AGENCY FINANCIAL REPORT

Fiscal Year 2007

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

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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:

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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

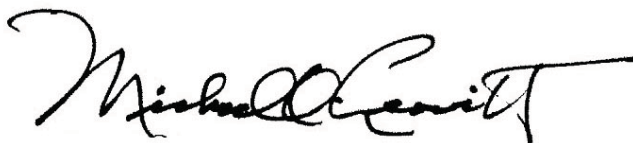
HHS has chosen to participate in the FY 2007 Office of Management and Budget's pilot approach to improving performance and accountability reporting. Pursuant to Office of Management and Budget Circular A-136, *Financial Reporting Requirements,* this *Agency Financial Report* represents the accountability 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

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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

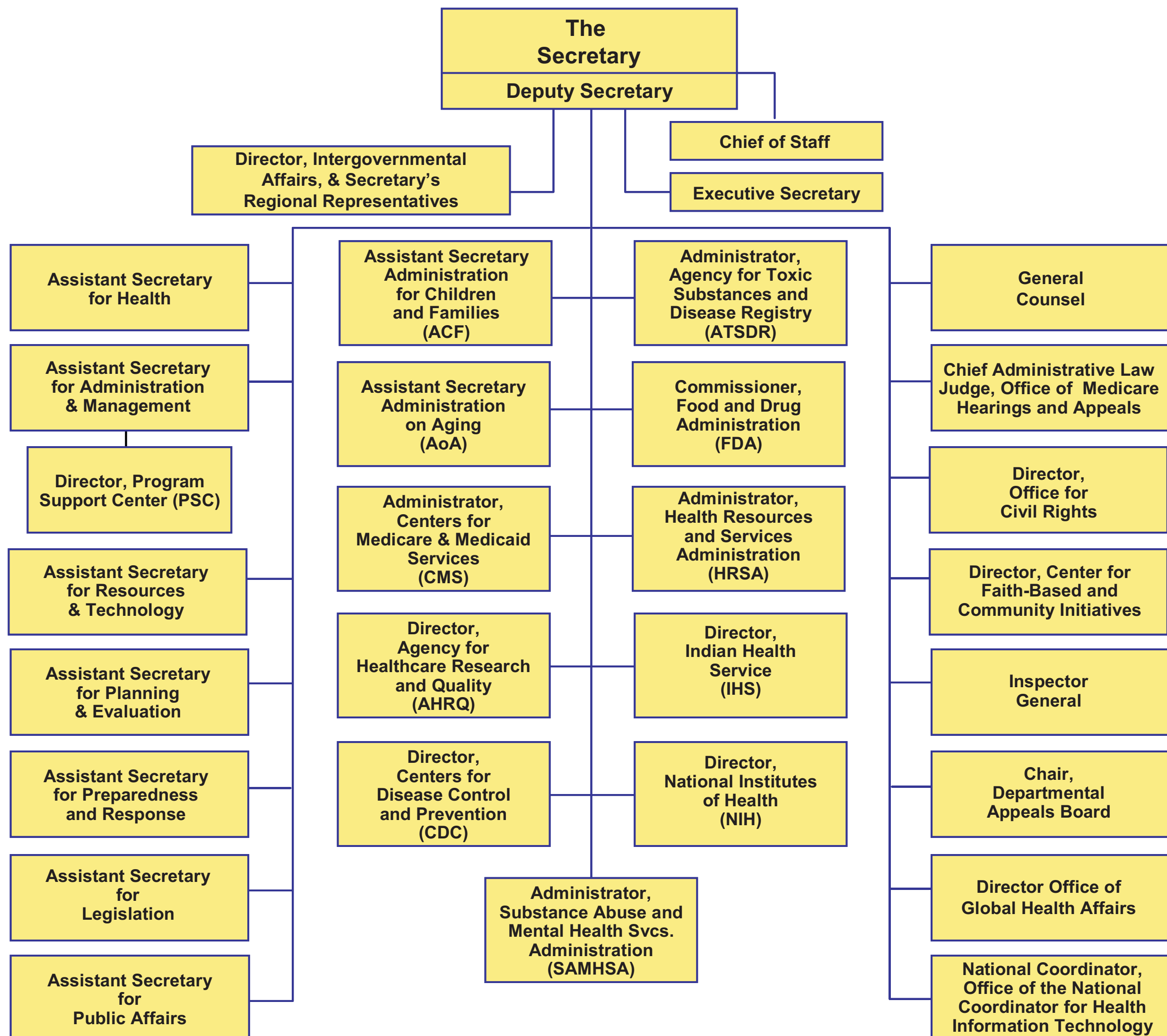
Mission

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.

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 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

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
Government wide	Competitive Sourcing	G	G	G	G
Government wide	Improved Financial Performance	R	G	R	G
Government wide	Expanded Electronic Government	R	Y	Y ↑	Y
Government wide	Performance Improvement (Renamed – Previously Budget-Performance Integration)	Y	G	R ↓	Y ↓
Program	Eliminating Improper Payments	R	G	Y ↑	G
Program	Faith-Based and Community Initiative	G	G	G	Y ↓
Program	Real Property Asset Management	Y	G	Y	G
Program	Health Information Quality & Transparency (New Initiative)	N/A	N/A	R	G

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%

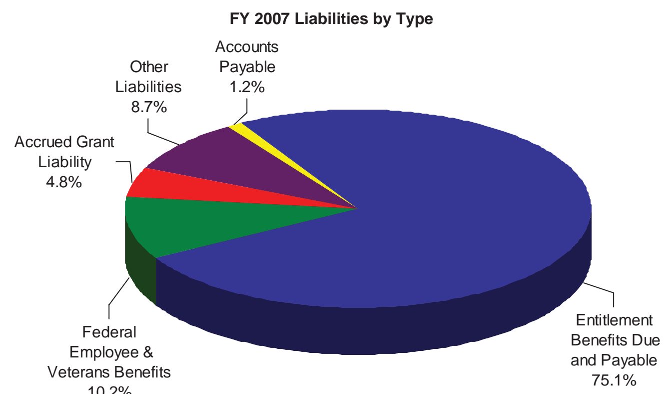
Assets – What Do We Own and Manage?

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?

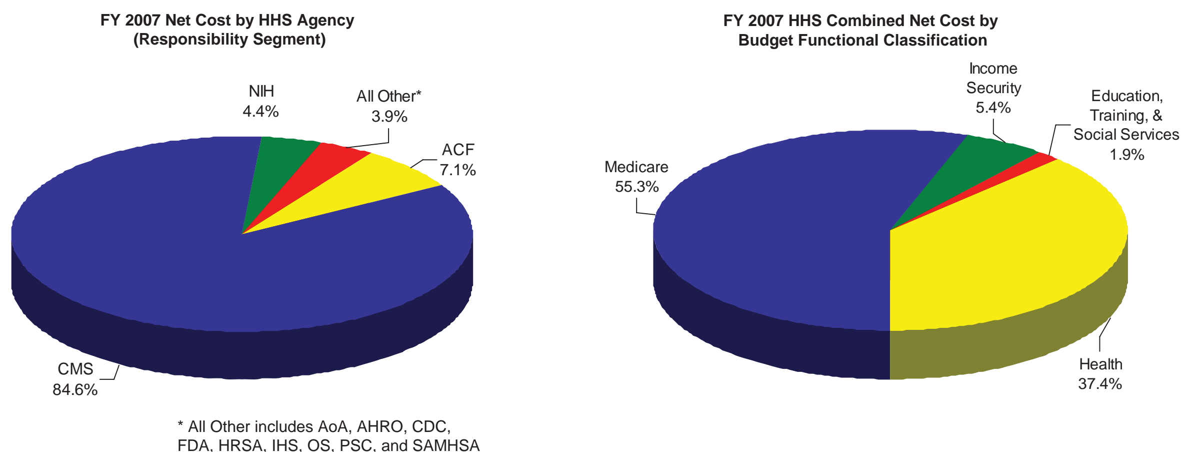
Our net position represents the difference between assets and liabilities. Changes to our net position are impacted by changes that occur within cumulative results of operations and unexpended appropriations. At the end of FY 2007, HHS'

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.



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.

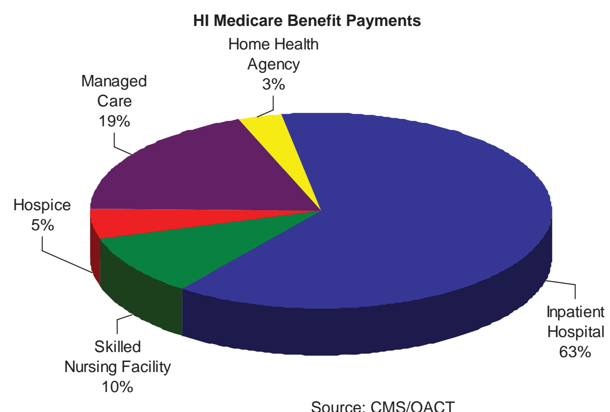
Medicare Trust Funds

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.

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.

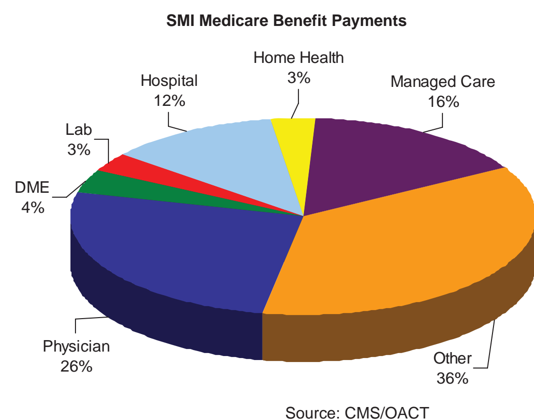
Supplementary Medical Insurance

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.



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.

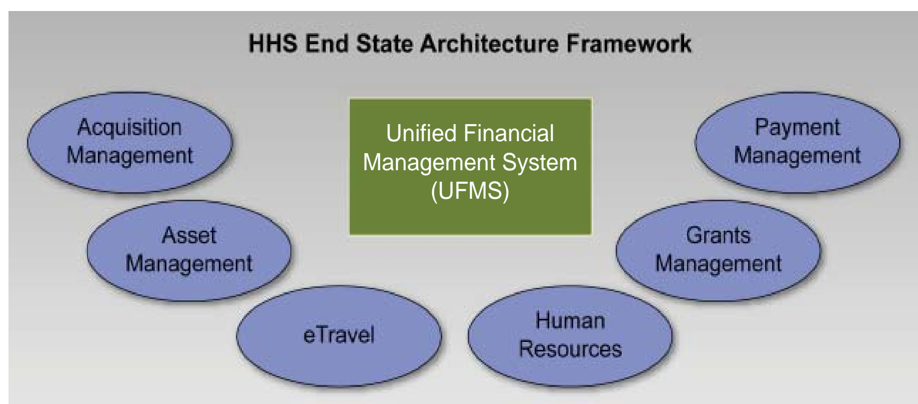
Systems

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:

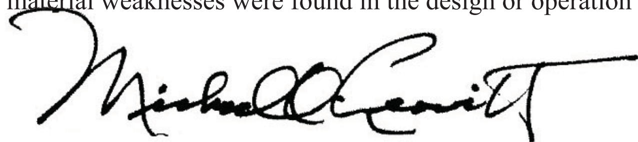
1. Financial Systems and Processes
2. Oversight and Management of Information System Controls

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.

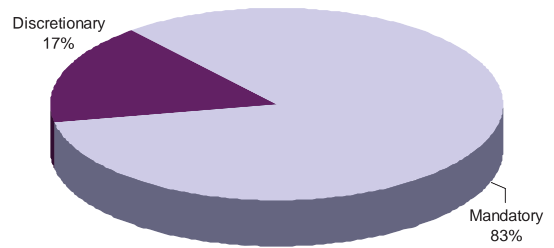
Over the last year, we have significantly enhanced our Office of Grants policy and system modernization capabilities in order to provide a firm foundation for future growth and expansion of our main line of business. Supporting these efforts are several major system modernization efforts, including the 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.

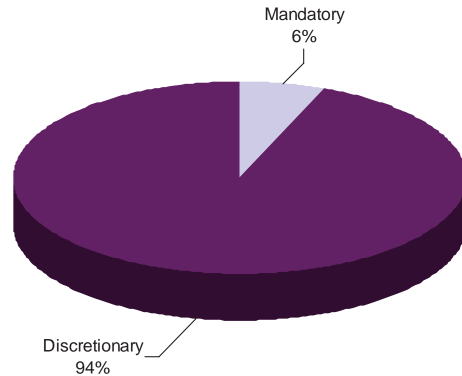
We manage two types of grants: mandatory and discretionary. Mandatory programs are those that a Federal agency is required by statute to award if the eligible recipient submits an application that meets the program requirements. Discretionary grants permit the Federal Government, according to specific 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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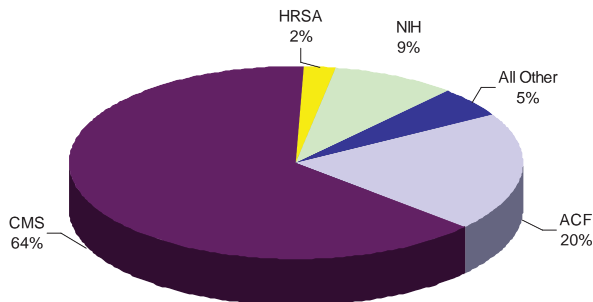
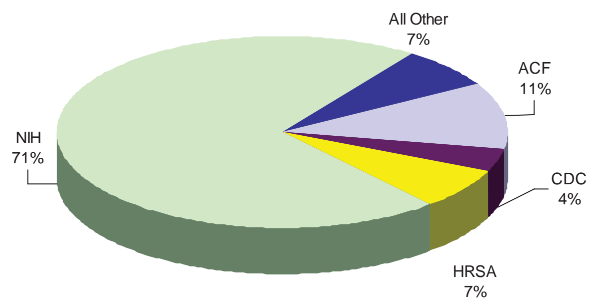
Average Component Proportion of Total Grant Dollars Fiscal Year 2006



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.

Section II: Financial

FY 2007 Agency Financial Report

Message From the Chief Financial Officer

Charles E. Johnson

As the Chief Financial Officer of the Department of Health and Human Services (HHS), I recognize that our Department is accountable to our ultimate stakeholders—the American Public. We are vigilant to use taxpayer resources wisely to carry out the Department's mission to enhance the health and well-being of Americans. With net outlays in excess of $650 billion in fiscal year (FY) 2007, we are one of the largest, most complex financial organizations in the world. Incorporating the tenets of the President's Management Agenda (PMA) into our daily routines is central to our continued success in accomplishing ambitious goals and delivering on the promise of the PMA.

This year, we have chosen to participate in the FY 2007 Office of Management and Budget's (OMB) pilot approach to improving performance and accountability reporting. Pursuant to OMB 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 to the Congress on February 4, 2008. As part of this pilot approach, we will also produce a "Highlights" document, which will be available 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.

This report also contains our audited annual financial statements. For the ninth year in a row, I am pleased to report that our independent auditors have issued an unqualified or "clean" opinion.

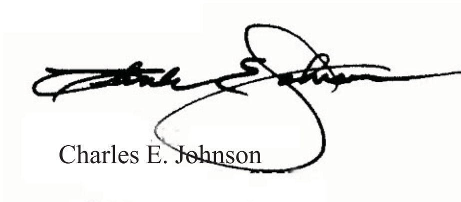
During FY 2007, the Department successfully sustained its standards for reporting and management controls. We have improved our reporting processes and successfully performed our second internal control assessment as required by OMB Circular A-123, *Management's Responsibility for Internal Control*. The Secretary's annual Statement of Assurance reflecting the results of our assessment is presented in Section I of this report.

With respect to our financial reporting capabilities, the Department successfully executed the next stage implementing our Unified Financial Management System (UFMS). In this phase of the system implementation, we now have all but one operating division reporting from UFMS. The last operating division was successfully converted to UFMS during the month of October 2007, and we will be completing our efforts with the implementation of the consolidated reporting solution at the end of fiscal year 2008. Key to this year's accomplishment was the full deployment of Federally mandated Treasury Reporting.

The independent auditors' report identifies material weaknesses that must be corrected relating to: (1) financial reporting systems and processes, (2) budgetary accounting, (3) financial management information systems, and (4) Medicare claims processing controls. The primary catalyst for addressing our financial reporting systems and processes, and budgetary accounting deficiencies is the full implementation of UFMS, most of which has been completed. We still have significant financial reporting and budgetary accounting process improvements necessary to resolve the noted weaknesses.

In addition, Financial Management Information System and Medicare claims process weaknesses were identified as material weaknesses relating to electronic data processing vulnerabilities identified in the Department and contractors. In addition to implementing UFMS, the Department continues a program to implement FFMIA-compliant systems at Medicare contractors by 2010. The Department recognizes the importance of effective internal control and is committed to resolving these material weaknesses promptly.

Finally, I want to thank our employees and partners – who work each day to achieve our Nation's noblest human aspirations for safety, compassion, and trust. This report -- and the accomplishments it describes -- is a reflection of their extraordinary dedication to our mission. Together we look forward to tackling our ambitious agenda for the future in 2008.



Charles E. Johnson

NOV 15 2007

Audit Reports

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Office of Inspector General Transmittal

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

NOV 14 2007

TO: The Secretary

Through: DS ________

COS ________

ES ________

FROM: Inspector General

SUBJECT: Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2007 (A-17-07-00001)

This memorandum transmits the independent auditors' reports on the Department of Health and Human Services (HHS) fiscal year (FY) 2007 financial statements, conclusions about the effectiveness of internal controls, and compliance with laws and regulations. The Chief Financial Officers Act of 1990 (Public Law 101-576), as amended, requires the Office of Inspector General (OIG) or an independent external auditor, as determined by OIG, to audit the HHS financial statements in accordance with applicable standards.

We contracted with the independent certified public accounting firm of PricewaterhouseCoopers, LLP (PwC), to audit the HHS consolidated balance sheet as of September 30, 2007, and the related consolidated statements of net cost and changes in net position, the combined statement of budgetary resources for the year then ended, and the statement of social insurance as of January 1, 2007. The contract required that the audit be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in the "Government Auditing Standards," issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 07-04, Audit Requirements for Federal Financial Statements.

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Results of Independent Audit

Based on its audit, PwC found that the FY 2007 HHS financial statements were fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America. However, PwC noted four matters involving internal controls over financial reporting that were considered to be material weaknesses under standards established by the American Institute of Certified Public Accountants:

- *Financial Reporting Systems and Processes.* HHS continued to have serious internal control weaknesses in its financial management systems and reporting processes. Substantial manual procedures, numerous adjusting entries, and untimely and incomplete reconciliations and accrual processes hindered its ability to produce timely and reliable financial statements. HHS's financial management systems did not substantially comply with Federal financial management systems requirements or the U.S. Government Standard General Ledger at the transaction level.

- *Budgetary Accounting.* HHS lacked sufficient controls over its accounting and business processes to ensure that budgetary transactions were properly recorded, monitored, and reported. Management routinely used high-level analysis to develop adjustments and to derive budgetary balances for financial reporting purposes. Improved procedures are needed to ensure accurate reporting of the status of budgetary resources.

- *Financial Management Information Systems.* General control issues in both the design and the operation of key controls were noted. Of particular concern was the lack of pervasive information technology security standards for areas such as security settings on platforms, policies regarding the control and use of passwords, and policies regarding control over changes to applications.

- *Medicare Claim-Processing Controls.* Although improvements were made, HHS continued to have weaknesses in the Centers for Medicare & Medicaid Services (CMS) Medicare claim-processing controls. Concerns related primarily to direct update access to Medicare

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claim data, controls over edit settings in application systems, controls governing the use of supplemental software used to process claims, and lack of CMS oversight of contractor compliance with internal control requirements.

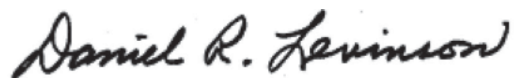
Evaluation and Monitoring of Audit Performance

In accordance with the requirements of OMB Bulletin 07-04, we reviewed PwC's audit of the HHS financial statements by:

- evaluating the independence, objectivity, and qualifications of the auditors and specialists;
- reviewing the approach and planning of the audit;
- attending key meetings with auditors and HHS officials;
- monitoring the progress of the audit;
- examining audit documentation related to the review of internal controls over financial reporting;
- reviewing the auditors' reports; and
- reviewing the HHS Management Discussion and Analysis, Financial Statements and Footnotes, and Supplementary Information.

PwC is responsible for the attached reports dated November 14, 2007, and the conclusions expressed in the reports. Our review, as differentiated from an audit in accordance with U.S. generally accepted government auditing standards, was not intended to enable us to express, and accordingly we do not express, an opinion on HHS's financial statements, the effectiveness of internal controls, whether HHS's financial management systems substantially complied with the Federal Financial Management Improvement Act, or compliance with laws and regulations. However, our monitoring review, as limited to the procedures listed above, disclosed no instances in which PwC did not comply, in all material respects, with U.S. generally accepted government auditing standards.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Joseph E. Vengrin, Deputy Inspector General for Audit Services, at (202) 619-3155 or through e-mail at Joseph.Vengrin@oig.hhs.gov. Please refer to report number A-17-07-00001.



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Attachment

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Report of Independent Auditors

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Report of Independent Auditors

To the Secretary of the Department of Health of Human Services and the Inspector General of the Department of Health and Human Services

We have audited the accompanying consolidated balance sheets of the Department of Health and Human Services (HHS) as of September 30, 2007 and 2006, and the related consolidated statements of net cost and changes in net position, and the combined statements of budgetary resources for the years then ended, and the statements of social insurance as of January 1, 2007 and 2006. These financial statements are the responsibility of HHS's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin No. 07-04, *Audit Requirements for Federal Financial Statements*. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above, present fairly, in all material respects, the financial position of HHS as of September 30, 2007 and 2006, and its net cost of operations, changes in net position and budgetary resources for the years then ended, and its social insurance program as of January 1, 2007 and 2006, in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 1 to the financial statements, the Office of Management and Budget has exempted HHS from certain requirements of OMB Circular No. A-11, *Preparation, Submission and Execution of the Budget*. Specifically, for the Medicare program, HHS is exempted from reporting refunds of prior year obligations separately from refunds of current year obligations on the SF-133. OMB has mandated that HHS report all Medicare cash collections as an offsetting receipt.

As discussed in Note 27 to the financial statements, the statements of social insurance present the actuarial present value of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust

funds' estimated future income to be received from or on behalf of the participants and estimated future expenditures to be paid to or on behalf of participants during a projection period sufficient to illustrate long-term sustainability of the social insurance program. In preparing the statements of social insurance, management considers and selects assumptions and data that it believes provide a reasonable basis for the assertions in the statements. However, because of the large number of factors that affect the statement of social insurance and the fact that future events and circumstances cannot be known with certainty, there will be differences between the estimates in the statement of social insurance and the actual results, and those differences may be material. In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, the SMI Part D projections have an added uncertainty in that they were prepared using very little program data upon which to base the estimates.

As discussed in Note 28 to the financial statements, the projected SMI Part B expenditure growth reflected in the statement of social insurance as of January 1, 2007 (the "2007 SOSI") is likely understated due to the structure of physician payment updates, which under current law would result in multiple years of significant reductions in physician payments, totalling an estimated 41 percent over the next nine years. Since these reductions are required in the future under the current-law payment system, they are reflected in the 2007 SOSI as required under generally accepted accounting principles. However, in practice it is not possible to anticipate what actions Congress might take, either in the near or long term, to alter the physician payment updates. For example, Congress has overridden scheduled reductions in physician payments for each of the last five years. The potential magnitude of the understatement of Part B expenditures, due to the physician payment updates can differ materially from the amount presented in the 2007 SOSI. In Note 28, management has illustrated the potential effects using two hypothetical examples of changes to current law. Under current law and as presented in the 2007 SOSI, the projected 75-year present value of future Part B expenditures is $18.2 trillion. In management's hypothetical examples, if Congress were to set future physician payment updates at zero percent per year, then, absent other provisions to offset these costs, the projected present value would increase to $22.6 trillion. Alternatively, if Congress were to set future physician payment updates equal to the Medicare Economic Index (projected to be 2 to 2.5 percent per year), the present value would be $25.4 trillion. Management's hypothetical examples have not been audited, and accordingly, we express no opinion on them.

The Management's Discussion and Analysis (MD&A), Required Supplementary Stewardship Information (RSSI) and Required Supplementary Information (RSI) are not a required part of the financial statements but are supplementary information required by the Federal Accounting Standards Advisory Board and OMB Circular A-136, *Financial Reporting Requirements.* We have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the MD&A, RSSI and RSI. However, we did not audit the information and express no opinion on it.

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Our audits were conducted for the purpose of forming an opinion on the consolidated and combined financial statements of HHS taken as a whole. The additional information presented on the statements of social insurance as of January 1, 2007 and 2006, is presented for purposes of additional analysis and is not a required part of the consolidated or combined financial statements. Such information has been subjected to the auditing procedures applied in the audit of the consolidated and combined financial statements and, in our opinion, is fairly stated in all material respects in relation to the consolidated and combined financial statements taken as a whole.

The other accompanying information is presented for purposes of additional analysis and is not a required part of the financial statements. Such information has not been subjected to the auditing procedures applied in the audit of the consolidated and combined financial statements and, accordingly, we express no opinion on it.

In accordance with *Government Auditing Standards,* we have also issued reports dated November 14, 2007 on our consideration of HHS's internal control and a report dated November 14, 2007on its compliance and other matters for the year ended September 30, 2007. The purpose of those reports is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. Those reports are integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audits.

PricewaterhouseCoopers LLP

November 14, 2007

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Report on Internal Control

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Report of Independent Auditors on Internal Control

To the Secretary of the Department of Health and Human Services and the Inspector General of the Department of Health and Human Services

We have audited the financial statements of the Department of Health and Human Services (HHS) as of and for the year ended September 30, 2007 and the statement of social insurance for the year ended January 1, 2007, and have issued our report dated November 14, 2007. We conducted our audit in accordance with auditing standards generally accepted in the United States of America, the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States, and Office of Management and Budget (OMB) Bulletin No. 07-04, *Audit Requirements for Federal Financial Statements.* The management of HHS is responsible for maintaining effective internal control over financial reporting.

In planning and performing our audit, we considered HHS's internal control over financial reporting by obtaining an understanding of the design effectiveness of HHS's internal control, determining whether these controls had been placed in operation, assessing control risk, and performing tests of HHS's controls in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide an opinion on the internal controls. Accordingly, we do not express an opinion on the effectiveness of the HHS's internal control over financial reporting.

We limited our control testing to those controls necessary to achieve the following OMB control objectives that provide reasonable, but not absolute assurance, that: (1) transactions are properly recorded, processed, and summarized to permit the preparation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and assets are safeguarded against loss from unauthorized acquisition, use, or disposition; (2) transactions are executed in compliance with laws governing the use of budget authority, government-wide policies and laws identified in Appendix E of OMB Bulletin No. 07-04, and other laws and regulations that could have a direct and material effect on the financial statements; and (3) transactions and other data that support reported performance measures are properly recorded, processed, and summarized to permit the preparation of performance information in accordance with criteria stated by management. We did not test all internal controls relevant to the operating objectives broadly defined by the Federal Managers' Financial Integrity Act of 1982.

A control deficiency exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect misstatements on a timely basis. A significant deficiency is a control deficiency, or combination of control deficiencies, that adversely affects HHS's ability to initiate, authorize, record, process, or report financial data reliably in accordance with generally accepted accounting principles such that there is more than a remote likelihood that a misstatement of HHS's financial statements that is more than inconsequential will not be prevented or detected by HHS's internal control.

A material weakness is a significant deficiency, or combination of significant deficiencies, that results in more than a remote likelihood that a material misstatement of the financial statements will not be prevented or detected by HHS's internal control. Our consideration of internal control was for the limited purpose described in the second paragraph of this report and would not necessarily identify all deficiencies in internal control that might be significant deficiencies or material weaknesses. We noted eight matters, discussed below, involving the internal control and its operation that we consider to be significant deficiencies (of which four are considered to be material weaknesses).

Material Weaknesses

I. Financial Reporting Systems and Processes

I.1 *Coordination and Communication*

HHS lacks a coordinated end-to-end process among cross-functional teams of financial management, information technology, actuarial and operations personnel to monitor business activities and identify those situations where accounting evaluation or decision-making may be necessary. The lack of coordination led to the following:

I.1.1 *Prescription Drug Program Accrual*

In FY 2006, HHS implemented the Part D Drug Program. The implementation of the new program created an enormous challenge for the agency, not only on the programmatic side but also for accounting challenges, that continues today. Management continues to identify and implement processes and controls to enable the agency to reflect the accounting impact of this complex and challenging program within their financial statements.

Throughout the plan contract year (calendar year), HHS makes prospective payments to the Part D plans. In general, the payment amounts are based on information in the approved plan bids, which includes the plans' estimate of direct and indirect remuneration, and on data provided by HHS that updates payments throughout the year.

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Subsequent to the contract year, HHS is required to reconcile the prospective Part D plan payments made during the year to actual drug costs incurred by the plans. Because the Part D program commenced operations in January 2006, the fiscal year ended September 2007 is the first year of the reconciliation. An accrual as of September 2007 was recorded on the books that included the contract year reconciliation (Calendar Year 2006) and estimated payable/receivables covering the fiscal year under audit.

In order to calculate the CY 2006 accruals, HHS developed a mechanism to obtain actual drug cost data from the plans, the Payment Reconciliation System (PRS), to automate the reconciliation process - including robust system documentation - and a SAS program to validate the calculation performed by the PRS system. The systems used to obtain actual drug data from the plans include edit checks that reject invalid data. In addition, management performs several outlier and analytical analyses to ensure the validity of the PRS results including analysis over the DIR amounts submitted by the plans.

The estimated accrual for the period of January 2007 to September 2007 was developed by actuarial analysis. HHS refined the methodology used during FY 2006 to better reflect the cyclical nature of the accrual, documented the methodology used to develop the estimate and retained appropriate evidence of the calculation.

The Part D reconciliation and accrual process, for all intended purposes, was a new process for HHS. This new process has not yet been fully developed and therefore; faced the following challenges during the current year.

- Validation of Actual Drug Costs and Direct and Indirect Remuneration (DIR)
  HHS does not currently have a monitoring control in place to ensure the accuracy of the prescription drug data (PDEs) submitted by the plans which forms the basis for the reconciliation. HHS relies on the plans to certify the accuracy of this data. Unsupported or erroneous drug cost data submitted by the plans could lead to inaccuracies within the reconciliation and erroneous payments.

  Similarly, HHS does not currently have monitoring controls in place to ensure the completeness and accuracy of the DIR information (commonly referred to as rebates). Management acknowledges the importance of complete and accurate DIR information due to the significant impact that it has on reimbursements to the plans.

- Timing of Estimate Development
  As of July 2007, HHS had not calculated the 2006 contract year reconciliation which would cover the period of January 2006 to December 2006, nor had HHS calculated the estimated accrual for the period of January 2007 to June 2007. The lack of timely calculation of the estimate resulted in inaccurate reporting within the interim financial statements.

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- Documentation of the Estimation Process
  HHS documented the procedures used to develop the 2006 Part D reconciliation within their Part D cycle memo; however, procedures and related controls to develop the FY 2007 Part D estimate, including the estimate related to invalidly rejected PDE data, was not documented within this memo. The calculation of the FY 2007 estimate was based upon an actuarial analysis. The methodology used by HHS to develop this estimate was significantly different from what was used during the prior fiscal year. In addition, as of September 2007, the methodology used by management to develop the estimate related to invalidly rejected PDE data and related controls had not been documented.

  Although all the elements of the estimate were eventually documented, all relevant controls have not yet been documented. According to OMB Circular A-123 *Implementation Guide* the level of detail of documentation should ensure management understands the entire financial reporting process and can identify how processes relate to financial reporting assertions, potential errors or misstatements, and control objectives.

I.1.2 *Obsolete Reports/Lack of Data*

With the Medicare Contractors transition to HIGLAS, HHS no longer requires the contractors to report certain data. This data which was collected in the Fiscal Intermediary Benefit Payment Report (IBPR) via the Contractor Administrative Budget and Finance Management (CAFM) systems is no longer available for those contractors who have implemented HIGLAS, which resulted in the following:

- Impact on the Statement of Social Insurance (SOSI):
  The IBPR provided data used by HHS to develop aspects of the SOSI projection. A total of six SOSI data sources and one validation source previously provided by the IBPR are no longer reported by contractors who have transitioned to HIGLAS. HHS was able to find suitable replacements for three of the data sources; however; it has not yet identified an appropriate source of data for the remaining three sources and for the validation source. Although the lack of data sources does not pose a significant risk to the current year SOSI calculation, because of the nature of the projection, the risk could increase on future projections.

- Entitlement Benefit Due and Payable Liability:
  The Entitlement Benefit Due and Payable Liability line item on the balance sheet is mainly composed of an estimate of claims incurred but not reported (IBNR). A key report used by HHS in the calculation of the IBNR liability is the National Claims History (NCH) processing report. Before this report is considered reliable and appropriate for use, management performs certain analytical procedures between the data in the report and data obtained from CMS-456 Intermediary Benefit Payment Report. However, since the CMS-456 report was produced from the CAFM system and is no longer submitted by those contractors that transition to HIGLAS, the appropriate NCH processing

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report validation procedures were not performed. In response to the issue, management has created a special HIGLAS query to generate the data previously reported by the CMS-456 report for the contractors under HIGLAS and is in the process of identifying an appropriate NCH processing report validation source.

I.2 ***Controls Over Trust Fund Draws***

In order to ensure amounts drawn from the HI and SMI trust funds are accurate and complete, management reconciles "cash" payment amounts recorded by HHS and the Department of the Treasury with the corresponding "incurred" claims amounts from Medicare claims data. However, this reconciliation is not performed at a level that allows management to detect errors timely.

The lack of a reconciliation at this level affected HHS's ability to identify that payments for hospice services were incorrectly being drawn from the Part B SMI trust fund. Because Hospice care is covered only under Part A of the Medicare program, these payments should have been drawn from the HI trust fund. The error led to an overstatement of benefit expenses attributed to the Part B Medicare program and an understatement of benefit expenses attributed to the Part A program. In addition, the error led to inaccuracies within the SOSI. These errors were corrected within the final financial statements.

I.3 ***Lack of Integrated Financial Management System***

Federal Agencies are required by law and OMB regulations to establish, "single integrated financial management systems" to be used to manage financial operations. As a result of implementing an integrated financial management system, agencies should be able to prepare timely and reliable financial reports, including financial statements. The completeness and accuracy of the financial statements are dependent on an integrated system which provides sufficient structure, effective internal controls and reliable data. HHS relies on decentralized processes and complex systems to accumulate data for financial reporting. In addition to an integrated financial system, a sufficient number of properly trained personnel and strong management oversight are needed to ensure periodic analyses and reconciliations are completed to detect and resolve errors and irregularities in a timely manner.

Within HHS, the newly implemented UFMS is designed to have three components, HIGLAS, the NIH Business System (NBS), and UFMS (Indian Health Services will implement UFMS in FY 2008). In addition, the consolidating reporting module is expected to be implemented in FY 2009. However, HHS's financial management systems, as currently configured, are not compliant with the Federal Financial Management Improvement Act of 1996 (FFMIA). FFMIA requires agencies to implement and maintain financial management systems that comply with Federal financial management systems requirements. More specifically, FFMIA requires Federal agencies to have an integrated financial management system that provides effective and efficient interrelationships between software, hardware, personnel, procedures, controls, and data contained within the systems, and compliance with the United States Standard General Ledger (USSGL) at the transaction level and applicable Federal accounting standards.

The lack of an integrated financial management system, non-compliance with the USSGL at the transaction level and weaknesses in internal controls and business processes impair HHS's ability to efficiently and effectively support and analyze accounts, as well as, prepare timely and reliable financial statements. HHS uses "work-arounds," cumbersome reconciliation and consolidation processes, and significant adjustments to produce the financial statements. The following matters illustrate the challenges presented by the existing systems:

- The majority of Medicare contractors currently rely on a combination of claims processing systems, personal computer based software applications and other ad hoc systems to tabulate, summarize and prepare information presented to HHS on the "750 – Statement of Financial Position Reports" and the "751 – Status of Accounts Receivable Reports". These reports are the primary basis for the accounts receivable amounts reported within the financial statements. Because both HHS and their contractors do not have a compliant financial management system, the preparation of the 750 and 751 reports and the review and monitoring of individual accounts receivable, are dependent on labor-intensive, manual processes that are subject to an increased risk of inconsistent, incomplete or inaccurate information being submitted to HHS. Likewise the reporting mechanism used by the HHS contractors to reconcile and report funds expended, the "1522 – Monthly Contractor Financial Report", is heavily dependent on inefficient, labor-intensive, manual processes, that are also subject to an increased risk of inconsistent, incomplete, or inaccurate information being submitted to HHS.

- HHS continues to experience significant challenges in resolving issues related to the UFMS conversion and implementation. This is evidenced by the following:

    - Despite the implementation of UFMS, HHS recorded more than 800 entries manually into the system during the year exceeding $170 billion. These entries were necessary to correct balances and accurately record transactions reported in UFMS.

    - During our testing, we noted transactions for current year activity that were inappropriately posting against opening balance accounts. These transactions were in excess of $1 billion which were not detected during the year through normal controls, but rather detected during the process of preparing the interim financial statements when it was noted that opening balances for the current financial statements were different from the ending balances of the prior financial statements.

    - HHS has not completed the development of management information reports from the UFMS system. Ad-hoc extracts from UFMS are used to support monthly reconciliations and the interim and year-end financial statements. HHS continues to use a cumbersome manual process to compile its financial statements.

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   - Management is unable to provide timely and complete transaction level extracts from UFMS to support general ledger balances including:
      - Undelivered Orders
      - Unfilled Customer Orders
      - Obligations
      - Offsetting Receipts
      - Reimbursable Revenue and Expenses
   - Systematic controls and front end edits have not been implemented to sufficiently mitigate the risk of Anti Deficiency Act (ADA) violations or a misstatement of financial management reports as evidenced by:
      - UFMS allows receiving transactions to be posted in excess of the corresponding obligation transactions.
      - UFMS allows the posting of grant expense accruals in excess of the funds available for grants.
      - UFMS allows the manual posting of entries which may not comply with the USSGL including inappropriate account combinations which omit the corresponding budgetary entries.

- The NBS had more than 2000 manual accounting entries for more than of $45 billion entered into the accounting system outside the automated transaction process. In addition, to prepare financial statements at year-end, 55 top-side adjustments totaling more than $85 billion were made. Processing these transactions was needed to ensure that the proprietary and budgetary accounts accurately reflected the current year activity. Additionally, the NBS does not provide for tracking manual or non-routine entries. As a result, adjustments and corrections cannot be readily identified. During our testing we noted that manual intervention is needed to assign appropriate transaction identifiers to ensure the correct classification within the financial statements.

- Systematic controls and front end edits have not been implemented to sufficiently mitigate the risk of Anti Deficiency Act (ADA) violations or a misstatement of financial management reports as evidenced by:
   - NBS does not have system edits to prevent the obligation of funds in excess of allowances, allotments, or appropriations.
   - NBS allows the manual posting of entries which may not comply with the USSGL including inappropriate account combinations which omit the corresponding budgetary entries.

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- The CORE accounting system is a data repository that was not designed to function as an accounting general ledger system. Accordingly, it does not capture all transactions properly and does not facilitate the preparation of timely financial statements. The accounting data in CORE must be downloaded and compiled to facilitate the preparation of adjusting entries. These entries are necessary to accurately reflect the current year activity and balances for financial reporting purposes. Approximately 30 miscellaneous journal vouchers were posted into CORE, each representing multiple accounting transactions with an aggregate value of $9 billion.

I.4 ***Financial Statement Preparation***

HHS compiles its financial statements through a multi-step process using a combination of manual and automated procedures. Responsibility segments must manually enter adjusted trial balances or statements into a separate system in order to generate consolidated financial statements and reports. Due to system limitations, HHS records numerous non-standard entries through journal vouchers as well as topside adjustments not entered into the general ledger systems and employs manually intensive procedures using Excel spreadsheets and database queries to prepare the financial statements. These processes increase the risk that errors may occur in the HHS financial statements. The following issues were identified during the financial statement preparation process:

- To prepare financial statements, information must be extracted from the general ledger systems and reviewed by an analyst to determine the following types of non-standard journal vouchers:
    - Correction of beginning balances that were incorrectly impacted by transactions during the year and for accounts that the system did not properly close or inadvertently dropped from the general ledger system.
    - Adjustment of balances to record the impact of reimbursable transactions that the system did not properly record during the year
    - Correction of the system trial balance for journal entries from the prior year that were not recorded in the system.
- During the testing of the supporting spreadsheets, calculations, and journal vouchers used to produce the financial statements we noted the following matters:
    - Calculation errors in the spreadsheet used to support the grant accrual.
    - Numerous journal vouchers for proprietary transaction did not contain the appropriate corresponding budgetary transaction as prescribed in the USSGL.
    - Journal vouchers posted to correct beginning balance errors were not recorded properly.

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- ° Manual keying errors where debits and credits were inversed and incorrect amounts were posted.
- ° Lack of standardized methodology that ensures the analysis used to determine adjustments includes the potential impact of subsequently performed adjustments.
- ° Procedures used to determine the reimbursable adjustments contained numerous deviations from the prescribed methodology resulting in multiple errors.

HHS does not have uniform policies and procedures for the preparation of the financial statements. This results in significant manual "work arounds" and delays in financial reporting. While the errors, unexplained differences, and unsupported entries noted were not material to the HHS financial statements taken as a whole, they serve to illustrate that errors are more likely to occur in an environment that necessitates a time-consuming, manually-intensive financial statement preparation process, as well as the need for additional strengthening of the HHS's financial statement preparation, review, and approval processes.

I.5 ***Incomplete and Untimely Completion of Reconciliations***

Since weaknesses currently exist in the financial management systems, management must compensate by implementing and strengthening mitigating controls to ensure that errors and irregularities are detected in a timely manner. A key compensating control is the monthly and quarterly reconciliations that are performed to ensure the balances in the general ledger system are accurate.

Our review of management's reconciliations disclosed a series of weaknesses that impact HHS's ability to report accurate financial information. We found that certain processes were not adequately performed to ensure that differences were properly identified, researched and resolved in a timely manner. The following issues were identified related to the reconciliation process:

- During the first half of the fiscal year, management did not perform key reconciliations due to an inability to obtain information from UFMS and the redirection of resources from these processes to allow for a successful conversion to UFMS. In addition, we noted other reconciliations were not completed within the timeframes established by Departmental policy.
- HHS policy and procedures do not provide thresholds that personnel are required to follow in determining whether a difference has to be investigated. This allows for individual staff to determine amounts that may be inconsistent with the design of these controls.
- The explanations of differences identified by management are incomplete and do not fully explain the business reasons for the outstanding items.

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- Reconciliations were incomplete with differences remaining unreconciled for more than 90 days. While individual items may appear to be immaterial to the Department no analysis is performed by management to determine the aggregate impact of all unreconciled items.

Recommendation

We recommend that management continue to develop and refine its financial reporting systems and processes. Specifically, HHS should:

- Establish appropriate policies, procedures and a protocol to address situations or transactions that require cross-functional involvement in order to ensure interim and year-end financial statements are accurate and complete. This includes policies and procedures to ensure changes to critical systems outputs are appropriately vetted with all users. The financial management function should serve as the primary coordinator to facilitate the input and involvement of the other cross-functional units whose involvement and input are important factors to consider in formulating accounting treatment and financial reporting implications.
- Continue to develop its policies and procedures related to the development, documentation, and validation of the Part D accrual process.
- Continue to implement an integrated financial management system for use by Medicare contractors and HHS to promote consistency and reliability in accounting and financial reporting.
- Management should develop appropriate reconciliation procedures between claims incurred to cash drawn from each of the trust funds that would enable the timely identification of potential errors in Medicare Trust Fund draws.
- Fully utilize the built in system functionality designed to perform complete transaction processing and financial reporting in compliance with Federal financial reporting requirements.
- Enhance the documentation related polices and procedures for the preparation of financial statements and ensure compliance through a monitoring process.
- Establish appropriate reconciliation policy and procedures which include the following:
    - Thresholds based on the type and purpose of the reconciliation to ensure differences are appropriately identified and researched.
    - Require the clearing of differences with ninety days of identification.
    - Require documentation to be completed which supports the explanation of the difference.

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II. Budgetary Accounting

HHS lacks sufficient controls over its accounting and business processes to ensure budgetary transactions are properly recorded, monitored and reported. Management routinely uses high level analysis to develop adjustments and derive balances for financial reporting purposes. Due to the lack of sufficient controls over the process, management has not mitigated the risk of a misstatement or potential violation of laws and regulations to an acceptable level. The following sections highlight the key issues that were identified with the budgetary process.

II.1 *Undelivered Orders (UDO)*

HHS does not have adequate controls in place to monitor undelivered orders which represent remaining amounts of obligated funds that have not been delivered nor appropriately deobligated. UDO oversight is the key to the status of budgetary resources is accurate.

Management was unable to provide evidence to demonstrate controls existed and operated effectively during the fiscal year. As a result we performed substantive test of details to quantify the potential misstatement due to the lack of controls. Our results revealed a projected error $1.1 billion in errors, including both over and understatements. The following types of errors were detected:

- Grants/Contracts which had expired periods were not closed and deobligated timely
- Obligations were recorded late or not recorded at all
- Deliveries were applied inaccurately to obligations which have been converted from prior systems as a lump sum and not at a document level
- Inaccurate and unsubstantiated postings to the general ledger

II.2 *Recoveries of Prior Year Obligations*

HHS does not have adequate controls in place to capture the recoveries of prior year obligations as required by federal accounting and reporting requirements, which require prior year recoveries to be recorded in a separate general ledger account and reported on the SF-133s and SBR. We noted inconsistent methodologies in use across the Department to derive the prior year recovery amounts.

During our testing we noted:

- One responsibility segment failed to report any recoveries on their financial statements.
- Nine responsibility segments must analyze transactions in other accounts to derive the balance.
- One responsibility segment currently has a waiver from OMB on reporting recoveries until the full implementation of their financial system is complete

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II.3 ***Recording of Obligations***

HHS does not have adequate controls to ensure its obligations are recorded appropriately. While the majority of HHS obligations are automatically posted through system interfaces, HHS lacks controls over its manually-processed obligations. During our testing of undelivered orders, we noted several obligating documents that were not recorded into the system. Additionally, we noted that management did not have a sufficient process in place to prevent or detect unrecorded obligations at year end.

Management performed an analysis of unrecorded obligations for all of HHS's operating divisions. Based on our review of this analysis the amount of unrecorded obligations at year end was not material to the fiscal year 2007 financial statements.

II.4 ***Budgetary Reimbursable Accounting***

Management manually analyzes revenues and expenses to derive the budgetary account balances for reimbursable activities. This process is prone to error. For year end reporting, HHS posted more than $2.5 billion in adjustments to the SBR to account for these activities. Our review of the journal vouchers and supporting documentation noted keying errors, incorrect application of the USSGL, and inconsistency in the calculations by HHS analysts which went undetected by management.

Recommendation

In order to remove the risks associated with the current budgetary reporting environment, HHS should:

- Implement department wide procedures requiring the periodic review of Undelivered Orders.
- Implement department wide policies and procedures requiring the recording of recoveries in accordance with federal accounting standards.
- Implement a commitment accounting function within the current general ledger system to allow automated reconciliation obligations.
- Implement the projects module of UFMS across the department to ensure obligations are recorded in a timely manner through automated processes.

III. Financial Management Information Systems

Many of the business processes that generate information for the financial statements are supported by HHS information systems. Adequate internal controls over these systems are essential to the confidentiality, integrity, and reliability of critical data while reducing the risk of errors, fraud, and other illegal acts. As part of our assessment of internal controls, we have conducted general control reviews for systems that are relevant to the financial reporting process. General controls involve the entity-wide

security programs, access controls (physical and logical), application development and program change controls, segregation of duties, operating systems software, and service continuity. General controls impact the integrity of all applications operating within a single data processing facility and are critical to ensure the reliability, confidentiality, and availability of financial information.

Our testing noted general controls issues in both the design and the operations of key controls. We noted weaknesses in the following review areas:

- Entity-wide security program,
- Access controls (physical and logical),
- Application development and program change controls, and
- Operating systems software, and
- Service continuity.

Of particular concern, we noted the lack of pervasive Information Technology (IT) security standards for areas such as IT security settings on platforms, policies regarding the control and use of passwords, and policies regarding the control over changes to applications whether they be developed in-house or purchased, for HHS at the department level. Our testing consistently noted that management of the various component entities within HHS either had developed their own IT security standards or simply stated that they do not follow HHS standards.

Because of the pervasive nature of general controls, the cumulative effect of these significant deficiencies represents a material weakness in the overall design and operation of internal controls. Detailed descriptions of control weaknesses may be found in SAS70 reports and the management letters issued on information technology general controls and audited applications. The following discusses the summary results by review area.

III.1 ***Entity-Wide Security Programs***

These programs are intended to ensure that security threats are identified, risks are assessed, control objectives are appropriately designed and formulated, relevant control techniques are developed and implemented, and managerial oversight is consistently applied to ensure the overall effectiveness of security measures. Security programs typically include formal policies on how and which sensitive duties should be separated to avoid conflicts of interest. Similarly, policies on background checks during the hiring process are usually stipulated. Entity-wide security programs afford management the opportunity to provide appropriate direction and oversight of the design, development, and operation of critical systems controls. Inadequacies in these programs can result in inadequate access controls and software

change controls affecting mission-critical, systems-based operations. Our procedures identified the following issues:

- **Information System Platform and Database Security Controls:** HHS lacks accepted and used standards for information system platform security settings that are consistent with NIST standards for securing information system platforms and databases.
- **Information System Platform and Database Security Control Monitoring:** HHS lacks processes to monitor security settings continuously to ensure they remain effective.
- **Security Plans:** Security plans for some of the systems have not been updated, finalized, approved, and communicated.
- **Certification & Accreditation:** Required certification and accreditation statements for some of the major financial applications and general support systems have expired or have not been reviewed or updated recently.
- **Security Training:** Relevant security and security awareness training was not provided to all employees and contractors.

III.2 ***Access controls (logical and physical)***

Access controls ensure that critical systems assets are physically safeguarded and that logical access to sensitive application, system utilities, and data is granted only when authorized and appropriate. Access controls over operating systems, network components, and communications software are also closely related. These controls help to ensure that only authorized users and computer processes can access sensitive data in an appropriate manner. Weaknesses in such controls can compromise the integrity of sensitive program data and increase the risk that such data may be inappropriately used and/or disclosed. Our procedures identified the following issues:

- **Access Authorizations**: For some of the systems, the approval of access requests was not, or was inadequately, documented.
- **Access Revalidations**: For some of the systems, the periodic revalidation of user accounts is either not performed or inadequately documented.
- **Password Controls**: The password controls applied to some of the systems do not provide an adequate level of authentication controls.
- **Access Assignments**: Access assignments were excessive for some systems and did not provide an adequate segregation of duties.
- **Access Removal**: For some of the systems, users' access was not terminated, upon termination of their role.

III.3 ***Systems software***

Systems software is a set of computer programs designed to operate and control the processing activities for a variety of applications on computer hardware and related equipment. The systems software helps coordinate the input, processing, output, and data storage associated with all of the applications that are processed on a specific system. Some systems software is designed to change data and programs without leaving an audit trail. Overall, problems in managing routine changes to systems software to ensure an appropriate implementation and related configuration controls were identified. Our procedures identified the following issues:

- **Configuration Controls**: Systems settings for selected databases and operating systems are not optimized to provide a secure computing environment.
- **Patch Management**: The controls over timely and consistent application of system patches are not effective for all of the systems.
- **Change Management**: Change management procedures were insufficient to ensure only properly authorized changes were implemented into some production systems.

III.4 ***Application software development and change controls***

A well defined and effectively controlled development and change management process should be in place to ensure that only authorized, tested, approved, and documented new programs, or changes to existing programs, are applied to the production environment. Additionally, the process facilitates that new or changed programs meet the requirements with regards to security and controls; such as providing for programmed integrity controls, audit trails, logging capabilities, etc. Our procedures, which included findings during our SAS70 Reviews of the Division of Financial Operations, the Centers for Information Technology, and the Human Resource Services operation, identified the following issues:

- **Change Controls**: For some applications, there is no formal and consistently applied change control process.
- **Change Management**: Evidence to support that change management procedures and processes were followed was not provided.
- **Access Controls**: Periodic reviews of user access permissions were not conducted and/or not documented. Procedures to approve access assignments and to control terminated and transferred employees were either non-existent or not followed.
- **Application Controls**: Error reports were not properly reviewed and used to correct issues noted and reconciliations of application data were not always performed.

- **Configuration Controls**: Password controls and system lockouts for incorrect password attempts were not sufficient to provide effective security. Platform security configuration settings were also insufficient to provide effective security.

III.5 ***Application Specific Concerns - General Ledger System***

As part of our assessment of internal controls, we have conducted application control reviews for systems that are relevant to the financial reporting process. Application controls involve access controls, data input controls, data processing controls and data output controls. Our testing noted application controls issues in both the design and the operations of key controls. We noted weaknesses in the following review areas:

III.5.1 Access Control

Procedures related to the conversion and entry of data through terminals should be established to deter unauthorized use. Key duties and responsibilities performed within the application should be adequately separated to reduce the risk of errors, waste, or wrongful acts.

- **Access Authorization:** For some users, access to key financial system was not appropriately granted.

- **Password Controls**: The password controls applied to some of key financial systems do not provide an adequate level of authentication controls.

- **Access Assignments**: Access assignments were excessive for some key financial systems and did not provide an adequate segregation of duties, with more than 600 possible segregation of duties issues identified in the G/L system. Assignment conflicts represent instances whereby accesses assigned may have allowed users to perform all phases of transactions without intervention by other users or approvers. For example, creation and approval of transactions from inception of the transaction to payment.

- **Access Removal**: For some of key financial systems, user's access was not terminated, upon termination of their role.

III.5.2 ***Data Input***

All authorized source documents should be complete and accurate, properly accounted for, and transmitted in a timely manner for input to the computer system. Input data should be validated and edited to provide reasonable assurance that erroneous data are detected before processing. Procedures should be established for the conversion and entry of data that ensure a separation of duties as well as routine verification of work performed in the input process. Formal procedures should be established

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for data processing to ensure that data is processed completely, accurately, and on time. We noted the following weaknesses:

- **System Interfaces:** For some key financial systems consistent policies and procedures do not exist over these interfaces to ensure that necessary inputs are processed, control logs are monitored and reviewed with issues adequately followed up, and errors held in rejection files during processing are resolved.

- **Configuration Controls**: Application settings are not optimized to provide a controlled processing environment. For example, edits were not properly configured to prevent erroneous input of data.

- **Data Processing Controls:** Procedures were not established for the entry of data to ensure a separation of duties as well as routine verification of work performed during processing. Errors identified during data processing should be promptly investigated, corrected, and resubmitted.

- **Audit Trails:** For some systems, it was not possible to identify the user or users who made modification to key system transactions and standing data. Further, audit trails were generated showing a count of transactions performed in each module by specific users.

III.5.3 ***Data Output***

Procedures should exist to report and control errors contained in output. Reports produced outside the normal production cycle (i.e. ad hoc reporting) should be adequately controlled. Output should be balanced to record counts and control totals, and audit trails should be available to facilitate tracing and reconciliation. We noted the following weaknesses:

- **Error Handling Activities**: Procedures do not exist that the Global Error Handler is monitored and that transactions held in error are reviewed and processed timely. Business owners indicated that documentation to evidence the review of transactions in the Global Error Handler was not maintained.

- **Key management reports**: Procedures do not exist to ensure that key management reports are reviewed and maintained

Recommendations

To provide a secure computing environment for critical applications throughout all the operating divisions, HHS should:

- Develop overall HHS platform configuration security standards for all operating platforms and databases, following the guidance issued by NIST, for all components.

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- Ensure the acceptance and implementation of the platform configuration security standards by all components.
- Develop and implement effective tools, policies and procedures to review platform security settings for all components, on a continuing basis.
- Develop an effective and documented patch management process for all critical systems to reduce systems vulnerabilities to a minimum.
- Enhance policies and procedures to ensure that system administrators perform periodic reviews of access authorizations for all applications and that a process exists for communicating terminated employees to administrators for their timely removal.
- Revalidate access rights on a periodic basis to limit systems access to the least privilege required to perform job responsibilities.
- Complete certification and accreditation activities, including the corresponding risk assessments, to limit the residual risk to an acceptable level.
- Maintain system security plans to provide security and controls commensurate with risk changes associated with systems.
- Train all employees and contractors on security awareness and responsibilities to effectively communicate security policies and expectations.
- Maintain effective program change controls processes for all applications to limit the risk of unauthorized changes to the production systems.

IV. Medicare Claims Processing Controls

Overview

HHS relies on extensive information systems operations at the Centers for Medicare and Medicaid Services Central Office (CMS Central Office) and Medicare contractor sites to administer the Medicare program and to process and account for Medicare expenditures. Internal controls over these operations are essential to ensure the integrity, confidentiality and reliability of the Medicare data and to reduce the risk of errors, fraud and other illegal acts. The internal control structure is inclusive of, but not limited to, automated controls. The internal control structure also includes monitoring controls over claims processing.

Our internal control testing for the audit covered both general and application controls. General controls involve organizational security plans, referred to as entity-wide security plans (EWSP), access controls

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(physical and logical), application software development and program change controls, segregation of duties, operating systems software for servers and mainframe platforms, and service continuity plans and testing. General controls provide the foundation to ensure the integrity of application systems, and combined with application level controls, are essential to ensure proper processing of transactions and integrity of stored data. Application controls include controls over input, processing of data, and output of data from HHS application systems.

Our audit included various general controls testing for nine contractors and site visits to six data centers supporting Medicare claims processing. We also reviewed application controls at the CMS Central Office and at Medicare contractors for systems integral to Medicare financial information including the Fiscal Intermediary Shared System (FISS), the Viable Information Processing Systems (VIPS) Medicare System (VMS), the Multi-Carrier System (MCS) and the Common Working File (CWF). At CMS Central Office we performed procedures over the Financial Accounting Control System (FACS), Health Plan Management System (HPMS), Medicare Advantage Prescription Drug System (MARx), Healthcare Integrated General Ledger Accounting System (HIGLAS), Medicaid Budget and Expenditure System (MBES), and Children Budget and Expenditure System (CBES).

We also conducted vulnerability reviews of network controls at six data center sites and the CMS Central Office. Further, desktop-based audit procedures were conducted to review the high level management controls regarding direct access to claims data, control over edits within the FISS, MCS and VMS systems, and controls over software supplementing the FISS, MCS and VMS systems used to process Medicare claims. We noted some improvements in each of these 3 areas, which were first identified in FY 2006 or earlier audits, but the progress of these improvements was not sufficient enough to address the concerns expressed below.

During FY 2004, management launched a program to evaluate the security levels of all contractors regarding their compliance with the Federal Information Security Management Act (FISMA) under the requirements of the Medicare Modernization Act. This evaluation program includes all eight key areas of FISMA: periodic risk assessments; policies and procedures to reduce risk; systems security plans; security awareness training; periodic testing and evaluation of the effectiveness of IT security policies and procedures; remedial activities, processes and reporting for deficiencies; incident detection, reporting and response; and continuity of operations for IT systems. We believe that the evaluations obtained as a result of this effort have served and continue to serve HHS greatly in better understanding the current state of security operations at all Medicare contractors; not just those contractors tested as a result of the financial statement audit or for which a SAS 70 was conducted.

In addition to the steps noted above, to address the material weakness conditions, HHS continues its programs to review the contractors through SAS 70 audits, an extensive contractor self-assessment program, and reporting process and greater central oversight by contractor management. Additionally, HHS continues to request and receive system security plans, risk assessments, contingency plans,

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self-assessments, and test results of contingency plans from its contractors and has a certification and accreditation program initiative featuring system vulnerability assessments for all contractors.

Efforts to address the findings noted in our review have been and will continue to be challenged by budgetary constraints and the decentralized nature of Medicare operations, the complexity of fee-for-service processing, the modernization of the claims processing applications and the ongoing contractor transition process related to the legislative mandate under MMA to competitively procure claims administration contractors to replace fiscal intermediaries and carriers by 2011. According to HHS officials, the HHS modernization program to centralize data processing and reduce the number of data centers represents a long-term solution to simplify the application software code and change controls needed for more robust security. HHS is also in the process of implementing significant changes to its claims administration contracting environment, which will result in consolidation and reduce the number of contractors and data centers.

IV.1 ***Direct Update Access to Medicare Claims Data***

For the direct update access to Medicare claims data control weakness, improvements were noted regarding the number of employees at contractors who had been granted access to directly change claims data, thereby bypassing application controls built into the FISS, MCS and VMS systems. Specifically, the audit showed that fewer employees generally had such access. This progress could be attributable in large measure to further guidance and information that HHS provided to contractors both in a series of briefings, and in writing via joint signature memoranda (JSM) and distributing white papers specifying in detail how to meet the requirement for users of the mainframe ACF2, RACF and Top Secret security packages.

Still, the audit noted significant numbers of contractor employees who had been granted direct access without consistent logging and review. The ability to directly change claims without comprehensive review provides no assurance that changes performed by such employees will result in proper claims payment. We consistently noted employees, particularly those at contractors using the MCS system, who had been granted inappropriate standing update access to Medicare data but who did not require direct access to data and application software programs to perform their job responsibilities. Further, activity was not logged and reviewed.

IV.2 ***Control Over Edit Settings in the FISS, VMS and MCS Application Systems***

For controls over edit settings in the FISS, VMS and MCS application systems, management worked diligently during FY 2006 to establish workgroups to determine the proper settings for controlling edits within each of these three applications processing Medicare claims. Additionally, the CMS Central Office issued a JSM to formally establish procedures to report and control changes to edits in these systems.

During FY 2007, our audit noted general compliance and improvement with the FISS mandated edits (when claims are processed within the common working file software), and the VMS mandated edits. However, our audit noted exceptions at selected contractors. Moreover, we noted that the JSM procedures and workgroup settings for MCS were not correct for numerous edits resulting in incorrect edit setting at contractors.

Additionally, we noted that management could not provide reports to document the volume and nature of claims bypassing the CWF application. Approximately 2,000 edits were not enforced within the FISS application because the edits were redundant in the CWF application. The inability to determine the number of claims bypassing CWF does not allow management to understand the effect of claims not subjected to CWF edits. Thousands of edit controls were built into the Medicare claims processing applications to enforce consistency over claims processing. The ability of claims to bypass application edit controls may result in inconsistent and uncertain claims processing leading to payment inaccuracies.

IV.3 ***Controls Governing the Use of Supplemental Software Used to Process Claims***

We noted a lack of controls with respect to software supplementing the FISS, MCS and VMS systems used to process Medicare claims. The inability of the FISS, MCS and VMS claims processing application systems to efficiently process all Medicare claims types has caused Medicare contractors to develop additional programs to effectively process claims. These additional systems, sometimes referred to as automated adjudication systems (AAS), were developed to automate the handling of claims that could not be processed by the standard claims processing applications without human intervention. AAS programs are developed and used independent of the standard application systems to process valid claims rejected by the standard systems. During FY 2006, management established formal control processes for the use of the AAS, including methods to establish, test, peer review and approve AAS programs prior to their use. Our testing noted issues at numerous contractors regarding compliance with these processes. AAS systems provide a powerful tool to process large volumes of Medicare claims rapidly, without human intervention. The use of such programs without the enforcement of strong controls could again result in inconsistent and uncertain claims processing leading to payment inaccuracies.

IV.4 ***Lack of CMS Oversight***

For the areas of direct update access to Medicare claims data, control over edit settings in the FISS, VMS and MCS application systems, and controls over the use of supplemental software used to process claims into the FISS, VMS and MCS application systems, we observed that often CMS Central Office had issued guidance and requirements to address internal control concerns. In each of these areas, we noted instances where contractors simply did not implement the needed controls although they had been directed to do so. In some cases the contractor staff simply did not appear to understand what was needed, for example the direct access to data instructions are of necessity quite technical. In other cases,

contractors on the verge of leaving the Medicare program may no longer have the same incentive to comply with requirements. Regardless, HHS lacks sufficient management processes and procedures in place to track compliance with its requirements and to assess the impact of exceptions and findings on the HHS financial statements.

1V.5 ***Other Matters***

Of lesser risk, our audit noted the following issues:

IV.5.1 ***Logical Access Controls***

Access controls ensure that critical system assets are physically protected from unauthorized access and that logical controls provide assurance that only authorized personnel may access data and programs maintained on systems. Besides the access control issues described in the "Direct Update Access to Medicare Claims Data" section, we noted that numerous contractors were not consistently recertifying user access to systems to ensure such access was needed for job requirements. We also noted that contractor management was not effectively performing reviews of violations for the FISS, MCS and VMS application systems. These security weaknesses could allow internal users to access and update sensitive systems, program parameters and data without proper authorization. Our review did not disclose any exploitation of critical systems tested; however, clear potential existed.

We also noted that many contractors had not performed procedures to recertify access granted to employees on an annual basis as required by HHS standards. As a result, we noted inconsistencies regarding access assignments, removal of access for terminated or transferred employees and the enforcement of policies and procedures regarding the administration of access approval and maintenance at the contractor sites.

IV.5.2 ***Systems Software***

Systems software is a set of computer programs designated to operate and control the processing activities for all applications processed on a specific computer, including network servers, mainframe systems, and personal computers. Controls over access to, and use of, such software are especially critical. We again noted inconsistencies in logical security controls over various platforms at contractor sites. Although contractors have established configuration security standards for platforms such as the mainframe, WINDOWS and UNIX, such standards were not consistently established on these platforms and/or monitored to ensure they remained in effect. Of mention, we did not note significant issues at three of the data center locations we audited which shows progress by HHS compared to prior year audits. Guidance issued by HHS for the implementation of controls, configurations, and design of the mainframe OS/390 and z/OS may have contributed to this improvement.

Recommendation

During FY 2007, management worked to establish and document consistent controls over the use of direct update access to claims data, control over edits within FISS, MCS and VMS and the use and control of AAS programs. However, the processes to consistently enforce these controls over twenty eight contractor and thirteen data center locations remains challenging. Although, the controls have not been fully implemented, we encourage management to continue their efforts to gain contractor support for full implementation of these controls. Effective management controls over the use of direct update access to claims, changes to edits within the three major Medicare application processing systems and AAS programs is imperative to establish a reasonable range of comfort over the accuracy of Medicare claims processing.

Additionally, we recommend that management should:

- Establish a process to periodically review and test contractor reports of employees with direct update access to Medicare claims data. The testing should include steps to ensure such access is logged and reviewed by contractors.
- Establish ongoing workgroups to review FISS, MCS and VMS edits that should be turned on or off and establish processes to distribute quarterly the results of these reviews to the contractors to allow them to determine their compliance.
- Establish a formal review process to, on a selected and unannounced basis, obtain and review actual in use edit settings for the FISS, VMS and MCS systems running at the contractor sites.
- Use the results of bullet point three above to identify edit settings not in compliance with the recommended edit settings suggested by the workgroups. For edits not matching the workgroup recommendations, match these differences to error trends resulting from contractor claims processed during periods when edits are turned off (use CWFMQA report results). Document the results, including specific matching of error types to contractors from which the errors emanated, and follow-up with contractors. Alternatively, management may wish to research other methods to more efficiently identify and track errors for subsequent review with contractors.
- Establish reports to determine the volume and reason for claims bypassing the CWF application.
- Work with contractors and maintainers of the FISS, MCS, and VMS systems to ensure AAS programs such as SuperOps and SCF maintain complete audit trails and that changes to programs associated with these systems follow the rules outlined in CR 3011 for testing, peer review and approval.
- Continue to enhance processes for the recertification of contractor employee access and the review of violation reports for the FISS, MCS and VMS application systems.

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Significant Deficiencies

I. Inadequate Oversight of Managed Care Organizations

Overview

HHS is responsible for 1) determining which organizations are eligible to contract and participate in the Medicare Managed Care (Part C) and Part D programs, 2) making payments to the participating organizations, and 3) providing oversight over the participating organizations.

Our prior year audits identified weaknesses in HHS internal control surrounding the management procedures to review and process Medicare Part C and Part D payments, and lack of documentation and procedures to determine eligibility of organizations during the initial application review. During our current year audit, we noted significant improvements in those areas. Specifically, management enhanced the procedures used to validate and authorize payments for Medicare Part C and the Part D benefit. Enhancements were made to a number of validation functions including the Beneficiary Payment Validation (BPV), the Plan Payment Validation (PPV), and the monitoring and tracking of payment issues. In addition, management made significant improvements in documentation that evidence their determination of eligibility of organizations during the initial application review.

However, we noted recurring issues with management oversight of the Medicare Advantage Organizations (MAOs). Management's oversight of MAOs is a monitoring control designed to ensure MAOs are in compliance with regulations established within applicable Medicare law, and therefore eligible to participate in the Managed Care program. Our review of the monitoring procedures in place over MAOs noted the following:

I.1 ***Monitoring Review Selection Methodology***

Because of the significant increase in MAOs in the managed care program and limited resources, management developed a risk-based approach for their oversight of the Managed Care organizations. The risk-based approach was used to identify which plans would be within the scope of the review, in addition to what organizational eligibility elements would be reviewed. The following inconsistencies were noted with the newly-developed selection approach:

- Management sporadically provided us with a complete set of formal monitoring policies and procedures used throughout the fiscal year. The inability of HHS to readily provide a comprehensive set of the guidance to be used throughout the fiscal year increases the risk of inappropriate execution of the reviews.

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- Management did not properly document the rationale and sampling approach for the population or universe used for each element selected for review. In addition, management selected an arbitrary percentage for sampling for the PACE organization reviews, with no documentation of the rationale.

- Management has a process in place for the completion of a standard form if additional elements and/or reviews are performed, by a Regional Office Manager. However, we noted instances where management deviated from the risk-based approach and included or excluded elements of the review without documenting the rationale for inclusion or exclusion.

I.2 ***Monitoring Review Documentation***

HHS has ten Regional Offices which perform the monitoring reviews. Management issues Standard Operating Procedures and holds training sessions for new releases to the monitoring audit guides.

However, because of a lack of formalized policies and procedures regarding the level of documentation required to evidence the review, management was unable to provide sufficient documentation to evidence the appropriate on going monitoring of managed care organizations by the Regional Offices. The following was noted:

I.2.1 ***Evidence of Review***

During the review, the reviewer must identify if organizational requirements are “met” or “not met”.

- We noted instances where the reviewer noted that the MAO had “met” the required element; however; documentation supporting the rationale and conclusion were not available.

- We noted significant inconsistencies with how the determination of “met,” “met with note,” and “not met” was made on different reviews for the same element.

- Documentation available to support the review varied by Regional Office.

I.3 ***Corrective Actions***

Upon the completion of the review, management is required to communicate non-compliances identified during the review to the organizations and the organizations are required to submit a corrective action plan. Management is required to evaluate the corrective action plan in order to make a final determination of the plan’s eligibility.

- We found instances where findings identified during the review and corrective action plans developed by the MAO in response to the review, were not released and/or approved within the prescribed time frame. In some cases, required corrective action plans were not received at all. In these instances, documentation supporting the ultimate conclusion to continue to allow the organization to participate as a MAOs did not exist.

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- We noted the acceptance of corrective action plans that did not properly identify how the MAO would correct each of the items identified.

I.4 ***Oversight Status Tracking***

The Health Plan Management System (HPMS) is used by HHS to monitor the execution and status of managed care organization oversight. This system lies at the core of HHS's management process for MAOs. Inaccurate information within HPMS weakens management ability to monitor the MAOs. We noted the following:

- Management uses a Microsoft Excel spreadsheet and HPMS to monitor the progress of the monitoring reviews, versus one central tracking module. We noted additional reviews were performed that were not tracked within the spreadsheet or HPMS.
- The HPMS monitoring review module was not updated, in accordance with HHS's policy, with the results of review. We noted multiple instances where Regional Offices did not update HPMS with exception items noted during the reviews of the managed care organizations.

Recommendation

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

- Establish policies for Regional Office monitoring of the various organizations (MA, MA-PD, PDP, PACE, RPPO, etc.) that include tailored procedures to address the unique requirements or risks of each organization.
- Ensure that existing policies and procedures for the monitoring of organizations within the Managed Care program are consistently implemented and applied and that the monitoring of these organizations is documented in accordance with appropriate standards and guidelines.
- Develop detailed policies and procedures outlining the minimum documentation requirements that must be maintained as part of the monitoring reviews, in order to appropriately support the review outcome.
- Document the compliance with regulations for the monitoring of specific chapters and/or elements for organizations. For example, PACE organizations are required to be monitored every year for the first three years of acceptance into the program, and every other year thereafter.
- Ensure findings, corrective action plans, and acceptance of the provider's correction action plans are provided, reviewed, and released within the proposed time frames.

- Ensure that relevant data are updated timely in order to provide the information necessary for adequate management oversight.

II. Lack of Controls over Monitoring of Grant Closeout

One of the largest work streams at HHS is the management of grants, with the award of more than $200 billion in discretionary and mandatory grants each year and over one trillion dollars in open grants under management throughout the year.

II.1 ***Grant Closeouts***

The closeout portion of the *HHS Grants Policy Statement* is insufficient as it does not require the respective Grants Management Offices to develop formal and detailed controls to address final grant closeout.

Based on inquiry with grant management personnel, an effort to closeout grants is being made, but the Department has limited authority to ensure grantees comply with HHS grant closeout policy. The compliance actions available (i.e., drawdown restrictions and withholding of future awards) are rarely utilized because there is not a directive in the existing policy to support and encourage the grant offices to use these actions. The Division of Payment Management (DPM) _Grant Closeout Eligibility Report is considered unreliable by the Grants Management Offices and thus is not utilized for grant close-out monitoring.

The DPM report identified more than 25,000 grants with a remaining net obligation balance of $1.5 billion that are potentially eligible for closeout. For 80% of the grants identified as potentially eligible for closeout by management, the grant project period expired more than eighteen months ago. The inability to properly closeout grants has a corresponding effect on funds which have been obligated to settle claims from grantees. To the extent that HHS is able to closeout grants in a timely manner, additional funds could be de-obligated and returned to the US Treasury as required by appropriations law.

II.2 ***Grant Documentation Retention***

While HHS has documentation retention policies related to grants that set minimum standards, this policy is not being followed and the systems in place are not sufficient to allow for document retrieval on an as needed basis. This was evidenced by management's inability to provide all requested documentation for 12 out of 105 sample items tested during our audit.

Examples of missing grant documentation include:

- Approved Applications
- Ranks and Approval Lists
- Secondary Review Documentation for grant above $50 thousand

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II.3 ***Grant Monitoring***

Management was unable to provide documentation to evidence their ongoing monitoring of open grants. Examples of missing grant documentation are the grant monitoring statements and progress reports.

Financial Status Reports (FSRs or SF-269s) were not submitted in a timely manner and evidence of follow-up by the respective Grants Management Offices (GMO) was not available. The following causes were identified during our testing:

- The grant management automated information systems utilized by HHS do not provide notification (alert) to the Grant Management Specialist (GMS) when an FSR has not been received within the allotted time period.
- Management communicated it does not have sufficient staffing to ensure the FSRs are submitted within the allotted time period.

If the FSR is not received, management is unable to accurately determine if grant funds are being spent in accordance with the approved budget. Management is also unable to tell if financial benchmarks such as cost sharing are being attained by the grant recipient.

In addition, there are no sanctions mentioned in the HHS Grants Management policy that can be imposed on a grantee when they are late in providing an FSR. Repercussions only exist when a grantee is applying for a future award, at which time the grantee must provide the delinquent FSR.

Recommendation

To improve the oversight of grants, better safeguard taxpayer monies and decrease the administrative costs related to grants HHS should:

- Implement a standard document retention system. At a minimum, the system should be organized by unique identifier (grant document number) so that each grant and all of the associated documentation can be retrieved as needed.
- Scan hard-copy documents into their document retention systems, thus reducing the dependence on extensive paper files.
- Assign a GMS to focus solely on monitoring the FSR submission during the course of the project period.
- Develop standardized documentation requirements to ensure all correspondence between a GMS and a grantee is completed consistently and timely. The HHS Grant Policy Statement should be updated to include specific repercussions for not complying with the documentation requirements.

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- Management should implement a systematic function to provide automated alerts to the appropriate GMS when the FSR has not been received by the due date.

III. Lack of Controls over Timely Invoice Payment

HHS lacks standardized policies and procedures for the processing of invoices to ensure proper and timely payment as well as compliance with the Prompt Payment Act (5CFR 1350). During our testing we noted the following:

- The Division of Financial Operations (DFO) accounting technician processing the invoice enters the invoice receipt date in UFMS, using the date of the Paying Office (DFO) receipt date of the invoice rather than the actual invoice receipt date by the receiving (program) office. This methodology is inconsistent with the Prompt Pay Act.

- Not all receiving (program) offices have a requirement to date stamp invoices upon their receipt. While some receiving (program) offices are utilizing date stamps upon receipt of invoices, this process is not performed consistently. Without a date stamp, HHS is unable to ensure that invoices are paid in a timely manner.

- According to the HHS policy, the receiving date should be entered into the UFMS system upon receipt of goods or services by the project officer or their designee. However, during our testing we found instances where entry of receiving date was delayed by up to one month, causing the receiving date to be incorrect. The UFMS system calculates the payment due date based on the later of the goods being received or the receipt of a valid invoice. Payment will not be made until the receiving date is entered into UFMS by the project officers which, if not entered timely, results in the payment due date being inaccurately calculated.

During our testing we noted 19 invoices being paid on average 54 days after the receipt of goods and invoices. In 6 of these instances, HHS failed to pay interest to the vendor as required by the Prompt Payment Act. In addition, in 6 of the 13 invoices where interest was paid it was calculated incorrectly. The lack of controls has resulted in violations of the Prompt Pay Act and the use of tax payer monies for the payment of interest that could have been used for program expenses to benefit the public.

Recommendation

In order to ensure compliance with the Prompt Pay Act and decrease the monies paid on interest that could be used for program expense, management should:

- HHS management should assign a "Designated Agency Office" on all contracts, purchase orders and agreements to receive invoices and date stamp the invoices to ensure consistency and timely payment of invoices. Management should also ensure that vendors are aware of the procedures to send invoices to the Designated Agency Office.

- Develop stronger polices at the receiving (program) offices to ensure timely entry of goods received. There should also be regular monitoring of these dates involving reconciliation of financial system data to the hard-copy receiving reports.
- HHS should ensure that the training for employees who enter receiving into the financial system is clear as to what the receiving date should be and that receiving officials are aware of the importance of entering receiving information correctly and within the specified time period.

IV. Statement of Social Insurance (SOSI)

The SOSI is a long-term projection of the present value of income to be received from or on behalf of existing and future participants of social insurance programs, the present value of the benefits to be paid to those same individuals, and the difference between the income and benefits.

Starting in FY 2006, the SOSI was required to be presented as part of the basic financial statements rather than as RSSI as previously presented. As such, the process for preparing the SOSI must comply with appropriate financial reporting internal control requirements established by OMB.

HHS has implemented policies, processes, controls and related documentation that will enable them to support the related financial statement assertions. During the current year audit, we noted significant improvements in the areas of change control, access controls, and internal control documentation. However the following control design deficiencies where noted:

- Data are moved within and between spreadsheets by copying the data from cells and pasting the data to new cell locations. Errors from this process could result in significant unintended changes to the SOSI. While the input of data is subjected to secondary validation and review by supervisory actuarial personnel, such manual validation and review processes do not sufficiently mitigate the risk associated with the copying and pasting of data from cell to cell within this complex set of spreadsheets.
- Spreadsheets are named with the same name as the prior version after changes. Further, there are no automated controls to prevent users from inadvertently overwriting changes made by other users. This could result in unintended changes to critical spreadsheets resulting in unreliable outputs.
- Formulae changes are not in all cases independently tested, reviewed and verified. While formulae changes are subjected to secondary validation and review by supervisory actuarial personnel, such manual validation and review processes do not sufficiently mitigate the risk associated with the direct posting of formulae changes into cells by users of this complex set of spreadsheets.

The lack of robust automated controls over spreadsheet changes may result in output that varies significantly from management's intentions.

Recommendation

We recommend that HHS continue to develop and refine its SOSI financial reporting spreadsheet applications and processes. Specifically, HHS should:

- Implement automated controls to ensure that data moved between and within spreadsheets are moved correctly.
- Implement automated controls to prevent the possibility of overwrite to critical spreadsheet data or formula cells due to insufficient naming convention protocols.
- Implement automated controls to test, review and verify all formulae changes within and between spreadsheets (e.g. spreadsheet change logging capabilities).

* * * * * * * * * * * * *

Internal Control Related to Key Performance Indicators and RSSI

With respect to internal control relevant to data that support reported performance measures, we obtained an understanding of the design of significant internal controls relating to the existence and completeness assertions, as required by OMB Bulletin No. 07-04. Our procedures were not designed to provide assurance on internal control over reported performance measures. Accordingly, we do not provide an opinion on such controls.

We also identified other less significant matters that will be reported to HHS's management in a separate letter.

This report is intended solely for the information and use of the management of HHS, the Office of the Inspector General of HHS, OMB, and Congress. This report is not intended to be and should not be used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

November 14, 2007

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Report on Compliance and Other Matters

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Report of Independent Auditors on Compliance and Other Matters

To the Secretary of the Department of Health and Human Services and the Inspector General of the Department of Health and Human Services

We have audited the financial statements of the Department of Health and Human Services (HHS) as of and for the year ended September 30, 2007 and the statement of social insurance for the year ended January 1, 2007, and have issued our report dated November 14, 2007. We conducted our audit in accordance with auditing standards generally accepted in the United States of America, the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States, and Office of Management and Budget (OMB) Bulletin No. 07-04, *Audit Requirements for Federal Financial Statements.* The management of the HHS is responsible for compliance with laws and regulations.

As part of obtaining reasonable assurance about whether the financial statements are free of material misstatement, we performed tests of compliance with laws and regulations including laws governing the use of budgetary authority, laws, regulations, and government-wide policies identified in Appendix E of OMB Bulletin No. 07-04 and other laws, noncompliance with which could have a direct and material effect of the determination of financial statement amounts. Under FFMIA, we are required to report whether the HHS financial management systems substantially comply with the Federal financial management systems requirements, applicable Federal accounting standards, and the United States Government Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA section 803(a) requirements.

We limited our tests of compliance to the provisions of law and regulation cited in the second paragraph of this report. Providing an opinion on compliance with those provisions was not an objective of our audit, and, accordingly, we do not express such an opinion.

The results of our tests of compliance with the laws and regulations described in the second paragraph of this report disclosed instances of noncompliance with laws and regulations or other matters that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 07-04, as described below.

The Improper Payments Information Act (IPIA) of 2002 requires Federal agencies to identify the program and activities that may be susceptible to significant improper payments and estimate the amount of the improper payments. HHS has begun to implement the requirements of IPIA, but has not yet completed its implementation of a process to fully estimate improper payments.

The Prompt Payment Act of 1982 requires Federal agencies to pay their bills on a timely basis and to pay interest penalties when payments are made late. During our testing we identified multiple instances of non-compliance with the Prompt Payment Act where interest was not appropriately paid.

In the accompanying Agency Financial Report, HHS has reported violations of the Anti-Deficiency Act (ADA). HHS reported that these violations occurred over a period of several prior fiscal years and the amounts involved were sufficiently small that they would not have been material to any year's financial statements and that management is committed to resolving these issues and complying with all aspects of the ADA.

The HHS OIG determined that HHS did not comply with appropriation statutes and the Federal Acquisition Regulations related to the modification of a contract where the requested services were not allowable under the contracting vehicle, the contract should have gone through a full and open competition, and the contract was incorrectly funded from a prior fiscal year's appropriation.

The results of our tests of HHS's compliance with FFMIA requirements disclosed, as described below, that the HHS is not in substantial compliance with the requirements of FFMIA section 803(a).

In our report on internal control dated November 14, 2007, we reported material weaknesses related to Medicare Claims Processing Controls, Financial Reporting Systems and Processes, Financial Management Information Systems and Budgetary Accounting. We believe these matters taken together; represent substantial non-compliance with FFMIA. Further details surrounding these findings, together with our recommendations for corrective action, have been reported separately to HHS in our report on internal control dated November 14, 2007.

This report is intended solely for the information and use of the management of HHS, the Office of the Inspector General of HHS, OMB, and Congress. This report is not intended to be and should not be used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

November 14, 2007

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Department's Response to Audit Reports

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

NOV 1 5 2007

Mr. Daniel R. Levinson
Inspector General
Department of Health and Human Services
330 Independence Avenue, S.W., Room 5250
Washington, D.C. 20201

Dear Mr. Levinson:

This letter responds to the audit report submitted by the Office of the Inspector General in connection with the Department of Health and Human Services' fiscal year 2007 financial statement audit. We concur with the findings and recommendations presented to us.

We are pleased that, once again, your report reflects an unqualified, or "clean," audit opinion for the Department. Through our joint efforts, the audit was completed on time.

We acknowledge that we have material weaknesses in internal control relating to financial reporting systems and processes, budgetary accounting, financial management information technology systems, and Medicare claims processing. The Department's plan to resolve the financial reporting systems and processes, and budgetary accounting weaknesses is to continue our efforts to improve our financial management processes and to fully utilize the Unified Financial Management System (UFMS) functionality and control capabilities.

In addition, the Department will be formulating entity-wide goals for correcting the information technology weakness. The Centers for Medicare and Medicaid Services will continue efforts to strengthen the controls related to Medicare electronic data processing operations at its contractor sites as well.

I would like to extend my appreciation to you and your staff for the professionalism that was demonstrated in working with us through this challenging year.

Sincerely,

Charles E. Johnson
Assistant Secretary for Resources
and Technology and Chief Financial Officer

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Financial Statements and Notes

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Financial Statements

CONSOLIDATED BALANCE SHEETS
As of September 30, 2007 and 2006
(In Millions)

	2007	2006
Assets (Note 2)		
Intragovernmental		
Fund Balance with Treasury (Note 3)	$ 114,774	$ 159,921
Investments, Net (Note 5)	365,875	341,976
Accounts Receivable, Net (Note 6)	1,164	726
Other (Note 9)	43	132
Total Intragovernmental	481,856	502,755
Accounts Receivable, Net (Note 6)	13,021	3,207
Cash and Other Monetary Assets (Note 4)	129	145
Inventory and Related Property, Net (Note 7)	3,161	2,322
General Property, Plant & Equipment, Net (Note 8)	5,064	4,971
Other (Note 9)	576	509
Total Assets	**$ 503,807**	**$ 513,909**
Stewardship PP&E (Note 29)		
Liabilities (Note 10)		
Intragovernmental		
Accounts Payable	$ 533	$ 620
Accrued Payroll and Benefits	86	88
Other (Note 14)	815	955
Total Intragovernmental	1,434	1,663
Accounts Payable	484	562
Entitlement Benefits Due and Payable (Note 11)	61,470	61,164
Accrued Grant Liability (Note 13)	3,941	3,833
Federal Employee & Veterans' Benefits (Note 12)	8,368	7,532
Accrued Payroll & Benefits	718	804
Other (Note 14)	5,479	2,867
Total Liabilities	**$ 81,894**	**$ 78,425**
Net Position		
Unexpended Appropriations - Earmarked funds	8,887	27,665
Unexpended Appropriations - Other funds	78,830	102,832
Unexpended Appropriations, Total	87,717	130,497
Cumulative Results of Operations - Earmarked funds	332,966	304,465
Cumulative Results of Operations - Other funds	1,230	522
Cumulative Results of Operations, Total	334,196	304,987
Total Net Position	**$ 421,913**	**$ 435,484**
Total Liabilities & Net Position	**$ 503,807**	**$ 513,909**

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

CONSOLIDATED STATEMENTS OF NET COST
For the Years Ended September 30, 2007 and 2006
(In Millions)

Responsibility Segments	**2007**	**2006**
Centers for Medicare & Medicaid Services (CMS)		
Gross Cost	$ 612,411	$ 574,245
Exchange Revenue	(50,304)	(49,847)
CMS Net Cost of Operations	$ 562,107	$ 524,398
Other Segments:		
Administration for Children & Families (ACF)	$ 47,336	$ 47,123
Administration on Aging (AoA)	1,373	1,388
Agency for Healthcare Research & Quality (AHRQ)	131	15
Centers for Disease Control & Prevention (CDC)	8,105	6,555
Food & Drug Administration (FDA)	1,913	1,906
Health Resources & Services Administration (HRSA)	6,897	6,205
Indian Health Service (IHS)	4,250	4,093
National Institutes of Health (NIH)	28,489	28,147
Office of the Secretary (OS)	2,169	2,598
Program Support Center (PSC)	1,414	872
Substance Abuse & Mental Health Services Administration (SAMHSA)	3,320	3,343
Other Segments Gross Cost of Operations	$ 105,397	$ 102,245
Exchange Revenue	(2,905)	(2,706)
Other Segments Net Cost of Operations	$ 102,492	$ 99,539
Net Cost of Operations	**$ 664,599**	**$ 623,937**

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

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION
For the Year Ended September 30, 2007
(In Millions)

	2007			
	Earmarked Funds	**All Other Funds**	**Eliminations**	**Consolidated Total**
Cumulative Results of Operations:				
Beginning Balances	$ 304,465	$ 522	$ -	$ 304,987
Budgetary Financing Sources:				
Appropriations Used	190,742	296,631	-	487,373
Nonexchange Revenue				
Non-exchange Revenue - Tax Revenue	188,219	-	-	188,219
Non-exchange Revenue - Investment Revenue	18,474	-	-	18,474
Non-exchange Revenue - Other	242	36	115	393
Donations and Forfeitures of Cash and Cash Equivalents	44	3	-	47
Transfers-in/out without Reimbursement	(1,920)	911	-	(1,009)
Other budgetary financing sources	(4)	5	-	1
Other Financing Sources (Non-Exchange):				
Donations and forfeitures of property	-	3	-	3
Transfers-in/out without reimbursement (+/-)	(1)	(18)	1	(18)
Imputed financing	26	399	(112)	313
Other (+/-)	-	12	-	12
Total Financing Sources	395,822	297,982	4	693,808
Net Cost of Operations (+/-)	367,321	297,274	4	664,599
Net Change	28,501	708	-	29,209
Cumulative Results of Operations	**$ 332,966**	**$ 1,230**	**$ -**	**$ 334,196**
Unexpended Appropriations				
Beginning Balances	$ 27,665	$ 102,832	$ -	$ 130,497
Budgetary Financing Sources				
Appropriations Received	199,309	274,565	-	473,874
Appropriations transferred in/out	(98)	88	-	(10)
Other Adjustments	(27,247)	(2,024)	-	(29,271)
Appropriations Used	(190,742)	(296,631)	-	(487,373)
Total Budgetary Financing Sources	(18,778)	(24,002)	-	(42,780)
Total Unexpended Appropriations	8,887	78,830	-	87,717
Net Position	**$ 341,853**	**$ 80,060**	**$ -**	**$ 421,913**

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

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION
For the Year Ended September 30, 2006
(In Millions)

	2006			
	Earmarked Funds	**All Other Funds**	**Eliminations**	**Consolidated Total**
Cumulative Results of Operations:				
Beginning Balances	$ 271,485	$ (1,307)	$ -	$ 270,178
Budgetary Financing Sources:				
Other Adjustments	-	369	-	369
Appropriations Used	173,571	287,273	-	460,844
Nonexchange Revenue				
Non-exchange Revenue - Tax Revenue	180,576	-	-	180,576
Non-exchange Revenue - Investment Revenue	17,227	-	-	17,227
Non-exchange Revenue - Other	311	247	116	674
Donations and Forfeitures of Cash and Cash Equivalents	32	4	-	36
Transfers-in/out without Reimbursement	(2,105)	861	-	(1,244)
Other Financing Sources (Non-Exchange):				
Donations and forfeitures of property	-	4	-	4
Transfers-in/out without reimbursement (+/-)	(1)	(26)	(2)	(29)
Imputed financing	25	406	(118)	313
Other (+/-)	-	(24)	-	(24)
Total Financing Sources	369,636	289,114	(4)	658,746
Net Cost of Operations (+/-)	336,656	287,285	(4)	623,937
Net Change	32,980	1,829	-	34,809
Cumulative Results of Operations	**$ 304,465**	**$ 522**	**$ -**	**$ 304,987**
Unexpended Appropriations				
Beginning Balances	$ 6,877	$ 80,473	$ -	$ 87,350
Budgetary Financing Sources				
Appropriations Received	201,231	323,104	-	524,335
Appropriations transferred in/out	-	(121)	-	(121)
Other Adjustments	(6,872)	(13,351)	-	(20,223)
Appropriations Used	(173,571)	(287,273)	-	(460,844)
Total Budgetary Financing Sources	20,788	22,359	-	43,147
Total Unexpended Appropriations	27,665	102,832	-	130,497
Net Position	**$ 332,130**	**$ 103,354**	**$ -**	**$ 435,484**

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

COMBINED STATEMENTS OF BUDGETARY RESOURCES
For the Years Ended September 30, 2007 and 2006
(In Millions)

	2007		2006	
	Budgetary	Non-Budgetary Credit Program Financing Accounts	Budgetary	Non-Budgetary Credit Program Financing Accounts
Budgetary Resources:				
Unobligated Balance, Brought Forward, October 1:	$ 67,726	$ 194	$ 18,001	$ 206
Recoveries of Prior Year Unpaid Obligations				
Actual	17,604	-	14,481	-
Budget Authority				
Appropriation	937,162	1	948,366	4
Spending Authority from Offsetting Collections				
Collected	6,104	28	6,741	172
Change in Receivables from Federal sources	650	-	(77)	-
Change in unfilled customer orders				
Advance received	13	-	37	-
Without advance from Federal sources	(1,406)	-	1,903	-
Expenditure Transfers from trust funds				
Actual	3,325	-	3,328	-
Change in Receivables from Trust Funds	290	-	-	-
Subtotal	946,138	29	960,298	176
Nonexpenditure transfers, net, anticipated and actual	(91)	-	59	-
Temporarily not available pursuant to Public Law	(20,607)	-	(34,551)	-
Permanently not available (-)	(29,619)	(29)	(5,847)	-
Total Budgetary Resources	$ 981,151	$ 194	$ 952,441	$ 382
Status of Budgetary Resources:				
Obligations Incurred				
Direct	$ 949,517	$ 49	$ 877,128	$ 4
Reimbursable	7,105	-	7,587	184
Subtotal	956,622	49	884,715	188
Unobligated Balances – Available				
Apportioned	17,155	58	60,075	106
Exempt from apportionment	126	-	73	-
Subtotal	17,281	58	60,148	106
Unobligated Balances - Not Available	7,248	87	7,578	88
Total Status of Budgetary Resources	$ 981,151	$ 194	$ 952,441	$ 382
Change in Obligated Balance:				
Obligated Balance, Net				
Unpaid obligations, brought forward, October 1	$ 142,161	$ 3	$ 123,768	$ -
Uncollected customer payments from Federal sources, brought forward, October 1	(7,327)	-	(5,700)	-
Total unpaid obligated balance, net	134,834	3	118,068	-
Obligations incurred net	956,622	49	884,715	188
Gross outlays	(938,981)	(52)	(851,874)	(185)
Obligated Balance Transferred, Net				
Actual transfers, unpaid obligations	18	-	-	-
Total Unpaid obligated balance transferred, net	18	-	-	-
Recoveries of prior year unpaid obligations, actual	(17,604)	-	(14,481)	-
Change in uncollected customer payments from Federal sources	466	-	1,739	-
Obligated Balance, Net, End of Period				
Unpaid Obligations	142,248	-	142,161	3
Uncollected customer payments from Federal sources	(6,893)	-	(7,327)	-
Total, unpaid obligated balance, net, end of period	135,355	-	134,834	3
Net Outlays				
Gross outlays	938,981	52	851,874	185
Offsetting collections	(9,442)	(28)	(10,338)	(172)
Distributed Offsetting receipts	(257,704)	-	(226,844)	(31)
Net Outlays	**$ 671,835**	**$ 24**	**$ 614,692**	**$ (18)**

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

STATEMENT OF SOCIAL INSURANCE
75-Year Projection as of January 1, 2007 and Prior Base Years
(In Billions)

	2007	2006	2005 unaudited	2004 unaudited	2003 unaudited
			Estimates from Prior Years		
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 27 and 28)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age (age 15 – 64)					
HI	$ 5,975	$ 5,685	$ 5,064	$ 4,820	$ 4,510
SMI Part B	12,112	12,446	11,477	10,505	8,796
SMI Part D	7,285	7,366	7,895	7,545	-
Have attained eligibility age (age 65 and over)					
HI	178	192	162	148	128
SMI Part B	1,648	1,606	1,436	1,310	1,160
SMI Part D	746	750	817	713	-
Those expected to become participants (under age 15)					
HI	4,870	4,767	4,209	4,009	3,773
SMI Part B	4,460	3,562	3,658	3,514	2,817
SMI Part D	2,735	2,134	2,522	2,511	-
All current and future participants:					
HI	11,023	10,644	9,435	8,976	8,411
SMI Part B	18,221	17,613	16,571	15,329	12,773
SMI Part D	10,766	10,250	11,233	10,770	-
Actuarial present value for the 75-year projection period of estimated future cost for or on behalf of: (Notes 27 and 28)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age (age 15 – 64)					
HI	15,639	15,633	12,668	12,054	10,028
SMI Part B	12,130	12,433	11,541	10,577	8,845
SMI Part D	7,273	7,338	7,913	7,566	-
Have attained eligibility age (age 65 and over)					
HI	2,558	2,397	2,179	2,168	1,897
SMI Part B	1,834	1,773	1,622	1,475	1,306
SMI Part D	794	792	880	773	-
Those expected to become participants (under age 15)					
HI	5,118	3,904	3,417	3,246	2,653
SMI Part B	4,257	3,407	3,408	3,277	2,622
SMI Part D	2,699	2,121	2,440	2,431	-
All current and future participants:					
HI	23,315	21,934	18,264	17,468	14,577
SMI Part B	18,221	17,613	16,571	15,329	12,773
SMI Part D	10,766	10,250	11,233	10,770	-
Actuarial present values for the 75-year projection period of estimated future excess of income (excluding interest) over cost (Notes 27 and 28)					
HI	$ (12,292)	$ (11,290)	$ (8,829)	$ (8,492)	$ (6,166)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Additional Information					
Actuarial present values for the 75-year projection period of estimated future excess of income (excluding interest) over cost (Notes 27 and 28)					
HI	$ (12,292)	$ (11,290)	$ (8,829)	$ (8,492)	$ (6,166)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Trust fund assets at start of period					
HI	300	285	268	256	235
SMI Part B	38	23	19	24	34
SMI Part D	1	-	-	-	-
Actuarial present value for the 75-year projection of estimated future excess of income (excluding interest) and Trust Fund assets at start of period over cost (Note 27 and 28)					
HI	$ (11,993)	$ (11,006)	$ (8,561)	$ (8,236)	$ (5,931)
SMI Part B	38	23	19	24	34
SMI Part D	1	-	-	-	-

Note: Totals do not necessarily equal the sums of rounded components.

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

Notes to the Financial Statements
For the Years Ended September 30, 2007 and 2006

Note 1. Summary of Significant Accounting Policies

Reporting Entity

The Department of Health and Human Services (HHS or Department) is a Cabinet-level agency of the Executive Branch of the Federal Government. Its predecessor, the Department of Health, Education and Welfare (HEW), was officially established on April 11, 1953. In 1979, the Department of Education Organization Act of 1979 (*Public Law 96-88*) was signed into law, providing for a separate Department of Education. HEW officially became HHS on May 4, 1980. The Department is responsible for protecting the health of all Americans and providing essential human services.

Organization and Structure of HHS

The HHS comprises the Office of the Secretary and 11 Operating Divisions (OPDIVs) with diverse missions and programs. The Office of the Secretary and each OPDIV are considered a responsibility segment representing a component that is responsible for carrying out a mission, conducting a major line of activity, or producing one or a group of related products or services. Although it is part of the Office of the Secretary, the Program Support Center reports on its activity separately because its business activities encompass offering services to other OPDIVs and Federal agencies. The Agency for Toxic Substances and Disease Registry is combined with the Centers for Disease Control and Prevention for financial reporting purposes; therefore, these footnotes will refer to them as one responsibility segment. The managers of the responsibility segments report to the entity's top management directly, and the resources and results of operations can be clearly distinguished from those of other responsibility segments of the entity. The 12 responsibility segments are:

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

Basis of Accounting and Presentation

The HHS financial statements have been prepared to report the financial position and results of operations of the Department, pursuant to the requirements of 31 U.S. Code 3515(b), the Chief Financial Officers Act of 1990 (*Public Law 101-576*), as amended by the Government Management Reform Act of 1994, and presented in accordance with the requirements in the Office of Management and Budget (OMB)

Circular No. A-136, *Financial Reporting Requirements*. These statements have been prepared from the Department's financial records using an accrual basis in conformity with accounting principles generally accepted in the United States. The generally accepted accounting principles (GAAP) for Federal entities are the standards prescribed by the Federal Accounting Standards Advisory Board (FASAB) and recognized by the American Institute of Certified Public Accountants as Federal GAAP. These statements are, therefore, different from financial reports prepared pursuant to other OMB directives that are primarily used to monitor and control the HHS' use of budgetary resources.

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

The financial statements consolidate the balances of approximately 160 appropriations and fund accounts, and a number of accounts used for suspense, collection of receipts, and general government functions. Transactions and balances among the HHS OPDIVs have been eliminated in the presentation of the Consolidated Balance Sheets and Statements of Net Cost and of Changes in Net Position. The Combined Statements of Budgetary Resources are presented on a combined basis, therefore intra-HHS and intra-OPDIV transactions and balances have not been eliminated from these statements. Supplemental information is accumulated from the OPDIV reports, regulatory reports, and other sources within the HHS. These statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation providing resources and budget authority for the HHS.

Reconciliation of Net Cost of Operations (Proprietary) to Budget

Effective for FY 2007, OMB Circular No. A-136 changed disclosure requirements for the explanation of the differences between budgetary and financial accounting. The Reconciliation of Net Cost of Operations (Proprietary) to Budget, formerly the Statement of Financing, was transferred from the basic financial statements to a footnote disclosure. The Reconciliation is disclosed in Note 30.

Unified Financial Management System (UFMS)

The HHS continues to streamline and integrate its financial management systems through a phased development of the UFMS. The HHS' financial management goals seek to (1) provide decision makers with timely, accurate, and useful financial and program information; and (2) ensure that the HHS resources are used appropriately, efficiently, and effectively. With UFMS, the HHS will also standardize business processes for all core functions including general ledger, accounts payable, accounts receivable, cost management, budget execution, and financial reporting. In FY 2001, the CMS began the Healthcare Integrated General Ledger Accounting System (HIGLAS) project to replace the Medicare contractors' and CMS accounting systems with a single, unified system. As of September 30, 2007, ten Medicare contractors were using HIGLAS. The CDC and the FDA went live with UFMS in April 2005. The ACF, AoA, AHRQ, HRSA, OS, PSC, and the SAMSHA went live in October 2006. The final deployment of UFMS for the IHS occurred in October 2007.

Use of Estimates in Preparing Financial Statements

Preparation of financial statements in accordance with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent liabilities as of the date of the financial statements. Estimates and assumptions also affect the revenues and expenses accrued and reported in the financial statements. Actual results may differ from those estimates.

Entity and Non-Entity Assets

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

Non-entity assets are those assets held by the reporting entity but not available for use. An example of a non-entity asset is the interest accrued on overpayments and cost settlements reported by the Medicare contractors.

Entity and non-entity assets are combined into one line on the face of the balance sheet as required by OMB Circular No. A-136.

Fund Balance with Treasury

The HHS maintains its available funds with the Department of the Treasury (Treasury or U.S. Treasury) except for the Medicare Benefit accounts maintained at commercial banks. The Fund Balance with Treasury is available to pay current liabilities and finance authorized purchases. Cash receipts and disbursements are processed by Treasury, and the HHS' records are reconciled with those of the Treasury on a regular basis.

Investments, Net

Investments consist of Treasury securities including the CMS par value securities that represent the majority of the HHS earmarked funds carried at face value, and other securities carried at amortized cost. Section 1817 for the Hospital Insurance Trust Fund (HI) and Section 1841 for the Supplementary Medical Insurance Trust Fund (SMI) of the Social Security Act require that trust investments not necessary to meet current expenditures be invested in interest-bearing obligations of the U.S. Government, or in obligations guaranteed as to both principal and interest by the U.S. Government.

The FASAB Statement of Federal Financial Accounting Standard (SFFAS), No. 27, *Identifying and Reporting Earmarked Funds*, prescribes certain disclosures concerning earmarked investments. The Federal government does not set aside assets to pay future benefits or other expenditures associated with the HI or SMI trust funds. The cash receipts collected from the public for an earmarked fund are deposited in the U.S. Treasury, which uses the cash for general government purposes. Treasury securities are issued to the HI and SMI trust funds as evidence of their receipts. The Treasury securities are an asset to the HI and SMI trust funds and a liability to the U.S. Treasury. Because the HI and SMI trust funds and the U.S. Treasury are part of the Federal government, these assets and liabilities offset each other from the standpoint of the Federal government as a whole and are eliminated from presentation in the consolidation of the U.S. Government-wide financial statements.

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

No provision is made for unrealized gains or losses on these securities since it is the Department's intent to hold investments to maturity. Interest income is compounded semiannually in June and December.

Accounts Receivable, Net

Accounts receivable consist of the amounts owed to the HHS by other Federal agencies and the public as the result of the provision of goods and services. Intragovernmental accounts receivable arise generally from the provision of reimbursable work to other Federal agencies and no allowance for uncollectible accounts is established as they are considered to be fully collectible. Accounts receivable also include interest due to the HHS that is directly attributable to delinquent accounts receivable.

Accounts receivable from the public are primarily composed of provider and beneficiary overpayments, Medicare Secondary Payer overpayments, Medicare Premiums, and Medicaid Audit Disallowances. They are presented net of an allowance for uncollectible accounts. The allowance for uncollectible accounts is determined based on past collection experience and an analysis of outstanding balances.

Direct Loans and Loan Guarantee Receivables and Liabilities

Direct Loans:

The Health Care Infrastructure Improvement Program was enacted into law as part of the Medicare Modernization Act of 2003. This loan program provides loans to hospitals or entities that are engaged in research in the causes, prevention, and treatment of cancer; and are designated as cancer centers by the National Cancer Institute, or are designated by the State legislature as the official cancer institute of the State, and such designation by the State legislature occurred prior to December 8, 2003, for payment of the capital costs of eligible projects. The HHS reasonably expects any loans made under this program to be forgiven as it is anticipated that the borrowers will meet the requirements for forgiveness.

Loan Guarantees:

The HHS administers guaranteed loan programs for the Health Center and the Health Education Assistance Loans (HEAL) programs. Loans receivable represent defaulted guaranteed loans, which have been paid to lenders under this program. Loans receivable also include interest due to the HHS on the defaulted loans. The loans guarantee liabilities are valued at the present value of the cash outflows from the HHS less the present value of related inflows.

As required under the Federal Credit Reform Act (FCRA) of 1990, for loan guarantees committed on or after October 1, 1991, guaranteed loans are reduced by an allowance for subsidy representing the present value of the amounts not expected to be recovered and thus having to be subsidized by the government for loan guarantees. The FCRA also requires that the subsidy cost estimate be based on the net present

value of the specified cash flows discounted at the interest rate of marketable Treasury securities of similar maturities. The liability for loan guarantees committed on or after October 1, 1991, is reported at present value.

For loan guarantees committed prior to October 1, 1991, loan guarantee principal and interest receivable are reduced by an allowance for estimated uncollectible amounts. The allowance is estimated based on past experience and an analysis of outstanding balances. The liability for loan guarantees committed prior to October 1, 1991, is established based upon an average default rate. The liability is adjusted each year for the change in default rates.

Advances to Grantees/Accrued Grant Liability
The HHS awards grants to various grantees and provides advance payments to grantees to meet their cash needs to carry out their programs. Advance payments are recorded as "Advances to Grantees" and are liquidated upon grantees' reporting expenditures. In some instances, grantees incur expenditures before drawing down funds that, when claimed, would reduce the "Advances to Grantees" account. An accrued grant liability occurs when the accrued grant expenses exceed the outstanding advances to grantees, resulting in a negative balance in the "Advances to Grantees" account. The HHS grants are classified into two categories: "Grants Not Subject to Grant Expense Accrual" and "Grants Subject to Grant Expense Accrual." Progress payments on work in process are not included in grants.

Grants Not Subject to Grant Expense Accrual: These grants represent formula grants (also referred to as "block grants") under which grantees provide a variety of services or payments to individuals and local agencies. Expenses are recorded as the grantees draw funds. These grants are funded on an allocation basis determined by budgets and agreements approved by the sponsoring OPDIV as opposed to a reimbursable basis. Therefore, they are not subject to grant expense accrual.

Grants Subject to Grant Expense Accrual: For grants subject to grant expense accrual, commonly referred to as "non-block grants," grantees draw funds (recorded as Advances to Grantees) based on their estimated cash needs. As grantees report their actual disbursements (quarterly), the amounts are recorded as expenses, and their advance balances are reduced. At year-end, the OPDIVs report both actual payments made through the fourth quarter and an unreported grant expenditures estimate for the fourth quarter based on historical spending patterns of the grantees. The year-end accrual estimate equals the estimate of fourth quarter disbursements plus an average of two weeks annual expenditures for expenses incurred prior to the cash being drawn down.

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

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

Inventory Held for Sale consists of small equipment and supplies held by the Service and Supply Fund for sale to HHS components and other Federal entities. Inventories held for sale are valued at historical cost using the weighted average valuation method for PSC inventories and using the moving average valuation method for the NIH inventories.

Operating Materials and Supplies consist of pharmaceuticals, biological products, and other medical supplies used in providing medical services and conducting medical research. Operating materials and supplies are recorded as assets when purchased and are expensed when they are consumed. Operating materials and supplies are valued at historical cost.

Stockpile Materials are materials held in reserve to respond to local and national emergencies. In addition, the CDC maintain a stockpile of vaccines to meet unanticipated needs in the case of a national emergency. As required by the Project BioShield Act of 2004, the Department of Homeland Security transferred Strategic National Stockpile materials to the HHS in FY 2004. The Strategic National Stockpile materials are not available for sale and are valued at historical cost using the FIFO cost flow assumption and the CDC's vaccine stockpile is valued at historical cost.

General Property, Plant and Equipment, Net

General Property, Plant and Equipment (PP&E) consist of buildings, structures, and facilities used for general operations; land acquired for general operating purposes; equipment; assets under capital lease; leasehold improvements; construction-in-progress; and internal use software. The basis for recording purchased PP&E is full cost, net of accumulated depreciation including all costs incurred to bring the PP&E to a form and location suitable for its intended use. The cost of PP&E acquired under a capital lease is the amount recognized as a liability for the capital lease at its inception. The cost of PP&E acquired through donation is the estimated fair market value when acquired. The cost of PP&E transferred from other Federal entities is the net book value of the transferring entity. All PP&E with an initial acquisition cost of $25,000 or more and an estimated useful life of two years or more are capitalized, except for internal use software discussed below.

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

The SFFAS No. 10, *Accounting for Internal Use Software,* requires that the capitalization of internally developed, contractor-developed and commercial off-the-shelf (COTS) software begin in the software development phase. In FY 2004, the HHS incurred development costs for UFMS, a COTS software package, and began capitalizing the cost. The estimated useful life for internal use software was determined to be five to ten years for amortization purposes. The HHS began amortization when the internal use software was placed in use. Capitalized costs include all direct and indirect costs. In FY 2005, the CMS began amortizing HIGLAS over ten years using the straight-line method in accordance with the HHS policy for UFMS. In addition, the CMS has other capitalized internal use software that is currently being amortized over a useful life of five years.

The capitalization threshold for internal use software costs for appropriated fund accounts is $1 million and the capitalization threshold for revolving funds is $500 thousand. Costs below the threshold levels

are expensed. The software is depreciated for a period of time consistent with the estimated useful life used for planning and acquisition purposes.

Stewardship Property, Plant & Equipment

Stewardship PP&E consist of heritage assets and stewardship land whose physical properties resemble those of general PP&E that are traditionally capitalized in financial statements. Based on SFFAS No. 29, *Heritage Assets and Stewardship Land*, and due to the difficulty in valuing these assets, the HHS does not report a related amount on the balance sheet. This standard requires that the balance sheet reference a note that discloses information but not an amount for Stewardship PP&E.

Liabilities

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

Liabilities Covered by Budgetary Resources: Available budgetary resources include: (1) new budget authority, (2) spending authority from offsetting collections, (3) recoveries of expired budget authority, (4) unobligated balances of budgetary resources at the beginning of the year, and (5) permanent indefinite appropriation or borrowing authority.

Liabilities Not Covered by Budgetary Resources: Sometimes funding has not yet been made available through Congressional appropriations or current earnings. The major liabilities in this category include employee annual leave earned but not taken, amounts billed by the Department of Labor (DOL) for Federal Employees' Compensation Act (FECA) disability payments, and portions of the Entitlement Benefits Due and Payable liability (discussed below) for which no obligations have been incurred. Also included in this category is the actuarial FECA liability determined by DOL but not yet billed. For HHS revolving funds, all liabilities are funded as they occur.

Accounts Payable

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

Accrued Payroll and Benefits

Accrued Payroll and Benefits consist of salaries, wages, leave and benefits earned by employees, but not disbursed as of September 30. Liability for annual and other vested compensatory leave is accrued when earned and reduced when taken. At the end of each fiscal year, the balance in the accrued annual leave liability account is adjusted to reflect current pay rates. Annual leave earned but not taken is considered an unfunded liability since this leave will be funded from future appropriations when it is actually

taken by employees. Sick leave and other types of leave are not accrued and are expensed when taken. Intragovernmental Accrued Payroll and Benefits consists of the HHS FECA liability.

Entitlement Benefits Due and Payable

Entitlement Benefits Due and Payable primarily represent the liability for Medicare and Medicaid for medical services incurred but not reported (IBNR) as of the balance sheet date.

Medicare

The Medicare liability is developed by the Office of the Actuary of the Centers for Medicare & Medicaid Services and includes (a) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment, (b) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (c) checks that have been issued by the Medicare contractors in payment of claims that have not yet been cashed by payees, (d) periodic interim payments for services rendered in the current fiscal year but paid in the subsequent fiscal year, and (e) an estimate of retroactive settlements of cost reports submitted to the Medicare contractors by health care providers.

Medicaid

The Medicaid estimate represents the net Federal share of expenses incurred by the States but not yet reported to CMS. The September 2007 estimate was developed based on historical relationships between prior Medicaid net payables and current Medicaid activity.

Federal Employee and Veterans' Benefits

Most HHS employees participate in either the Civil Service Retirement System (CSRS) – a defined benefit plan, or the Federal Employees Retirement System (FERS) – a defined benefit and contribution plan. For employees covered under CSRS, the Department contributes a fixed percentage of pay. Most employees hired after December 31, 1983, are automatically covered by FERS. For employees covered under FERS, the Department contributes the employer's matching share for Social Security and Medicare Insurance. A primary feature of FERS is that it offers a Thrift Savings Plan into which the Department automatically contributes one percent of employee pay and matches employee contributions up to an additional four percent of pay.

The U.S. Office of Personnel Management is the administering agency for both of these benefit plans and, thus, reports CSRS or FERS assets, accumulated plan benefits, or unfunded liabilities applicable to Federal employees. Therefore, the HHS does not recognize any liability on its balance sheet for pensions, other retirement benefits, and other post-employment benefits with the exception of Commissioned Corps (see below). The HHS does, however, recognize an expense in the Consolidated Statements of Net Cost and an imputed financing source for the annualized unfunded portion of pension and post-retirement benefits in the Consolidated Statements of Changes in Net Position.

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

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

Revenue and Financing Sources

The Department receives the majority of funding needed to support its programs through Congressional appropriation and through reimbursement for the provision of goods or services to other Federal agencies. The United States Constitution prescribes that no money may be expended by a Federal agency unless and until funds have been made available by Congressional appropriation. Appropriations are recognized as financing sources when related expenses are incurred or assets are purchased. Revenues from reimbursable agreements are recognized when the goods or services are provided by the Department. Other financing sources, such as donations and transfers of assets without reimbursements, are also recognized on the Consolidated Statements of Changes in Net Position.

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

Exchange and Non-Exchange Revenue. The HHS classifies revenues as either exchange or non-exchange. Exchange revenues are recognized when earned, i.e., when goods have been delivered or services have been rendered. These revenues reduce the cost of operations borne by the taxpayer.

Non-exchange revenues result from donations to the government and from the government's sovereign right to demand payment, including taxes. Non-exchange revenues are recognized when a specifically identifiable, legally enforceable claim to resources arises, but only to the extent that collection is probable and the amount is reasonably estimable. Non-exchange revenues are not considered to reduce the cost of the Department's operations and are reported in the Statements of Changes in Net Position.

For periods after December 31, 1993, employees and employers are each required to contribute 1.45 percent of employee wages and self-employed persons are required to contribute 2.90 percent of net income, with no limitation, to the General Fund of the Treasury. The Social Security Act requires the transfer of these contributions from the General Fund of the Treasury to the HI trust fund based on the amount of wages certified by the Social Security Administration (SSA) from SSA records of wages established and maintained by the SSA in accordance with wage information reports. The SSA uses the wage totals reported annually by employers and self-employed individuals to the Internal Revenue Service as the basis for conducting quarterly certification of regular wages.

With minor exceptions, all receipts of revenues by Federal agencies are processed through the Treasury's central accounting system. Regardless of whether they derive from exchange or non-exchange transactions, all receipts not earmarked by Congressional appropriation for immediate departmental use are deposited in the general or special funds of the Treasury. Amounts not retained for use by the HHS are reported as transfers to other government agencies on the HHS Statements of Changes in Net Position.

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

Other Financing Sources. Medicare's HI program, or Medicare Part A, is financed through the HI trust fund, whose revenues come primarily from the Medicare portion of payroll and self-employment taxes collected under the Federal Insurance Contribution Act (FICA) and under the Self-Employment Contribution Act (SECA). Contribution rates are discussed under *Exchange and Non-Exchange Revenue*. Medicare's Supplemental Medical Insurance (SMI) program, or Medicare Part B, is financed primarily by general fund appropriations (Payments to the Health Care Trust Funds) provided by Congress and by monthly premiums paid by beneficiaries.

Contingencies

A loss contingency is an existing condition, situation, or set of circumstances involving uncertainty as to possible loss to the Department. The uncertainty should ultimately be resolved when one or more future events occur or fail to occur. The likelihood that the future event or events will confirm the loss or the incurrence of a liability can range from probable to remote. SFFAS No. 5, *Accounting for Liabilities of the Federal Government,* as amended by SFFAS No. 12, *Recognition of Contingent Liabilities from Litigation*, contain the criteria for recognition and disclosure of contingent liabilities. With the exception of pending, threatened, or potential litigation, a contingent liability is recognized when a past transaction or event has occurred; a future outflow or other sacrifice of resources is more likely than not to occur; and the related future outflow or sacrifice of resources is measurable. For pending, threatened, or potential litigation, a liability is recognized when a past transaction or event has occurred, a future outflow or other sacrifice of resources is likely to occur, and the related future outflow or sacrifice of resources is measurable.

Parent/Child Reporting

The HHS is a party to allocation transfers with other federal agencies as both a transferring (parent) entity and/or a receiving (child) entity. Allocation transfers are legal delegations by one department of its authority to obligate budget authority and outlay funds to another department. A separate fund account (allocation account) is created in the U.S. Treasury as a subset of the parent fund account for tracking and reporting purposes. All allocation transfers of balances are credited to this account, and subsequent obligations and outlays incurred by the child entity are charged to this allocation account as

they execute the delegated activity on behalf of the parent entity. Generally, all financial activity related to these allocation transfers (e.g., budget authority, obligations, outlays) is reported in the financial statements of the parent entity, from which the underlying legislative authority, appropriations and budget apportionments are derived.

Exceptions to this general rule affecting the HHS include Treasury-Managed Trust Funds: Federal Supplementary Medical Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, the Vaccine Injury Compensation Program Trust Fund and the Healthcare Fraud and Abuse Control Account, for which the HHS is the child in the allocation transfer but, per OMB guidance, will report all activity relative to these allocation transfers in the HHS financial statements.

In addition to these funds, the HHS allocates funds, as the parent, to the Department of the Interior, Bureau of Indian Affairs. The HHS receives allocation transfers, as the child, from the Environmental Protection Agency and the Departments of Homeland Security, Justice and State.

Intragovernmental Relationships and Transactions

In the course of its operations, the HHS has relationships and financial transactions with numerous Federal agencies. The more prominent of these are the SSA and the Department of the Treasury. The SSA determines eligibility for Medicare programs and also allocates a portion of Social Security benefit payments to the Medicare Part B Trust Fund for Social Security beneficiaries who elect to enroll in the Medicare Part B program. The Treasury receives the cumulative excess of Medicare receipts and other financing over outlays and issues interest-bearing securities in exchange for the use of those monies. Similarly, Medicare Part D is also primarily financed by the General Fund of the Treasury.

Earmarked Funds

SFFAS No. 27, *Identifying and Reporting Earmarked Funds,* defines earmarked funds and requires that they be shown separately from all other funds on the Statement of Changes in Net Position, as well as in the Net Position section of the Balance Sheet. Earmarked funds are defined as those financed by specifically identified revenues, often supplemented by other financing sources, which remain available over time; are required by statute to be used for designated activities, benefits or purposes; and must be accounted for separately from the Government's general revenues. "Fund" in this statement's definition of earmarked funds refers to a "fiscal and accounting entity with a self-balancing set of accounts recording cash and other financial resources, together with all related liabilities and residual equities or balances, and changes therein, which are segregated for the purpose of carrying on specific activities or attaining certain objectives in accordance with special regulations, restrictions, or limitations."

Whether the appropriation is provided by authorizing legislation or annual appropriations acts, the cumulative results of operations arising from earmarked funds are reserved or restricted to the designated activity, benefit or purpose. The standard also requires that condensed information on assets, liabilities and costs for earmarked funds be disclosed. An earmarked fund may be classified in the unified budget as a trust, special or public enterprise fund. Examples of the HHS earmarked funds include the HI trust fund that is used to process claims associated with Part A benefits and the SMI trust fund that is used to process claims associated with Part B and Part D benefits.

Medicare Hospital Insurance (HI) Trust Fund – Part A
Section 1817 of the Social Security Act established the Medicare Hospital Insurance Trust Fund. Medicare contractors are paid by the HHS to process Medicare claims for hospital inpatient services, hospice, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the HI trust fund. The HHS payments to Medicare Advantage plans (previously known as Managed Care plans) are also charged to this fund. The financial statements include the HI trust fund activities administered by the Department of Treasury. This trust fund has permanent indefinite authority. Employment tax revenue is the primary source of financing for Medicare's HI program. Medicare's portion of payroll and self-employment taxes is collected under FICA and SECA. Employee and employers are both required to contribute 1.45 percent of earnings, with no limitation, to the HI trust fund. Self-employed individuals contribute the full 2.9 percent of their net income. The Social Security Act requires the transfer of these contributions from the General Fund of Treasury to the HI trust fund based on the amount of wages certified by the Commissioner of Social Security from SSA records of wages established and maintained by SSA in accordance with wage information reports. The SSA uses the wage totals reported annually by employers via the quarterly Internal Revenue Service Form 941 as the basis for conducting quarterly certification of regular wages.

Medicare Supplementary Medical Insurance (SMI) Trust Fund – Part B
Section 1841 of the Social Security Act established the Supplementary Medical Insurance Trust Fund. Medicare contractors are paid by CMS to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, end-stage renal disease treatment (ESRD), rural health clinics, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the SMI trust fund. The HHS payments to Medicare Advantage plans are also charged to this fund. The financial statements include SMI trust fund activities administered by Treasury. The SMI trust fund has permanent indefinite authority.

The SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and are matched by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year.

Medicare Prescription Drug Benefit – Part D
The Medicare Prescription Drug Benefit – Part D, established by the Medicare Modernization Act (MMA) of 2003, became effective January 1, 2006. The program makes a prescription drug benefit available to everyone who is in Medicare, though beneficiaries must join a drug plan to obtain coverage. The drug plans are offered by insurance companies and other private companies approved by Medicare and are of two types: Medicare Prescription Drug Plans (which add the coverage to basic Medicare) and Medicare Advantage Prescription Drug Plans and other Medicare Health Plans in which drug coverage is offered as part of a benefit package that includes Part A and Part B services. In addition, Medicare helps employers or unions continue to provide retiree drug coverage that meets Medicare's standards through

the Retiree Drug Subsidy (RDS). In addition, the Low Income Subsidy (LIS) helps those with limited income and resources. Medicare also reimburses States who have paid prescription drug costs for dual eligibles who have had difficulty accessing Part D benefits.

The Part D is considered part of the SMI trust fund and is reported in the Medicare column of financial statements where required.

Medicare and Medicaid Integrity Program

The Health Insurance Portability and Accountability Act of 1996 (HIPAA, *Public Law No. 104-191, § 202*) established the Medicare Integrity Program at section 1893 of the Social Security Act, and codified Medicare program integrity activities previously known as "payment safeguards." HIPAA section 201 also established the Health Care, "Fraud and Abuse Control Account, which provides a dedicated appropriation for carrying out the Medicare Integrity Program." Through the Medicare Integrity program, the CMS contracts with eligible entities to perform such activities as medical and utilization reviews, fraud reviews, cost report audits, and the education of providers and beneficiaries with respect to payment integrity and benefit quality assurance issues. The Medicare Integrity Program is funded by the HI trust fund.

Separately, the Medicaid Integrity Program was established by the Deficit Reduction Act of 2005 (DRA, *Public Law No. 109-171. § 6034*), and codified at section 1936 of the Social Security Act. The Medicaid Integrity Program represents the Federal government's first effort to directly review and audit Medicaid providers, tasks that were formerly performed solely by States. Under the Medicaid Integrity Program, which is still in the implementation phase, CMS will contract with eligible entities to perform, with respect to Medicaid providers, activities generally similar to those currently performed by Medicare Integrity Program contactors with respect to Medicare providers.

Medicaid

Medicaid, the health care program for low-income Americans, is administered by CMS in partnership with the States. Grant awards limit the funds that can be drawn by the States to cover current expenses. The grant awards, prepared at the beginning of each quarter and amended as necessary, are an estimate of the CMS' share of States' Medicaid costs. At the end of each quarter, States report their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by the CMS for the difference between approved expenses reported for the period and grant awards previously issued. Medicaid is financed by general funds and is not classified as "earmarked."

The State Children's Health Insurance Program (SCHIP)

SCHIP, included in the Balanced Budget Act of 1997 (BBA), was designed to provide health insurance for children, many of whom come from working families with incomes too high to qualify for Medicaid, but too low to afford private health insurance. The BBA set aside funds for ten years to provide this insurance coverage. The Grant awards, prepared at the beginning of each quarter and amended as necessary, are based on a State approved plan to fund SCHIP. At the end of each quarter, States report their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by CMS for the difference between the approved expenses reported for the period and the grant awards previously issued.

Statement of Social Insurance

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

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

The assumptions underlying the SOSI actuarial projections, and the projections themselves, are drawn from the Social Security and Medicare Trustees Reports for 2007. Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.

The additional information on the SOSI of actuarial present values of estimated future income (excluding interest) less expenditures plus assets at the start of the period is presented for purposes of additional analysis and is not a required part of the financial statements.

Note 2. Non-Entity Assets

Non-entity assets at September 30, 2007 and 2006, consisted of the following:

(In Millions)	2007	2006
Intragovernmental:		
Fund Balance with Treasury	$ 22	$ 26
Total Intragovernmental	22	26
Accounts receivable	15	14
Total Non-Entity Assets	37	40
Total Entity Assets	503,770	513,869
Total Assets	$ 503,807	$ 513,909

The $22 million non-entity asset Fund Balance with Treasury primarily consists of Federal tax refunds collected by the Internal Revenue Service for delinquent child support payments that were transferred to ACF for distribution to the States and also includes $9 million in NIH collections of royalties from licenses for which a portion is paid to inventors under the Federal Technology Transfer Act. The $15 million net accounts receivable primarily represents CMS' receivables for interest and penalties.

Note 3. Fund Balance with Treasury

The Fund Balance with Treasury (FBWT) and the status of the fund balance as of September 30, 2007 and 2006, are listed below by fund type.

(In Millions)	2007	2006
Fund Balance with Treasury		
Trust Funds	$ 9,047	$ 28,985
Revolving Funds	5,613	896
Appropriated Funds	99,225	129,292
Other Funds	889	748
Total	$ 114,774	$159,921

Status of Fund Balance with Treasury		
Unobligated Balance	2007	2006
Available	$ 17,339	$ 60,254
Unavailable	7,335	7,666
Obligated Balance not yet Disbursed	135,355	134,837
Non-Budgetary FBWT	(45,255)	(42,836)
Total	$ 114,774	$ 159,921

Other Funds include balances in deposit, suspense, clearing, and related non-spending accounts. The Unobligated Balance includes $2.2 billion for both September 30, 2007 and 2006, which is restricted for future use and is not apportioned for current use. The $2.2 billion reported for September 30, 2007, includes restricted amounts for the ACF Contingency Fund for State Welfare Programs, the CMS Program Management and State Grants and Demonstrations, the NIH Royalties owed to Inventors, the HRSA Federal Interest Subsidies for Medical Facilities Guarantee and Loan Fund, the FDA Imprest Fund and the PSC Service and Supply Funds.

The Non-Budgetary FBWT negative balances reported for September 30, 2007 and 2006, are primarily due to CMS Medicare trust funds temporarily precluded from obligation.

Note 4. Cash and Other Monetary Assets

Cash and Other Monetary Assets consist primarily of the time account balances at the Medicare contractors' commercial banks. The HHS uses the "Checks Paid Letter-of-Credit" method for reimbursing Medicare contractors for the payment of covered Medicare services. Medicare contractors issue checks against Medicare Benefits Accounts maintained at commercial banks. To compensate the commercial banks for handling the Medicare Benefits Accounts, Medicare funds are deposited into non-interest bearing time accounts. The interest foregone by HHS on these time accounts is used to reimburse the commercial banks for the service. The account balances as of September 30, 2007 and 2006, were $129 million and $145 million, respectively.

Note 5. Investments, Net

The HHS' investments as of September 30, 2007 and 2006, are summarized below:

	2007			
(In Millions)	Cost	Unamortized (Premium) Discount	Investments, Net	Market Value Disclosure
Intragovernmental Securities				
Marketable	$ 41	$ -	$ 41	$ 41
Non-Marketable: Par Value	358,625	-	358,625	358,625
Non-Marketable: Market-based	2,629	(3)	2,626	2,626
Subtotal	361,295	(3)	361,292	361,292
Accrued Interest	4,583	-	4,583	4,583
Total, Intragovernmental	$ 365,878	$ (3)	$365,875	$ 365,875

	2006			
(In Millions)	Cost	Unamortized (Premium) Discount	Investments, Net	Market Value Disclosure
Intragovernmental Securities				
Marketable	$ 29	$ -	$ 29	$ 29
Non-Marketable: Par Value	335,247	-	335,247	335,247
Non-Marketable: Market-based	2,383	7	2,390	2,390
Subtotal	337,659	7	337,666	337,666
Accrued Interest	4,310	-	4,310	4,310
Total, Intragovernmental	$ 341,969	$ 7	$341,976	$ 341,976

The HHS invests entity trust fund balances in excess of current needs in U.S. Treasury securities. The Department of Treasury acts as the fiscal agent for the U.S. Government's investments in securities. The HHS securities purchased and redeemed include Marketable, Non-Marketable (Par Value), and Non-Marketable Market-based (MK) securities. These investments are carried at face value as determined by Treasury. Interest income is compounded semiannually (June and December) and was adjusted to include an accrual for interest earned from July 1 to September 30.

The Medicare bonds interest rates ranged from 3.50 percent to 7.25 percent from October 1, 2006, to September 30, 2007, and 3.50 percent to 7.375 percent from October 1, 2005, to September 30, 2006. The One Day Certificates are short-term and paid between 4.50 percent and 4.75 percent from

October 1, 2006, to September 30, 2007 and 4.75 to 5.25 percent from October 1, 2005, to September 30, 2006.

The HHS invests in One Day Certificates, Market-Based Notes and Market-Based Bills. The MK securities purchased by the HHS mirror marketable securities terms that are not traded on any securities exchange; these include Non-Marketable, MK, and One Day Certificates. The MKs are purchased by HRSA's Vaccine Injury Compensation Program (VICP) trust fund. Discounts on Market-Based Bills are amortized on a straight-line basis, and discounts and premiums on Market-Based Notes are amortized on an effective interest basis. Currently, securities held by the VICP will mature in fiscal years 2008 through 2012. The Market-Based Notes paid from 3.00 percent to 5.50 percent from October 1, 2006, to September 30, 2007, and from 3.00 percent to 6.25 percent from October 1, 2005, to September 30, 2006. One Day Certificates paid from 4.58 percent to 5.34 percent from October 1, 2006, to September 30, 2007.

Marketable securities purchased by the NIH gift funds are recorded at cost based on market terms and are invested in interest bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States.

Note 6. Accounts Receivable, Net

The HHS' accounts receivable as of September 30, 2007 and 2006, are summarized below:

	2007							
(In Millions)	Accounts Receivable Principal	Interest Receivable	Penalties, Fines, & Admin Fees Receivable	Accounts Receivable, Gross	Allowance	Net OPDIV Receivables Consol.	Inter-OPDIV Eliminations	Net HHS Receivables Consol.
Intragovernmental								
Entity	$ 1,621	$ -	$ -	$ 1,621	$ -	$ 1,621	$ (457)	$ 1,164
Non-Entity	-	-	-	-	-	-	-	-
Total	$ 1,621	$ -	$ -	$ 1,621	$ -	$ 1,621	$ (457)	$ 1,164
With the Public								
Entity								
Medicare	$ 13,827	$ -	$ -	$ 13,827	$(2,483)	$ 11,344	$ -	$ 11,344
Other	1,886	2	1	1,889	(227)	1,662	-	1,662
Non-Entity	13	49	-	62	(47)	15	-	15
Total	$ 15,726	$ 51	$ 1	$ 15,778	$(2,757)	$ 13,021	$ -	$ 13,021

	2006							
(In Millions)	Accounts Receivable Principal	Interest Receivable	Penalties, Fines, & Admin Fees Receivable	Accounts Receivable, Gross	Allowance	Net OPDIV Receivables Consol.	Inter-OPDIV Eliminations	Net HHS Receivables Consol.
Intragovernmental								
Entity	$ 978	$ -	$ -	$ 978	$ -	$ 978	$(252)	$ 726
Non-Entity	-	-	-	-	-	-	-	-
Total	$ 978	$ -	$ -	$ 978	$ -	$ 978	$(252)	$ 726
With the Public								
Entity								
Medicare	$4,784	$ -	$ -	$4,784	$(1,919)	$2,865	$ -	$2,865
Other	590	2	1	593	(265)	328	-	328
Non-Entity	9	43	-	52	(38)	14	-	14
Total	$5,383	$45	$ 1	$5,429	$(2,222)	$3,207	$ -	$3,207

The Hospital Insurance (HI) Trust Fund accrues a receivable from the Railroad Retirement Board (RRB) for amounts transferred through a financial interchange between the HI Trust Fund and the RRB. The transfer is intended to place the HI trust fund in the same position it would have been had railroad employment been covered by the Federal Insurance Contributions Act. Of the Intragovernmental Accounts Receivable, Net, as of September 30, 2007 and 2006, $484 million and $473 million were owed by the RRB, respectively.

Medicare Secondary Payer (MSP) receivables are composed of paid claims in which Medicare should have been the secondary payer rather than the primary payer. Claims that have been identified to a primary payer are included in the MSP receivable amount.

For Medicare receivables, the HHS calculates the allowance for uncollectible accounts receivable based on the collection activity and the age of the debt for the most current fiscal year, while taking into consideration the average uncollectible percentage for the preceding five years. The Medicaid accounts receivable has been recorded at a net realizable amount based on historic analysis of actual recoveries and the rate of disallowances found in favor of the States.

Note 7. Inventory and Related Property, Net

The HHS' inventory and related property, net, at September 30, 2007 and 2006, are summarized below:

(In Millions)	2007	2006
Inventory Held for Sale:		
Inventory Held for Current Sale	$ 13	$ 19
Total Inventory Held for Sale	13	19
Operating Materials and Supplies:		
Operating Materials and Supplies Held for Use	4	4
Total Operating Materials and Supplies	4	4
Stockpile Materials:		
Stockpile Materials Held for Emergency or Contingency	3,144	2,299
Total Stockpile Materials	3,144	2,299
Inventory and Related Property, Gross	3,161	2,322
Inventory and Related Property, Net	$ 3,161	$ 2,322

Note 8. General Property, Plant and Equipment, Net

Major categories of the HHS General Property, Plant and Equipment (PP&E) at September 30, 2007 and 2006, are listed below:

(In Millions)	Depreciation Method	Estimated Useful Lives	2007 Acquisition Cost	2007 Accumulated Depreciation	2007 Net Book Value
Land & Land Rights	-	-	$ 50	$ -	$ 50
Construction in Progress	-	-	737	-	737
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	4,419	(1,574)	2,845
Equipment	Straight Line	3-20 Yrs	1,140	(695)	445
Internal Use Software	Straight Line	5-10 Yrs	1,116	(262)	854
Assets Under Capital Lease	Straight Line	1-20 Yrs	140	(42)	98
Leasehold Improvements	Straight Line	*Life of Lease	43	(8)	35
Totals			$7,645	$ (2,581)	$ 5,064

*7 to 15 years or the life of the lease.

(In Millions)	Depreciation Method	Estimated Useful Lives	2006 Acquisition Cost	2006 Accumulated Depreciation	2006 Net Book Value
Land & Land Rights	-	-	$ 48	$ -	$ 48
Construction in Progress	-	-	718	-	718
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	4,179	(1,458)	2,721
Equipment	Straight Line	3-20 Yrs	1,281	(620)	661
Internal Use Software	Straight Line	5-10 Yrs	863	(179)	684
Assets Under Capital Lease	Straight Line	1-20 Yrs	41	(38)	103
Leasehold Improvements	Straight Line	*Life of Lease	43	(7)	36
Totals			$7,273	$(2,302)	$ 4,971

*7 to 15 years or the life of the lease.

Note 9. Other Assets

Other assets as of September 30, 2007 and 2006, are comprised of the following, all of which are considered entity assets:

(In Millions)	2007	2006
Intragovernmental		
Advances to Other Federal Entities	$ 438	$ 499
Other		1
OPDIV Combined, Intragovernmental	438	500
Intra-OPDIV Eliminations	(392)	(365)
OPDIV Consolidated, Intragovernmental	46	135
Inter-OPDIV Eliminations	(3)	(3)
HHS Consolidated, Intragovernmental	$ 43	$ 132
With the Public		
Prepayments and Deferred Charges	$ 1	$ -
Travel Advances & Emergency Employee Salary Advances	12	139
Other	563	370
HHS Consolidated, With the Public	$ 576	$ 509

Advances to other Federal entities is largely comprised of advances from the NIH to the NIH Service and Supply Fund and the Management Fund for financing the NIH Business System and the NIH Clinical Center, as well as advances from the CDC and the OS to the Department of Veterans Affairs for Strategic National Stockpile items.

As of September 30, 2007, the CMS had $161 million ($124 million in FY 2006) in Other Assets representing advances made to various contractors and vendors. The HRSA has Health Education Assistance Loan programs from which the net loan receivable comprises a large portion of Other Assets with the Public.

Note 10. Liabilities Not Covered by Budgetary Resources

The HHS' liabilities not covered by budgetary resources at September 30, 2007 and 2006 are summarized below:

(In Millions)	2007	2006
Intragovernmental		
Accrued Payroll and Benefits	$ 29	$ 27
Other (Note 14)	613	526
Total Intragovernmental	642	553
Federal Employees and Veterans' Benefits (Note 12)	8,368	7,532
Accrued Payroll and Benefits	392	458
Other (Note 14)	4,371	1,889
Total Liabilities Not Covered by Budgetary Resources	13,773	10,432
Total Liabilities Covered by Budgetary Resources	68,121	67,993
Total Liabilities	$ 81,894	$ 78,425

Note 11. Entitlement Benefits Due and Payable

Entitlement Benefits Due and Payable represent benefits due and payable to the public at year-end from entitlement programs enacted by law. The Medicare and Medicaid programs are the largest entitlement programs in the HHS and comprise all of the HHS Entitlement Benefits Due and Payable.

Entitlement Benefits Due and Payable at September 30, 2007 and 2006, are summarized in the following schedule:

	2007			2006		
(In Millions)	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total
Medicare	$ 41,604	$ -	$ 41,604	$ 40,824	$ -	$40,824
Medicaid	19,414	-	19,414	19,182	-	19,182
Other	452	-	452	1,158	-	1,158
Totals	$ 61,470	$ -	$ 61,470	$ 61,164	$ -	$61,164

Medicare benefits payable consists of a $35,063 million estimate ($36,628 million in FY 2006) by CMS Office of the Actuary of Medicare services incurred but not paid as of September 30, 2007.

Medicare Advantage and Prescription Drug Program benefits payable consist of a $2,653 million estimate ($1,683 million in FY 2006) for amounts owed to plans relating to risk and other payment related adjustments in addition to $982 million owed to plans after the completion of the Prescription Drug Payment reconciliation.

The Retiree Drug Subsidy (RDS) consists of a $2,906 million estimate ($2,377 million in FY 2006) of payments to plan sponsors of retiree prescription drug coverage incurred but not paid as of September 30, 2007. As part of MMA (incorporated in Section 1860D-22 of the Social Security Act), the RDS program makes subsidy payments available to sponsors of retiree prescription drug coverage. The program is designed to strengthen health care coverage for Medicare-eligible retirees by encouraging the retention of private, employer- and union-based retiree prescription drug plans.

During FY 2006, CMS implemented the State to Plan Reconciliation Demonstration project under the authority of Section 402 of the Social Security Amendments of 1967 in order to ensure appropriate care continuation for dual eligibles and other low-income subsidy entitled beneficiaries. As of September 30, 2006, the liability of $136 million relating to the demonstration project represents estimated amounts to be paid to States for costs incurred in assisting dual eligible beneficiaries to transition to the Medicare Part D Prescription Drug Benefit. As of September 30, 2007, no liability exists because the project was completed during FY 2007.

Undocumented aliens consist of a $163 million estimate ($170 million in FY 2006) of emergency health services furnished by providers to eligible aliens but not paid as of September 30. As part of the MMA, Section 1011, Congress mandated HHS directly pay hospitals, physicians, and ambulance providers for their otherwise un-reimbursed costs of providing services required by section 1867 of the Social Security Act related to undocumented aliens.

Medicaid benefits payable of $19,414 million ($19,182 million in FY 2006) is an estimate of the net Federal share of expenses that have been incurred by the States but not yet reported to CMS as of September 30, 2007. An estimated SCHIP benefits payable of $289 million has been recorded ($284 million in FY 2006) for the net Federal share of expenses that have been incurred by the States but not yet reported to CMS as of September 30, 2007.

A liability reported at September 30, 2006, for Katrina relief waivers of $704 million which consisted of $543 million in actual services rendered but not paid plus a $161 million estimate for services incurred but not paid by eligible States with respect to evacuees who did not have other coverage for assistance through insurance under title XIX of the Social Security Act does not exist as of September 30, 2007. Services were rendered by September 30, 2006, and the payments were made during FY 2007. CMS has this authority under an approved Multi-State Section 1115 Demonstration Project of Public Law 109-171, Subtitle C.

Note 12. Federal Employee and Veterans' Benefits

The HHS' Federal Employee and Veterans' Benefits at September 30, 2007 and 2006, are summarized below. These liabilities are not covered by budgetary resources.

(In Millions)	2007	2006
With the Public		
Liabilities Not Covered by Budgetary Resources		
PHS Commissioned Corp Pension Liability	$ 7,575	$ 6,583
PHS Commissioned Corp Post-retirement Health Benefits	516	680
Workers' Compensation Benefits (Actuarial FECA Liability)	277	269
Total, Federal Employee and Veterans' Benefits	$ 8,368	$ 7,532

Public Health Service (PHS) Commissioned Corps: The HHS administers the PHS Commissioned Corps Retirement System for approximately 5,913 active duty officers and 5,441 retiree annuitants and survivors. Authorized by *Public Law 78-410,* it is a defined noncontributory benefit plan. At September 30, 2007, the actuarial present value of accumulated plan pension benefits was $7,575 million, of which $578 million was not vested, and the liability for medical benefits was actuarially determined to be $697 million.

Significant assumptions used by the actuary in its reports on the pension and medical programs as of September 30, 2007, were as follows:

Interest on Federal securities	6.00 percent
Annual basic pay scale increase	3.75 percent
Annual inflation	3.00 percent

Withdrawal and retirement rates are based on the historical trends of officers in the PHS retirement system. The HHS applies the aggregate entry age normal actuarial cost method to both programs to determine its liabilities.

The following shows key valuation results as of September 30, 2007 and 2006, in conformance with the actuarial reporting standards set forth in the Statement of Federal Financial Accounting Standards No. 5, *Accounting for Liabilities of the Federal Government*.

(In Millions)	**2007**	**2006**
SFFAS 5 Expense		
(a) Normal Cost	$ 153	$ 156
(b) Interest Cost	443	425
(c) Ongoing Cost (a & b)	596	581
(d) Prior Service Cost & (Gains)/Losses	533	34
(e) Total Expense	$ 1,129	$ 615

Workers' Compensation Benefits: The actuarial liability for future workers' compensation benefits include the expected liability for death, disability, medical, and miscellaneous costs for approved compensation cases, plus a component for incurred but not reported claims.

The liability utilizes historical benefit payment patterns to predict the ultimate payment related to a period. Consistent with past practice, these projected annual benefit payments have been discounted to present value using the OMB's economic assumptions for 10-year Treasury notes and bonds. Interest rate assumptions utilized for discounting in FY 2007 and 2006 appear below.

FY 2007	**FY 2006**
4.930% in Year 1	5.170% in Year 1
5.078% in Year 2 and thereafter	5.313% in Year 2 and thereafter

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

FY	COLA	CPIM
2007	3.13%	4.01%
2008	2.40%	4.01%
2009	2.40%	4.01%
2010	2.43%	4.09%
2011+	2.30%	3.94%

Note 13. Accrued Grant Liability

Grant advances are liquidated upon the grantees' reporting of expenditures on the quarterly Federal Cash Transaction Report (SF-272). In many cases, the HHS receives these reports several months after the grantees incur the expense. To avoid understating grant expenses, the HHS developed departmental procedures to estimate and accrue amounts due grantees for their unreported expenses through September 30.

At September 30, the OPDIVs record the liability based on the estimated accrual for unreported grantees' expenses. If the amount of the collective OPDIV advances outstanding exceeds the amount of the collective estimated expenses, HHS reports the difference as "Advances to Grantees." If the amount of the estimated expenses exceeds the amount of the collective advances outstanding, the HHS reports the difference as "Accrued Grant Liability."

The HHS' net grant advances (liability) at September 30, 2007 and 2006, are summarized below:

(In Millions)	2007	2006
Grant Advances Outstanding (before year-end grant accrual)	$15,528	$15,590
Estimated Accrual for Amounts Due to Grantees	(19,469)	(19,423)
Net Grant Liability	$ (3,941)	$ (3,833)

Note 14. Other Liabilities

The HHS' other liabilities at September 30, 2007 and 2006 are summarized below:

2007	Intragovernmental			With the Public		
(In Millions)	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total
Advances from Others	$ 477	$ -	$ 477	$ 59	$ -	$ 59
Deferred Revenue	410	-	410	555	-	555
Contingent Liabilities (Note 20)	-	-	-	5	4,111	4,116
Capital Lease Liability (Note 15)	-	80	80	27	5	32
Custodial Liabilities	-	480	480	-	(15)	(15)
Vaccine Injury Compensation Program	-	-	-	-	221	221
Environmental and Disposal Costs	-	-	-	4	33	37
Other	60	53	113	458	16	474
Combined OPDIV Totals	947	613	1,560	1,108	4,371	5,479
Intra-OPDIV Eliminations	(392)	-	(392)	-	-	-
Consolidated OPDIV Totals	555	613	1,168	1,108	4,371	5,479
Inter-OPDIV Eliminations	(353)	-	(353)	-	-	-
Consolidated HHS Totals	$ 202	$ 613	$ 815	$ 1,108	$ 4,371	$ 5,479

2006	Intragovernmental			With the Public		
(In Millions)	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total
Advances from Others	$ -	$ -	$ -	$ -	$ -	$ -
Deferred Revenue	480	-	480	746	-	746
Contingent Liabilities (Note 20)	-	34	34	-	1,601	1,601
Capital Lease Liability (Note 15)	-	83	83	27	9	36
Custodial Liabilities	-	409	409	-	10	10
Vaccine Injury Compensation Program	-	-	-	-	221	221
Environmental and Disposal Costs	-	-	-	1	36	37
Other	471	-	471	204	12	216
Combined OPDIV Totals	951	526	1,477	978	1,889	2,867
Intra-OPDIV Eliminations	(365)	-	(365)	-	-	-
Consolidated OPDIV Totals	586	526	1,112	978	1,889	2,867
Inter-OPDIV Eliminations	(157)	-	(157)	-	-	-
Consolidated HHS Totals	$ 429	$ 526	$ 955	$ 978	$ 1,889	$ 2,867

The majority of the other liabilities include Deferred Revenue, Custodial Liabilities, Contingent Liabilities, the Vaccine Injury Compensation Program, and Other Intragovernmental Liabilities.

Deferred Revenue:

The CMS receives premium payments on behalf of select categories of beneficiaries from third parties. In some instances, the payments received exceed the amount billed. As of the end of the accounting

period, the excess collections are reported as deferred revenue received that will be applied against the next month's premium bill. The CMS accounts for $329 million of the deferred revenue with the public.

The IHS accounts for $137 million of the intragovernmental deferred revenue for construction-in-process projects primarily under the Contribution Indian Health Facilities fund, and $173 million of the deferred revenue with the public for the Tribal Buybacks. The SAMHSA accounts for $160 million intragovernmental deferred revenue for interagency agreements with another Federal agency to award and administer the Drug Free Communities program grants. The Vaccine Injury Compensation Program administered by the HRSA accounts for $90 million in intragovernmental deferred revenue arising from the provision of goods and services by the program. The NIH accounts for $46 million deferred revenue with the public for unearned Cooperative Research and Development Agreement (CRADA) revenue. The AHRQ accounts for $23 million of intragovernmental deferred revenue for Public Health Service Evaluations.

Other Intragovernmental Liabilities:
Other Intragovernmental Liabilities of $815 million are primarily comprised of $530 million which CMS owes to other Federal entities, primarily to the Department of the Treasury ($480 million at September 30, 2007). The CMS' payable to Treasury is a result of the receivables from the beneficiaries and Medicare contractors. The CMS owes other Federal entities $50 million for services performed through interagency agreements.

Environmental and Disposal Costs:
The Comprehensive Environmental Response Compensation and Liability Act, the Comprehensive Environmental Cleanup and Responsibility Act, the Superfund Amendments and Reauthorization Act of 1986, and the Conservation Recovery Act of 1976 are several laws and regulations which require the HHS to remove, contain, and/or dispose of hazardous waste. Environmental and disposal costs are the costs of removing, containing, and/or disposing of (1) hazardous waste from property, and/or (2) material and/or property that consist of hazardous waste at a permanent or temporary closure or shutdown of associated property, plant, or equipment. The majority of the environmental and disposal costs consist of the IHS liabilities associated with surveying, testing, and remediating contaminated sites and the NIH ground water remediation project in accordance with applicable laws and regulations.

Note 15. Leases

Capital Leases:
The HHS has entered into various capital leases with Native American and Alaskan Native tribes and with the General Services Administration (GSA) for office and warehouse space. Lease terms vary from 1 to 20 years. Capitalized assets acquired under capital lease agreements and the related liabilities are reported at the present value of the minimum lease payments. Assets under Capital Lease amounts are reported in Note 8, General Property, Plant and Equipment.

Operating Leases:
The HHS has commitments under various operating leases with private entities and GSA for offices, laboratory space, and land. Leases with private entities have initial or remaining noncancelable lease

terms from 1 to 20 years. The GSA leases in general are cancelable with 120 days notice. Under an operating lease, the cost of the lease is expensed as incurred.

A Summary of Net Assets under Capital Lease and Future Minimum Lease Payments at September 30, 2007 and 2006, is presented in the schedules that follow:

(In Millions)	2007	2006
Summary of Net Assets Under Capital Lease		
Land and Building	$ 139	$ 140
Machinery and Equipment	1	1
Subtotal	$ 140	$ 141
Accumulated Amortization	(42)	(38)
Assets Under Capital Lease	$ 98	$ 103

(In Millions)	2007		2006	
Future Minimum Lease Payments	Capital Leases	Operating Lease	Capital Leases	Operating Lease
Year 1	$ 13	$ 341	$ 12	$ 319
Year 2	13	349	12	333
Year 3	13	325	13	333
Year 4	11	313	13	285
Year 5	11	290	11	253
Later Years	127	1,069	137	859
Total Minimum Lease Payments	$ 188	$ 2,687	$ 198	$ 2,382
Imputed Interest	(76)		(79)	
Total Capital Lease Liability	$ 112		$ 119	

Note 16. Consolidated Gross Cost and Earned Revenue by Budget Function Classification

Intragovernmental transactions are between Federal entities meaning both the buyer and seller are Federal. Exchange revenue with the public is a transaction when the buyer of the goods or services is a non-Federal entity and the seller is Federal.

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

The HHS' consolidated gross cost and exchange revenue by budget functional classification for the years ended September 30, 2007 and 2006, are summarized below:

(In Millions)	2007							2006
	Education Training and Social Services	Health	Medicare	Income Security	OPDIV Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals	HHS Consolidated Totals
Intragovernmental								
Gross Cost	$ 135	$ 4,261	$ 612	$ 33	$ 5,041	$ (1,553)	$ 3,488	$ 3,320
Earned Revenue	(9)	(2,880)	(7)	(11)	(2,907)	1,557	(1,350)	(1,101)
Net Cost, Intragovernmental	$ 126	$ 1,381	$ 605	$ 22	$ 2,134	$ 4	$ 2,138	$ 2,219
With the Public								
Gross Cost	$ 12,858	$248,560	$417,205	$35,697	$ 714,320	$ -	$ 714,320	$ 673,170
Earned Revenue	-	(1,599)	(50,259)	(1)	(51,859)	-	(51,859)	(51,452)
Net Cost, With the Public	$ 12,858	$246,961	$366,946	$35,696	$ 662,461	$ -	$ 662,461	$ 621,718
Totals								
Gross Cost	$ 12,993	$252,821	$417,817	$35,730	$ 719,361	$ (1,553)	$ 717,808	$ 676,490
Earned Revenue	(9)	(4,479)	(50,266)	(12)	(54,766)	1,557	(53,209)	(52,553)
Net Cost of Operations	$ 12,984	$248,342	$367,551	$35,718	$ 664,595	$ 4	$ 664,599	$ 623,937

Note 17. Exchange Revenue

The HHS recognizes its revenue from exchange transactions when goods and services are provided. Total exchange revenue was $53 billion and $53 billion through September 30, 2007 and 2006, respectively. The HHS exchange revenue primarily consists of Medicare premiums collected from beneficiaries.

Premiums collected are used to finance Supplemental Medical Insurance (SMI) benefits and administrative expenses. Monthly premiums paid by Medicare beneficiaries are matched by the Federal Government through the General Fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year.

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

Note 18. Custodial Activity
The ACF receives monies from the Internal Revenue Service for outlay to the States for child support. These monies represent delinquent child support payments withheld from Federal tax refunds. Receipts are transferred to the HHS appropriation 75X6234 to cover outlays. During FY 2007, receipts amounted to $1,682 million ($1,571 million for FY 2006) and outlays amounted to $1,682 million ($1,556 million for FY 2006).

The FDA custodial activity involves collections of civil monetary penalties (CMP) assessed by the Department of Justice on behalf of FDA. Penalties are assessed for violations in areas such as illegally manufactured, marketed, and distributed animal feeds and drug products. Total CMP collections in FY 2007 were $10 million ($24.8 million for FY 2006). The CMP collections are immediately forwarded to the Department of the Treasury and cannot be used for FDA operations.

The CDC custodial activity consists of collections of interest on outstanding receivables and funds received from debts in collection status. Total custodial liabilities for FY 2007 and FY 2006 were $4.3 million and $3.6 million, respectively. CDC custodial collections are also forwarded to the Department of the Treasury and cannot be used for CDC operations.

Note 19. Federal Matching Contribution
The monthly SMI premium per beneficiary was $88.50 from October 2006 through December 2006 and $93.50 from January 2007 through September 2007. Premiums collected from beneficiaries totaled $45.7 billion in FY 2007 ($41.6 billion in FY 2006) and were matched by $137.8 billion ($129.1 billion in FY 2006) contribution from the Federal Government.

Note 20. Contingencies
Contingent Liabilities:
The HHS is a party in various administrative proceedings, legal actions, and tort claims which may ultimately result in settlements or decisions adverse to the Federal Government. Management, in consultation with legal counsel, has determined that it is reasonably possible that certain claims may result in an adverse outcome to the Department. The HHS has accrued contingent liabilities where a loss is determined to be probable and the amount can be estimated. Other contingencies exist where losses are reasonably possible, and an estimate can be determined or an estimate of the range of possible liability has been determined.

The Medicaid amount for $1,702 million consists of Medicaid audit and program disallowances of $463 million and $1,239 million, respectively, for reimbursement of State plan amendments. Contingent liabilities have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the States. In all cases, the funds have been returned to CMS. The CMS will be required to pay these amounts if the appeals are decided in the favor of the States. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a State. There are also outstanding reviews of the State expenditures in which a final determination has not been made. Examples of these reviews are the Office of Inspector General Audits, Focused Financial Management Reviews, and Quarterly Medicaid Statement of Expenditures Report (Form CMS-64) reviews. The appropriate Center for Medicaid & State Operations (CMSO) Regional Office is responsible for reviewing the findings and recommendations.

The monetary effect of these reviews is not known until a final decision is determined and rendered by the CMSO Director. The outcome of these reviews is that CMS could be owed funds.

As of September 30, 2007, CMS recorded $1,742 million for a contingent liability for asserted and unasserted claims that could be owed to States arising from the payment of claims by State Medicaid Programs for beneficiaries who allegedly were eligible for Medicare. In FY 2006, CMS believed this contingent liability to be reasonably possible and disclosed it in the footnotes. On September 24, 2007, one state asserted a claim in a civil action brought in federal district court. The agency intends to defend against this claim. Because appropriation law requires Congress to authorize the transfer of funds out of the Medicare trust funds into an appropriation account, the Medicare trust funds cannot reimburse the Health Program accounts in the general fund of the Treasury absent Congressional authorization. The CMS does not intend to seek such Congressional authorization and there will be no transactions recorded between the trust funds and the Health Programs' accounts in the general fund.

The CMS has accrued $667 million as of September 30, 2007, for a contingent liability to providers for previous years' disputed cost report adjustments for disproportionate share hospitals.

Vaccine Injury Compensation Program (VICP):
The VICP is administered by HRSA and provides compensation for vaccine-related injury or death. The $221 million VICP liability represents the estimated future payment value of injury claims outstanding for VICP as of September 30, 2007.

Appeals at the Provider Reimbursement Review Board:
Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. As of September 30, 2006, there were 5,886 PRRB cases (5,737 in FY 2005) under appeal. A total of 2,901 new cases (2,422 in FY 2006) were filed in FY 2007. The PRRB rendered decisions on 119 cases (85 in FY 2006) in FY 2007 and 2,024 additional cases (2,188 in FY 2006) were dismissed, withdrawn or settled prior to an appeal hearing. The PRRB gets no information on the value of these cases that are settled prior to an appeal hearing. Since data is available for only the 119 cases that were decided in FY 2007, a reasonable liability estimate cannot be projected for the value of the 6,644 cases (5,886 in FY 2006) remaining on appeal as of September 30, 2007. As cases are decided, the settlement value paid is considered in the development of the actuarial liability estimate.

Obligations Related to Cancelled Appropriations:
Payments may be required of up to one percent of current year appropriations for valid obligations incurred against prior year appropriations that have been cancelled pursuant to the National Defense Authorization Act of FY 1991 (*Public Law 101-150*). The total payments related to cancelled appropriations are estimated at $1,358 million and $1,009 million as of September 30, 2007 and 2006, respectively.

Note 21. Apportionment Categories of Obligations Incurred
Obligations incurred by apportionment categories at September 30, 2007 and 2006, are summarized below:

(In Millions)	2007 Direct	2007 Reimbursable	2007 Totals
Category A (Distributed by Quarter)	$ 136,544	$ 6,913	$ 143,457
Category B (Restricted and Distributed by Activity)	411,939	192	412,131
Exempt from Apportionment	401,083	-	401,083
Total Obligations Incurred	$ 949,566	$ 7,105	$ 956,671

(In Millions)	2006 Direct	2006 Reimbursable	2006 Totals
Category A (Distributed by Quarter)	$ 125,641	$ 7,340	$ 132,981
Category B (Restricted and Distributed by Activity)	388,707	431	389,138
Exempt from Apportionment	362,784	-	362,784
Total Obligations Incurred	$ 877,132	$ 7,771	$ 884,903

Obligations incurred consist of expended authority and the change in undelivered orders. OMB has exempted CMS from the OMB Circular No. A-11 requirement to report Medicare's refunds of prior year obligations separately from refunds of current year obligations on the SF-133.

Note 22. Legal Arrangements Affecting Use of Unobligated Balances

The unobligated balances consist of appropriated funds, revolving funds, management funds, trust funds, Cooperative Research and Development Agreement (CRADA) funds and royalty funds. The annual appropriations are available for sponsoring and conducting medical research and are available for new obligations in the year of appropriation and for adjustments to valid obligations for five subsequent years. The revolving and management funds are available for centralized research support services and administrative activities of the NIH. Revolving funds are no-year funds available until expended. The NIH management fund is available for two fiscal years. The trust funds consist of the Conditional, Unconditional, and Patient Emergency Funds and are also available until expended. The Patient Emergency Fund is intended solely for the benefit of patients. The Unconditional Gift Fund is available for any authorized purpose in the performance of NIH functions. The Conditional Gift Fund is restricted to a specific purpose determined by the donor. The NIH is not authorized to spend the funds to support functions not encompassed within the terms of the conditions. However, for conditional monetary gifts, upon completion of the stipulated conditions, or circumstances rendering completion of the conditions impossible, any remaining unobligated conditional funds are transferred to the Unconditional Gift Fund for the support of any other objectives of the recipient organization. The funds received for CRADA are available for the performance of the contractual agreement, and are available for the term of the agreement. The Royalty funds are available for obligations for two fiscal years after the fiscal year in which the funds are received and are available for a variety of purposes, such as rewards to scientific, engineering, and technical employees of the laboratory, to educate and train employees and to pay expenses incidental to the administration of intellectual property by the entity.

All trust fund receipts collected in the fiscal year are reported as new budget authority in the Statements of Budgetary Resources. The portion of trust fund receipts collected in the fiscal year that exceeds the amount needed to pay benefits and other valid obligations in that fiscal year is precluded by law from

being available for obligation. This excess of receipts over obligations is reported as "Temporarily Not Available Pursuant to Public Law" in the Statements of Budgetary Resources and, therefore, is not classified as budgetary resources in the fiscal year collected. However, all such excess receipts are assets of the trust funds and currently become available for obligation as needed. The entire trust fund balances in the amount of $313,882 million as of September 30, 2007 ($292,426 million in FY 2006), are included in Investments on the Balance Sheet.

The FDA received $168 million in funding in FY 2002, to remain available until expended, to support counter-terrorism projects that recognize the important role FDA plays in protecting the public health. The attacks of September 11, 2001 and subsequent national events resulted in an accelerated and intensified need for attention to activities related to counter-terrorism. The amount obligated for counter-terrorism projects through FY 2007 was approximately $167.7 million.

Note 23. Explanation of Differences between the Statement of Budgetary Resources (SBR) and the Budget of the United States Government

The FY 2009 *President's Budget*, with actual amounts for FY 2007, has not yet been published, and, therefore, no comparisons can be made between FY 2007 amounts presented in the SBR with amounts reported in the "Actual" column of the *President's Budget*. The FY 2009 *President's Budget* is expected to be released in February 2008, and may be obtained from the Office of Management and Budget website http://www.whitehouse.gov/omb/budget or the Government Printing Office.

The *Budget of the United States Government, FY 2008 – Appendix* was used as the reference for the HHS total budgetary resources amount. Information in the "Federal Programs by Agency and Account" in the FY 2008 Analytical Perspectives volume of the *Budget of the United States Government* was used as the reference for the net outlays (less offsetting receipts) amount in the following reconciliation of the SBR to the *President's Budget* for FY 2006:

(In Millions)	2006			
	Budgetary Resources	Obligations Incurred	Offsetting Receipts	Net Outlays (Less Offsetting Receipts)
Statement of Budgetary Resources	$952,823	$884,903	$226,875	$841,549
Unobligated Balances – Not Available	(5,078)	-	-	-
Other	7	275	(84)	(89)
Budget of the U.S. Government	$947,752	$885,178	$226,791	$841,460

For the budgetary resources reconciliation, the amount used from the *President's Budget* was the total budgetary resources available for obligation. Therefore, a reconciling item that is contained in the SBR and not in the *President's Budget* is the budgetary resources that were not available. The "Unobligated Balances – Not Available" line in the above schedule includes expired authority, recoveries, and other amounts included in the SBR that are not included in the *President's Budget*. The "Other" adjustments in Obligations Incurred primarily consist of NIH's $179 million obligations in expired accounts and $28 million of Gift Fund obligations not included in the *President's Budget*.

Note 24. Permanent Indefinite Appropriations

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

The list below includes the Treasury Fund Symbols that meet the criteria stated above and are considered permanent indefinite appropriations. The list also includes the period of availability (fiscal year or no-year) and the titles of the accounts.

75 0170 (fiscal year) HHS Accrual Contribution to the Uniformed Services Retiree Health Care Fund, Office of the Assistant Secretary for Health
75 0340 (fiscal year) Health Education Assistance Loans Program
75X0350 (no year) Health Centers Loan Program, HRSA
75X0513 (no year) Payments for Credits Against Health Care Contributions
75X0585 (no year) Taxation on Old-Age, Survivors, and Disability Insurance Benefits
75 1552 (fiscal year) Temporary Assistance for Needy Families
75 1553 (fiscal year) Children's Research and Technical Assistance
75X1553 (no year) Children's Research and Technical Assistance
75X4305 (no year) Health Prof. Grad. Student Loan Insurance Fund, Liquidating Account
75X5071 (no year) Operation and Maintenance of Quarters, IHS
75X5145 (no year) Cooperative Research and Development Agreements, NIH
75X5146 (no year) Cooperative Research and Development Agreements, CDC
75X5148 (no year) Cooperative Research and Development Agreements, FDA
75X8073 (no year) Contributions, Indian Health Facilities, IHS
75X8247 (no year) FDA Unconditional Gift Fund
75X8248 (no year) NIH Unconditional Gift Fund
75X8249 (no year) Unconditional Gift Fund, HRSA
75X8250 (no year) Gifts and Donations, CDC
75X8253 (no year) NIH Conditional Gift Fund
75X8254 (no year) Conditional Gift Fund, HRSA
75X8307 (no year) Transitional Drug Assistance, CMS
75X8308 (no year) Medicare Prescription Drug Account, CMS
75X8510 (no year) Administration on Aging Gift Fund
75X8511 (no year) Indian Health Service Gift Fund
75X8512 (no year) AHRQ Gift Fund
75X8513 (no year) SAMHSA Gift Fund
75X8514 (no year) OS Gift Fund
75X8888 (no year) Patients Benefit Fund, NIH
75X8889 (no year) Patients Benefit Fund, HRSA
75-20X8004 (no year) Federal Supplementary Medical Insurance Trust Fund, CMS
75-20X8005 (no year) Federal Hospital Insurance Trust Fund, CMS
75-20X8175 (no year) Vaccine Injury Compensation Trust Fund, HRSA

Note 25. Undelivered Orders at the End of the Period
The HHS reported $74,436 million of budgetary resources obligated for undelivered orders as of September 30, 2007, and $76,429 million as of September 30, 2006.

Note 26. Earmarked Funds
Medicare is the largest earmarked fund group managed by the Department; therefore, Medicare financial data is presented in a separate column in the schedule below.

The HHS has designated as earmarked funds the HI and SMI trust funds, which also include the Payments to the Health Care Trust Funds appropriation and the Health Care Fraud and Abuse Control Account. In addition, portions of the Program Management appropriation have been allocated to the HI and SMI trust funds.

The Medicare programs include: (a) Medicare HI Trust Fund, (b) Medicare SMI Trust Fund, (c) Medicare Prescription Drug Benefit – Part D, and (d) Medicare/Medicaid Integrity Program (MIP).

The Social Security Act provides for payments to the HI and SMI trust funds: HI (for the Uninsured and Federal Uninsured payments) and SMI (appropriated funds to provide for Federal matching of SMI premium collections). The Medicare Modernization Act of 2003 prescribes that funds covering the Medicare Prescription Drug Benefit, retiree drug coverage reimbursements to the States and Transitional Assistance benefits be transferred from Payments to the Health Care Trust Funds to SMI. A transfer of general funds to the HI Trust Fund is made in amounts equal to Self-Employment Contribution Act tax credits and the increase to the tax payment from Old Age Survivors and Disability Insurance beneficiaries.

There were no legislative changes that significantly changed the purpose of or redirected a significant portion of an earmarked fund during this reporting period.

Earmarked Funds (In Millions)	Earmarked Funds			Earmarked Funds
	Medicare	Others	Eliminations	Total
Balance Sheet as of September 30, 2007				
Assets				
Fund balance with Treasury	$ 8,793	$ 679	$ -	$ 9,472
Investments	363,195	2,680	-	365,875
Other Assets	65,614	24	(53,206)	12,432
Total Assets	$ 437,602	$ 3,383	$ (53,206)	$387,779
Entitlement Benefits Due and Payable	$ 41,604	$ -	$ -	$ 41,604
Other Liabilities	57,089	439	(53,206)	4,322
Total Liabilities	$ 98,693	$ 439	$ (53,206)	$ 45,926
Unexpended Appropriations	$ 8,978	$ (91)	$ -	$ 8,887
Cumulative Results of Operations	329,931	3,035	-	332,966
Total Liabilities and Net Position	$ 437,602	$ 3,383	$ (53,206)	$387,779
Statement of Net Cost For the Period Ended September 30, 2007				
Gross Program Costs	$ 417,817	$ 380	$ -	$ 418,197
Earned Revenues	(50,266)	(610)	-	(50,876)
Net Cost of Operations	$ 367,551	$ (230)	$ -	$ 367,321
Statement of Changes in Net Position For the Period Ended September 30, 2007				
Net Position Beginning of Period	$ 329,511	$ 2,619	$ -	$ 332,130
Non-Exchange Revenue	206,598	337	-	206,935
Other Financing Sources	170,351	(242)	-	170,109
Net Cost of Operations	(367,551)	230	-	(367,321)
Change in Net Position	$ 9,398	$ 325	$ -	$ 9,723
Net Position End of Period	$ 338,909	$ 2,944	$ -	$ 341,853

Earmarked Funds (In Millions)	Earmarked Funds Medicare	Earmarked Funds Other	Eliminations	Earmarked Funds Total
Balance Sheet as of September 30, 2006				
Assets				
Fund balance with Treasury	$ 28,726	$ 820	$ -	$ 29,546
Investments	339,545	2,431	-	341,976
Other Assets	46,484	42	(42,637)	3,889
Total Assets	$ 414,755	$ 3,293	$ (42,637)	$375,411
Entitlement Benefits Due and Payable	$ 40,824	$ -	$ -	$ 40,824
Other Liabilities	44,420	674	(42,637)	2,457
Total Liabilities	$ 85,244	$ 674	$ (42,637)	$ 43,281
Unexpended Appropriations	$ 27,658	$ 7	$ -	$ 27,665
Cumulative Results of Operations	301,853	2,612	-	304,465
Total Liabilities and Net Position	$ 414,755	$ 3,293	$(42,637)	$375,411
Statement of Net Cost For the Period Ended September 30, 2006				
Gross Program Costs	$ 386,924	$ 199	$ -	$387,123
Earned Revenues	(49,955)	(512)	-	(50,467)
Net Cost of Operations	$ 336,969	$ (313)	$ -	$336,656
Statement of Changes in Net Position For the Period Ended September 30, 2006				
Net Position Beginning of Period	$ 276,020	$ 2,342	$ -	$278,362
Non-Exchange Revenue	197,843	155	116	198,114
Other Financing Sources	192,617	(191)	(116)	192,310
Net Cost of Operations	(336,969)	313	-	(336,656)
Change in Net Position	$ 53,491	277	-	53,768
Net Position End of Period	$ 329,511	$ 2,619	$ -	$332,130

The list below includes the Treasury fund symbols that are "Other Earmarked Funds":

75X8510 (no year) Administration on Aging Gift Fund
75X8512 (no year) Agency for Healthcare Research and Quality Gift Fund
75X0943 (no year) Disease Control, Research, & Training, CDC (partial – user fee portion only)
75 0943 (fiscal year) Disease Control, Research, & Training, CDC (partial – multi-year royalties)
75X5146 (no year) Cooperative Research and Development Agreements, CDC
75X8250 (no year) Gifts and Donations, CDC
20X8145 (no year) Allocation Transfer from EPA Hazardous Superfund, CDC
75X5148 (no year) Cooperative Research and Development Agreements, FDA
75X8247 (no year) Food and Drug Administration Unconditional Gift Fund
75X0600 (no year) User Fee Act(s), FDA
75X4309 (no year) Revolving Fund for Certification and Other Services, FDA

75X8249 (no year) Unconditional Gift Fund, HRSA
75X8254 (no year) Conditional Gift Fund, HRSA
75X8889 (no year) Patients Benefit Fund, HRSA
20X8175 (no year) Vaccine Injury Compensation Trust Fund, HRSA
75X5071 (no year) Operation and Maintenance of Quarters, IHS
75X8073 (no year) Contributions, Indian Health Facilities, IHS
75X8511 (no year) IHS Gift Fund
75X8248 (no year) NIH Unconditional Gift Fund
75X8253 (no year) NIH Conditional Gift Fund
75X8393 (no year) Health Care Fraud and Abuse Control Accounts, CMS
75X8888 (no year) Patients Benefit Fund, NIH
75X5145 (no year) Cooperative Research and Development Agreements, NIH
75 3966 (fiscal year) Royalties, NIH
75X8513 (no year) SAMHSA Gift Fund
75X8514 (no year) Office of the Secretary Gift Fund

Note 27. Statement of Social Insurance Disclosures

The Statement of Social Insurance (SOSI) presents the projected 75-year actuarial present value of the income and expenditures of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds. Future expenditures are expected to arise from the health care payment provisions specified in current law for current and future program participants and from associated administrative expenses. Actuarial present values are computed on the basis of the intermediate set of assumptions specified in the Annual Report of the Board of Trustees. These assumptions represent the Trustees' best estimate of likely future economic, demographic, and healthcare-specific conditions.

Actuarial present values are computed as of the year shown and over the 75-year projection period beginning January 1 of that year. They are calculated by discounting the future annual amounts of non-interest income and expenditures (including benefit payments as well as administrative expenses) at the projected average rates of interest credited to the HI trust fund. HI income includes the portion of FICA and SECA payroll taxes allocated to the HI trust fund, the portion of Federal income taxes paid on Social Security benefits that is allocated to the HI trust fund, and receipts from fraud and abuse control activities. SMI income includes premiums paid by, or on behalf of, beneficiaries and general revenue contributions made on behalf of beneficiaries. Transfers from State governments are also included as income for Part D of SMI. Since all major sources of income to the trust funds are reflected, the actuarial projections can be used to assess the financial condition of each trust fund.

Actuarial present values of estimated future income (excluding interest) and estimated future expenditures are presented for three different groups of participants: (1) current participants who have not yet attained eligibility age; (2) current participants who have attained eligibility age; and (3) new entrants, or those who are expected to become participants in the future. Current participants are the "closed group" of individuals who are at least age 15 at the start of the projection period, and are participating in the program as either taxpayers, beneficiaries, or both. Since the projection period consists of 75 years, the period covers virtually all of the current participants' working and retirement years.

The SOSI sets forth, for each of these three groups, the projected actuarial present value of all future HI (Part A) and SMI (Parts B and D) expenditures and all future non-interest income for the next 75 years. The SOSI also presents the net present value of future net cash flows for each fund, which is calculated by subtracting the actuarial present value of future expenditures from the actuarial present value of future income. The existence of a large actuarial deficit for the HI trust fund indicates that, under these assumptions as to economic, demographic, and health cost trends for the future, HI income is expected to fall substantially short of expenditures over the next 75 years. Neither Part B nor Part D of SMI has similar problems because each account is automatically in financial balance every year due to its financing mechanism.

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

Since its enactment in 1965, the Medicare program has experienced substantial variability in expenditure growth rates. These different rates of growth have reflected new developments in the treatment of medical care, demographic factors affecting the relative number and average age of beneficiaries and covered workers, and numerous economic factors. The future cost of Medicare will also be affected by further changes in these factors that are inherently uncertain. Consequently, Medicare's actual cost over time, especially for periods as long as 75 years, cannot be predicted with certainty and such actual cost could differ materially from the projections shown in the SOSI. Moreover, these differences could affect the long-term sustainability of this social insurance program.

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

The most significant underlying assumptions used in the projections of Medicare spending displayed in this section are included in the Table 1 below. The assumptions underlying the 2007 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2007. Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The projected beneficiary cost increases summarized below reflect the overall impact of these more detailed assumptions.

Table 1: Significant Assumption and Summary Measures Used for the Statement of Social Insurance 2007

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[9]
2007	2.04	1,075,000	839.8	2.7	4.6	1.9	2.6	6.4	6.2	0.1	2.9
2010	2.03	1,000,000	825.3	1.4	4.2	2.8	2.6	5.0	4.6	8.6	2.8
2020	2.02	950,000	764.5	1.0	3.8	2.8	2.1	4.5	4.7	7.6	2.9
2030	2.00	900,000	705.4	1.1	3.9	2.8	2.0	5.8	5.6	5.5	2.9
2040	2.00	900,000	652.8	1.1	3.9	2.8	2.0	5.8	5.4	5.2	2.9
2050	2.00	900,000	606.6	1.1	3.9	2.8	2.0	4.9	4.8	4.9	2.9
2060	2.00	900,000	565.7	1.1	3.9	2.8	1.9	4.7	4.8	4.6	2.9
2070	2.00	900,000	529.3	1.1	3.9	2.8	1.9	4.6	4.5	4.4	2.9
2080	2.00	900,000	496.8	1.1	3.9	2.8	1.9	4.3	4.3	4.3	2.9

[1]Average number of children per woman.

[2]Includes legal immigration, net of emigration, as well as other, non-legal, immigration.

[3]The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2000, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year.

[4]Difference between percentage increases in wages and the CPI.

[5]Average annual wage in covered employment.

[6]Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services.

[7]The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth.

[8]These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.

[9]Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

The ultimate values of the above-specified assumptions used in determining the estimates for each of the five years presented in the Statement of Social Insurance are listed within table 2 below. They are based on the intermediate assumptions of the respective Medicare Trustee Reports.

Table 2: Significant Ultimate Assumptions used for the Statement of Social Insurance, FY 2007 – 2003

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[9]
2007	2.00	900,000	496.8	1.1	3.9	2.8	1.9	4.3	4.3	4.3	2.9
2006	2.00	900,000	497.6	1.1	3.9	2.8	1.9	4.3	4.3	4.3	2.9
2005	1.95	900,000	495.5	1.1	3.9	2.8	1.8	5.2	5.1	5.1	3.0
2004	1.95	900,000	497.2	1.1	3.9	2.8	1.8	5.2	5.1	5.1	3.0
2003	1.95	900,000	447.9	1.1	4.1	3.0	1.8	5.3	5.1	–	2.9

[1]Average number of children per woman. The ultimate fertility rate is assumed to be reached in the 25th year of the projection period.

[2]Includes legal immigration, net of emigration, as well as other, non-legal, immigration. The ultimate assumption is reached by the 20th year of each projection period.

[3]The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2000, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year. The annual rate declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.

[4]Difference between percentage increases in wages and the CPI. The ultimate assumption is reached within the first 10 years of the projection period.

[5]Average annual wage in covered employment. The ultimate assumption is reached within the first 10 years of the projection period.

[6]Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services. The ultimate assumption is reached within the first 10 years of the projection period.

[7]The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth. The annual rate declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.

[8]These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The annual rate of growth declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.

[9]Average rate of interest earned on new trust fund securities, above and beyond rate of inflation. The ultimate assumption is reached within the first 10 years of the projection period.

Part D Projections
In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, the Part D program is new (having begun operations in January 2006), with very little actual program data currently available. The actual 2006 and 2007 bid submissions by the private plans offering this coverage, together with preliminary data on beneficiary enrollment, has been used in the current projections. Nevertheless, there remains a high level of uncertainty surrounding these cost projections, pending the availability of sufficient data on actual Part D expenditures to establish a trend baseline.

Hospice Benefits Mis-Posting
Beginning in May 2005, expenditures for certain Part A hospice benefits were posted to the Part B account of the SMI trust fund, rather than from the HI trust fund. Correction of this mis-posting will increase Part A expenditures and reduce Part B expenditures in 2008 and later years, compared to the projections shown in the 2007 Medicare Trustees Report. It will also result in adjustments to the HI and SMI trust funds to account for the misallocated hospice expenditures during fiscal years 2005 through 2007. The present values displayed in the Statement of Social Insurance have been revised to include the estimated impact of correcting this mis-posting. The impact on the Part A and Part B expenditure projections presented in the Statement of Social Insurance is roughly $465 billion over the entire 75-year period, equivalent to a 2.0-percent increase for Part A and a 2.5-percent decrease for Part B. However, the change in Part A expenditures also resulted in a very slight change to the discount rates used to calculate all of the present values in the SOSI, thereby contributing to a further minor change in the present value amounts for Parts A, B, and D relative to the original Trustees Report projections.

Note 28. SMI Part B Physician Update Factor
The projected Part B expenditure growth reflected in the accompanying SOSI is significantly reduced as a result of the structure of physician payment updates under current law. In the absence of legislation, this structure would result in multiple years of significant reductions in physician payments, totaling an estimated 41 percent over the next 9 years. Reductions of this magnitude are very unlikely to occur fully. For example, Congress has overridden scheduled negative updates for each of the last 5 years. However, since these reductions are required in the future under the current-law payment system, they are reflected in the accompanying SOSI as required under generally accepted accounting principles. Consequently, the projected actuarial present values of Part B expenditure shown in the accompanying SOSI are likely to be understated.

The potential magnitude of the understatement of Part B expenditures due to the physician payment mechanism can be illustrated using two hypothetical examples of changes to current law. These examples were developed by management for illustrative purposes only; the calculations have not been audited; and the examples do not attempt to portray likely or recommended future outcomes. Thus, the illustrations are useful only as general indicators of the substantial impacts that could result from future legislation on physician payments under Medicare and of the broad range of uncertainty associated with such impacts.

Under current law, the projected 75-year present value of future Part B expenditures is $18.2 trillion. An alternate scenario indicates that if Congress were to set future physician payment updates at zero percent per year, then, absent other provisions to offset these costs, the projected present value would increase to

$22.6 trillion. Similarly, if Congress were to set future physician payment updates equal to the Medicare Economic Index (projected to be 2 to 2.5 percent per year), the present value would be $25.4 trillion.

The extent to which actual future Part B costs could exceed the projected current-law amounts due to physician payments depends on both the level of physician payment updates that might be legislated and on whether Congress would pass further provisions to help offset such costs (as it did, for example in the Deficit Reduction Act in 2006). As noted, these examples only reflect hypothetical changes to physician payments.

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

Note 29. Stewardship Property, Plant & Equipment

The HHS assets, regardless of their status, are used to support the day-to-day operations of providing healthcare to American Indians and Alaskan Natives in remote areas of the country where no other facilities exist. For stewardship reporting purposes, the HHS identifies two types of assets: Heritage and Indian Trust Lands.

Heritage assets are historically, architecturally, or culturally significant. This category includes:

- Buildings Located in a Historic District or Included with a National Landmark
- Buildings Determined to be Historic in Nature
- Building Submitted to Tribal Historic Preservation or State Historic Preservation Offices for Determination
- Buildings Having Some Potential Historic Significance

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

Currently, the HHS asset accountability reports differentiate Indian Trust land parcels, by site and installation numbers and trust lands, from general PP&E situated thereon. The IHS is developing new procedures to strengthen its stewardship over real property accounting and reporting. The Required Supplementary Information (RSI) provides additional information for Stewardship PP&E.

Note 30. Reconciliation of Net Cost of Operations (Proprietary) to Budget (In Millions)

	2007	2006
RESOURCES USED TO FINANCE ACTIVITIES		
Budgetary Resources Obligated		
Obligations Incurred	$ 956,671	$ 884,903
Spending Authority from Offsetting Collections and Recoveries	(26,608)	(26,585)
Obligations Net of Offsetting Collections and Recoveries	930,063	858,318
Offsetting Receipts	(257,704)	(226,875)
Net Obligations	672,359	631,443
Other Resources		
Net Non-Budgetary Resources Used to Finance Activities	310	264
Total Resources Used to Finance Activities	672,669	631,707
RESOURCES USED TO FINANCE ITEMS NOT PART OF THE NET COST OF OPERATIONS		
Change in Budgetary Resources Obligated for Goods, Services and Benefits Ordered but Not Yet Provided	980	(4,249)
Resources That Fund Expenses Recognized in Prior Periods	1	15,278
Budgetary Offsetting Collections and Receipts That Do Not Affect Net Cost of Operations:		
Credit Program Collections That Increase Liabilities for Loans Guarantees or Allowances for Subsidy	28	90
Other	(234)	(242)
Resources That Finance the Acquisition of Assets or Liquidations of Liabilities	1,262	1,296
Other Resources or Adjustments to Net Obligated Resources That Do Not Affect Net Cost of Operations	373	(3,352)
Total Resources Used to Finance Items Not Part of the Net Cost of Operations	2,410	8,821
Total Resources Used to Finance the Net Cost of Operations	670,259	622,886
COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD		
Components Requiring or Generating Resources in Future Period	(6,913)	(7)
Components Not Requiring or Generating Resources	1,253	1,058
Total Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period	(5,660)	1,051
NET COST OF OPERATIONS	**$ 664,599**	**$ 623,937**

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Required Supplementary Stewardship Information

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Investment in Human Capital
For the Year Ended September 30, 2007
(In Millions)

RESPONSIBILITY SEGMENT PROGRAM	2007	2006	2005	2004	2003
ACF					
Administration on Developmental Disabilities	$ 8	$ 7	$ 8	$ 9	$ 10
NIH					
Research Training and Career Development	1,756	1,747	1,699	1,696	1,405
Totals	**$ 1,764**	**$ 1,754**	**$ 1,707**	**$ 1,705**	**$ 1,415**

"Investments in Human Capital" are expenses incurred by Federal education and training programs for the public, which are intended to maintain or increase national productive capacity. Two operating divisions of the Department conduct education and training programs under this category: Administration for Children and Families, and the National Institutes of Health.

Administration for Children and Families (ACF)

The ACF is able to estimate investment in human capital for the Administration for Developmental Disabilities (ADD) using existing data collection activities. Under ADD, 46 grants are anticipated to be awarded for Projects of National Significance (PNS). As of September 30, 2007, all of the 46 PNS grants have been awarded for FY 2007. PNS grants are awarded to public or private, non-profit institutions to enhance the independence, productivity, integration and inclusion into the community of people with developmental disabilities. Monies also support the development of national and state policy to serve this community. Grants awarded total $8 million in FY 2007.

National Institutes of Health (NIH)

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

Investment in Research and Development
For the Year Ended September 30, 2007
(In Millions)

	2007				Total				
Responsibility Segments	**Basic**	**Applied**	**Develop-mental**	**Total**	**2006**	**2005**	**2004**	**2003**	**Grand Total**
ACF	$ -	$ 16	$ -	$ 16	$ 39	$ 21	$ 21	$ 24	$ 121
AHRQ	198		-	198	175	162	170	163	868
CDC		563	-	563	478	521	549	557	2,668
FDA *	37		3	40	37	31	28	31	167
HRSA			-		28	23	16	16	83
NIH	15,679	10,452	-	26,131	25,780	25,320	23,700	21,359	122,290
Totals	**$ 15,914**	**$ 11,031**	**$ 3**	**$ 26,948**	**$ 26,537**	**$ 26,078**	**$ 24,484**	**$ 22,150**	**$ 126,197**

*FDA restated its FY 2003 amount by $1 million as compared to their FY 2003 statements.

The many research and development programs in HHS include the following:

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

The OPD Program was established by the Orphan Drug Act (Public Law 97-414, as amended) with the purpose of identifying orphan products and facilitating their development. An orphan product is a drug, biological product, medical device, or medical food that is intended to treat a rare disease or condition (i.e., one with a prevalence of fewer than 200,000 people in the United States).

The FDA Research Grants Program is a grants program which is listed as No. 93-103 under the Catalog of Federal Domestic Assistance, whose purpose is to assist public and non-public institutions and for-profit organizations to establish, expand, and improve research, demonstration, education, and information dissemination activities concerned with a wide variety of FDA areas.

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

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

ACF and AHRQ oversee research and development programs that contribute to a better understanding of how to improve the economic and social well being of families and children so that they lead more healthy and productive lives.

Required Supplementary Information

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Combining Statement of Budgetary Resources
For the Year Ended September 30, 2007
(In Millions)

	CMS			Other Agency Budgetary Accounts[1]	Agency Combined Totals
	Medicare HI	Medicare SMI	Medicaid		
Budgetary Resources:					
1. Unobligated balance, brought forward, October 1	$ -	$ -	$ 26,486	$ 41,434	$ 67,920
2. Recoveries of prior year unpaid obligations	168	485	13,899	3,052	17,604
3. Budget Authority	222,844	187,674	168,614	367,035	946,167
4. Nonexpenditure transfers, net, anticipated & actual	(8,614)	8,036	(2,805)	3,292	(91)
5. Temporarily not available pursuant to Public Law	(8,190)	(12,603)	-	186	(20,607)
6. Permanently not available (-)	(22)	(37)	-	(29,589)	(29,648)
7. Total Budgetary Resources	$ 206,186	$ 183,555	$ 206,194	$ 385,410	$ 981,345
Status of Budgetary Resources:					
8. Obligations Incurred	$ 206,173	$ 183,543	$ 202,378	$ 364,576	$ 956,670
9. Unobligated Balances - Available	-	-	3,644	13,696	17,340
10. Unobligated Balances - Not Available	13	12	172	7,138	7,335
11. Total Status of Budgetary Resources	$ 206,186	$ 183,555	$ 206,194	$ 385,410	$ 981,345
Relationship of Obligations to Outlays:					
12. Obligated Balance, Net	$ 21,041	$ 19,495	$ 19,183	$ 75,118	$ 134,837
13. Obligations incurred, Net (+/-)	206,173	183,543	202,378	364,576	956,670
14. Gross outlays	(206,574)	(183,039)	(188,247)	(361,173)	(939,033)
15. Obligated balance transferred, Net	-	-	-	18	18
16. Recoveries of prior year unpaid obligations	(168)	(485)	(13,899)	(3,052)	(17,604)
17. Change in uncollected customer payments	-	-	-	466	466
18. Obligated balance, Net, end of period	$ 20,472	$ 19,514	$ 19,415	$ 75,953	$ 135,354
19. Net Outlays	$ 187,488	$ (53,984)	$ 187,888	$ 350,467	$ 671,859

Summary of Other Agency Budgetary Accounts

	Budgetary Resources	Status of Budgetary Resources	Net Outlays
ACF	$ 51,414	$ 51,414	$ 46,248
AoA	1,392	1,392	1,361
AHRQ	357	357	142
CDC	9,990	9,990	8,288
CMS	265,431	265,431	249,071
FDA	2,135	2,135	1,147
HRSA	7,216	7,216	6,676
IHS	4,874	4,874	3,315
NIH	32,524	32,524	28,112
OS	5,438	5,438	2,418
PSC	1,130	1,130	480
SAMHSA	3,509	3,509	3,209
	$ 385,410	$ 385,410	$ 350,467

[1] "Other Agency Budgetary Accounts" includes the budgetary accounts of the eleven HHS Agencies other than CMS, as well as the remaining budgetary accounts not reported by CMS under Medicare and Medicaid.

Deferred Maintenance
For the Years Ended September 30, 2007 and 2006
(In Millions)

Deferred maintenance is maintenance that was not performed when it should have been, was scheduled and not performed, or was delayed for a future period. Maintenance is the act of keeping fixed assets in acceptable condition, including preventive maintenance, normal repairs, replacement of parts and structural components and other activities needed to preserve the asset so that it continues to provide acceptable services and achieves its expected life. Maintenance does not include activities aimed at expanding the capacity of an asset or otherwise upgrading it to serve needs different from, or significantly greater than, those originally intended. Maintenance expense is recognized as incurred. The Centers for Disease Control and Prevention, the National Institutes of Health, and the Food and Drug Administration all use the condition assessment survey for all classes of property. The Indian Health Service uses two types of surveys to assess installations – annual general inspections and deep look surveys.

		Cost to Return to Acceptable Condition	
Category of Asset	**Condition**	**2007**	**2006**
General PP&E			
Buildings	1 - 4	$ 1,077	$ 925
Equipment	4	8	8
Other Structures	1 - 4	55	22
Total		$ 1,140	$ 955

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

Stewardship Property, Plant, and Equipment
For the Year Ended September 30, 2007

The HHS has two types of property, plant, and equipment (PP&E) for stewardship reporting: Heritage Assets, and Indian Trust Lands.

Heritage Assets are PP&E of historical, natural, cultural, educational, or artistic significance. Heritage Assets are generally expected to be preserved indefinitely. This category includes buildings on the National Historic Register, cemetery sites, etc.

Indian Trust lands are those lands that do not meet the definition of Stewardship land (i.e., land other than those acquired for or used in connection with general (capitalized) PP&E), but have always been held by IHS as separate and distinct, because of the Government's long-term trust responsibility. All Trust lands, when no longer needed by IHS in connection with its general use PP&E, must be returned to the Department of the Interior's Bureau of Indian Affairs, for continuing trust responsibilities and oversight.

The IHS' draft guidelines will establish procedures for stewardship real property accountability and reporting. Currently, the IHS asset accountability reports differentiate Indian Trust land parcels, by site and installation numbers and trust lands, from general PP&E situated thereon. Indian Trust land balances are removed from IHS FY 2007 Balance Sheet, and reported as Stewardship Assets - Indian Trust Lands.

IHS Stewardship Classes and Trust Land

Asset Description	Number of Sites	Total Square Footage	Federal Hectares	Total Hectares
Heritage Assets	1	2,295		
Indian Trust Lands	79	N/A	424.9 (1,049 acres)	424.9 (1,049acres)

Distribution of Stewardship Assets by Type and Area

	Heritage Assets			Indian Trust Lands	
	Number of Sites	Square Footage	Total Hectares	Number of Sites	Total Hectares
Aberdeen				9	75
Albuquerque				4	4
Bemidji				2	9
Billings				7	48
Navajo				35	255
Oklahoma City				1	2
Phoenix	1	2,295		13	19
Portland				3	1
Tucson				5	12
Total IHS	1	2,295		79	425

Social Insurance
For the Year Ended September 30, 2007

Medicare, the largest health insurance program in the country, has helped fund medical care for the nation's aged and disabled for slightly over four decades. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (known informally as the Medicare Modernization Act, or MMA) introduced the most sweeping changes to the program since its enactment in 1965. The most significant change is that, beginning in 2004, the MMA established a prescription drug benefit. A separate Part D account within the SMI trust fund handles the transactions for this coverage. A brief description of the provisions of Medicare's Hospital Insurance (HI, or Part A) trust fund and Supplementary Medical Insurance (SMI, or Parts B and D) trust fund is included in Note 1 of this Financial Report.

The required supplementary information (RSI) contained in this section is presented in accordance with the requirements of the Federal Accounting Standards Advisory Board (FASAB). Included are a description of the long-term sustainability and financial condition of the program and a discussion of trends revealed in the data.

The RSI material is generally drawn from the *2007 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions. The projections have been revised slightly since the preparation of the 2007 Trustees Report, to adjust for the impact of an accounting error that was discovered in August of this year. Beginning in May of 2005, Part A hospice expenditures were inadvertently drawn from the Part B account of the SMI trust fund rather than from the HI trust fund. Therefore, Part A expenditures in the 2007 Trustees Report were understated slightly and Part B expenditures were correspondingly overstated.

The Medicare Trustees emphasize that the SMI Part B expenditures projected under current law are significantly understated. Congress is very likely to continue overriding certain statutory provisions that would otherwise require reductions in physician payment rates of about 10 percent in 2008 and another 5 percent per year in 2009 through at least 2016.

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

Actuarial Projections

Cashflow in Nominal Dollars

Using nominal dollars[1] for short-term projections paints a reasonably clear picture of expected performance with particular attention on cashflow and trust fund balances. Over longer periods, however, the changing value of the dollar can complicate efforts to compare dollar amounts in different periods and can create severe barriers to interpretation, since projections must be linked to something that can be reasonably comprehended in today's experience.

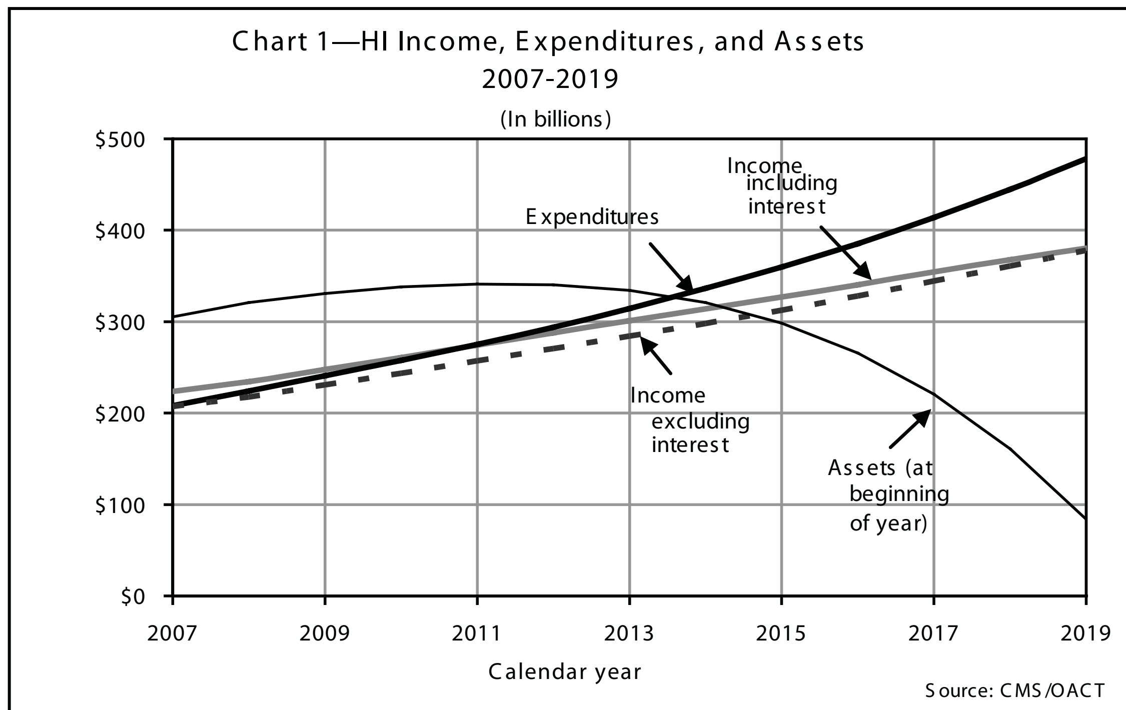
For this reason, long-range (75-year) Medicare projections in nominal dollars are seldom used and are not presented here. Instead, nominal-dollar estimates for the HI trust fund are displayed only through the projected date of depletion, currently the year 2018[2]. Corresponding estimates for SMI Parts B and D are presented only for the next 10 years, primarily due to the fact that under present law, the SMI trust fund is automatically in financial balance every year.

HI

Chart 1 shows the actuarial estimates of HI income, expenditures, and assets for each of the years 2007 through 2018, in nominal dollars. Income includes payroll taxes, income from the taxation of Social Security benefits, interest earned on the U.S. Treasury securities held by the HI trust fund, and other miscellaneous revenue. Expenditures include benefit payments and administrative expenses. The estimates are for the "open group" population—all persons who will participate during the period as either HI taxpayers or beneficiaries, or both—and consist of payments from, and on behalf of, employees now in the workforce, as well as those who will enter the workforce through 2018. The estimates also include income and expenditures attributable to these current and future workers, in addition to current beneficiaries.

[1] Dollar amounts that are not adjusted for inflation or other factors are referred to as "nominal."

[2] The 2007 Trustees Report projected that the HI trust fund would be depleted in 2019, which was one year later than what was estimated in the 2006 Trustees Report. However, due to the accounting error explained earlier, Part A expenditures were understated in the 2007 Trustees report. Correcting for this error moves the depletion date from 2019 to 2018.



As chart 1 shows, HI expenditures are expected to exceed income excluding interest in 2007 and, under the intermediate assumptions, would begin to exceed income including interest in 2010. This situation arises as a result of health cost increases that are expected to continue to grow faster than workers' earnings. Beginning in 2010, the HI trust fund would start redeeming its assets; by the end of 2018, the assets would be depleted. For the fourth year in a row, the HI trust fund does not meet an explicit test of short-range financial adequacy, as assets are predicted to fall below expenditures within the next 10 years.

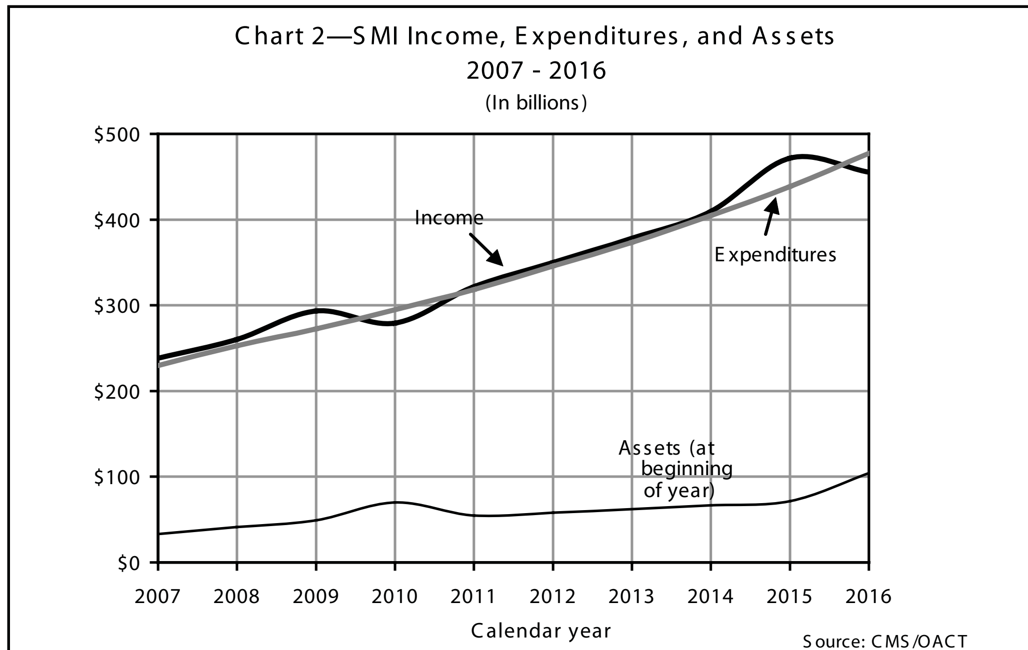
The projected year of depletion of the HI trust fund is very sensitive to assumed future economic and other trends. Under less favorable conditions the cash flow could turn negative much earlier and thereby accelerate asset exhaustion.

SMI

Chart 2 shows the actuarial estimates of SMI income, expenditures, and assets, for Parts B and D combined, for each of the years 2007 through 2016, in nominal dollars. Whereas HI estimates are displayed through 2018, SMI estimates cover only the years through 2016, as SMI differs fundamentally from HI in regard to the way it is financed. In particular, financing for SMI Parts B and D is not based on payroll taxes but rather on a combination of monthly beneficiary premiums and income from the general fund of the U.S. Treasury—both of which are established annually to cover the following year's expenditures.[3]

[3] The Part D account also receives special payments from the States, representing a portion of their forgone Medicaid expenditures attributable to the Medicare drug benefit.

Estimates of SMI income and expenditures, therefore, are virtually the same, as illustrated in chart 2, and so are not shown in nominal dollars separately beyond 2016.[4]



Income includes monthly premiums paid by, or on behalf of, beneficiaries, transfers from the general fund of the U.S. Treasury, certain payments by the States to the Part D account, and interest earned on the U.S. Treasury securities held by the SMI trust fund. Chart 2 displays only total income; it does not separately show income excluding interest. The difference between the two depictions of income is not visible graphically since interest is not a significant source of income.[5] Expenditures include benefit payments as well as administrative expenses.

As chart 2 indicates, SMI income is very close to expenditures. As mentioned earlier, this is because of the financing mechanism for Parts B and D. Under present law, both accounts are automatically in financial balance every year, regardless of future economic and other conditions.

HI Cashflow as a Percentage of Taxable Payroll

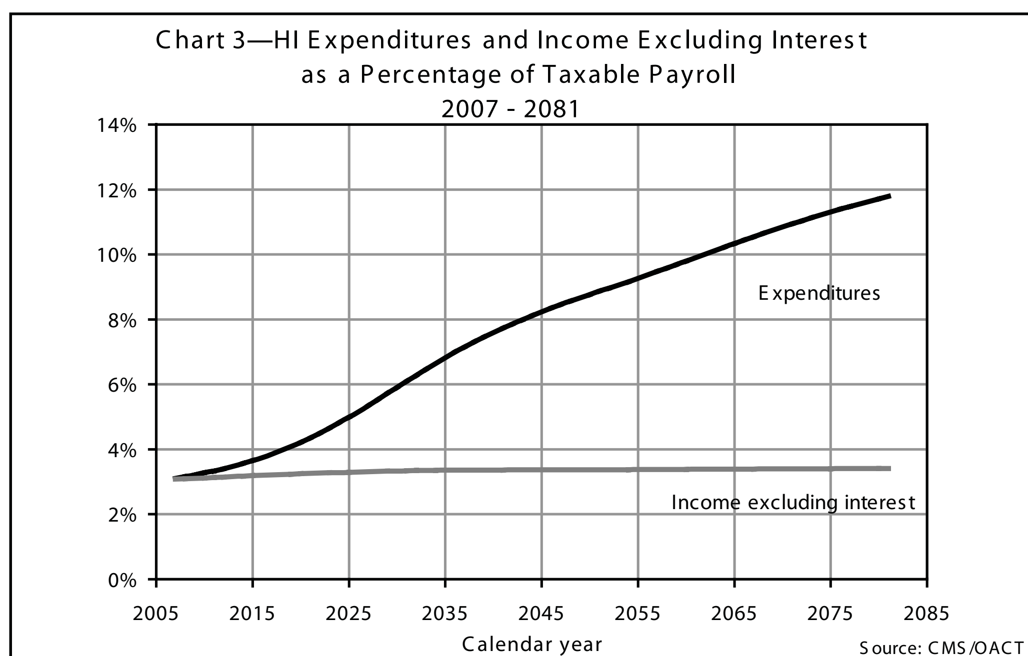
Each year, estimates of the financial and actuarial status of the HI trust fund are prepared for the next 75 years. Because it is difficult to meaningfully compare dollar values for different periods without some type of relative scale, income and expenditure amounts are shown relative to the earnings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

[4] Delivery of Social Security benefit checks normally due January 3, 2010 is expected to occur on December 31, 2009. Consequently, the Part B premiums withheld from the checks and the associated general revenue contributions are expected to be added to the Part B account on December 31, 2009. Likewise, January 3, 2016 will fall on a Sunday, and therefore delivery of the majority of Social Security checks is expected to occur on December 31, 2015. These amounts are excluded from the premium income and general revenue income for 2010 and 2016, resulting in the income pattern shown in chart 2.

[5] Interest income is generally about 1 percent of total SMI income.

Chart 3 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. Prior to last year's Trustees Report, the long-range increase in average expenditures per beneficiary was assumed to equal growth in per capita gross domestic product (GDP) plus 1 percentage point. Beginning with the 2006 report, the Board of Trustees adopted a refinement of these long-range growth assumptions. The refinement provides a smoother and more realistic transition from current Medicare cost growth rates, which have been significantly above the level of GDP growth, to the ultimate assumed level of GDP plus zero percent for the indefinite future.

Based on these projections, the Medicare Trustees apply a formal test of "long-range close actuarial balance." The HI trust fund fails this test by a wide margin, as it has in almost all previous years.



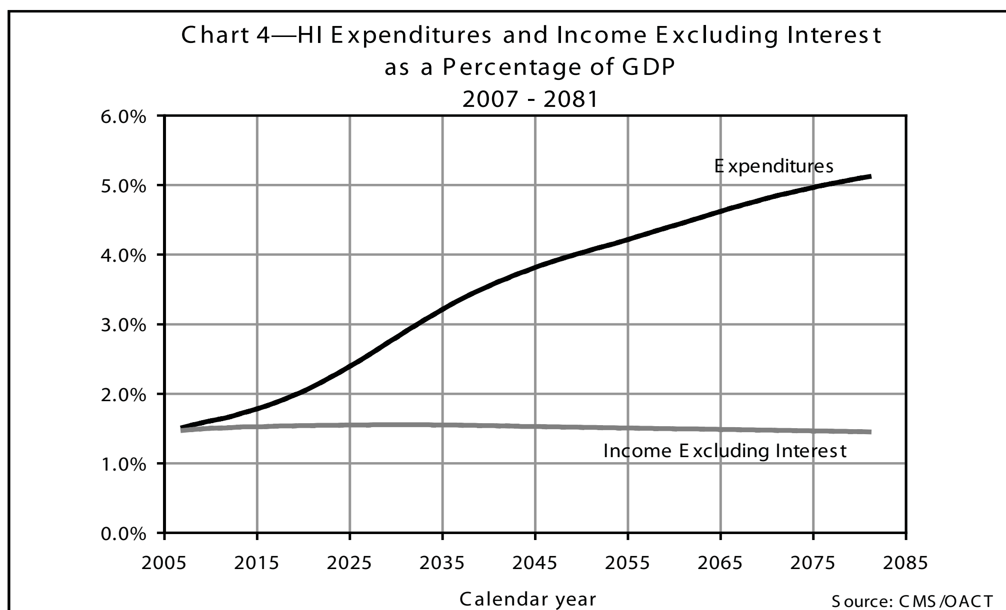
Since HI payroll tax rates are not scheduled to change in the future under present law, payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. Income from taxation of benefits will increase only gradually as a greater proportion of Social Security beneficiaries become subject to such taxation over time. Thus, as chart 3 shows, the income rate is not expected to increase significantly over current levels. On the other hand, expenditures as a percentage of taxable payroll sharply escalate—in part due to health care cost increases that exceed wage growth, but also due to the attainment of Medicare eligibility of those born during the 1946-1964 baby boom.

HI and SMI Cashflow as a Percentage of GDP

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

HI

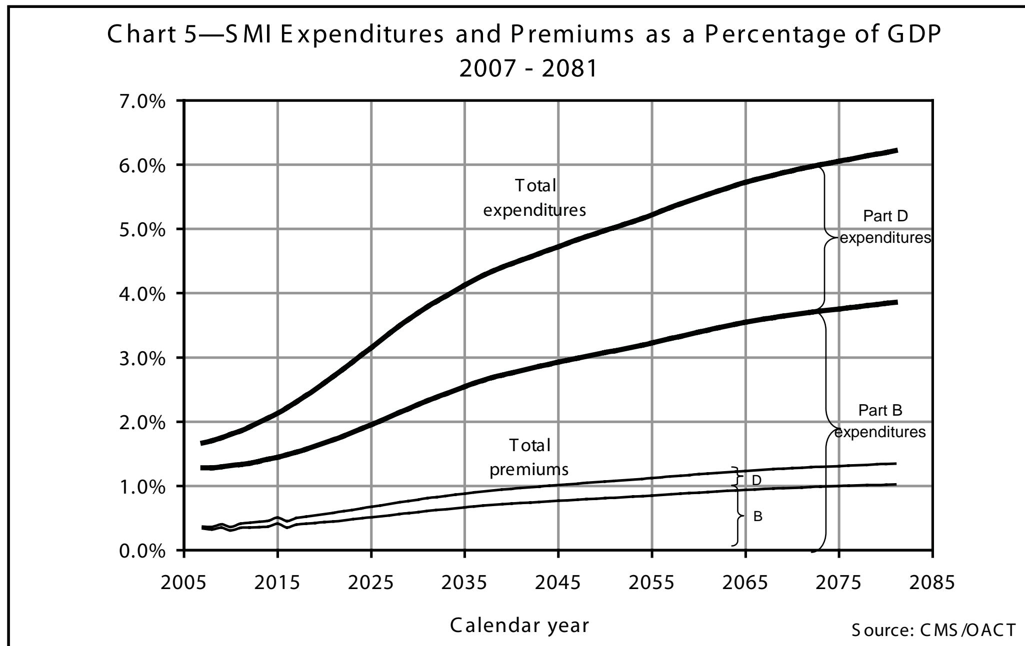
Chart 4 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2006, the expenditures were $191.9 billion, which was 1.4 percent of GDP. This percentage is projected to increase steadily throughout the remainder of the 75-year period.



SMI

Because of the Part B and Part D financing mechanism in which income mirrors expenditures, it is not necessary to test for long-range imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and Federal general revenue payments. Chart 5 shows projected total SMI (Part B and Part D) expenditures and premium income as a percentage of GDP. As in the projections for HI, the assumed long-range increase in average expenditures per beneficiary was refined in last year's Trustees Report. This refinement provides a more gradual transition from current health cost growth rates to the ultimate assumed level of GDP plus zero percent just after the 75th year and for the indefinite future. The growth rates are estimated year by year for the next 12 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 13 to 25 is assumed to grade smoothly into the long-range assumption.

Under the intermediate assumptions, annual SMI expenditures were $216.4 billion, or about 1.6 percent of GDP, in 2006. Then, in about 25 years, they would grow to almost 4 percent of GDP and to more than 6 percent by the end of the projection period.

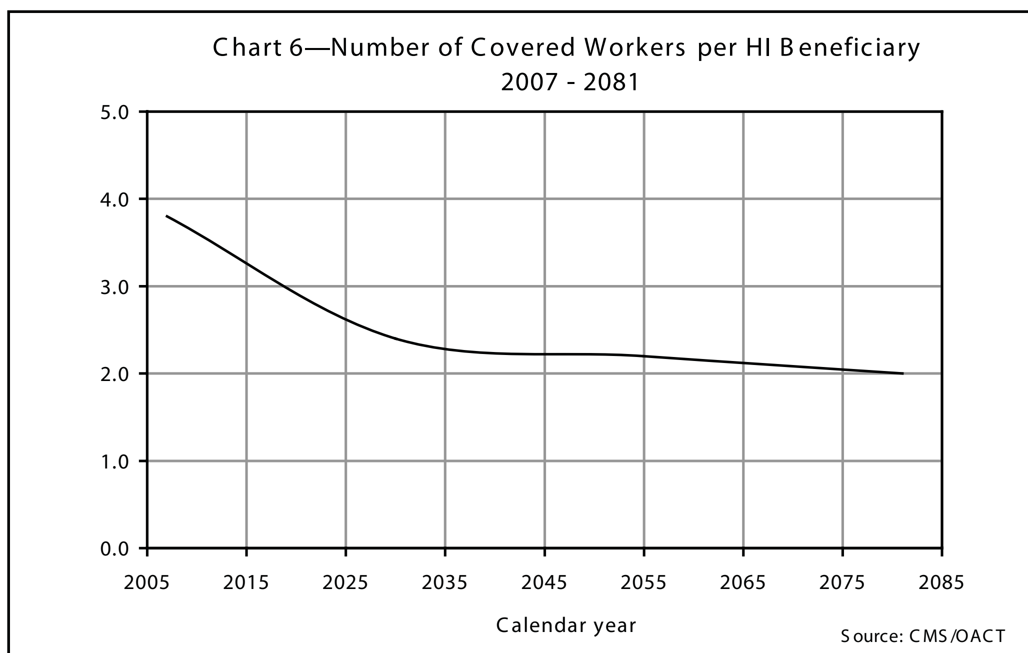


To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time. In fact, average per-beneficiary costs for Part B and Part D benefits are projected to increase in most years by at least 5 percent annually. The associated beneficiary premiums—and general revenue financing—would increase by approximately the same rate. The special State payments to the Part D account are set by law at a declining portion of the States' forgone Medicaid expenditures attributable to the Medicare drug benefit. The percentage was 90 percent in 2006, phasing down to 75 percent in 2015 and later. Then, after 2015, the State payments are also expected to increase faster than GDP.

Worker-to-Beneficiary Ratio

HI

Another way to evaluate the long-range outlook of the HI trust fund is to examine the projected number of workers per HI beneficiary. Chart 6 illustrates this ratio over the next 75 years. For the most part, current benefits are paid for by current workers. The retirement of the baby boom generation will therefore be financed by the relatively smaller number of persons born after the baby boom. In 2006, every beneficiary had 3.9 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.4 workers per beneficiary. The projected ratio continues to decline until there are just 2.0 workers per beneficiary by 2081.



Sensitivity Analysis

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

In order to illustrate the sensitivity of the long-range projections, six of the key assumptions were varied individually to determine the impact on the HI actuarial present values and net cashflows.[6] The assumptions varied are the health care cost factors, fertility rate, net immigration, real-wage differential, CPI, and real-interest rate.[7]

For this analysis, the intermediate economic and demographic assumptions in the *2007 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund*s are used as the reference point. Each selected assumption is varied individually to produce three scenarios. All present values are calculated as of January 1, 2007 and are based on estimates of income and expenditures during the 75-year projection period.

Charts 7 through 12 show the net annual HI cashflow in nominal dollars and the present value of this net cashflow for each assumption varied.[8] In most instances, the charts depicting the estimated net cashflow indicate that, after increasing in the early years, net cashflow decreases steadily through 2081 under all three scenarios displayed. On the present value charts, the same pattern is evident, in most cases, until around 2060, when the present values begin to increase (or become less negative). This occurs as a result of the discounting process used for computing present values, which is used to help interpret the net cashflow deficit in terms of today's dollar. In other words, the amount required today to cover this deficit begins to decrease at the end of the 75-year period.

Health Care Cost Factors

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

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[6] Sensitivity analysis is not done for Parts B or D of the SMI trust fund due to the financing mechanism for each account. Any change in assumptions would have no impact on the net cashflow, since the change would affect income and expenditures equally.

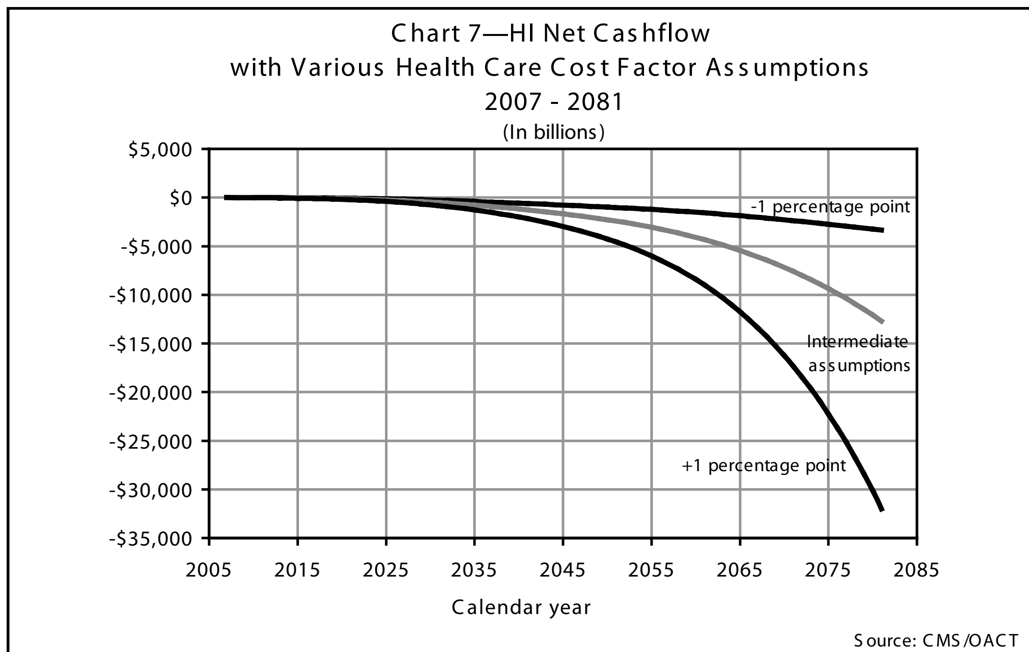
[7] The sensitivity of the projected HI net cash flow to variations in future mortality rates is also of interest. At this time, however, relatively little is known about the relationship between improvements in life expectancy and the associated changes in health status and per beneficiary health expenditures.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

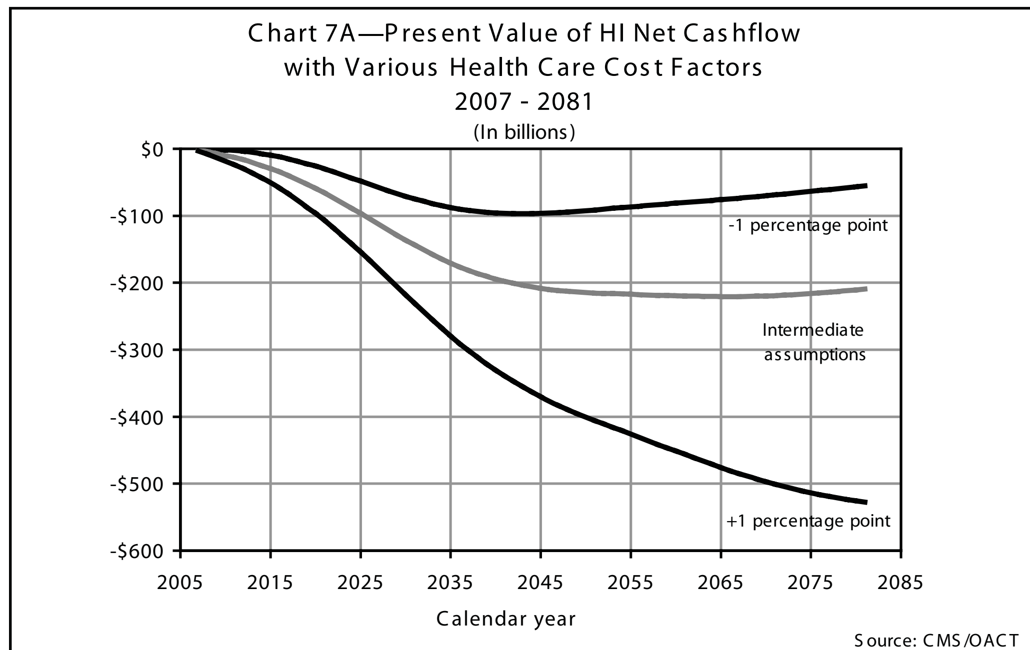
[8] As noted previously, long-range projections expressed in nominal dollar amounts can be very difficult to interpret, due to the changing value of the dollar over time. Amounts expressed in present values are less subject to this difficulty.

Table 1—Present Value of Estimated HI Income Less Expenditures under Various Health Care Cost Growth Rate Assumptions			
Annual cost/payroll relative growth rate	-1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures (in billions)	-$5,053	-$12,292	-$24,051

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $7,240 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases more substantially, by $11,758 billion.

Charts 7 and 7A show projections of the net cashflow under the three alternative annual growth rate assumptions presented in table 1.





This assumption has a dramatic impact on projected HI cashflow. Several factors, such as the utilization of services by beneficiaries or the relative complexity of services provided, can affect costs without affecting tax income. As charts 7 and 7A indicate, the financial status of the HI trust fund is extremely sensitive to the relative growth rates for health care service costs.

Fertility Rate

Table 2 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.7, 2.0, and 2.3 children per woman.

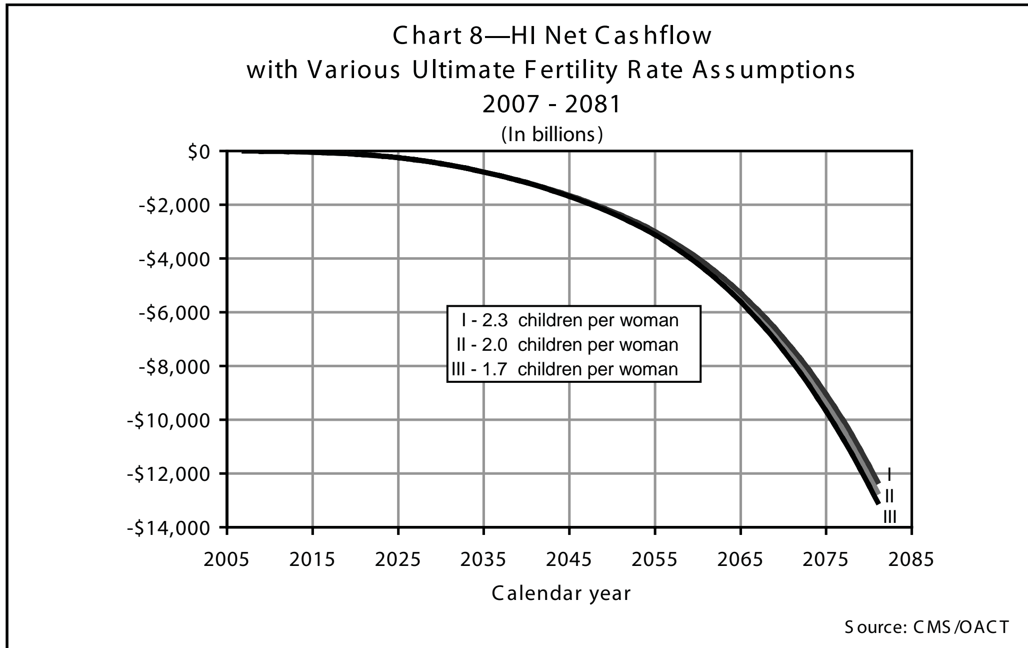
Table 2—Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

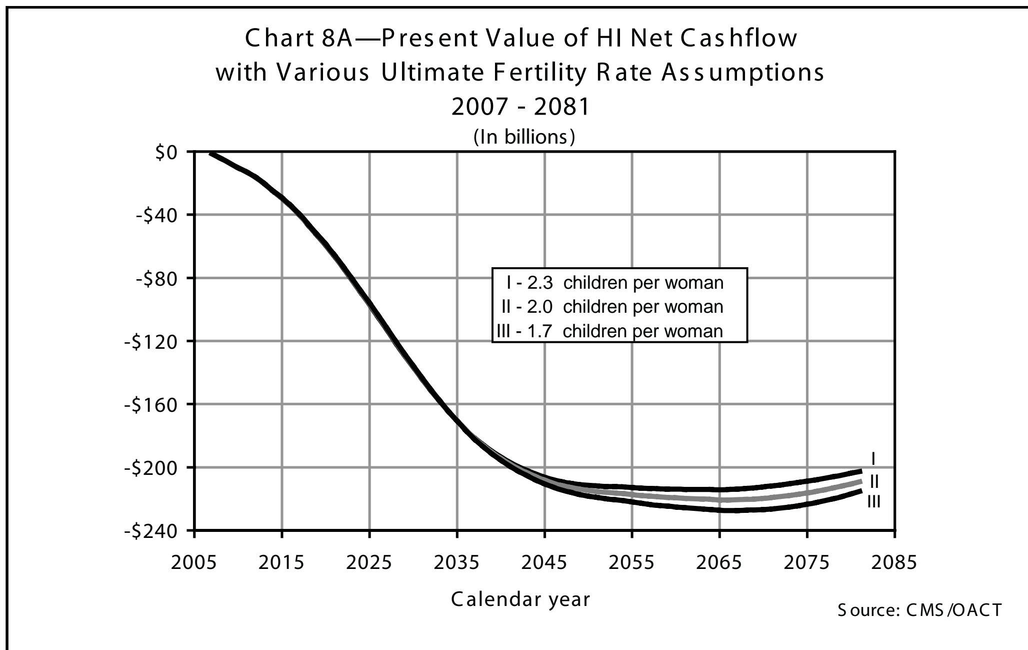
Ultimate fertility rate[1]	1.7	2.0	2.3
Income minus expenditures (in billions)	-$12,503	-$12,292	-$12,091

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

As table 2 demonstrates, for an increase of 0.3 in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately $205 billion.

Charts 8 and 8A show projections of the net cashflow under the three alternative fertility rate assumptions presented in table 2.





As charts 8 and 8A indicate, the fertility rate assumption has only a negligible impact on projected HI cashflows. In fact, higher fertility in the first year does not affect the labor force until roughly 20 years have passed (increasing HI payroll taxes slightly) and has virtually no impact on the number of beneficiaries within this period. Over the full 75-year period, the impacts are expected to be somewhat greater, as illustrated by the present values in table 2.

Net Immigration

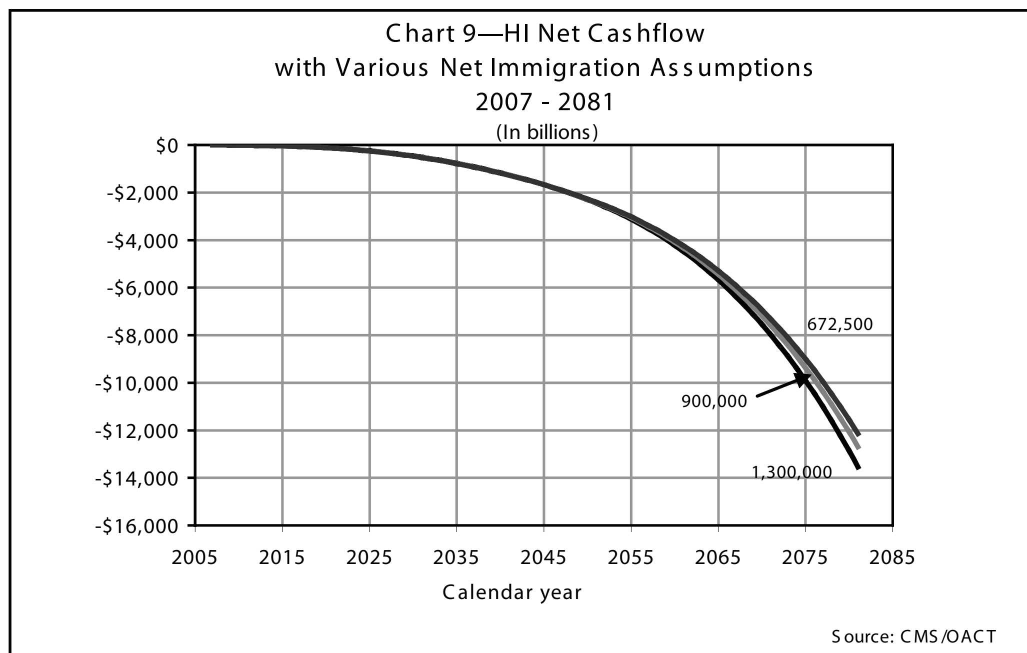
Table 3 shows the net present value of cashflow during the 75-year projection period under three alternative net immigration assumptions: 672,500 persons, 900,000 persons, and 1,300,000 persons per year.

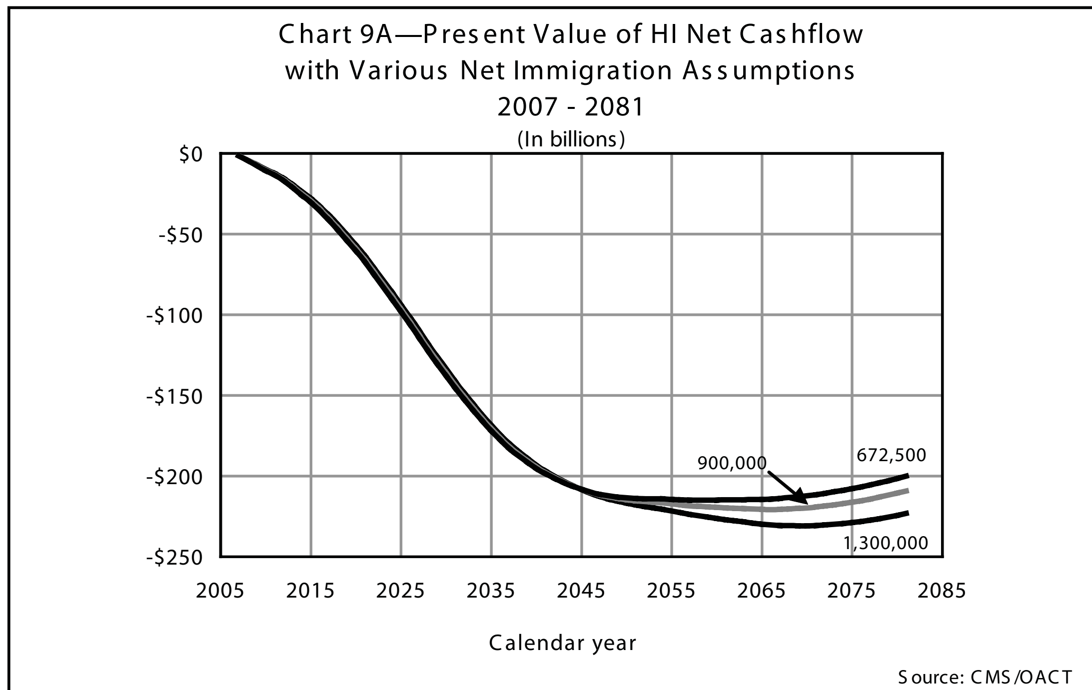
Table 3—Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions

Ultimate net immigration	672,500	900,000	1,300,000
Income minus expenditures (in billions)	-$12,149	-$12,292	-$12,516

As shown in table 3, if the ultimate net immigration assumption is 672,500 persons, the deficit decreases by $144 billion. Conversely, if the ultimate net immigration assumption is 1,300,000 persons, the deficit increases by $224 billion.

Charts 9 and 9A show projections of the net cashflow under the three alternative net immigration assumptions presented in table 3.





As charts 9 and 9A indicate, this assumption has an impact on projected HI cashflow starting almost immediately. Because immigration tends to occur among those who work and pay taxes into the system, in the short term payroll taxes increase faster than benefits; in the long term, however, the opposite occurs, as those individuals age and become beneficiaries in a period with much greater health care costs per beneficiary.

Real-Wage Differential

Table 4 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential[9] assumptions: 0.6, 1.1, and 1.6 percentage points. In each case, the ultimate CPI-increase is assumed to be 2.8 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.4, 3.9, and 4.4 percent, respectively.

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

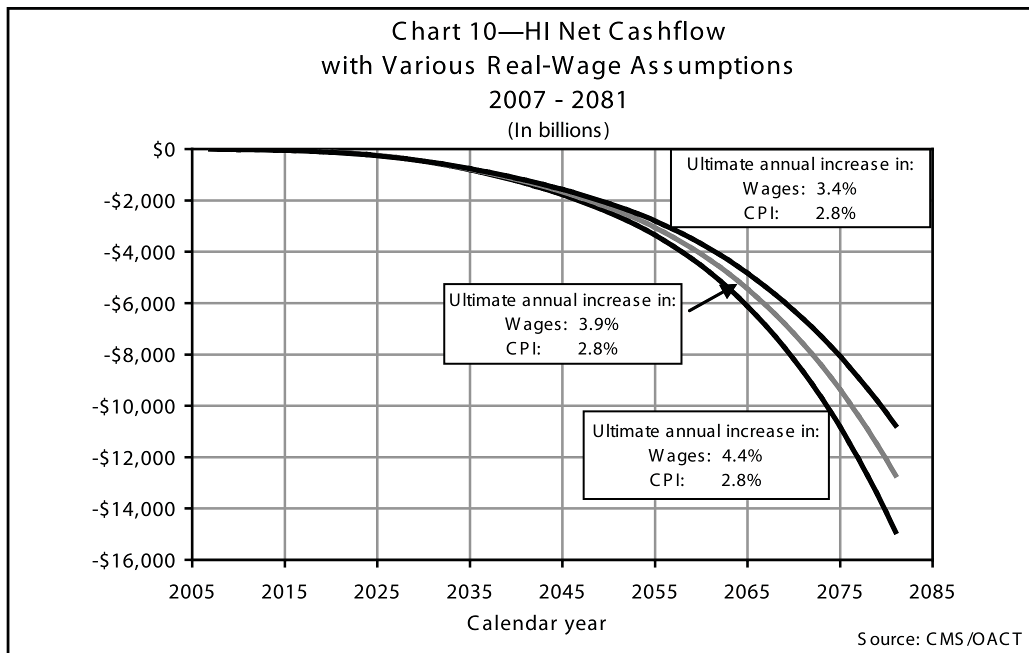
Ultimate percentage increase in wages - CPI	3.4 - 2.8	3.9 - 2.8	4.4 - 2.8
Ultimate percentage increase in real-wage differential	0.6	1.1	1.6
Income minus expenditures (in billions)	-$11,411	-$12,292	-$13,376
Income minus expenditures (as a percentage of taxable payroll)	-4.04%	-3.69%	-3.43%

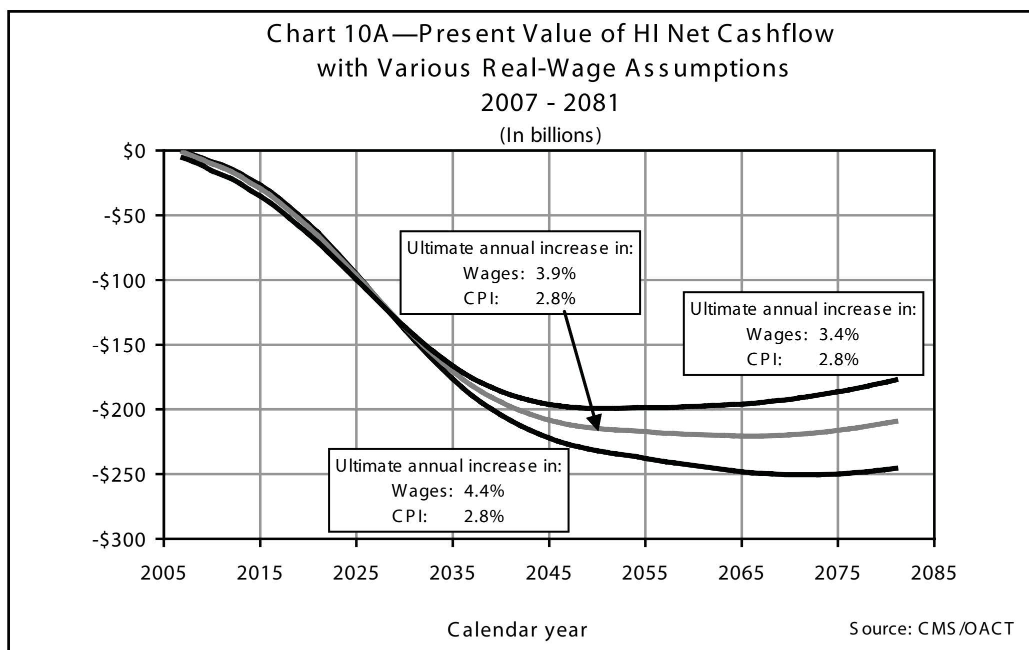
As indicated in table 4, for a half-point increase in the ultimate real-wage differential assumption, the deficit—expressed in present-value dollars—increases by approximately $980 billion. In this instance, the results expressed in present-value dollars do not reveal the full implications of faster or slower growth

[9] The difference between the percentage increases in the average annual wage in covered employment and the average annual CPI.

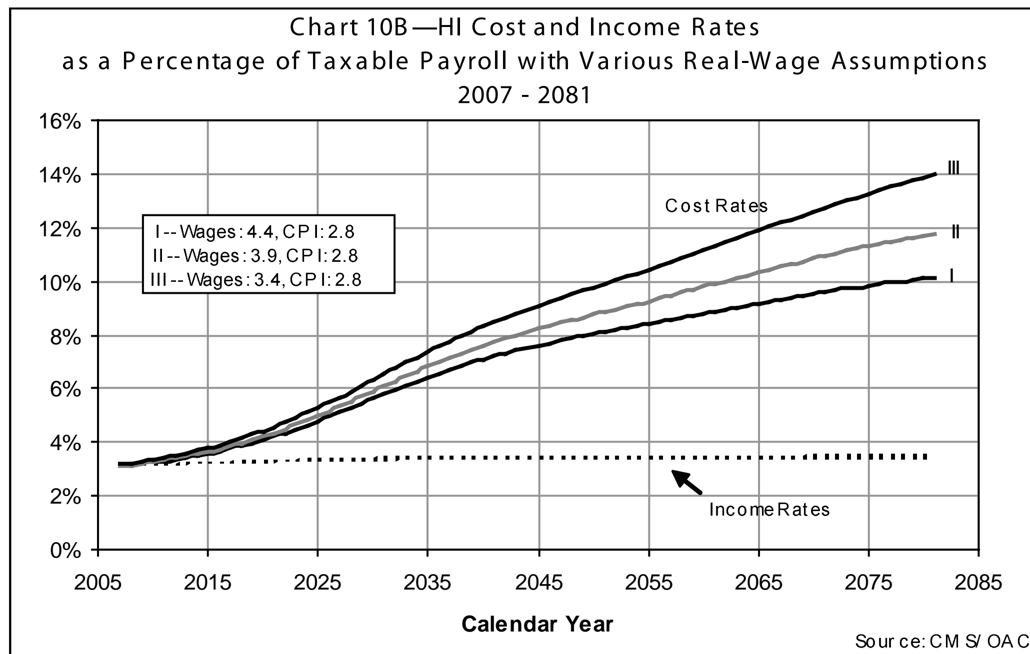
in real wages. While the dollar amount of the trustfund deficit is lower, for a smaller real-wage differential, table 4 also indicates that the deficit represents a higher percentage of taxable payroll. In other words, with slower growth in real wages, a higher tax increase would be necessary to cover the corresponding HI trust fund deficit. In practice, slow growth in real wages worsens the financial status of the HI trust fund, and, conversely, rapid growth in real wages improves the fund's condition. The reasons for the apparent inconsistency between the present-value and taxable-payroll measures are described below.

Charts 10 and 10A show projections of the net cashflow under the three alternative real-wage differential assumptions presented in table 4.





As noted previously and illustrated in charts 10 and 10A, slower real-wage growth results in smaller HI cashflow deficits, when expressed in either nominal or present-value dollars. While this result appears to suggest that the financial status of the HI trust fund improves with slower real-wage growth, in practice the opposite is true. To better illustrate this result, chart 10B shows projected HI expenditures and tax revenues under the three scenarios, expressed as a percent of taxable payroll.



As indicated in chart 10B, HI expenditures represent a significantly higher proportion of taxable payroll under conditions of slow real-wage growth (and vice versa). HI tax revenues, however, as a percentage of taxable payroll, are largely unaffected. As a result, the HI deficit as a percentage of taxable payroll increases substantially with slow wage growth, and faster real-wage growth leads to lower HI cost rates and deficits.

A higher real-wage differential immediately increases both HI expenditures for health care and wages for all workers. There is a full effect on wages and payroll taxes, but the effect on benefits is only partial, since not all health care costs are wage-related. In dollar terms (either nominal or present-value), expenditures, revenues, deficits, and taxable payroll all increase with faster real-wage growth. In relative terms, however, faster wage growth increases taxable payroll, and thus tax revenues, more than it increases expenditures. This scenario leads to an improved financial status, where a smaller increase in the HI payroll tax rate would be required to attain financial balance. Similarly, slower real-wage growth worsens the financial outlook for the HI trust fund. For these reasons, the dollar cashflow measures required by Federal accounting standards do not adequately describe the sensitivity of the HI financial status to changes in the real-wage assumptions and must be supplemented by other measures.

Consumer Price Index

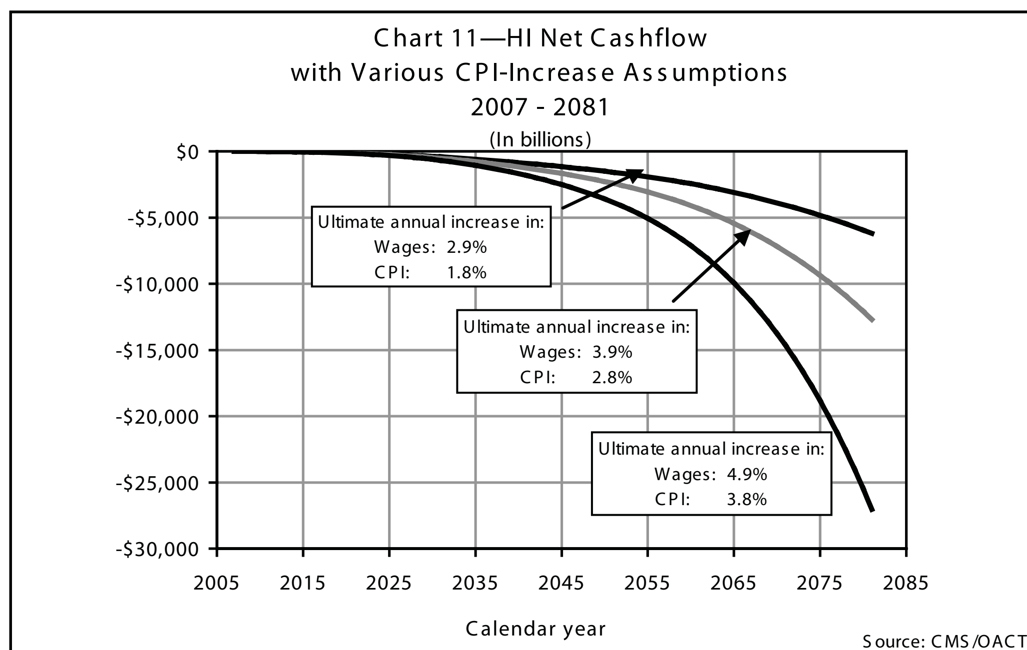
Table 5 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 1.8, 2.8, and 3.8 percent. In each case, the ultimate real-wage differential is assumed to be 1.1 percent, yielding ultimate percentage increases in average annual wages in covered employment of 2.9, 3.9, and 4.9 percent, respectively.

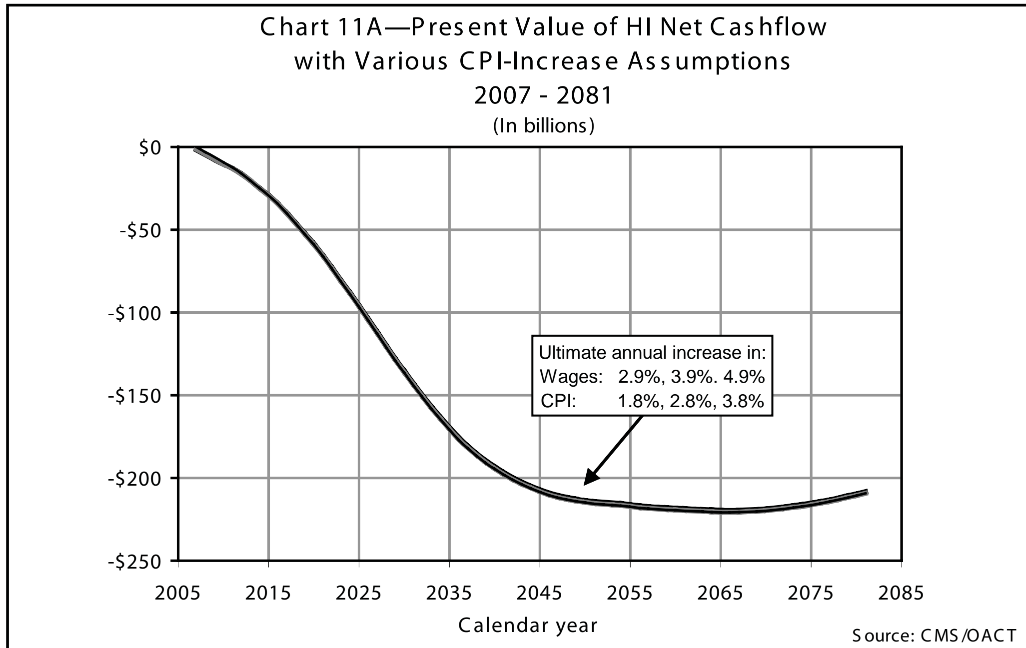
Table 5—Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions

Ultimate percentage increase in wages - CPI	2.9 - 1.8	3.9 - 2.8	4.9 - 3.8
Income minus expenditures (in billions)	-$12,230	-$12,292	-$12,299

Table 5 demonstrates that if the ultimate CPI-increase assumption is 1.8 percent, the deficit decreases by $63 billion. On the other hand, if the ultimate CPI-increase assumption is 3.8 percent, the deficit increases by only $6 billion.

Charts 11 and 11A show projections of the net cashflow under the three alternative CPI rate-of-increase assumptions presented in table 5.





As charts 11 and 11A indicate, this assumption has a large impact on projected HI cashflow in nominal dollars but only a negligible impact when the cashflow is expressed as present values. The relative insensitivity of the projected present values of HI cashflow to different levels of general inflation occurs because inflation tends to affect both income and costs in a similar manner. In nominal dollars, however, a given deficit "looks bigger" under high-inflation conditions but is not significantly different when it is expressed as a present value or relative to taxable payroll. This sensitivity test serves as a useful example of the limitations of nominal-dollar projections over long periods.

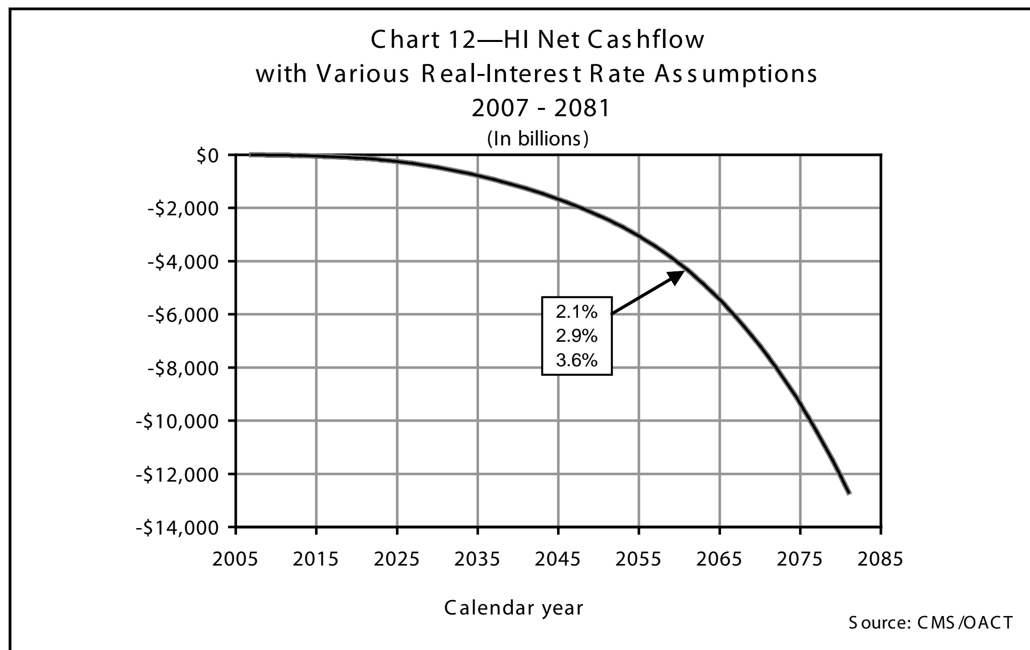
Real-Interest Rate

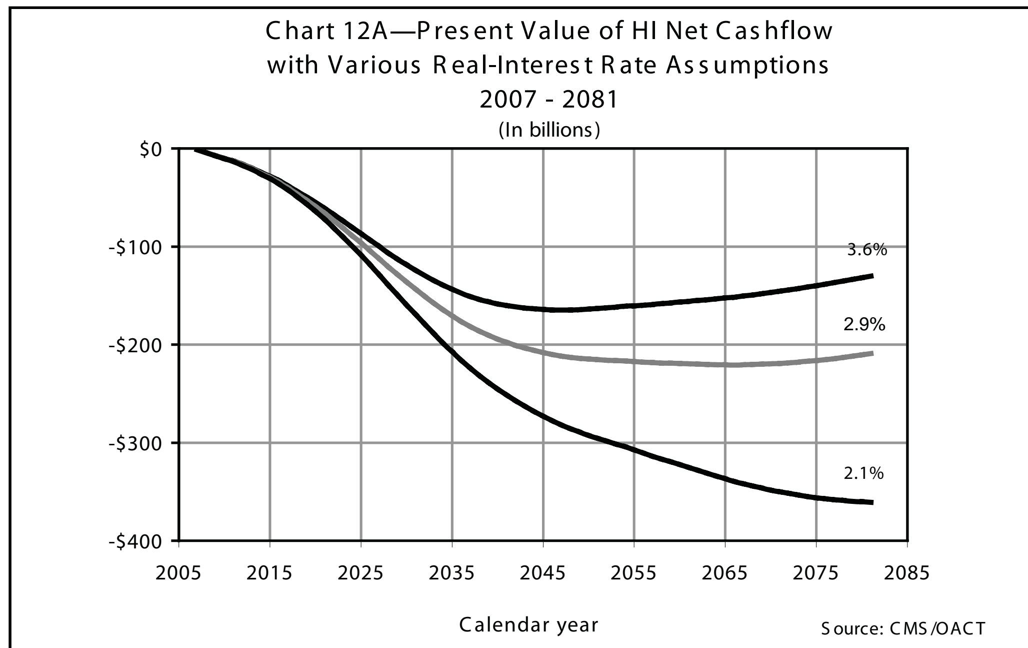
Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-interest assumptions: 2.1, 2.9, and 3.6 percent. In each case, the ultimate annual increase in the CPI is assumed to be 2.8 percent, resulting in ultimate nominal annual yields of 4.9, 5.7, and 6.4 percent, respectively.

Table 6—Present Value of Estimated HI Income Less Expenditures under Various Real-Interest Assumptions			
Ultimate real-interest rate	2.1 percent	2.9 percent	3.6 percent
Income minus expenditures (in billions)	-$17,269	-$12,292	-$9,264

As illustrated in table 6, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $530 billion.

Charts 12 and 12A show projections of the net cashflow under the three alternative real-interest assumptions presented in table 6.





As shown in charts 12 and 12A, the projected HI cashflow when expressed in present values is more sensitive to the interest assumption than when it is expressed in nominal dollars. This is not an indication of the actual role that interest plays in HI financing. In actuality, interest finances very little of the cost of the HI trust fund because, under the intermediate assumptions, the fund is projected to be relatively low and exhausted by 2018. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), resulting in a smaller overall net present value.

Trust Fund Finances and Sustainability

HI

Under the Medicare Trustees' intermediate assumptions, the HI trust fund is projected to be exhausted in 2018, the same as was estimated in last year's report. Income from all sources is projected to exceed expenditures for only the next 4 years and to fall short by steadily increasing amounts in 2010 and later. These shortfalls can be met with increasing reliance on interest payments on invested assets and the redemption of those assets, thereby adding to the draw on the Federal Budget. In the absence of corrective legislation, a depleted HI trust fund would initially produce payment delays, but very quickly lead to a curtailment of health care services to beneficiaries. In practice, Congress has never allowed a Medicare or Social Security trust fund to become fully depleted.

The HI trust fund is substantially out of financial balance in the long range. Bringing the fund into actuarial balance over the next 75 years under the intermediate assumptions would require very substantial increases in revenues and/or reductions in benefits. These changes are needed in part as a result of the impending retirement of the baby boom generation.

SMI

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

The financing established for the Part B account for calendar year 2007 is adequate to cover 2007 expected expenditures and to restore the financial status of the Part B account in 2007 to a satisfactory level. Because the net trust fund ratio would still be at the lower end of the desirable range, the Part B financing rates for 2008 would have to be increased slightly above the estimated expenditure increase.

No financial imbalance is anticipated for the Part D account, since the general revenue subsidy for this benefit is expected to be drawn on a daily, as-needed basis. The projected Part D costs shown in this section are significantly lower than previously estimated, reflecting the latest data on drug cost trends generally and Part D bid and enrollment levels.

For both the Part B and Part D accounts, beneficiary premiums and general revenue transfers will be set to meet expected costs each year. However, a critical issue for the SMI trust fund is the impact of the past and expected rapid growth of SMI costs, which place steadily increasing demands on beneficiaries, the Federal Budget, and society at large.

Medicare Overall

The Medicare Modernization Act requires the Board of Trustees to determine whether the difference between Medicare outlays and "dedicated financing sources" is projected to exceed 45 percent of total Medicare outlays within the next 7 fiscal years (2007-2013).[10] This difference is projected to first exceed 45 percent of total expenditures in 2013, which is within the 7-year test period. Consequently, the Trustees issued a determination of projected "excess general revenue Medicare funding," as required by law. A similar determination was made in their 2006 annual report to Congress. Under the MMA, these two consecutive determinations trigger a "Medicare funding warning," indicating that the general revenues provided to Medicare under current law are becoming a substantial proportion of total program costs. This finding requires the President to submit to Congress, within 15 days after the release of the next budget, proposed legislation to respond to the warning.[11] Congress is then required to consider this legislation on an expedited basis. This new requirement will help call attention to Medicare's impact on the Federal Budget.

[10] Dedicated Medicare financing sources include HI payroll taxes; income from taxation of Social Security benefits; State transfers for the prescription drug benefit; premiums paid under Parts A, B, and D; and any gifts received by the Medicare trust funds.

[11] The next such budget submission will be the President's Fiscal Year 2009 Budget, which will be released in early February 2008.

The projections shown in this section continue to demonstrate the need for the Administration and the Congress to address the financial challenges facing Medicare—both the long-range financial imbalance facing the HI trust fund and the heightened problem of rapid growth in expenditures. In their 2007 annual report to Congress, the Medicare Boards of Trustees emphasized the seriousness of these concerns and urged the nation's policy makers to take "prompt, effective, and decisive action…to address these challenges." They also stated: "Consideration of such reforms should occur in the relatively near future."

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Section III. Other Accompanying Information

FY 2007 Agency Financial Report

Section III: Other Accompanying Information

This section contains the HHS Inspector General's summary of the most significant management and performance challenges facing the Department, the Department's response to the Inspector General's assessment, HHS' detailed Improper Payments Information Act of 2002 Report, and Other Financial Information.

FY 2007 Top Management and Performance Challenges Identified by the Office of the Inspector General

Management Issue 1: Oversight of Medicare Part D

Management Challenge:

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Public Law 108-173) established a Medicare outpatient prescription drug benefit, known as Medicare Part D, which took effect on January 1, 2006. This voluntary benefit is available to all 43 million Medicare beneficiaries. According to the "2007 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," during 2006, the first year of the benefit, expenditures totaled more than $47 billion. According to the Centers for Medicare & Medicaid Services (CMS), as of January 2007, nearly 24 million beneficiaries were enrolled in Part D and an additional 7 million beneficiaries were enrolled in retiree drug coverage plans that receive the Retiree Drug Subsidy (RDS). The magnitude of expenditures and impact of this benefit on beneficiaries, from both health and financial perspectives, make it critical that Medicare Part D operates efficiently and effectively and is protected from fraud and abuse.

The structure and operation of the Part D benefit contain features that present significant management challenges. Part D coverage is provided by private entities, known as drug plan sponsors, that contract with CMS to provide Part D drug plans. Qualified employer-sponsored plans may also receive a subsidy, the RDS, to maintain drug coverage for the Medicare beneficiaries. Within the Department, CMS bears primary responsibility for implementing and administering Part D. However, administration of Medicare Part D depends upon extensive coordination and information sharing among Federal and State Government agencies, drug plan sponsors, contractors, health care providers, and third party payers.

Payments to drug plan sponsors based on bids, risk adjustments, and reconciliations add to the complexities and challenges of the benefit. Medicare pays plans prospectively based on sponsors' bids, which are submitted and approved prior to the plan year. Subsequently, Medicare reconciles payments to plans through a multi-stage process that begins 6 months after the conclusion of the plan year.

Based on our analysis of preliminary reconciliation amounts, OIG estimated that Part D sponsors owe Medicare a net total of $4.4 billion for 2006. Eighty percent of sponsors owe money to Medicare, whereas 20 percent of sponsors will receive money from Medicare. The majority of the funds' that sponsors owe are profits that they must repay to Medicare as a result of risk-sharing requirements. CMS does not currently have mechanisms in place to collect these funds or to adjust prospective payments prior to reconciliation. As a result, sponsors have had the use of over $4 billion owed to Medicare for a significant length of time. Additionally, sponsors' overestimates of their costs also resulted in higher beneficiary premiums; however, beneficiaries do not directly recoup any money paid in higher premiums.

During the coverage year, the relative financial responsibilities of Medicare, drug plan sponsors, and beneficiaries vary through four distinct phases (deductible, initial coverage period, coverage gap, and catastrophic coverage), depending on the beneficiaries' total drug costs and true out-of-pocket (TrOOP) spending at a given time. Drug plan sponsors are responsible for tracking enrollees' TrOOP, the out-of-pocket costs that count toward the catastrophic coverage threshold. Accurate tracking of TrOOP is essential to ensuring that each party pays the appropriate share of drug costs.

CMS and drug plan sponsors share responsibility for protecting the Part D program from fraud, waste, and abuse. CMS is responsible for oversight and implementation of safeguards to protect the integrity of the Part D benefit. In an initial review, OIG found that as of October 2006, CMS's safeguard activities needed further development and application. For example, neither CMS nor the one Medicare Drug Integrity Contractor (MEDIC) that was operating as of October 2006 had conducted any significant data analysis for fraud detection purposes. CMS relied largely on complaints to identify fraud and abuse, but OIG found that not all complaints were investigated timely. OIG also identified impediments to CMS's effective oversight of drug plan sponsors' financial reporting, Part D marketing, and utilization management.

Part D plan sponsors are required to implement compliance plans that include comprehensive plans to detect, correct, and prevent fraud, waste, and abuse. OIG found that as of January 2006, all prescription drug plan sponsors had compliance plans in place but that few sponsors met all of CMS's requirements for compliance plans. Further, most sponsors' compliance plans did not address all of CMS's recommendations regarding fraud detection, correction, and prevention. In addition, sponsors' compliance plans contained only the broad outlines of a fraud and abuse plan and did not include details or describe specific processes. OIG is conducting follow-up work focused on sponsors' detection and reporting of fraud and abuse.

Several additional OIG reviews of Part D are under way. Some examples include reviews of plan bids and CMS's bid review process, point-of-sale drug prices, potential duplicate payments for drugs, States' contributions to the costs for coverage of dual eligibles, RDS payments for employer-sponsored coverage, tracking beneficiaries' TrOOP costs, and drug plan marketing materials. OIG is also involved in a number of investigations related to Medicare Part D. These cases involve potential wrongdoing committed by a variety of actors, including marketing agents, drug plan sponsors, and pharmacists.

Assessment of Progress in Addressing the Challenge:

CMS has demonstrated progress in protecting Medicare Part D from fraud and abuse, but further implementation of safeguards is needed. OIG identified six major types of Part D safeguard activities that CMS is planning or implementing, including (1) the complaint process, (2) data monitoring, (3) financial audits, (4) monitoring compliance of drug plan sponsors, (5) oversight of drug plan sponsors' efforts to reduce fraud and abuse, and (6) education and guidance. CMS is in various stages of implementation with respect to each of these safeguards. For example, the complaint process

has been in place since November 2005, but the first financial audits are not expected to begin until January 2008. Data-monitoring efforts have been slow to materialize, but CMS has taken some promising steps. For example, CMS has entered into a contract to develop a centralized data repository, known as One Program Integrity System Integrator (One PI). This database is intended to warehouse Medicare prescription drug data as well as data on inpatient care, physician services, and other services provided under Medicare Parts A and B and Medicaid. When developed, One PI is expected to offer powerful data analysis and fraud detection tools.

In its comments on OIG's report on CMS's implementation of safeguards during FY 2006, CMS reported several advances since the beginning of 2007. These include continued progress towards commencing the financial audits by the end of CY 2007, commencement of routine PDP compliance audits in February 2007, improvement in processing complaints timely, and release of four new chapters of the Prescription Drug Benefit Manual.

Although many of the Part D safeguard activities are to be conducted by MEDICs, for most of 2006, CMS had contracted with only one functioning MEDIC. In September 2006, three regional MEDICs and a data-focused MEDIC were awarded contracts, with operations scheduled to begin December 2006. The MEDICs have had challenges in obtaining complete Part D claims data to carry out these integrity activities. CMS reported to OIG that its top priority is to increase the MEDICs' access to Part D data and that additional funding will support the MEDICs' access to data and allow the MEDICs to provide additional analysis and thus sustain fraud, waste, and abuse prevention activities.

In response to OIG's report on reconciliation amounts owed, CMS stated that it believes that the variance between prospective and reconciled payments will markedly decrease over time as actual program data becomes available to CMS and drug plan sponsors. CMS also concurred with OIG's recommendation that the data collected from the 2006 and subsequent plan years be used in the review of future bid submissions.

Management Issue 2: Integrity of Medicare Payments

Management Challenge:

The size and scope of the Medicare program place it at high risk for payment errors. In fiscal year (FY) 2006, Medicare benefit payments totaled about $382 billion for services provided to approximately 43 million beneficiaries. To ensure both the solvency of the Trust Fund and beneficiaries' continued access to quality services, correct and appropriate payments must be made for properly rendered services.

From FY 1996 through FY 2002, OIG developed and reported on the annual Medicare fee-for-service paid claims error rate. In FY 2003, CMS assumed responsibility for developing the error rate. In its 2006 financial report, CMS reported a gross paid claims error rate (overpayments plus underpayments) of 4.4 percent ($10.8 billion) for the fiscal year. However, OIG's FY 2006 financial statement audit reported internal control weaknesses in managed care and the prescription drug benefit program and the lack of an integrated general ledger accounting system within CMS. Further, OIG audits continue to show that Medicare has serious internal control weaknesses in its financial systems and processes.

Targeted audits and evaluations by OIG also continue to identify significant improper payments and problems in specific parts of the program. These reviews have revealed payments for unallowable services, improper coding, and other types of improper payments. For example, OIG identified $1.1 billion in improper payments for services billed as consultations, $718 million in improper payments for Part B mental health services, an estimated $402 million in

improper payments for ambulance transports, and $377.9 million in inaccurate hospital wage data that impact future Medicare payments. In additional reviews, OIG found $72.4 million in improper payments to hospitals that incorrectly coded claims as discharges to home rather than transfers to post-acute care facilities. OIG also identified $71.5 million in improper payments to independent diagnostic testing facilities for services that were not reasonable and necessary, were not sufficiently documented, or were performed without the knowledge of treating physicians.

OIG has also consistently found that the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) benefit is vulnerable to fraud and abuse. For example from 2002 to 2006, OIG excluded from the Medicare and Medicaid programs 121 DMEPOS companies and 457 individuals associated with DMEPOS. During this same period, OIG's investigations resulted in 289 successful criminal prosecutions of DMEPOS suppliers and 76 civil settlements or judgments were imposed. Together these criminal convictions and civil adjudications resulted in more than $796 million in restitution, fines, and penalties.

In other work, OIG has identified weaknesses in the DMEPOS enrollment process and CMS's oversight of infusion claims that make Medicare vulnerable to fraudulent billing practices for these services. In a 2007 report, OIG found that 31 percent of DMEPOS suppliers in three South Florida counties (Miami-Dade, Broward, and Palm Beach) did not maintain physical facilities or were not open and staffed, contrary to Medicare participation guidelines. The guidelines are intended to ensure that only qualified suppliers are enrolled in the Medicare program. In a separate review, OIG determined that in the second half of 2006, the claims originating in the same three Florida counties constituted 50 percent of the submitted charges and 37 percent of the amount Medicare paid for services on behalf of beneficiaries with HIV/AIDS. These counties also accounted for 79 percent of the amount submitted to Medicare nationally for drug claims involving HIV/AIDS patients. However, only 10 percent of Medicare beneficiaries with HIV/AIDS lived in these three counties. Other metropolitan areas exhibited patterns of aberrant billing similar to those in South Florida, but to a lesser extent.

Additionally, in a 2007 report, OIG reviewed Part B claims for beneficiaries who were in Part A-covered skilled nursing facility stays for which the Part B services are reimbursed as part of the Part A payment. For calendar years (CY) 1999-2002, before the Common Working File edits were fully operational, OIG found that Medicare Part B made $100.8 million in potential overpayments to suppliers of DMEPOS on behalf of beneficiaries in Part A-covered skilled nursing facility stays. For CY 2003, after the edits were fully operational, OIG identified potential DMEPOS overpayments of $15.4 million and estimated that durable medical equipment regional carriers had not recovered approximately 69 percent ($11.2 million) of these overpayments.

To help combat DMEPOS fraud, OIG, in conjunction with the U.S. Attorney's Office for the Southern District of Florida, the Federal Bureau of Investigation, and the Department of Justice (DOJ) launched a health care initiative designed to identify suspicious suppliers and review questionable financial activities. Since its inception in September 2006, the initiative has recovered more than $10 million from nominee account holders who agreed to turn over the funds in the bank accounts when confronted by law enforcement officials. In most cases, the nominee account holders stated that they had no operational control of the businesses and had only lent their names in return for remuneration.

Assessment of Progress in Addressing the Challenge:

The FY 2006 gross paid claims error rate of 4.4 percent reported by CMS is 0.8 percentage points lower than the 5.2 percent error rate it reported the previous year. CMS has demonstrated continued vigilance in monitoring the error

rate and is developing appropriate corrective action plans. For example, CMS has worked with the health care provider community to clarify reimbursement rules and to impress upon providers the importance of fully documented services. CMS also has taken a number of steps to improve compliance with Medicare coverage and reimbursement requirements to curb inappropriate payments. These steps include increasing and refining one-on-one educational contacts with providers and working with contractors to assist providers in submitting sufficient documentation to support billed services.

CMS received an unqualified opinion on its FY 2006 financial statements. However, the material weakness related to Medicare electronic data processing and the reportable conditions related to managed care and prescription drug payment cycles, taken together, represent substantial noncompliance with the Federal financial management system requirements. In addition, although the Healthcare Integrated General Ledger Accounting System (HIGLAS) is operational at numerous Medicare contractors, CMS has not yet completed its implementation and, as a result, is not compliant with the U.S. Government Standard General Ledger at the transaction level. Although CMS has also made improvements to its general and application controls (such as access controls, application software development controls, and program change controls), OIG's financial statement audit identified weaknesses in application controls at Medicare contractors, at data centers where Medicare claims are processed, at sites that maintain the "shared" application system software used in claims processing, and at the CMS central office.

To address the potential improper payment exposure for durable medical equipment, the Secretary of the Department of Health and Human Services (HHS) announced a 2-year effort aimed at stopping fraudulent billing to the Medicare program and protecting beneficiaries and taxpayers. Under the initiative, CMS will implement a demonstration project requiring DMEPOS suppliers in South Florida and Southern California to reapply for participation in the Medicare program to maintain their billing privileges. Those who fail to reapply within 30 days of receiving a letter from CMS; fail to report a change in ownership or address; or fail to report having owners, partners, or managing employees who have committed felonies within the past 10 years will have their billing privileges revoked. CMS has also recently announced a demonstration project in South Florida focusing on infusion therapy. Under this demonstration, currently enrolled infusion therapy clinics located in the targeted area will be required to submit new enrollment applications and will undergo mandatory site visits.

Additionally, CMS issued a proposed rule on August 1, 2007 (72 FR 42001) that would require all DMEPOS suppliers, except those that are Government operated, to obtain and retain surety bonds in the amount of $65,000. Under this rule, Medicare can recover erroneous payments up to $65,000 that result from fraudulent or abusive supplier billing practices. This requirement may also help to ensure that only legitimate DMEPOS suppliers are enrolled in the program.

Management Issue 3: Appropriateness of Medicaid and SCHIP Payments

Management Challenge:

Medicaid is a joint Federal and State program that provides medical assistance to an estimated 50 million low-income and disabled Americans. The Federal share of the Medicaid and State Children's Health Insurance Program (SCHIP) expenditures in FY 2006 was approximately $185 billion. Because Medicaid and SCHIP are Federal/State matching programs, improper payments by States lead to corresponding improper Federal payments. Identifying payment errors and their causes in the Medicaid and SCHIP programs is particularly difficult because of the diversity of State programs and the variation in their administrative and control systems.

Payment Error Rates

Until recently, little was known about payment error rates in the Medicaid and SCHIP programs. This lack of information represented a substantial vulnerability in preventing fraud, waste, and abuse. In July 2001, CMS invited States to participate in a demonstration project to develop a Payment Accuracy Measurement (PAM) methodology for Medicaid, i.e., a single methodology that can produce both State-specific and national-level payment error estimates. The PAM model was later modified to comply with the requirements of the Improper Payments Information Act of 2002 which requires heads of Federal agencies to estimate improper payments for the programs they oversee, report to Congress annually, and submit reports on actions the agencies are taking to reduce such payments.

The PAM project has since been renamed the Payment Error Rate Measurement (PERM) program and was published in late August 2006 as an interim final rule with comment. The final PERM rule was published on August 31, 2007 (72 FR 50490). The PERM includes the error rate processes for Medicaid and SCHIP—fee-for-service, managed care, and eligibility. CMS is using a national contracting strategy to produce Medicaid and SCHIP managed care and fee-for-service error rates. The PERM also sets forth the State requirements for conducting reviews and estimating payment error rates due to errors in eligibility determinations.

To assist CMS with its development of PERM and at the request of the Office of Management and Budget (OMB), OIG conducted audits of Medicaid and SCHIP eligibility in three States: New York, California, and Florida. These reviews found significant eligibility errors in these programs. For the 6-month period ending June 30, 2006, approximately $363 million (Federal share) in Medicaid payments and $67.2 million (Federal share) in SCHIP payments were made on behalf of beneficiaries who did not meet Federal and State eligibility requirements in these three States. For the majority of these Medicaid and SCHIP improper payments, beneficiaries were ineligible because household incomes exceeded the threshold on the dates of service, citizenship requirements were not being met, Social Security numbers were lacking, and spend-down requirements were not being complied with.

OIG also conducts targeted program reviews to identify vulnerabilities and inappropriate payments associated with specific types of services. For example, in a 2007 report, OIG assessed the appropriateness of Medicaid payments for pediatric dental services in five States and found that 31 percent of Medicaid pediatric dental services provided in those States during 2003 did not meet State and Federal requirements, resulting in improper payments of approximately $155 million (Federal share $96 million). OIG recommended that CMS increase efforts to ensure that States enforce existing policies relating to the proper documentation of pediatric dental services and provide assistance to States to promote provider compliance with documentation requirements.

In addition, ongoing and planned work includes various reviews to identify payment error vulnerabilities in the Medicaid managed care program, to determine whether children enrolled in separate SCHIPs should be enrolled in Medicaid, and identify potential inappropriate payments for durable medical equipment. OIG is also conducting reviews to oversee the Medicaid and SCHIP error rate determination process.

Medicaid Prescription Drugs

CMS estimates that Medicaid expenditures for prescription drugs in 2006 totaled more than $28 billion. Although Medicaid drug expenditures declined significantly in 2006 because of the shift of the expenditures for dual eligibles to the new Medicare Part D program, drug spending continues to represent significant Medicaid expenditures.

States have substantial discretion in setting reimbursement rates for drugs covered under Medicaid. In general, Federal regulations require that each State's reimbursement for a drug not exceed the lower of the estimated acquisition cost plus a reasonable dispensing fee or the provider's usual and customary charge for the drug. In addition, CMS sets Federal upper limits (FUL) and many States have maximum allowable cost limits for multiple-source drugs (drugs with generic equivalents) that meet specific criteria.

Although States must reasonably reimburse pharmacies for prescription drugs provided to Medicaid beneficiaries, they often lack access to pharmacies' actual purchase prices. Because of this lack of pricing data, States rely on estimates to determine Medicaid reimbursement. Most States base their calculations of estimated acquisition costs on average wholesale prices (AWP), or wholesale acquisition costs (WAC), which are published prices that States obtain through national drug pricing compendia. AWPs are not defined by law or regulation and are not necessarily based on actual sales transactions.

OIG has produced a body of work related to Medicaid's pharmacy reimbursement and has consistently recommended that Medicaid programs reimburse pharmacies for drugs based on prices that more accurately reflect pharmacies' acquisition costs. Earlier OIG reports demonstrated that the published AWPs used to determine Medicaid drug reimbursement amounts generally did not reflect the prices incurred by retail pharmacies.

The DRA impacts both Medicaid prescription drug reimbursement to pharmacies and the rebates that manufacturers are required to pay to State Medicaid programs. It changes the basis for establishing the FUL amounts from the lowest published price (e.g. the AWP or WAC) to the lowest average manufacturer price (AMP). The DRA also requires CMS to make AMPs available to State Medicaid programs on a monthly basis. With respect to Medicaid rebates, the DRA also addresses issues related to rebates on clarifying the AMP, including physician-administered drugs and the treatment of authorized generics.

OIG is continuing to address pricing of Medicaid drugs. In 2007, OIG issued a report comparing the FUL amounts based on the new formula to estimates of pharmacies' acquisition costs. OIG found that under the new calculation method established by the DRA, FUL amounts are likely to decrease substantially, as intended, but OIG has concerns that, at least initially, some of the new FUL amounts may be below pharmacy acquisition costs. OIG recommended that CMS take steps to identify when a new FUL amount may not be representative of a drug's acquisition cost to pharmacies.

In addition to identifying problems with pharmacy reimbursement, OIG is also concerned that State Medicaid programs may not be receiving the proper amount of drug rebates that they are entitled to receive from drug manufacturers. The statutory drug rebate program, which became effective in January 1991, requires drug manufacturers to pay rebates to State Medicaid programs. Medicaid rebates are based on a formula that includes the reported AMPs. However, OIG has found that manufacturers may not always report AMPs in a timely manner or, in some cases, may not report them at all. Further, in a 2006 report mandated by the DRA, OIG found that manufacturers make inconsistent interpretations regarding how to calculate the reported AMPs. OIG has recommended that CMS work to ensure that manufacturers provide accurate and timely AMP data and provide additional clarification on how to determine reported AMPs.

OIG has also found instances in which pharmaceutical manufacturers have defrauded the Medicaid drug rebate program. For example, in 2005, the United States entered into a civil settlement with King Pharmaceuticals, Inc., for more

than $124 million to resolve allegations that King improperly calculated its Medicaid rebate pricing information and underpaid rebates due to the States' Medicaid programs. Several other major drug manufacturers have entered settlements with the United States in which Medicaid drug rebate violations were one of several issues resolved.

Additionally, OIG has investigated a number of cases involving retail pharmacy chains that allegedly billed Medicaid for prescription drugs that were not provided to beneficiaries. OIG and its law enforcement partners also have pursued cases in which pharmacies switched the drugs prescribed to patients to exploit Medicaid reimbursement rules. For instance, in November 2006, the Government entered into a $49.5 million settlement with Omnicare, Inc., a nationwide institutional pharmacy that serves nursing home patients exclusively. The investigation found that Omnicare switched generic Zantac tablets with capsules to avoid a FUL set by CMS and the maximum allowable cost set by State Medicaid programs for the tablets. By these and other drug switches, Omnicare gained additional Federal and State dollars to which it was not otherwise entitled.

Given the high Federal and State expenditures and the potential for significant savings, CMS should continue to be attentive in its oversight of Medicaid reimbursement for prescription drugs and the Medicaid drug rebate program. In particular, CMS should work to ensure that the cost-saving provisions in the Deficit Reduction Act (DRA) are effectively implemented and monitored. Further, States need accurate data that reliably reflect the actual costs of drugs paid by pharmacies and are based on pricing data that can be validated. Therefore it is essential that all manufacturers report timely and accurate data to CMS to ensure appropriate payments are made and correct rebates are collected.

Assessment of Progress in Addressing the Challenge:

Payment Error Rates

The FY 2006 CMS "Performance and Accountability Report" (PAR) included the results of the PERM pilot. The FY 2007 report will include a preliminary national Medicaid fee-for-service error rate based on a sample of States and of claims within those States for the first two quarters of FY 2006. The final national Medicaid fee-for-service error rate for FY 2006 will be reported in the FY 2008 PAR, as will the national Medicaid and SCHIP fee-for-service, managed care and eligibility error rates for FY 2007. CMS expects to be fully compliant with the Improper Payments Information Act requirements by FY 2008.

In response to OIG audits of Medicaid and SCHIP eligibility in New York, California, and Florida, the States generally agreed to improve their eligibility processes. The payments made on behalf of ineligible beneficiaries will be adjudicated by CMS as part of its audit clearance process. Additionally, in response to OIG's 2007 review of claims for Medicaid pediatric dental services, CMS indicated that its Medicaid Integrity Group plans to work with States to enforce existing policies related to the proper documentation for pediatric dental services as well as other Medicaid services.

Medicaid Prescription Drugs

CMS has been directed by section 6001(f) of the DRA to conduct a monthly survey of retail prices for prescription drugs. This information is to be provided to the States monthly and compared to State payment rates annually. CMS currently provides AMP data to State Medicaid agencies as mandated by the DRA.

On July 17, 2007, CMS published in the Federal Register a final rule with comment period (72 FR 39142) that (1) implements the provisions of the DRA pertaining to prescription drugs under the Medicaid program, (2) adds to existing regulations Medicaid rebate policies, and (3) solicits public comments on the FUL outlier and AMP sections of

the rule. In accordance with the DRA, the rule includes requirements related to State plans, Federal financial participation for drugs, and the payment for covered outpatient drugs under Medicaid.

In the final rule, CMS describes an outlier policy that precludes the lowest AMP from being used in the FUL calculation. In the notice of proposed rulemaking, CMS proposed excluding lowest AMPs that were 70 percent less than the second-lowest AMP. In the final rule, this threshold was decreased to 60 percent of the lowest AMP (the same threshold as in the OIG report). In those cases in which the lowest AMP is determined to be an outlier, the second lowest AMP will be used in the FUL calculations. CMS stated that this level will ensure that at least two drugs have AMPs at or below the FUL amount. Further, in response to the OIG draft report analyzing the impact of the new FULs, CMS strongly disagreed with the OIG's findings concerning the effect of the DRA-related changes to the FUL calculation. CMS stated that adequate reimbursement can be achieved with FULs based on AMP. In addition, CMS asserted that the analysis in the OIG is deficient in numerous ways and such deficiencies lead to flawed results and misleading conclusions. In the final report, the OIG responded that the data contained in the report are the best available for the timeframe, and any limitations have marginal impact and do not change the overall findings and conclusions.

Management Issue 4: Medicaid Administration

Management Challenge:

The Federal share of Medicaid outlays in FY 2006 exceeded $180 billion. The Federal share, known as the Federal Medicaid Assistance Percentage, is determined annually by a statutory formula based on State average per capita income and by statute can range from 50 to 83 percent in the various State programs.

Over the past 6 years, OIG's work has identified significant problems in State Medicaid financing arrangements involving the use of intergovernmental transfers (IGT). Specifically, OIG found that six States inappropriately inflated the Federal share of Medicaid by more than $3 billion by requiring providers operated by units of government, such as county-owned nursing homes, to return Medicaid payments to State governments through IGTs. Once the payments are returned, funds cannot be tracked, and they may be used by the States for purposes unrelated to Medicaid. This practice shifts the cost of Medicaid to the Federal Government, contrary to Federal and State cost-sharing principles. Although this practice can occur with any type of Medicaid payment to facilities operated by units of government, OIG identified serious problems in Medicaid supplemental payments to public hospitals and long-term care facilities available under the upper payment limit (UPL) rules.

In addition, OIG has identified significant Federal overpayments involving school-based health services, disproportionate share hospital (DSH) payments, and targeted case management services. For example, OIG has consistently found that schools have not adequately supported the claims submitted to States for school-based health services. Particularly in New York, OIG identified significant overpayments involving speech therapy and transportation claims. From 2004 through 2006, OIG issued six reports questioning unallowable Federal funds to the New York Medicaid program totaling more than $1 billion. Major findings included payments for services that were not sufficiently documented, services not authorized, and services rendered by providers who did not have required qualifications. In another example, in a 2006 roll-up report, OIG found that in 9 of the 10 DSH programs reviewed, States made DSH payments that exceeded the hospital specific limits by approximately $1.6 billion ($902 million Federal share). In another 2006 report, OIG also identified a State Medicaid agency that claimed Federal funding totaling $86 million for unallowable targeted case

management services. Contrary to Federal regulations, the targeted case management claims included social workers' salary costs related to direct social services, such as child protection and welfare services.

OIG is also working closely with DOJ to investigate and pursue False Claims Act cases concerning fraudulent billing of targeted case management and school-based health services. In a case settled in July 2007, the Federal Government entered into an agreement with Maximus, Inc., for $42.6 million to settle allegations that Maximus caused the District of Columbia to submit false claims for targeted case management services that were never provided. As part of the settlement, Maximus also entered into a Corporate Integrity Agreement (CIA) with OIG that contained several unprecedented provisions. Under the CIA, OIG will review Maximus's contracts and require dissemination of the review findings to Maximus's clients.

As a result of another investigation by OIG and DOJ, the Medford School District in Oregon agreed to pay the United States $830,000 to settle claims that, from January 1998 until December 2001, the school district improperly billed the Medicaid program for school based health services and transportation expenses that were not properly documented, were for services that did not qualify for school-based health services Medicaid reimbursement, or were for services that students did not actually receive.

Assessment of Progress in Addressing the Challenge:

To curb abuses in State Medicaid financing arrangements, CMS promulgated final regulations (effective March 13 and November 5, 2001, and May 14, 2002) that modified upper payment limit (UPL) regulations pursuant to the Benefits Improvement and Protection Act of 2000. The rules created three aggregate UPLs: one each for private, State, and non-State government-operated facilities. The new regulations will be gradually phased in and become fully effective on October 1, 2008. CMS projects that these revisions will save a total of $79.3 billion in Federal Medicaid funds over the 10-year period from 2002-2011. However, when fully implemented, these regulatory changes will limit, but not eliminate, the risk of Medicaid monies being returned by public providers to the State and then used for non-Medicaid purposes because the regulations do not require the provider to keep and use the enhanced funds to provide medical services to Medicaid beneficiaries.

CMS also has been working with States to stop the inappropriate use of IGTs. CMS should continue to work to ensure that all States eliminate the use of inappropriate IGTs involving supplemental payments made pursuant to UPL regulations, or any other type of Medicaid payment to a provider operated by a unit of government.

In addition, in May 2007, CMS placed a Final Rule with Comment Period, CMS-2258-FC (Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership) on display at the Federal Register (May 29, 2007; 72 Fed.Reg. 29748) that would modify Medicaid reimbursement. Consistent with OIG recommendations, this regulation codifies existing statutory authority that health care providers retain the total Medicaid payments received. This change, in addition to the UPL regulatory changes, will help ensure that Medicaid funds are used to provide necessary services to Medicaid beneficiaries. However, Public Law 110-28 prohibits implementation of the regulation for 1 year following the date of enactment, May 25, 2007.

CMS also is working to finalize regulations to clarify policies regarding reimbursement for school-based transportation services and administrative costs, DSH payments, and targeted case management services.

Management Issue 5: Quality of Care

Management Challenge:

Ensuring the quality of care provided to beneficiaries of Federal health care programs continues to be a high priority of OIG. OIG has produced a large body of work related to quality-of-care issues in a variety of settings, such as hospitals, nursing homes, and clinical trials. OIG has also examined a variety of factors that may affect the provision of care, including the impact of reimbursement systems on the provision of care, the effectiveness of oversight and enforcement systems, and the adequacy of mechanisms used to screen potential health care employees. Additionally, OIG partners with DOJ, Medicaid Fraud Control Units, and other State law enforcement offices to investigate and prosecute instances of substandard care that led to patient harm.

To supplement or, when appropriate, substitute for CMS or State enforcement actions, OIG pursues administrative remedies, often in conjunction with civil actions brought by DOJ. The False Claims Act, the Federal Government's primary civil enforcement tool for fraud, has been used successfully to address poor quality of care. These cases often involve allegations of widespread or systemic problems that result in harm to residents of nursing facilities, such as staffing shortages, failure to implement medical orders or services identified on the care plan, failure to ensure that residents are protected from harm, medication errors, and the unnecessary development of facility-acquired medical complications such as infected pressure ulcers. OIG is also developing exclusion actions against individuals and entities whose conduct results in poor care, with particular emphasis on higher level officials of nursing facilities and chains.

To illustrate, Federal prosecutors in Missouri charged American Healthcare Management (AHM), a long-term care facility management company, its Chief Executive Officer, and three nursing homes with criminal conspiracy and health care fraud based on their imposition of budgetary constraints that prevented the facilities from providing adequate care to residents. The investigation found that numerous residents suffered from dehydration and malnutrition, went for extended periods of time without cleaning or bathing, and contracted preventable pressure sores. The corporate defendants were convicted and fined, entered into a False Claims Act settlement requiring them to pay $1.25 million, and agreed to be excluded from participation in Federal health care programs. The primary owner was convicted of a false statement misdemeanor offense, was sentenced to 2 months' incarceration, and agreed to be excluded for 20 years. Finally, in February 2007, AHM's former CEO was sentenced to 18 months of incarceration and fined $29,000.

OIG also negotiates quality-of-care CIAs as part of the settlement of such False Claims Act cases. In cases involving poor quality of care, the CIA requires an outside quality-of-care monitor selected by the OIG and includes effective enforcement remedies for breach of the CIA, such as specific performance requirements, stipulated penalties, and exclusion. Over the last 7 years, many major nursing home chains, mid-size corporations, and individual health care facilities have operated under CIAs with independent quality monitors. OIG currently has 10 CIAs with nursing homes and psychiatric facilities (or chains) with independent quality monitor requirements. These 10 active quality-of-care CIAs cover operations in about 400 long-term care and psychiatric facilities across the country. In addition to conducting these ongoing monitoring efforts, OIG is examining the performance of nursing home chains operating under CIAs over the past several years to evaluate the effect of those CIAs on compliance and the quality of care provided by those chains.

OIG continues to have concerns about shortcomings in program oversight and enforcement systems that may result in insufficient identification or prevention of the delivery of substandard care in a variety of health care settings. For

example, a 2007 OIG study assessed services provided to beneficiaries with consecutive Medicare stays involving hospitals and skilled nursing facilities and found that 35 percent of consecutive stay sequences were associated with quality-of-care problems and/or fragmentation of services. For this study, OIG defined fragmentation as a pattern of unnecessary discharges or transfers across multiple stay sequences when the same levels and types of services could have been consolidated into fewer stays. Medicare paid an estimated $4.5 billion for these fragmented or poor quality services. Quality-of-care problems that reviewers found included medical errors, accidents, failure to treat patients in a timely manner, inadequate monitoring and treatment of patients, inadequate care planning, and inappropriate discharges. OIG recommended that CMS direct Quality Improvement Organizations (QIO) to monitor fragmentation and quality of care across consecutive stay sequences and the quality of care provided during the individual stays within those sequences, and encourage both QIOs and fiscal intermediaries to monitor the medical necessity and appropriateness of services provided within these consecutive stay sequences.

In another 2007 report, OIG assessed CMS's oversight of the Medicare hospice program. Currently, hospices are assigned a lower priority for survey and certification inspections than other health care organizations. The report found that, as of July 2005, 14 percent of hospices were past due for certification and, on average, had not been surveyed for 9 years—3 years longer than the CMS standard at that time. OIG also found that health and safety deficiencies were cited for 46 percent of hospices surveyed, most frequently for patient care planning and quality deficiencies. OIG recommended that CMS provide guidance to State agencies and CMS regional offices regarding analysis of existing data to target "at-risk" hospices for certification surveys. OIG also recommended that hospices be included in Federal comparative surveys and annual State performance reviews and that CMS should seek legislation to establish additional enforcement remedies for poor hospice performance. At present, CMS's only enforcement remedy is termination of a hospice provider from the Medicare program.

In a 2006 report, OIG reviewed the requirements for, and State oversight of, Medicaid personal care service attendants. These attendants assist the elderly and persons with disabilities or temporary or chronic conditions with daily activities (e.g., bathing, dressing, meal preparation). This review found substantial variation, both across States and within States, in the requirements for these attendants and found that oversight and administration of personal care programs were fragmented among different State agencies. OIG concluded that more consistent attendant requirements, less fragmentation in program administration, or some level of standardization within States may make monitoring attendant requirements less cumbersome and enhance quality assurance.

OIG is continuing to evaluate systemic issues that directly affect patient care. For example, studies are currently under way to examine the cyclical noncompliance of home health agencies with conditions of participation, to determine the nature and extent of hospice services provided to beneficiaries residing in nursing homes, to review the oversight of quality of care in Federal health centers, and to assess the impact of Part D on dual-eligible nursing home residents' receipt of prescription drugs. OIG is also undertaking a congressionally mandated review of serious medical errors, referred to as "never events," such as a physician performing surgery on the wrong patient.

Assessment of Progress in Addressing the Challenge:

In response to OIG's recent report related to consecutive inpatient hospital and skilled nursing facility stays, CMS plans to increase monitoring of quality-of-care problems associated with consecutive stays. CMS is also working with the providers to improve care for Medicare beneficiaries regardless of where care is provided. Additionally, CMS is requiring

the QIOs to categorize complaints to provide better data on lapses in care continuity with an emphasis on improved documentation.

CMS noted that it has included hospices in the annual State Performance Standards System that measures State performance in survey and certification activities. CMS is also exploring and implementing methods to become more efficient in targeting its resources toward providers most at risk of failing to meet quality of care requirements. Additionally, CMS plans to publish new Conditions of Participation (CoP) for hospices in 2008. The new CoPs will establish a framework for Quality Assessment and Performance Improvement and will amend the hospice section of the "State Operation Manual" to enable State surveyors to make more consistent decisions regarding compliance with Medicare regulations. CMS is also considering whether to pursue establishing new enforcement remedies for poor hospice performance. Finally, CMS indicated that greater inclusion of hospices in the validation surveys must await additional resources.

CMS is also taking steps to improve its enforcement of nursing home quality requirements. Recognizing the need to focus more attention on homes that historically provided poor care to residents, in January 1999, CMS implemented a Special Focus Facility program that involved enhanced monitoring of two nursing homes in each State. In December 2004, CMS revised its Special Focus Facility program to expand the scope of the program from about 100 homes nationwide to about 135 homes. CMS also revised the method for selecting nursing homes by reviewing 3 years' rather than 1 year's worth of deficiency data to better target homes with a history of noncompliance. Additionally, CMS strengthened its enforcement for Special Focus Facilities by requiring immediate sanctions for homes that failed to significantly improve their performance from one survey to the next, and by requiring termination for homes with no significant improvement after three surveys over an 18-month period. In 2004, CMS also established a voluntary program to help nursing homes improve the quality of care provided to residents. QIOs worked for 12 months with one to five nursing homes with significant quality problems in 18 States to help them redesign their clinical practices.

Management Issue 6: Public Health Emergency Preparedness and Response

Management Challenge:

Recent events, such as the terrorist attacks of September 11, 2001; the 2005 Gulf Coast hurricanes; and the potential for future public health emergencies, such as the threat of pandemic influenza, continue to underscore the importance of having a comprehensive national public health infrastructure that is prepared to rapidly respond to public health emergencies. OIG work in this area has focused on assessing how well HHS programs and their grantees plan for, recognize, and respond to outside health threats; the security of HHS and grantee laboratory facilities; the management of these grant programs and funds by the Department and grantees; and the readiness and capacity of responders at all levels of Government to protect the public's health. Recent OIG work has shown that, although some progress had been made, the States and localities are still generally under prepared.

Bioterrorism Preparedness

The security of internal HHS and Department-funded laboratories, including those using select agents, and the security of assets and materials to be used to respond to emergencies continue to be concerns of OIG. In 2002 and 2003, OIG reviewed Departmental and external (non-Federal) laboratories for compliance with laws and regulations governing select agents and found that many laboratories did not adequately safeguard the agents against theft or loss. Soon

afterward, when legal requirements for the possession and use of select agents became more strict, OIG initiated audits of non-Federal entities with select agents from November 2003 to November 2004 and found that, contrary to the revised regulations, laboratories had problems with maintaining accurate inventory and access records, controlling access, security planning, and other areas.

In 2006, OIG also completed a number of physical security and environmental control audits of the Strategic National Stockpile managed by the Centers for Disease Control and Prevention (CDC) to provide ready access to drugs and medical supplies during medical emergencies. OIG identified methods to increase the sites' protection against theft, tampering, destruction, or other loss. Additionally, OIG has recently commenced work at Federal laboratories with select agents and begun two related reviews: an audit of select agent transfers and a follow-up audit on CDC's management of the select agent program.

As follow up to earlier work, in December 2006, OIG issued a report that determined that at the close of the CDC Bioterrorism Program in August 2005, about $996 million, or 15.8 percent, of the program funds awarded to States and major health departments remained unobligated. Many awardees did not fully execute their expenditure plans or submit timely financial status reports, so CDC did not always receive the information needed to encourage the expenditure of funds and minimize unobligated balances. Under its new Public Health Emergency Preparedness Program, which began in August 2005, CDC strengthened its guidance and established additional oversight controls. OIG is currently performing additional reviews of CDC's oversight of Preparedness and Response for Bioterrorism and Public Emergency Program Funds.

Disaster Response

Since 2005, OIG has worked with the President's Council on Integrity and Efficiency (PCIE) Homeland Security Roundtable and Disaster Relief Working Group, as well as with other Federal, State, and local partners, to assess the overall effectiveness of the Department's deployment and recovery activities in response to Hurricanes Katrina and Rita. As part of a coordinated oversight effort, OIG assessed Departmental procurements and associated management controls, beneficiary protections, and the delivery of critical health care services. In a 2006 report, OIG reviewed the emergency preparedness and response of a selection of nursing homes in five Gulf Coast States and found that all experienced problems during the 2004 and 2005 hurricanes, whether evacuating or sheltering in place. OIG recommended that CMS consider strengthening Federal certification standards for nursing home emergency plans. At the same time, OIG reviewed the U.S. Public Health Service Commissioned Corps response to Hurricanes Katrina and Rita. In this 2007 report, OIG found that although the Corps provided valuable support to the States, more officers were needed. Many of the officers lacked the necessary experience and effective training, and many experienced logistical difficulties in deployment. OIG recommended improved training for officers, a streamlined travel system, and staggered deployments for continuity of operations.

OIG also evaluated the use of Government purchase cards in support of the Department's response operations for the Gulf Coast hurricanes. Based on the findings of this 2007 report, OIG recommended that the Assistant Secretary for Administration and Management (ASAM) provide additional written guidance when cards are issued to employees to reduce the probability of misuse, deliberate or otherwise, and conduct annual training using mock scenarios to improve purchasing approvals. To enhance controls, OIG also recommended that ASAM develop a tracking system to monitor Government card purchases during emergency situations.

Additionally, OIG recently issued several reports on its review of the procurement process for pharmaceuticals and other relief-related products and services associated with the HHS response to the Gulf Coast hurricanes. OIG audited 51 contracting actions and procurements with a total value of $79.6 million and found that procurement officials generally complied with the Federal Acquisition Regulations in awarding the contracts. OIG is reviewing CDC's Bioterrorism Preparedness Program and the Office of the Assistant Secretary for Preparedness and Response's (ASPR) Hospital Preparedness Program (formerly administered by HRSA) in the Gulf Coast States and will determine whether grantees are spending the funds on costs that are reasonable and allowable under the terms of the grant.

OIG will continue to identify and monitor areas of critical importance to ensure that the Department is ready to respond to future public health emergencies. For example, OIG is working in collaboration with ASPR to develop a cross-disciplinary initiative to build upon OIG's array of emergency preparedness and response work.

Assessment of Progress in Addressing the Challenge:

States and localities are making progress in strengthening their public health emergency preparedness programs. However, OIG findings still demonstrate the need for significant improvements for local health departments to be fully prepared to detect and respond to bioterrorism and, by extension, naturally occurring disasters. Federal, State, and local health departments are striving to work cooperatively to ensure that potential bioterrorist attacks are detected early and responded to appropriately. CDC has taken steps to improve its capacity to detect and respond to harmful agents and to expand the availability of pharmaceuticals needed in the event of chemical, biological, or radiological attacks. Both CDC and ASPR have updated their Public Health and Hospital Preparedness Cooperative Agreements to incorporate stronger performance measures and clearer guidance for grant recipients. For example, recent CDC guidance now requires States to establish electronic systems that can effectively detect and report disease outbreaks and other public health emergencies. CDC also plans to implement automated data entry in laboratories, establish a forum for information sharing, as well as identify additional technical resources to increase State and local capacity to respond to a potential terrorist threat.

In the aftermath of Hurricanes Katrina and Rita in 2005, the Department placed new emphasis on preparedness outside the realm of terrorism and adopted an "all-hazards" approach to State and local emergency preparedness. This approach incorporates comprehensive preparedness plans that include more definitive and accurate performance measures to prepare stakeholders for a wide array of natural or terrorist threats on multiple scales. The Department will focus more efforts toward monitoring preparedness at the local level, including the testing of local preparedness plans to evaluate how governments perform when plans are put into action. The 2006 Pandemic and All-Hazards Preparedness Act (PAHPA) provides the Department with additional authority and responsibility to carry out its mission, including the creation of the Office of the Assistant Secretary for Preparedness and Response. The PAHPA, among other things, authorizes the creation of a Biomedical Advanced Research and Development Authority, the transfer of the National Disaster Medical System from the Department of Homeland Security to HHS, and the expansion of the Medical Reserve Corps and other volunteer health professional registries.

The 2005 hurricanes underscored the need for a comprehensive Federal plan to respond quickly and effectively to a mass public health emergency event that also requires a seamless integration with responses at the State and local levels. In response to our 2006 nursing home emergency response and preparedness report, CMS is exploring ways to strengthen Federal certification standards for nursing home emergency preparedness and to promote better coordination among

Federal, State, and local emergency management entities. The Office of the Surgeon General, Office of Public Health and Science, is implementing many of OIG's recommendations related to the Commissioned Corps, including identifying, rostering, training, and equipping designated response teams of Commissioned Corps officers. And, in response to OIG's report on the use of purchase cards in responding to the 2005 hurricanes, ASAM has issued revised guidelines to improve the Department's purchase card program.

Management Issue 7: Oversight of Food, Drug, and Medical Device Safety

Management Challenge:

Through the work of FDA, the Department is responsible for ensuring the safety, efficacy, and security of human and veterinary drugs, medical devices, the Nation's food supply, cosmetics, and products that emit radiation. FDA is also responsible for protecting the rights, safety, and well-being of human subjects who participate in trials conducted for the products it regulates. Through the work of NIH, the Department is responsible for acquiring knowledge that can help prevent, diagnose, and treat disease and disability. Given these critical public health mandates, NIH and FDA must have in place policies and programs that ensure the integrity of medical research endeavors, protect human research subjects, provide for preapproval and postapproval monitoring of regulated medical products and treatments, and ensure the safety of the nation's food supply.

Over the past decade, numerous OIG evaluations and audits have consistently documented weaknesses in the Department's oversight system for protecting human research subjects in clinical trials associated with NIH grants and those conducted by manufacturers seeking FDA approval for regulated products. In 2007, OIG examined FDA's oversight of clinical trials through its Bioresearch Monitoring (BiMo) program. This work identified vulnerabilities, such as data limitations, that inhibit FDA's ability to effectively manage the BiMo program. OIG also found that FDA inspected only one percent of clinical trial sites during the FY 2000-2005 period. OIG recommended that FDA improve its information systems and processes, establish a mechanism to provide feedback to BiMo investigators on inspection findings, and seek legal authority to provide oversight that reflects current clinical trial practices. Looking forward, OIG will follow up on its previous work on protections for human research subjects and oversight of clinical trials. For example, in FY 2008, OIG will evaluate the review process for the Office of Human Research Protection (OHRP), which is charged with oversight of all research involving human subjects that is conducted or funded by the Department. OIG will also evaluate the use of data safety monitoring boards for clinical trials sponsored by NIH.

Recent OIG work has also identified weaknesses in FDA's monitoring of drugs following their approval for marketing. In 2006, OIG examined FDA's monitoring of drug sponsors' postmarketing study commitments and the timeliness with which these studies are completed. This work identified several vulnerabilities that limit FDA's ability to readily identify whether or how timely these commitments are progressing toward completion. As a result, OIG recommended that FDA instruct drug applicants to provide additional, meaningful information in their annual status reports about postmarketing studies. OIG also recommended that FDA improve its management system for monitoring postmarketing study commitments and ensure that these commitments are being monitored. In the months following the OIG report, the Institute of Medicine issued a report that highlighted FDA's resource limitations and lack of regulatory authority to enforce required postmarketing studies. The challenge of monitoring a drug's safety after its initial approval has also been highlighted in media accounts and congressional inquiries. For example, Congress recently held hearings on an approved

diabetes drug, Avandia, that was associated with an elevated risk of heart attacks. In FY 2008, OIG will expand its review of FDA's postmarketing efforts to evaluate adverse events reports for medical devices.

OIG has recently conducted other evaluations of FDA's preapproval and postapproval oversight of drugs. In 2006, OIG completed a review of FDA's National Drug Code (NDC) Directory, which is intended to be a complete and accurate listing of currently marketed prescription drug products. OIG found that the NDC Directory is neither complete nor accurate and recommended that FDA improve guidance for industry and streamline the NDC submission and verification processes. Further, because of concerns about a generic drug review backlog, OIG is currently evaluating FDA's review process for generic drugs.

Since the terrorist attacks of 2001, and emphasized by the recent cases of microbial pathogens found in spinach, tomatoes, and peanut butter and a toxic chemical found in pet food, the security of the Nation's food supply has also been a great concern for the Department, as well as for public health and homeland security experts. OIG is assessing whether food can be traced through the distribution chain and whether food facilities are complying with the new requirements. In FY 2008, OIG also plans to review FDA's food safety operations related to its oversight of imported food products. As part of this study, OIG will review FDA's food facility inspection process, FDA's oversight of imported food, and FDA's procedures and activities related to 2007 recall of tainted pet food.

Assessment of Progress in Addressing the Challenge:

HHS has implemented many changes to protect human research subjects and to strengthen FDA and NIH oversight of scientific research. Within the Office of the Secretary, OHRP coordinates closely with both NIH and FDA in carrying out its responsibility to ensure human subject protections. In June of 2006, FDA announced a Human Subject Protection/Bioresearch Monitoring (HSP/BIMO) initiative and formed a HSP/BIMO permanent council that is responsible for central coordination and human subject protection. FDA also published a proposed rule in July 2004 for the creation of an institutional review board registry. Additionally, in 2006 and 2007, FDA released several draft guidances that addressed various bioresearch-monitoring topics. Finally, in response to OIG's recent report on the oversight of clinical trials, FDA indicated that it is developing an internal listing of all ongoing clinical trials as part of a broader effort to electronically manage FDA's regulated product information.

FDA has also contracted with Booz Allen Hamilton to assess the decisionmaking, tracking, and review process behind requests for postmarketing study commitments (PMCs) for human drugs and biologics to develop recommendations for improving the quality of the PMC processes. On September 27, 2007, the Food and Drug Administration Amendment Act of 2007 (the Act) was signed into law, providing FDA with increased resources for improving its postmarketing safety surveillance. Among other things, the Act reauthorized the prescription drug user fee program, with increased funding for post-market safety surveillance and the review of direct-to-consumer advertising submitted by companies to FDA. The Act also reauthorized the medical device user fee program which includes additional post-market safety checks, and provided FDA with the authority to require label changes on drugs to reflect new safety information, and to fine companies that do not comply with requests for additional trials after a drug reaches the market.

Recent events have demonstrated the critical need to protect the Nation's food supply and have drawn specific attention to the safety and security of imported food. FDA is now implementing provisions of the Public Health Security and

Bioterrorism Preparedness and Response Act of 2002, which requires, among other things, all parties within the food distribution chain to establish and maintain records that identify sources and recipients of food products, allows for the detention of food under certain circumstances, requires food facility registration, and requires that the FDA receive prior notice of food imported into the United States. In 2007, FDA announced the creation of a new position, Assistant Commissioner for Food Protection.

Management Issue 8: Grants Management

Management Challenge:

The Department's public health and human service agencies rely on grants and cooperative agreements to meet mission objectives, such as providing health and social services safety nets, preventing the spread of communicable diseases, and researching causes and treatments of diseases. In FY 2008, the Department expects to issue grants totaling $270 billion ($38 billion discretionary and $232 billion mandatory). Medicaid, which constitutes the largest portion of mandatory grants ($204 billion in grants expected in FY 2008), is discussed under Issues 3, 4, and 5, where its program vulnerabilities are identified.

Grants management remains a challenge because of the very nature of a grant. A grant is financial assistance for an approved activity with performance responsibility resting primarily on the grantee, with little or no Government involvement in the funded activity. This expectation of minimal Government involvement is compounded by the fact that many HHS grantees have limited experience in managing Federal funds. New, inexperienced grantees are particularly likely to receive funding when new grant programs are created or existing programs are expanded. In addition, even experienced grantees sometimes allegedly use grant funds for nonapproved purposes, as evidenced by recent grant-fraud-related settlements between DOJ and several major universities.

To ensure the integrity of HHS's grant programs, OIG will continue to examine grants management, including the agencies' grant selection and oversight processes, program performance and results, implementation of information technology efforts to increase program access and operational efficiency, and accountability for Federal funds. OIG continues to direct particular attention to vulnerabilities associated with expanded grant programs, newly funded initiatives, and first-time Federal grantees.

Discretionary Grants

Inadequate grant oversight and monitoring continues to be a concern of OIG. In 2007, OIG issued two reports on HRSA's distribution and use of Ryan White Comprehensive AIDS Resources Emergency (CARE) Act funding to grantees. Contrary to the CARE Act, HRSA did not recoup certain unobligated funds from States and reallocate them. HRSA also authorized States to carry over unobligated funds beyond one budget period and did not use its offset authority as provided by the Act. OIG has initiated a nationwide review of CARE Act AIDS Drugs Assistance Program funds. The review will examine compliance with the payer of last resort provision which requires that grant funds be used for payment only after reimbursement has been obtained from other Federal, State, or private sources.

In 2006, OIG completed a review of the Agency for Healthcare Research and Quality's (AHRQ) monitoring of its patient safety grants, which totaled $128 million in FYs 2001 through 2003. OIG found that although grantee performance reports generally complied with Federal requirements, most Financial Status Reports were not received or were late and Federal requirements for closeout were not met. OIG recommended that AHRQ require submission of interim financial

information, establish a tracking system for Financial Status Reports, require grantees with no-cost extensions to submit Financial Status Reports in compliance with Federal requirements, and ensure that grants awaiting closeout are closed promptly.

HHS agencies have historically had several grants management tools at their disposal, including the Department Alert List. Failure to use these tools increases the risk that grant funds will be used for purposes other than those intended. In 2005 and 2006, OIG completed two related reviews examining HRSA's and CDC's adherence to departmental policies governing placement on and use of the Alert List. The Alert List contains the names of high-risk grantees and is used by the Department to ensure that such grantees are known to the HHS grant-making agencies and to safeguard Department funds. OIG found that HRSA and CDC did not consistently follow Alert List policies for placing grantees on the list and monitoring their status. OIG also found that HRSA grants officers did not use the information on the list to make grant decisions. OIG recommended that both HRSA and CDC develop methods to ensure that grants officers follow Alert List policies. As of FY 2007, the HHS Office of Grants suspended the use of Department Alert List, pending a major redesign to increase internal control over its usage and to better support post-award monitoring and oversight.

Even when grantees are providing the intended services, they may not comply with all programmatic or financial requirements. A series of reviews of HRSA's Ryan White HIV/AIDS service providers completed in 2004 and 2005 indicated that the intended services were generally being provided but that certain aspects of grantee or subrecipient operations, such as service delivery and fiscal management, could be improved. For example, a provider of emergency housing served some clients beyond the time period established in agency guidelines, while other potential clients were on waiting lists. OIG also identified a number of grantees that claimed costs at budgeted levels, rather than actual costs as required by Federal cost principles.

At NIH and university grantee sites, OIG has several additional ongoing initiatives aimed at evaluating the allowability of costs charged to NIH grants, focusing primarily on administrative and clerical costs charged to NIH grants. OIG also plans to evaluate the extent to which the National Cancer Institute (NCI) monitors its research project grants. This work will focus primarily on the extent to which NCI evaluates required reports, initiates actions in response to these evaluations, and ensures grantee responsiveness to action requests to comply with regulatory requirements and grant terms and conditions.

Mandatory Grants

Since 2002, OIG has performed reviews in 13 States that have focused on the appropriateness of Federal reimbursement related to Foster Care and Adoption Assistance training and administrative costs and maintenance claims. These reviews identified approximately $58 million in unallowable, improperly allocated, and unsupported costs. During FY 2007, OIG performed reviews in three States to identify erroneous payments in the Administration for Children and Families (ACF) Temporary Assistance for Needy Families (TANF) program, which had a FY 2006 funding level of $17.2 billion. Preliminary results in these three States have identified substantial improper payments. In addition, during FY 2008, OIG will perform an eight-State review to develop a nationwide improper payment rate for the TANF program.

Assessment of Progress in Addressing the Challenge:

Through the governmentwide Federal Grant Streamlining Program, the HHS grants management environment is continually undergoing significant changes. The program is intended to implement the Federal Financial Assistance

Management Improvement Act of 1999 (Public Law 106-107), which requires agencies to improve the effectiveness and performance of their grant programs, simplify the grant application and reporting process, improve the delivery of services to the public, and increase communication among entities responsible for delivering services. The initiative requires grant officials to examine the way they do business, focusing not only on streamlining the grant process but also on ensuring that results are achieved and that Federal funds are used appropriately for the maximum benefit of program recipients. It is crucial that HHS agencies adequately manage and monitor their grantees' and, to the extent possible, their subgrantees' program performance and require fiscal accountability through the life of the grants. A critical part of this streamlining process involves the consistent use of departmentwide grants management policies. Over the next fiscal year, OIG will continue to address departmentwide efforts to improve the streamlining of Federal assistance programs, grants management, and program oversight and monitoring.

In response to OIG's report on the Alert List, in FY 2007 the Office of Grants suspended the alert listing it maintained pending a major redesign to increase internal control over its usage. This management decision was based in large part on critical concerns documented by OIG. AHRQ indicated that the recommendations in OIG's 2006 review of patient safety grants reinforce ongoing improvements begun subsequent to the years that we reviewed or support ongoing improvement activities. And, in response to recent OIG reviews of the TANF program, ACF indicated that it plans to use the findings and recommendations from OIG's review to provide technical assistance to the State grantees.

Management Issue 9: Integrity of Information Technology Systems and Infrastructure

Management Challenge:

In 2001, the President identified the development and implementation of an "interoperable health information technology infrastructure" as a key initiative. To facilitate this, in April 2004, the President issued Executive Order 13335, which established the position of the National Health Information Technology Coordinator (National Coordinator) and outlined incentives for the use of health information technology (health IT). According to the order, "[t]he National Coordinator shall, to the extent permitted by law, develop, maintain, and direct the implementation of a strategic plan to guide the nationwide implementation of interoperable health information technology in both the public and private health care sectors that will reduce medical errors, improve quality, and produce greater value for health care expenditures." The Secretary established for the National Coordinator the Office of the National Coordinator for Health Information Technology (ONC).

In a 2007 report on State Medicaid agencies' initiatives on health IT and health information exchange (HIE), OIG found that almost a quarter of State Medicaid agencies have implemented health IT initiatives, and over three quarters of States are developing similar health IT initiatives. Additionally, a number of Medicaid agencies are involved in the planning of statewide HIE networks and are incorporating the Medicaid Information Technology Architecture (MITA) into their health IT and HIE planning. Based on these findings, OIG recommended that CMS continue to support the goals of MITA to help facilitate future State Medicaid health IT and HIE initiatives. OIG also recommended that CMS, in collaboration with other Federal agencies and offices, assist State Medicaid agencies with developing privacy and security policies as well as continue to work with ONC to ensure that State Medicaid initiatives are consistent with national goals.

Additionally, there remains a need to ensure adherence to general controls. OIG's work indicates that the Medicare payment errors are due more often to the input by people of incorrect information than due to computer system or programming errors. For example, for the 7 years during which OIG produced the Medicare fee-for-service error rate,

the overwhelming majority (more than 95 percent) of the improper payments identified were detected through medical reviews. When these claims were submitted for payment to Medicare contractors, they contained no visible errors. Clearly this represents a challenge to implement controls that ensure progressive improvement with respect to data integrity.

The recent expansion of HHS programs, such as the new Medicare Part D benefit, significantly increases the programmatic and system demands on the Department and creates new relationships or expands existing relationships with business partners. In turn, these new or expanded relationships create the potential for new system security exposures that have to be evaluated and, if need be, mitigated to ensure the confidentiality, integrity, and availability of critical assets. As part of the HHS responsibility to protect critical data assets and to protect the privacy of medical records, the Department oversees and endorses the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules, which identify privacy standards for certain individually identifiable health information and specify a series of administrative, technical, and physical security procedures for covered entities to use to ensure the confidentiality of electronic protected health information. The security standards are delineated into either required or addressable implementation specifications.

The development and expansion of Department IT systems brings new focus to additional areas of risk. For instance, over the past several years, the importance of protecting personal data has become much more visible, as illustrated by media attention to personal data lost by accounting firms, credit bureaus, universities, and insurance companies, and most recently, the serious loss of data by Federal agencies. OMB has recently reemphasized Federal agency responsibilities under the law and policies to appropriately safeguard sensitive, personally identifiable information and train Federal employees regarding their responsibilities in this area. The OIG Federal Information Security Management Act assessments also found that many identified security weaknesses are attributed to either an absence of a process to protect resources or a failure to comply with an already established process.

OIG has also identified that the human factor is a critical component of an effective security program and may be overlooked in the development of technical solutions to address weaknesses in entity wide security, access controls, service continuity, application controls and development, and segregation of duties.

Therefore, OIG continues its efforts to monitor HHS oversight of its vital IT systems to ensure that all necessary technical and policy measures are being taken to protect sensitive information, the systems that store that information, and the physical or electronic transport of that information. Through planned work, OIG will place new emphasis on controls designed to ensure the protection of personal data. OIG will also continue to review the controls that are designed to ensure the integrity of data for numerous vital programs on which critical systems depend for the accurate payment of billions of dollars through the Department's many programs. OIG will also review CMS's activities related to the enforcement of the HIPAA Security Rule. The review will focus on an internal control assessment at CMS headquarters as well as include vulnerability assessments at a sample of covered entities.

Assessment of Progress in Addressing the Challenge:

HHS has made progress in the security of the Department's most critical and essential assets, both physical and cyber based, such as laboratories, computer systems, and data communication networks. The Secure One HHS project, begun in FY 2003 and supported through a multiyear contract, was initiated by the Department to improve IT security from

the top down by providing security policy, procedures, and guidance to HHS agencies. The goals of this project are to improve the overall security of the Department's IT operations, ensure adequate departmentwide security standards, support integration of IT security practices into all phases of HHS operations, and promote an environment in which employee actions reflect the importance of IT security.

Additionally, as part of its efforts to encourage the development and use of health IT, on August 8, 2006, the Department issued final regulations that establish new exceptions (71 FR 45140) under the physician self-referral law and new safe harbors (71 FR 45110) under the anti-kickback statute involving the donation of certain electronic health IT and services. The final rules seek to lower perceived barriers to the adoption of health IT through exceptions and safe harbors that promote the adoption of electronic prescribing technology and interoperable electronic health record systems while safeguarding the Federal programs and beneficiaries against undue risks of fraud and abuse. As required by the MMA, the first exception and safe harbor establish the conditions under which hospitals and certain other health care entities may donate to physicians and certain other recipients' hardware, software, or IT and training services necessary and used solely for e-prescribing. The second exception and safe harbor establish conditions under which certain entities may donate to physicians and certain other recipients interoperable electronic health records (EHR) software, IT, and training services necessary and used predominantly for EHRs.

Management Issue 10: Ethics Program Oversight and Enforcement

Management Challenge:

OIG has historically been involved in oversight and enforcement of the Department's ethics program. OIG's activities have ranged from evaluating agency ethics programs at selected Operating Divisions (OPDIV) to determine whether they comply with regulations issued by the Office of Government Ethics (OGE) and HHS to investigating allegations of criminal ethics violations by current and former HHS employees. In the past, OIG oversight has primarily focused on ethical issues related to scientific research and grants management. OIG's efforts related to ethics issues have steadily increased as a result of congressional hearings, Government Accountability Office (GAO) reviews, press reports, and investigative activity. Since 2005, ethics program oversight has been acknowledged within the Department's top management challenges in the context of both grants management and research and regulatory oversight management challenges.

Congress established OGE in 1978 to assist the executive branch in preventing and resolving conflicts of interest by Government employees. In partnership with executive branch agencies, OGE fosters high ethical standards to strengthen the public's confidence that the Government's business is conducted with impartiality and integrity. The Secretary of HHS has delegated responsibility for the day-to-day administration of the ethics program to the Designated Agency Ethics Official (DAEO). The DAEO appoints Deputy Ethics Counselors (DECs) to serve as ethics advisers in the OPDIVs and Staff Divisions. In addition, Congress has imposed prohibitions to help ensure that Federal employees are not compromised by conflicts of interest when performing their official duties. For example, the criminal conflicts-of-interest statute, 18 U.S.C. § 208, prohibits employees from participating in official matters where they and certain others (such as spouses) have a financial interest.

Although the DAEO is responsible for administering the Department's ethics program, OIG is responsible for enforcement of the criminal ethics statutes. Within OIG, the Special Investigations Unit (SIU) provides a central point

for the DAEO and DECs to refer potential criminal violations and to discuss matters to determine whether referral is appropriate. Federal regulations and the Department's "General Administration Manual" require HHS employees or supervisors to report nonfrivolous allegations of "criminal offenses" (including conflict of interest) to OIG. Allegations of improper conduct with no criminal potential may be handled by agency management through administrative remedies.

Oversight

In late 2003, widespread press reports described apparent improprieties in the private consulting activities of some scientists at the National Institutes of Health (NIH). OIG undertook a study of the NIH outside activity process, culminating in a July 2005 report. This evaluation reviewed all outside activity requests for senior-level employees at NIH between January 1, 2001, and December 31, 2003. OIG identified several vulnerabilities that inhibited NIH's ability to effectively review outside activities. For example, some approved outside activities were not disclosed on the annual financial disclosure forms as required of senior employees by regulation, and frequently the approved outside activities did not have complete documentation or supervisory signatures confirming approval of the requests. In addition, there were several problems with the review process itself, such as approvals after the start date, limited use of written recusals, and inadequate followup regarding ongoing outside activities. To address these vulnerabilities, OIG recommended that NIH improve the quality and extent of information it receives for outside activity requests and address inadequacies in the review process for outside activities.

OIG also undertook a study of possible conflict-of-interest actions by employees of the Food and Drug Administration (FDA). Released in February 2006, this report identified a variety of vulnerabilities in the FDA process for review and approval of outside activities between CYs 2000 and 2003. Most of these outside activities involved teaching, lecturing, speechwriting, and presenting. OIG found that FDA employees submitted limited information regarding outside activities. OIG also identified several problems in the review process itself, such as approvals after the start date, multiple activities listed on a single activity request, and inadequate followup for ongoing outside activities. To address these vulnerabilities, OIG recommended that FDA improve the quality and extent of information it receives from its employees for outside activities and address inadequacies in the review process for outside activities.

In addition, in late 2006, OIG issued a memorandum to the HHS General Counsel outlining vulnerabilities in the Department's issuance of conflict-of-interest waivers. These vulnerabilities were identified through an inquiry conducted by OIG regarding a conflict-of-interest waiver granted to a former Administrator of CMS. OIG identified four vulnerabilities. These included use of boilerplate language, insufficient oversight processes, absence of time limits on waivers, and lack of monitoring mechanisms. OIG provided four recommendations to eliminate the vulnerabilities. First, waivers should be improved by a more detailed discussion of the individual circumstances of the requester. Second, the Department should adopt additional safeguards for the issuance of waivers which might include a policy requiring consultation with OGE on the issuance of ethics waivers covering negotiations for future employment. Third, appropriate time limits should be incorporated into the waivers. And fourth, the Department should monitor the continued appropriateness of such waivers by requiring employees who have received waivers to report periodically on the status of their employment negotiations.

OIG's ongoing work at selected OPDIVs reflects continued attention to ensuring effectiveness in the administration of the Department's ethics program. In a review similar to the NIH and FDA outside activity reviews, OIG will examine

the procedures used by CDC officials to review possible conflicts of interest related to certain categories of employees. Compliance with the ethics statutes and standards of ethical conduct is of particular concern with CDC employees because their research results and regulatory decisions affect the Nation's public health security.

Additionally, in an April 2007 report, GAO concluded that the lack of clear recusal policies for senior employees at NIH is a vulnerability in NIH's conflict-of-interest policies. GAO recommended that NIH expeditiously clarify its policies with regard to written recusals and supervisory notification related to senior employees' use of recusal to resolve conflicts of interest. Despite changes in the operation of the NIH ethics program, the program remains decentralized and comprised of various offices. OIG is conducting a review of how these various NIH offices interact and manage allegations of employee conflicts of interest.

Although intramural research undertaken within the Department is vital and therefore the professional ethics of agency employees is of paramount concern, the bulk of the Department's research funding goes to the private sector, primarily to research universities that undertake work pursuant to contracts and grants. As a result, administration of the Department's ethics program also encompasses potential conflicts of interest relating to members of advisory panels and grantees. For this reason, OIG is reviewing NIH monitoring of extramural conflicts of interest. This review will identify the number and nature of financial conflicts of interest that are reported by grantee institutions to NIH and determine the extent to which NIH oversees grantee institutions' financial conflicts of interest. In addition, OIG will be initiating an assessment of the nature of financial interests disclosed by clinical investigators to FDA; the extent to which drug, biologic, and device applicants monitor their clinical investigators for conflicting financial interests; and the extent to which FDA monitors the financial interests disclosed by clinical investigators.

OIG's work also reflects congressional concern and related mandates associated with identification of conflicts of interest associated with experts and consultants at NIH and advisory committees and panels at FDA. Under the recent reauthorization of NIH (H.R. 6164, Public Law 109-482), the Director of NIH is required to submit annual reports to the Inspector General of HHS, the Secretary, and relevant congressional committees. The report must identify the number of experts and consultants whose services were obtained by NIH or its agencies and describe the qualifications of and the need for hiring such experts and consultants. The report will also include the income, gifts, assets and liabilities disclosed to NIH. Similar to the NIH reporting requirement, FDA is also required (H.R. 2744, section 795(c), Public Law 109-97) to submit a quarterly report to OIG and relevant congressional committees on the efforts made to identify qualified persons with minimal or no potential conflicts of interest for appointment to an advisory committee or panel of the FDA.

Enforcement

In addition to performing systemic reviews identifying vulnerabilities in the administration of the Department's ethics program, on the enforcement side, OIG has managed a significant caseload of conflict-of-interest matters. The caseload of the OIG SIU continues to increase, with the number of cases involving potential conflict of interest under investigation by this unit tripling between 2005 and 2006. As a recent example, an SIU investigation focused on the former FDA Commissioner's false reporting that he had sold stock in companies regulated by FDA when in fact he continued to hold shares in those firms. He entered guilty pleas to two criminal charges for false writings and conflict of interest and was fined approximately $90,000, received 3 years of supervised probation, and was ordered to perform 50 hours of community service. In another example, OIG handled a case involving an NIH senior scientist. The Chief of the Geriatric Psychiatry Branch at NIH pled guilty in December 2006, to conflict-of-interest charges relating to his alleged acceptance of $285,000 in consulting fees and additional travel expenses from a drug company without the required approval of and

disclosure to NIH officials. A third example is the SIU review of NIH's handling of 103 cases that potentially revealed conflicts of interest by NIH employees identified in the files of the NIH Office of Management Assessment (OMA). The SIU and OIG ethics attorneys examined these 103 cases and have made determinations regarding those cases in which additional investigation is warranted. In order to improve the efficiency of the referral process, the SIU created a new, comprehensive form for the DAEO and the DECs to use to refer conflict of interest cases to OIG for investigation.

In May 2007, OIG hosted a 1-day Conflict of Interest and Ethics Summit and invited HHS ethics officials as well as officials from all other Federal Departments and agencies. Attended by approximately 200 Federal officials, the goal of the Summit was to establish an ongoing dialogue between the oversight, enforcement, and ethics policy communities regarding ethics and conflict-of-interest issues. OGE plans to incorporate many of the themes raised at the Summit as it develops best practices as part of an ongoing Leadership Initiative.

Assessment of Progress in Addressing the Challenge:

Actions have been taken to address ethics issues identified by OIG. While the OIG study of outside activities at NIH was progressing, other reviews were being conducted by OGE and the Secretary's Office. NIH itself convened a Blue Ribbon Panel appointed by the NIH Director. The heightened focus on ethics in the Department brought about significant changes. The Department's Supplemental Standards of Ethical Conduct were revised in 2005, adding prohibitions on outside activities and financial holdings for certain employees at NIH. The revised Supplemental Standards also imposed a more detailed process for reviewing outside activity requests departmentwide.

Additionally, the staff of the DAEO, housed in the OGC Ethics Division, was expanded, nearly tripling its size. The Division has been organized into separate branches to reflect the specialized work performed. One branch handles ethics advisory services, with a specific attorney assigned to provide assistance to each operating and staff division of the Department, and also has a separate section responsible for financial disclosure matters. Another branch is responsible for developing and providing ethics training, as well as conducting reviews of the ethics programs of the various operating and staff divisions of the Department.

In March 2007, FDA posted procedures on the FDA web site for the completion and review of outside activity forms (Form 520) at FDA. FDA prepared two documents: (1) a guide on how to complete the Form 520 (useful to employees), and (2) a guide on how to review the Form 520 (useful to ethics reviewers).

The DAEO is also taking steps to tighten up the waiver process. The DAEO recently issued guidance to all DECs reminding them of their responsibility to (1) send copies of all 18 U.S.C. § 208(b)(1) and (b)(3) waivers granted to Department employees to the DAEO, along with data regarding the number of waivers issued; (2) establish a reliable tracking system for waivers; and (3) consult with an Ethics Division attorney prior to granting any 18 U.S.C. § 208 (b)(1) waiver and when granting 18 U.S.C. § 208 (b)(3) waivers if there are unique fact patterns, special circumstances, or unusual situations.

In addition, ethics staff in the DAEO's office are reaching out on a monthly basis to ethics contacts for each OPDIV and Staff Division to inquire about the operation of the divisions' ethics programs, including the review of waivers. The DAEO is also planning to issue a package with waiver guidance and information regarding which officials in the Department have the delegated authority to issue waivers.

Summary of Financial Statement Audit and Management Assurances

Table 1.
Summary of Financial Statement Audit

Audit Opinion	Unqualified				
Restatement	No				
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Ending Balance
Financial Management Systems & Reporting	☑				☑
Budgetary Accounting		☑			☑
Financial Management Information Systems	☑				☑
Medicare Claims Processing		☑			☑
Total Material Weaknesses	2	2	0	0	4

Definition of Terms

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

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

Consolidated: The combining of two or more findings.

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

Ending: The agency's year-end balance.

Table 2.
Summary of Management Assurances

Effectiveness of Internal Control over Financial Reporting (FMFIA #2)

Statement of Assurance	Qualified					
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
Medicare Advantage & Prescription Drug Benefit Payments	✓		✓			
Financial Systems & Processes	✓					✓
Total Material Weaknesses	2	0	1	0	0	1

Effectiveness of Internal Control over Operations (FMFIA #2)

Statement of Assurance	Qualified					
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
Medicare Electronic Data Processing Operations	✓			✓		
Oversight and Management of Information System Controls		✓				✓
Total Material Weaknesses	1	1	0	1	0	1

Conformance with financial management system requirements (FMFIA #4)

Statement of Assurance	Nonconformance					
Non-Conformances	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
Financial Systems & Processes	✓					✓
Medicare Electronic Data Processing Operations	✓			✓		
Oversight and Management of Information System Controls		✓				✓
Total non-conformances	2	1	0	1	0	2

Compliance with Federal Financial Management Improvement Act (FFMIA)

	Agency	Auditor
Overall Substantial Compliance	No	No
1. System Requirements	No	
2. Accounting Standards	Yes	
2. USSGL at Transaction Level	No	

Improper Payment Information Act Report

This report follows the format prescribed by the Office of Management and Budget (OMB) in Circular A-136, Financial Reporting Requirements.

I. Describe the risk assessment(s), performed subsequent to completing its full program inventory. List the risk-susceptible programs (i.e., programs that have a significant risk of improper payments based on OMB guidance thresholds) identified through its risk assessments. Be sure to include the programs previously identified in the former Section 57 of OMB Circular A-11 (now located in Circular A-123, Appendix C).

Risk assessments were last completed in FY 2006 using a model developed by the Department. HHS did not identify any new high-risk programs in its FY 2006 risk assessment work. OMB Circular A-123 Appendix C requires risk assessments once every three years. As a result, HHS did not perform risk assessments during FY 2007.

Seven HHS programs are identified as high-risk programs in OMB Circular A-123, Appendix C. These seven programs are: Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), Temporary Assistance for Needy Families (TANF), Foster Care, Head Start and the Child Care Development Fund. The sections below contain information on HHS activities related to estimating and reducing improper payments in these programs. HHS anticipates reporting error rates for all seven high-risk programs in FY 2008.

II. Describe the statistical sampling process conducted to estimate the improper payment rate for each program identified.

A. Medicare Fee-For-Service

The Medicare fee-for-service (FFS) improper payment estimate is derived from two programs: the Comprehensive Error Rate Testing (CERT) Program and the Hospital Payment Monitoring Program (HPMP). The CERT program reviews claims that account for approximately 60 percent of the total Medicare FFS payments. HPMP reviews claims that comprise the remaining 40 percent. The CERT Program calculates the error rate for Carriers, Medicare Administrative Contractors (MACs), Durable Medical Equipment Medicare Administrative Contractors, and non-Prospective Payment System (PPS) inpatient Hospital claims submitted to Fiscal Intermediaries (FIs). The HPMP calculates the error rate for PPS inpatient hospital claims submitted to the FIs. The Medicare FFS improper payment methodology includes:

- Randomly selecting approximately 140,000 claims;
- Requesting medical records from providers on these claims;
- Reviewing the claims and medical records for compliance with Medicare coverage, coding and billing rules; and
- Treating non-response by a provider as an error.

B. Medicare Advantage

A methodology to estimate improper payments in the Medicare Advantage (MA) program is currently being developed. During FY 2007, HHS prepared a comprehensive project plan to develop error rates for the MA program and a comprehensive risk assessment to determine potential areas vulnerable to payment error in the MA program. These efforts led to the completion of a measurement project on the payment systems calculation.

Payment System Calculation Discrepancies (PSCD) is one of the areas identified in the risk assessment. The PSCD measures monthly discrepancies between the payment processing system and a simulation of monthly prospective payments that are calculated independently. The simulated payment amounts are generated from a series of Statistical Analysis Software (SAS) programs that use 100 percent of the monthly beneficiary-level payments in MA from the Monthly Membership Reports to independently calculate the monthly prospective payments. The simulated payments are used to validate the monthly prospective payments. Discrepancies identified could contribute to future improper payments if not resolved. Most PSCDs are adjusted in the multiple reconciliation processes and systems in place at HHS. It is important to note that since MA payments are made prospectively and reconciled at the end of the year, the PSCDs are not improper payments. In the MA program, a payment is considered improper if the amount paid was incorrect after final reconciliation.

C. Medicare Prescription Drug Benefit

A methodology to estimate improper payments in the Medicare Prescription Drug Benefit (MPDB) program is currently being developed. During FY 2007, HHS prepared a comprehensive project plan to develop error rates for the MPDB program and a comprehensive risk assessment to determine potential areas vulnerable to payment error in the MPDB program. These efforts led to the completion of a measurement project on the payment systems calculation.

Payment System Calculation Discrepancies (PSCD) is one of the areas identified in the risk assessment. The PSCD measures monthly discrepancies between the payment processing system and a simulation of monthly prospective payments that are calculated independently. The simulated payment amounts are generated from a series of Statistical Analysis Software (SAS) programs that use 100 percent of the monthly beneficiary-level payments in MPDB from the Monthly Membership Reports to independently calculate the monthly prospective payments. The simulated payments are designed to validate the monthly prospective payments. Discrepancies identified could contribute to future improper payments if not resolved. Most PSCDs are adjusted in the multiple reconciliation processes and systems in place at HHS. It is important to note that since MPDB payments are made prospectively and reconciled at the end of the year, the PSCDs are not improper payments. In the MPDB program, a payment is considered improper if the amount paid was incorrect after final reconciliation.

D. Medicaid

To measure Medicaid improper payments, seventeen states, from a total of 50 states plus the District of Columbia, were selected each year to create a three year rotation cycle. To select the 17 states for each year of the 3-year cycle, states were ranked by size based on their past Federal FFS expenditures and grouped into three major strata with 17 states in each stratum. The expenditure data showed that nine states represented a substantial portion (approximately 50%) of the total Federal FFS expenditures. To get a precise estimate for the national rate, it was important to group these nine high-expenditure states into their own stratum. Therefore, the 17 states in Strata 1 were further divided into two substrata – Stratum 1A (consisting of the nine states with the highest federal FFS expenditures) and Strata 1B (consisting of the eight remaining highest-expenditure states). The states were sampled such that three states were selected from Strata 1A each year. Given the criterion that each state would be selected once over a three-year cycle, for each stratum there is one year in which only 5 states are sampled. The sample distribution over the three year period, by strata, is illustrated in Table 1 on the next page.

Table 1: Number of States to be Selected from Each Stratum in Each Year

Strata	Year 1	Year 2	Year 3
1A	3	3	3
1B	3	3	2
2	6	5	6
3	5	6	6

Each state's sample size is determined based on annual expenditures. The average FFS annual sample size for each state included in the FY 2007 rate is 1,000 claims. States submit quarterly adjudicated claims data from which a randomly selected sample of approximately 250 FFS claims, stratified by service type, is drawn each quarter. Each selected FFS claim is subjected to a medical and data processing review.

In FY 2008, HHS expects to report a comprehensive national Medicaid error rate that includes a FFS, managed care, and eligibility component.

E. State Children's Health Insurance Program

The SCHIP program did not measure an improper payment rate in FY 2007.

In FY 2008, HHS expects to report a comprehensive national SCHIP error rate that includes a FFS, managed care, and eligibility component.

F. Temporary Assistance for Needy Families

HHS' Office of the Inspector General (OIG) has developed a methodology to measure improper payments in the TANF program. In FY 2007, pilot reviews were conducted in three states. The OIG randomly selected 150 cash assistance cases in each state and reviewed the eligibility and payment status of the sampled cases based on Federal and state requirements.

In FY 2008, HHS expects to report a national TANF error rate.

G. Foster Care

Foster Care Eligibility Reviews are conducted systematically in each state (the 50 states, the District of Columbia and Puerto Rico) every three years. During these primary reviews, a team comprised of Federal and state staff review 80 cases selected from the state's title IV-E foster care population during a six month period, the Period Under Review (PUR). The reviews determine a state's level of compliance in meeting the Federal regulatory eligibility requirements for the Foster Care Program and validate the accuracy of a state's claim for Federal reimbursement of Foster Care payments.

Each regulatory review specifies the number of error cases and the amount of payment errors. An error case is defined as a case in which a payment is made on behalf of an ineligible child during the PUR. Payment errors may include payments for error cases, "ineligible" payments made to non-error cases which failed to meet an eligibility criterion outside the PUR, and "unallowable" payments for services not covered by Title IV-E or its regulatory provisions (e.g. therapy). The information gathered in the regulatory monitoring review is used to correct underpayments as well as overpayments.

HHS employs a 10 percent error threshold to determine the level of state compliance in meeting the Federal requirements in the Foster Care program. If a state exceeds the error threshold for both the case and payment error rates in the primary review, the state will receive a secondary review. During the secondary review, 150 cases are selected. If a state exceeds the error threshold for both the case and payment error rates in a secondary review, the state is assessed an additional extrapolated disallowance, which is equal to the lower limit of a 90 percent confidence interval for the state foster care population's total dollars in error during the six-month PUR. The extrapolation increases geometrically the resulting disallowance. Since FY 2000, HHS has systematically conducted more than 110 regulatory Foster Care reviews, with over 8,000 Foster Care cases reviewed.

H. Head Start

HHS is legislatively required to perform reviews of each Head Start program every three years. The design of the sample for the Erroneous Payments Study of Head Start programs is a three-stage element sample. Since each program is reviewed once every three years, the first stage of the sample is to identify the programs up for review. The second stage of the sample is to select the programs to be reviewed. As was done in the FY 2006 Erroneous Payments study, the FY 2007 study selected 50 programs and 10 alternates. Programs were selected through a stratified random sample, where programs were divided into five stratum by enrollment. The number of programs sampled within each stratum is roughly proportional to the number of children represented in each stratum, based on the most recent Program Information Report funded enrollment data. The third stage of the sample is to select the records to be reviewed in each selected program, using a systematic sampling scheme.

In the FY 2007 Erroneous Payments Study, 50 Head Start programs from 31 states were reviewed. A total of 11,083 records were examined. The purpose of the reviews was to determine whether documentation demonstrated that a Head Start child was income eligible. A payment error in the Head Start program is defined as a payment for an enrolled child from a family whose income exceeds the allowable limit (in excess of the 10 percent program allowance for families above the income limit). To make this determination, reviewers were required to look at each sample child's folder and determine if the child was ineligible. A child was deemed ineligible if (1) there was not, as required by 45 CFR Part 1305.4(e), a signed statement by a Head Start employee stating the child was eligible to participate or (2) there was income documentation in the child's folder that, in the reviewer's judgment, suggested the child was not Head Start eligible. In FY 2007, reviewers were asked to review income documentation regardless of whether there was a signed statement from the staff in the file.

I. Child Care and Development Fund

During FY 2004, HHS initiated an improper payment pilot project to measure improper payments and to assess the efforts of states to prevent and reduce improper payments in its Child Care program. The project was implemented in two phases with a total of nine states participating in the measurement portion of the project. HHS reported the results of

the first phase of the pilot project, which included four states, in its FY 2005 PAR. The second phase of the pilot project was completed by the remaining five states in FY 2007.

In addition to completing the remaining pilot projects, in FY 2007, HHS promulgated a Final Rule revising the Child Care and Development Fund (CCDF) regulations to provide for the measuring and reporting of error rates in the fifty states, District of Columbia and Puerto Rico.

In FY 2008, HHS expects to report a national Child Care improper authorization for payment error rate.

III. Describe the Corrective Action Plans for:

Reducing the estimated rate of improper payments for each type or category of error. This discussion must include the corrective action(s) for each different type or cause of error, and the corresponding steps necessary to prevent or reduce future recurrence. If the efforts are ongoing, include that information in this section also. If the actions are planned for future implementation, include the anticipated date of realization.

A. Medicare FFS

Categories of error and associated corrective actions:

- No Documentation and Insufficient Documentation Errors
  - Educate providers about the CERT program so that providers are not hesitant about supplying medical records.
  - Modify the medical record request letters to clarify the components of the medical record needed for CERT review and to encourage the billing provider to forward the request to the appropriate location if the medical record is not on-site.
  - Customize the “second chance” letters to list the parts of the medical record that are needed to complete the review.
- Medically Unnecessary Services
  - Complete and distribute an extensive workbook designed to be a resource for hospitals in their compliance efforts and activities.
  - Task each Carrier, DMERC, and FI with developing an Error Rate Reduction Plan (ERRP) that targets medical necessity errors in their jurisdiction.
  - Develop national and state-specific models for predicting payment errors to help increase understanding of areas prone to payment error and where Quality Improvement Organizations (QIOs) should focus corrective actions.
- Incorrect Coding Errors
  - Increase and refine educational contacts with providers who are billing in error.
  - Develop and install new correct coding edits.
- Other
  - Release a List of Over-utilized Codes to show error rates and improper payments by service for each CERT cluster.
  - Conduct a demonstration in three states to see if using recovery auditing contractors can help lower the error rates in these states by (1) improving provider compliance more quickly than states that do not have recovery auditing contractors, and (2) allowing regular contractors to spend fewer resources on post-payment review and focus more time and effort on prepayment review and education.

- ◦ Consider contractor-specific error rates when evaluating contractors.

Results of the actions taken to address the causes: As a result of these actions, the Medicare paid claims error rate decreased from 4.4 percent ($10.8 billion) in FY 2006, to 3.9 percent ($10.8 billion) in FY 2007. The FY 2007 paid claims error rate of 3.9 percent exceeded the HHS Medicare Fee-for-Service FY 2007 error rate GPRA goal of 4.3 percent.

B. Medicare Advantage

During FY 2007, HHS prepared a comprehensive project plan to develop error rates for the Medicare Advantage program and prepared a comprehensive risk assessment to determine potential areas vulnerable to payment error in the Medicare Advantage program. HHS has completed a measurement project on one of the areas identified in the comprehensive Medicare Advantage risk assessment, the Payment System Calculation Discrepancies (PSCD). It is important to note that these discrepancies are not payment errors because final payment is not determined until after reconciliation.

However, the PSCD is the first step in developing an improper payment error rate. When a PSCD is identified, HHS makes adjustments through multiple reconciliation processes to remedy the discrepancy and prevent future discrepancies. Once a comprehensive Medicare Advantage error rate has been established, HHS will develop and implement a corrective action plan to reduce improper payments, as appropriate.

C. Medicare Prescription Drug Benefit

During FY 2007, HHS prepared a comprehensive project plan to develop error rates for the Medicare Prescription Drug Benefit program and prepared a comprehensive risk assessment to determine potential areas vulnerable to payment error in the Medicare Prescription Drug Benefit program. HHS has completed a measurement project on one of the areas identified in the comprehensive Medicare Prescription Drug Benefit risk assessment, the Payment System Calculation Discrepancies (PSCD). It is important to note that these discrepancies are not payment errors because final payment is not determined until after reconciliation.

However, the PSCD is the first step in developing an improper payment error rate. When a PSCD is identified, HHS makes adjustments through multiple reconciliation processes to remedy the discrepancy and prevent future discrepancies. Once a comprehensive Medicare Prescription Drug Benefit error rate has been established, HHS will develop and implement a corrective action plan to reduce improper payments, as appropriate.

D. Medicaid

Based on preliminary fee for service findings from reviewing two quarters worth of data, categories of error are:

- No Documentation
- Insufficient Documentation
- Medically Unnecessary Services; and
- Policy Violations

States will develop and implement corrective actions once the final component error rate is established.

E. State Children's Health Insurance Program

The SCHIP program did not measure an improper payment rate in FY 2007.

F. Temporary Assistance for Needy Families

Based on findings identified in the pilot reviews, categories of error are:

- Ineligible Recipients: families that exceeded income thresholds on payment dates, did not meet household composition requirements or exceeded the 60 month benefit limit.
- Incorrect Payment Amount: families received an incorrect benefit amount based on incorrect household size or income.
- Insufficient Documentation: the documentation was insufficient to make an affirmative determination that the family was eligible to receive benefits.

HHS will issue reports to the states on recommended corrective actions to address the above findings. States may employ these recommendations in their corrective action efforts.

G. Foster Care

In 2007, the number of payment errors continued to steadily decline in all error categories. The overall frequency of all types of payment errors in the composite foster care sample (i.e., across all States) has been reduced from 678 in 2006 to 528 in 2007. This represents a decrease of 22 percent in the number of payment errors for the program. Since HHS began measuring foster care improper payments in FY 2004, six types of eligibility errors have accounted for the majority of all errors identified in the title IV-E reviews.

Over the last year, HHS has made significant progress in reducing each type of error:

- Permanency finalization not timely:
  - 171 errors in 2006 to 52 errors in 2007 (reduction of 70 percent)
- Provider not licensed or approved:
  - 126 errors in 2006 to 65 errors in 2007 (reduction of 48 percent)
- No reasonable efforts to prevent removal
  - 91 errors in 2006 to 30 errors in 2007 (reduction of 67 percent)
- Criminal records check not completed
  - 64 errors in 2006 to 25 errors in 2007 (reduction of 61 percent)
- Not AFDC eligible at time of removal
  - 55 errors in 2006 to 42 errors in 2007 (reduction of 24 percent)
- No contrary to welfare determination
  - 45 errors in 2006 to 26 errors in 2007 (reduction of 42 percent)

In FY 2007, the most frequently identified payment error was underpayments (137 errors, or 26 percent of errors).

These reductions represent positive movement toward reducing improper payments in the foster care program. HHS will continue its efforts to implement the effective corrective action strategies that have proven successful, as follows:

- HHS performs onsite reviews and post-site reviews activities to effectively validate the accuracy of a state's claim for reimbursement of payments made on behalf of children and their foster care providers.
- States are required to develop and execute state-specific Program Improvement Plans.
- Program Improvement Plans that target corrective action to the root cause of payment errors in the state. These plans generally are approved for a period of one year, and the state submits quarterly progress reports to an HHS regional office for monitoring purposes.
- HHS provides onsite training and technical assistance to states to develop and implement program improvement strategies.
- HHS works toward heightening judicial awareness of, and investment in, the title IV-E eligibility and Child and Family Services Reviews.
- HHS works closely with the Court Improvement Program in states where judges require training and court orders warrant modification in order to meet title IV-E requirements and reduce the error rate for judicial determinations.
- HHS conducts secondary reviews for states that are not determined to be in substantial compliance as a result of their primary reviews, and takes appropriate disallowances consistent with the review findings.

As a result of these actions, the Foster Care error rate decreased from 7.68 percent ($134 million) in FY 2006 to 3.3 percent ($51.6 million in FY 2007).

H. Head Start

<u>Categories of error and associated corrective actions:</u>

- Absence of a signed income verification statement, meeting regulatory requirements, in grantee file
  - Grantee is to develop corrective action plan based on its findings.

In addition, HHS has taken the following actions:

- Issued a memorandum reminding all grantees of documentation requirements.
- HHS regional offices are providing increased oversight regarding documentation.
- During regularly scheduled program and fiscal reviews, required a review of a sample of grantee records to verify compliance with income eligibility determination requirements.
- Increased grantee's emphasis for on-going monitoring through training and development of a monitoring protocol to review management systems.

As a result of these actions, the Head Start error rate decreased from 3.1 percent ($210 million) in FY 2006 to 1.3 percent ($88 million) in FY 2007.

I. Child Care and Development Fund

Categories of error based on findings identified in the pilot reviews and associated corrective actions:

- Missing Documentation

  - Training to increase staff awareness of the problem and knowledge of policy, interviewing skills, and quality of routine case reviews.
- Income Errors
  - Initiatives targeting income verification and calculation policies.
- Miscalculation of Hours of Care
  - Training of case record reviewers.
- Incorrect Parental Fee Calculations
  - Training of case record reviewers.

Other planned strategies States are considering to address causes of errors:

- Strengthen supervision of new eligibility workers.
- Clarify selected policies with eligibility workers.
- Improve information technology system elements to 1) prevent or decrease calculation errors, 2) generate exception reports to highlight areas of potential problems or concern, 3) operationalize automatic income calculations, and 4) enhance the capability of extracting data from other data systems.
- Provide extensive technical assistance in counties to address error-prone areas.
- Institute changes in the monitoring process.
- Introduce statutory changes to simplify access to other state databases.
- Examine state policies to determine what changes may be necessary to provide a more consistent application of policies and procedures.

IV. Program improper payment reporting

a. The table is required for each reporting agency. Agencies must include the following information:

i. all risk susceptible programs whether or not an error measurement is being reported;

ii. where no measurement is provided, indicate the date by which a measurement is expected;

iii. if the Current Year (CY) is the baseline measurement year, indicate by either footnote or by "n/a" in the Prior Year (PY) column;

iv. if any of the dollar amount(s) included in the estimate correspond to newly established measurement components in addition to previously established measurement components, separate the two amounts to the extent possible;

v. include outlay estimates for CY +1, +2, and +3; and

vi. Agencies are expected to report on CY activity, or if this is not feasible, then activity from the most recent prior year is acceptable. Future year outlay estimates (CY+1, +2 and +3) should match the outlay estimates for those years as reported in the most recent President's Budget.

Improper Payment Reduction Outlook FY 2006 – FY 2010

($ in millions)

Program	PY Outlays	PY %	PY$	CY Outlays	CY IP%	CY IP$	CY+1 Est Outlays	CY+1 IP%	CY+1 IP$	CY+2 Est Outlays	CY+2 IP%	CY+2 IP$	CY+3 Est Outlays	CY+3 IP%	CY+3 IP$
Medicare FFS	$246,800 Note (a)	4.4%	$10,800 (9.8B over, 1.0B under)	$276,200 Note (b)	3.9%	$10.8B (9.8B over, 1.0B under)	$ 312,062 Note (c)	3.8%	$11.9	$ 333,535	3.7%	$12.3	$ 347,700	3.6%	$12.5
Medicare MC	55,919 Note (d)	N/A	N/A	75,128	N/A Note (1)	N/A Note (1)	91,768	N/A	N/A	98,926	N/A	N/A	110,391	N/A	N/A
Medicare Drug	31,717 Note (e)	N/A	N/A	49,256	N/A Note (2)	N/A Note (2)	59,174	N/A	N/A	66,484	N/A	N/A	75,143	N/A	N/A
Medicaid	180,625 Note (f)	N/A	N/A	70,117 Note (g)	18.45 Note (3)	12,900 Note (3)	209,835	N/A	N/A	223,628	N/A	N/A	240,147	N/A	N/A
SCHIP	5,451 Note (h)	N/A	N/A	6,294	N/A	N/A	5,691	N/A	N/A	5,525	N/A	N/A	5,542	N/A	N/A
TANF	16,897	N/A	N/A	17,318	N/A Note (4)	N/A Note (4)	17,296	N/A	N/A	17,208	N/A	N/A	16,812	N/A	N/A
Foster Care	1,621	7.68	124.5	1,565	3.30	51.6	1,518	3.25	49.3	1,469	3.10	45.5	1,426	3.00	42.8
Head Start	6,771	3.1	210	6,771	1.3	88	6,771	1.2	81.3	6,771	1.1	74.5	6,771	1.0	67.7
Child Care	5,252	N/A	N/A	4,852	N/A Note (5)	N/A Note (5)	4,853	N/A	N/A	4,955	N/A	N/A	4,940	N/A	N/A

(a) PY Outlays for Medicare FFS are from the November 2006 Improper Medicare FFS Payments Report (based on CY 2005 claims).
(b) CY Outlays for Medicare FFS are from the November 2007 Improper Medicare FFS Payments Report (based on CY 2006 claims).
(c) Medicare FFS CY+1, CY+2, and CY+3 outlay numbers based on Mid-session Review (Medicare Outlays Current Law (CL).
(d) Medicare Advantage PY, CY, CY+1, CY+2, and CY+3 outlay numbers based on Mid-session Review (Medicare Outlays (CL)
(e) Medicare Prescription Drug Benefit PY, CY, CY+1, CY+2, and CY+3 outlay numbers based on Mid-session Review (Medicare Outlays (CL)
(f) Medicaid PY, CY, CY +1, CY +2, and CY +3 outlay numbers based on Mid-session Review (Medicaid Net Outlays (CL), excluding CDC Program Vaccine for Children obligations)
(g) Medicaid CY outlay number based on FY 2006 fee-for-service claims processed by the states during the first six months for which the preliminary rate was calculated.
(h) SCHIP PY, CY+1, CY+2, and CY+3 outlay numbers based on Mid-session Review (SCHIP Total Outlays (CL).

Improper Payment Reduction Outlook Notes:

(1) HHS is in the process of developing a Medicare Advantage (Part C) error rate. In FY 2007, HHS prepared a Part C Risk Assessment and identified the payment system calculation as one risk susceptible area. HHS has provided an initial estimate of the Payment System Calculation Discrepancies (PSCD) for FY 2007 Medicare Advantage prospective payments from January-June 2007. The PSCD Estimate is a measure of the accuracy of the payment system calculations of the prospective capitation payments. These discrepancies are not payment errors because a payment error would only occur after final reconciliation amounts have been determined for a given plan year. The PSCD Estimate is not based on final payments and is not a comprehensive measurement of the Part C payment error rate. HHS calculated a Medicare Advantage PSCD Estimate of 0.642 percent for payment made January- June 2007 and the PSCD gross amount for January – June 2007 totaled $234,267,567.

(2) HHS is in the process of developing a Medicare Prescription Drug (Part D) error rate. In FY 2007, HHS prepared a Part D Risk Assessment and identified the payment system calculation as one risk susceptible area. HHS has provided an initial estimate of the Payment System Calculation Discrepancies (PSCD) for FY 2007 Prescription Drug prospective payments from January-June 2007. The PSCD Estimate is a measure of the accuracy of the payment system calculations of the prospective capitation payments. These discrepancies are not payment errors because a payment error would only occur after final reconciliation amounts have been determined for a given plan year. The PSCD Estimate is not based on final payments and is not a comprehensive measurement of the Part D payment error rate. HHS calculated a Part D PSCD Estimate of 0.020 percent for payment made January- June 2007 and the PSCD gross amount for January – June 2007 totaled $4,102,667.

(3) This preliminary error rate is from 17 States for 6 months only and was calculated in September 2007. CMS is completing the remaining 6 months and will report an annual 2006 Medicaid fee-for-service error rate in the 2008 PAR. This preliminary error rate does not reflect the late implementation of policies in the measurement cycle. These factors should be considered when reviewing the preliminary rate and may impact the final calculation of the annual error rate.

(4) HHS OIG conducted a pilot review of TANF cash assistance payments in three states. The error rates for the pilots ranged from 11.5 percent to 40 percent. Documentation errors comprised at least 22 percent of each of the error rates.

(5) In FY 2007, the Child Care program completed pilot projects measuring improper payments based on state eligibility criteria. The payment error rates for these pilots ranged from 2 percent to 18 percent based on a 90 percent confidence level.

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b. Discuss your agency's recovery of improper payments, if applicable. Include in your discussion the dollar amount of cumulative recoveries collected beginning with FY 2004.

A. Medicare Fee-For-Service—

As part of the error rate measurement process, CERT and HPMP review a sample of Medicare FFS claims and estimate a projected improper payment amount based on errors found in the sample. The Carriers, Fiscal Intermediaries, Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs are notified of the actual overpayments that

were identified so they can implement the necessary adjustments. Since 2004, CERT and HPMP identified $50,823,393 in actual overpayments and have collected $44,397,199 of those overpayments. For the 2007 reporting period, the CERT program identified $888,291 in actual overpayments and, as of the final cut-off date for the report, collected $592,286. HPMP identified $15,083,413 in actual overpayments and collected $12,542,875 as of the cut-off date for the report.

B. Medicare Advantage

Once a baseline error rate is established, HHS will develop a strategy to recover improper payments identified in the Medicare Advantage measurement program, if applicable.

C. Medicare Prescription Drug Benefit

Once a baseline error rate is established, HHS will develop a strategy to recover improper payments identified in the Medicare Prescription Drug Benefit measurement program, if applicable.

D. Medicaid

States must return the Federal share of overpayments based on identified errors in accordance with current statutory requirements at section 1903(d)(2) of the Social Security Act and related regulations at 42 CFR part 433, subpart F.

E. State Children's Health Insurance Program

The SCHIP program did not measure an improper payment rate in FY 2007. In the future, quarterly Federal payments must be reduced in accordance with section 2105(e) of the Social Security Act and related regulations at 42 CFR Part 457, subpart B.

F. Temporary Assistance for Needy Families

Due to legislative restrictions, HHS is not able to recover improper payments in the TANF program.

G. Foster Care

As part of the error rate measurement process, foster care disallows improper payment maintenance payments and administrative costs associated with sample review cases as well as any other improper payment identified during the review.

The states are required to "refund" (as applicable) the amount of funds that have been disallowed within 30 days of receipt of the disallowance letter, unless they choose to appeal some or all of the disallowance. HHS recovers the funds through increasing adjustments the state makes via its quarterly expenditure report. Since FY 2004, HHS has disallowed over $7 million in foster care maintenance payments and administrative costs as follows:

FY 2004	$1,601,415
FY 2005	1,017,790
FY 2006	704,607
FY 2007	3,691,254
TOTAL	$7,015,066

H. Head Start

As reflected in the low improper payment error rates for Head Start over the past few years, the incidence of improper payments has been minimal. Cost disallowances for the Erroneous Payment Study have generally not been taken since income eligibility is a complex issue subject to various criteria. Head Start is focusing its efforts on identifying grantees whose enrollment of over-income children is frequent, substantial, and willful.

I. Child Care and Development Fund

Improper payments under the CCDF are subject to disallowance procedures as set forth at 45 CFR 98.66 of the CCDF regulations.

In addition, pursuant to CCDF regulations at 45 CFR 98.60(i), a state Lead Agency is required to recover child care payments that are the result of fraud. The Lead Agency has discretion as to whether to recover misspent funds that were not the result of fraud, such as in cases of administrative error. Improperly spent funds are subject to disallowance regardless of whether the state pursues recovery.

In the event that improper payments are recovered, 45 CFR 98.60(g) provides that such payments shall (1) if received by the Lead Agency during the applicable obligation period (described in 45 CFR 98.60(d) and (e)), be used for activities specified in the Lead Agency's approved plan and must be obligated by the end of the obligation period; or (2) if received after the end of the applicable obligation period, be returned to the Federal government.

V. Recovery auditing reporting

a. Discuss your agency's recovery auditing efforts. Include any contract types excluded from this review and the justification for doing so, the actions taken to recoup improper payments, and the business process changes and internal controls instituted and/or strengthened to prevent further occurrences.

In July 2004, HHS awarded a contingency fee contract to a recovery auditing firm to review FY 2002 and FY 2003 contract payments. During FY 2006, HHS exercised an option under the contract for review of FY 2004 and FY 2005 contract payments. To date, our recovery auditors have found the HHS payment systems to be secure and without major program integrity issues. As of September 30, 2007, $74,401 has been recovered out of more than $24 billion of contracts reviewed. Full results for the 2002-2005 period are displayed in the table below.

b. Complete the table below.

Agency Component	Amount Subject to Review for CY Reporting	Actual Amount Reviewed and Reported CY	Amounts Identified for Recovery CY	Amounts Recovered CY	Amounts Identified for Recovery PYs	Amounts Recovered PYs	Cumulative Amounts Identified for Recovery (CY + PYs)	Cumulative Amounts Recovered (CY + PYs)
HHS	$24.2 billion	$24.2 billion	$635, 728	$19,549	$950,915	$54,852	$1,586,643	$74, 401

VI. Describe the steps the agency has taken and plans to take (including timeline) to ensure that agency managers and accountable officers (including the agency head) are held accountable for reducing and recovering improper payments.

HHS has initiated a number of measures to ensure that agency managers and appropriate officers are held accountable for reducing and recovering improper payments. HHS' commitment to this initiative is illustrated through HHS' Top Twenty Department-Wide Objectives. One of HHS' top twenty objectives is to Eliminate Improper Payments. This objective demonstrates HHS' dedication to meeting the President's Management Agenda "green" standards for success.

This initiative is tracked quarterly by the Office of Management and Budget at the Department level using the President's Management Agenda scorecard. The Department's score reflects HHS' progress in achieving its improper payment goals. In addition, HHS issues interim scorecard ratings to each of its operating divisions during each quarter. These interim ratings help facilitate HHS leadership discussion and accountability as well as to help ensure that HHS will meet its quarterly goals.

Further, HHS management performance plan objectives hold agency managers, beginning at the top of the leadership and cascading down through HHS Senior Executives (including component heads) and below, accountable for achieving progress in this initiative. As part of the semi-annual and annual performance evaluation, HHS Senior Executives are evaluated on the progress the agency achieves toward its stated goals.

VII. Agency information systems and other infrastructure.

a. **Describe whether the agency has the information systems and other infrastructure it needs to reduce improper payments to the levels the agency has targeted.**

b. **If the agency does not have such systems and infrastructure, describe the resources the agency requested in its most recent budget submission to Congress to obtain the necessary information systems and infrastructure.**

A. Medicare Fee-For-Service

HHS has the information systems and other infrastructure needed to reduce improper Medicare FFS payments to the levels that HHS has targeted. HHS has several systems that contain information that allows it to identify developing and continuing aberrant billing patterns based upon a comparison of local payment rates with state and national rates. All the systems, both at the contractor level and at the central HHS level, are tied together by a high-speed secure network that allows rapid transmission of large data sets between systems. Transmissions are made nightly and include all claims processed during the preceding day. No other systems or infrastructure are needed at this time.

B. Medicare Advantage

The information systems and other infrastructure that would be valuable to HHS in reducing improper payments will not be known until implementation is complete and results are available.

C. Medicare Prescription Drug Benefit

The information systems and other infrastructure that would be valuable to HHS in reducing improper payments will not be known until implementation is complete and results are available.

D. Medicaid

The information systems and other infrastructure that would be valuable to HHS in reducing improper payments will not be known until full implementation is complete and results are available.

E. State Children's Health Insurance Program

The information systems and other infrastructure that would be valuable to HHS in reducing improper payments will not be known until full implementation is complete and results are available.

F. Temporary Assistance for Needy Families

The information systems and other infrastructure that would be valuable to HHS in reducing improper payments will not be known until the methodology has been fully implemented and results are available.

G. Foster Care

HHS has the information systems and other infrastructure needed to reduce improper Foster Care payments to the levels that HHS has targeted. HHS uses the Adoption and Foster Care Analysis and Reporting System for the regulatory reviews. Utilizing this existing source of data reduces the burden on states to draw their own samples, promotes uniformity in sample selection, and employs the database in a practical and beneficial manner. No other systems or infrastructure are needed at this time.

H. Head Start

HHS has the information systems and infrastructure needed to reduce improper Head Start payments to the levels that HHS has targeted. HHS has two systems in place that identify grantees that are not complying with Head Start's income eligibility requirements. All review reports are processed centrally by HHS as part of Head Start monitoring. Both systems allow HHS to identify grantees that fail to comply with income eligibility requirements. No other systems or infrastructure are needed at this time.

I. Child Care and Development Fund

The information systems and other infrastructure that would be valuable to HHS in reducing improper payments will not be known until full implementation is complete and results are available.

VIII. Describe any statutory or regulatory barriers which may limit the agencies' corrective actions in reducing improper payments and actions taken by the agency to mitigate the barriers' effects.

A. Medicare Fee-For-Service

No statutory or regulatory barriers for limiting corrective actions have been identified.

B. Medicare Advantage

Statutory or regulatory barriers for limiting corrective actions will not be known until full implementation is complete and results are available.

C. Medicare Prescription Drug Benefit

Statutory or regulatory barriers for limiting corrective actions will not be known until full implementation is complete and results are available.

D. Medicaid

Statutory or regulatory barriers for limiting corrective actions will not be known until full implementation is complete and results are available.

E. State Children's Health Insurance Program

Statutory or regulatory barriers for limiting corrective actions will not be known until full implementation is complete and results are available.

F. Temporary Assistance for Needy Families

Corrective actions that could help reduce improper payments would have to be implemented at the state level. The TANF statute prohibits HHS from requiring state TANF agencies to implement and report on corrective actions.

G. Foster Care

Program regulations define the sample size, the disallowance assessment following the primary review, including an additional disallowance extrapolation following the secondary review, and the current corrective action process. Any proposed changes in the compliance framework or current methodology for estimating improper payments would need to go through the rulemaking process.

H. Head Start

No statutory or regulatory barriers for limiting corrective actions have been identified.

I. Child Care and Development Fund

Statutory or regulatory barriers for limiting corrective actions will not be known until full implementation is complete and results are available.

IX. Additional comments, if any, on overall agency efforts, specific programs, best practices, or common challenges identified, as a result of IPIA implementation.

HHS currently has seven programs that have been deemed risk susceptible: Medicare Fee-for Service, Medicaid, State Children's Health Insurance Program (SCHIP), Temporary Assistance for Needy Families (TANF), Head Start, Child Care, and Foster Care. Currently Medicare FFS, Foster Care and Head Start report error rates. In FY 2008, HHS expects that all seven risk susceptible programs will report error rates.

In the third quarter of FY 2007, HHS was elevated to "Yellow" on status for the Eliminating Improper Payments initiative under the President's Management Agenda (PMA). This upgrade was a result of having an OMB-approved measurement plan in place for all risk susceptible programs and a corrective action plan in place with OMB-approved targets for all programs that have been measured.

Once baselines have been established for all programs, reduction targets and corrective action plans can be developed for those programs that do not currently have them. Meeting and maintaining the reduction targets is the next milestone towards achieving a "Green" rating under the PMA.

Beginning in 2005, HHS engaged in a Demonstration Project for Improving Program Integrity in Medicare. Under secton 306 of the Medicare Prescription Drug Improvement Modernization Act of 2003 (MMA), HHS was given the authority to conduct a demonstration project to demonstrate the use of recovery audit contractors (RACs) in identifying underpayments and overpayments and recouping overpayments under the Medicare Fee-for-Service program. HHS initiated this 3-year demonstration in the three states with the highest Medicare utilization rates. HHS provided the recovery audit contractors with over $167 billion worth of claims submitted between FY 2002 and FY 2005 that are potentially subject to review. From the inception of the RAC program through September 30, 2007, HHS has collected $432 million in payments determined to be improper.

Although the RAC demonstration is scheduled to end in March 2008, Section 302 of the Tax Relief and Health Care Act of 2006 makes the RAC Program permanent and requires the Secretary to expand the program to all 50 states no later than 2010. HHS has already begun expanding the RAC program. As of September 2007, the RAC demonstration has expanded into 2 additional states (Massachusetts and South Carolina) and is formulating plans to begin expanding into Arizona by the end of the calendar year.

By 2010, HHS plans to have four permanent RACS in place. Each RAC will be responsible for identifying overpayment and underpayments in approximately one-quarter of the country.

In FY 2007, HHS began utilizing contracting actions, specifically award fee plans to create incentives for the Medicare Administrative Contractors to further reduce improper payments. For the first time HHS included a "pilot" Comprehensive Error Rate Testing Program award fee metric into the award fee plan for the Jurisdiction 3 (J3) Medicare Administrative Contractor. Under this award fee plan, the J3 contractor can earn some, all or none of the award fee pool for the Comprehensive Error Rate Testing program metric based on its FY 2008 error rate. HHS will utilize lessons learned from this pilot to help structure future contracting incentives.

In FY 2007, HHS published final rules to measure error rates in Medicaid, SCHIP, and Child Care.

In FY 2007, HHS-OIG conducted a three state pilot program to review errors in its TANF basic assistance program.

In FY 2007, HHS began to implement the Medicaid Payment Error Rate Measurement program using a national contractor to determine the Medicaid FFS payment error rate based on medical reviews and data processing errors.

In FY 2007, HHS finalized a draft methodology and protocol to determine whether states accurately claim and properly allocate costs for administrating the title IV-E foster care program. Field testing of this methodology also began in FY 2007 and will continue in FY 2008.

In FY 2007, the Public Assistance Reporting Information System (PARIS) expanded its scope to include two more program matches, Child Care and Workers' Compensation. As a result, the August 2007 data match was the largest to date, both in terms of number of States participating and number of SSNs submitted. In the fall of 2007 Ohio notified HHS of their intention to join PARIS which will bring the total number of States involved to 42, or 44 total jurisdictions, including DC and Puerto Rico.

Other Financial Information

Net Cost of HHS Top 50 Programs

For the Years Ended September 30, 2007 and 2006

(in Millions)

HHS Program	HHS Net Cost ($)		Rank by ($)		Budget Function	HHS Component Responsible for Program
	FY 2007	FY 2006	FY 2007	FY 2006		
Medicare	$ 367,551	$ 336,969	1	1	Medicare	Centers for Medicare and Medicaid Services
Medicaid	187,940	179,481	2	2	Health	Centers for Medicare and Medicaid Services
Research	28,250	27,852	3	3	Health	National Institutes of Health
Temporary Assistance to Needy Families	17,044	17,063	4	4	Education, Training & Social Services / Income Security	Administration for Children and Families
Child Welfare	7,609	7,347	5	5	Education, Training & Social Services / Income Security	Administration for Children and Families
Head Start	6,922	6,834	6	6	Education, Training & Social Services	Administration for Children and Families
SCHIP	6,010	5,739	7	7	Health	Centers for Medicare and Medicaid Services
Child Care	5,145	5,246	8	8	Education, Training & Social Services / Income Security	Administration for Children and Families
Infectious Diseases	4,466	3,471	9	10	Health	Centers for Disease Control & Prevention
Child Support Enforcement	4,262	4,290	10	9	Income Security	Administration for Children and Families
Low-Income Home Energy Assistance	2,473	2,635	11	11	Income Security	Administration for Children and Families
HIV/AIDS Programs	2,142	2,123	12	12	Health	Health Resources and Services Administration
Social Services Block Grant	1,963	1,848	13	15	Education, Training & Social Services	Administration for Children and Families
Primary Care	1,948	1,382	14	18	Health	Health Resources and Services Administration
Clinical Services	1,676	1,611	15	17	Health	Indian Health Service
Substance Abuse Prevention & Treatment Block Grant	1,654	1,685	16	16	Health	Substance Abuse and Mental Health Services Administration
Public Health and Social Services	1,297	1,960	17	13	Health	Office of the Secretary
Community Based Services	1,250	1,273	18	19	Education, Training & Social Services	Administration on Aging
PHS Commissioned Corps	1,231	727	19	22	Health	Program Support Center
Health Promotion	1,007	971	20	20	Health	Centers for Disease Control & Prevention
Maternal and Child Health	908	880	21	21	Health	Health Resources and Services Administration
Terrorism	849	320	22	36	Health	Centers for Disease Control & Prevention
Community Services	736	714	23	23	Education, Training & Social Services	Administration for Children and Families
Health Professions	698	695	24	24	Health	Health Resources and Services Administration
Healthcare Systems	667	478	25	29	Health	Health Resources and Services Administration
Program of Regional National Significances/Targeted Capacity Expansion	642	565	26	26	Health	Substance Abuse and Mental Health Services Administration
Foods and Cosmetics	584	579	27	25	Health	Food and Drug Administration
Refugee Resettlement	509	518	28	27	Income Security	Administration for Children and Families
Contract Health Care	502	485	29	28	Health	Indian Health Service
Ticket to Work	455	1,940	30	14	Health	Centers for Medicare and Medicaid Services
Community Mental Health Services Block Grant	407	423	31	30	Health	Substance Abuse and Mental Health Services Administration
General Departmental Management	355	347	32	33	Health	Office of the Secretary
Environmental Health and Injury	354	352	33	32	Health	Centers for Disease Control & Prevention
Business Services Support	353	369	34	31	Health	Centers for Disease Control & Prevention
Youth	303	241	35	41	Education, Training & Social Services	Administration for Children and Families
Medical Devices & Radiological Health	284	275	36	39	Health	Food and Drug Administration
Tribal Activities: Contract Support	252	251	37	40	Health	Indian Health Service
Family Planning	247	300	38	37	Health	Health Resources and Services Administration
Program of Regional National Significances-Science to Service (Note 1)	242	332	39	35	Health	Substance Abuse and Mental Health Services Administration
Public Health Improvement and Leadership	240	219	40	42	Health	Centers for Disease Control & Prevention
Biologics	239	153	41	48	Health	Food and Drug Administration
Hospitals-Facilities Support	216	277	42	38	Health	Indian Health Service
Human Drugs	190	342	43	34	Health	Food and Drug Administration
Occupational Safety and Health	177	176	44	44	Health	Centers for Disease Control & Prevention
Global Health	175	154	45	47	Health	Centers for Disease Control & Prevention
Developmental Disabilities	170	177	46	43	Education, Training & Social Services	Administration for Children and Families
Rural Health	166	168	47	45	Health	Health Resources and Services Administration
Diabetes Initiative	133	162	48	46	Health	Indian Health Service
Domestic Violence	126	122	49	50	Education, Training & Social Services	Administration for Children and Families
Health Information and Service (new)	119	118	50	51	Health	Centers for Disease Control & Prevention
All Other HHS Programs	1,461	1,298			Various Components	Various Components
Total Net Costs (Note 2)	**$ 664,599**	**$ 623,937**				

Note 1. Name of the program changed; in FY 2006 was "Program of Regional National Significances-Best Practices".

Note 2. Total Net Costs agrees with OPDIV combined Totals in the Consolidating Statement of Net Cost by Budget Function located in Other Accompanying Information.

Consolidating and Combining Statements

Consolidating Balance Sheet by Budget Function

As of September 30, 2007

(In Millions)

	Education, Training & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals
Assets (Note 2)							
Intragovernmental							
Fund Balance with Treasury (Note 3)	$ 6,612	$ 84,330	$ 8,793	$ 15,039	$ 114,774	$ -	$ 114,774
Investments, Net (Note 5)	-	2,680	363,195	-	365,875	-	365,875
Accounts Receivable, Net (Note 6)	7	1,282	53,690	6	54,985	(53,821)	1,164
Other (Note 9)	-	438	-	-	438	(395)	43
Total Intragovernmental	$ 6,619	$ 88,730	$ 425,678	$ 15,045	$ 536,072	$ (54,216)	$ 481,856
Accounts Receivable, Net (Note 6)	1	1,676	11,344	-	13,021	-	13,021
Cash and Other Monetary Assets (Note 4)	-	-	129	-	129	-	129
Inventory and Related Property, Net (Note 7)	-	3,161	-	-	3,161	-	3,161
General Property, Plant & Equipment, Net (Note 8)	1	4,671	392	-	5,064	-	5,064
Other (Note 9)	-	517	59	-	576	-	576
Total Assets	**$ 6,621**	**$ 98,755**	**$ 437,602**	**$ 15,045**	**$ 558,023**	**$ (54,216)**	**$ 503,807**
Stewardship PP&E (Note 29)							
Liabilities (Note 10)							
Intragovernmental							
Accounts Payable	$ 12	$ 214	$ 53,777	$ -	$ 54,003	$ (53,470)	$ 533
Accrued Payroll and Benefits	2	81	4	-	87	(1)	86
Other (Note 14)	-	1,057	503	-	1,560	(745)	815
Total Intragovernmental	$ 14	$ 1,352	$ 54,284	$ -	$ 55,650	$ (54,216)	$ 1,434
Accounts Payable	-	484	-	-	484	-	484
Entitlement Benefits Due and Payable (Note 11)	-	19,866	41,604	-	61,470	-	61,470
Accrued Grant Liability (Note 13)	740	2,335	-	866	3,941	-	3,941
Federal Employee and Veterans Benefits (Note 12)	5	8,353	10	-	8,368	-	8,368
Accrued Payroll and Benefits	10	656	51	1	718	-	718
Other (Note 14)	20	2,698	2,744	17	5,479	-	5,479
Total Liabilities	**$ 789**	**$ 35,744**	**$ 98,693**	**$ 884**	**$ 136,110**	**$ (54,216)**	**$ 81,894**
Net Position							
Unexpended Appropriations - earmarked funds	-	(91)	8,978	-	8,887	-	8,887
Unexpended Appropriations - other funds	5,861	58,799	-	14,170	78,830	-	78,830
Unexpended Appropriations, Total	5,861	58,708	8,978	14,170	87,717	-	87,717
Cumulative Results of Operations - earmarked funds	-	3,035	329,931	-	332,966	-	332,966
Cumulative Results of Operations - other funds	(29)	1,268	-	(9)	1,230	-	1,230
Cumulative Results of Operations, Total	(29)	4,303	329,931	(9)	334,196	-	334,196
Total Net Position	$ 5,832	$ 63,011	$ 338,909	$ 14,161	$ 421,913	$ -	$ 421,913
Total Liabilities and Net Position	**$ 6,621**	**$ 98,755**	**$ 437,602**	**$ 15,045**	**$ 558,023**	**$ (54,216)**	**$ 503,807**

Consolidating Balance Sheet by Operating Division
As of September 30, 2007
(In Millions)

	ACF	AoA	AHRQ	CDC	CMS	FDA	HRSA	IHS	NIH	OS	PSC	SAMHSA	Agency Consolidated Totals	Intra-HHS Eliminations	HHS Consolidated Totals
Assets (Note 2)															
Intragovernmental															
Fund Balance with Treasury (Note 3)	$ 21,091	$ 560	$ 26	$ 6,682	$ 39,005	$ 769	$ 5,407	$ 1,503	$ 31,184	$ 5,837	$ 100	$ 2,610	$ 114,774	$ -	$ 114,774
Investments, Net (Note 5)	-	-	-	-	363,195	-	2,639	-	41	-	-	-	365,875	-	365,875
Accounts Receivable, Net (Note 6)	13	-	131	91	484	7	69	36	-	426	269	95	1,621	(457)	1,164
Other (Note 9)	-	-	-	31	-	-	-	1	1	13	-	-	46	(3)	43
Total Intragovernmental	21,104	560	157	6,804	402,684	776	8,115	1,540	31,226	6,276	369	2,705	482,316	(460)	481,856
Accounts Receivable, Net (Note 6)	-	1	-	12	12,808	18	5	148	13	9	7	-	13,021	-	13,021
Cash and Other Monetary Assets (Note 4)	-	-	-	-	129	-	-	-	-	-	-	-	129	-	129
Inventory and Related Property, Net (Note 7)	-	-	-	684	-	1	-	5	7	2,458	6	-	3,161	-	3,161
General Property, Plant & Equipment, Net (Note 8)	1	-	-	1,141	424	313	-	904	2,149	130	2	-	5,064	-	5,064
Other (Note 9)	-	-	-	2	161	1	402	2	7	1	-	-	576	-	576
Total Assets	**$ 21,105**	**$ 561**	**$ 157**	**$ 8,643**	**$ 416,206**	**$ 1,109**	**$ 8,522**	**$ 2,599**	**$ 33,402**	**$ 8,874**	**$ 384**	**$ 2,705**	**$ 504,267**	**$ (460)**	**$ 503,807**
Stewardship PP&E (Note 29)															
Liabilities (Note 10)															
Intragovernmental															
Accounts Payable	$ 12	$ -	$ 106	$ -	$ 436	$ -	$ 59	$ 14	$ 5	$ (4)	$ -	$ 11	$ 639	$ (106)	$ 533
Accrued Payroll and Benefits	2	-	-	14	4	10	6	15	27	4	2	3	87	(1)	86
Other (Note 14)	-	-	23	81	530	10	98	173	84	6	3	160	1,168	(353)	815
Total Intragovernmental	$ 14	$ -	$ 129	$ 95	$ 970	$ 20	$ 163	$ 202	$ 116	$ 6	$ 5	$ 174	$ 1,894	$ (460)	$ 1,434
Accounts Payable	-	-	-	4	-	3	(6)	1	414	63	5	-	484	-	484
Entitlement Benefits Due and Payable (Note 11)	-	-	-	-	61,470	-	-	-	-	-	-	-	61,470	-	61,470
Accrued Grant Liability (Note 13)	1,507	99	12	288	-	-	392	15	1,552	38	-	38	3,941	-	3,941
Federal Employee and Veterans Benefits (Note 12)	4	1	1	39	11	24	25	76	59	19	8,094	15	8,368	-	8,368
Accrued Payroll and Benefits	10	1	3	103	55	83	10	81	316	42	7	7	718	-	718
Other (Note 14)	37	-	12	59	4,500	41	357	201	173	26	44	29	5,479	-	5,479
Total Liabilities	**$ 1,572**	**$ 101**	**$ 157**	**$ 588**	**$ 67,006**	**$ 171**	**$ 941**	**$ 576**	**$ 2,630**	**$ 194**	**$ 8,155**	**$ 263**	**$ 82,354**	**$ (460)**	**$ 81,894**
Net Position															
Unexpended Appropriations - earmarked funds	-	-	-	-	8,978	(98)	4	3	-	-	-	-	8,887	-	8,887
Unexpended Appropriations - other funds	19,570	461	1	6,397	9,889	(404)	4,437	1,538	28,503	5,935	32	2,471	78,830	-	78,830
Unexpended Appropriations, Total	19,570	461	1	6,397	18,867	(502)	4,441	1,541	28,503	5,935	32	2,471	87,717	-	87,717
Cumulative Results of Operations - earmarked funds	-	-	1	24	329,931	296	2,441	(3)	276	-	-	-	332,966	-	332,966
Cumulative Results of Operations - other funds	(37)	(1)	(2)	1,634	402	1,144	699	485	1,993	2,745	(7,803)	(29)	1,230	-	1,230
Cumulative Results of Operations, Total	(37)	(1)	(1)	1,658	330,333	1,440	3,140	482	2,269	2,745	(7,803)	(29)	334,196	-	334,196
Total Net Position	$ 19,533	$ 460	$ -	$ 8,055	$ 349,200	$ 938	$ 7,581	$ 2,023	$ 30,772	$ 8,680	$ (7,771)	$ 2,442	$ 421,913	$ -	$ 421,913
Total Liabilities and Net Position	**$ 21,105**	**$ 561**	**$ 157**	**$ 8,643**	**$ 416,206**	**$ 1,109**	**$ 8,522**	**$ 2,599**	**$ 33,402**	**$ 8,874**	**$ 384**	**$ 2,705**	**$ 504,267**	**$ (460)**	**$ 503,807**

Supplemental Statement of Net Cost

For the Year Ended September 30, 2007 and 2006
(In Millions)

Responsibility Segments	Agency Consolidated Totals	Inter-Agency Eliminations Costs (-)	Inter-Agency Eliminations Earned/Exchange Revenues (+) [1]	HHS Consolidated Totals
2007				
ACF	$ 47,330	$ (10)	$ 45	$ 47,365
AoA	1,372	(4)	3	1,371
AHRQ	6	(204)	13	(185)
CDC	7,899	(305)	117	7,711
CMS	561,938	(7)	176	562,107
FDA	1,461	(33)	95	1,523
HRSA	6,823	(66)	129	6,886
IHS	3,303	(31)	62	3,334
NIH	28,250	(124)	681	28,807
OS	1,853	(260)	174	1,767
PSC	1,204	(389)	24	839
SAMHSA	3,156	(120)	38	3,074
Net Cost of Operations	$ 664,595	$ (1,553)	$ 1,557	$ 664,599
2006				
ACF	$ 47,114	$ (13)	$ 64	$ 47,165
AoA	1,386	(4)	4	1,386
AHRQ	7	(308)	21	(280)
CDC	6,330	(305)	127	6,152
CMS	524,156	(6)	248	524,398
FDA	1,527	(30)	102	1,599
HRSA	6,041	(23)	162	6,180
IHS	3,259	(43)	59	3,275
NIH	27,852	(112)	710	28,450
OS	2,431	(397)	149	2,183
PSC	629	(388)	20	261
SAMHSA	3,209	(84)	43	3,168
Net Cost of Operations	$ 623,941	$ (1,713)	$ 1,709	$ 623,937

[1] Eliminations for non-exchange revenue are reported in the Statement of Changes in Net Position

Consolidating Statement of Net Cost by Budget Function

For the year Ended September 30, 2007

(In Millions)

Responsibility Segments:	Education, Training, & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra-HHS Eliminations Cost (-)	Intra-HHS Eliminations Revenue	HHS Consolidated Totals
ACF	$ 11,612	$ -	$ -	$ 35,718	$ 47,330	$ (10)	$ 45	$ 47,365
AoA	1,372	-	-	-	1,372	(4)	3	1,371
AHRQ	-	6	-	-	6	(204)	13	(185)
CDC	-	7,899	-	-	7,899	(305)	117	7,711
CMS	-	194,387	367,551	-	561,938	(7)	176	562,107
FDA	-	1,461	-	-	1,461	(33)	95	1,523
HRSA	-	6,823	-	-	6,823	(66)	129	6,886
IHS	-	3,303	-	-	3,303	(31)	62	3,334
NIH	-	28,250	-	-	28,250	(124)	681	28,807
OS	-	1,853	-	-	1,853	(260)	174	1,767
PSC	-	1,204	-	-	1,204	(389)	24	839
SAMHSA	-	3,156	-	-	3,156	(120)	38	3,074
Net Cost of Operations	**$ 12,984**	**$ 248,342**	**$ 367,551**	**$ 35,718**	**$ 664,595**	**$ (1,553)**	**$ 1,557**	**$ 664,599**

Gross Cost and Exchange Revenue

For Year Ended September 30, 2007
(In Millions)

Responsibility Segments	Intragovernmental						With the Public		HHS Consolidated Net Cost of Operations
	Gross Cost			Less: Exchange Revenue					
	Combined	Eliminations	Consolidated	Combined	Eliminations	Consolidated	Gross Cost	Less: Exchange Revenue	
ACF	$162	$(14)	$148	$19	$(49)	$(30)	$47,188	$1	$47,365
AoA	10	(4)	6	5	(3)	2	1,367	-	1,371
AHRQ	36	(204)	(168)	329	(13)	316	299	-	(185)
CDC	802	(305)	497	504	(117)	387	7,608	7	7,711
CMS	668	(7)	661	65	(176)	(111)	611,750	50,415	562,107
FDA	542	(33)	509	28	(95)	(67)	1,404	457	1,523
HRSA	387	(66)	321	116	(129)	(13)	6,576	24	6,886
IHS	328	(31)	297	146	(62)	84	3,953	832	3,334
NIH	3,874	(2,459)	1,415	2,588	(3,016)	(428)	27,074	110	28,807
OS	345	(280)	65	591	(194)	397	2,104	5	1,767
PSC	89	(389)	(300)	591	(24)	567	1,714	8	839
SAMHSA	157	(120)	37	284	(38)	246	3,283	-	3,074
Totals	$7,400	$(3,912)	$3,488	$5,266	$(3,916)	$1,350	$714,320	$51,859	$664,599

Management Report On Final Action October 1, 2006 - September 30, 2007

Background

The Inspector General Act Amendments of 1988 (P.L. 100-504) require Departments and Agencies to report to Congress on the actions they have taken and the amount of funds recovered or saved in response to the Office of Inspector General's (OIG) audit recommendations. This annual management report provides the status of OIG A-133 audit reports in the Department and summarizes the results of actions taken to implement OIG audit recommendations during the reporting period.

Departmental Findings

For the fiscal year covered by this report, the Department accomplished the following:

- Initiated action to recover $1,894,936,000 through collection, offset, or other means (see Table I);
- Completed action to recover $246,669,000 through collection, offset, or other means (see Table I);
- Initiated action to put to better use $1,000,645,000 (see Table II); and
- Completed action that over time will put to better use $1,024,261,000 (see Table II).

Departmental Conflict Resolution

In the event that HHS agencies and OIG staff cannot resolve differences on specific report recommendations, a conflict resolution mechanism is available. During FY 2007, there were no disagreements requiring the convening of the Conflict Resolution Council.

Status of Audits in the Department

In general, HHS Agencies follow up on OIG recommendations effectively and within regulatory time limits. The HHS Agencies usually reach a management decision within the 6-month period that is prescribed by P.L. 100-504 and OMB Circular A-50, *Audit Follow-up*. For the most part, they also complete their final actions on OIG reports, including collecting disallowed costs and carrying out corrective action plans, within a reasonable amount of time. However, the Department continues to monitor this area to improve procedures and ensure compliance with corrective action plans.

The HHS Process

Four Key Elements to the HHS Audit Resolution and Follow-up Process

- The HHS Agencies have a lead responsibility for implementation and follow-up on most OIG and independent auditor recommendations;
- The Assistant Secretary for Resources and Technology establishes policy and monitors HHS Agencies' compliance with audit follow-up requirements;
- The audit resolution process includes the ability to appeal disallowances administratively under such programs as Head Start, Foster Care and Medicaid pursuant to the Departmental Grant Appeals Board's regulations in 45 C.F.R. Part 16; and
- If necessary, the Assistant Secretary for Resources and Technology or the Deputy Secretary resolves conflicts between the HHS Agencies and the OIG.

Report on Final Action Tables

The following tables summarize the Department's actions in collecting disallowed costs and implementing recommendations to put funds to better use. Disallowed costs are those costs that are challenged because of a violation of law, regulation, grant term or condition, etc. Funds to be put to better use relate to those costs associated with cost avoidances, budget savings, etc. The tables are set up according to the requirements of Section 106(b) of *P.L. 100-504*.

TABLE I
Management Action on Costs Disallowed in OIG Reports
As of September 30, 2007
(in thousands)

	Number	Disallowed Costs
A. Reports for which final action had not been taken by the commencement of the reporting period. See Note 1.	280	$607,270
B. Reports on which management decisions were made during the reporting period. See Note 2.	329	$1,894,936
Subtotal (A+B)	609	$2,501,306
C. Reports for which final action was taken during the reporting period:		
i. The dollar value of disallowed costs were recovered through collection, offset, property in lieu of cash, or otherwise.	273	$246,669
ii. The dollar value of disallowed costs that were written off by management.	2	$784
Subtotal (i+ii)	275	$247,453
D. Reports for which no final action has been taken by the end of the reporting period. See Note 3.	334	$2,253,853

Notes:

1. Includes adjustments of amended disallowance and disallowance excluded from the previous reporting period.
2. Represents the amount of management concurrence with the OIG's recommendations. For this fiscal year, the OIG's reconciliation with the HHS Agencies showed a variance that represents the two organizations having different cut-off dates.
3. In addition to current unresolved cases, this figure includes the list of audits over 1 year old with outstanding balances to be collected, audits under administrative or judicial appeal, and audits under a current collection schedule.

TABLE II
Management Action on OIG Reports
with Recommendations That Funds Be Put to Better Use
As of September 30, 2007
(in thousands)

	Number	Disallowed Costs
A. Reports for which final action had not been taken by the commencement of the reporting period. See Note 1.	9	$26,402
B. Reports on which management decisions were made during the reporting period.	23	$1,000,645
Subtotal (A+B)	32	$1,027,047
C. Reports for which final action was taken during the reporting period:		
i. The dollar value of recommendations that were actually completed based on management action or legislative action.	23	$1,024,261
ii. The dollar value of recommendations that management has subsequently concluded should not or could not be implemented or completed.	0	$0
Subtotal (i+ii)	23	$1,024,261
D. Reports for which no final action has been taken by the end of the reporting period. See Note 3.	9	$2,786

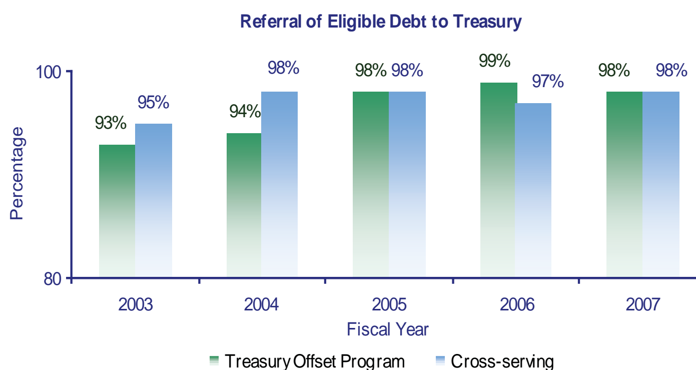
Notes:

1. Includes adjustments of amended disallowances and disallowances excluded from the previous reporting period.

Other Required Reporting

Debt Collection Improvement Act

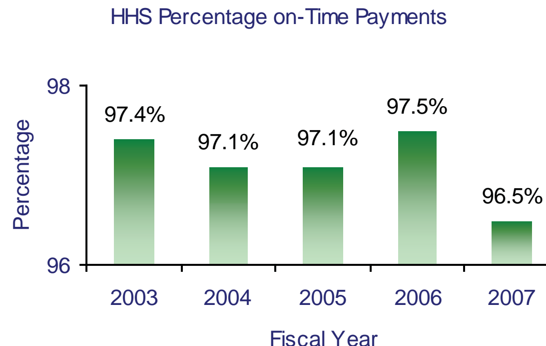
HHS manages its delinquent debt pursuant to the Debt Collection Improvement Act of 1996. The Department refers delinquent debt to the Department of the Treasury (Treasury) for cross-servicing and offset. HHS's debt referral process is centralized through its delinquent debt collection center at the Program Support Center. Treasury granted a cross-servicing exemption for several types of program debts (e.g., Medicare Secondary Payer and various health professional loans). These debts are cross-serviced by the PSC, who also refers them to the Treasury Offset Program.



HHS referral rates at the end of the third quarter FY 2007 were: 98 percent of debt eligible for referral was referred to the Treasury Offset Program and 98 percent of debt eligible for referral was cross-serviced. HHS collections exceeded $21.2 billion at the end of the third quarter FY 2007. (Year-end figures will not be available before November 15.)

Prompt Payment Act

The Prompt Pay Act requires Federal agencies to make timely vendor payments and to pay interest penalties when payments are late. HHS has maintained a timely payment rate above 95% for the last five years. HHS' prompt pay rate for FY 2007 was 96.46%.



Federal Civil Penalties Inflation Adjustment Act

Civil monetary penalties are non-criminal penalties for violation of Federal law. The Federal Civil Penalties Inflation Adjustment Act of 1990 mandates periodic evaluation to ensure that the penalties maintain their deterrent value and are properly accounted for and collected. During FY 2006, only the Centers for Medicare and Medicaid Services and the Food and Drug Administration imposed civil monetary penalties.

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Glossary

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GLOSSARY OF TERMS USED IN REPORT	
ACF	Administration for Children and Families
ADD	Attention Deficit Disorder
AHM	American Healthcare Management
AHRQ	Agency for Healthcare Research and Quality
AIDS	Acquired Immunodeficiency Syndrome
AMP	Average Manufacturer Price
AoA	Administration on Aging
ASAM	Assistant Secretary for Management and Administration
ASP	Average Sale Price
ASPR	Assistant Secretary for Preparedness and Response
ATSDR	Agency for Toxic Substances and Disease Registry
AWP	Average Wholesale Price
BBA	Balanced Budget Act of 1997
BIMO	Bioresearch Monitoring
CARE	Comprehensive AIDS Resources Emergency
CCDF	Child Care Development Fund
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CERT	Comprehensive Error Rate Testing
CFR	Code of Federal Regulations
CIA	Corporate Integrity Agreement
CMP	Civil Monetary Penalties
CMS	Centers for Medicare & Medicaid Services
CMSO	Center for Medicaid and State Operations
COLA	Cost of Living Adjustment
CoP	Conditions of Participation
COTS	Commercial-off-the-shelf
CPI	Consumer Price Index

GLOSSARY OF TERMS USED IN REPORT	
CPIM	Consumer Price Index Medical
CSRS	Civil Service Retirement System
CY	Calendar Year (or Current Year in IPIA Tables)
DAEO	Designated Agency Ethics Officer
DC	District of Columbia
DECs	Deputy Ethics Counselors
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DMERC	Durable Medical Equipment Regional
DOJ	Department of Justice
DOL	Department of Labor
DRA	Deficit Reduction Act
DSH	Disproportionate Share Hospital
EBDP	Entitlement Benefits Due and Payable
ERRP	Error Rate Reduction Plan
e-Gov	Electronic Government
EPA	Environmental Protection Agency
FASAB	Federal Accounting Standards Advisory Board
FBWT	Fund Balance with Treasury
FCRA	Federal Credit Reform Act
FDA	Food and Drug Administration
FECA	Federal Employees' Compensation Act
FERS	Federal Employees Retirement System
FFMIA	Federal Financial Management Improvement Act of 1996
FFS	Fee-for-Service
FI	Fiscal Intermediary
FICA	Federal Insurance Contribution Act

GLOSSARY OF TERMS USED IN REPORT	
FISMA	Federal Information Security Management Act of 2002
FMFIA	Federal Managers' Financial Integrity Act of 1982
FUL	Federal Upper Limit
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	U.S. Government Accountability Office
GDP	Gross Domestic Product
GPRA	Government Performance and Results Act of 1993
GSA	General Services Administration
HEAL	Health Education Assistance Loans
HEW	Department of Health, Education and Welfare (now HHS)
HHS	Department of Health and Human Services
HI	Hospital Insurance
HIE	Health Information Exchange
HIGLAS	Healthcare Integrated General Ledger Accounting System
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIV	Human Immunodeficiency Virus
HPMP	Hospital Payment Monitoring Program
HSP/BIMO	Human Subject Protection/Bioresearch Monitoring
HRSA	Health Resources and Services Administration
IBNR	Incurred But Not Reported
IG	Inspector General
IGT	Intergovernmental Transfers
IHS	Indian Health Service
IP	Improper Payment
IPIA	Improper Payments Information Act
IT	Information Technology
J3	Jurisdiction 3

GLOSSARY OF TERMS USED IN REPORT	
LLP	Limited Liability Partnership
MA	Medicare Advantage
MACs	Medicare Administrative Contractors
MC	Managed Care
MEDIC	Medicare Drug Integrity Contractor
MITA	Medicaid Information Technology Architecture
MK	Non-Marketable Market Based
MMA	Medicare Prescription Drug, Improvement and Modernization Act 0f 2003
MPDB	Medicare Prescription Drug Benefit
N/A	Not Applicable
NCI	National Cancer Institute
NHIN	National Health Information Network
NIH	National Institutes of Health
NRS	National Reporting System
OACT	Office of the Actuary
OGE	Office of Government Ethics
OHRP	Office of Human Research Protection
OIG	Office of Inspector General
OMB	Office of Management and Budget
ONC	Office of the National Coordinator (for Health Information Technology)
OnePI	One Program Integrity System Integrator
OPD	Orphan Products Development
OPDIV	Operating Division
OS	Office of the Secretary
PAHPA	Pandemic and All-Hazards Preparedness Act
PAM	Payment Accuracy Measurement
PAR	Performance and Accountability Report

GLOSSARY OF TERMS USED IN REPORT	
PARIS	Public Assistance Reporting Information System
PART	Program Assessment Rating Tool
PDP	Prescription Drug Plan
PERM	Payment Error Rate Measurement
PHIN	Public Health Information Network
PHS	Public Health Service
P.L.	Public Law
PMA	President's Management Agenda
PMCs	Postmarketing Study Commitments
PMS	Payment Management System
PNS	Projects of National Significance
PP&E	Property, Plant and Equipment
PPS	Prospective Payment System
PRRB	Provider Reimbursement Review Board
PSC	Program Support Center
PSCD	Payment System Calculation Discrepancies
PUR	Period Under Review
PwC	PricewaterhouseCoopers
PY	Prior Year
QIO	Quality Improvement Organization
R&D	Research and Development
RACs	Recovery Audit Contractors
RDS	Retiree Drug Subsidy
RRB	Railroad Retirement Board
RSI	Required Supplementary Information
RSSI	Required Supplementary Stewardship Information
SAMHSA	Substance Abuse and Mental Health Services Administration
SAS	Statement of Auditing Standards

GLOSSARY OF TERMS USED IN REPORT	
SBR	Statement of Budgetary Resources
SCHIP	State Children's Health Insurance Program
SECA	Self-Employment Contribution Act of 1954
SFFAS	Statement of Federal Accounting Standards
SIU	Special Investigations Unit
SMI	Supplementary Medical Insurance
SOSI	Statement of Social Insurance
SSA	Social Security Administration
TANF	Temporary Assistance for Needy Families
Treasury	Department of the Treasury
TrOOP	True Out-of-Pocket (cost)
TROR	Treasury Report on Receivables
UFMS	Unified Financial Management System
UPL	Upper Payment Limit
US	United States
VICP	Vaccine Injury Compensation Program
WAC	Wholesale Acquisition Cost