetic opioid deaths. In response to this public health emergency, HHS announced a [5-Point Strategy](#) for combatting opioid morbidity and mortality:

1. Improve access to prevention, treatment, and recovery support services;
2. Target the availability and distribution of overdose-reversing drugs;
3. Strengthen public health data and reporting;
4. Support cutting-edge research; and
5. Advance the practice of pain management.

HHS has continued to monitor progress on the implementation of this [5-Point Strategy](#) through a variety of reporting tools, which include the HHS Reducing Opioid Morbidity and Mortality APG. This APG reports multiple key indicators; HHS provides three in this report – decrease the Morphine Milligram Equivalents dispensed,

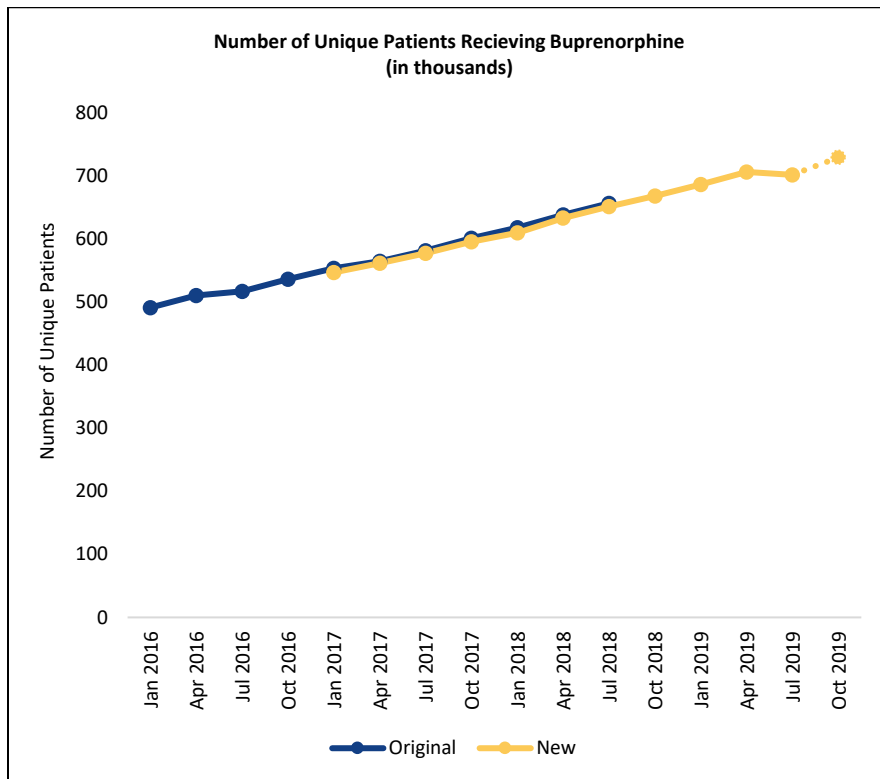
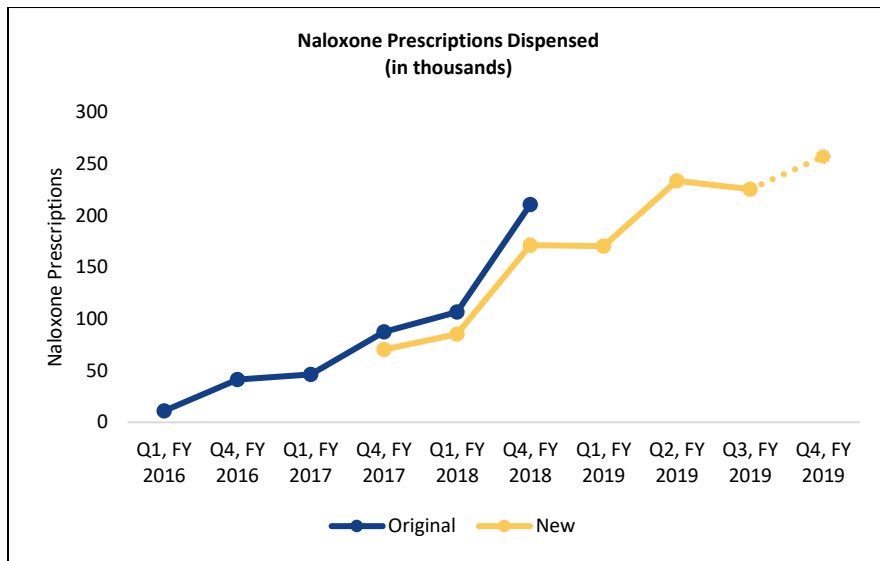


¹ Morphine Milligram Equivalents is a standardized unit of the amount of opioid prescribed that allows HHS to combine opioids of varying potencies and dosages into one composite measure.

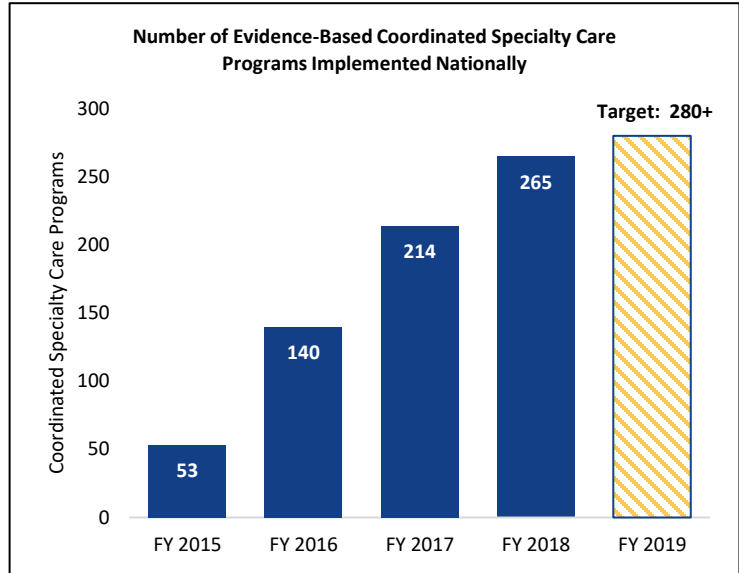


increase naloxone access, and increase the number of unique patients receiving buprenorphine prescriptions. Please refer to Performance.gov for information on the remaining key indicators and other report updates.

In FY 2019, HHS began reporting data that exclude voided or reversed prescriptions. This change caused a break in the trend lines between FY 2018 and FY 2019. HHS revised the targets for these measures to reflect the baseline of the new dataset. HHS increased the target for Naloxone Prescriptions Dispensed based on linear projections for FY 2017—2018 data. The new target is a 150 percent increase in prescriptions in FY 2019. A dotted line in the charts indicates targets for FY 2019. FY 2019 end-of-year results will be available by December 2019.



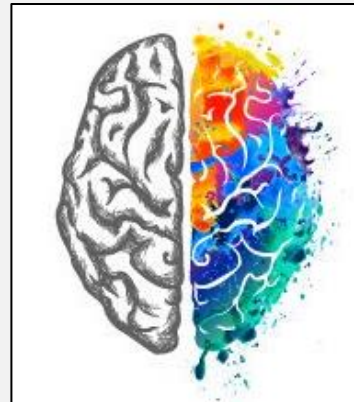
Serious Mental Illness. Approximately 114,000 youth and young adults experience a first episode of psychosis (FEP) every year, with life-altering disruptions in school, work, and social adjustment. Typically, treatment for FEP is delayed 1 to 3 years after symptoms appear, and treatment is often fragmented and ineffective. Without timely and effective care, symptoms and functional impairments typically worsen, and individuals are at high risk for suicide, substance misuse, school dropout/unemployment, criminal justice involvement, and involuntary hospitalization. Most communities lack the infrastructure and programming to address this critical period. Coordinated Specialty Care is an evidence-



based practice that uses an interdisciplinary team approach to provide personalized care to individuals with FEP. A required 10 percent early intervention set-aside within the SAMHSA Mental Health Block Grant (MHBG) provides a platform for states to build Coordinated Specialty Care programs.¹ FY 2019 data for this measure will be available in March 2020.

Did you know?

One in five people in the U.S. have a mental health condition. Mental health challenges are not always obvious. To learn more about signs and symptoms of mental health conditions, visit the [National Institute of Mental Health website](#). For general information on mental health and to locate local treatment services, visit the [Substance Abuse and Mental Health Services Administration website](#).



¹ Each state that receives a SAMHSA MHBG must use 10 percent of that grant to support evidence-based programs that provide treatment for those with FEP.



Looking Ahead to 2020

HHS is the U.S. Government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. While HHS is a domestic agency, the interconnectedness of our world requires HHS to engage globally to fulfill its mission. Our 11 OpDivs, including 8 agencies in the U.S. Public Health Service and 3 human services agencies, administer HHS's programs. In addition, StaffDivs provide leadership, direction, and policy guidance to achieve the Department's strategic goals and objectives.

Through the guidance of the [HHS Strategic Plan](#), in 2020 HHS will address important health care, public health, and human services issues that impact all Americans.

HHS Strategic Goal 1: Reform, Strengthen, and Modernize the Nation's Healthcare System

Drug Pricing: HHS will continue its efforts to lower the list prices of prescription drugs through competition, negotiation, and pricing incentives to ensure that Americans have access to affordable prescription drugs. We will continue reforms to increase competition in areas such as approval of generic drugs and biosimilars, as well as pursue payment policies to help patients take advantage of this competition.

Insurance Reform: HHS will focus on the cost and availability of health insurance to ensure Americans have access to affordable insurance that meets their needs. In addition, we will continue our efforts to restore balance and enhance sustainability in the Medicaid program and eliminate barriers for people looking to move from dependence on Medicaid to independence.

Price and Quality Transparency: HHS will focus on improving and developing price and quality transparency initiatives to ensure that healthcare patients can make well-informed decisions about their care.

The Healthcare Workforce and Infrastructure: HHS will identify and address gaps in the health care workforce to enhance and improve the capacity of the existing workforce, and identify opportunities to maximize health care productivity.

Value Based Care: HHS is putting patients at the center of the health care system, making sure they have the information they need to determine value and make choices. We will address the value of health care services by moving from a system where payments are made based on the volume of services provided to a system where payments are based on outcomes and value.

HHS Strategic Goal 2: Protect the Health of Americans Where They Live, Learn, Work, and Play

Kidney Health: HHS aims to reduce morbidity and mortality associated with end-stage renal disease and to increase patient choice by reducing the risk of kidney failure through detection, prevention, and treatment of risk factors; improving access to home-based dialysis; encouraging the development of new renal replacement therapies such as an artificial kidney; and increasing access to kidney transplants.

Maternal Health: To improve maternal health outcomes, HHS is developing strategies for women to attain and maintain healthy outcomes throughout the life course, an approach to conceptualizing health care needs and services; clinicians to screen and treat risk factors; and health systems to address maternal safety, health disparities, and social determinants of health. In support of these efforts, HHS aims to improve the quality of maternal health

data and bolster research efforts to better understand risk factors while continuing to identify effective, evidence-based, best practices in maternal health.

The Opioid Crisis: HHS will continue to empower states and local communities on the frontlines of the opioid crisis by implementing its [5-Point Strategy](#). We will advance efforts to increase access to treatment by (1) addressing workforce shortages and treatment coverage, including medication-assisted treatment; (2) increase the timeliness and accuracy of data to monitor opioid use, misuse, and overdose; (3) improve pain management with a focus on increasing the availability of effective non-opioid alternatives; (4) better target the availability of overdose-reversing drugs; and (5) support cutting edge research on pain and addiction. HHS will add to this focus efforts to address the increasing number psychostimulant-involved overdose deaths—sometimes referred to as the “fourth wave” of the opioid crisis.

Rural Health: HHS will continue to improve access to, and the quality of, care in rural and underserved areas by identifying policies that deliver the right care, at the right place, at the right time in rural America.

Suicide Prevention: HHS will increase its emphasis on and direct greater resources toward suicide prevention. Suicides rose nearly 30 percent between 1999-2016 and have increased in 49 of the 50 states with 25 states experiencing increases over 30 percent. With the rising number of suicides among adults, particularly middle-aged and older adults, focusing on preventing suicide among adults is urgently required to reduce suicide nationally.

HHS Strategic Goal 3: Strengthen the Economic and Social Well-Being of Americans Across the Lifespan

Dependence to Independence: To build self-sufficiency and move families from dependence to independence, HHS will strive to fully engage all Americans and move them from the economic sidelines into the workforce. We will launch the U.S. Interagency Council on Economic Mobility to streamline and coordinate federal programs and policy designed to promote work and economic mobility across the lifespan.

Child Welfare and Adoption: HHS will work to increase child and family well-being by putting greater emphasis on preventing child maltreatment. We will continue to look at increasing adoptions, an underutilized option in the U.S., for teens and women facing a crisis pregnancy, and to achieve permanency for children in the child welfare system, especially older children.

Did you know?

There are more than 100,000 children and teens in foster care awaiting the love and security of a permanent home. Adoption from foster care is a great way to help a child while growing your family. To learn more about foster care, visit the [Administration for Children and Families website](#).



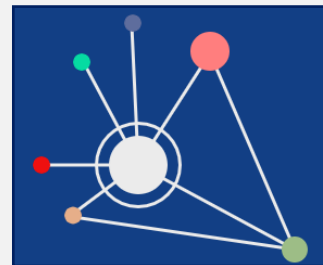


HHS Strategic Goal 4: Foster Sound, Sustained Advances in the Sciences

Data and Evidence: HHS develops, uses, and analyzes data to support the best science and generate new evidence. We are beginning to implement the *Foundations for Evidence-Based Policymaking Act of 2018* which will create a new paradigm for developing and using evidence for decision-making. Efforts across HHS continue to ensure better access to HHS data for lower-cost analysis; support patient-centered outcomes research; improve how we use evaluation and performance management data to drive learning, improvement, and analysis for better decision-making; and translate science into practice to ensure the best outcomes possible for the people served by HHS programs and policies.

Did you know?

The HHS Office of the Chief Technology Officer and the Chief Data Officer have been co-hosting a series of Roundtables to identify ways to improve the use and sharing of health data to achieve the HHS mission. These Roundtables discuss opportunities and strategies for sharing and utilizing health data for artificial intelligence to improve health care. To learn more about the HHS data initiative, visit the [HHS website](#).



HHS Strategic Goal 5: Promote Effective and Efficient Management and Stewardship

Enterprise Risk Management: Federal agencies are charged with implementing an enterprise risk management approach to address significant risks, improve mission delivery, and prioritize corrective actions. Enterprise risk management is a strategic discipline that seeks to proactively and deliberately address the full spectrum of an organization's risks. HHS uses a framework that outlines building blocks being used to develop and implement a successful enterprise risk management discipline within the Department. Making enterprise risk management part of how the Department functions improves HHS's ability to deliver on our mission of enhancing and protecting the health and well-being of all Americans.

HHS ACCELERATE: Initially part of *ReImagine HHS*, the HHS ACCELERATE program was developed to help address acquisition challenges across the Department, and enable HHS to effectively extract value from its \$24 billion spend and vast amount of behavioral and transactional data related to acquisition.

ACCELERATE is a transformative program that revamps the ways HHS acquires goods and services, conducts its acquisition operations and invests in acquisition support technology. It uses a combination of emerging technologies, including blockchain, artificial intelligence, and robotic process automation, to create and extract value from a standardized acquisition data layer. This is a first of a kind solution in government and enables acquisition savings, workforce savings through measurable process improvement such as reduced time to award, and IT investment savings. This system will revolutionize the acquisition lifecycle for all stakeholders.

Systems, Legal Compliance, and Internal Control

Systems

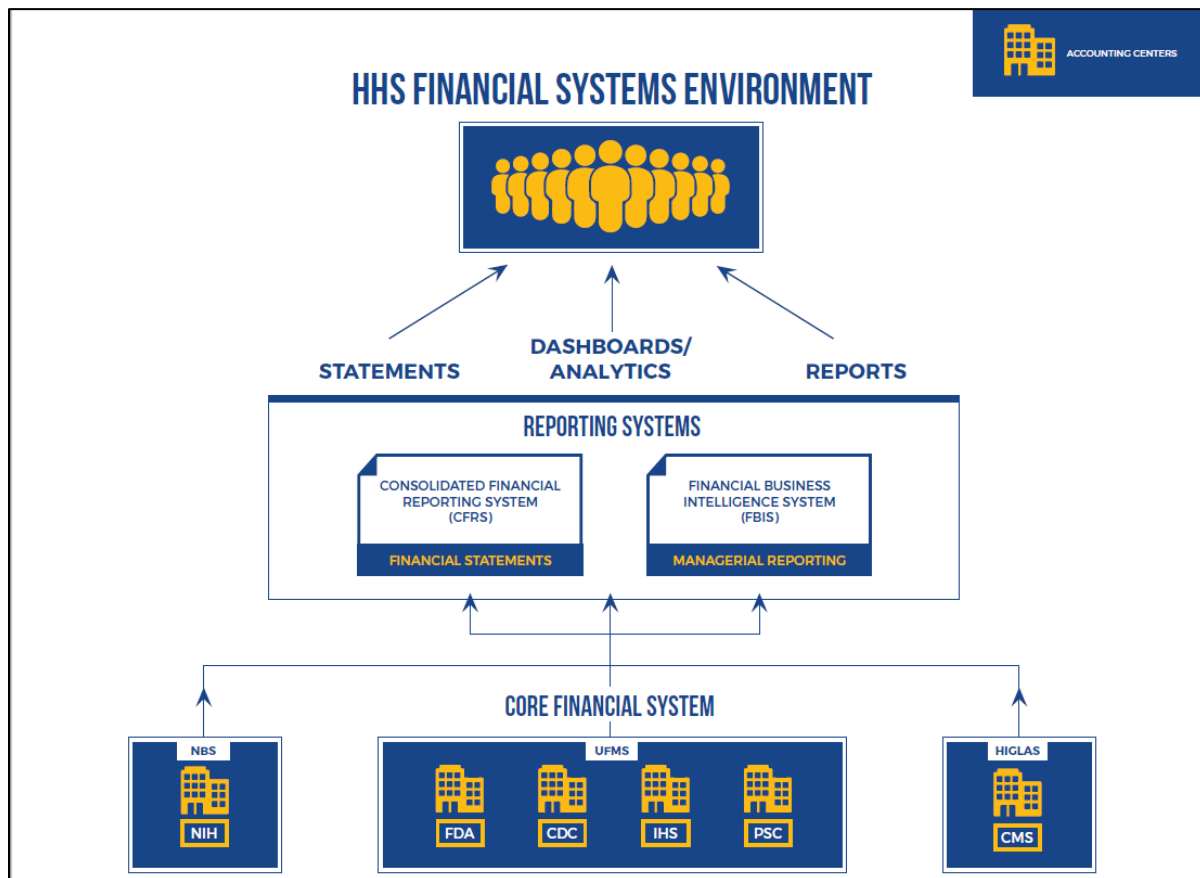
HHS's Chief Financial Officer (CFO) community continuously strives to enhance the financial management systems environment to sustain HHS's diverse portfolio of mission-oriented programs and business operations. The purpose of the financial management systems environment is to: (1) efficiently process financial transactions in support of program activities and HHS's mission; (2) provide complete and accurate financial information for decision-making; (3) improve data integrity; (4) strengthen internal control; and (5) mitigate risk.

The robust financial systems framework at HHS forms the financial and accounting foundation for managing the approximately \$1.9 trillion in budgetary resources entrusted to the Department in FY 2019.

Outlined in detail in the figure and tables that follow, the HHS financial management systems environment consists of a core financial system (with three instances, or components) and two Department-wide reporting systems used for financial and managerial reporting. Together, these systems support the Department's financial accounting and reporting needs.

Figure 3 graphically depicts the current financial management systems environment.

Figure 3: HHS Financial Management Systems Environment





Core Financial System

The core financial system’s three instances all operate on the same commercial off-the-shelf platform to support data standardization and facilitate Department-wide reporting.

Three Instances of the Core Financial System

Instance	Description
Healthcare Integrated General Ledger Accounting System (HIGLAS)	HIGLAS supports four lines of CMS business, which include the Medicare FFS, Medicare Secondary Payer, Federal Facilitated Marketplace, and the Administrative Program Accounting activities. It processes an average of five million transactions daily.
NIH Business System (NBS)	NBS combines NIH administrative processes and financial information under one centralized component, supporting NIH’s diverse biomedical research program; and business, financial, acquisition and logistics requirements for 27 NIH Institutes and Centers. NBS supports grant funding to more than 300,000 researchers at over 2,500 universities, medical schools, and other research institutions in every state and around the world.
Unified Financial Management System (UFMS)	UFMS integrates with over 50 program, business, and administrative systems (i.e., mixed business systems) to create a secure, reliable, and highly available financial management environment supporting the following Accounting Centers: CDC, FDA, IHS, and PSC. PSC provides shared service accounting support for all other OpDivs (except CMS, NIH, and the other three UFMS Accounting Centers) and all StaffDivs.

Reporting Systems

Reporting systems within the HHS financial management systems environment consist of two Department-wide applications that facilitate financial statement compilation, financial and managerial reporting, and data analysis.

HHS Reporting Systems

System	Description
Consolidated Financial Reporting System (CFRS)	CFRS systematically consolidates information from all three instances of the core financial system. It generates Departmental quarterly and year-end consolidated financial statements on a consistent and timely basis while supporting HHS in meeting regulatory reporting requirements.
Financial Business Intelligence System (FBIS)	FBIS is the financial enterprise business intelligence application that supports the information needs of HHS stakeholders at all levels by retrieving, combining, and consolidating data from the core financial system. It provides tools for analyzing data and presenting actionable information, including metrics and key performance indicators, dashboards with graphical displays, interactive reports, and ad-hoc reporting. FBIS enables executives, managers, and operational end users to make informed business decisions to support their organization’s mission.

Relevant Legislation and Guidance

The HHS financial management systems environment must comply with all relevant federal laws, regulations, and authoritative guidance. In addition, HHS must conform to federal financial management and systems requirements including:

**Financial Systems Environment Improvement Strategy**

HHS continues to implement a Department-wide strategy to advance its financial systems environment through the Financial Systems Improvement Program (FSIP) and Financial Business Intelligence Program (FBIP). The portfolio of projects within these programs addresses immediate business needs and positions the Department to take advantage of state-of-the-art tools and technology. The goals of the strategy are to improve the effectiveness and efficiency of the Department's financial management capabilities, mature the overall financial systems environment, and strengthen accountability and financial stewardship. This is a multi-year initiative, and the Department continues to make significant progress in each of the following six key strategic areas.

1. Financial Systems Modernization

- **Strategy:** HHS initiated FSIP with foundational projects that included a major core financial system upgrade and transition of key financial systems to a cloud service provider for hosting and application management. With those major initiatives successfully completed, HHS is now directing resources toward incrementally improving the efficiency and effectiveness of the modern financial systems environment. Taken together, the design of these projects will significantly mature the HHS financial systems environment, offering benefits that include: safeguarding system security and privacy; enhancing information access; complying with and implementing evolving federal requirements; achieving efficiencies and promoting standardization; eliminating security and control vulnerabilities; and maximizing the return on existing system investments.
- **Progress:** In FY 2019, the Department transitioned from the partially manual *Digital Accountability and Transparency Act of 2014* (DATA Act) solution, to a system-based reporting process. This significantly reduced the stakeholder data calls and manual crosswalks needed to produce DATA Act-compliant outputs, leveraging reports now available directly from the financial system. The solution links data across multiple enterprise-wide systems – improving enterprise-wide data quality and integration –





and enables HHS to continue to accurately report approximately \$330 billion in quarterly obligation award activity. Further, the HHS solution enables microservice-based automated integration with the Department of Treasury (Treasury) Broker – the first Broker integration of its kind in the federal government, which significantly improves the efficiency of reporting enterprise-wide data.

Additionally, HHS modernized key financial system infrastructure, generating a cost avoidance of over \$9.17 million, while enabling improved customer experience through enhanced system performance of up to 45-60 percent across key programs, minimized maintenance downtimes (increased system availability), and increased network bandwidth. Looking forward, the Department developed a comprehensive implementation strategy for a Department-wide electronic invoicing solution to drive efficiency through automation and standardization of current manual invoice processing. HHS developed a working group of over 170 members, spanning 6 accounting centers, 3 financial system owners, 11 acquisition offices, and the Treasury Invoice Processing Platform implementation team, to ensure the enterprise-wide solution adheres to the diverse HHS business needs.

2. Business Intelligence and Analytics

- **Strategy:** Leveraging the FBIS platform, HHS is expanding the use of business intelligence and analytics across the Department to establish an information-driven financial management environment in which stakeholders at all levels have access to timely and accurate information required for measuring performance, increasing transparency, and enhancing decision-making. This will allow the Department to more effectively meet evolving information demands for fiscal accountability, performance improvement, and external compliance requirements.
- **Progress:** Since first deployed in FY 2012, FBIS has provided operational and business intelligence to users across the HHS financial management community. FBIS offers accurate, consistent, near real-time data from UFMS and NBS (together serving 5 of 6 HHS Accounting Centers) and summary data from HIGLAS, supporting over 1,500 users across the Department. In FY 2019, HHS continued extending the FBIS solution, enhancing the Department's managerial reporting capabilities and facilitating improved stewardship and decision making. This included developing new, insight-driven FBIS reports and dashboards: (1) the Control Monitoring Dashboard was matured further to extend the FY 2017 UFMS security redesign and strengthen segregation of duties controls; and (2) Project Analytics dashboards and reports, including a Project Executive dashboard that offers a comprehensive organizational view, empowering executives by providing the visibility and control they need to monitor performance and project health. To better serve current users and promote the growth of FBIS, HHS spent significant effort in FY 2019 focusing on the FBIS customer experience. This included tailored training and workshops, as well as developing a Customer Strategy to better understand user behavior, business needs, and engagement opportunities. Based on user feedback, the initiation of a targeted performance improvement effort resulted in 50-90 percent performance improvement in report run times and a significant increase in FBIS user satisfaction.

3. Systems Policy, Security, and Controls

- **Strategy:** The reliability, availability, and security of HHS's financial systems are of paramount importance. HHS places a high priority on enhancing its financial systems security and controls environment, strengthening policy, proactively monitoring emerging issues, and ensuring progress toward remediating identified weaknesses. HHS continues to implement a comprehensive enterprise-wide financial systems policy, security, and controls program to mature the environment and to decrease risk.

- **Progress:** For the first time in 23 years of *Chief Financial Officers Act of 1990* (CFO Act) audits, in FY 2018 HHS no longer had a material weakness in its financial management systems, as a result of the Department's integrated strategy to mature its financial systems security and controls environment and remediate vulnerabilities. In downgrading the material weakness to a significant deficiency, the independent auditors specifically noted the "differential investments in key financial systems" provided a more mature controls baseline. Building on this significant progress, HHS continues to execute on its strategy to strengthen oversight, improve risk management, and enhance information and communication. Persistent weaknesses are being addressed, and targeted efforts are further reducing risk across the financial management systems portfolio as the annual closure rate of findings in high-risk control areas (access controls, configuration management, and segregation of duties) continues to increase year-over-year. Beyond simply tracking closure of individual weaknesses to assess progress, HHS also developed and has continued to refine a comprehensive management framework, including evaluation criteria and target measurements, to better inform HHS leadership and other stakeholders of overall progress made, the current maturity level of the security and control environment, and the associated level of risk. This framework provided HHS management with the evidence-based, objective data required to assert that the Department did not have a material weakness.

Encouraging collaboration and communication across the Department, the Financial Management Governance Board (FGB) chartered a cross-functional working group with representation from OpDiv CFO, Chief Information Officer (CIO), and Chief Information Security Officer Communities, that continues to meet monthly to address pervasive issues, recommend comprehensive remediation approaches, and monitor implementation progress. Additionally, in FY 2019 the Department hosted its second annual HHS IT Audit, Internal Control, and Risk Management workshop, which earned recognition from Department CIO and CFO leadership as a key forum for driving improved IT security and control maturity across the Department.

4. Governance

- **Strategy:** The Department established the FGB as an executive-level forum to address enterprise-wide issues impacting HHS and its OpDivs, including those related to financial management policies and procedures, financial data, financial systems, and technology. The FGB's goals include, providing HHS financial management governance through formal structures, policies, and accountability; providing people, processes, and technology to support governance; and engaging stakeholders through effective communication and management strategies.
- **Progress:** The FGB convenes monthly to facilitate executive-level oversight of financial management-related areas by engaging senior leadership from the OpDivs and StaffDivs; as well as across functions such as finance, budget, acquisitions, grants, human resources, and IT. The FGB effectively transformed the way in which financial management initiatives and activities are accomplished in HHS, moving from a Division-specific, vertical focus to a more enterprise-wide approach, solving problems and implementing standards for financial management excellence.

Beyond improving collaboration and strengthening oversight across HHS's financial management and systems environment, the FGB serves as an advisory body, providing actionable recommendations to support project teams and guide future initiatives. Recent areas of focus have included key initiatives and federal mandates, such as the continued modernization of the Department's financial accounting systems, the implementation of the DATA Act long-term solution, and the HHS Consolidated





Acquisition Solution PRISM upgrade. The FGB anticipates focusing on key topics that will enable the HHS financial management community to effectively address evolving opportunities and challenges.

5. Program Management

- **Strategy:** HHS established Department-wide financial systems program management to support FSIP, FBIP, and enhance collaboration across project teams. Enterprise program management provides a sustaining framework that OpDivs, StaffDivs, and CFO community stakeholders across HHS can collaborate on programs and projects to realize strategic goals and outcomes. Enterprise program management provides leadership support by developing and maintaining processes, standards, tools, and best practices for program and project management. This includes the Financial Systems Consortium, a body of federal project managers and contractors representing the three core financial systems: UFMS, HIGLAS, and NBS. The Consortium is designed to leverage and share work products to lower costs, reduce development timelines, and minimize purchasing similar work for related programs and projects. The forum also provides an opportunity to introduce new tools, technologies, and industry best practices that may benefit HHS's financial management systems environment.
- **Progress:** Department-wide program management and the Financial Systems Consortium continues to play a critical role in support of major system enhancements. In FY 2019, enhancements included developing a framework (Strategic Template and Resources Tools) for enterprise-wide projects that aligns with HHS's Enterprise Performance Life Cycle process and assists project managers in identifying necessary deliverables for successful implementation. As the Department's business needs evolve, the Enterprise Program Management Office continues to mature and support ongoing collaboration and coordination across the financial systems environment and modernization initiatives.

6. Sharing Opportunities

- **Strategy:** As a key FSIP component, HHS is actively pursuing multiple initiatives to generate efficiencies and improve effectiveness by implementing shared solutions. The Department has an established framework to continuously identify sharing opportunities in its financial systems environment.
- **Progress:** Examples of sharing opportunities pursued to-date include, transitioning key financial systems to a cloud service provider, the use of shared acquisition contracts and streamlining of system operations and maintenance contracts, the implementation of a Department-wide Accounting Treatment Manual, consolidation of three legacy managerial reporting systems into FBIS, and sharing solutions across the HHS financial community. Currently, the HHS finance, acquisition, and IT communities are collaboratively implementing the Department-wide solution for electronic invoicing, as well as developing and refining an implementation plan for the U.S. Department of the Treasury's Government Invoicing solution. Implementation of these solutions will support specific business needs identified across HHS while maintaining compliance with the Office of Management and Budget (OMB) direction and Treasury requirements. The FGB continues to assess future sharing opportunities across the enterprise to further align with financial management and system policies, business processes and operations, and the overall financial system vision and architecture.



Legal Compliance

Antideficiency Act

The *Antideficiency Act* (ADA) prohibits federal employees from obligating in excess of an appropriation, or before funds are available, or from accepting voluntary services. As required by the ADA, HHS notifies all appropriate authorities of any ADA violations. ADA reports can be found on [U.S. Government Accountability Office \(GAO\) - ADA](#).

HHS management is taking necessary steps to prevent violations. On August 1, 2016, the Director of OMB approved HHS's updated Administrative Control of Funds policy, as required by United States Code, Title 31, *Money and Finance*, Section 1514, "Administrative Division of Apportionments." This policy provides HHS's guidelines for budget execution that specifies basic fund control principles and concepts, including the administrative control of all funds for HHS and its OpDivs, StaffDivs, and Accounting Centers. With respect to three potential issues, HHS is working through investigations and further assessment where necessary. HHS remains fully committed to resolving these matters appropriately and complying with all aspects of the law.

Improper Payments Information Act of 2002, Improper Payments Elimination and Recovery Act of 2010, and Improper Payments Elimination and Recovery Improvement Act of 2012

An improper payment occurs when a payment should not have been made, 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. In addition, improper payments cited do not necessarily represent expenses that should not have occurred. Instances where there is no or insufficient documentation to support the payment as proper or improper are cited as improper payments. 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), requires federal agencies to review their programs and activities to identify programs that may be susceptible to significant improper payments, and for high risk programs, to estimate the amount of improper payments and develop and implement corrective actions. HHS works to better prevent, detect, and reduce improper payments through close review of our programs and activities using sound risk models, statistical estimates, and internal controls.

HHS has shown tremendous leadership in the improper payments arena. HHS has a robust improper payments estimation and reporting process that has been in place for many years and has taken many corrective actions to prevent, detect, and reduce improper payments in our programs. In compliance with the IPIA, as amended, HHS completed 31 improper payment risk assessments in FY 2019 (representing risk assessments of programs and charge cards) and determined that these programs were not susceptible to significant improper payments. In addition, HHS is publishing improper payment estimates and associated information for seven high risk programs in this year's AFR, of which four programs reported lower improper payment rates in FY 2019 compared to FY 2018. Lastly, HHS also utilizes the Do Not Pay portal to check payments and awardees to identify potential improper payments or ineligible recipients. In FY 2019, HHS screened more than \$493.4 billion in Treasury-disbursed payments through the Do Not Pay portal. A detailed report of HHS's improper payment activities and performance is presented in the "Other Information" section of this AFR, under "Payment Integrity Report."





Patient Protection and Affordable Care Act

The *Patient Protection and Affordable Care Act* (PPACA) established Health Insurance Exchanges through which qualified individuals and qualified employers can purchase health insurance coverage. Many individuals who enroll in Qualified Health Plans through individual market Health Insurance Exchanges are eligible to receive a premium tax credit to reduce their costs for health insurance premiums. Premium tax credits can be paid in advance directly to the consumer's Qualified Health Plan 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 on this process.

PPACA also included provisions that address fraud and abuse in health care by toughening the sentences for perpetrators of fraud, employing enhanced screening procedures, and enhancing the monitoring of providers. These authorities have facilitated the government's efforts to reduce improper payments. For detailed information on improper payment efforts, see the "Other Information" section of this AFR, under "Payment Integrity Report."

Digital Accountability and Transparency Act of 2014

The *Digital Accountability and Transparency Act of 2014* (DATA Act) expanded the *Federal Funding Accountability and Transparency Act of 2006* (FFATA) to increase accountability and transparency in federal spending, making federal expenditure information more accessible to the public. It directed 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 [USAspending.gov](https://www.usaspending.gov). Among other goals, the DATA Act aimed to improve the quality of the information on [USAspending.gov](https://www.usaspending.gov), as verified through regular reviews of posted data, and to streamline and simplify reporting requirements through clear data standards.

The DATA Act requires agencies to generate data from their financial accounting systems using common field, format, and definitions for financial and award data in accordance with the DATA Act Information Model Schema. Treasury collects procurement, financial assistance, and recipient award data from government-wide databases reported under other FFATA requirements and merges it with the financial data produced from the HHS financial system. On a quarterly basis, agencies must certify the accuracy, completeness, and timeliness of the data considered reportable under these standards. HHS is responsible for ensuring the linkage between these sets of internally-maintained and externally-managed data is valid and reliable.

Since May 2017, HHS has successfully submitted financial and award-level data for quarterly certification to Treasury's DATA Act Broker. The processes in place at the Department have successfully ensured alignment between the internally maintained records and the external data in all submissions since the initial one. HHS submissions average over \$300 billion in award-level obligations per quarter. HHS completely reconciles to an average of 98 percent of award-level obligations. HHS has undergone both GAO and OIG audits of their DATA Act submission since the initial reporting window, yielding a zero percent error rate on sampled records through FY 2018.

In June of 2018, the revised Appendix A to OMB Circular A-123 contained a cover letter adding a requirement for agencies to develop and execute a Data Quality Plan. Consideration of this plan must be included in agencies' existing annual assurance statement for internal controls over reporting beginning in FY 2019 and continuing through the assurance statement covering FY 2021, at a minimum, or until agencies determine that they can provide reasonable assurance over the data quality controls that support achievement of the reporting objectives in accordance with the DATA Act. HHS's Data Quality Plan was finalized on October 1, 2018.



Federal Information Technology Acquisition Reform Act

The *Federal Information Technology Acquisition Reform Act* (FITARA), enacted on December 19, 2014, established an enterprise-wide approach to federal IT investments and provided the CIO of CFO Act agencies with greater authority over IT investments, including authoritative oversight of IT budgets, budget execution, and IT-related personnel practices and decisions. In FY 2019, HHS continued its “M3” improvement initiative to strengthen performance on the agency’s biannual Committee on Oversight and Government Reform scorecard. For example, HHS emphasized *Federal Information Security Management Act* and cybersecurity throughout FY 2019, understanding that these elements would impact agency scores on the revised Biannual Scorecard 8.0. To that end, the Office of the CIO focused on implementing modern tools and capabilities that enhance HHS’s cybersecurity posture while lowering risk exposure.

On June 26, 2019, the Committee on Oversight and Government Reform released its Biannual Scorecard 8.0. HHS’s overall grade on this new Scorecard decreased from the previous version, attributed mainly to the CIO’s reporting structure. We are working with our regulators to address this challenge and expect improvements on future Scorecards. It is notable that HHS maintained the four “A’s” previously received under FITARA 7.0, and under FITARA 8.0, HHS also identified additional IT portfolio cost savings and adopted an incremental delivery approach for 97 percent of its projects. HHS’s ability to adopt new processes that align with FITARA is a testament to how HHS has matured, monitored, and maintained through its “M3” initiative.

Grants Oversight and New Efficiency Act

The *Grants Oversight and New Efficiency Act* (GONE Act) was signed into law on January 28, 2016 with the goal to facilitate the closing of expired grants and cooperative agreements, and to improve government efficiency. The GONE Act requires federal agencies to submit to Congress a report for all grants and cooperative agreements expired for 2 or more years and their attributed dollar balances, which have not been closed out. Agencies were also required to explain, for the 30 oldest federal grant awards, why each grant had not been closed out.

In 2019, HHS submitted an updated report for all grants and cooperative agreements reported in the FY 2017 GONE Act submission identifying whether each remained open or had been closed. In addition, HHS also provided an update on the 30 oldest federal grants.

Although GONE Act reporting requirements are complete, HHS continues to prioritize long-standing management challenges specifically related to closeout. Under the direction of the Deputy Secretary, the Department established an Executive Steering Committee comprised of senior executives to provide guidance and approval to take one-time actions to reduce the backlog and conduct business process re-engineering.

In August 2018, the Department established the Grants Closeout Remediation Integrated Project Team (IPT) with the specific purpose of reducing the current backlog of open but expired documents. The IPT, comprised of subject-matter experts across the Department, defined and analyzed the population of open grants and associated closeout risks. As of September 30, 2019, the team successfully closed approximately 14,000 documents.

In March 2019, the Department established the Business Process Re-engineering IPT, comprised of grants policy and operations experts across the Department, to develop recommendations to improve business processes and prevent future backlogs.





Fraud Reduction and Data Analytics Act of 2015

The Department continues to engage in various fraud reduction efforts, including activities to meet the requirements under the *Fraud Reduction and Data Analytics Act of 2015* (FRDAA). Since FRDAA's enactment in 2016, HHS has participated in the required OMB-led interagency working group. As part of this working group, in FY 2019 HHS assisted in developing a fraud taxonomy that agencies can use to identify potential fraud vulnerabilities. Also in FY 2019, HHS attended the Improper Payment and Fraud Prevention International Forum with the United Kingdom and Canada and participated in other interagency discussions around fraud risk management. These meetings shared lessons learned and discussed future opportunities for sharing best practices, knowledge, and experience to assist agencies in identifying and preventing fraud. In addition, HHS collaborated with Treasury on the implementation of the Program Integrity Antifraud Playbook (Playbook), including attending interagency meetings and discussions, and providing Treasury with information on HHS's program integrity and analytic efforts. The Playbook, released in October 2018, includes many resources for agencies to consider in developing antifraud initiatives. HHS will continue working with OMB and other agencies to implement FRDAA and to further advance fraud risk management activities.

HHS continues to take steps, at both the Department and OpDiv/StaffDiv levels, to implement FRDAA, and to adopt leading practices in fraud risk management, as presented in GAO's *Fraud Risk Management Framework and Selected Leading Practices* published in July 2015. Select fraud risk management activities at the Department are below:

- HHS is drafting a Fraud Risk Management Implementation Plan that outlines actions taken or planned to enhance financial and administrative controls relating to fraud. HHS expects to complete this implementation plan in FY 2020;
- HHS is considering fraud and financial management risk as part of its internal control assessments and in accordance with the law and OMB Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*;
- HHS is considering fraud risk in individual programs or payment activities as part of its improper payment risk assessments, and HHS is analyzing the FY 2018 and FY 2019 data; and
- HHS continually reviews and updates its financial policies and provides relevant and timely training sessions. For example, in FY 2019, HHS held a grants training conference for OpDiv/StaffDiv representatives that included a joint HHS and OIG session on fraud-related observations, and fraud indicators that lead to a suspension and debarment.

HHS OpDivs and StaffDivs generally manage fraud risk within other scopes of responsibility (e.g., yearly internal control reviews and audits; reviews of allegations involving misuse of grant or contractor funds, conflicts of interest, or other misconduct or misuse cases; continuous monitoring of grant recipients [audit resolution, special conditions/drawdown restrictions, site visits, performance reports, etc.]; the use of [SAM.gov](https://www.sam.gov) [e.g., Suspension and Debarment]); and other activities. Some specific efforts at two Divisions are described below:

- NIH assessed the extramural grant program in FY 2019 following the GAO Fraud Risk Framework. The fraud risk assessment helped NIH identify vulnerabilities and develop mitigation strategies to proactively help reduce the risk of fraud in NIH extramural programs. In response to the fraud risk assessment, NIH launched an online Fraud Awareness Training course. This course is available to all NIH personnel via the HHS Learning Management System. This course provides NIH staff with a definition of fraud, circumstances that lead to fraud, common examples of fraud, and how to report suspected fraud. This training raises NIH's fraud awareness by familiarizing employees with the types of fraud that potentially impact NIH operations. The training contributes to NIH's organizational culture of accountability by ensuring alertness and stewardship practices for public funds by NIH personnel.



- CMS utilizes a centralized, vulnerability management process to identify, prioritize, track, and mitigate vulnerabilities that affect the integrity of federal health programs. The centralized component of this process, known as the Vulnerability Collaboration Council (VCC), is comprised of CMS leadership and subject matter experts that work collaboratively to identify vulnerabilities that lead to fraud, waste, and abuse, and develop comprehensive risk strategies to mitigate these vulnerabilities. HHS aligned the VCC's risk-based approach with GAO's Fraud Risk Framework. By aligning with the GAO framework, CMS standardized the vulnerability management process by focusing on the identification and mitigation of key risk factors through the development of measurable, verifiable, and time-bound action plans.

Federal Managers' Financial Integrity Act of 1982 and Federal Financial Management Improvement Act of 1996

The *Federal Managers' Financial Integrity Act of 1982* (FMFIA) requires federal agencies to annually evaluate and assert the effectiveness and efficiency of their internal control and financial management systems. Agency heads must annually provide a statement of 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 any identified material weaknesses and provide a plan and schedule for correcting the weaknesses.

In September 2014, GAO released an updated edition of its *Standards for Internal Control in the Federal Government*, effective FY 2016. The document takes a principles-based approach to internal control, with a balanced focus over operations, reporting, and compliance. In July 2016, OMB released revised Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*. The revised Circular complements GAO's Standards, and it implements requirements of the FMFIA with the intent to improve accountability in federal programs and increase federal agencies' consideration of Enterprise Risk Management. The Department, with its OpDiv and StaffDiv stakeholders, are working together to implement these requirements.

The *Federal Financial Management Improvement Act of 1996* (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 a Department-wide approach to Enterprise Risk Management. Based on thorough ongoing internal assessments and FY 2019 audit findings, HHS provides reasonable assurance that controls are operating effectively. We are actively engaged with our OpDivs to correct their identified material weaknesses and noncompliances through a corrective action process focused on addressing the true root cause of deficiencies and supported by active management oversight. More information on the Department's internal control efforts and the HHS Statement of Assurance follows.





Internal Control

FMFIA requires agency heads to annually 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 reporting, and compliance with applicable laws and regulations. The safeguarding of assets is a subset of these objectives. HHS performs rigorous, risk-based evaluations of its internal controls in compliance with OMB Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*. HHS is also continuing to make progress toward adopting Enterprise Risk Management and integrating with Internal Control.

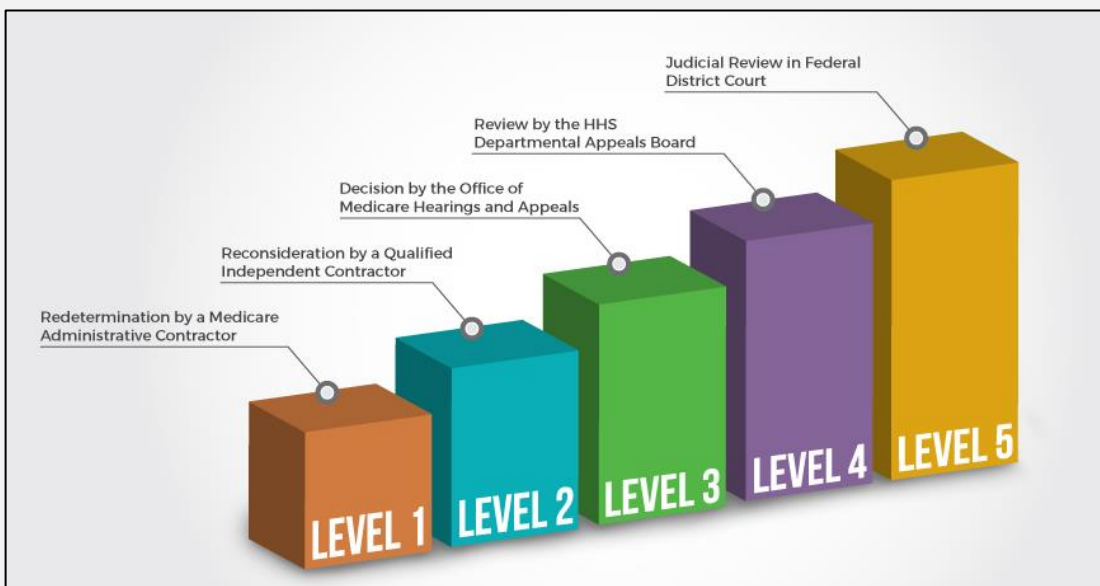
HHS management is directly responsible for establishing and maintaining effective internal controls in their respective areas of responsibility. As part of this responsibility, management regularly evaluates internal control and HHS executive leadership provides annual assurance statements reporting on the effectiveness of controls at meeting objectives. The HHS Risk Management and Financial Oversight Board evaluates OpDivs' management assurances and recommends a Department assurance for the Secretary's consideration and approval, resulting in the Secretary's annual Statement of Assurance.

HHS aims to strengthen its internal control assessment and reporting process to more effectively identify key risks, develop effective risk responses, and implement timely corrective actions. The HHS FY 2019 OMB Circular A-123 assessment recognizes material noncompliances with: the *Improper Payments Information Act* (IPIA), with two instances related to Error Rate Measurement; the *Social Security Act* related to the Medicare appeals process; and the Federal Acquisition Regulation related to contracting for services. Based on the results of this assessment, HHS provides reasonable assurance that its overall financial management systems substantially comply with the FFMA.

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.

Did you know?

There are five levels in the Medicare Part A and Part B appeals process. The levels are:



For more information on the Medicare Appeals process, refer to [CMS.gov](https://www.cms.gov).

Management Assurances

Statement of Assurance



THE SECRETARY OF HEALTH AND HUMAN SERVICES WASHINGTON, D.C. 20201

The Department of Health and Human Services' (HHS or the Department) management is responsible for managing risks and maintaining effective internal control to meet the objectives of Sections 2 and 4 of the *Federal Managers' Financial Integrity Act of 1982* (FMFIA). These objectives are to ensure (1) effective and efficient operations; (2) reliable reporting; and (3) compliance with applicable laws and regulations. The safeguarding of assets is a subset of these objectives.

HHS conducted its assessment of risk and internal control in accordance with OMB Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*. Based on the results of the assessment, the Department provides reasonable assurance that internal controls over operations, reporting, and compliance were operating effectively as of September 30, 2019, with the exception of material noncompliances with: the *Improper Payments Information Act* (IPIA), with two instances related to Error Rate Measurement; the *Social Security Act* related to the Medicare appeals process; and the *Federal Acquisition Regulation* related to contracting for services.

HHS is taking steps to address the material noncompliance related to the Medicare appeals process and Federal Acquisition Regulation, as described in the "Corrective Action Plans" section. Remediation for one instance of material noncompliance related to Error Rate Measurement relies on a modification to legislation requiring states to participate in an improper payment rate measurement. HHS is addressing the other instance of material noncompliance related to Error Rate Measurement, as described in the "Corrective Action Plans" section.

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 evaluation of financial management systems for compliance with FFMIA in accordance with OMB Circular A-123, Appendix D. Based on the results of this assessment, HHS provides reasonable assurance that its overall financial management systems substantially comply with the FFMIA and substantially conform to the objectives of FMFIA, Section 4.

HHS will continue to ensure accountability and transparency over the management of taxpayer dollars, and strive for the continuing progress and enhancement of its internal control and financial management programs.

/Alex M. Azar II/

Alex M. Azar II
Secretary
November 13, 2019



Summary

1. Error Rate Measurement

HHS identified two instances of material noncompliance with IPIA: (1) not reporting a Temporary Assistance for Needy Families (TANF) improper payment rate, and (2) reporting improper payment rates for Medicaid and Children's Health Insurance Program (CHIP) via the Payment Error Rate Measurement (PERM) program that are above the IPIA requirements.

HHS identified the TANF process limitation in a prior year and it continues to exist in FY 2019. The TANF program is unable to report an error rate for FY 2019 due to statutory limitations precluding HHS from requiring states to participate in a TANF improper payment measurement.

The improper payment rates for Medicaid and CHIP are based on reviews of the Fee-For-Service, managed care, and eligibility components. The PERM program uses a 17-state rotational approach to measure the 50 states and the District of Columbia over a 3-year period. As a result, HHS measures each state once every 3 years. National improper payment rates include findings from the most recent three cycle measurements. Each time a cycle of states is measured, HHS removes the previous findings for that cycle and includes the newest findings. Factors that led to noncompliance in FY 2019 include:

- The reintegration of the PERM eligibility component for the first cycle of 17 states;
- Improper payments due to insufficient documentation to verify eligibility, related primarily to income or resource verification for (1) situations where the required verification was not done, (2) where there is an indication the verification was initiated but there was no documentation to validate the verification process was completed, and (3) noncompliance with eligibility redetermination requirements;
- Noncompliance with requirements for provider revalidation of enrollment and rescreening;
- Noncompliance with provider enrollment, screening, and National Provider Identifier requirements; and
- The CHIP improper payment rate was also driven by claims where the beneficiary was incorrectly determined to be eligible for CHIP, but upon review was eligible for Medicaid.

2. Medicare Appeals Process

Several factors, including the growth in Medicare claims – partially driven by the aging population – and HHS's continued investment and focus on ensuring program integrity, have led to more appeals than Levels 3 and 4 of the Medicare appeals process can adjudicate within contemplated time frames.

From FY 2010 through FY 2019, the HHS Office of Medicare Hearings and Appeals (OMHA) and the HHS Departmental Appeals Board (DAB) experienced a large increase in the number of Medicare related appeals received. As a result, at the end of Quarter 3 of FY 2019, 318,254 appeals were waiting to be adjudicated by OMHA and 17,719 appeals were waiting to be reviewed at the DAB. This has led to the inability to meet statutory decisional timeframes of 90 days at Levels 3 and 4 of the Medicare appeals process.

Under current resources and continuing ongoing administrative actions (and without any additional appeals), it would take 2 years for OMHA and 8 years for the DAB to process their respective backlogs.

3. Contracting

HHS has identified (1) several known and potential violations of laws and regulations related to its acquisition processes at both the Department and Operating Division Levels, and (2) related internal control vulnerabilities. Management identified several noncompliance issues related to the Federal Acquisition Regulation (FAR) and began a broader review of acquisition compliance.



Corrective Action Plans

1. Error Rate Measurement

Since TANF is a state-administered program, corrective actions to reduce improper payments would be implemented at the state level. Since HHS cannot require states to participate in a TANF improper payment measurement, the Department is also unable to compel states to collect the required information to implement and report on corrective actions. Despite these limitations, HHS uses a multi-faceted approach to support states in improving TANF program integrity and preventing improper payments, including efforts such as: conducting and using results of a detailed risk assessment to mitigate payment risks at the federal level; promoting and supporting innovation using TANF data to better understand how states ensure program integrity; and monitoring compliance with the final regulations regarding “State Reporting on Policies and Practices to Prevent the Use of TANF Funds in Electronic Benefit Transfer Transactions in Specified Locations” (81 Federal Register 2092, January 15, 2016). In addition, the FY 2020 President’s Budget includes a legislative proposal that would give HHS the authority to collect quantitative and qualitative program integrity information from TANF programs, which will lay the groundwork for the data collection efforts needed to provide information on states’ improper payments.

To address Medicaid and CHIP PERM related errors, HHS is developing a notice of proposed rulemaking (NPRM) to introduce more stringent requirements designed to strengthen the integrity of the eligibility determination process and avoid improper payments. The proposed rule will address several of the most persistent drivers of eligibility errors such as insufficient recordkeeping, verification of eligibility, redeterminations, and compliance with eligibility requirements when individuals experience a change in circumstances that may impact eligibility. The Center for Medicaid and CHIP Services (CMCS) within HHS’s Centers for Medicare & Medicaid Services (CMS) also is publishing an Information Bulletin to remind states about federal requirements and expectations already codified in existing regulations for completing renewals for Medicaid and CHIP beneficiaries. HHS will also complete the review of the remaining 34 states under the new eligibility component and establish a baseline in FY 2021 once all states are measured under the new requirements.

In addition to the NPRM, to further address PERM errors that may be related to a need for states to implement or increase operational process efficiencies, CMCS will use learning collaboratives and targeted technical assistance to identify root cause analysis for states with chronic processing issues to develop best practices that can be shared. In summary, HHS will:

- Develop a notice of proposed rulemaking to strengthen the integrity of the eligibility determination process;
- Increase the timeline density of oversight by using the Medicaid Eligibility Quality Control (MEQC) program in the two off-cycle PERM years to address Medicaid beneficiary eligibility vulnerabilities on areas not addressed through PERM reviews and on areas identified as error-prone through the PERM program;
- Conduct risk based audits of beneficiary eligibility determinations in states identified as such in PERM, OIG, and state auditor findings;
- Conduct outreach during off-cycle PERM years to address issues identified in corrective action plans; and
- Facilitate national best practice calls to share ideas across states to increase support in areas where deficiencies may be due to operational inefficiencies.

In addition, HHS works closely with all states through enhanced technical assistance and guidance to develop state-specific corrective action plans to reduce improper payments. All states are responsible for implementing, monitoring, and evaluating their corrective action plan’s effectiveness with assistance and oversight from HHS. When developing corrective action plans, states focus on the major causes of improper payments.





Lastly, the FY 2020 President's Budget also includes a proposal that would strengthen CMS's ability to recoup Medicaid improper payments related to states' inaccurate beneficiary eligibility determinations. The proposal would give CMS authority to recover overpayments from states that receive federal resources for ineligible or misclassified beneficiaries.

2. Medicare Appeals Process

HHS has a strategy to improve the Medicare appeals process through investing new resources at all levels of appeal to increase adjudication capacity and implement new strategies to alleviate the current backlog; taking administrative actions to reduce the number of pending appeals and encourage resolution of cases earlier in the process; and proposing legislative reforms that provide additional funding and new authorities to address the appeals volume.

HHS has undertaken, and continues to explore, new administrative actions expected to have a favorable impact on the Medicare appeals backlog. The FY 2020 President's Budget request includes a comprehensive legislative package aimed at both helping the Department process a greater number of appeals and reducing the number of appeals that reach OMHA and DAB. Based on projected impacts of current administrative actions, and the proposed funding increases and legislative actions outlined in the FY 2020 President's Budget, HHS projects that the backlog at Level 3 would be approximately 100,000 appeals by the end of FY 2021, while the backlog at Level 4 could start decreasing in future years.

3. Contracting

HHS places a high priority on complying with appropriations and acquisitions law, and avoiding violations of the FAR. When a violation is suspected, HHS obtains legal review and advice from the Office of the General Counsel before determining whether a violation exists. HHS management has taken certain corrective actions in FY 2019, including a reorganization of the HHS Acquisitions office resulting in a separate Office of Acquisitions with independent executive oversight, and a review of its policies and procedures against current federal government regulations. HHS is still in the process of reviewing its acquisition program. The review of this matter will continue in FY 2020 to ensure timely corrective actions, as appropriate.

Financial Summary and Highlights

HHS received an unmodified audit opinion on the principal financial statements and notes² for the year ended September 30, 2019. This is the 21st year for an unmodified opinion. HHS takes pride in the preparation of the financial statements, yet it can sometimes be difficult to draw the relationships between the information in the statements and the overall performance of an agency. This section is presented as an interpretation of the principal financial statements, which include the Consolidated Balance Sheets, Consolidated Statements of Net Cost, Consolidated Statement of Changes in Net Position, Combined Statement of Budgetary Resources, Statement of Social Insurance, and the Statement of Changes in Social Insurance Amounts, as well as selected notes to the principal financial statements. HHS presents these in the “Financial Section” of this report. Included in this analysis is a year-over-year summary of key financial balances, nature of significant changes, and highlights of key financial events to assist readers in establishing the relevance of the financial statements to the operations of HHS.

As a federal entity, HHS’s financial position and activities are significant to the government-wide statements. Based on the *FY 2018 Financial Report of the United States Government*, HHS’s net operating cost was larger than any single agency across the entire federal government.³ A similar relationship exists within HHS, where the Department is significantly represented by one OpDiv, CMS. CMS alone consistently stewards the largest share of HHS’s resources. Therefore, noteworthy changes in HHS balances are primarily related to fluctuations in CMS program activity.

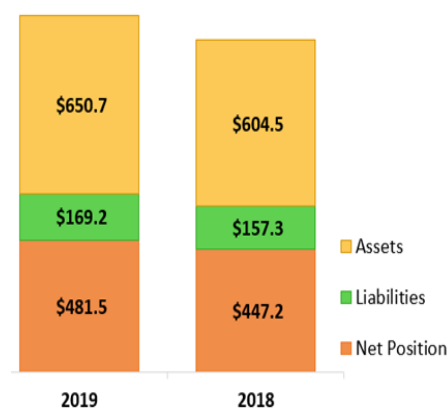
Balance Sheets

To communicate performance for HHS at fiscal year-end, the Consolidated Balance Sheets show the resources available to HHS (Assets) and claims against those assets (Liabilities). The remainder represents the equity retained by HHS (Net Position). The table below summarizes the major components of the FY 2019 and FY 2018 year-end balances of HHS’s assets available for use, the liabilities owed by HHS, and the equity retained by HHS.

Financial Conditions Summary

(In Billions)

	2019	2018	\$ Change (2019-2018)	% Change (2019-2018)
Fund Balance with Treasury	\$ 296.3	\$ 250.2	\$ 46.1	18%
Investments, Net	309.3	307.1	2.2	1%
Accounts Receivable	25.0	27.9	(2.9)	(10)%
Advances	2.6	2.9	(0.3)	(10)%
Other Assets	17.5	16.4	1.1	7%
Total Assets	\$ 650.7	\$ 604.5	\$ 46.2	8%
Accounts Payable	\$ 2.4	\$ 2.0	\$ 0.4	20%
Entitlement Benefits Due and Payable	110.1	99.1	11.0	11%
Accrued Liabilities	15.5	14.5	1.0	7%
Federal Employee and Veterans' Benefits	14.8	14.4	0.4	3%
Other Liabilities	26.4	27.3	(0.9)	(3)%
Total Liabilities	\$ 169.2	\$ 157.3	\$ 11.9	8%
Net Position	\$ 481.5	\$ 447.2	\$ 34.3	8%
Total Liabilities and Net Position	\$ 650.7	\$ 604.5	\$ 46.2	8%



² Due to the uncertainty of the long-range assumptions used in the Statement of Social Insurance model, the auditors were not able to express an opinion on the Statement of Social Insurance, the Statement of Changes in Social Insurance Amounts, and associated footnotes.

³ HHS’s net cost is 25 percent of the federal government’s total costs, Social Security Administration’s net cost is 23 percent, Department of Defense’s net cost is 15 percent, Department of Veterans Affairs’ net cost is 8 percent, and Treasury’s Interest on Treasury Security Held by the Public’s net cost is 8 percent. All remaining agencies combined only represent 21 percent. Source: *FY 2018 Financial Report of the United States Government* [fiscal.treasury.gov/fsreports/rpt/finrep/fr/fr_index.html](https://www.fiscal.treasury.gov/fsreports/rpt/finrep/fr/fr_index.html)



Assets

The total Assets for HHS were \$650.7 billion at year-end, representing the value of what HHS owns and manages. This is an increase of approximately \$46.2 billion or 8 percent over September 30, 2018. Fund Balance with Treasury (FBWT) and Investments comprise \$605.6 billion or 93 percent of HHS's total assets, which increased \$48.3 billion or 9 percent.

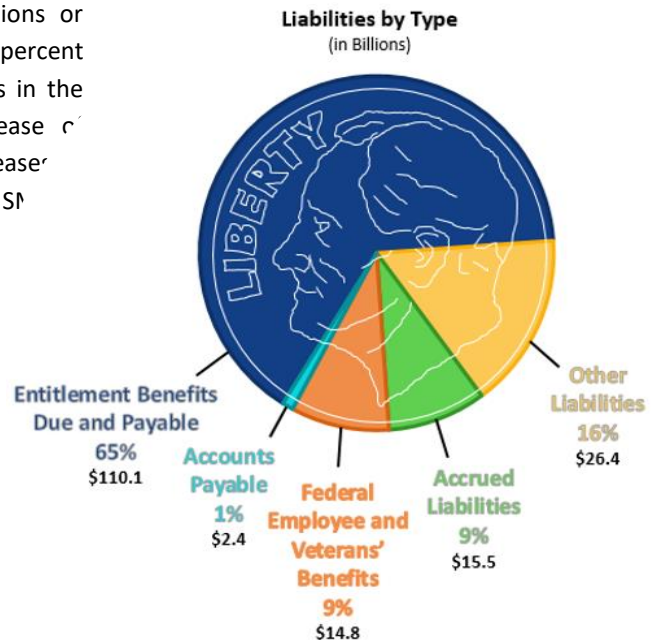
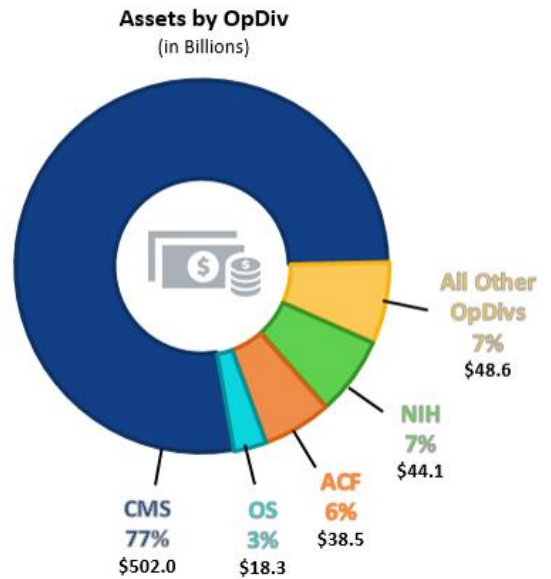
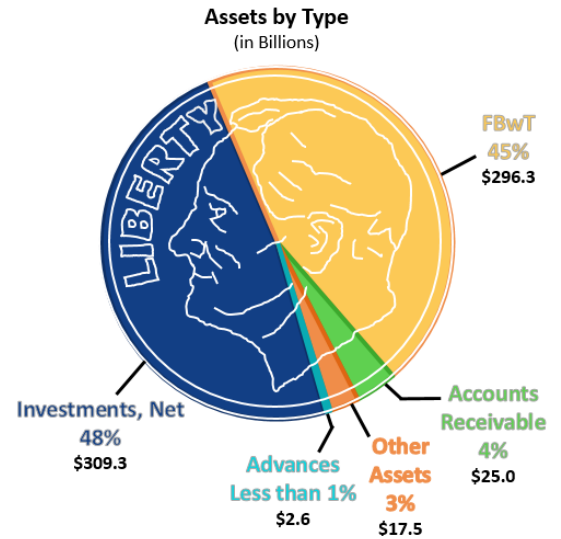
The FBWT line contains the largest net change between FY 2019 and FY 2018 with a \$46.1 billion or 18 percent increase. This primarily consists of a \$36.3 billion increase in Supplementary Medical Insurance (SMI), \$2.0 billion in Medicaid due to retention of full FY 2019 definite authority, \$2.5 billion in the Refugee and Entrant Assistance program, and \$1.2 billion for the Temporary Assistance for Needy Families program.

Investments had an increase of \$2.2 billion or 1 percent primarily due to an increase of \$6.5 billion in SMI premiums, offset by a decrease of \$4.4 billion in Hospital Insurance (HI).

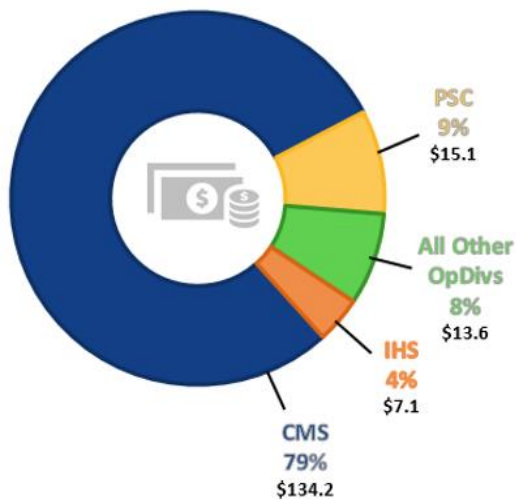
The HHS "Assets by OpDiv" chart demonstrates asset distribution within HHS, excluding eliminations. The OpDiv asset balances ranged from \$355 million at AHRQ (shown in All Other OpDivs) to \$502.0 billion at CMS. CMS had the largest percentage and dollar value asset increases at \$34.7 billion or 7 percent over FY 2018 primarily due to the changes in FBWT and Investments mentioned above.

Liabilities

The total Liabilities for HHS were \$169.2 billion at year-end, representing the amounts HHS owes from past transactions or events. This is an increase of approximately \$11.9 billion or 8 percent over September 30, 2018. The majority of the increase is in the Entitlement Benefits Due and Payable line. This increase of \$11.0 billion or 11 percent from FY 2018 consists of increased medical services/claims incurred but not reported for SMI of \$6.5 billion, \$2.9 billion in HI, and \$1.6 billion in Medicaid.



Liabilities by OpDiv
(in Billions)

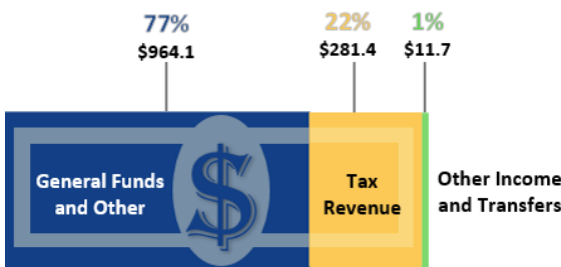


The HHS “Liabilities by OpDiv” chart shows liability distribution within HHS, excluding eliminations. The OpDivs with the largest and smallest asset balances are also the OpDivs with the largest and smallest liabilities. With the majority share, CMS reports \$134.2 billion or 79 percent of the HHS liabilities, while AHRQ (shown in All Other OpDivs) has liabilities of \$29 million. CMS had the largest OpDiv dollar value increase in liabilities over FY 2018 of \$10.7 billion.

Statement of Changes in Net Position

The Consolidated Statement of Changes in Net Position displays the activities affecting the difference between the beginning net position and ending net position, as shown on the HHS Consolidated Balance Sheets. This is also represented as the difference between assets and liabilities.

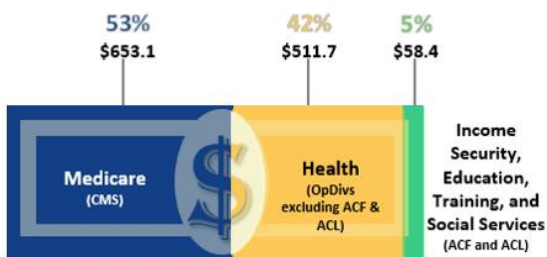
HHS Gets the Money From...
(in Billions)



Changes in assets are shown by identifying where HHS gets the money from, known as financing sources. Financing sources include both the Total Financing Sources and Total Budgetary Sources lines from the Statement of Changes in Net Position.

HHS receives the majority of the funding through Congressional appropriations and reimbursement for the provision of goods or services to other federal agencies. HHS’s largest financing source, General Funds and Other, increased since FY 2018 by \$53.9 billion or 6 percent. The fluctuations in tax revenue of \$16.9 billion or 6 percent is related to the *Federal Insurance Contributions Act (FICA)* and *Self Employed Contributions Act (SECA)*.

HHS Used the Money For...
(in Billions)



Statements of Net Cost

The Consolidated Statements of Net Cost represents how HHS spent the money. This can also be stated as the difference between the costs incurred by HHS’s programs less associated revenues. The Net Cost of Operations for the year ended September 30, 2019, totaled approximately \$1.2 trillion. The “HHS Used the Money For ...” chart shows consolidating costs by major budget function⁴, which are the categories displayed in the [Federal Budget](#). Most agencies have one or two budget functions, where HHS has many.

⁴ Totals in the chart are exclusive of Intra-HHS eliminations from the Consolidating Statement of Net Cost by Budget Function. This statement can be found in Section III, Other Information.



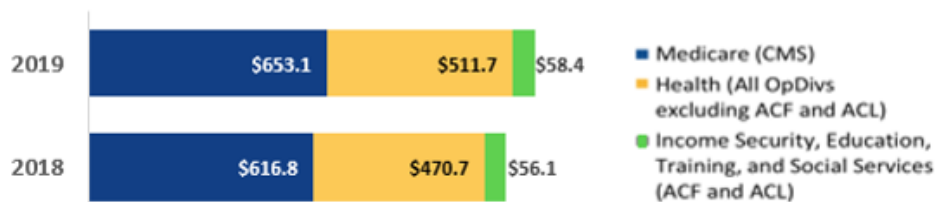
The table below presents FY 2019 Consolidated Net Cost of Operations, which breaks costs into Responsibility Segments between CMS and the remaining OpDivs in Other Segments. Net cost for CMS increased by \$78.0 billion or 8 percent over FY 2018. The majority of this increase relates to Medicaid benefit expenses of \$27.5 billion. In addition, SMI and HI expenses increased by \$26.6 billion and \$16.1 billion, respectively. There was an increase in total Net Cost of Operations for the remaining HHS segments at \$1.5 billion or 1 percent over FY 2018.

Net Cost of Operations
(in Billions)

	2019	2018	\$ Change (2019 2018)	% Change (2019 2018)
Responsibility Segments:				
CMS Gross Cost	\$ 1,201.6	\$ 1,115.2	\$ 86.4	8%
CMS Exchange Revenue	(114.7)	(106.3)	(8.4)	8%
CMS Net Cost of Operations	\$ 1,086.9	\$ 1,008.9	\$ 78.0	8%
Other Segments:				
Other Segments Gross Cost	\$ 141.9	\$ 140.2	\$ 1.7	1%
Other Segments Exchange Revenue	(6.0)	(5.8)	(0.2)	3%
Other Segments Net Cost of Operations	\$ 135.9	\$ 134.4	\$ 1.5	1%
Net Cost of Operations	\$ 1,222.8	\$ 1,143.3	\$ 79.5	7%

HHS classifies costs by major budget functions such as Medicare, Health, Income Security, and Education, Training, and Social Services. This is shown on the Consolidating Statement of Net Cost by Budget Function in the “Other Information” section of this report. The graph below shows the two-year cost trends for these major budget functions.⁵ In FY 2019, total net costs for Medicare of \$653.1 billion and Health of \$511.7 billion account for 95 percent of HHS’s annual net costs.

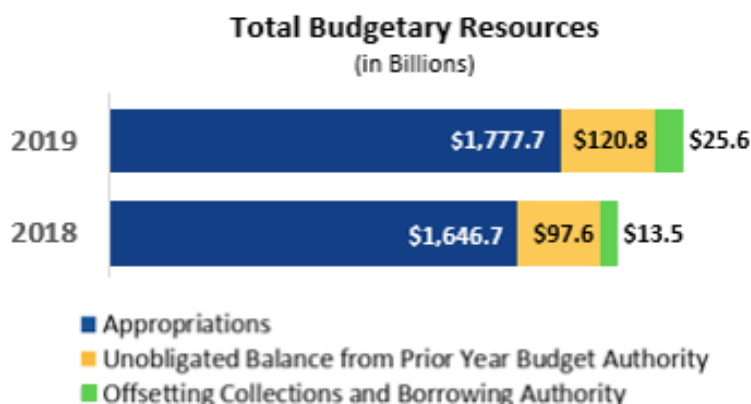
Cost by Major Budget Function
(in Billions)



Statement of Budgetary Resources

The Combined Statement of Budgetary Resources displays the budgetary resources available to HHS throughout FY 2019 and FY 2018, and the status of those resources at the fiscal year-end. The primary components of HHS’s resources, totaling approximately \$1.9 trillion for FY 2019, are appropriations from Congress, resources not yet used from previous years (unobligated balances from prior year budget authority), and spending authority from offsetting collections and borrowing authority. This represents an increase of \$166.4 billion or 9 percent, over FY 2018. The following graph highlights trends in these balances over the past 2 fiscal years.

⁵ Totals in the chart are exclusive of Intra-HHS eliminations from the Consolidating Statement of Net Cost by Budget Function.



The increase in appropriations of \$131.0 billion or 8 percent is primarily related to increases in Payments to the Trust Funds (PTF) of \$50.1 billion, SMI of \$44.4 billion, HI of \$28.8 billion, CHIP of \$5.1 billion, and Medicaid of \$1.3 billion. For further details, see the Combining Statement of Budgetary Resources in the “Financial Section” of this report.

The increase of \$23.2 billion or 24 percent in unobligated balance from prior year budget authority is primarily due to unobligated balances brought forward from the preceding fiscal year of \$15.1 billion in Medicaid, \$12.6 billion in All Others/Program Management, \$6.4 billion in PTF, and \$4.3 billion in CHIP. The increase is offset by a decrease in recoveries of prior year unpaid obligations of \$9.8 billion and an additional decrease due to the change in unobligated balance of \$9.8 billion.

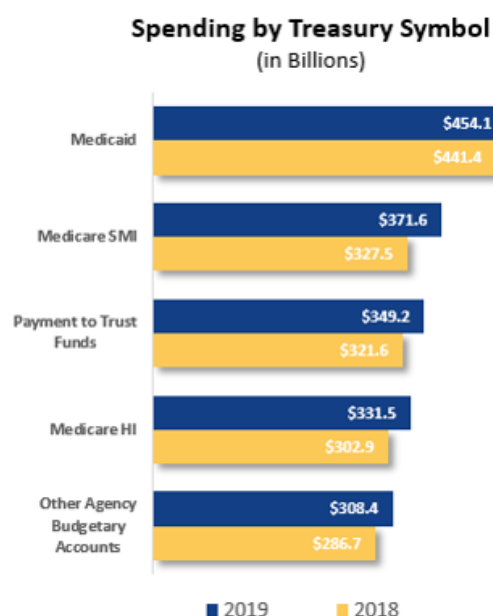
Schedule of Spending

HHS has elected to present the trends in spending in the audited notes to the principal financial statements titled, Combined Schedule of Spending. The chart below illustrates spending as of September 30, 2019 and 2018 for the top four Treasury Account Symbols (TAS). The remaining TAS are presented in Other Agency Budgetary Accounts.

The New Obligations and Upward Adjustments line on the Combined Statement of Budgetary Resources is the same as Total Amounts Agreed to be Spent line on the Combined Schedule of Spending. Total obligations for FY 2019 were approximately \$1.8 trillion with an 8 percent increase over FY 2018.

The HHS’s total spending is once again significantly represented by four of CMS’s TAS (Medicaid, Medicare SMI, PTF, and Medicare HI) at 83 percent of HHS total obligations.

As the American public will see more clearly on the USA Spending.gov website, the majority of HHS spending was made through Grants, Subsidies, and Contributions at \$884.2 billion or 49 percent. HHS is the largest grant-making agency in the federal government. Additionally, HHS has incurred obligations for Insurance Claims and Indemnities totaling \$789.1 billion or 43 percent. HHS classifies obligations by items or services provided into categories known as object classes. For more information refer to Note 21, Combined Schedule of Spending in the “Financial Section” of this report.





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 important information regarding the potential future cost of the program. These projected potential future obligations are not included in the Consolidated Balance Sheets, 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 [2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds](#) (Trustees Report).

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) decreased from \$(4.7) trillion, determined as of January 1, 2018, to \$(5.5) trillion, determined as of January 1, 2019.

Including the combined HI and SMI trust fund assets increases the present value. As of January 1, 2019, the future cash flow for all current and future participants was \$(5.2) trillion for the 75-year valuation period. The comparable closed group of participants, including the combined HI and SMI trust fund assets, is \$(12.7) trillion.

Did you know?

Medicare spending accounts for 15 percent of the entire federal budget. Learn more about CMS's 5 part strategy intended to modernize program integrity methods at [CMS.gov](https://www.cms.gov).





HI TRUST FUND SOLVENCY

Pay-as-you-go Financing

The HI trust fund is deemed to be solvent as long as assets are sufficient to finance program obligations. Such solvency is indicated, for any point in time, by the maintenance of positive trust fund assets. In recent years, current expenditures have exceeded program income for the HI program, and thus, the HI trust fund assets have been declining. The following table shows that HI trust fund assets, expressed as a ratio of the assets at the beginning of the fiscal year to the expenditures for the year. This ratio has steadily dropped from 73 percent at the beginning of FY 2015 to 62 percent at the beginning of FY 2019.

Trust Fund Ratio Beginning of Fiscal Year ⁶	
FY	HI
2019	62%
2018	66%
2017	66%
2016	67%
2015	73%

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 2019 Trustees Report indicate that the HI trust fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the 2019 Trustees Report, the HI trust fund ratio is estimated to decline steadily until the fund is depleted in calendar year 2026. Assets at the end of calendar year 2018 were \$200.4 billion and are expected to decrease steadily until depleted in 2026.

Long-Term Financing

The short-range outlook for the HI trust fund is similar to what was projected last year. The trust fund ratio declines until the fund is depleted in 2026, the same date as projected last year. HI financing is not projected to be sustainable over the long term with the projected tax rates and expenditure levels. Program cost is expected to exceed total income in all years. When the HI trust fund is exhausted, full benefits cannot be paid on a timely basis. The percentage of expenditures covered by tax revenues is projected to decrease from 89 percent in 2026 to 78 percent in 2043 and then to increase to about 83 percent by the end of the projection period.

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 individuals eligible for benefits drops from 3.0 in 2018 to about 2.2 by 2093. 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 \$5.3 trillion, which is 0.9 percent of taxable payroll and 0.4 percent of Gross Domestic Product (GDP) 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 Federal Accounting Standards Advisory Board.

SMI TRUST FUND SOLVENCY

The SMI trust fund consists of two accounts – Part B and Part D. In order to evaluate the financial status of the SMI trust fund, each account needs to be assessed individually, since financing rates for each part are established separately, 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

⁶ Assets at the beginning of the year to expenditures during the year.





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, the appropriation for Part D has generally been set such that amounts can be transferred to the Part D account on an as-needed basis; under this process, there is no need to maintain a contingency reserve. In September 2015, a new policy was implemented to transfer amounts from the Treasury into the account five business days before the benefit payments to the plans.

As a result, the Trustees expect the Part D account to include a more substantial balance at the end of most months to reflect this policy.

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 income less expenditures for the 75-year projection period is \$(36.8) trillion.

Even though from a program perspective, the unfunded liability is \$0, there is concern over the rapid increase in cost of the SMI program as a percent of GDP. In 2018, SMI expenditures were 2.1 percent of GDP. By 2093, SMI expenditures are projected to grow to 4.2 percent of the GDP.

The following table presents key amounts from CMS's basic financial statements for fiscal years 2017 through 2019.

Table of Key Measures⁷
(in Billions)

	2019	2018	2017
Net Position (end of fiscal year)			
Assets	\$ 502.0	\$ 467.3	\$ 444.2
Less Total Liabilities	134.2	123.5	137.5
Net Position (assets net of liabilities)	\$ 367.8	\$ 343.8	\$ 306.7
Costs (end of fiscal year)			
Net Costs	\$ 1,087.3	\$ 1,009.1	\$ 963.3
Total Financing Sources	1,079.0	1,017.7	984.6
Net Change in Cumulative Results of Operations	\$ (8.3)	\$ 8.6	\$ 21.3
Statement of Social Insurance (calendar year basis)			
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), current year valuation (as of 1/1/2019)	\$ (5,484)	\$ (4,708)	\$ (3,532)
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), prior year valuation (as of 1/1/2018)	\$ (4,708)	\$ (3,532)	\$ (3,822)
Change in Present Value	\$ (776)	\$ (1,176)	\$ 290

Statement of Changes in Social Insurance Amounts

The Statement of Changes in Social Insurance Amounts 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. In general, an increase in the present value of

⁷ The table or other singular presentation showing the measures described above.



net cash flow represents a positive change (improving financing), while a decrease in the present value of net cash flow represents a negative change (worsening financing).

The present value as of January 1, 2019, decreased by \$201 billion due to advancing the valuation date by one year and including the additional year 2093, by \$200 billion due to changes in projection base, and by \$402 billion due to changes in economic and health care assumptions. However, the present value increased by \$27 billion due to changes in demographic assumptions. The net overall impact of these changes is a decrease in the present value of \$776 billion.

Required Supplementary Information

As required by Statement of Federal Financial Accounting Standards (SFFAS) 17, *Accounting for Social Insurance* (as amended by SFFAS 37, *Social Insurance: Additional Requirements for Management Discussion and Analysis and Basic Financial Statements*), HHS has included information about the Medicare trust funds – HI and SMI. The Required Supplementary Information (RSI) presents required long-range cash-flow projections, the long-range projections of the ratio of contributors to individuals with Medicare (dependency ratio), and the sensitivity analysis illustrating the effect of the changes in the most significant assumptions on the actuarial projections and present values. The SFFAS 37 does not eliminate or otherwise affect the SFFAS 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 2019 Trustees Report, 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 in the “Financial Section” have been prepared to report HHS’s financial position and results of operations, pursuant to the requirements of 31 U.S.C. §3515(b). Although the statements have been prepared from HHS’s books and records in accordance with generally accepted accounting principles for federal entities and the formats prescribed by the OMB, the statements are in addition to the financial reports used to monitor and control budgetary resources, which are prepared from the same books and records.

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



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