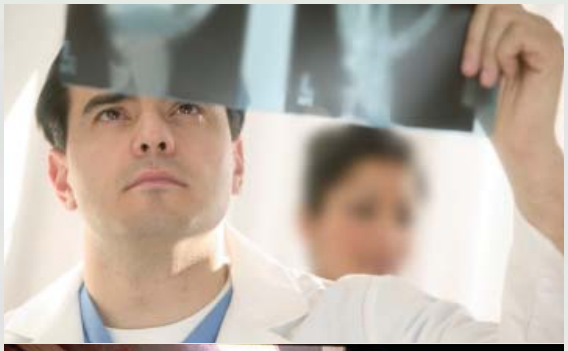

AGENCY FINANCIAL REPORT

Fiscal Year 2007

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

FY 2007 Agency Financial Report

Contents

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Introduction

Purpose of This Report

The Department of Health and Human Services' fiscal year (FY) *2007 Agency Financial Report* provides fiscal and high-level performance results that enable the President, Congress, and American people to assess our accomplishments for the reporting period October 1, 2006, through September 30, 2007. This report provides an overview of our programs, accomplishments, challenges, and management's accountability for the resources entrusted to us. We have prepared this report in accordance with the requirements of Office of Management and Budget Circular A-136, *Financial Reporting Requirements*.

We have chosen to participate in the FY 2007 Performance and Accountability Report pilot, as defined in the Office of Management and Budget's Circular A-136, in an effort to enhance our ability to provide transparency and more enhanced performance reporting. For FY 2007, the Department is producing an alternative to the consolidated *Performance and Accountability Report* called an *Agency Financial Report*. The Department will provide its *FY 2007 Annual Performance Report* and *FY 2009 Performance Plan* in its *Congressional Budget Justification* and supporting reports that will be located on the Web site at www.hhs.gov not later than February 4, 2008. In addition, we will produce a consolidated "Highlights" document on the Web site www.hhs.gov by February 4, 2008. We anticipate that this approach will improve the presentation of financial and performance reporting by providing decision-makers and the American public with more meaningful and transparent information.

How This Report is Organized

This report includes a Message from the Secretary, followed by three sections:

Section I: Management's Discussion and Analysis, which contains information on the Department's mission and organizational structure; strategic goals and highlights of our accomplishments; President's Management Agenda; analysis of the financial statements and stewardship information; systems, legal compliance and controls; and other management information, and initiatives.

Section II: Financial Report, which contains a Message from the Chief Financial Officer, the independent auditor's reports, the financial statements and notes, Required Supplementary Stewardship Information, and Required Supplementary Information.

Section III: Other Accompanying Information, which includes the Inspector General's Summary of Management and Performance Challenges; Summary of Financial Statement Audit and Management Assurances; Improper Payments Information Act Reporting Details, and other annually required reports.

We Welcome Your Comments

Thank you for your interest in the Department of Health and Human Services. We welcome your comments and questions regarding this Agency Financial Report and would appreciate any suggestions for improving this report for our readers. Please contact us at:

Department of Health and Human Services
Office of Finance/DFSA
Mail Stop 522D
200 Independence Avenue, SW
Washington, DC 20201


Michael O. Leavitt

Message From the Secretary

During fiscal year (FY) 2007, the Department of Health and Human Services (HHS) continued to fulfill its charge to protect the health of all Americans and provide essential human services, especially for those who are least able to help themselves. In support of this mission, HHS made tremendous strides in achieving the President's vision of a healthier, safer, and more hopeful America, while ensuring good stewardship of the taxpayers' money.

To accomplish this vision, HHS achieved significant progress in a number of program areas during FY 2007, including the protection of our citizens from infectious disease threats; the improvement of transparency of health care information, thus providing better value and health care to consumers; streamlining and providing better choices for seniors and people with disabilities receiving prescription drug benefits; and the improvement of drug safety information.

Value Driven Health Care

Consumers deserve to know the quality and cost of their health care. Providing transparent cost and reliable quality information empowers consumer choice, leads to incentives at all levels of the health care system and provides better care for less money.

In 2007, efforts to provide incentives to physicians voluntarily reporting quality measures began. Information collected through these efforts will become the basis for bonus payments to be paid mid-2008. Also, in 2007, incentives by Medicare led to two mortality measures, for heart attack and heart failure, to be added to the core set of quality measures on which most hospitals now report. Efforts to add additional measures of patient satisfaction by spring 2008 are underway. Following last year's posting of price information for common and elective inpatient and outpatient hospital procedures, ambulatory surgery center procedures, and physician office procedures under Medicare, pricing information is now updated on an annual basis.

Through the American Health Information Community, a Federal advisory committee, HHS seeks to further empower and protect consumers in the management of their health through the use of interoperable, portable personal health records. Increased efficiencies realized through a Nationwide Health Information Network (NHIN), which will offer consumers safe and secure access to their personal health information anywhere in the nation. FY 2007 also marked HHS' successful completion of NHIN prototype demonstrations. These demonstrations incorporated the functions, standards, and specifications for the exchange of data through a model NHIN that would both shape and strengthen the health care system by emphasizing the importance of quality and expanded access.

Personalized Health Care

The combination of genomic medicine, health information technology, and better use of medical evidence will make possible more effective, personalized health care. HHS has several personalized health care efforts underway, including development of genome studies to identify elements in disease. Trial implementations of the Nationwide Health

Information Network will bring us closer to a Health Information Technology system that will improve quality of care, increase efficiencies in health care, as well as improve disease prevention.

Stewardship

HHS has chosen to participate in the FY 2007 Office of Management and Budget's pilot approach to improving performance and accountability reporting. Pursuant to Office of Management and Budget Circular A-136, *Financial Reporting Requirements,* this *Agency Financial Report* represents the accountability report for FY 2007. The *FY 2007 Performance Report* and *FY 2009 Performance Plan* will be included as part of our *Congressional Budget Justification* due on February 4, 2008. As part of this pilot approach, HHS will also produce a "Highlights" document, which will be found at www.hhs.gov on February 4, 2008. HHS anticipates that this approach will make information more transparent and useful to the President, Congress, and American people.

I am proud to report that for the ninth consecutive year, HHS earned an unqualified or "clean" audit opinion on the Department's consolidated financial statements. This demonstrates our commitment to ensuring the highest measure of accountability to the American people.

With the implementation of a more modern financial management system, HHS has made significant progress toward ensuring reliable, timely information is available for decision-makers. HHS managers use the financial information summarized in this report to improve the quality and effectiveness of services to the American people. The financial and performance data presented in this report is reliable, complete, and provides the latest data available, except where otherwise noted.

As required by the Federal Managers' Financial Integrity Act and Office of Management and Budget Circular A-123, *Management's Responsibility for Internal Control*, HHS has evaluated its internal controls and financial management systems. Section I of this report includes the Department's qualified assurance statement that describes two material weaknesses in the Department: 1) Financial Systems and Processes, and 2) Oversight and Management of Information System Controls. These also constitute system non-conformances under Section 4 of the Federal Managers' Financial Integrity Act. To facilitate improvements, the Department is taking the following actions: continued deployment of the Unified Financial Management System across the Department to improve the financial systems and processes, and continued improvement of information technology general and application controls. More information is presented in Sections I and III of this document.

HHS' accomplishments would not have been possible without the dedication and commitment of our employees and partners. They should be very proud of the positive impact their contributions have on the lives of Americans.

Michael O. Leavitt

NOV 15 2007

Section I: Management's Discussion and Analysis

FY 2007 Agency Financial Report

Section I: Management's Discussion and Analysis

Agency Financial Report Acknowledgement

The Department of Health and Human Services has chosen to participate in the FY 2007 Performance and Accountability Report pilot, as defined in the Office of Management and Budget's Circular A-136, *Financial Reporting Requirements*, to provide more transparent and enhanced financial and performance reporting. For FY 2007, the Department is producing an alternative to the consolidated *Performance and Accountability Report* called an *Agency Financial Report*. The Department will provide its *FY 2007 Annual Performance Report* and *FY 2009 Performance Plan* in its *Congressional Budget Justification* and supporting reports and a "Highlights" document. These documents will be available on the Web site www.hhs.gov by February 4, 2008. We anticipate that this approach will improve the presentation of financial and performance reporting by providing decision-makers and the American public with more meaningful and transparent information.

Mission and Organizational Structure

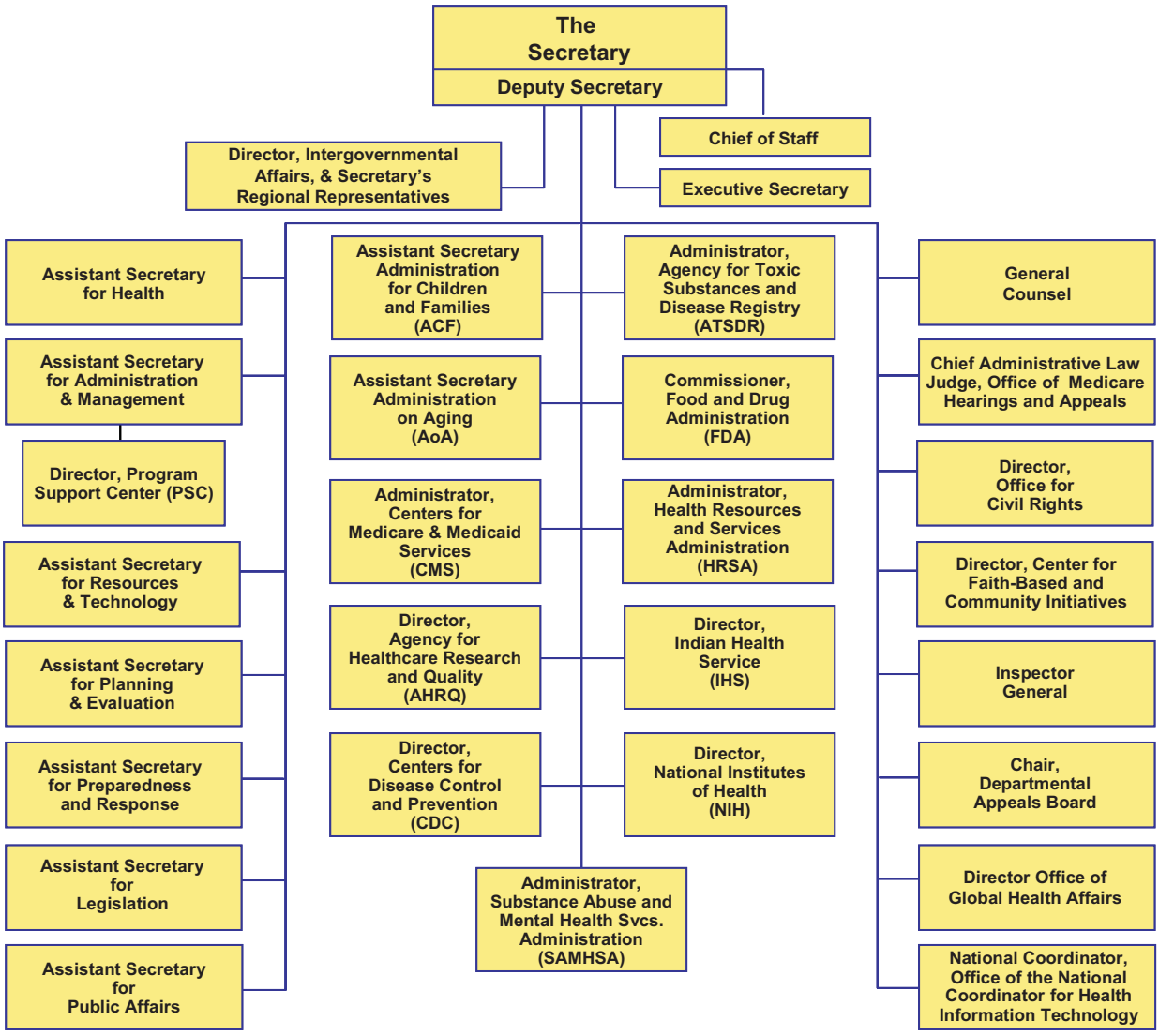
Mission

The mission of the Department of Health and Human Services (HHS) is to enhance the health and well-being of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences, underlying medicine, public health, and social services.

At the Department, our number one priority will always be to protect the health of all Americans and provide essential human services, especially for those who are least able to help themselves.

Organizational Structure

The Secretary leads a Department that provides a wide range of services and benefits to the American people. Below is an organizational chart. Further details concerning each major Departmental component's role in accomplishment of the overall mission and strategic goals are discussed on the following pages.



Strategic Goals

We strive for continuous improvement in the health and well-being of Americans, and other people throughout the world. This is achieved through leadership in medical sciences, and public health and human services programs.

We accomplish our mission through more than 300 programs and initiatives that cover a wide spectrum of activities. With an FY 2007 budget of $698 billion, we represent almost a quarter of all Federal expenditures and administer more grant dollars than all other Federal agencies combined. Our four strategic goals are related to the components with primary responsibility for these efforts in the table on the next page.

The four strategic goals, designed to accomplish this mission, are articulated in the recently released *FY 2007-2012 Strategic Plan*.

Goal 1. *Health Care*. Improve the safety, quality, affordability, and accessibility of health care, including behavioral health care and long-term care.

Goal 2. *Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness*. Prevent and control disease, injury, illness, and disability across the lifespan, and protect the public from infectious, occupational, environmental, and terrorist threats.

The Department administers more than 300 programs, covering a wide spectrum of activities. The Department priorities for America's health care future include:

- Every American's Access to Insurance
- Insurance for the Neediest Children
- Value-Driven Health Care
- Information Technology
- Personalized Health Care
- Health Diplomacy
- Prevention
- Louisiana Health Care System
- Preparedness

Goal 3. *Human Services.* Promote the economic and social well-being of individuals, families, and communities.

Goal 4. *Scientific Research and Development*. Advance scientific and biomedical research and development related to health and human services.

The *FY 2007 President's Budget* focused upon eight strategic goals reflected in the *Strategic Plan* submitted to Congress in 2004. To continue helping Americans live longer, healthier, and better lives, the Department submitted to Congress an updated Strategic Plan for FY 2007 – 2012 that highlights four strategic goals, located at http://ww.hhs.gov/strategic_plan. A crosswalk between the prior and updated strategic plans is included below.

HHS Prior Strategic Plan Fiscal Years 2004 – 2009	HHS Current Strategic Plan Fiscal Years 2007 – 2012
Goal 1 (Prior): Reduce the major threats to the health and well-being of Americans	Goal 1: Health Care Goal 2: Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness
Goal 2 (Prior): Enhance the ability of the Nation's health care system to effectively respond to bioterrorism and other public health challenges	Goal 2: Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness
Goal 3 (Prior): Increase the percentage of the Nation's children and adults who have access to health care services, and expand consumer choices	Goal 1: Health Care
Goal 4 (Prior): Enhance the capacity and productivity of the Nation's health science research enterprise	Goal 4: Scientific Research and Development
Goal 5 (Prior): Improve the quality of health care services	Goal 1: Health Care
Goal 6 (Prior): Improve the economic and social well-being of individuals, families, and communities, especially those most in need	Goal 3: Human Services
Goal 7 (Prior): Improve stability of healthy development of our Nation's children and youth	Goal 3: Human Services
Goal 8 (Prior): Achieve excellence in management practices	Responsible stewardship and effective management is expected across all four strategic goals.

To reach its goals, the Department places the utmost importance on fostering a culture of leadership and accountability through responsible stewardship and effective management. The chart on the next page shows the Department's components, their missions, and the Department-wide strategic goal(s) to which they are major contributors.

Department Component Related to Strategic Goals

Component	Component Mission	Health Care	Public Health	Human Services	Scientific Research & Development
ACF	*To promote the economic and social well-being of families, children, individuals, and communities.*			✓	
AHRQ	*To support, conduct, and disseminate research that improves access to care and the outcomes, quality, cost, and utilization of health care services.*	✓	✓		✓
AOA	*To promote the dignity and independence of older people, and to help society prepare for an aging population.*			✓	
ATSDR	*To serve the public by using the best science, taking responsive public health actions, and providing trusted health information to prevent harmful exposures and diseases related to toxic substances.*	✓	✓		✓
CDC	*To promote health and quality of life by preventing and controlling disease, injury, and disability.*	✓	✓		✓
CMS	*To ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries.*	✓		✓	
FDA	*To rigorously assure the safety, efficacy, and security of human and veterinary drugs, biological products, and medical devices, and assure the safety and security of the Nation's food supply, cosmetics, and products that emit radiation.*	✓	✓		
HRSA	*To provide the national leadership, program resources, and services needed to improve access to culturally competent, quality health care.*	✓	✓		
IHS	*To raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.*	✓	✓		✓
NIH	*To employ science in pursuit of fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to extend healthy life and reduce the burdens of illness and disability.*	✓	✓	✓	✓
SAMHSA	*To build resilience and facilitate recovery for people with or at risk for substance abuse and mental illness.*	✓	✓	✓	

As a management tool to guide progress toward the vision to improve the health and quality of life for all Americans, Secretary Leavitt initially established *a 500-Day Plan*, with *a 250-Day Update* published during FY 2007. The *250-Day Update* continues to reflect the values in the original *500-Day Plan* – a health care system based on access and affordability, wellness, prevention and personal responsibility, and advancement of innovation and technology. For more information on the *500-Day* Plan and the *250-Day Update*, visit www.hhs.gov/500DayPlan/250update.html.

Strategic Goal Highlights

We accomplish our strategic goals by managing and delivering hundreds of programs across several disciplines. Our ability to meet the health and human service needs of Americans is tied directly to the commitment, cooperation, and success generated by our employees and partners, such as other Federal agencies, State and local governments, tribal organizations, community-based organizations, faith-based organizations, and the business community. The accomplishments described below, as related to our four strategic goals, represent highlights of our accomplishments. We believe that these accomplishments demonstrate progress toward achievement of our mission and strategic goals. As a major grant-making agency, in many cases our outcomes are influenced by outside parties and partnership efforts with State and Local governments and private organizations. We have provided the latest information available. More detailed performance results will be published in our *Annual Performance Report*, available online February 4, 2008 at www.hhs.gov.

Strategic Goal 1. Health Care.

Improvements to the Medicare Prescription Drug Benefit. In FY 2006, 90 percent of beneficiaries had prescription drug coverage through Medicare Part D or other sources. The Centers for Medicare & Medicaid Services continues to make improvements to the Medicare prescription drug benefit, including streamlining processes, enhancing choices for beneficiaries, and improving relationships with States and pharmacists.

Medicaid Modernization Efforts. The Centers for Medicare & Medicaid Services are exploring innovative ways to make the Medicaid program more sustainable over time. Some Medicaid modernization activities include increasing the number of individuals transitioned from institutions to communities, promoting private long-term care insurance coverage, and working with States to give Medicaid beneficiaries access to modern health insurance products.

Drug Safety. In March 2007, the Food and Drug Administration issued final guidance that describes the current approach to communicating drug safety information to the public. Our drug safety communications are directed toward patients and health professionals. Additional information, including patient and health care professional fact sheets and alerts can be accessed through MedWatch, which is a safety information and reporting program: www.fda.gov/Medwatch/index.html.

Access to Recovery. In 2003, President Bush announced the Access to Recovery initiative to increase the Nation's capacity to provide substance abuse treatment and recovery support services. The initiative is a 3-year grant program which ensures free and independent client choice of providers through the use of vouchers and improved access to a comprehensive array of clinical treatment and recovery support services. As of June 30, 2007, the program had provided services to 190,734 clients, 53 percent above the original three-year target of 125,000 clients. In FY 2007, a new cohort of 24 grantees was funded which is expected to serve approximately 160,000 clients over the 3-year grant period.

Improved Healthcare Cost Information. Data collected through the Agency for Healthcare Research and Quality Medical Expenditure Panel Survey is used extensively by providers, consumers, and policymakers to identify areas for improving the value of the current U.S. health care system. This data has been used to determine the costs of alternative health insurance policies, and the cost of care to individual consumers. The data are also used in the computation of the U.S. Gross Domestic Product.

Expanded Access to Healthcare. We have expanded access to care for the Nation's low-income, underserved, and medically vulnerable populations. In FY 2007, the Health Resources and Services Administration funded 337 new or significantly expanded health care sites, for a total of more than 4,000 service delivery sites nationwide. Additionally, the Ryan White HIV/AIDS Program's State AIDS Drug Assistance Program has ensured that more than 157,988 individuals received essential HIV/AIDS medications in FY 2006.

Healthy Lifestyles. The percentage of premature heart disease deaths in American Indians and Alaska Natives exceeds other ethnic groups. In FY 2007, the Indian Health Service established a baseline rate of 30 percent for a comprehensive cardiovascular disease-related assessment measure to ensure that all individuals 22 years and older who have ischemic heart disease receive appropriate screenings related to cardiovascular health. This proactive approach, which includes education and counseling to promote lifelong healthy behaviors, is essential to address the increasing prevalence of cardiovascular disease, diabetes, obesity, and smoking rates in the American Indian and Alaska Native population.

Strategic Goal 2. Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness.

Protection from infectious disease threats. The Centers for Disease Control and Prevention's Global Disease Detection program works with international partners to protect Americans from infectious disease threats. The program has been strengthening the global influenza surveillance network through bilateral support to 12 countries and enhanced communications and laboratory capabilities in five strategic countries (Thailand, Kenya, Guatemala, China, and Egypt). All five Response Centers have implemented pandemic influenza preparedness activities, including training and equipping hundreds of response teams. In FY 2006, the program responded with antitoxin to one of the largest reported outbreaks of botulism in Thailand. Plans include enhanced preparedness for pandemic influenza by establishing influenza networks globally through bilateral cooperative agreements. The global networks will actively produce usable samples for testing as measured by geographic and population coverage.

Mitigation of Health Risks or Disease. The Agency for Toxic Substance and Disease Registry gathers information at sites that pose urgent or public health hazards and then tracks the sites where human health risks or disease have been mitigated. Since FY 2006, information indicates that health risks or disease were mitigated at 65 percent of its urgent and public hazard sites. We respond to toxic substance releases when they occur or as they are discovered and provide recommendations for protecting public health to the Environmental Protection Agency, State regulatory agencies, or private agencies. Four consecutive years of performance data indicate increase in the percentage of adopted recommendations. The Agency for Toxic Substance and Disease Registry established a long-term target of 87 percent adopted recommendations by 2012.

Improved Protection through Immunizations and Vaccines. In April 2007, the Food and Drug Administration announced the first approval in the United States of a vaccine for humans against the H5N1 influenza virus, commonly known as avian or bird flu. We have purchased the vaccine for inclusion within the National Stockpile for distribution by public health officials. For more information on the government's preparedness efforts, visit: www.pandemicflu.gov.

A study published in the *Archive of Pediatrics and Adolescent Medicine* indicates that the Centers for Disease Control and Prevention's immunization efforts have resulted in cost savings through the dissemination of seven vaccines. An economic evaluation of the impact of seven vaccines (Diphtheria, Tetanus, and Pertussis, Tetanus and Diphtheria, bacterial meningitis , polio, Measles Mumps Rubella, hepatitis B, and chicken pox) routinely given as part of the

childhood immunization schedule found that vaccines are extremely cost effective. Childhood vaccination with the seven tested vaccines, which prevent more than 14 million cases of disease and more than 33,000 deaths over the lifetime of children born in any given year, resulted in annual savings of $9.9 billion in direct medical costs and more than $33.4 billion in indirect societal costs.

Preventive Care and Assessments. The Indian Health Service continues to support and provide technical assistance to Tribes in the development of programs to address violence against women by funding 16 new local programs, for a total of 30. These programs provide for the development and implementation of domestic violence screening policies and procedures, and staff development to ascertain information in a culturally appropriate manner. They also provide resources for community support for women and families in need. Through marketing and incorporating domestic violence screening as a routine part of women's health care, the screening rate has increased from 13 percent in FY 2005 to 36 percent in FY 2007.

Veteran Suicide Hotline. On July 25, 2007, the Department of Veterans Affairs and the Substance Abuse and Mental Health Services Administration collaboratively launched a new suicide hotline initiative for veterans. The National Suicide Prevention Lifeline (1-800-273-TALK) began offering veterans an option to be routed to a special call center staffed by counselors with special training on veterans' mental health needs and resources.

Strategic Goal 3. Human Services.

Welfare Reform. In FY 2006, 32 percent of adult Temporary Assistance to Needy Families recipients were working (including unsubsidized employment and work preparation), compared with less than 7 percent in 1992 and 11 percent in 1996. The recent welfare reform reauthorization and the interim final regulations published in June 2006 set forth a more meaningful work participation rate so that more families will achieve self-sufficiency. The new regulations further strengthen work participation requirements.

Child Support Enforcement Program. The number of child support cases with support orders rose to 12 million out of 15.9 million cases in FY 2005. Preliminary data indicate this program distributed $23.9 billion in child support in FY 2006, representing a 4 percent increase over FY 2005.

Long-Term Care. The Administration on Aging helps seniors remain in their homes and communities by providing a variety of supportive, nutrition, and caregiver services and by implementing initiatives to create greater balance in long-term care, to improve access, and to emphasize prevention. Aging and Disability Resource Centers, funded in partnership with the Centers for Medicare & Medicaid Services, provide consumers in 43 States with objective information about their care options and help States to streamline access and control costs. Evidence-based Disease Prevention projects assist aging service provider organizations in 48 communities to translate research findings into high-quality preventive interventions targeted to seniors.

Strategic Goal 4. Scientific Research and Development.

Pharmaceutical Outcomes Portfolio. The Agency for Healthcare Research and Quality launched the Effective Health Care Program to help patients, health care providers, and policymakers make informed health care decisions by providing current, unbiased, high-quality research that can inform these decisions.

National Institutes of Health-sponsored Clinical Trial. The initial results of an ongoing clinical trial suggest that more HIV-infected infants survive if they are given therapy early on, regardless of their apparent state of health. Because these findings should cause experts to consider changes in standards of care, details of the interim results have been released to the World Health Organization, local ethics committees, regulatory authorities and other key stakeholders for their consideration and evaluation for possible implementation. The current standard of HIV care in many parts of the world is to treat infants with therapy only after signs of illness or a weakened immune system.

Female Childhood Sexual Abuse Study. A new study has shown that girls who suffered childhood sexual abuse are more likely to develop alcoholism later in life if they possess a particular variant of a gene involved in the body's response to stress. The new finding could help explain why some individuals are more resilient to profound childhood trauma than others. This finding underscores the central role that gene-environment interactions play in the pathogenesis of complex diseases such as alcoholism.

Autism and Autism Spectrum Disorder Study. A new study has found that boys with autism and autism spectrum disorder had higher levels of hormones involved with growth in comparison to boys who do not have autism. The finding is a promising new lead in the quest to understand autism.

Online Registry of Mental Health and Substance Abuse Interventions. The Substance Abuse and Mental Health Services Administration launched its expanded National Registry of Evidence-based Programs and Practices in March 2007. It is a searchable online registry of independently reviewed and rated mental health and substance abuse interventions. The purpose of this registry is to assist the public in identifying scientifically tested approaches to preventing and treating mental and substance use disorders that can be readily disseminated to the field. During FY 2007, approximately 50 interventions were reviewed and included in the registry, and roughly 90 additional interventions previously determined to be effective were transitioned to the new Web site (www.nrepp.Samhsa.gov).

President's Management Agenda

Scorecard Results

The President's Management Agenda articulates the Administration's strategy "for improving the management and performance of government." The President's Management Agenda established five government-wide and eleven program-specific initiatives. Agencies were required to develop and implement action plans to achieve goals related to these initiatives.

Through the use of scorecards, agencies and their management are publicly held accountable for achieving established goals. The scorecards, released quarterly, employ a simple grading system of green for success, yellow for mixed results, and red for unsatisfactory to measure status and progress toward attainment of goals. (For more information about the President's Management Agenda, visit www.results.gov.)

We participate in five government-wide and four program-specific initiatives, with consistently high performance. Overall, in FY 2007, we finished the year with green progress ratings for 6 of 9 initiatives, signifying our commitment to achieving the President's Management Agenda goals. We believe we have made significant achievements on the scorecard relative to management excellence. Our FY 2007 scorecard, including a comparison to FY 2006, is presented on the following page.

It is noteworthy that during FY 2007, our status score for the "Eliminating Improper Payments" initiative improved from "red" to "yellow," as a result of establishing error measurement methodologies for each of our high-risk programs. Our report on the eliminating improper payments initiative, required by the Improper Payments Information Act of 2002, is presented in Section III, Other Accompanying Information, which describes some of our FY 2007 accomplishments.

President's Management Agenda Scorecard Results

		September 30, 2006		September 30, 2007	
Initiative Type	**Target Area**	**Status**	**Progress**	**Status**	**Progress**
Government wide	Strategic Management of Human Capital	G	G	G	G
	Competitive Sourcing	G	G	G	G
	Improved Financial Performance	R	G	R	G
	Expanded Electronic Government	R	Y	Y ↑	Y
	Performance Improvement (Renamed – Previously Budget-Performance Integration)	Y	G	R ↓	Y ↓
Program	Eliminating Improper Payments	R	G	Y ↑	G
	Faith-Based and Community Initiative	G	G	G	Y ↓
	Real Property Asset Management	Y	G	Y	G
	Health Information Quality & Transparency (New Initiative)	N/A	N/A	R	G

G Green — Successful Results

Y Yellow — Mixed Results

R Red — Unsatisfactory Results

↑ Performance Improvement

↓ Performance Decline

Analysis of Financial Statements and Stewardship Information

For the ninth consecutive year, HHS received an unqualified or "clean" audit opinion on its financial statements. The financial statements were prepared in accordance with Federal accounting standards and audited by the independent accounting firm of PricewaterhouseCoopers, LLP, under the direction of the Department of Health and Human Service's Inspector General. Preparation and audit of these statements are required by the Chief Financial Officers Act of 1990 and are part of the Department's efforts for continuous improvement of financial management. The production of accurate and reliable financial information is necessary for sound decision-making, assessing performance, and allocating resources. The Department's audited financial statements and notes are presented in Section II of this report.

Financial Condition – What is Our Financial Picture?

The following chart summarizes trend information concerning components of our financial condition -- assets, liabilities, net position, and net cost of operations. The consolidated Balance Sheet presents a picture of our financial condition as of September 30, 2007, as compared to FY 2006, and displays assets, liabilities and net position. Another component of our financial picture is our consolidated Statement of Net Cost. Each of these components is discussed below, and in Section II of this document.

FINANCIAL CONDITION (Dollars in Billions)	FY 2003 Restated	FY 2004	FY 2005	FY 2006	FY 2007	Increase (Decrease)	% Change
Total Assets	$389.3	$403.8	$428.5	$513.9	$503.9	$(10.1)	(2.0%)
Total Liabilities	$ 63.2	$ 66.8	$ 71.0	$ 78.4	$ 81.9	$ 3.5	4.5%
Net Position	$326.1	$337.0	$357.5	$435.5	$421.9	$(13.6)	(3.1%)
Net Cost of Operations	$510.4	$547.2	$581.3	$623.9	$664.6	$ 40.7	6.5%

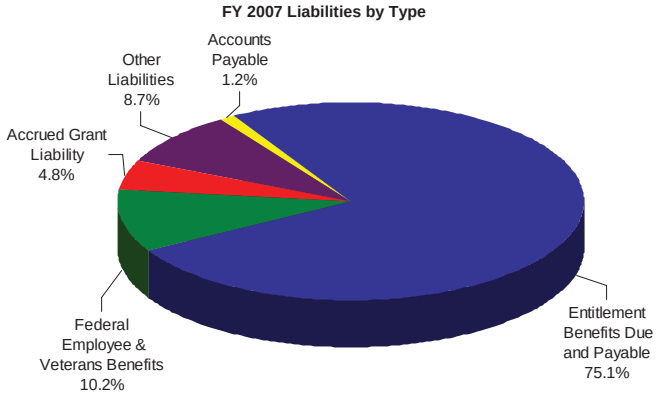
Assets – What Do We Own and Manage?

Assets represent the amounts that we own or manage. Our assets were $503.8 billion at the end of FY 2007. This represents a decrease of $10.1 billion (-2.0 %) below the prior year's assets. This decrease is largely attributable to the net effect of a decrease of $45.1 billion in Fund Balance with Treasury and an increase of $23.9 billion in Net Investments. The Fund Balance with Treasury decrease of $45.1 billion resulted primarily from decreases of $19.9 billion in Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) and $30.1 billion in HHS appropriations. The Net Investments increase of $23.9 billion was largely related to growth in the Medicare trust funds for HI and SMI. Funds not currently needed to pay Medicare benefits and related expenses are held in separate trust funds and invested in U.S. Treasury securities.

Fund Balance with Treasury and Net Investments together comprise 95.4 percent of total assets. The remaining assets (4.6%) consist of Accounts Receivable, Cash and Other Monetary Assets, Inventory and Related Property, General Property, Plant, and Equipment, and Other Assets.

ASSETS (Dollars in Billions)	Restated FY 2003	FY 2004	FY 2005`	FY 2006	FY 2007	Increase (Decrease	% Change
Fund Balance with Treasury	$ 86.3	$ 97.7	$ 99.6	$159.9	$114.8	$(45.1)	(28.2%)
Investments, Net	$282.4	$287.9	$300.7	$342.0	$365.9	$ 23.9	7.0%
Other Assets	$ 20.6	$ 18.2	$ 28.2	$ 12.0	$ 23.1	$ 11.1	92.5%
Total Assets	$389.3	$403.8	$428.5	$513.9	$503.8	$(10.1)	(2.0%)

Liabilities – What Do We Owe?



Our liabilities at the end of FY 2007, or amounts that we owe as a results of past transactions or events, were $81.9 billion. This represents an increase of $3.5 billion, or 4.5 percent above the prior year's liabilities. Entitlement benefits due and payable to the public from the Medicare and Medicaid insurance programs represent more than 75 percent of the liabilities. Of the $.3 billion increase in FY 2007 entitlements, $.8 billion was attributed to the Medicare program, $.2 billion was attributed to the Medicaid program, and ($.7) billion was attributed to other entitlement programs. Of the $.9 billion increase in Federal Employee and Veterans' Benefits, the majority relates to the Public Health Service Commissioned Corps Pension Liability, which is determined by an actuary under the Commissioned Corps' defined noncontributory benefit plan authorized under Public Law 78-410. The increase in Other Liabilities is attributed primarily to an increase in CMS' contingent liabilities. Contingent liabilities are accrued where a loss is determined to be probable and the amount can be estimated. It is important to note that no liability has been recognized on HHS' balance sheet (nor were costs included in the Statement of Net Cost) for future payments to be made to current and future program participants beyond the existing Incurred but Not Reported Medicare claim amounts as of September 30, 2007. This is because Medicare is accounted for as a social insurance program rather than a pension program, consistent with Federal accounting standards.

LIABILITIES (Dollars in Billions)	FY 2003 Restated	FY 2004	FY 2005	FY 2006	FY 2007	Increase (Decrease)	% Change
Accounts Payable	$ 1.2	$ 1.4	$ 1.1	$ 1.2	$ 1.0	$ (.2)	(16.7%)
Entitlement Benefits Due and Payable	$48.1	$49.2	$53.8	$61.2	$61.5	$ .3	.5%
Accrued Grant Liabilities	$ 3.8	$ 3.8	$ 3.8	$ 3.8	$ 3.9	$ .1	2.6%
Federal Employee & Veterans Benefits	$ 6.9	$ 7.2	$ 7.2	$ 7.5	$ 8.4	$ .9	12.0%
Other Liabilities	$ 3.2	$ 5.2	$ 5.1	$ 4.7	$ 7.1	$2.4	51.1%
Total Liabilities	$63.2	$66.8	$71.0	$78.4	$81.9	$3.5	4.5%

Ending Net Position – What Have We Done Over Time?

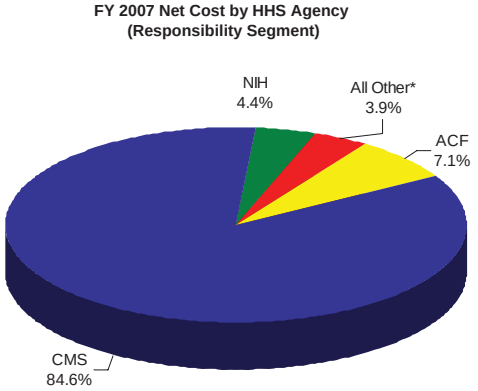
Our net position represents the difference between assets and liabilities. Changes to our net position are impacted by changes that occur within cumulative results of operations and unexpended appropriations. At the end of FY 2007, HHS'

Net Position shown on the Consolidated Balance Sheet and the Consolidated Statement of Changes in Net Position was $ 421.9 billion, a decrease of $ 13.6 billion (3.1 percent) from the previous year. This was due to the net effect of an increase of $29.2 billion in cumulative results of operations and a decrease of $42.8 billion in unexpended appropriations. Net Position is the sum of the cumulative results of operations since inception and unexpended appropriations, those appropriations provided to HHS that remain unused at the end of the fiscal year.

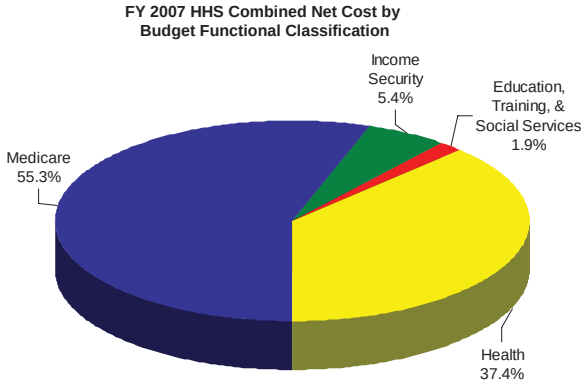
Net Cost of Operations – What Are Our Sources and Uses of Funds?

Our net cost of operations represents the difference between the costs incurred by our program less receipts. We receive the majority of funding through Congressional appropriations and reimbursement for the provision of goods or services to other Federal agencies. HHS net cost of operations during FY 2007 totalled $664.6 billion. This represents an increase of $40.7 billion, or 6.5 percent more than FY 2006 costs of $ 623.9 billion. The Medicare program accounted for the majority of the increase for FY 2007. HHS component gross cost for FY 2007 increased $41.4 billion over FY 2006 and exchange revenues increased $.7 billion, largely due to an increase in Medicare premiums collected from beneficiaries. The largest share of increase in gross costs is attributed to the Centers for Medicare & Medicaid Services, where costs increased $38.2 billion.

The following two charts depict HHS' net cost of operations by HHS component and by Major Budget Function.



* All Other includes AoA, AHRO, CDC, FDA, HRSA, IHS, OS, PSC, and SAMHSA



Budgetary Resources – What Were Our Resources and Status of Funds?

The Combined Statement of Budgetary Resources provides information on how budgetary resources were made available and their status at the end of the year. Total resources of $981.3 billion for FY 2007 were an increase of $28.5 billion over FY 2006, a 3.0 percent increase. FY 2007 obligations of $956.7 billion were $71.8 billion over FY 2006 obligations, a 8.1 percent increase. Resources at year end were $24.7 billion of which $7.3 billion was not available for expenditure. Total net outlays of $671.9 billion, cash disbursed for the Department's obligations, increased $57.2 billion (9.3 percent) over FY 2006 outlays. Outlays for Medicare (excluding Part D) and Medicaid combined were $19.9 billion more than in FY 2006 and outlays for all other HHS programs in FY 2007 were $37.3 billion more than the previous year. The greater difference was in "other" HHS programs, which includes Part D. Budgetary resources provided were 3.0 percent greater, obligations incurred increased 8.1 percent and outlays increased 9.3 percent.

Social Insurance

The Statement of Social Insurance is presented as a basic financial statement, in accordance with Statement of Federal Financial Accounting Standards No. 25, *Reclassification of Stewardship Responsibilities and Eliminating the Current Services Assessments*. This Statement presents the 75-year actuarial present value of the income and expenditures of the Hospital Insurance and Supplementary Medical Insurance trust funds. Future expenditures are expected to arise from the formulas specified in current law for current and future program participations. These projections are considered to be important information regarding the potential future cost of the Medicare program.

Medicare Trust Funds

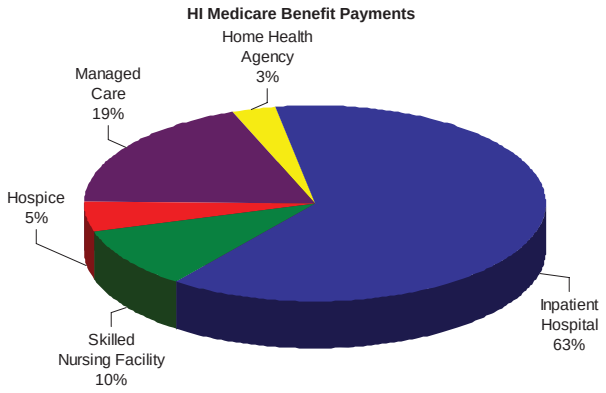
The Medicare program is by far the largest of all HHS programs. At the end of FY 2007, approximately $363.2 billion or 99.3 percent of HHS investments were in U.S. Treasury securities to support the Medicare trust funds. Established in 1965 as Title XVIII of the Social Security Act, Medicare was legislated as a complement to Social Security retirement, survivors, and disability benefits, and originally covered people age 65 and over. In 1972, the program was expanded to cover the disabled, people with end-stage renal disease requiring dialysis or kidney transplant, and people age 65 or older who elect Medicare coverage. Medicare is a combination of four programs: HI, SMI, Medicare Advantage, and Medicare Prescription Drug Benefit. Since 1966 Medicare enrollment has increased from 19 million to approximately 44 million beneficiaries.

In December 2003, the President signed the Medicare Prescription Drug, Improvement & Modernization Act to improve and modernize the Medicare program, including the addition of a drug benefit (Part D). The Medicare Prescription Drug program represents the largest change to the Medicare program since its enactment in 1965, and FY 2007 is the first year to reflect a full year of costs.

Hospital Insurance

Hospital Insurance or Medicare Part A usually is provided automatically to people age 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security or Railroad Retirement benefits. The program pays for in-patient hospital, skilled nursing home, home health, hospice care, and managed care and is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the Hospital Insurance trust fund, and invested in U.S. Treasury securities.

Based on estimates from the Mid-Session Review of the FY 2008 President's Budget, the majority of outlays relate to inpatient hospital spending (63%), managed care (19%), and skilled nursing facility (10%). During FY 2007, Hospital Insurance benefit outlays grew by 10.7 percent. The outlays are projected to increase by 8.5 percent to $4,610 per enrollee.



Source: CMS/OACT

Under the Trustees' intermediate set of assumptions, and as displayed in the Statement of Social Insurance, the Hospital Insurance trust fund will incur an actuarial deficit of nearly $12,292 billion ($12.3 trillion) over the 75-year projection period, as compared to $11,290 billion ($11.3 trillion) in the FY 2006 financial report. In order to bring the HI trust fund into actuarial balance over the next 75 years, very substantial increases in revenues and/or reductions to benefits would be required.

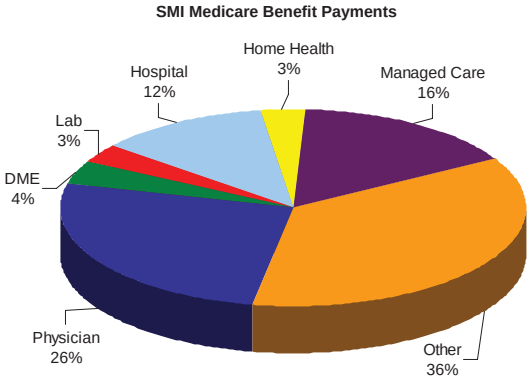
Supplementary Medical Insurance

Supplementary Medical Insurance, or Medicare Part B and Medicare Part D, is available to nearly all people age 65 and over, the disabled, and people with end-stage renal disease who are entitled to Part A benefits. The program pays for physician, outpatient hospital, home health, laboratory tests, durable medical equipment, designated therapy, Medicare prescription drug discount care enrollment fees, managed care, prescription drug expenses for Transitional Assistance beneficiaries, and other services not covered by Hospital Insurance. The coverage is optional and beneficiaries are subject to monthly premium payments. Approximately 94 percent of Hospital Insurance enrollees elect to enroll in Supplementary Medical Insurance.

The program is financed primarily by transfers from the general fund of the U.S. Treasury and by the monthly premiums. As with Part A, funds not needed to pay benefits and related expenses are held in the Supplementary Medical Insurance trust fund and invested in U.S. Treasury securities.

The chart below displays Supplementary Medical Insurance benefit outlays based upon the Mid-Session review of the FY 2008 President's Budget. Based on these estimates, the benefit outlays grew by 42.9 percent during FY 2007. During FY 2007, the benefit outlays per enrollee were projected to increase 41.3 percent to $5,560 per enrollee.

As reported in the Required Supplementary Information section of this report that income, including interest on U.S. securities, is very close to expenditures. Expenditures include benefit payments as well as administrative expenses. This is because Supplementary Medical Insurance funding differs fundamentally from Hospital Insurance. Parts B and D are not based on payroll taxes, but rather on a combination of monthly beneficiary premiums and income from the U.S. Treasury. Both are established annually to cover the following year's expenditures, thus B and D accounts are automatically in financial balance every year, regardless of future economic and other conditions.



Source: CMS/OACT

Under the Trustees' intermediate set of assumptions, and as displayed in the Statement of Social Insurance, the situation over the 75-year period is entirely different from Hospital Insurance projections due to the financing explained above. The projected future expenditures for Part B will be $18,221 billion ($18.2 trillion), or $0.6 trillion more than the FY 2006 projection. The projected future expenditures for Part D will be $10,766 billion ($10.8 trillion), or $.5 billion more than the FY 2006 projection. A substantial level of uncertainty surrounds these projections pending the availability

of sufficient data, especially on Part D expenditures, to help establish a trend baseline. Also, the reader must take into consideration that estimates have been made on the assumption that the trust fund will continue to operate without change in current law.

Limitations of the Principal Financial Statements

The principal financial statements in Section II of this report have been prepared to report the financial position and results of operations of HHS, pursuant to the requirements of 31 U.S.C. 3515 (b). While the statements have been prepared from the books and records of HHS in accordance with generally accepted accounting principles for Federal entities and the formats prescribed by the Office of Management and Budget, 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.

Systems, Legal Compliance, and Controls

The Department's overall goals for its financial management systems focus on ensuring effective internal controls, systems integration, and the ability to produce timely and reliable financial and performance data for reporting. One of management's immediate priorities is to address weaknesses that are identified in audits, evaluations, and assessments of its financial management controls, systems, and processes.

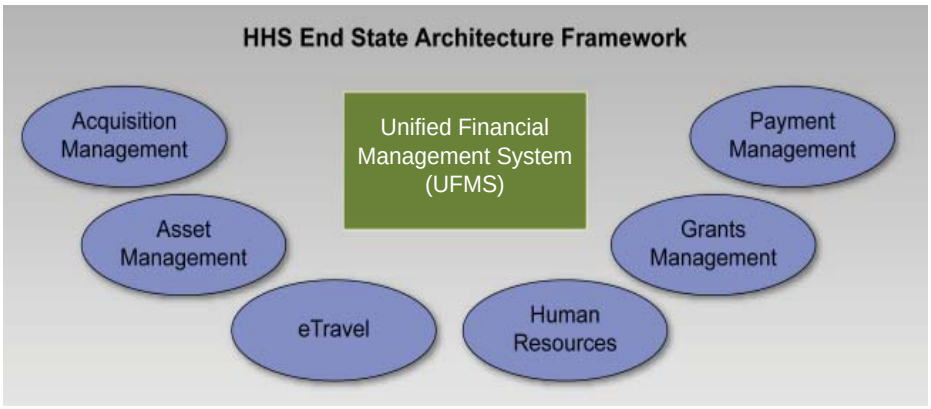
Systems

A cornerstone to improving our management practices is our ability to maintain management systems, processes, and controls that ensure financial accountability; provide useful management information; and meet requirements of Federal laws, regulations, and guidance. We seek to comply with a variety of Federal financial management systems requirements, including those articulated by the Federal Managers' Financial Integrity Act, the Chief Financial Officers Act, the Government Management Reform Act, the Federal Financial Management Improvement Act of 1996 ("Clinger-Cohen Act"), the Federal Information Security Management Act of 2002, and the Office of Management and Budget Circular A-127, *Financial Management Systems*. This section includes an overview of our current key systems and our implementation of a Unified Financial Management System.

System Goals and Strategies

Our financial system is a web-based, commercial, off-the-shelf product that serves as the foundation for integrated financial management across the Department. The system provides a unified approach for enhancing financial management performance by eliminating duplication, streamlining processes, and establishing a common information technology infrastructure across the enterprise.

A fully implemented financial system meets the standards for success in receiving a green status rating under the President's Management Agenda initiative "Improved Financial Performance." Once the Unified Financial Management System (UFMS) and related systems projects are fully implemented, our financial management systems framework will be as depicted below:



The financial system will replace five legacy accounting systems with one modern accounting system with three components: The Healthcare Integrated General Ledger Accounting System, National Institutes of Health Business System and UFMS Global. The Healthcare Integrated General Ledger Accounting System supports the Centers for Medicare and Medicaid Services and the Medicare contractors; National Institutes of Health Business System and UFMS Global will serve the rest of the Department, both hosted on a single platform with shared services around system administration and database administrative support. UFMS has successfully replaced three out of five legacy accounting systems through the end of FY 2007. The UFMS Global implementation was partially completed in FY 2007, with full implementation in the first quarter of FY 2008. The National Institutes of Health implementation was completed in June 2007. The Centers for Medicare & Medicaid Services implementation will be fully operational by 2011.

Statement of Auditing Standards (SAS) 70 Systems Reviews

Independent examinations of HHS internal controls are completed annually. The auditors' examinations for the Department's service providers for FY 2007 were completed under the guidelines of the American Institute of Certified Public Accountants Statement of Auditing Standards (SAS) Number 70, *Service Organizations*, as amended. The annual examination is a "Type 2" report providing an opinion on the internal controls placed in operation and includes tests of operating effectiveness. During FY 2007, SAS-70 examinations were performed for the Program Support Center's Payment Management System, Enterprise Support Services, and the National Institutes of Health Information Technology service organizations for periods from October 1, 2006 to June 30, 2007. In the examiner's opinion, the controls that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during that period, with the exception of logical and physical access controls noted by the examiners. The Department is in the process of developing and/or implementing plans and systems to address deficiencies identified in these examinations.

Legal Compliance

Anti-Deficiency Act

As discussed in our prior year report, the Department discovered violations of the Anti-Deficiency Act in a program managed by one of its operating divisions. These violations occurred over a period of several prior fiscal years and any amounts relating to these violations would not be material to any year's financial statements. The Department is continuing to investigate and is committed to appropriately resolving these matters and complying with all aspects of the Anti-Deficiency Act.

Controls

Department-wide Assurance Statement

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

As required by Office of Management and Budget Circular A-123, *Management's Responsibility for Internal Control*, HHS has evaluated its internal controls and financial management systems to determine whether these objectives are being met. Accordingly, HHS provides a qualified statement of reasonable assurance that its internal controls and financial systems meet the objectives of FMFIA. This statement is qualified due to the following two material weaknesses (noted in Table I) which also constitute non-conformances under Section 4 of FMFIA:

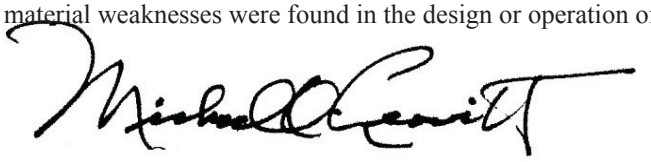
1. Financial Systems and Processes
2. Oversight and Management of Information System Controls

Assurance for Internal Control over Operations and Compliance

HHS conducted its assessment of internal control over the effectiveness and efficiency of operations and compliance with applicable laws and regulations in accordance with Office of Management and Budget Circular A-123, *Management's Responsibility for Internal Control*. Based on the results of this evaluation, HHS identified one material weakness in its internal control over the effectiveness and efficiency of operations under Section 2 of FMFIA relating to the oversight and management of the Department's information system controls, which also constitutes a non-conformance under Section 4 of FMFIA as of September 30, 2007. Other than the exception noted above and described in Table I, the Department provides reasonable assurance that internal controls over operations and compliance with applicable laws and regulations as of September 30, 2007, were operating effectively and no other material weaknesses were found in the design or operation of these internal controls.

Assurance for Internal Control over Financial Reporting

HHS conducted its assessment of the effectiveness of internal control over financial reporting, which includes safeguarding of assets and compliance with applicable laws and regulations, in accordance with the requirements of Appendix A of Office of Management and Budget Circular A-123, *Management's Responsibility for Internal Control*. Based on the results of this assessment, HHS identified one material weakness in its internal control over financial reporting as of June 30, 2007, relating to the Department's financial systems and processes, which also constitutes a non-conformance under Section 4 of FMFIA. Other than the exception noted above and described in Table I, the internal controls over financial reporting as of June 30, 2007, were operating effectively and no other material weaknesses were found in the design or operation of the internal control over financial reporting.



Michael O. Leavitt
NOV 15 2007

Table I

Summary of Material Weaknesses and Systems Non-conformance

	FMFIA Section 2			FMFIA Section 4
Control Area	**Operations (As of 9/30/2007)**	**Compliance (As of 9/30/2007)**	**Financial Reporting (As of 6/30/2007)**	**Non-Conformance**
Financial Systems and Processes	–	–	**X**	**X**
Oversight and Management of Information System Controls	**X**	–	–	**X**

Financial Systems and Processes

HHS' financial management systems are not in substantial compliance with the requirements of the Federal Financial Management Improvement Act (FFMIA) of 1996 because they do not fully comply with the Federal financial management systems requirements of Office of Management and Budget Circular A-127, *Financial Management Systems*, and the United States Government Standard General Ledger at the transaction level.

As in prior years, HHS continues to have internal control weaknesses in its financial management systems and processes for producing financial statements. While significant progress has been made in FY 2007, continuing our phased deployment of FFMIA compliant systems throughout the Department, the lack of completion of the fully integrated financial management system, and weaknesses in internal controls make it difficult for HHS to prepare timely and reliable financial statements. Substantial manual reporting processes, continuing adjustments to reported balances, and processes performed outside the general ledger system are needed to produce the financial statements.

Oversight and Management of Information System Controls

Weaknesses in the oversight and management of information system controls were detected in key financial management systems. The primary findings included access controls, which can compromise the integrity of Department data and increase the risk that the Department's data may be inappropriately used or disclosed. The pervasive nature of these and other findings leads management to conclude that the findings warrant classification as a material weakness. In addition, the financial management systems are not currently in conformance with legal and regulatory guidelines as established by the appropriate governing bodies.

Table II
Corrective Action Plan and Impact of Material Weakness

The following table lists the corrective actions for the control weaknesses, the related corrective action dates, and the impact of the material weakness on the Financial Statements.

Material Weakness and Corrective Action Plan	Corrective Action Date	Impact of Material Weakness on Financial Statements
(1) Financial Systems and Processes	FY 2009	Through significant manual effort and controls, the risk of misstating the Financial Statements is mitigated.
(2) Oversight and Management of Information System Controls	FY 2009	Sufficient compensating controls exist through manual efforts that the risk of misstating the Financial Statements is mitigated.

Other Management Information and Initiatives

Grants Management

Our main line of business is the provision of assistance funds to be used for the improvement of health and human services for the citizens of this Nation and other nations around the world. Increasingly, successful attainment of our mission is linked to global issues and communities. We continue to be the largest assistance awarding agency in the Federal Government. Added to this distinction is the fact that our partners may be the widest spectrum of Federal assistance recipient types, including millions of individuals; American Indian, Alaska Native, and Native American governments; State governments and various sub-agencies; local governments and various sub-agencies; major research and training universities and colleges; a vast array of highly performing nonprofit organizations; and a growing number of research and service-oriented hospitals. We utilize payments, grant instruments of varying complexity, and a corresponding range of cooperative agreements to provide needed funding to recipients.

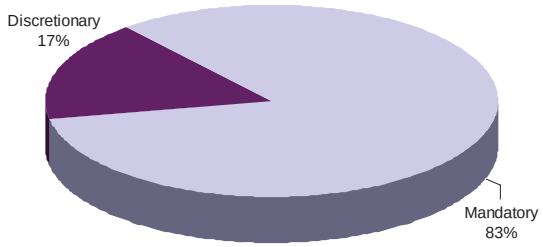
Over the last year, we have significantly enhanced our Office of Grants policy and system modernization capabilities in order to provide a firm foundation for future growth and expansion of our main line of business. Supporting these efforts are several major system modernization efforts, including the maintenance and improvement of the Tracking Accountability in Government Grants System, a comprehensive Department-wide data base with full search capabilities for all awards, including grants, cooperative agreements, and contracts. This data base also provides access to current policies, regulations, and other pertinent grants-related information at www.taggs.hhs.gov. We continue to serve as the managing partner for www.grants.gov, which is a unified, citizen-centric website designed to make information accessible in a single location to simplify the grants application process.

The coupling of grants policy with system modernization may best exemplified in the new *Forecast of HHS Grant Opportunities* tool now under development by the Office of Grants. This will be released for public use during fall 2007 to enable all applicants to identify upcoming assistance funding opportunities well in advance of their posting to www.Grants.gov, which is the Federal Government's central storehouse for information on over 1,000 grant programs and access to approximately $400 billion in annual awards. We are committed to providing applicants with the maximum time available to prepare for making application for its awards. Although some forecasted programs may not be funded, at least applicants can identify a group of potential interest and be prepared to pursue those as they are posted for formal application.

We manage an assortment of grant programs in basic and applied science, public health, income support, child development, and health and social services. Through these programs, we awarded nearly 75,600 grants totaling more than $228 billion in FY 2006. These programs are our primary means to achieving our strategic goals.

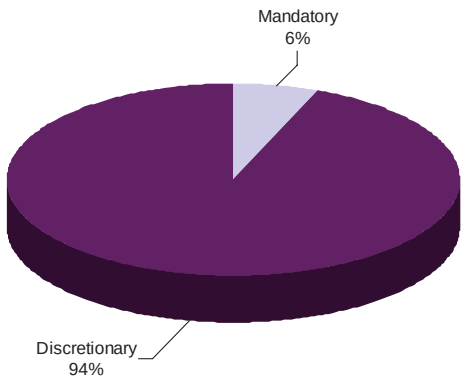
We manage two types of grants: mandatory and discretionary. Mandatory programs are those that a Federal agency is required by statute to award if the eligible recipient submits an application that meets the program requirements. Discretionary grants permit the Federal Government, according to specific legislation, to exercise judgment in selecting the project or proposal to be supported and selecting the recipient organization. The Federal agency may use discretionary funds for both unsolicited proposals and those announced opportunities that require a competitive process.

Proportion of Mandatory vs. Discretionary Grant Dollars for Fiscal Year 2006



As is the case with prior years, most of our grants awards were discretionary (94 percent of total grant volume awarded), yet most dollars associated with Departmental grants were mandatory (83 percent of total dollars awarded).

Proportion of Mandatory vs. Discretionary Grant Volume for Fiscal Year 2006



The National Institutes of Health awards the majority (71 percent) of our total discretionary awards, but only 9 percent of total grant dollars, indicating a low dollar per grant ratio. The Administration for Children and Families awards the greatest number of mandatory awards, while the Centers for Medicare & Medicaid Services award the majority of mandatory dollars (64 percent) through a small number of awards, indicating a high dollar per grant ratio. The percentages of our component total grant dollars and volume essentially have remained the same since FY 2001.

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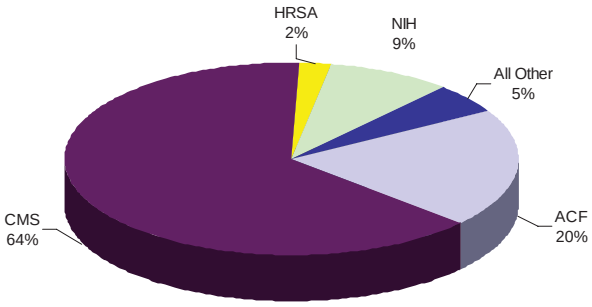
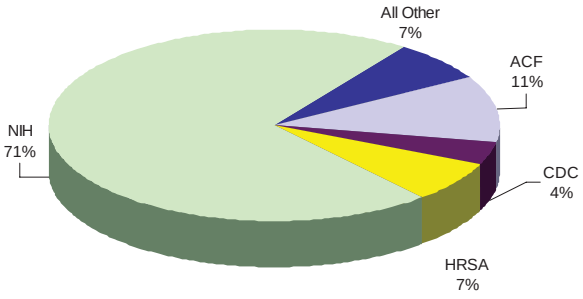
Average Component Proportion of Total Grant Dollars Fiscal Year 2006



Average Component Proportion of Total Grant Volume Fiscal Year 2006



Looking Ahead to 2008—Department Management Challenges and High-Risk Areas

The breadth of essential human services the Department delivers to fulfill the President's vision of a healthier, safer, and more hopeful America create a number of management challenges. To ensure good stewardship of the taxpayer's resources, the Department is committed to efforts to make improvements related to these challenges.

In recent years, HHS has made significant strides in improving the lives of Americans. This has been accomplished through the efforts of every HHS component. Breakthroughs in health information technology have accelerated the development and adoption of this promising resource. Medicare beneficiaries have greater access to their medications because of the Medicare prescription drug benefit. Medicaid modernization efforts have made the program more flexible and sustainable so that benefits can be tailored to needs. HHS deployed medical supplies and Federal Medical Shelters from the Strategic National Stockpile to help with mass casualty care needed after Hurricanes Katrina and Rita. The newly created Drug Safety Oversight Board has provided independent recommendations related to drug safety to the Food and Drug Administration and shared information with health care professionals and patients. The HHS Compassion Capital Fund has strengthened the capacity of grassroots, faith-based, and community organizations to provide a wide range of social services. Advances in the understanding of basic human biology enabled sequencing of the human genome to be accomplished 2 years ahead of schedule.

While HHS has made great progress, it must continue its current efforts to sustain positive outcomes and augment them with new, innovative strategies to continue to improve the Nation's health and well-being. HHS efforts and progress in addressing these challenges are discussed in more detail in the Top Management Challenges portion of the Other Accompanying Information, Section III. Further information concerning the Department's efforts and actions to resolve OIG audit findings can be found in the FY 2007 Management's Report on Final Action contained in Section III.