Department of Health and Human Services

FY 2008 Agency Financial Report

November 17, 2008

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GLOSSARY

INTRODUCTION

Purpose of This Report

The Department of Health and Human Services' fiscal year (FY) *2008 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, 2007 through September 30, 2008. 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 (OMB) Circular A-136, *Financial Reporting Requirements*.

How This Report is Organized

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

Section I: Management's Discussion and Analysis contains information on the Department's mission and organizational structure; strategic goals and highlights of our accomplishments; the 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 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 includes the Office of Inspector General's Summary of Top Management Challenges; the Department's response to challenges identified by the Office of Inspector General; 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 appreciate any suggestions for improving this report for our readers. Please contact us at hhsdeputycfo@hhs.gov or at:

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Office of Finance/DFMP
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200 Independence Avenue, SW
Washington, DC 20201

MESSAGE FROM THE SECRETARY


Michael O. Leavitt

The Department of Health and Human Services has made tremendous strides in our efforts to protect the health of all Americans and to provide essential human services, especially for those who are least able to help themselves. We achieved significant progress in a number of program areas during FY 2008 to accomplish our mission, and I am proud to submit our progress and accomplishments in this year's *Agency Financial Report*. Several of our programs have produced significant accomplishments that support the improvement of the health and well-being of Americans. These accomplishments are evident in the many health care, research programs, and services we provide.

Access to Health Care

Healthy and productive individuals, families, and communities are the foundation of our Nation's future. We support the health and well-being of people throughout the world through improving access to health services**.**

In the past year, we improved access to health care through several of our program efforts. We funded transformation grants to test changes designed to improve the efficiency, economy, and quality of health care provided by Medicaid. We implemented more efficient and economical ways of delivering high quality care in many States. We collaborated with the U.S. Department of Veterans Affairs in a joint effort to provide essential consumer-directed home and community-based services to older Americans and veterans. This historic initiative provides more people, including our Nation's veterans, with improved long-term care options. We continued access to care for the Nation's low-income, underserved, and medically vulnerable populations through the Health Centers program. This program has experienced substantial growth, specifically in the areas of mental health, substance abuse services, and pharmacy services.

Enhancing the Health, Safety, and Well-Being of People

Our combined efforts to enhance the health, safety, and well-being of people helped fulfill our vision for a healthier, safer, and more hopeful America. We began implementing the Nationwide Health Information Network, which will create a secure foundation for basic health information exchange. This work will advance the Nation toward most Americans having access to secure electronic health records. We continued to mobilize resources to protect the Nation's food supply, to enhance the safety of imported products, to raise awareness about the importance of long-term care planning, and to develop faster, low-cost influenza tests. We continued to make strides in HIV/AIDS outreach. We also focused on pandemic preparedness by reaching out to partners across the globe and by developing faster influenza diagnostic tests within our own Nation.

Stewardship

The Department's second year of participation in the *Performance and Accountability Report* pilot, as defined in the Office of Management and Budget's Circular A-136, *Financial Reporting Requirements*, provides more transparent and enhanced financial and performance reporting. The pilot includes our *FY 2008 Agency Financial Report; Annual Performance Report; Budget, Performance, and Financial Snapshot*; and *Citizens' Report*. Today, we are issuing our *Agency Financial Report*; we will issue our *Budget, Performance, and Financial Snapshot* on December 15, 2008, and our *Annual Performance Report* and *Citizens' Report* on January 15, 2009. These reports will be available on our website at www.hhs.gov by these dates.

For the tenth consecutive year, we obtained an unqualified or "clean" audit opinion, provided by our independent accountants Ernst & Young LLP, on our 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 made significant progress toward providing decision-makers with reliable, timely information. The Department's managers used the financial information presented in this report to improve the quality and effectiveness of services to the American people. The financial and performance data presented in this report are reliable, complete, and provide the latest data available.

As required by the *Federal Managers' Financial Integrity Act* and Office of Management and Budget Circular A-123, *Management's Responsibility for Internal Control*, the Department 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 Reporting Systems and Processes, and (2) Information Systems Control and Security. These weaknesses also constitute system non-conformances under Section 4 of the *Federal Managers' Financial Integrity Act*. Sections I and III of this report provide further detailed information concerning corrective actions the Department is taking to remediate these weaknesses.

Looking to the Future

The Statement of Social Insurance included in this document shows a future obligation of over $50 trillion for Medicare benefits based on the current law. However, as indicated in Note 29 of our Financial Statements, if Congress were to set future physician payment updates at the Medicare Economic Index, absent other Congressional actions, this obligation would increase by $4.2 trillion.

As we look to the future, we must remember that healthy and productive individuals, families, and communities support the foundation of the Nation's present and future. HHS will continue to focus on our priorities such as access to health coverage, insurance for the neediest children, value-driven health care, information technology, personalized health care, health diplomacy, prevention, and preparedness. We have accomplished much in the past few years. With the continued dedication and commitment of our employees and partners, I am confident that the Department will continue enhancing the health and well-being of every American.

Michael O. Leavitt

November 17, 2008

Handwritten Note: P.S. In my capacity as a Trustee of the Medicare Trust Fund, I want to draw special attention to this point (arrows pointing to the lines "a future obligation of over $50 trillion" and "if Congress were to set future physician payment updates at the Medicare Economic Index, absent other Congressional actions, this obligation would increase by $4.2 trillion.") . Every American needs to understand the urgency of the need to take action to reverse this unsustainable trend.

Section I: Management's Discussion and Analysis

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AGENCY FINANCIAL REPORT ACKNOWLEDGEMENT

The Department of Health and Human Services chose to participate for the second year in the *Performance and Accountability Report* pilot, as defined in the Office of Management and Budget's Circular A-136, *Financial Reporting Requirements*. We believe this format provides the reader and decision-makers more transparent and enhanced financial and performance reporting. The Department produced an alternative to the consolidated *Performance and Accountability Report* called an *Agency Financial Report*. The Department will prepare its *FY 2008 Budget, Performance, and Financial Snapshot* by December 15, 2008 and its *FY 2008 Annual Performance Report* and a *Citizens' Report*, which will be available on our website www.hhs.gov no later than January 15, 2009.

MISSION AND ORGANIZATIONAL STRUCTURE

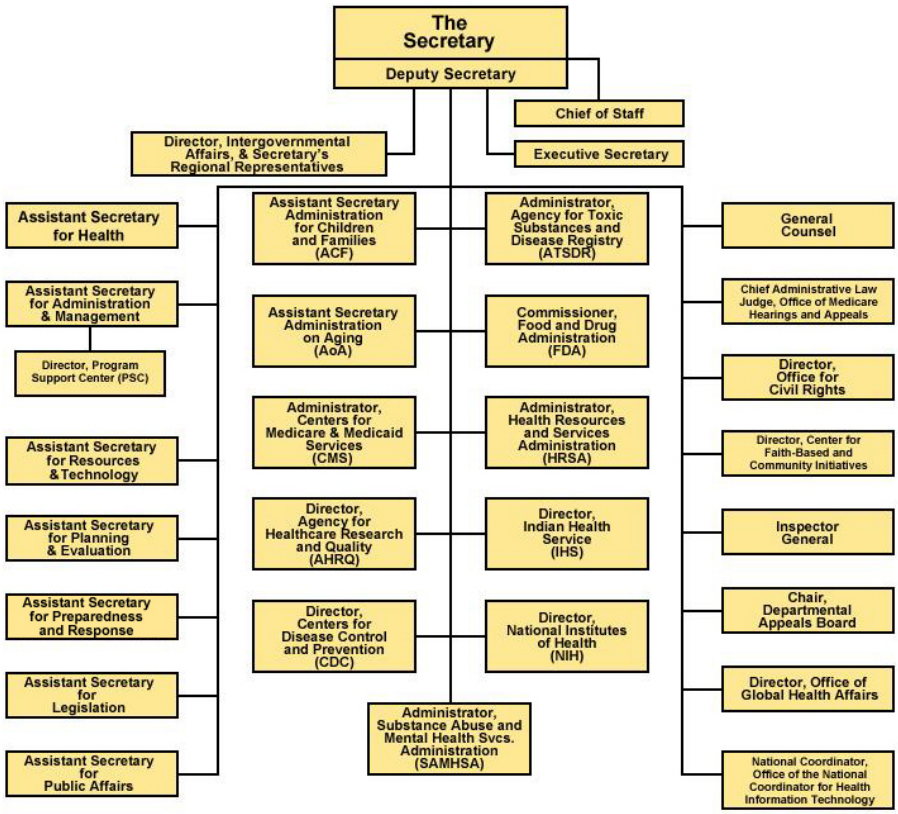
Mission

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.

The Department's number one priority is to protect the health of all Americans and to 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. To the right is a depiction of the Department's organizational chart. The Department is composed of 11 operating components and 15 staff divisions that support the component agencies and the Department as a composite entity. Further details concerning each major Departmental component's role in accomplishment of the overall mission and strategic goals are presented in the following pages.



STRATEGIC GOALS

We strive for continuous improvement to enhance the health and well-being of Americans. We achieve our vision for a healthier and more hopeful America 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. Our FY 2008 budget of $716 billion represented almost a quarter of all Federal expenditures. In addition, we administer more grant dollars than all other Federal agencies combined.

Our four strategic goals relate to each of our components. Primary responsibility for these efforts by component is included in the table on the next page. The *FY 2007-2012 Strategic Plan*, available at www.hhs.gov/strategic_plan, articulates the strategic goals designed to accomplish our mission.

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

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

Goal 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.

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 below shows the Department's components, their missions, and the strategic goal(s) to which they are major contributors.

Department Components' Relationship to Strategic Goals

Component	Component Mission	Health Care	Public Health	Human Services	Scientific Research & Development	Budget Function
ACF	*To promote the economic and social well-being of families, children, individuals, and communities.*			✓		ETSS IS
AHRQ	*To support, conduct, and disseminate research that improves access to care and the outcomes, quality, cost, and utilization of health care services.*	✓	✓		✓	H
AOA	*To promote the dignity and independence of older people, and to help society prepare for an aging population.*	✓		✓		ETSS
ATSDR (component of CDC)	*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.*		✓		✓	H
CDC	*To promote health and quality of life by preventing and controlling disease, injury, and disability.*	✓	✓	✓	✓	H
CMS	*To ensure effective, up-to-date health care coverage and to provide quality care for beneficiaries.*	✓		✓		H M
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.*	✓	✓		✓	H
HRSA	*To provide the National leadership, program resources, and services needed to improve access to culturally competent, quality health care.*	✓	✓	✓		H
IHS	*To raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.*	✓	✓		✓	H
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.*	✓	✓	✓	✓	H
SAMHSA	*To build resilience and facilitate recovery for people with or at risk for substance abuse and mental illness.*	✓	✓	✓		ETSS IS

Budget Functions: ETSS= Education, Training & Social Services; H=Health; IS=Income Security; M=Medicare

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. 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. As a major grant-making agency, outside parties, partnership efforts with State and local governments, and private organizations influence our outcomes. We publicly report our progress toward achievement of our mission and strategic goals by featuring nearly 700 program-specific performance measures at www.ExpectMore.gov. More than half of these measures track *outcomes* – for example, the adoption rate for children involved in the Child Welfare System. A fifth of our performance measures track the *efficiency* with which we provide our services, reflecting our goal of getting better value for each dollar spent. Each year, we set performance targets for all of our measures, and each year we publicly report on whether we met each of our performance targets. In 2007, HHS met or exceeded 71% of our performance targets. For this report, we are providing the latest information available. More detailed performance results will be published in our Citizens' Report and *Annual Performance Report*, available on January 15, 2009 at www.hhs.gov.

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. These accomplishments demonstrate progress toward the achievement of our mission and strategic goals. For a discussion of our financial and program challenges, please see Looking Ahead, included later in this Section.

Strategic Goal 1. Health Care.

Improvements to Medicaid. In FYs 2007 and 2008, CMS awarded $150 million to 35 States, the District of Columbia, and Puerto Rico to fund the research and design of transforming changes designed to improve Medicaid efficiency, economy, and quality of care. States are using the funds to implement innovative systems to achieve more value from dollars spent providing health care to low-income citizens, including the elderly, disabled, and children. Innovative approaches used by grantees to reform and improve Medicaid programs include adopting health information technology, such as electronic health records and prescriptions. Additional innovative approaches include improving child health outcomes, strengthening and streamlining eligibility determination processes, and implementing state-of-the-art fraud and abuse detection systems. "These transformation grants express the core goal of this Administration to give States the kind of flexibility they need to deliver high quality care in an efficient and more economical way," Secretary Leavitt said.

Expanded Access to Health Care. We continued expansion of access to care for the Nation's low-income, underserved, and medically vulnerable populations through the Health Centers program operated by the Health Resources and Services Administration. During the past 40 years, the national network of Health Centers (comprised of community health centers, migrant health centers, health care for the homeless centers, and public housing primary care centers) grew substantially. Today, nearly 1,100 Health Center grantees operate approximately 7,000 service delivery sites across every State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin. About 52 percent of all Health Center grantees serve rural populations. In addition to primary health care, most Health Center sites offer access to oral health, mental health, substance abuse services, and pharmacy services.

> ***"People served by Health Centers are among the most vulnerable in America. By extending care of communities where none existed before, we are strengthening the Nation's health care safety net for those with no where to turn."***
> **Secretary Michael O. Leavitt**

The last 6 years have been a period of unprecedented growth in the Health Center system, fueled by President Bush's Health Center Growth initiative that began in 2001. Between 2001 and 2007, the number of patients treated at Health Centers grew by 5.8 million, representing an increase exceeding 50 percent. The number of patients served at Health Centers topped the 16 million in 2007.

About 64 percent of Health Center patients are racial or ethnic minorities. Of the total patient population served, about 90 percent have incomes at or below 200 percent of the Federal poverty level. Approximately 40 percent have no health insurance.

Improved Health Care Quality and Patient Safety. The *Patient Safety and Quality Improvement Act of 2005* authorized Patient Safety Organizations (PSOs). The law addresses an important barrier to improved patient safety faced by health care providers -- the fear of legal liability or sanctions that can result from discussing and analyzing patient safety events. In early 2008, we announced a proposed regulation that will establish PSOs to improve the quality and safety of health care for all Americans. PSOs may collect, aggregate, and analyze data from health care providers while maintaining confidentiality of patient information. The organizations provide feedback to help clinicians and health care organizations improve health care quality that allows for more consistent, voluntary reporting of patient safety events. Our Agency for Healthcare Research and Quality (AHRQ) will administer the rules for certifying or "listing" qualified PSOs; the Department's Office for Civil Rights (OCR) will be responsible for enforcing the confidentiality provisions of the laws and the final rule.

Electronic Health Records. As a major step toward the goal of access to secure, interoperable electronic health records, we announced a demonstration project conducted by the Centers for Medicare & Medicaid Services that will encourage small to medium-sized physician practices to adopt electronic health records (EHRs). The demonstration, which permits participation by up to 1,200 physician practices, will affect approximately 3.6 million consumers. Over a 5-year period that began in the spring of FY 2008, the program provides financial incentives to physician groups using certified EHRs to meet certain clinical quality measures. A bonus will be provided each year based on a physician group's score on a standardized survey. In June 2008, 12 communities were selected from a pool of 30 applicants to participate in the demonstration project. Further information is available at www.hhs.gov/secretary/connecthealthcare.

Nationwide Health Information Network. In conjunction with nine health information exchanges, we began trial implementations of the Nationwide Health Information Network (NHIN). This effort will create a secure foundation for basic health information exchange between select health information exchanges, which will enable functions that are more complex over time. This work will advance the Nation toward the President's goal of most Americans having access to secure electronic health records by 2014 by creating a secure foundation for health information exchange that can follow Americans throughout their lives. Participating contractors will collaborate to test and demonstrate the exchange of private and secure health information among providers, patients, and other health care stakeholders.

Ryan White HIV/AIDS Program Grants. Every year, the Ryan White HIV/AIDS Program, administered by the Health Resources and Services Administration, helps more than half a million people access the care and services they need to live longer, healthier lives. People living with HIV disease are, on average, poorer than the general population, and Ryan White HIV/AIDS Program clients are poorer still. The Ryan White HIV/AIDS Program is the payor of last resort for the uninsured, those who have inadequate insurance, and those who have no other source to cover the costs of care.

In 2008, the program awarded more than $2 billion in grants to public and private entities for primary medical care, support services, medications, health care provider training, and technical assistance to help address the needs of persons living with HIV/AIDS. More than $1 billion were awarded, under Part B of the authorizing legislation, to 59 States and territories to improve the availability, organization, and quality of HIV/AIDS health care and services. This included approximately $800 million to provide access to FDA-approved HIV-related medications through the AIDS Drug Assistance Program (ADAP), which is the Nation's prescription drug safety net for people living with HIV/AIDS. In 2006, ADAP served nearly 158,000 persons. Data on persons served in FY 2008 will not be available until early 2010. The HIV/AIDS program helps ensure that persons affected by HIV/AIDS have access to the care they need by strengthening community, city, and State capacities to care for those with HIV/AIDS.

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

Pandemic Influenza Vaccination. HHS and Homeland Security released guidance on allocating and targeting the pandemic influenza vaccine. The guidance provides a planning framework to help State, Tribal, local and community leaders ensure that vaccine allocation and use will reduce the effect of a pandemic on public health and minimize disruption to society and the economy. As part of developing the guidance, HHS held public engagement and stakeholder meetings and received more than 200 written public comments on the goals and objectives of pandemic vaccination. As a result, the guidance reflects four objectives: (1) protect persons critical to the pandemic response and who provide care for persons with pandemic illness; (2) protect persons who provide essential community services; (3) protect persons who are at high risk of infection because of their occupation; and (4) protect children. The ultimate goal of the pandemic vaccination program is to vaccinate every person in the United States who wants to be vaccinated.

Childhood Obesity Prevention Campaign. As part of CDC's long-term objective to reduce the rate of growth of adult obesity by FY 2014, we launched the new Childhood Overweight and Obesity Prevention Initiative. CDC's plans include (1) reduction of adults who engage in no leisure-time physical activity by nearly 3 percent and (2) slowing the annual rate of increase in obesity rates by nearly .5 percent by 2014. This initiative targets obesity prevention and the promotion of healthy weight for children. According to a CDC survey conducted from 2003 to 2004, the prevalence of overweight children has increased since 1980. For children aged 2-5 years, the prevalence increased from 5.0 percent to 13.9 percent; for those aged 6-11 years, prevalence increased from 6.5 percent to 18.8 percent; and for those aged 12-19 years, prevalence increased from 5.0 percent to 17.4 percent. Our officials and community stakeholders will develop and foster programs that support the goal of providing options for community-based interventions. The interventions include self-assessments and planning guides, activity and nutrition programs, diabetes prevention activities, using nutrition fact labels, and encouraging physical fitness.

Food Protection Plan. We launched a Food Protection Plan to bolster efforts to protect the Nation's food supply. The plan, found at www.fda.gov/oc/initiatives/advance/food/plan.html, uses science and a risk-based approach to ensure the safety of domestic and imported foods eaten by American consumers. It implements a strategy of prevention, intervention, and response to build safety into every step of the food supply chain. The basis of the plan is to prevent harm before it can occur, to intervene at key points in the food production system, and to respond immediately to problems as they occur. Within these three overarching areas of protection, the plan contains a number of action steps as well as a set of legislative proposals. Taken together, these efforts will provide a food protection framework that ensures that the U.S. food supply remains safe.

Import Safety. Last year, the United States imported more than $2 trillion worth of products. These products were brought to the United States by approximately 825,000 importers, through more than 300 ports of entry. All projections indicate that this volume will continue to rise sharply over the coming years as the scale and complexity of international trade multiplies. On July 1, 2008, the Interagency Import Safety Working Group, established by President Bush and chaired by Secretary Leavitt, released a new report, *Import Safety – Action Plan Update,* found at www.importsafety.gov. The report describes steps taken by the Federal government, the private sector, and international partners to bolster import safety. As an example, we began processes during FY 2008 to improve import safety practices, including taking strong enforcement actions, signing agreements with key trading partners, including bilateral and multilateral agreements, and sharing critical information shared on safety and best practices.

Improved Consumer Hospital Awareness. CMS posted new survey information at the Hospital Compare consumer website, found at www.hospitalcompare.hhs.gov offering consumers information about the hospitals in their communities, including information about Medicare benefits for elective procedures. For the first time, consumers have the information needed to make effective decisions about the quality and value of health care available through local hospitals, such as patient satisfaction surveys and pricing for specific procedures.

HIV/AIDS Outreach. A gateway to all Federal domestic HIV /AIDS information and resources, found at www.AIDS.gov, now has an innovative look and feel that incorporates a blog, podcasts, and other new media tools. The website focuses on using interactive forms of communication in the fight against HIV/AIDS. In addition, website visitors can listen to and view a monthly podcast series, which feature a government official talking about topics affecting the lives of people living with, or at risk for, HIV/AIDS. Many HHS agencies collaborate to make AIDS.gov a user-friendly, accessible, and helpful source of information. Non-HHS partners include the Department of Housing and Urban Development, the Department of Veterans Affairs, the White House Office of National AIDS Policy, and the Department of State's Office of the U.S. Global AIDS Coordinator. The site includes the latest HIV/AIDS news, basic HIV/AIDS information, information on prevention, education, treatment, and care resources.

Hurricane Relief Efforts. We activated more than 1,600 agency personnel to assist Gulf States in preparing for and responding to Hurricane Ike and to assist with recovery from Hurricane Gustav. Among those personnel activated were more than 550 U.S. Public Health Service Commissioned Corps officers. In preparation for Hurricane Ike in Texas, teams evacuated patients from health care facilities and moved medical and pharmacy supplies into place to support the medical needs of affected communities. While augmenting hospital emergency room staffs in Louisiana, HHS medical teams treated more than 1,300 patients affected by Hurricane Gustav. In addition, post-hurricane efforts included providing prescription drug and durable medical equipment assistance for uninsured hurricane victims. In conjunction with these efforts, Secretary Leavitt announced the implementation of the Disaster Case Management demonstration program (ACF) to make it easier for disaster victims to obtain a wide range of assistance and social services. "This program is intended to provide fast, one-stop shopping for those who need help. Our goal is a coordinated system that links disaster victims with a single contact who will help them determine what help they need, who provides it, and how to get it," Secretary Leavitt said.

Public Health and Medical Emergencies. We provided nearly $1.1 billion to continue assisting public health departments, hospitals, and other health care organizations in strengthening their ability to respond to public health and medical emergencies caused by a terrorist attack or naturally occurring event. Two separate but interrelated cooperative agreements funded the awards. The Centers for Disease Control and Prevention (CDC) provided $.7 billion to upgrade public health departments' preparedness and response to public health emergencies, including terrorist events, pandemic influenza, and other natural emergencies. In addition, we awarded $.4 billion to improve the readiness of hospitals and other health care organizations.

Strategic Goal 3. Human Services.

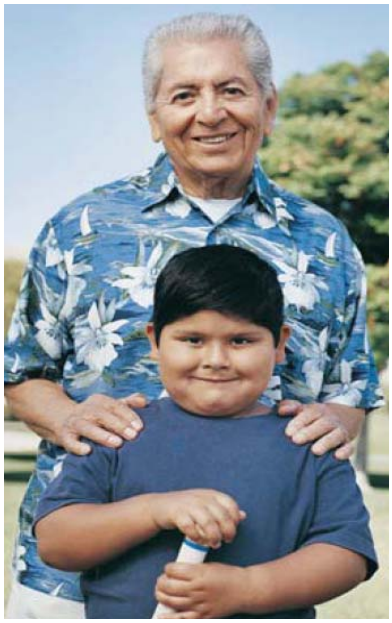
Compassion Capital Fund. We provided $47.6 million in grant awards through the Compassion Capital Fund (CCF). CCF awards helped 168 faith-based and community organizations enhance their ability to provide social services to those most in need. The goal of the fund is to serve the poor among us in the most effective way possible. As the signature initiative of the community renewal agenda, the CCF increases our ability to help more people gain control of their lives.

> ***"Our goal is to serve the poor among us in the most effective way possible. By supporting grass-roots organizations already serving those in need in their communities, we are increasing our ability to help more people gain control of their lives."***
> **Secretary Michael O. Leavitt**

Energy Assistance. We released $2.6 billion in energy assistance to help eligible low-income household meet home energy costs. The

Low Income Home Energy Assistance Program funds provide States with heating assistance for the winter months. This assistance will help ensure the safety of those individuals most in need, including children, the elderly, and the disabled.

Helping Older Americans and Veterans Remain Independent. HHS announced $36 million in new grant programs to 28 States to help older Americans and veterans remain independent and to support people with Alzheimer's disease to remain in their homes and communities. Just over $19 million of this funding involves a new collaboration with the Department of Veterans Affairs (VA). HHS Secretary Leavitt and VA Secretary Peake, announced the joint effort to provide essential consumer-directed home and community-based services to older Americans and veterans of all ages, as part of a Nursing Home Diversion grants program. The new initiative builds on the similar missions of HHS and the VA with regard to caring for the populations they serve. In announcing the collaboration, Secretary Leavitt said, "This historic HHS-VA initiative combines the expertise of the HHS' national network of aging services providers with the resources of the Veterans Health Administration to provide more people, including our Nation's veterans, with improved long-term care options. Through this joint program, many people who would have been placed in nursing homes will be able to remain at home."



Mentoring Children of Prisoners Program. Approximately 2 million children have at least one parent in a correctional facility. In 2007, we awarded $45.6 million in grant funding supporting 220 mentoring programs. The voucher segment of the Mentoring Children of Prisoners program was established to expand access to mentoring services nationwide. On July 16, 2008, the Mentoring Children of Prisoners Program made 100,000 matches, thus achieving the President's goal for the program. To date, there have been more than 107,000 matches. The first vouchers for mentoring services for children of prisoners have been issued through the Mentoring Children of Prisoners Program. In the first year of the demonstration, 3,008 vouchers were redeemed throughout the Nation, exceeding the goal of 3,000. In the second year, $10 million has been authorized which will allow 8,000 vouchers to be provided. In the final year of the project, $15 million will provide at least 13,000 vouchers to families of children of prisoners.

Long-Term Care. We continued to increase the public's awareness about the importance of long-term care planning through the "Own Your Future" initiative. This initiative, administered by our Centers for Medicare & Medicaid Services, Administration on Aging, and Office of the Assistant Secretary for Planning and Evaluation, will help Americans take an active role in planning for their future long-term care needs. Approximately 13 million Americans needed long-term care in 2000. This number is expected to grow substantially in the next 30 years as the population ages. The Bureau of the Census estimates that the percentage of the population 65 and older will rise from 12.6 percent in 2000 to 20.5 percent in 2040, and the percentage of the population aged 85 and older will rise from 1.6 percent in 2000 to 3.8 percent in 2040. These demographic changes point to a predictable increase in demand for long-term care services.

Strategic Goal 4. Scientific Research and Development.

Development of Faster Influenza Diagnostic Tests. We awarded $12.9 million for the development of low-cost influenza tests that can detect and differentiate seasonal human influenza viruses from avian influenza within 3 hours. Currently, the process for testing for avian influenza A (H5N1) can take up to 24 hours. These awards will support advanced development of laboratory influenza tests. These tests, performed in a hospital or a commercial laboratory setting, expedite the diagnosis for large numbers of patients. The expanded testing capability enhances the hospital laboratory-based pandemic and seasonal

flu diagnostic capacity in the United States. Using a molecular biology technique, these tests use a device to detect flu virus and differentiate between seasonal and novel influenza.

Coronary Heart Disease Prevention. This year, about 450,000 Americans will die of coronary heart disease -- the leading cause of death for both men and women. New results from three studies provide the strongest evidence to date that a simple blood test for high-sensitivity C-reactive protein (hsCRP) is a useful marker for cardiovascular disease. These studies expand our understanding of the role of inflammation in detecting early signs of cardiovascular disease and identifying adults who are at risk for heart attack or stroke. The findings from these studies will be part of the rigorous scientific review to distill the scientific evidence and generate an evidence-based, comprehensive, set of clinical guidelines for primary care practitioners to help adult patients reduce their risk for cardiovascular disease.

PRESIDENT'S MANAGEMENT AGENDA

The President's Management Agenda articulates the Administration's strategy "for improving the management and performance of government." We develop and implement action plans to achieve pre-defined goals related to these initiatives, and are publicly accountable for achieving established goals. The Administration evaluates our status and progress toward achieving established goals through quarterly scorecards that employ a simple grading system of green for success, yellow for mixed results, and red for unsatisfactory results. 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 or improving performance. Overall, as of September 2008, we achieved green progress ratings for all of our initiatives, signifying our commitment to and progress towards achieving the President's Management Agenda goals. We achieved green status ratings for 3 of 9 initiatives. It is noteworthy that we improved our status for 2 of 9 initiatives, the Performance Improvement and Health Information initiatives. We also improved our progress for the E-Government, Performance Improvement, and Faith-Based and Community initiatives.

In FY 2008, key Department financial managers launched an unprecedented approach to improving financial performance. This approach consisted of a Department-wide effort to correct financial processes that ultimately lead to solid financial management. The success of this approach set the stage for the Department's Chief Financial Officer (CFO) community to develop a *CFO Community Strategic Plan*. This plan provides the foundation for the improvement of our financial performance and charts our course for the future.

A comparison of our September 2008 Scorecard results to our September 2007 results is presented below.

		September 30, 2007		September 30, 2008	
Initiative Type	**Target Area**	**Status**	**Progress**	**Status**	**Progress**
Government-wide	Strategic Management of Human Capital	G	G	Y ↓	G
	Commercial Services Management	G	G	G	G
	Financial Performance	R	G	R	G
	E-Government	Y	Y	Y	G ↑
	Performance Improvement	R	Y	G ↑	G ↑
Program	Eliminating Improper Payments	Y	G	Y	G
	Faith-Based and Community Initiative	G	Y	G	G ↑
	Real Property Asset Management	Y	G	Y	G
	Health Information	R	G	Y ↑	G

Green G Successful Results

Yellow Y Mixed Results

Red R Unsatisfactory Results

↑ Performance Improvement

↓ Performance Decline

ANALYSIS OF FINANCIAL STATEMENTS AND STEWARDSHIP INFORMATION

For the tenth consecutive year, HHS obtained 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 Ernst & Young LLP under the direction of the Department's Inspector General. The *Chief Financial Officers Act* requires preparation and audit of these statements, which 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, and net position. The Consolidated Balance Sheet presents a snapshot of our financial condition as of September 30, 2008, compared to FY 2007, 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 2004	FY 2005	FY 2006	FY 2007	FY 2008	Increase (Decrease)	% Change
Total Assets	**$403.8**	**$428.5**	**$513.9**	**$503.8**	**$529.3**	**$25.5**	**5.1%**
Fund Balance with Treasury	$ 97.7	$99.6	$159.9	$114.8	$124.3	$9.5	8.3%
Investments, Net	$287.9	$300.7	$342.0	$365.9	$385.4	$19.5	5.3%
Other Assets	$18.2	$28.2	$12.0	$23.1	$19.6	$(3.5)	(15.2)%
Total Liabilities	**$66.8**	**$71.0**	**$78.4**	**$81.9**	**$86.6**	**$4.7**	**5.7%**
Accounts Payable	$1.4	$1.1	$1.2	$1.0	$1.0	$0.0	0%
Entitlement Benefits Due and Payable	$49.2	$53.8	$61.2	$61.5	$65.9	$4.4	7.2%
Accrued Grant Liabilities	$3.8	$3.8	$3.8	$3.9	$3.9	$0.0	0%
Federal Employee & Veterans Benefits	$7.2	$7.2	$7.5	$8.4	$8.8	$0.4	4.8%
Other Liabilities	$5.2	$5.1	$4.7	$7.1	$7.0	$(0.1)	(1.4)%
Net Position	**$337.0**	**$357.5**	**$435.5**	**$421.9**	**$442.7**	**$20.8**	**4.9%**
Total Liabilities and Net Position	**$403.8**	**$428.5**	**$513.9**	**$503.8**	**$529.3**	**$25.5**	**5.1%**

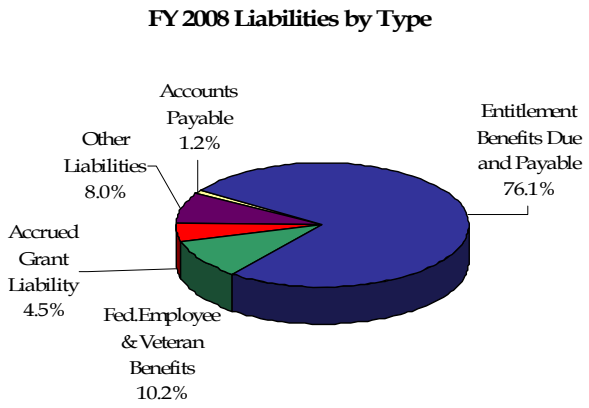
Assets—What Do We Own and Manage?

Assets represent the amounts that we own or manage. Our assets were $529.3 billion on September 30, 2008. This represents an increase of $25.5 billion (5.1%) above the prior year's assets. This increase is largely attributable to the net effect of an increase of $9.5 billion in Fund Balance with Treasury and an increase of $19.5 billion in Net Investments, offset by a decrease in Medicare Accounts Receivable of $6.5 billion that relates to Medicare Part D. The Fund Balance with Treasury increase of $9.5 billion resulted primarily from increases of $3.5 billion in Supplementary Medical Insurance (SMI) and $7.0 billion in various HHS appropriations. The majority of the $19.5 billion increase in Net Investments resulted from growth in the Medicare Trust Fund's SMI of $20.0 billion, offset by a decrease in Health Insurance (HI) of $0.8 billion. The majority of the SMI increase relates to a $18.9 billion increase in investments in bonds. Separate trust funds hold assets not currently needed to pay Medicare benefits and related expenses. We invest these funds in U.S. Treasury securities.

Fund Balance with Treasury and Net Investments together comprise 96.3 percent of total assets. The remaining assets (3.7%) consist of Accounts Receivable, Cash and Other Monetary Assets, Inventory and Related Property, General Property, Plant, and Equipment, and Other Assets.

Liabilities – What Do We Owe?

Our liabilities, amounts that we owe from past transactions or events, were $86.6 billion at the end of September 30, 2008. This represents an increase of $4.7 billion, or 5.7 percent above the prior year's liabilities. Entitlement benefits due and payable to the public from the Medicare and Medicaid insurance programs represent 76.1 percent of the liabilities. Of the $4.4 billion increase in FY 2008 entitlements, $3.3 billion related to the Medicare program and $1.0 billion related to the Medicaid program. Consistent with Federal accounting standards, we recognize the responsibility for future program participants of Medicare as a social insurance program, rather than a pension program. Accordingly, we have not recognized a liability for future payments to current and future program participants. The estimated long-term cost is included in the Statement of Social Insurance in Section II.

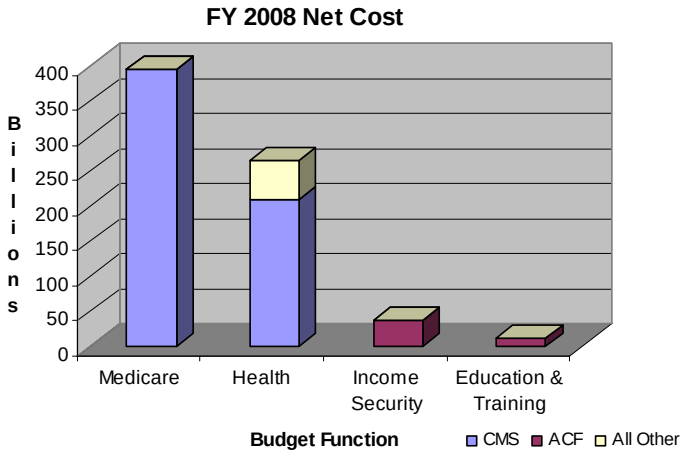


Ending Net Position—What Have We Done over Time?

Our net Position represents the difference between assets and liabilities. Changes to our net position resulted from changes that occur within cumulative results of operations and unexpended appropriations. At the end of FY 2008, our net position was $442.7 billion, an increase of $20.8 billion (4.9 percent) from the previous year. This was due to the net effect of an increase of $15.0 billion in cumulative results of operations and an increase of $5.8 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 revenues. 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 for the year ended September 30, 2008 totalled $709.1 billion. The chart at the right depicts HHS' FY 2008 net cost of operations by major budget function and component. The majority of our FY 2008 net costs relate to Medicare ($395.1 billion) and Health ($264.2 billion) programs, or nearly 93 percent of our annual costs. The table below depicts our net cost of operations by component for the last 5 years. The FY 2008 net cost represents an increase of $44.5 billion



or 6.7 percent more than the FY 2007 net cost. Approximately 85 percent of the increase relates to Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and other health programs managed by the Centers for Medicare & Medicaid Services.

NET COST OF OPERATIONS *(Dollars in Billions)*	2004	2005	2006	2007	2008	Chg	% Chg
Responsibility Segments							
Centers for Medicare & Medicaid Services (CMS) Gross Cost	$483.6	$521.7	$574.2	$ 612.4	$657.9	$45.5	7.4%
CMS Exchange Revenue	(32.0)	(38.1)	(49.8)	(50.3)	(54.0)	(3.7)	7.4%
CMS Net Cost of Operations	$451.6	$483.6	$524.4	$562.1	$603.9	$41.8	7.4%
Other Segments:							
Other Segments Gross Cost of Operations	$97.8	$100.3	$102.2	$105.4	$108.3	$2.9	2.8%
Exchange Revenue	(2.2)	(2.6)	(2.7)	(2.9)	(3.1)	.2	6.9%
Other Segments Net Cost of Operations	$95.6	$97.7	$99.5	$102.5	$105.2	$2.7	2.6%
Net Cost of Operations	**$547.2**	**$581.3**	**$623.9**	**$664.6**	**$709.1**	**$44.5**	**6.7%**

Budget Resources – What Were Our Resources and the 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 $1,033.3 billion for FY 2008 represented an increase of $51.9 billion, or 5.3 percent, over FY 2007. FY 2008 obligations of $998.8 billion increased $42.2 billion, or 4.4 percent, over FY 2007. Resources at year-end were $34.4 billion, of which $8.1 billion were not available for expenditure. Total net outlays of $701.0 billion, cash disbursed for the Department's obligations, increased $29.1 billion (4.3 percent) from FY 2007 net outlays.

Social Insurance

The Statement of Social Insurance is presented as a principal 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 formulae 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

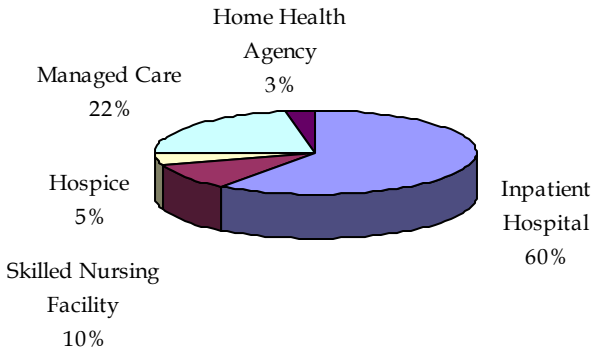
Medicare is a combination of four programs: HI, SMI, Medicare Advantage, and Medicare Prescription Drug Benefit. At the end of FY 2008, approximately $382.5 billion or 99.2 percent of HHS investments were in U.S. Treasury securities to support the Medicare trust funds. Established in 1965 as Title XVIII 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. Since 1966, Medicare enrollment has increased from 19 million to approximately 45 million beneficiaries.

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

Hospital Insurance

Hospital Insurance, or Medicare Part A, usually is available 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, financed primarily by payroll taxes paid by workers and employers, pays for in-patient hospital, skilled nursing home, home health, hospice care, and managed care. The annual payroll taxes fund benefits for current beneficiaries. The Hospital Insurance Trust Fund invests in U.S. Treasury securities for funds not currently needed to pay benefits and related expenses.

HI Medicare Benefit Payments



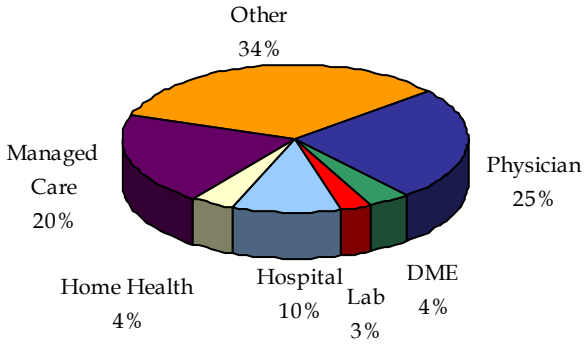
Based on estimates from the Mid-Session Review of the *FY 2009 President's Budget*, inpatient hospital spending accounted for 60 percent of HI benefit outlays. Managed care spending comprised 22 percent of total HI outlays. During FY 2008, HI benefit outlays grew by 6.3 percent and projections indicate an estimated increase in the HI benefit outlays per enrollee of 4.5 percent, or $4,890.

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 nearly $12,737 billion ($12.7 trillion) over the 75-year projection period, as compared to $12,292 billion ($12.3 trillion) in the FY 2007 financial report. To bring the HI Trust Fund into actuarial balance over the next 75 years, very substantial increases in revenues and/or reductions to benefits will 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 93 percent of Hospital Insurance enrollees elect to enroll in Supplementary Medical Insurance.

SMI Medicare Benefit Payments



Source: CMS/OACT

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.

Based on estimates from the Mid-Session Review of the *FY 2009 President's Budget*, SMI benefit outlays grew by 3.7 percent during FY 2008. Physician services, the largest component of SMI, accounted for 25 percent of SMI benefit outlays. During FY 2008, projections indicate an estimated increase of 2.2 percent, or $5,600 in the SMI benefit outlays per enrollee.

As reported in the Required Supplementary Information section of this report, 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. The projected future expenditures for Part B will be $21,197 billion ($21.2 trillion), or $3.0 trillion more than the FY 2007 projection. The projected future expenditures for Part D will be $9,964 billion ($10.0 trillion), or $.8 billion less than the FY 2007 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. The Trustees' estimates assume 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 INTERNAL CONTROLS

The Department's overall goals for our 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 previously identified in audits, evaluations, and assessments of our financial management controls, systems, and processes.

The cornerstone to improving our management practices is the ability to maintain financial management systems, processes, and controls that ensure accountability; provide useful management information; and meet requirements of Federal laws, regulations, and guidance. We seek to comply with Federal financial management systems requirements, including the:

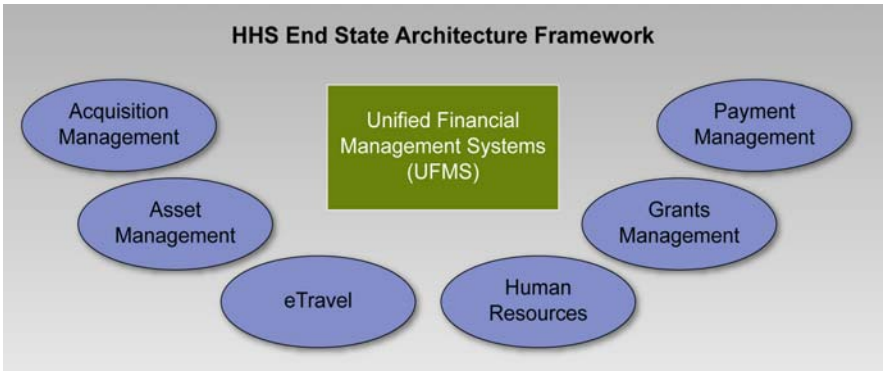
- *Federal Managers' Financial Integrity Act*
- *Chief Financial Officers Act*
- *Government Management Reform Act*
- *Federal Financial Management Improvement Act* (and OMB Circular A-127, *Financial Management Systems*)
- *Information Technology Management Reform Act* and the *Federal Acquisition Reform Act,* which were combined to become the *Clinger-Cohen Act*
- *Federal Information Security Management Act*

This section provides an overview of the Department's current key systems and our implementation of the Unified Financial Management System (UFMS).

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 requires a unified approach for enhancing financial management performance by eliminating duplication, streamlining processes, producing consolidated reports, and establishing a common information technology infrastructure across the enterprise.

A fully implemented financial management system is a requirement for a green status rating for the President's Management Agenda initiative "Improved Financial Performance." The diagram below shows how our systems framework will appear when the UFMS and its related systems projects are fully implemented:



Our new financial system replaces various legacy accounting systems with one modern accounting system with three major components: The Healthcare Integrated General Ledger Accounting System supports the Centers for Medicare & Medicaid Services; the National Institutes of Health Business System supports the

National Institutes of Health; and UFMS serves the rest of the Department. The core of these three components is a Financial Systems Integration Office (FSIO) federally certified commercial off-the-shelf financial management system.

The UFMS implementation was completed in the first quarter of FY 2008 when the Indian Health Service went live in a production environment. The National Institutes of Health Business System has been deploying modules since 2004 and will continue to deploy the E-Travel module, scheduled for completion in 2009. The Healthcare Integrated General Ledger Accounting System will be implemented in 2012. Full implementation of these three systems will facilitate integration for our consolidated reporting and greatly enhances the goal of achieving a Department-wide concept.

Statement of Auditing Standards (SAS) 70 Systems Reviews

Independent examinations of HHS internal controls are completed annually. The auditors completed their examinations for the Department's service providers for FY 2008 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 2008, independent accountants performed SAS-70 examinations on the Program Support Center's Payment Management System and the National Institutes of Health's Center for Information Technology service organizations for periods from July 1, 2007 to June 30, 2008. 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 access and change controls noted by the examiners. The Department is developing and implementing plans to address deficiencies identified in these examinations.

Legal Compliance

Anti-Deficiency Act

As discussed in our FY 2007 report, the Department discovered *Anti-Deficiency Act* violations in a program managed by one of its components. These violations occurred over a period of several prior fiscal years and the amounts relating to these violations were not material to any year's financial statements. During FY 2008, the Department discovered a potential *Anti-Deficiency Act* violation in a program managed by another component. The Department is continuing to investigate and is committed to resolving this matter appropriately and complying with all aspects of the *Anti-Deficiency Act*.

To prevent future violations, we have provided significant training throughout the Department related to funds control. We plan to finalize and issue shortly HHS-wide policy to improve internal controls related to requirements of the *Anti-Deficiency Act*.

Internal 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 (OMB) Circular A-123, *Management's Responsibility for Internal Control*, dated December 21, 2004. These objectives are to ensure (1) effective and efficient operations; (2) compliance with applicable laws and regulations; and (3) reliable financial reporting.

As required by OMB Circular A-123, *Management's Responsibility for Internal Control*, HHS has evaluated its internal 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 Reporting Systems and Processes
2. Information System Controls and Security

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 OMB Circular A-123, *Management's Responsibility for Internal Control*. Based on the results of this evaluation, HHS identified one material weakness in its internal control over the effectiveness and efficiency of operations under Section 2 of FMFIA relating to the Department's information systems controls and security, which also constitutes a non-conformance under Section 4 of FMFIA as of September 30, 2008. 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, 2008, 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 OMB Circular A-123, *Management's Responsibility for Internal Control*. Based on the results of this assessment, HHS identified one material weakness in its internal control over financial reporting as of June 30, 2008, relating to the Department's financial reporting systems and processes, which 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, 2008, 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

Table I

Summary of Material Weaknesses and System Non-conformances

	FMFIA Section 2			FMFIA Section 4
Control Area	Operations (As of 9/30/2008)	Compliance (As of 9/30/2008)	Financial Reporting (As of 6/30/2008)	Non-Conformance
Financial Reporting Systems and Processes	–	–	X	X
Information System Controls and Security	X	–	–	X

Financial Reporting Systems and Processes

HHS' financial management systems are not in substantial compliance with the requirements of the *Federal Financial Management Improvement Act* (FFMIA) because they do not yet fully comply with the Federal financial management systems requirements of OMB 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 reporting systems and processes for producing financial statements. While progress has been made over the last few years, the lack of a 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, significant adjustments to reported balances, and numerous accounting entries recorded outside the general ledger system are necessary to produce the consolidated financial statements. We completed the UFMS implementation for all of our components and we are in the process of integrating the component reporting into a consolidated reporting system. The consolidated reporting system will also include the National Institutes of Health Business System and the Healthcare Integrated General Ledger Accounting System.

Information System Controls and Security

HHS acknowledges internal control weaknesses for system security, including general and application controls in our financial management systems. Although no one financial management system had a material weakness, the pervasive nature of the findings across the Department leads management to ascertain that these findings warrant classification as a material weakness. The financial management systems are not yet in conformance with the appropriate legal and regulatory guidelines as established by the appropriate governing bodies with respect to overall system security. Due to the sensitive nature of information security controls, detailed findings and corrective actions are submitted separately through governance of the *Financial Information Security Information Act* (FISMA).

Table II

Corrective Action Plan and Impact of Material Weaknesses

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

Material Weakness and Corrective Action Plan	Corrective Action Date	Impact of Material Weakness on Financial Statements
(1) Financial Reporting Systems and Processes	FY 2011	Through significant manual effort and controls, the risk of misstating the Financial Statements is mitigated.
(2) Information System Controls and Security	FY 2009	Sufficient compensating controls exist through manual efforts that the risk of misstating the Financial Statements is mitigated.

OTHER MANAGEMENT INFORMATION AND INITIATIVES

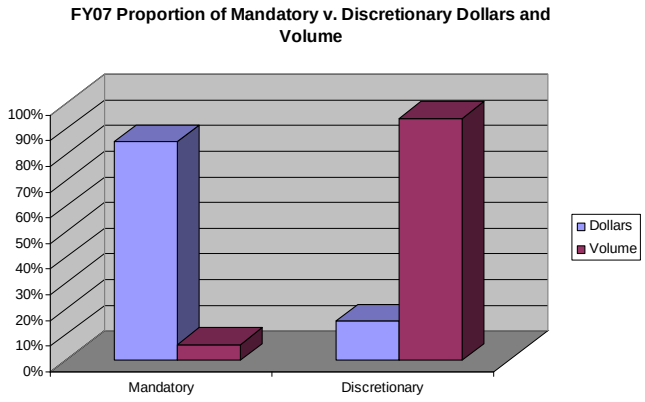
Grants Management

HHS is the principal U.S. government agency for protecting the health of all Americans and providing essential human services to those in need. As the largest Federal agency, the Nation's largest health insurer, and the largest grant-making agency, HHS represents almost a quarter of all Federal outlays and administers more grant dollars than all other Federal agencies combined. HHS manages an array 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 76,100 grants totaling more than $273 billion in FY 2007. Collectively these programs are the Department's primary means to achieve its strategic goals and objectives, described in the Department's *FY 2007-2012 Strategic Plan*, available at www.hhs.gov/strategic_plan

To achieve these goals, HHS forms partnerships with other Federal departments; State, local, and Tribal governments; academic institutions; hospitals; the business community; nonprofit and volunteer organizations including faith-based and community-based organizations; and foreign countries and international organizations. The primary vehicle used in these partnerships is a grant. Grants are financial assistance awards that provide support or stimulation to accomplish a public purpose authorized by Federal statute. The primary beneficiary under a grant or cooperative agreement is the public, as opposed to the government.

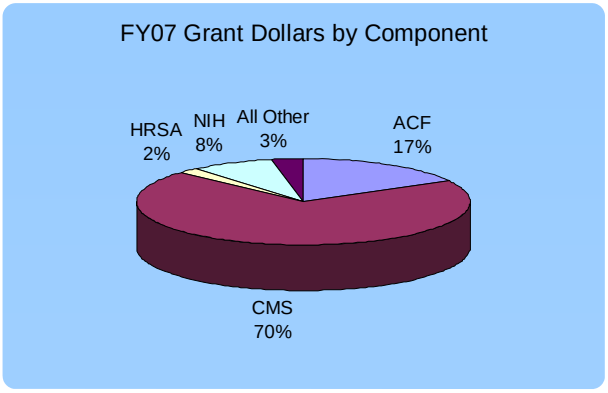
Over the last year, the Office of Grants has implemented a grants forecast system for announcing potential areas to be funded through grants, thereby assisting applicants in their yearly planning. Supporting these efforts is the Tracking Accountability in Government Grants System (TAGGS), a comprehensive Department-wide database with full search capabilities (www.taggs.hhs.gov) for all awards, including grants and cooperative agreements. The TAGGS program also gathers agency data for the *Federal Funding Accountability and Transparency Act* and forwards that data to the national program system. We continue to serve as the managing partner for www.grants.gov, which is the Federal Government's central storehouse for information on more than 1,000 grant programs and access to approximately $400 billion in annual awards.

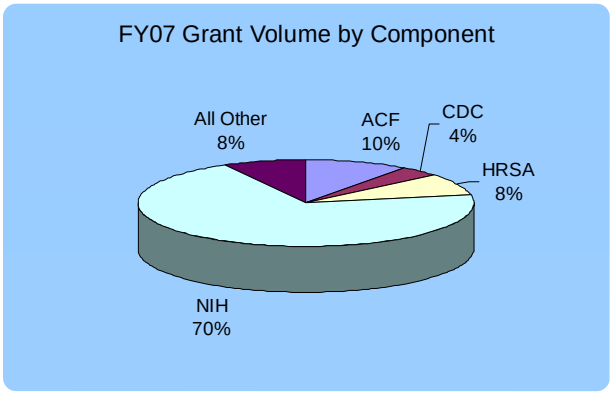
We manage two types of grants: mandatory and discretionary. Mandatory programs are those that a Federal agency is required by statute to award if the eligible recipient submits an application that meets the program requirements. Discretionary grants permit the Federal Government, according to specific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



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 (85 percent of total dollars awarded).

The majority of our total FY 2007 grant dollars were awarded by the Centers for Medicare & Medicaid Services (70 percent) and the Administration for Children and Families (17 percent). By volume, the National Institutes of Health awarded 70 percent of the grants, while the Administration for Children and Families awarded 10 percent.





LOOKING AHEAD TO 2009—DEPARTMENT'S MANAGEMENT CHALLENGES AND HIGH-RISK AREAS

Financial Management Challenges

We are the largest Federal agency in the U.S. government. Our budget of approximately $700 billion represents almost a quarter of all Federal expenditures. We are one of the largest financial organizations in the world; our total Net Cost of Operations is almost double the revenues of the largest *Fortune 500* companies. The sheer magnitude and size, combined with the diverse nature of our operating components, constantly challenges our efforts to standardize and improve financial management across the Department. We have found that a cohesive, coordinated, and unified approach makes these challenges less difficult to overcome.

Internal Control Corrective Action Plans

In FY 2008, key Department financial managers addressed this challenge by creating and implementing an unprecedented approach to correct critical financial management control deficiencies by focusing on 18 critical corrective actions related to the FY 2007 audit findings. The design of this approach utilized the knowledge and expertise of financial managers across the organization. This process involved the development of cross-functional teams led by members of the Department's Chief Financial Officer (CFO) community who were accountable to selected Senior Executives for achieving results. While much work remains, we made significant progress towards resolving long-standing control weaknesses during FY 2008 and expect to use this approach to strengthen controls in the years ahead.

The success of this approach was not solely the improvement of key business processes, but the resulting collaboration within and among the CFO community to design, develop, and implement Department-wide solutions and policies. Throughout this process, the informal network of financial management professionals evolved into a collaborative CFO community that shares challenges, strengths, and successes to drive results throughout HHS.

Strategic Planning

This process also achieved a paradigm shift in the way the CFO Community works together to solve Departmental challenges, which resulted in the development of a *CFO Community Strategic Plan* to chart a course for the future. Rather than executing a traditional strategic planning exercise to develop individual, component-specific plans, the HHS CFO community came together with an integrated perspective to build the foundation of a "strategic thinking" culture across the Department.

This strategic planning process resulted in the following guiding principles for the future of the CFO community:

- Conduct business in a cross-organizational, collaborative and transparent manner.
- Implement the strategic course for the future as outlined in the *CFO Community Strategic Plan*.
- Revisit the *CFO Community Strategic Plan* on a regular basis to ensure applicability to short-and-long-term issues.
- Promote the value of financial accountability in supporting HHS' mission.

As we carry out our efforts to promote and improve financial accountability, compliance, and manage risk across HHS, this collaboration provides a solid foundation for progress. Coming together as a community ensures a balanced achievement of our distinct organizational goals with a coordinated pursuit of fostering financial management excellence throughout HHS.

Program Challenges

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 effective stewardship of the taxpayer's resources, the Department is committed to efforts to make improvements related to these challenges.

In recent years, we made significant strides to improve the lives of Americans through the efforts of all our components. Breakthroughs in health information technology 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 improved and reformed programs, resulting in streamlined eligibility processes. We expanded access to health care for America's low-income, underserved, and medical vulnerable populations, with unprecedented growth in the health care center system. Between 2001 and 2007, the number of patients treated grew by more than 50 percent, with over 16 million patients served in 2007.

While we made great progress, we must continue our current efforts to sustain positive outcomes and augment them with new, innovative strategies to continue to improve the Nation's health and well-being. Below is a *Summary of Top Management Challenges Identified by the Inspector General*. The full text of the Inspector General's assessment and HHS management's response to the Inspector General's top management challenges are presented in Section III, Other Accompanying Information. Additionally, Section III includes further information concerning our efforts and actions to resolve Office of Inspector General audit findings in the FY 2008 *Management's Report on Final Action*.

Summary of Top Management Challenges Identified by the Inspector General

1. Oversight of Medicare Part D	2. Integrity of Medicare Payments	3. Appropriateness of Medicaid and SCHIP Payments
The *Medicare Prescription Drug, Improvement, and Modernization Act (P.L. 108-173)* established Medicare Part D, a voluntary outpatient prescription drug benefit made available to all Medicare beneficiaries. Challenges include: • Limited oversight of Part D program • Internal controls to ensure payment accuracy and program safeguards to prevent and detect fraud, waste, and abuse • Inaccurate bids by plan sponsors resulting in higher subsidies and premiums • Access to drugs and accurate information	Due to the size and scope of the Medicare program, errors in payment can quickly add up to billions of dollars in losses to the Trust Fund and to taxpayers. Challenges include: • Minimizing inappropriate payments • Holding accountable unscrupulous providers who defraud the program • Closing loopholes being exploited • Examining payment and pricing methods to ensure that Medicare, its beneficiaries, and taxpayers realize value for program expenditures	Medicaid is a joint Federal-State program that provides medical assistance to Americans with low incomes or disabilities. The State Children's Health Insurance Program (SCHIP) provides coverage to uninsured low-income children who do not qualify for Medicaid. Challenges include: • Coordination between multiple Federal and State entities with oversight and enforcement responsibilities (CMS, OIG, State Medicaid agencies, State Medicaid Fraud Control Units). • Oversight due to shared responsibilities and diversity between programs (size, structure, and administration)

4. Quality of Care	5. Public Health and Medical Emergency Preparedness	6. Oversight of Food, Drug, and Medical Device Safety
Ensuring the quality of care provided to beneficiaries of Federal health care programs is a high priority. Challenges include: • Ensuring that resources are not improperly diverted from patient care, and preventing providers from withholding needed care or rendering unnecessary or even harmful services • Examining factors that may affect care, including incentives stemming from the structure of reimbursement systems; the effectiveness of oversight and enforcement mechanisms, including survey and certification systems; and the mechanisms used to screen potential health care employees	The ability to effectively prepare for and respond to a public health emergency requires planning, coordination, and communication across a wide range of entities that includes Federal agencies; States, localities, and tribal organizations; the private sector; individuals and families; and international partners. Challenges include: • Unprecedented coordination demands on HHS, the Federal agency responsible for managing the Nation's health response in the event of a disaster • Need for HHS leadership to develop a comprehensive National public health infrastructure that can rapidly and capably respond to "all hazards" in public health emergencies	The Food and Drug Administration ensures the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, food supply, cosmetics, and products that emit radiation. The National Institutes of Health acquires knowledge to help prevent, diagnose, and treat disease and disability. Challenges include: • Adequacy and effectiveness of policies and programs that protect the food supply, ensure the safety of drugs, biologics, and medical devices, and protect human research subjects • Fraudulent marketing activities by drug and device manufacturers (kickbacks and promotion of unapproved drugs or drug usage)

7. Grants Management	8. Integrity of Information Technology Systems and the Implementation of Health Information Technology	9. Ethics Program Oversight and Enforcement
HHS is the largest grant-awarding Federal agency; our 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. Challenges include: • Limited oversight because performance responsibility and management of a grant rest primarily with the grantee, with little or no Government involvement in the funded activity • Vulnerabilities stemming from limited oversight are compounded by the limited experience of many HHS grantees • Ensuring that grant monies are used for their intended purposes and are overseen efficiently and effectively	HHS must ensure the integrity of information systems and a new health information technology infrastructure. Challenges include: • Ensuring confidentiality, integrity, and reliability of critical data that support operations • Adequacy of internal controls over HHS information systems and security • Ensuring reliability, confidentiality, privacy, and security when exchanging, storing, and using electronic health information	OIG is involved in oversight of our ethics program. OIG's activities range from evaluating agency ethics programs to investigating allegations of criminal ethics violations by current and former HHS employees. OIG's activities related to ethics issues have increased steadily since 2005. Challenges include: • Ethics considerations in grants management and research and regulatory oversight management challenges • Ensuring that Federal employees are not compromised by conflicts of interest when performing their official duties (employees cannot participate in official matters in which they and related parties have a financial interest) • Conflict-of-interest issues related to non-Federal entities and participants in our programs (grantees, clinical investigators, contractors)