Section II: Financial Reports

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MESSAGE FROM THE CHIEF FINANCIAL OFFICER

As the Chief Financial Officer (CFO) of the Department of Health and Human Services (HHS), I recognize we are 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 an annual budget in excess of $845 billion in fiscal year (FY) 2010, we are one of the largest, most complex financial organizations in the world. Through collaboration, our CFO community manages financial accountability, compliance, and risk across HHS by maximizing resources to drive results.

This *Agency Financial Report* represents our accountability report for FY 2010. We will issue the *FY 2010 Annual Performance Report, the Congressional Budget Justification*, and the *Summary of Performance and Financial Information* in February 2011. During FY 2010, the Department successfully sustained its standards for reporting and management controls. We have improved our reporting processes and successfully performed our fourth annual, more rigorous 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.

During FY 2010, we continued in our role as stewards of the public trust. This year we obtained a clean opinion on our Consolidated Balance Sheet, Statement of Net Cost, Statement of Changes in Net Position, and the Combined Statement of Budgetary Resources. However, the auditors did not express an opinion on the Statement of Social Insurance, which is developed using information from the annual report of the Medicare trust funds. The FY 2010 Statement of Social Insurance projections contained in this report incorporate the effects of the *Affordable Care Act*, and are prepared in accordance with the standards issued by the Federal Accounting Standards Advisory Board and reflect current law. Please refer to the auditor's reports, the financial statements, and notes contained in Section II of this *Agency Financial Report*.

The FY 2010 independent auditors' report on controls identifies two internal control material weaknesses that must be corrected relating to: (1) financial reporting systems, analyses, and oversight, and (2) financial management information systems. The Department recognizes the importance of effective internal control and is committed to resolving these material weaknesses promptly. During FY 2011, we plan to continue our collaborative efforts to improve our financial management and to further enhance information available through the implementation of a consolidated reporting solution.

With respect to our financial reporting capabilities, the Department continues to convert Medicare contractor systems and fully implement our consolidated reporting system, which will substantially comply with the *Federal Financial Management Improvement Act (FFMIA)* in early FY 2011. During FY 2010, our CFO executives throughout the Department worked together as a community to provide the public with transparent information concerning our continued implementation of the *American Recovery and Reinvestment Act of 2009* and first year of implementation of the *Affordable Care Act of 2010*. While work remains, we are committed towards resolving long-standing issues to strengthen our internal control structure. Many of these improvements resulted from our strong commitment to accountability, transparency, and effective stewardship.

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 2011.

/Ellen G. Murray/

Ellen G. Murray
Assistant Secretary for Financial Resources, and
Chief Financial Officer
November 15, 2010

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AUDIT REPORTS

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

NOV 15 2010

TO: The Secretary
Through: DS _____
COS _____
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FROM: Inspector General

SUBJECT: Report on the Financial Statement Audit of the Department of Health & Human Services for Fiscal Year 2010 (A-17-10-00001)

This memorandum transmits the independent auditors' reports on the Department of Health & Human Services (HHS) fiscal year (FY) 2010 financial statements, conclusions about the effectiveness of internal controls, and compliance with laws and regulations. The Chief Financial Officers Act of 1990 (P.L. No. 101-576), as amended, requires the Office of Inspector General (OIG) or an independent external auditor, as determined by OIG, to audit the HHS financial statements in accordance with applicable standards.

We contracted with the independent certified public accounting firm of Ernst & Young, LLP (E&Y), to audit the HHS consolidated balance sheet as of September 30, 2010, 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 I, 2010. 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, as amended, *Audit Requirements for Federal Financial Statements*.

Results of Independent Audit

Based on its audit, E&Y found that the FY 2010 HHS consolidated balance sheet and the related consolidated statements of net cost and changes in net position and the combined statement of budgetary resources were fairly presented, in all material respects in conformity with accounting principles generally accepted in the United States of America. E&Y was unable to determine whether the statement of social insurance was fairly presented because of the uncertainties reported by the Chief Actuary in the *2010 Annual Report of The Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. E&Y also noted two 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, Analyses, and Oversight* - HHS's financial management systems are not compliant with the Federal Financial Management Improvement Act (FFMIA.) of 1996. More specifically, the FFMIA requires Federal agencies to have an integrated financial management system that provides effective and efficient interrelationships among software, hardware, personnel, procedures, controls, and data contained within the systems and compliance with the United States Standard General Ledger at the transaction level and applicable Federal accounting standards. HHS's lack of an integrated financial management system continues to impair its ability to support and analyze account balances reported. Because of continued weaknesses in the financial management systems, management must compensate for the weaknesses by implementing and strengthening additional controls to ensure that errors and irregularities are detected in a timely manner. Review of internal controls disclosed a series of weaknesses that impact HHS's ability to report accurate financial information on a timely basis. For example, the audit found that HHS did not have adequate controls in place to monitor undelivered orders which represent remaining amounts of obligated funds that had not been delivered or appropriately deobligated. As of September 30, 2010, the audit identified approximately 102,500 transactions totaling an approximate $1.8 billion that were more than 2 year s old without activity. Additionally, during FY 2010, OIG, the Office of General Counsel, and management from HHS and the operating divisions completed reviews of various multiyear contracts and found contracts reviewed were funded inconsistent with the legal requirements.

- *Financial Information Systems* - Issues in the design and the operation of key controls in both general and application controls were noted. In particular, weaknesses were identified in information security program and application configuration management. For example, external and internal system vulnerabilities such as weak password configurations, insecure system configuration, and unnecessary system services continue to exist and pose a significant risk, and change management procedures were insufficient to ensure that only properly authorized changes were implemented into production systems. In addition, audit log monitoring and contingency management were identified as deficiencies that warrant attention.

Evaluation and Monitoring of Audit Performance

In accordance with the requirements of OMB Bulletin 07-04, we reviewed E&Y'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:

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- 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.

E&Y is responsible for the attached reports dated November 15, 2010, and the conclusions expressed in those reports. Our review, as differentiated from an audit in accordance with U.S. generally accepted government auditing standards, was not intended to enable us to express, and accordingly we do not express, an opinion on HHS's financial statements, the effectiveness of internal controls, whether HHS's financial management systems substantially complied with the FFMIA, or compliance with laws and regulations. However, our monitoring review, as limited to the procedures listed above, disclosed no instances in which E&Y 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 George M. Reeb, Acting Deputy Inspector General for Audit Services, at (202) 619-3155 or through e-mail at George.Reeb@oig.hhs.gov. Please refer to report number A-17-10-00001.

/Daniel R. Levinson/

Daniel R. Levinson

Attachment

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

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

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Report of Independent Auditors

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

We have audited the accompanying consolidated balance sheets of the U.S. Department of Health and Human Services (DHHS) as of September 30, 2010 and 2009, and the related consolidated statements of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal years then ended, and the statements of social insurance as of January 1, 2009 and 2008. We were engaged to audit the statement of social insurance as of January 1, 2010. These financial statements are the responsibility of DHHS's management. Our responsibility is to express an opinion on these financial statements based on our audits. The statements of social insurance as of January 1, 2007 and 2006, were audited by other auditors whose report dated November 14, 2007, expressed an unqualified opinion on those statements.

Except as discussed in the following paragraphs with respect to the accompanying statement of social insurance as of January 1, 2010, we conducted our audits in accordance with auditing standards generally accepted in the United States, 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*, as amended. Those standards and bulletin require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of DHHS's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of DHHS's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As discussed in Note 24 to the financial statements, the statement of social insurance presents the actuarial present value of the Centers for Medicare and Medicaid Services' (CMS) Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds' estimated future income to be received from or on behalf of the participants and estimated future expenditures to be paid to or on behalf of participants during a projection period sufficient to illustrate long-term sustainability of the social insurance program. In preparing the statement of social insurance, management considers and selects assumptions and data that it believes provide a reasonable basis for the assertions in the statement. 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, and as discussed below, significant additional variability has been introduced by the passage of recent legislation as well as issues regarding the sustainability of the underlying assumptions under current law.

As further described in Note 25 to the financial statements, with respect to the estimates for the DHHS social insurance program presented as of January 1, 2010, management has reflected in the projections of the program the direct impact, but not the secondary impacts, if any, of productivity adjustments (reductions in anticipated rates of increase) and reductions in Medicare payment rates for physician services mandated in the Patient Protection and Affordable Care Act (ACA), and current law. Prior legislation mandating reductions in provider payments has been overridden in whole or in part by new legislation, including frequent adjustments to scheduled reductions in physician payments and to prior efforts to adjust payments for inpatient hospital services. Management has noted that actual future costs for Medicare are likely to exceed those shown by the current-law projections, and has developed illustrative alternative scenarios and projections intended to provide additional context to users of the actuarial estimates regarding the long-term sustainability of the social insurance program. As a result of these limitations, we were unable to obtain sufficient evidential support for the amounts presented in the statement of social insurance as of January 1, 2010.

Because of the matters discussed in the preceding paragraph, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the financial condition of the DHHS social insurance program as of January 1, 2010.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of DHHS as of September 30, 2010 and 2009, and its net cost, changes in net position, and budgetary resources for the years then ended, and the financial condition of its social insurance program as of January 1, 2009 and 2008, in conformity with accounting principles generally accepted in the United States.

In accordance with *Government Auditing Standards*, we also have issued our reports dated November 15, 2010, on our consideration of DHHS's internal control over financial reporting and on our tests of its compliance with certain provisions of laws and regulations and other matters. The purpose of those reports is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audit.

Report of Independent Auditors
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Our audits were conducted for the purpose of forming an opinion on the 2010 and 2009 basic financial statements taken as a whole. The information presented in Management's Discussion and Analysis, required supplementary stewardship information, required supplementary information, and other accompanying information is not a required part of the basic financial statements but is supplementary information required by OMB Circular No. A-136. The other accompanying information has not been subjected to the auditing procedures applied in our audits of the basic financial statements and, accordingly, we express no opinion on it. For the remaining information, we have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the supplementary information. However, we did not audit the information and express no opinion on it.

/Ernst & Young LLP/

November 15, 2010
McLean, VA.

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Report on Internal Control Over Financial Reporting Based on an Audit of the Financial Statements Performed in Accordance with *Government Auditing Standards*

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

We have audited the financial statements of the U.S. Department of Health and Human Services (DHHS) as of and for the year ended September 30, 2010, and we were engaged to audit the statement of social insurance as of January 1, 2010, and have issued our Report on Independent Auditor, therein dated November 15, 2010. That report states that because of the matters discussed therein, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2010. Except for the matters discussed in the fourth paragraph of the Report of Independent Auditors, we conducted our audit in accordance with auditing standards generally accepted in the United States, 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*, as amended.

In planning and performing our audit, we considered the Department's internal control over financial reporting as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Department's internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Department's internal control over financial reporting. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin No. 07-04, as amended. We did not test all internal controls relevant to operating objectives as broadly defined by the Federal Managers' Financial Integrity Act of 1982 (FMFIA), such as those controls relevant to ensuring efficient operations.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis.

Our consideration of internal control over financial reporting was for the limited purpose described in the second paragraph and was not designed to identify all deficiencies in internal control that might be deficiencies, significant deficiencies or material weaknesses and, therefore, there can be no assurance that all deficiencies, significant deficiencies, or material weaknesses have been identified. However, as discussed below, we identified certain deficiencies in internal control that we consider to be material weaknesses.

Material Weaknesses

Financial Reporting Systems, Analyses, and Oversight

Overview

In Fiscal Year (FY) 2010, DHHS continued its efforts in remediating significant weaknesses that impact DHHS and its operating division (OPDIV) financial management processes. However, the passage of significant legislation and other challenges, including resource limitations, the decentralized nature and complexities within the organization, and the need for training to address policy changes, have impacted the pace of progress.

As reported in FY 2009, the American Recovery and Reinvestment Act (Recovery Act), which was established on February 17, 2009, increased DHHS budgets by approximately $141 billion over ten years and provided for strict guidelines on how and exactly when those funds should be distributed, accounted for, monitored, and reported to OMB and Congress. These funds were distributed among most of DHHS's operating divisions and required new processes to be developed or modified within a very short time frame under DHHS's American Recovery and Reinvestment Implementation Plan to ensure compliance with the Act and OMB regulation. During FY 2010, DHHS expended approximately $55.4 billion related to the Recovery Act. Total Recovery Act expenditures to date are $88.3 billion.

In addition to ARRA, effective March 23, 2010, DHHS was entrusted with the responsibility for implementing many major provisions of the health reform bill, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (combined known as Affordable Care Act or ACA). For FY 2010, the ACA included appropriated funding for approximately 34 provisions. Of the 34 provisions, Congress appropriated approximately $18.7 billion for 32 provisions, and "such sums as may be necessary" for 2 provisions. This amount includes funding that was appropriated in FY 2010 to be available for one or for multiple years and excludes amounts appropriated to other Departments or Agencies. Congress also authorized, but did not appropriate, funding for over 100 provisions in FY 2010.

The implementation of such significant legislation required much focus and significant resources across the Department. Our testing of internal control continued to identify significant internal control weaknesses in financial systems and processes for producing financial statements, including lack of integrated financial management systems and inability to reconcile certain significant account balances which impaired DHHS's ability to report accurate and timely financial information. Within the context of the approximately $854 billion in departmental net outlays, the ultimate resolution of such amounts is not material to the financial statements taken as a whole. However, these matters are indicative of serious systemic issues that must continue to be resolved.

Lack of Integrated Financial Management System

In FY 2004, DHHS began its implementation of a commercial web-based off-the-shelf product modified to replace five legacy accounting systems and numerous subsidiary systems with one modern accounting system with three components. The three components include:

- Healthcare Integrated General Ledger Accounting System (HIGLAS) - developed to support the financial activities of the Centers for Medicare & Medicaid Services (CMS) and its Medicare contractors by integrating the CMS contractors' standard claims processing system and eventually replace the CMS current mainframe-based financial system with a web-based accounting system (currently, the web-based accounting system has been placed "on top" of the current mainframe-based financial system). Based on the ability to generate financial statements, CMS named HIGLAS as its official financial management system of record. Although initiated in FY 2005, full implementation is not expected until FY 2013.
- National Institutes of Health (NIH) Business System (NBS) - developed to support the financial activities at NIH. NIH completed certain aspects of its implementation in FY 2008 with more ancillary modules expected to be implemented over the next few years.
- Unified Financial Management System (UFMS) - developed to support the financial activities at the remaining OPDIVs with full implementation completed in FY 2008. Certain processes to refine the implementation and address systemic issues are ongoing.

Although progress to fully implement the new financial systems is underway, DHHS's financial management systems are not compliant with the Federal Financial Management Improvement Act (FFMIA) of 1996. 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 continues to impair DHHS's and its OPDIVs' abilities to adequately support and analyze account balances reported.

Although DHHS implemented a commercial off-the-shelf product, approved by the former Joint Financial Management Improvement Program (JFMIP), DHHS's accounting systems lack integration and do not conform to the requirements. DHHS's management has identified configuration issues that result in inappropriate transactional postings. Finally, the financial systems are not fully integrated and are not expected to have full integration until FY 2012. Specific weaknesses noted include the following:

- Although progress was made during FY 2010, thousands of manual journal vouchers in excess of $621 billion in absolute value were required to be recorded in UFMS and NBS to post certain types of transactions - including transactions to record certain proprietary and budgetary entries, record accruals, perform adjustments between governmental and nongovernmental accounts, perform adjustments to agree budgetary to proprietary accounts, perform other reconciliation adjustments at period end, and correct errors identified related to configuration issues within UFMS and NBS. These entries are nonstandard postings to UFMS and NBS to record both the proprietary and budgetary effects of certain financial activities for which the financial system is not configured properly to post automatically. Although these entries are required to be posted to the general ledger in order for the financial statements to be accurate, many of these entries should have been configured as routine systematic entries within the systems.
- By the end of FY 2010, certain Medicare contractors have not implemented HIGLAS and continue to rely on a combination of claims processing systems, personal computer-based software applications and other ad hoc systems to tabulate, summarize and prepare information that is reported to CMS on the *750 - Statement of Financial Position Reports*, the *751 - Status of Accounts Receivable Reports,* and the reporting of funds expended, the *1522 - Monthly Contractor Financial Report*. The accuracy of these reports remains 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 CMS. Although CMS has begun preparing financial statements using HIGLAS, full functionality of the HIGLAS system has not been implemented.
- As discussed in further detail below, reviews of general and application controls over financial management systems identified certain departures from requirements specified in OMB Circulars A-127, *Financial Management Systems*, and A-130, *Management of Federal Information Resources*. Additionally, we identified certain issues, including access control deficiencies related to systems, as part of our Federal Information Security Management Act and other Office of Inspector General (OIG) engagements. Finally, DHHS management has identified financial management information systems as a material weakness as a result of its OMB Circular A-123 and FMFIA assessments discussed within the Management Discussion & Analysis of the Department's FY 2010 Annual Financial Report.
- Although the OPDIVs are using UFMS, HIGLAS or NBS to account for financial activities within the OPDIVs, DHHS is utilizing the Automated Financial Statements System (AFS) to compile the consolidated financial statements. AFS, a spreadsheet macro-driven process, requires the OPDIVs to manually enter their trial balances and footnote disclosures for DHHS to compile the Department-level consolidated financial statements. The key entry process can be error-prone if effective controls are not in place. The Department is expected to implement a reporting tool that will automate its consolidation in FY 2011.

- Due to certain configuration issues within UFMS, NBS and HIGLAS, certain financial statement balances on the Statement of Budgetary Resources (SBR) require analysis of other accounts to derive/estimate the amounts reported. For example, financial accounting and reporting standards require that DHHS record prior year recoveries in a separate general ledger account and report these amounts on the SF-133 and the SBR. These items are currently not being captured. As a result, most OPDIVs are required to analyze transactions in other accounts to derive the balance.

Resource limitations and other priorities were noted as causes for delays in upgrading certain system and financial internal control processes limiting DHHS's ability to comply with requirements under FFMIA.

Financial Analysis and Oversight

The U.S. Government Accountability Office's (GAO) *Standards for Internal Control in the Federal Government* states that internal control activities help ensure that management's directives are carried out. The control activities should be effective and efficient in accomplishing the organization's control objectives. Examples of control activities include: top-level reviews, reviews by management at the functional or activity level, segregation of duties, proper execution of transactions and events, accurate and timely recording of transactions and events, and appropriate documentation of transactions and internal control.

Because weaknesses continue to exist in the financial management systems, management must compensate for the weaknesses by implementing and strengthening additional controls to ensure that errors and irregularities are detected in a timely manner. Our review of internal control disclosed a series of weaknesses that impact DHHS's ability to report accurate financial information on a timely basis. Consistent with prior years, during FY 2010, we found that certain controls were not adequately performed to ensure differences were properly identified, researched, and resolved in a timely manner, and that account balances were complete and accurate. We noted the following items in the current year audit that indicate additional improvements in the financial reporting systems and processes are required:

Department/Operating Division Periodic Analysis and Reconciliation

When weaknesses exist in financial systems, as discussed above, management must compensate by implementing and strengthening other manual or compensating controls to ensure that errors and irregularities are detected in a timely manner. These manual and compensating controls would include monitoring of budgets, reconciliations of accounts, analyses of fluctuations, and aging of accounts. During our audit, we found that certain controls were not adequately performed. The following represent specific areas we noted that need enhanced periodic reconciliation and analysis procedures:

- Fund Balance with Treasury (FBWT) - Treasury regulations require that each federal entity ensure that it reconciles, on a monthly basis, its financial records with Treasury's records and that it promptly resolves differences. If this reconciliation is not adequately performed, loss, fraud, and irregularities could occur and not be promptly detected, and/or financial reports that are inaccurate may be prepared and used in decision-making. On a monthly basis, DHHS is responsible for reconciling approximately 500 Treasury appropriation symbols. As of June 30, 2010, the general ledger and Treasury's records differed by more than an approximate absolute value of $3 billion. This primarily relates to three OPDIVs that did not adequately research and clear differences noted in the Suspense Account Reconciliation. The differences were primarily caused by a backlog of differences dating back to 2004. During the fourth quarter, management focused additional efforts on its suspense account reconciliations which resulted in progress in reducing differences at September 30, 2010, to an approximate $400 million. Additionally, management was not fully compliant with the U.S. Treasury FBWT Suspense Waiver according to all terms and conditions. Certain disbursements were not related to allowable transactions within the waiver, and differences in the Suspense Account Reconciliation were not properly cleared within the 60 days required timeframe.

- Indian Health Service's (IHS) Financial Management Environment - During our testing of internal controls surrounding cash receipts, cash disbursements other than compacts and contracts, fund balance with Treasury and suspense account reconciliations, IHS was unable to provide sufficient documentation to assess the effectiveness of internal controls surrounding such account activity. IHS management represented that due to resource limitations, timing for hiring contractors, strategy decisions that would ultimately resolve underlying causes, and the decentralized nature of the entity, it had not taken corrective actions to remediate certain control issues identified in FY 2009. As such, interim testing was not conducted over internal controls surrounding fund balance with Treasury and suspense reconciliations, cash receipts and cash disbursements other than compacts and contracts. During the fourth quarter of FY 2010, significant efforts were taken to reduce the reconciling items in the fund balance with Treasury and suspense account reconciliations and to resolve $525 million of data integrity issues dating back several years identified in the preparation of reconciliation between certain budgetary and proprietary accounts. The fund balance with Treasury difference at September 30, 2010, was $209 million. We assessed the differences in fund balance with Treasury, suspense account reconciliations and proprietary and budgetary tie-point reconciliations at year end and found differences not to be significant to the financial statements taken as a whole. However, efforts are ongoing and are not expected to be completed until mid-2011.

- OPDIV Financial Reconciliation Activity Certifications - As part of the accounting centers' monthly processes, the Department has instituted a policy whereby the accounting centers certify the status of completing required periodic reconciliations. For each required reconciliation, the preparer and approver sign off and provide a date of completion. On a monthly basis, the document is forwarded to the Department. No supporting documentation is required to be provided as part of the submission. Our

- review of the OPDIVs' submissions and the supporting documentation maintained at the OPDIVs identified inconsistencies in the procedures performed, the reports utilized, and the results provided among the various OPDIVs. Our review of prepared certifications identified that although certain reconciliations were signed off and dated, the reconciliation had not been completed as differences within the reconciliation had not been identified on a timely basis. Further, we noted that although the financial statements are submitted to OMB on the 21st day after the end of the quarter and we received draft financial statements on October 22, reconciliations were not required to be completed and certified until the end of the month. Finally, we noted that although desk officers have been assigned the responsibility of reviewing specific OPDIV financial reporting, the desk officers do not consistently review the supporting documentation to ensure that the submissions are accurate. During our review of the September 30, 2010 financial statements, we identified over $400 million of unsupported adjustments or differences in the financial statements.

- Undelivered Orders - As reported in the past, DHHS does not have adequate controls in place to monitor undelivered orders which represent remaining amounts of obligated funds that have not been delivered or appropriately de-obligated. As of September 30, 2010, we noted approximately 102,500 transactions totaling an approximate $1.8 billion which were over two years old without activity. Many of these transactions represented travel, grants, and contracts awaiting close-out. Additionally, for grants, although progress was noted, during our review of FY 2010 grant activity provided from the Payment Management System (PMS) as of March 31, 2010, we noted approximately 1,750 grant obligations totaling $165 million that were dated prior to FY 2004 that had not been closed out. We continue to note that these grants were already beyond a reasonable timeframe for close-out. In prior years, a lack of resources was noted as the cause of backlog in closing out expired grants. Management needs to increase emphasis on close-out to reduce the backlog and ensure consistency between PMS and the OPDIVs' official subsidiary systems.

- Budgetary Analyses - Within the federal government, the budget is a primary financial planning and control tool. OMB Circular A-11, *Preparation, Submission and Execution of the Budget,* establishes the requirements of budget formulation and execution including requirements related to apportionments, accounting systems to control spending, proper recording of obligations, and closing accounts. For internal control purposes, budgetary monitoring is a key management control that, if implemented correctly, identifies cost overruns and potential material misstatements in a timely fashion. Currently, DHHS has completed its investigation and will be reporting to appropriate authorities a series of violations as discussed in the Procurement Activities section below. To ensure these violations do not continue, enhanced budgetary monitoring processes are required. Additionally, in our review of the Statement of Budgetary Resources, we compared balances in budgetary accounts to their related proprietary accounts. Based on our review and discussions with management, we noted differences of $794 million that could not be explained.

- Procurement Activities - During FY 2008, the Senior Procurement Executive (SPE) of the DHHS performed an extensive review across all OPDIVs of its multiple year contract funding activities, to (a) assess compliance with pertinent requirements of the Federal Acquisition Regulation (FAR), HHS Acquisition Regulation (HHSAR) and "Bona Fide Needs" rule; and (b) identify avenues to improve multiple year contracting and funding strategies within the framework of those requirements. The report on the SPE review, issued in July 2009, identified significant compliance concerns including a misunderstanding of the above appropriation-related guidance and its applicability to planning, awarding and funding DHHS contracts. In August 2009, DHHS management contracted for an independent assessment which generally confirmed apparent deviations from such guidance. During FY 2010, DHHS OIG, Office of General Counsel (OGC), and Departmental and OPDIV management continued their reviews of the affected contracts and found contracts reviewed were funded inconsistent with legal requirements. We understand that the Department is committed to notifying the appropriate authorities of violations of the Anti-Deficiency Act. DHHS management indicated that it has also taken, or is taking, the following actions to prevent future problems:
  - issued comprehensive guidance in June 2010,
  - enhanced DHHS' standard acquisition plan template to reinforce the need for (a) program and contracting officials to consider appropriation issues as early as possible in the acquisition cycle, and (b) proper, informed funds reviews and certifications,
  - developed an appropriation law decision tree for the DHHS acquisition workforce, with plans to web-enable it for user-friendly linkage to pertinent guidance,
  - developing and requiring training courses on appropriations law and contract funding, and committing – at all levels within the Department – to the proper funding of all DHHS contracts in FY2011 and beyond.

- Monitoring of Financial Operations
  GAO's *Standards for Internal Control in the Federal Government* states that "…information should be recorded and communicated to management and others within the entity who need it and in a form and within a time frame that enables them to carry out their internal control and other responsibilities." Further, the standard indicates that financial statement information is needed not only on a periodic basis for external reporting but also on a day-to-day basis to make operating decisions, monitor performance, and allocate resources. Within a decentralized complex organization like DHHS, a single integrated financial system with strong internal controls is required for up-to-date accurate financial information needed for certain decision-making responsibilities. Currently, due to the number of manual correcting entries, evolving internal control, and outdated policies and procedures, accurate information needed for decision-making at all levels of the organization may not be readily available on a day-to-day or even monthly basis as required by FFMIA. Currently, except for the compilation of quarterly financial statements, there is limited available reporting of accurate financial activities at the program, OPDIV, and/or consolidated department level. During FY 2010, it is our

understanding that certain OPDIVs have moved to a monthly close process; however, full implementation is not expected until FY 2011 with the implementation of the automated reporting process.

Policies and Procedures and Additional Training of Personnel

DHHS's formalized policies and procedures are out of date and may be inconsistent with actual processes taking place. During our internal control documentation and testing phases, we noted that, although various internal control processes had been changed or updated, the Department had not completed its updating of procedural manuals or provided sufficient formalized guidance/training to personnel to ensure sufficient knowledge of financial management systems/processes or consistency, and adequacy of internal control. For example, we noted that certain policies and procedures, including certain accrual processes, had not been updated since the mid-1980s. Further, we noted additional training on the financial systems was needed to enable DHHS personnel in their ability to access needed information from the system to complete their day-to-day responsibilities - including the preparation of reconciliations, research of differences noted, and the ability to identify and clear older "stale" transactions dating back several years.

It is our understanding that the Department and its OPDIVs are currently updating their procedures and developing further training for their personnel in the use of Oracle and other financial related systems and processes. Further training is expected to include training on Government-wide (including OMB and Treasury), DHHS, and OPDIV level policies and procedures; the use of UFMS and other subsidiary systems; the preparation of financial statements and related analysis and reconciliations; and system security.

In addition, the implementation of the ACA, including the Community Living Assistance Services and Support Act (CLASS), Health Benefit State Exchanges, Temporary Insurance for early retirees, the Qualified High Risk Pool for Preexisting Conditions, and other significant programs, will have significant impacts with financial activity totaling in the billions to the Department over the next several years. The ACA will require extensive coordination, numerous resources, policy development, and training across the various OPDIVs to ensure the programs are operating and monitored effectively and accounted for correctly in accordance with Federal Accounting requirements.

CMS Required Coordination, Communication and Collaboration to Facilitate an Effective Financial Management System

Considering the recent realignment of the Agency and the passage of significant legislation in the current year, CMS should critically assess its process for managing the cross-functional teams of financial management, information technology, actuarial, general counsel, operations, and other personnel to better monitor business activities, generate and share financial and other information and identify situations where accounting evaluation or decision-making may be required to arrive at and document an appropriate conclusion in a timely manner. Critical accounting matters such as accruals and contingencies require a robust process on a quarterly

basis including the documentation of these critical accounting matters through a series of white papers. Albeit that CMS has strengthened its ability to identify contingencies on a quarterly basis, these white papers supporting the conclusions on several critical accounting matters had not been timely prepared and approved to effectuate a change in policies or procedures. In addition, the white papers were either not finalized or not available for review until after the fiscal year end. The dispersed nature of the environment leaves CMS vulnerable to delays in the financial management implications of issues being recognized and addressed. Additional examples of these include:

- While the most significant legal matters are recorded, CMS does not ensure that the legal accrual is recorded in accordance with generally accepted accounting principles in the United States.

- During the FY 2009 budgetary closing process, CMS did not return $8.1 billion in indefinite authority related to its Medicaid ARRA funds. CMS and Department of Health and Human Services (DHHS) management indicated that the authority had not been returned due to several miscommunications between the CMS budget and finance offices, DHHS and OMB. In January 2010, through and after discussions with OMB and Treasury, DHHS requested a negative warrant to be processed to return the funds. For the FY 2009 financial statement purposes, no restatement of balances was required as they represented the actual relative positions of the entities, as they stood at the time. Although CMS drafted a white paper document to address financial and budgetary accounting and reporting issues, the document never was finalized and no documentation was prepared to support the concurrence by the various entities of the corrective actions to be taken. During FY 2010, CMS identified and implemented corrective actions, including reviews of subsequent period apportionments to ensure that funds not available for carryover would be returned during the year-end closing process.

- Insufficient communications within the organization resulted in understatement/overstatement of accounts receivable and related interest from, and payables to, the States for Medicaid and ARRA advances. For example, in the prior year a state was in an overdrawn position that should have resulted in an accounts receivable; however, it was not reflected in the financial statement until the current fiscal year. In addition, the finalization of grant awards is not performed consistently or timely for all States. Efforts to continuously monitor State draws and reinforce applicable cash management and grant oversight activities, including working to resolve issues with disclaimed or qualified opinions reflected in grantee compliance audit reports (States' A-133 compliance reports) merit continued focus.

- Contemporaneously addressing the financial reporting implications in connection with the deliberations ultimately reflected in the Trustees Report and accompanying Office of the Actuary (OACT) reports and projections might have been useful in mitigating the impact on the Statement of Social Insurance reporting.

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- As CMS continues to enhance its data analyses capability, further improvement can be made by developing robust analytical procedures or measures against benchmarks to monitor and mitigate risks associated with the decentralized nature of CMS operations. To the extent more robust analysis occurs within Centers and Offices, cataloging and reviewing such analysis would assist in ensuring that a perspective which incorporates a financial reporting point of view is captured and considered.

CMS Financial Management Analysis Function

The dispersed nature of the financial management environment requires a high degree of coordination between the financial and program management personnel to ensure the effective operation of the controls. The decentralized nature of the organization results in a significant number of controls being performed at the contractors, regional offices, Centers and Offices outside of OFM. Critical accounting matters identified within the organization require a robust review process, including timely documentation to capture CMS' considerations, analyses and ultimate conclusions.

Consistent with the prior years, we noted that CMS does not perform a claims-level detailed look-back analysis for the Medicaid Entitlement Benefits Due and Payable (EBDP) to determine the reasonableness of the various state calculations of incurred but not reported (i.e., unpaid claims) liability. The Medicaid EBDP is approximately $27.0 billion as of September 30, 2010, and is a significant liability on the financial statements. Currently, CMS is not able to validate its methodology in a manner similar to the Medicare methodology by using a claims-based approach. CMS continues to rely on its estimation methodology (which is based on using a historical three-year average) to record the Medicaid EBDP without the ability to confirm the reasonableness of its methodology.

All individuals within the organization are responsible for establishing, managing and maintaining an effective control environment. A good control environment not only ensures accountability but also provides oversight and reasonable assurance that the organization's goals are met. During the internal control tests, errors were noted that were not detected by the organization's monitoring and review function, and accordingly, the control was not functioning as designed or intended. The errors identified by our audit procedures at the central office, regional offices and Medicare contractor locations may be summarized, including an example for each category, as follows: (i) activity or accounts for which no formal, documented review or monitoring function was established (identified as a design deficiency) (for example, no documentation or certification of the review that the premium calculation spreadsheets are reviewed for accuracy prior to publication of the premium); (ii) review or monitoring function was established but was not performed or effective (for example, reconciling items identified in the benefit payment reconciliation were not investigated and resolved timely); and (iii) the review or monitoring function was not performed timely (for example, the monthly National Claims History (NCH) validation process, which compares the NCH paid claims to the Medicare contractor reported draws, was not performed in the current fiscal year).

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CMS Business Partner Risk Management

CMS administers an extensive internal control program to protect the Agency's resources from fraud, waste and mismanagement. CMS also relies heavily on third-party contractors as it outsources substantially all the day-to-day operations for its information technology systems, the payment of Medicare fee-for-service and Medicaid claims and certain services related to the Medicare Advantage (Part C) and Part D Drug programs.

CMS has developed internal controls that help prevent fraud and waste from occurring such as edits in the claims processing systems that attempt to identify and filter inappropriate claims. CMS also has developed internal controls that will help detect fraud and waste that may have occurred. Any strong control environment will have a combination of both prevent and detect controls with a greater emphasis on prevent controls.

While we noted during the current year audit that CMS had both prevent and detect controls in operation, we noted several examples of areas where improvements could be made in the overall control environment. This is especially true of CMS' relationships with its third-party contractors referred to herein as "contractors."

- The contracts between CMS and its Medicare contractors include provisions that require the Medicare contractor to develop and follow policies and procedures or objectives established by CMS, as described more fully in the CMS Medicare Financial Reporting Management Manual (Chapter 5). The specific objectives followed at each location are to be documented by the Medicare contractors, supporting documentation must be maintained and available for review and audit, all shared systems must be able to produce any system report required by Medicare contractors on a month-end basis and the Medicare contractor must be able to support all summary amounts reported on any system report with transaction level detail. In addition, Medicare contractors are required to periodically (e.g., monthly) certify to the completeness and accuracy of the financial information transmitted to CMS for their responsible workloads. Through its A-123 process, CMS tests the Medicare contractors' compliance with its policies and procedures and the financial controls established.

  While this approach to financial integrity supports monitoring of the Medicare contractors' financial controls, the monitoring process has not been fully effective in identifying and resolving financial recording and reporting issues or ensuring that they are timely remediated by the Medicare contractors. As CMS continues their efforts to transition to the Healthcare Integrated General Ledger Accounting System (HIGLAS) and to implement the provisions of ACA, there will be a greater significance placed on monitoring the Medicare and other contractors, accentuating not only the value, but the consequences, to the Agency. During our audit activities, we identified weaknesses in financial reporting oversight, including:

  - Neither CMS nor the Medicare contractors were able to provide a system-generated subsidiary ledger or detail schedule for the amounts payable to providers or beneficiaries (or amounts owed to CMS) for certain ancillary accounts (e.g., accounts payable other, refunds payable or custodial liabilities) as of a balance sheet date. While account

reconciliations are performed for the primary claims payable accounts, because there was no subsidiary ledger available for these ancillary accounts, neither CMS nor the Medicare contractors were able to fully reconcile these accounts on a periodic basis.

- For one Medicare contractor and two workloads, initially neither CMS nor the Medicare contractor were able to provide a system-generated subsidiary report for the adjudicated claims balances reported to CMS because the volume of transactions was greater than the HIGLAS capabilities and the report could not be successfully generated. Ultimately, CMS was able to provide a number of system-generated subsidiary reports by open year and fund (i.e., HI, SMI and general) to support the adjudicated claims balance. These reports reconciled to the balances reported by the Medicare contractor.
- Undelivered Medicare Summary Notices (MSNs) returned to the Medicare contractor were shredded by the Medicare contractor and are not being investigated as there is no existing CMS policy that addresses the actions in this circumstance. The result of the beneficiary not being able to review the MSN and notifying CMS of unusual services or charges may lead to improper payments going undetected.
- The Medicare contractors did not perform a periodic review of claims held (i.e., "invoices on hold" or payables held for specific reasons) and CMS did not monitor that the outstanding balances are properly and timely resolved. If the aged claims are not tracked or monitored by the Medicare contractor periodically, the claims may not be paid or disposed of in a timely manner and the payable balances reported by the Medicare contractor at the end of each reporting period may not be correct. We understand that CMS is in process of developing a policy or guidance that will require the Medicare contractors to perform a periodic review.

- During 2007, CMS transferred a majority of the Medicare Secondary Payor recovery process to a single contractor. This contractor is responsible for initiating collection of several hundred million dollars on an annual basis. Although some additional procedures were implemented, we continued to note several instances where internal controls related to this contractor were not designed or operating effectively, including lack of, or an ineffective level of, review and the untimely application of cash receipts.
- The processes designed to prevent errors should be supplemented by controls and analyses that highlight any material errors that may or could occur. In this regard, errors or abuses within the Medicare fee-for-service claim data, if material, should be detected in the annual Comprehensive Error Rate Testing (CERT) process, while for Medicaid the Payment Error Rate Measurement (PERM) process can be useful in this regard. These processes, which are primarily outsourced to contractors, are designed to assess accuracy rates as applicable. Similar processes are used to monitor Part C and D plans, particularly prescription drug event data. These processes continue to evolve and the error rate development processes developed to date, and further steps being taken to verify that only appropriate providers and beneficiaries participate in the programs are important steps forward in this regard. To be fully effective in compensating for inherent risks in the programs, the monitoring activities must be well understood, susceptible to replication and highly credible. We reviewed these

error analyses and these analyses quantify the challenges that CMS has regarding improper payments. Our audit procedures also consider the audit activities performed by the OIG and others for the Part C and D programs. Findings, such as timeliness of the plan audits and the accumulation of True-Out-of-Pocket costs (TROOP) and Prescription Drug Event (PDE) data, are inherent risks of the programs.

In 2008, the OIG recommended revisions to the error rate review methodology, which were implemented by CMS during fiscal year 2009 which resulted in higher projected error rates. Similarly, ensuring that a fully reconciled population of claims is susceptible to testing is an important starting point in the development of PERM error rates. The work previously performed by the OIG in reconciling such populations indicates that further focus on this area is needed.

Statement of Social Insurance (SOSI)

The Statement of Social Insurance (SOSI) for CMS presents a long-term projection of the present value, spanning a 75-year time horizon, of the benefits to be paid for the closed and open groups of existing and future participants of the Medicare social insurance programs, less the inflows to be received from or on behalf of those same individuals. The presentation assumes the programs will continue in their current form under current law, albeit with certain economic assumptions that serve to constrain growth of the programs and imply refinements in response to the burden of the programs on economic activity. Departure from the current law construct also is made in assuming that the programs would continue to provide substantially consistent benefits after exhaustion of the Trust Funds, while under current law payment reductions would otherwise reduce or defer such payments. This approach allows for illustration of the excess of payments beneficiaries may expect over the related funding streams.

The presentation includes estimates not only of the payroll taxes, premiums, and other contributions to be made directly by the participants, but also estimates of general fund contributions on their behalf to help finance the programs for which this funding mechanism exists. In contrast, the presentation included in the consolidated annual financial statements of the U. S. government excludes such intragovernmental transfers. The process for preparing the SOSI must comply with appropriate financial reporting internal control requirements and is intended to provide information useful in assessing the financial condition of the programs and related Trust Funds.

In FY 2010, the passage of the Affordable Care Act significantly impacted the projections embodied in the Trustees Report and SOSI. The application of the current law formulation to development of the SOSI projection created significant challenges in applying this legislation. These challenges included considering the impacts of an estimated 165 provisions affecting the Medicare program, including modeling significant changes in provider payments arising from legislative limitations to constrain growth in the cost of the programs, and considering potentially

wide ranging impacts from investments in combating fraud and abuse, initiating a major program of research and development, and implementing accountable care organizations to assist in coordinating care.

The projections always have been complex and need considerable care in interpreting the resulting SOSI. The degree of uncertainty regarding the projections increased in FY 2010 and certain matters called into question, and we were unable to assess, whether the presentation of the SOSI was fairly presented and fully useful for its intended purpose. Management has noted that the effects of some of ACA's provisions on Medicare are not known at this time, and the long-range feasibility of certain of the provisions is doubtful. The Trustees Report, related Actuarial Opinion and other materials incorporated by reference in the Trustees Report reflect uncertainty regarding the projections and reflect concerns that certain current law provisions are not sustainable or will, based on prior patterns, likely be modified. The extent to which the SOSI projections as presented are anchored in the current law formulation, are subject to additional uncertainty this year and may not reflect management's reasonable estimate of the ultimate cash flows of the social insurance programs, is discussed in the footnotes to the FY 2010 SOSI.

The disclosure steps taken by management appear to have been reasoned judgments to aid users of the financial statements in interpreting the information pending further refinement of the projections and a more fundamental reexamination of the assumptions underlying the development of the SOSI and Trustees Report. The efforts needed in modeling the impacts of the ACA include work which management anticipates regarding potentially refining the assumptions and narrowing the range of the projected outcomes for the cash flow models and seeking further input in comprehensively considering the secondary impacts of price changes mandated by current law on access and utilization. Enhancing the utility of the projections will require addressing systemic issues regarding patterns of legislative changes in the programs, including for example the physicians' payment update reduction deferrals of the last several years. It also may require positing sustainable operating models for the programs, their providers and beneficiaries, some of which may require postulating future changes in the legislative or regulatory formulations of the programs needed to sustain the programs. Developing auditable estimates for SOSI that fairly present the financial condition of the Trust Funds may require revisiting provisions of federal accounting standards and potentially reformulating the assumptions used in SOSI and the Trustees Report to help improve the usefulness of the estimates provided.

Certain efforts already underway within CMS will assist in narrowing areas of concern. While appointment of public trustees and a panel of advisors to assist in reviewing the projections and related assumptions came too late for the FY 2010 SOSI presentation and Trustee Report development, these measures will assist CMS during the refinement of future projections and in considering the appropriate response to concerns about the sustainability of current law provisions over the projection period, which are significant enhancements. The investment made by the Office of the Actuary in formulating alternative illustrative scenarios will help inform the process. Similarly, the Federal Accounting Standards Advisory Board departed from a current

law formulation when formulating guidance regarding developing analogous projections for sustainability reporting. The work devoted to this effort may also facilitate developing appropriate responses to the unique challenges faced by CMS in developing projections for SOSI under the current law construct referenced in applicable Federal reporting standards.

In addition to the overarching concerns, our work in review of the internal controls for the related models noted continue improvement, considering the magnitude of changes in the current fiscal year, with some areas warranting continued focus. The SOSI models are complex, 75-year projections that contain a high degree of estimation. The lack of robust controls over spreadsheet changes and inputs, and complexity of the models may result in output that varies from management's intentions. We noted the following deficiencies that, if improved, would enhance the reliability and credibility of the SOSI model and process:

- The SOSI model is password protected to ensure that only authorized access and changes are made to the analyses within the model. During our testing, we noted that four spreadsheets were not password protected, which could allow unauthorized access and changes to the SOSI model.
- CMS has developed and implemented a change management process over the SOSI model, which applies to significant changes or changes in methodology of the model. During our testing, we noted that certain spreadsheets were removed from the models and the reasons for being removed were not documented or tracked through the change management process.

Management Corrective Actions

During FY 2010, DHHS OPDIVs performed their annual OMB Circular No. A-123, *Management's Responsibility for Internal Control,* assessment procedures in support of the Department's annual FMFIA process. OMB Circular No. A-123 provides internal control standards and specific requirements for conducting management's assessment of the effectiveness of internal control over financial reporting. As part of these assessments, the various OPDIVs identified instances of non-compliance with federal accounting requirements and the Department's own policies - many of which had been identified in prior years. Consistent with the OMB No. A-123 assessment, our procedures identified a number of specific instances of deficiencies in application of DHHS' internal control.

In some cases, the DHHS management has not properly implemented corrective actions for long-standing deficiencies in internal controls. Certain deficiencies have been continuously identified and reported to management over the past decade. These include:

- untimely and incomplete suspense reconciliation processes;
- cleanup of old "stale" account balances;
- extensive manual adjustments in financial reporting; and

- significant weaknesses surrounding the various information technology systems upon which DHHS relies heavily for its operations and financial reporting.

This insufficient progress of implementing corrective actions has resulted in limited improvement and continues to impair DHHS's capability to support and report accurate financial information. In other cases, actions to address weaknesses are documented late in the fiscal year with limited or no documentation that the controls were placed in operation during the period under audit. To the extent circumstances such as resource constraints and implementation of new financial systems occur which can lead to multiple years of efforts in addressing issues, some delays may be unavoidable. A more robust process to assess ongoing risks and adopt strategies to mitigate control risks pending overarching solutions can assist in assuring stakeholders that management is systemically addressing control deficiencies and fostering a tone at the top to address audit findings on a timely basis.

* * * * *

Recommendations

We recommend that DHHS continue to develop and refine its financial management systems and processes to improve its accounting, analysis, and oversight of financial management activity. Specifically, we recommend that DHHS:

- Continue to strengthen controls related to its entity-wide structure for account reconciliation, analyses, and oversight by providing more in-depth on-site quality reviews of OPDIV and headquarters financial functions, periodically requesting the supporting documentation to compare to the results communicated, and improving communications between the various parties so that issues may be identified and resolved in a more timely manner. Additionally, we believe continued focus is especially needed in the areas of Fund Balance with Treasury reconciliations and related suspense accounts. Further, we recommend that the OPDIVs allocate adequate resources to perform the required account reconciliations and analyses on a timely basis.
- Continue to improve its financial reporting and internal quality review procedures to reasonably assure that information presented in the interim financial statements and Annual Financial Report are accurate, supported fully, and completed timely and consistently with the requirements of OMB Circular A-136, *Financial Reporting Requirements*, including rigorous use of checklists and enhanced supervisory review processes.
- Continue to improve its process to timely close out "stale" or old account balances, including undelivered orders, accounts receivable, accounts payable, and grants.

- Continue to devise short-term and long-term resolutions to systematic and integration issues that complicate use of UFMS and NBS. DHHS should continue to assess whether systems used to prepare the financial statements are working effectively and have been sufficiently tested prior to year-end reporting dates.
- Continue to offer updated guidance and training to personnel to ensure specific guidelines are documented as to the source of data, required follow-up with timetables, and documentation retention policies. Further, training should be provided to OPDIV and headquarters personnel to ensure a complete understanding of the financial management systems and the available reports to perform certain tasks.
- Consider moving to a monthly departmental close of financial data to provide for a more timely compilation of accurate data that may be needed for decision-makers at all levels. The monthly consolidation of financial statements will be more feasible with management's complete implementation of Hyperion to consolidate its financial statements, for which initial pilots occurred during FY 2009 and complete implementation is expected during the first quarter of FY 2011.
- Ascertain whether the OPDIVs, in conjunction with DHHS, properly track and implement corrective actions to mitigate deficiencies that impair the capability to support and report accurate financial information.
- Complete its implementation of corrective actions related to contracting activities to ensure compliance with Federal acquisition requirements.

Additionally, in regard to CMS, we recommend that CMS continue to develop, enhance, refine, and provide robust analyses over its financial reporting systems and processes. Specifically, CMS should:

- Establish specific policies, procedures and a protocol to address situations or transactions that require cross-functional involvement 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 discussed and reviewed 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 enhance it process related to the development, documentation and validation of critical accounting matters and the timeliness of its white papers.
- Delegate to and ensure that the Centers or Offices provide robust analytical analyses to OFM on a periodic basis (e.g., quarterly) that would be analyzed and reconciled by OFM in connection with the preparation of the quarterly CMS financial reports and available for use throughout the Agency.

- Establish a process to perform a claims-level detailed look-back analysis on the Medicaid EBDP to determine the reasonableness of the methodology utilized to record the $27.0 billion accrual. One potential method to verify the reasonableness of the Medicaid EBDP balance would be to use the detail claims data from the PERM process to calculate the average days outstanding or sample the largest states and determine if information is available for subsequent analysis.

- Evaluate the monitoring and review function to determine the reason the reviews are not performed effectively. Reinforce the importance of the detect control within the internal control structure, the accountability of the control and the oversight required to maintain an effective control environment.

- Continue to implement an integrated financial management system for use by Medicare contractors and CMS to promote consistency and reliability in accounting and financial reporting.

- Regularly evaluate its overall directives to contractors to ensure that adequate controls are in place and that appropriate documentation is maintained to support the conduct of those controls. As CMS transitions the contractors to HIGLAS or implements new legislation, CMS should challenge its current policies, procedures and methodologies to determine if such implementation has impacted the financial reporting and internal control processes (examples include generation and reconciliation of subsidiary ledgers, MSNs and HIGLAS reporting). If current methods are impacted, CMS should provide updated and relevant guidance and communication to, and collaborate with, the contractor to facilitate and properly incorporate the changes.

- Continue the process of enhancing the integrity, improving the process and capturing the benefits of the CERT, PERM, Part C and Part D error rate development and analysis tools. Error rate results should be developed at a sufficient level of detail to analyze, scrutinize and classify errors and identify anomalies to begin separate investigations or studies of the root causes of the errors and appropriate prevention, mitigation and recovery plans. Continue the efforts to further develop the eligibility processes to ensure only appropriate parties participate and use the periodic error rate processes to comprehensively test for eligibility and improper payments.

- Critically assess findings from OIG and other reviews of the Part C and D programs to ensure that the evolving nature of these programs are accompanied by robust internal control processes utilized by CMS to address the inherent risks of these programs. Continue to consider and implement the recommended audit results and modify the processes to hold plan sponsors more accountable for the findings identified. The financial management group should ensure it monitors and maintains oversight over the programs and its activities to identify the appropriate financial statement impact and disclosure. In light of the extraordinary financial crisis that existed in 2008, 2009 and continues in 2010, and the pattern of advances to Part D drug plans and states, we believe that CMS should continue to evaluate its risks with respect to all its grantees, contractors and providers to ensure that the Agency is appropriately protecting its resources.

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Developing SOSI projections for use in general purpose financial statements which represent management's reasonable estimate of the cash flows for the programs over a 75-year projection period will continue to be a challenge. The fact pattern presented in FY 2010 in developing the projections raises important issues regarding the role of SOSI reporting, and the merits of departing further from a current law formulation in instances in which management believes that legislative or regulatory changes will be needed to sustain the programs throughout the projection period. Pending resolution of these issues, the disclosures help to partially mitigate the potential adverse impact from presenting information management does not believe will actually occur. In pursuing the ultimate resolution of these matters, we suggest management consider the following:

- Continue efforts initiated late in FY 2010 to engage a panel of advisors to assist in addressing the challenges presented by the passage of ACA in developing and presenting projections for the Medicare programs which are reasonable estimates of the program cash flows.
- Continue and broaden discussions with key stakeholders and standard setting bodies, including the Federal Accounting Standards Advisory Board, to codevelop appropriate recommendations for potential revisions to the approaches used in presenting projections for the programs in the Trustees Report and standards applicable to presentation of the SOSI to aid in ensuring that the SOSI projection is meaningful and presents fairly the financial condition of the Trust Funds. These consultations should address how patterns of revisions to law, and situations in which a continuation of current law is anticipated to potentially not be feasible should be addressed, if at all, in the projections.
- Verify that all spreadsheets are password protected to avoid unauthorized access or changes.
- Adhere to established policies and procedures to ensure that the SOSI model methodology and related calculations and estimates are consistently documented. Adherence to these policies will ensure that the model is evaluated to verify that the input/output data is appropriate based on the expected results of the data and spreadsheet changes.
- Adhere to the established policies and procedures to ensure that the verification, review and approval process for the SOSI model occurs in a timely manner.

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Financial Information Systems

Overview

HHS is a highly decentralized organization with currently six separate accounting offices and numerous regional offices, contractors, and area offices with access to various components of the financial management system. In addition, although HHS has begun efforts to consolidate the accounting systems, separate accounting systems are still used to support the financial statements in FY 2010. They include: Unified Financial Management System (UFMS) for Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), Administration for Children and Family (ACF), Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), Program Support Center (PSC), Administration on Aging (AOA), Agency for Healthcare Research and Quality (AHRQ), Office of the Secretary (OS), and Indian Health Service (IHS); National Institute of Health's (NIH) Business System (NBS) for NIH; and the Healthcare Integrated General Ledger Accounting System (HIGLAS) for CMS. Although CMS maintains only one of the six separate accounting offices, the CMS'S HIGLAS system and its ancillary systems are responsible for over $ 729 billion or 85% of the Department's total net cost. As a result, we have discussed our results for CMS separately below.

CMS Information Systems Controls

During FY 2010, CMS made investments in additional processes, personnel, and technology to strengthen internal controls over information technology and continues to take proactive steps to improve information assurance at both the Central Office and its business partners, principally Fiscal Intermediaries (FIs) Carriers, Medicare Administrative Contractors (MACs), and Enterprise Data Centers (EDCs), collectively referred to as Medicare contractors. Examples of improvements are described in the context of these investments.

- CMS has strengthened the oversight of its Medicare contractors through improvements to existing and the introduction of new control activities. As such, CMS has:
  - Established the requirement for Medicare contractors to report in compliance with baseline security settings. When exceptions are reported, CMS determines whether the exception can be granted or requires the contractor to communicate a remediation plan.
  - Improved communication of roles and responsibilities between Medicare claims processors and Medicare data centers by requiring the execution of Joint Operating Agreements. These agreements between the data center and claims processor define the roles of each for information security controls and monitoring.

  - Initiated the monitoring of compliance with edit settings for shared system applications by Medicare contractors. Contractors are required to submit reports quarterly and provide business justification for non-compliance.
  - Developed new guidance on compliance requirements for access control over shared systems.
  - Continued efforts to monitor compliance with Medicare data access by contractor personnel.
  - Increased staffing at Central Office to support the monitoring of contractor security compliance reports.
- Strengthened the change control process through further formalization of change control boards for Central Office-managed applications.
- Reinforced enterprise IT vulnerability management through the implementation of new technologies that allows for vulnerability monitoring on a continuous basis.
- Increased awareness and collaboration around information assurance throughout CMS through monthly Security of Excellence meetings and other related activities.

In conjunction with the ongoing consolidation of the overall information processing environment, these activities have helped to reduce CMS' overall exposure to potential information security configuration and access deficiencies.

CMS' Business Environment Overview

Extensive information systems operations are necessary to support CMS' large size and decentralized business model. Substantially all of CMS' Medicare fee-for-service claims and related data are processed by geographically dispersed contractors. Additional key systems are processed at CMS' Central Office. These operations support numerous Medicare and Medicare-related application programs that are intended to assure consistency in administering the Medicare program, in addition to processing, accounting for, and reporting on Medicare expenditures and related assets and liabilities. Internal controls over these operations are essential to manage the integrity, confidentiality, and reliability of Medicare data and application programs and to reduce the risk of errors, frauds, or other illegal acts.

For Medicare fee-for-service claims, CMS has entered into contracts with several organizations known as Fiscal Intermediaries (FIs), Carriers, and Medicare Administrative Contractors (MACs) for claims processing software administration, claims payment, and audit/reimbursement services. CMS also has continued to centralize its ongoing data processing needs into three Enterprise Data Centers (EDCs). Other contractors known as software system maintainers make and test changes to the claims processing software to meet Congressional mandates and/or other business needs as defined by CMS. CMS maintains multiple claims processing systems depending on the type of claim. These systems include the Fiscal Intermediary Shared System (FISS), the Multi-Carrier System (MCS), the ViPS Medicare

System (VMS), and the Common Working File (CWF). Collectively these systems are referred to as shared systems. Other important financial systems processed by the CMS Central Office include the Financial Accounting and Control System (FACS), the Healthcare Integrated General Ledger Accounting System (HIGLAS), and the Medicare Advantage and Prescription Drug System (MARx).

CMS is subject to various federal information security and application software management guidelines. Primary guidance is included in the National Institute of Standards and Technology (NIST) Special Publication 800-53, *Recommended Security Controls for Federal Information Systems,* and NIST Special Publication 800-37, *Guide for Applying the Risk Management Framework to Federal Information Systems*. An independent assessment of CMS' compliance with the NIST guidance is in part accomplished through the performance of an annual review conducted by the HHS Office of Inspector General under the *Federal Information Security Management (FISMA) Act of 2002.*

CMS maintains a Business Partners Systems Security Manual (BPSSM) based on federal guidelines for its application software systems used to direct the information security activities at the Medicare contractors. CMS communicates the requirements of their information assurance program through the requirements of the BPSSM; monitoring compliance with the BPSSM is accomplished through the CMS Certification and Accreditation (C&A) program. Each contractor is required to maintain a System Security Plan (SSP) developed in accordance with the BPSSM that outlines the contractor's plan for maintaining a secure environment for the shared systems. Central Office and contractor personnel are required to receive annual security awareness training.

CMS principally monitors the compliance with its standards through the following processes:

(1) Evaluations of the implementation of information security requirements outlined in Section 912 of the Medicare Modernization Act of 2003,

(2) Annual reports on the MACs' controls placed in operation and tests of operating effectiveness issued by independent auditors in accordance with the AICPA's Statement on Auditing Standards No. 70, *Service Organizations,*

(3) Annual reviews in accordance with Office of Management and Budget (OMB) Circular No. A-123, *Management's Responsibility for Internal Control*, which provides updated internal control standards and specific requirements for conducting management's assessment of the effectiveness of internal control over financial reporting, and

(4) Additional monitoring procedures performed by CMS including ongoing contractor management assessments and regular reviews of computer security configurations submitted by the MACs and the EDCs.

These enterprise-wide CMS activities and our procedures continue to identify instances of non-compliance with CMS IT security and other requirements. While CMS continues to remediate identified findings and weaknesses, these monitoring activities also revealed a number of instances in which the remediation had not been timely implemented.

The complexity of the CMS environment, fast paced technological changes, and the evolution of threats pose a significant challenge to CMS. The age of the mainframe systems and associated software that CMS employs in its processing of Medicare, Medicaid and financially significant data will become more difficult to maintain and modify when integrating future changes in the Medicare program. CMS also requires constant vigilance in managing information security risks to ensure that weaknesses are identified and remediated timely.

CMS Information Security

When properly designed and implemented, access controls ensure that critical system assets are physically and logically protected from unauthorized usage and that only authorized personnel are granted access to data and programs; such controls include active monitoring of security events for proper assessment and timely remediation.

We identified the following weaknesses in information security that merit continued focus:

- CMS did not ensure that all Medicare contractors performed periodic reviews of user access to sensitive Medicare data and the related application systems. This condition continued at two MACs. Such periodic reviews are essential to ensure that all access continues to be appropriate and authorized.
- Unauthorized wireless access to Medicare networks was observed at the single testing contractor who completes testing on the four shared systems supported by the software maintainers. Such access introduces a vulnerability into the CMS network that is not consistent with the information security control standards of CMS and potentially permits non-authorized external users to access sensitive Medicare data and systems.
- Vulnerabilities in system configurations for contractor networks used to transport Medicare data were identified at two MACs. Providers and other health-care related organizations use these networks for transmission of claims data and other information using Electronic Data Interchange (EDI). These vulnerabilities could result in inappropriate network access and access to application systems connected to the network. At one MAC, the vulnerability identified permitted update access to the server supporting the Medicare EDI application.
- One EDC and one shared system maintainer had not completed their implementation of CMS-required computer system security configuration settings. At the EDC that processes claims for multiple MACs, security is managed using IBM's Resource Access Control Facility (RACF) software for which security settings were not set in accordance with the CMS security standards for RACF. Without full implementation of these settings, unauthorized access and usage of Medicare data and systems could occur.

- User security administration for access to shared systems was not effectively performed at three MACs. This could result in potentially unauthorized access to Medicare data and systems.
- SSPs for the single testing contractor and one MAC were incomplete. In addition, the single testing contractor's SSP had not been timely reviewed or approved by CMS.
- Data backup tapes managed by the EDCs contain unencrypted personally identifiable information (PII) related to Medicare information. CMS has not fully implemented HHS Standard for Encryption 2008-0007.001S, dated December 23, 2008. Such encryption is also required by OMB Memorandum No. M-06-16, *Protection of Sensitive Agency Information.* CMS has not obtained a waiver from OMB related to this weakness.
- Pending the decommissioning of FACS and the full implementation of HIGLAS, segregation of duties conflicts continued to exist at Central Office between the business fu*nction and information security administratio*n function of CMS' Office of Financial Management (OFM) for FACS. OFM has assigned personnel the function of system and security administrators; these personnel also were able to grant access to the FACS application and perform and process business transactions.
- CMS has not provided guidance to the MACs on how to establish segregation of duties between business processes for the shared systems applications. Since the systems are developed by the shared system maintainers and tested by the STC, the MACs do not have sufficient knowledge of the application processing to design appropriate segregation of duties controls. These controls are key to the effective administration of user access to the shared systems that process Medicare claims and are required by the NIST standards.

CMS Application Configuration Management

Configuration management is the process used to ensure that the Medicare applications used by the Central Office and Medicare contractors operate as intended by CMS. Configuration management depends on the consistent application of program change management processes and policies to the Medicare systems to ensure the continued integrity and security of financial and claims data.

CMS has contracted with several software system maintainers to provide software development and testing support for the majority of the systems used to process Medicare claims. Some of these maintainers provide services for the shared systems that include system development, system documentation, training, and testing. The MACs that use the shared systems are responsible for the configuration of programmed edits (e.g., a valid provider type was entered for the medical service rendered), the customization of automated adjudication software (AAS or "scripts"), and local information security user administration procedures.

We identified the following weaknesses:

- Change control boards are important in an organization as complex as CMS to oversee the interfacing of Medicare and financial data across numerous applications. While CMS has instituted several change control boards for these applications, there is no overall change control board or process to coordinate efforts to integrate necessary application interfaces. Further, CMS has developed a process requiring Interface Control Documents (ICDs) but these are not standardized in content and not used by all relevant programming groups. Without appropriate integration and proper data interfacing among the many business applications used by CMS, the accuracy and reporting of financial and beneficiary data may be impacted.
- Automated Adjudication Software (AAS) scripts and configurable edits implement the business rules for processing Medicare claims. MACs have the ability to develop and implement AAS scripts. MACs are also responsible for ensuring the configuration edits are set to CMS standards. We noted at two MACs that AAS scripts are not being tested when the programs that process these scripts change by the shared systems maintainer. We also noted at two MACs that configurable edits are not being managed in accordance with CMS requirements. If these tools for implementing business claims processing policies are not tested and configured in accordance with CMS policy, the exposure exists that claims will not be processed correctly resulting in improper payments.
- The shared systems (FISS, MCS, and VMS) use thousands of data edits to adjudicate claims against Medicare policies. However, CMS has not identified all the data edits that should be activated and accurately functioning in accordance with Medicare policies. This deficiency may result in inaccurate adjudication of Medicare claims.
- CMS has implemented a quarterly edit compliance process for all FIs, Carriers, and MACs. We found that for one quarter, the compliance process did not function properly and such errors were not identified timely. CMS was not able to determine the monetary impact of the edit compliance process not functioning for the quarter.

Recommendations

Through its added oversight procedures, CMS has made progress in identifying, monitoring, and remediating specific control weaknesses related to information security and its business applications. CMS should continue its efforts to increase contractor compliance by enhancing and consistently applying oversight activities, including proactive monitoring of contractor compliance with security settings and related directives for data access and the shared systems. A particular focus should be placed on reviewing and evaluating instances of non-compliance with stated Medicare policies, including the documentation of conclusions and approvals of instances of non-compliance and evaluating their impact on the financial statements.

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To achieve these objectives, CMS should continue to coordinate and implement control processes that will enhance the overall integrity of the Medicare information systems. Such coordination will require further integration of efforts by the Office of Financial Management (OFM), the Office of Information Services (OIS), and those charged with governance over the MACs in the Center for Medicare (CM).

We recommend that CMS:

- Further the implementation of enhanced and required information security policies and techniques developed by OIS over the Medicare information systems, including:
  - Periodic and timely information system user access reviews at the Central Office, FIs, Carriers, MACs, and EDCs.
  - Increased oversight of contractors' use of newer technologies, including wireless access and publicly accessible networks.
  - Consistent and enforceable policies for the encryption of PII on its information systems, including portable devices, as required by OMB and HHS.
  - Consistent and complete system security plans prepared by all system owners, MACs, EDCs, and software system maintainers.
  - Continued implementation of system and security settings at the Central Office and the EDCs in accordance with CMS policies, related monitoring procedures, and timely remediation of identified errors.
- Oversee an integrated effort by OIS and CM to ensure that:
  - Appropriate segregation of duties is established in all systems that support Medicare and financial processing at the FIs, Carriers, and MACs to prevent excessive or inappropriate access. In addition, access to all systems should be periodically reviewed to ensure that access remains appropriate and no incompatible duties exist.
  - Compliance detection systems for the timely implementation and activation of new Medicare claims edits are monitored timely and appropriate system corrections are made for identified errors.
  - All application changes to the Medicare systems, including FISS, MCS, VMS, and CWF, are tested adequately and completely.
  - All AAS programs (scripts), new or old, are documented, validated as to business need, and adequately tested prior to implementation at the MACs or whenever the Medicare applications that use the scripts are changed.
- Continue efforts by all three organizations (OFM, OIS, CM) to require that all changes to Medicare and related financial applications be subject to review by a designated enterprise-wide change control board. System interfaces should be identified and ICDs should be consistently completed and used for all systems. In addition, relevant NIST

guidance should be applied in the review and approval of changes. Documentation should be prepared for all phases of the change management process.

Non-CMS Financial Management Information Systems

Similar to CMS, the Department's OPDIVs initiated efforts in FY 2010 to improve IT infrastructure and financial application systems to support the program. Examples of these improvements are:

- HHS continued its implementation of Hyperion, consolidating reporting module, to automate the preparation of Department-level consolidated and individual operating division financial statements.
- NIH implemented logical access authentication to NIHNet using HHS PIV-cards.
- NIH provided IT security awareness training to 100% of their staff.
- NIH consolidated and improved monitoring of Windows servers and developed a continuous monitoring process aligned to NIST guidelines to support the annual assessment of one-third of FISMA system security controls.
- OS awarded a new multi-year IT Service contract that serves several OPDIVs, including ACF, AHRQ, AoA, SAMHSA, OS, and the regional offices of HRSA. The contract includes task order awards for computer and infrastructure support, for business application hosting, and for continuity of operations and disaster recovery planning. In addition, the contract contains new service level agreements for IT security.
- HHS established the Computer Security Incident Response Capability to perform a number of important Department-wide security incident response coordination functions.
- OS's acting CIO set a fiscal year goal to achieve a 50% reduction in the number of open/delayed weaknesses. On October 1, 2009, there were 866 open Plan of Action and Milestones (POA&M) items, and as of July 15, 2010, there were 458 open POA&M items.
- GATES remediated 70% of the weaknesses identified during the 2009 audit.
- UFMS management implemented the User Provisioning Automation (UPA) system to centralize and automate the provisioning process.
- NBS management implemented a rigorous compensating manual process for managing system changes.

Although progress was noted in remediating system vulnerabilities and refining financial IT processes, our audit results continued to show significant infrastructure and financial application system weaknesses**.** Our procedures noted issues in both the design and the operations of key controls in both general and application controls. The scope of audit included general controls

testing for the National Institutes of Health's (NIH) Center for Information Technology (CIT). In addition, we reviewed the Unified Financial Management System (UFMS), NIH Business System (NBS); Grants Administration, Tracking and Evaluation System (GATES); HHS Consolidated Application System (HCAS); Enterprise Human Resources and Payroll (EHRP) System; Information for Management, Planning, Analysis, and Coordination (IMPACII); Automated Financial Statements System (AFS); and Commissioned Corps Personnel and Payroll System (CCP). The following represents a number of specific instances of deficiencies identified during our procedures.

Non-CMS Information Security Program

The security program is 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 provide for the overall effectiveness of security measures. Our procedures identified the following issues:

- Vulnerability Management - The vulnerability scanning process in one OPDIV is in transition, and no formal policies and/or procedures were in place at the time of our review.
- Background Investigation - Management at one OPDIV has not fully implemented an information technology new hire personnel security program for new employee background investigation.
- Remote Access - Users may access the DHHS network using their own personal home computers; however, there is currently no monitoring or ability to enforce or confirm that minimum security requirements or authentication requirements are met for personal computers logging onto DHHS network.
- Penetration Testing - One OPDIV continues to decrease the total number of external and internal system vulnerabilities; however, the vulnerabilities that continues to exist pose a significant risk. Categories of these risks are 1) weak password configurations, 2) insecure system configuration, and 3) unnecessary system services. Specific examples of these weaknesses are:
  - Two external web applications allowed privileged system access with the default usernames and passwords;
  - Databases with default user names and passwords;
  - 30 instances of anonymous file transfer protocols; and
  - Outdated software such as secure mail transfer protocol, domain name services, and secure shell.
- Application User Access Management - For some users, access to key financial systems such as AFS, EHRP, GATES, HCAS, and UFMS was not appropriately granted, reviewed, recertified, or removed.

- User IDs and Passwords: - Application users on key financial systems such as EHRP, GATES, HCAS, IMPACII, and UFMS utilized generic shared system IDs or had multiple IDs associated to accounts. Sharing of user IDs eliminates personal accountability for any system activity. A number of other system password configurations do not comply with DHHS standards.
- Security Management - Documentation to support corrective actions is not complete or not provided for the POA&M items for GATES and HCAS.
- Certification & Accreditation - Compliance with the C&A policies and procedures has not been formalized for HCAS. Documentation is not complete or contains inconsistent language for EHRP, GATES, HCAS, IMPACII, and UFMS.

Non-CMS Application Configuration Management

Elements of sound CM programs consist of a wide range of activities starting with the a formal change management process, authorization and approval of all configuration changes, a comprehensive testing and an audit trail that clearly documents and tracks the configuration changes. For the majority of the significant financial applications, the framework of a sound CM program exists; however, the CM program has not fully matured nor been integrated.

- Change Management - Change management procedures for UFMS, NBS, HCAS, IMPACII, GATES, and EHRP were insufficient to ensure only properly authorized changes were implemented into production systems. For NBS as an example, they lacked an automated tool to manage the CM process. As a result, NBS management established a cumbersome manual compensating process that is prone to error. In the case of UFMS, the application users have the system capability to apply configuration changes. This level of system access poses a significant risk without an effective monitoring tool. Due to this concern, UFMS initiated the implementation of a system monitoring tool, which will provide the automated capability to monitor the system for all changes. For FY2010, however, we were unable to determine the appropriateness of these system changes.
- Segregation of Duties - Access assignments were excessive for UFMS, NBS, IMPACII, HCAS, GATES, EHRP, and AFS systems and did not provide an adequate segregation of duties. Assignment conflicts represent instances whereby access assigned may have allowed users to perform all phases of transactions without intervention by other users or approvers. In addition, application developers had full access to both development and production system.

Other deficiencies that warrant attention include the following:

- Audit Log Monitoring - For the AFS, HCAS, and UFMS systems, audit log monitoring procedures were not documented. Further, audit trails that were generated were not being monitored or reviewed.

- Contingency Management - Contingency plans for HCAS could be enhanced. Plans did not include effective scenarios to address business resumption or address effective testing.

Due to the pervasive nature of general and application controls, the cumulative effect of these significant deficiencies represents a material weakness in the overall design and operation of internal controls. DHHS should take a department-wide view in developing a top-down strategy in implementing information security programs to drive information security control design and operations in accordance with standards established by DHHS and other Federal government standards promulgated by NIST and OMB. Detailed descriptions of control weaknesses may be found in the management letters issued on information technology general controls and audited applications.

Recommendations

To provide a secure computing environment for critical applications throughout the Department, HHS should:

- Develop a top down approach to system and information management where support and functional personnel work in collaboration to support the HHS and OPDIV missions while maintaining focus on integrated security and information management through defined directives and initiatives from executive level Departmental management.
- Enhance overall security management programs to update documentation and review certification & accreditation, plan of action and milestones, vulnerability management, and background investigations.
- Develop safeguards around access controls to limit unauthorized access to system assets, including controls around remote access and penetration testing.
- Develop and implement effective tools, policies, and procedures to review platform security settings for all components on a continuing basis.
- Develop an overall HHS platform configuration security standards for all operating platforms and databases, following the guidance issued by NIST, for all components
- Continue to test, track, and authorize all system changes planned for released into the live environment.
- Continue to review segregation of duties logs to ensure least privilege access is granted to users with significant security and change management responsibilities.
- Review and update contingency plans for the applications and critical processing locations and ensure proper testing is performed.
- Continue to review verify that user access to critical financial applications is properly granted and to recertify or remove access on a periodic basis.

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- Maintain updated system security plans for all critical applications and validate that information is accurate.
- Develop an effective data management program to establish optimal security settings on the database.

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STATUS OF PRIOR YEAR FINDINGS

In the reports on the results of the FY 2009 audit of the DHHS financial statements, a number of issues were raised relating to internal control. The chart below summarizes the current status of the prior year items:

Material Weaknesses		
Issue Area	**Summary Control Issue**	**FY 2010 Status**
Financial Reporting Systems, Analyses, and Oversight	• Lack of Integrated Financial Management System • Financial Analysis and Oversight • Management Corrective Actions	Certain progress noted; certain issues need continued focus. Repeat Condition
Financial Management Information Systems	• Security Management • Access Control • Configuration Management • Segregation of Duties • Contingency Planning • Financial Application Specific Concerns	Certain progress noted, certain issues need continued focus. Modified Repeat Condition

We have reviewed our findings and recommendations with DHHS management. Management generally concurs with our findings and recommendations and will provide a corrective action plan to address the findings identified in this report. We did not audit DHHS's response and, accordingly, we express no opinion on it.

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

/Ernst & Young LLP/

November 15, 2010
McLean, VA

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

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

We have audited the financial statements of the U.S. Department of Health and Human Services (DHHS) as of and for the year ended September 30, 2010, and we were engaged to audit the statement of social insurance as of January 1, 2010, and have issued our Report of Independent Auditors therein dated November 15, 2010. That report states that because of the matters discussed therein, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2010. Except for the matters discussed in the fourth paragraph of the Report of Independent Auditors, we conducted our audit in accordance with auditing standards generally accepted in the United States, 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*, as amended.

As part of obtaining reasonable assurance about whether DHHS's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts, and certain other laws and regulations specified in OMB Bulletin No. 07-04, as amended, including the requirements referred to in the Federal Financial Management Improvement Act of 1996 (FFMIA). We limited our tests of compliance to these provisions, and we did not test compliance with all laws and regulations applicable to DHHS.

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 the following laws and regulations or other matters that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 07-04, as amended, as described below.

DHHS's management is investigating potential violations of certain provisions of the Anti-Deficiency Act (31 U.S.C. §1341-1342, 1349-1351, and 1517-1519) and OMB Circular A-11.

Additionally, the Improper Payments Information Act (IPIA) of 2002 and the Improper Payment Eliminations and Recovery Act (IPERA) of 2010 (hereinafter the Acts) require federal agencies to identify the program and activities that may be susceptible to significant improper payments and estimate the amount of the improper payments. While DHHS is not in full compliance with the requirements of the Acts, it has developed and reported error rates for each of its seven high-

risk programs, or components of such programs. DHHS continues its efforts to fully implement the Acts and OMB's implementing regulation.

Under FFMIA, we are required to report whether DHHS's financial management systems substantially comply with federal financial management systems requirements, applicable federal accounting standards, and the United States Standard General Ledger (USSGL) at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA Section 803(a) requirements. The results of our tests disclosed instances in which DHHS's financial management systems did not substantially comply with certain requirements as discussed above. We have identified the following instances of noncompliance:

- Certain subsidiary systems are not integrated with the Unified Financial Management System (UFMS) and are not complemented by sufficient manual preventative and detective type controls. For example, although operational at some of the Medicare Contractors, DHHS has not yet completed the implementation of the HIGLAS general ledger system. Additionally, manual key input continues to be required for each Operation Division (OPDIV) to upload trial balances into the Automated Financial Statements System for consolidation in preparation of the departmental consolidated financial statements. Further, certain OPDIV-level reconciliations/analyses were not performed on a timely basis.

- Certain reconciliations and clearance of differences are not completed timely due to the use of ad hoc inquiries and system limitations on matching debits and credits to resolve certain issues.

- During fiscal year 2010, hundreds of manual journal vouchers were required to be recorded in UFMS to post certain types of transactions - including budgetary and proprietary, not currently configured correctly within UFMS and for the purpose of developing quarterly financial statements.

- Reviews of general and application controls over financial management systems identified certain departures from requirements specified in OMB Circulars A-127, *Financial Management Systems*, and A-130, *Management of Federal Information Resources*. Additionally, the Office of Inspector General (OIG) identified certain issues, including access control deficiencies related to systems as part of its Federal Information Security Management Act and other OIG engagements. Finally, DHHS management has identified certain weaknesses within its information technology general and application controls during its assessment of corrective action status and its OMB A-123 processes.

* * * * *

Our Report on Internal Control dated November 15, 2010, includes additional information related to the financial management systems that were found not to comply with the

requirements, relevant facts pertaining to the noncompliance to FFMIA, and our recommendations related to the specific issues presented. It is our understanding that management agrees with the facts as presented and that relevant comments from DHHS's management responsible for addressing the noncompliance are provided as an attachment to its report. We did not audit management's comments and, accordingly, we express no opinion on them. Additionally, DHHS is updating its agency-wide corrective action plan to address FFMIA and other financial management issues.

Providing an opinion on compliance with certain provisions of laws and regulations was not an objective of our audit and, accordingly, we do not express such an opinion.

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

/Ernst & Young LLP/

November 15, 2010
McLean, VA

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DEPARTMENT'S RESPONSE TO THE AUDIT

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

November 12, 2010

To: Daniel R. Levinson, Inspector General

From: Ellen G. Murray, Assistant Secretary for Financial Resources and Chief Financial Officer

Subject: FY2010 Financial Statement Audit

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

We appreciate the opportunity to comment on the draft reports provided to us on November 5, 2010. We generally concur with the findings identified in the draft Report on Internal Control. The final reports will be included in our FY 2010 Agency Financial Report. In response to your reports, we will prepare corrective action plans to address the identified findings within the next 60 days.

HHS management is committed to working toward resolving these challenges. We look forward to continued collaboration with the OIG to improve our stewardship of taxpayer funds.

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FINANCIAL STATEMENTS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CONSOLIDATED BALANCE SHEET
As of September 30, 2010 and 2009
(in Millions)

	2010	2009
Assets (Note 2)		
Intragovernmental		
Fund Balance with Treasury (Note 3)	$ 182,235	$ 161,962
Investments, Net (Note 4)	359,882	381,116
Accounts Receivable, Net (Note 5)	1,137	913
Other (Note 8)	99	92
Total Intragovernmental	543,353	544,083
Accounts Receivable, Net (Note 5)	7,394	5,504
Inventory and Related Property, Net (Note 6)	6,077	5,604
General Property, Plant & Equipment, Net (Note 7)	5,263	5,047
Other (Note 8)	1,652	2,542
Total Assets	$ 563,739	$ 562,780
Stewardship PP&E (Note 1)		
Liabilities (Note 9)		
Intragovernmental		
Accounts Payable	$ 906	$ 566
Other (Note 13)	1,572	1,182
Total Intragovernmental	2,478	1,748
Accounts Payable	673	554
Entitlement Benefits Due and Payable (Note 10)	72,712	72,218
Accrued Grant Liability (Note 12)	4,204	4,040
Federal Employee & Veterans' Benefits (Note 11)	9,985	9,690
Contingencies & Commitments (Note 14)	6,079	4,048
Other (Note 13)	3,082	2,069
Total Liabilities	99,213	94,367
Net Position		
Unexpended Appropriations - Earmarked funds	1,675	3,492
Unexpended Appropriations - Other funds	140,468	124,037
Unexpended Appropriations, Total	142,143	127,529
Cumulative Results of Operations - Earmarked funds	317,334	336,811
Cumulative Results of Operations - Other funds	5,049	4,073
Cumulative Results of Operations, Total	322,383	340,884
Total Net Position	464,526	468,413
Total Liabilities & Net Position	$ 563,739	$ 562,780

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

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CONSOLIDATED STATEMENT OF NET COST
For the Years Ended September 30, 2010 and 2009
(in Millions)

	2010	2009
Responsibility Segments		
Centers for Medicare & Medicaid Services (CMS)		
Gross Cost	$ 789,713	$ 749,004
Exchange Revenue (Note 16 & 17)	(60,717)	(57,294)
CMS Net Cost of Operations	728,996	691,710
Other Segments:		
Administration for Children and Families (ACF)	56,369	52,326
Administration on Aging (AoA)	1,530	1,441
Agency for Healthcare Research and Quality (AHRQ)	86	(55)
Centers for Disease Control and Prevention (CDC)	10,482	9,274
Food and Drug Administration (FDA)	3,130	2,629
Health Resources and Services Administration (HRSA)	9,222	7,314
Indian Health Service (IHS)	5,262	5,225
National Institutes of Health (NIH)	33,776	30,369
Office of the Secretary (OS)	6,720	2,341
Program Support Center (PSC)	1,063	975
Substance Abuse and Mental Health Services Administration (SAMHSA)	3,362	3,501
Other Segments Gross Cost of Operations before Actuarial Gains and Losses	131,002	115,340
Actuarial (Gains) and Losses Commissioned Corp Retirement System and Commissioned Corps Post Retirement Medical Plan	(77)	675
Other Segments Gross Cost of Operations after Actuarial Gains and Losses	130,925	116,015
Exchange Revenue (Note 16 and 17)	(3,193)	(3,820)
Other Segments Net Cost of Operations	127,732	112,195
Net Cost of Operations	$ 856,728	$ 803,905

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

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION
For the Year Ended September 30, 2010
(in Millions)

	2010			
	Earmarked Funds	All Other Funds	Eliminations	Consolidated Total
Cumulative Results of Operations:				
Beginning Balances	$ 336,811	$ 4,073	$ -	$ 340,884
Budgetary Financing Sources:				
Appropriations Used	228,883	408,384	-	637,267
Nonexchange Revenue				
Non-exchange Revenue - Tax Revenue	183,812	-	-	183,812
Non-exchange Revenue - Investment Revenue	17,349	4	-	17,353
Non-exchange Revenue - Other	619	(9)	90	700
Donations and Forfeitures of Cash and Cash Equivalents	83	2	-	85
Transfers-in/out without Reimbursement	(3,290)	1,746	-	(1,544)
Other Financing Sources (Non-Exchange):				
Donations and Forfeitures of Property	-	5	-	5
Transfers-in/out Without Reimbursement (+/-)	-	1	-	1
Imputed Financing	39	667	(166)	540
Other (+/-)	-	8	-	8
Total Financing Sources	427,495	410,808	(76)	838,227
Net Cost of Operations (+/-)	446,972	409,832	(76)	856,728
Net Change	(19,477)	976	-	(18,501)
Cumulative Results of Operations	317,334	5,049	-	322,383
Unexpended Appropriations				
Beginning Balances	3,492	124,037	-	127,529
Budgetary Financing Sources				
Appropriations Received	230,499	427,065	-	657,564
Appropriations Transferred in/out	-	(544)	-	(544)
Other Adjustments	(3,433)	(1,706)	-	(5,139)
Appropriations Used	(228,883)	(408,384)	-	(637,267)
Total Budgetary Financing Sources	(1,817)	16,431	-	14,614
Total Unexpended Appropriations	1,675	140,468	-	142,143
Net Position	**$ 319,009**	**$ 145,517**	**$ -**	**$ 464,526**

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

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION
For the Year Ended September 30, 2009
(in Millions)

	2009			
	Earmarked Funds	All Other Funds	Eliminations	Consolidated Total
Cumulative Results of Operations:				
Beginning Balances	$ 346,287	$ 2,868	$ -	$ 349,155
Budgetary Financing Sources:				
Appropriations Used	209,273	373,868	-	583,141
Nonexchange Revenue				
Non-exchange Revenue - Tax Revenue	194,330	-	-	194,330
Non-exchange Revenue - Investment Revenue	18,686	1	-	18,687
Non-exchange Revenue - Other	503	(9)	(127)	367
Donations and Forfeitures of Cash and Cash Equivalents	128	3	-	131
Transfers-in/out Without Reimbursement	(2,918)	1,465	4	(1,449)
Other Financing Sources (Non-Exchange):				
Donations and Forfeitures of Property	-	5	-	5
Transfers-in/out Without Reimbursement (+/-)	-	9	(2)	7
Imputed Financing	32	498	(105)	425
Other (+/-)	-	(10)	-	(10)
Total Financing Sources	420,034	375,830	(230)	795,634
Net Cost of Operations (+/-)	429,510	374,625	(230)	803,905
Net Change	(9,476)	1,205	-	(8,271)
Cumulative Results of Operations	336,811	4,073	-	340,884
Unexpended Appropriations				
Beginning Balances	12,172	81,350	-	93,522
Budgetary Financing Sources				
Appropriations Received	213,023	431,868	-	644,891
Appropriations Transferred in/out	-	1,854	-	1,854
Other Adjustments	(12,430)	(17,167)	-	(29,597)
Appropriations Used	(209,273)	(373,868)	-	(583,141)
Total Budgetary Financing Sources	(8,680)	42,687	-	34,007
Total Unexpended Appropriations	3,492	124,037	-	127,529
Net Position	$ 340,303	$ 128,110	$ -	$ 468,413

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

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
COMBINED STATEMENT OF BUDGETARY RESOURCES
For the Years Ended September 30, 2010 and 2009
(in Millions)

	2010		2009	
	Budgetary	Non-Budgetary Credit Program Financing Accounts	Budgetary	Non-Budgetary Credit Program Financing Accounts
Budgetary Resources:				
Unobligated Balance, Brought Forward, October 1:	$ 50,305	$ 73	$ 34,349	$ 95
Recoveries of Prior Year Unpaid Obligations				
Actual	17,682	-	12,719	-
Budget Authority				
Appropriation	1,194,294	-	1,153,357	1
Borrowing Authority	-	-	-	2
Spending Authority from Offsetting Collections				
Collected	9,020	18	10,449	19
Change in Receivables from Federal Sources	290	-	(263)	-
Change in Unfilled Customer Orders				
Advance Received	279	-	154	-
Without Advance from Federal Sources	(102)	-	(766)	-
Previously Unavailable	293	-	306	-
Expenditure Transfers from Trust Funds				
Actual	3,721	-	3,512	-
Change in Receivables from Trust Funds	313	-	515	-
Subtotal	1,208,108	18	1,167,264	22
Nonexpenditure Transfers, Net, Anticipated and Actual	(663)	-	2,100	-
Temporarily not available pursuant to Public Law	(11,296)	-	(1,515)	-
Permanently not available (-)	(5,281)	(16)	(29,731)	-
Total Budgetary Resources	$ 1,258,855	$ 75	$ 1,185,186	$ 117
Status of Budgetary Resources:				
Obligations Incurred				
Direct	$ 1,191,984	$ 25	$ 1,127,560	$ 44
Reimbursable	7,596	-	7,321	-
Subtotal	1,199,580	25	1,134,881	44
Unobligated Balances Available				
Apportioned	48,476	50	40,647	72
Exempt from Apportionment	354	-	389	-
Subtotal	48,830	50	41,036	72
Unobligated Balances Not Available	10,445	-	9,269	1
Total Status of Budgetary Resources	$ 1,258,855	$ 75	$ 1,185,186	$ 117
Change in Obligated Balance:				
Obligated Balance, Net				
Unpaid Obligations, brought forward, October 1	$ 171,739	$ -	$ 145,222	$ -
Uncollected Customer Payments from Federal Sources, brought forward, October 1	(6,678)	-	(7,192)	-
Total unpaid Obligated Balance, Net	165,061	-	138,030	-
Obligations Incurred Net	1,199,580	25	1,134,881	44
Gross Outlays	(1,171,097)	(25)	(1,095,645)	(44)
Recoveries of Prior Year Unpaid Obligations, Actual	(17,682)	-	(12,719)	-
Change in Uncollected Customer Payments from Federal Sources	(501)	-	514	-
Obligated Balance, Net, End of Period				
Unpaid Obligations	182,540	-	171,739	-
Uncollected Customer Payments from Federal Sources	(7,179)	-	(6,678)	-
Total, Unpaid Obligated Balance, Net, End of Period	175,361	-	165,061	-
Net Outlays				
Gross Outlays	1,171,097	25	1,095,645	44
Offsetting Collections	(13,020)	(18)	(14,115)	(19)
Distributed Offsetting Receipts	(303,967)	(10)	(284,264)	(28)
Net Outlays	$ 854,110	$ (3)	$ 797,266	$ (3)

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

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
STATEMENT OF SOCIAL INSURANCE
75-Year Projection as of January 1, 2010 and Prior Base Years
(in Billions)

		Estimates from Prior Years			
	2010	2009	2008	2007	2006
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 24 and 25)	*unaudited*				
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 7,216	$ 6,348	$ 6,320	$ 5,975	$ 5,685
SMI Part B	12,688	16,323	14,932	12,112	12,446
SMI Part D	6,355	6,144	6,527	7,285	7,366
Have attained eligibility age (age 65 and over)					
HI	248	209	202	178	192
SMI Part B	1,972	1,924	1,785	1,648	1,606
SMI Part D	646	595	581	746	750
Those expected to become participants					
HI	6,944	5,451	5,361	4,870	4,767
SMI Part B	3,077	4,909	4,480	4,460	3,562
SMI Part D	2,714	2,632	2,856	2,735	2,134
All current and future participants:					
HI	14,408	12,008	11,883	11,023	10,644
SMI Part B	17,737	23,156	21,197	18,221	17,613
SMI Part D	9,715	9,371	9,964	10,766	10,250
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of:(Notes 24 and 25)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	12,032	18,147	17,365	15,639	15,633
SMI Part B	12,587	16,342	14,949	12,130	12,433
SMI Part D	6,355	6,144	6,527	7,273	7,338
Have attained eligibility age (age 65 and over)					
HI	2,648	2,958	2,747	2,558	2,397
SMI Part B	2,166	2,142	1,986	1,834	1,773
SMI Part D	646	595	581	794	792
Those expected to become participants					
HI	2,411	4,673	4,506	5,118	3,904
SMI Part B	2,984	4,672	4,262	4,257	3,407
SMI Part D	2,714	2,632	2,856	2,699	2,121
All current and future participants:					
HI	17,090	25,778	24,619	23,315	21,934
SMI Part B	17,737	23,156	21,197	18,221	17,613
SMI Part D	9,715	9,371	9,964	10,766	10,250
Actuarial present values for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 24 and 25)					
HI	$ (2,683)	$ (13,770)	$(12,737)	$(12,292)	$ (11,290)
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 expenditures (Notes 24 and 25)					
HI	$ (2,683)	$ (13,770)	$(12,737)	$(12,292)	$ (11,290)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Trust fund assets at start of period					
HI	304	321	312	300	285
SMI Part B	76	59	53	38	23
SMI Part D	1	1	3	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 expenditures (Notes 24 and 25)					
HI	$ (2,378)	$ (13,449)	$(12,425)	$ (11,993)	$ (11,006)
SMI Part B	76	59	53	38	23
SMI Part D	1	1	3	1	-

Note: Totals do not necessarily equal the sums of rounded components.
With the exception of the 2007 projections presented, current participants are assumed to be the "closed group" of individuals who are at least age 15 at the start of the projection period, and are participating in the program as either taxpayers, beneficiaries, or both. For the 2007 projections, the "closed group" are assumed to be individuals who are at least 18 at the start of the projection period, and are participating in the program as either taxpayers, beneficiaries, or both.

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

NOTES TO THE PRINCIPAL FINANCIAL STATEMENTS FOR THE YEARS ENDED SEPTEMBER 30, 2010 AND 2009

Note 1. Summary of Significant Accounting Policies

Reporting Entity

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

Organization and Structure of the HHS

The HHS is comprised of the Office of the Secretary and 10 other Operating Divisions (OPDIVs) with diverse missions and programs. The Office of the Secretary and the OPDIVs are each responsible for carrying out a mission, conducting a major line of activity, or producing one or a group of related products or services. Although organizationally located within the Office of the Secretary, the Program Support Center reports on its activity separately because its business activities encompass offering services to other Federal agencies and the HHS OPDIVs. 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. Managers of the responsibility segments report directly to the entity's top management, and the resources and results of operations can be clearly distinguished from those of other responsibility segments.

The 12 responsibility segments are:

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 and
   Agency for Toxic Substances and Disease Registry (CDC)
5. Centers for Medicare and 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 (OS) – excluding the Program Support Center
11. Program Support Center (PSC)
12. Substance Abuse and Mental Health Services Administration (SAMHSA)

The HHS partners with other governmental agencies to accomplish its mission. One such partnership is with the Department of Homeland Security for the Biodefense Countermeasures Fund, which is reported on the HHS financial statements under the Office of the Secretary responsibility segment.

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 (CFO) Act of 1990* (*P.L. 101-576*), as amended by the *Government Management Reform Act of 1994 (P.L. 103-356)*, and presented in accordance with the requirements in the Office of Management and Budget (OMB) Circular No. A-136, *Financial Reporting Requirements* (OMB Circular A-136). 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 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 200 appropriations and fund accounts. The fund accounts include accounts used for suspense, collection of receipts, and general government functions. Transactions and balances within the HHS have been eliminated in the presentation of the Consolidated Balance Sheet and Statements of Net Cost and Changes in Net Position. The Combined Statements of Budgetary Resources are presented on a combined basis; therefore, transactions and balances within the HHS 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.

Financial Management Systems Program

The HHS' financial management goals seek to (a) provide decision-makers with timely, accurate, and useful financial and program information and (b) ensure that the HHS resources are used appropriately, efficiently, and effectively. The HHS continues to strive for improvements in financial management and reporting by streamlining and integrating its financial management systems to ensure transparency and accountability.

The HHS established the Financial Management Systems Program to provide central management direction and oversight of financial management systems across the Department. The HHS facilitates collaboration between business owners and information technology professionals to maximize the HHS investment and reduce redundancies. The goal is to strengthen governance by engaging the business owners and the information technology professionals throughout the life cycle of the HHS financial management system.

Three major systems support HHS programs: the Healthcare Integrated General Ledger Accounting System (HIGLAS), the Unified Financial Management System (UFMS), and the NIH Business Systems (NBS). The HHS will continue its reporting and system enhancements to strengthen controls, operating performance, and reporting capabilities.

The Consolidated Financial Reporting System (CFRS) is under development to generate automated consolidated financial statements, and will be deployed for the first quarter of fiscal year 2011. CFRS addresses the Department's recurring *CFO Act* audit findings and the *Federal Financial Management Improvement Act of 1996 (P.L. 104-208)* system non-compliance. The system will eliminate the OPDIVs' manual intervention for the consolidation process. During FY 2010, the FDA piloted the Oracle Business Intelligence Enterprise Edition – a reporting dashboard for managers – to enhance the availability of financial management information.

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 reported amounts of assets and liabilities, and the disclosure of contingent liabilities as of the date of the financial statements. Estimates and assumptions also affect revenues and expenses accrued and reported in the financial statements. Actual results may differ from estimates.

Parent/Child Reporting

Allocation transfers are legal delegations by one agency of its authority to obligate budget authority and outlay funds to another agency. The HHS is party to allocation transfers with other Federal agencies as both a transferring (parent) entity and a receiving (child) entity.

A separate fund account (allocation account) is created in the Department of the Treasury (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.

In FY 2008, the HHS received an exception to the Parent/Child reporting requirements of OMB Circular No. A-136 as it pertains to the allocation transfer from the Department of Homeland Security (DHS) to the HHS for the Biodefense Countermeasures Fund for FY 2008 and beyond. Per this exception, the HHS, as the child, assumed the financial statement reporting responsibilities of this fund. Also, due to the revised definition of Parent/Child reporting, and revised Treasury Appropriation Codes made by Treasury in FY 2009, the Treasury-managed Trust Funds Supplementary Medical Insurance (SMI) Trust Fund, the Hospital Insurance (HI) Trust Fund, the Vaccine Injury Compensation Program (VICP) Trust Fund and the Health Care Fraud and Abuse Control Account, are no longer considered as Parent/Child reporting. These changes have no impact on the HHS reporting of the Treasury-managed Trust Funds.

In addition to these funds, the HHS allocates funds, as the parent, to the Department of Interior, Bureau of Indian Affairs and Department of Treasury, Internal Revenue Service. The HHS receives allocation transfers, as the child, from the Departments of Agriculture, Justice and State.

Reclassifications

Certain FY 2009 balances have been reclassified to conform to FY 2010 financial statement presentations, the effects of which are immaterial.

Earmarked Funds

Earmarked funds are financed by specifically identified revenues often supplemented by other financing sources, or other specific financing sources, which remain available over time. Earmarked funds must meet the following criteria:

- A statute committing the Federal Government to use specifically identified revenues and other financing sources only for designated activities, benefits or purposes;
- Explicit authority for the earmarked fund to retain revenues and other financing sources not used in the current period for future use to finance the designated activities, benefits, or purposes; and
- A requirement to account for and report on the receipt, use, and retention of the revenues and other financing sources that distinguishes the earmarked fund from the Government's general revenues.

The HHS' major earmarked funds are described below:

Medicare Hospital Insurance (HI) Trust Fund – Part A

Section 1817 of the *Social Security Act (P.L. Ch. 531, 49 Stat. 620, now codified as 42 U.S.C. Ch. 7, P.L. 104-191)* established the Medicare HI Trust Fund. Medicare contractors are paid by the HHS to process Medicare claims for hospital in-patient services, hospice, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the HI Trust Fund. A portion of HHS payments to Medicare Advantage Plans (previously known as Managed Care plans) are also charged to this fund. The financial statements include the HI Trust Fund activities administered by the Treasury. The HI Trust Fund has permanent indefinite authority.

Employment tax revenue is the primary source of financing for the Medicare HI program. Medicare's portion of payroll and self-employment taxes is collected under the *Federal Insurance Contributions Act (FICA) (26 U.S.C. Ch 21)* and *Self Employment Contributions Act (SECA) of 1954 (Chapter 2 of Subtitle A of the Internal Revenue Code, 26 U.S.C. §1401 through §1403*). Employees and employers are both

required to contribute 1.45 percent of earnings, with no limitation, to the HI Trust Fund. Self-employed individuals contribute the full 2.9 percent of their net income. The *Social Security Act* requires the transfer of these contributions from the Treasury General Fund to the HI Trust Fund based on the amount of wages certified by the Commissioner of Social Security from the Social Security Administration (SSA) records of wages. The SSA uses the wage totals reported by employers via the quarterly Internal Revenue Service, *Employer's Quarterly Federal Tax Return,* as the basis for conducting quarterly certification of regular wages.

Medicare Supplementary Medical Insurance (SMI) Trust Fund – Part B

Section 1841 of the *Social Security Act* established the Medicare SMI Trust Fund. Medicare contractors are paid by the HHS to process Medicare claims for physicians, medical suppliers, hospital out-patient services and rehabilitation, end–stage renal disease treatment, rural health clinics, laboratory services, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the SMI Trust Fund. A portion of HHS payments to Medicare Advantage Plans are also charged to this fund. The financial statements include SMI Trust Fund activities administered by the Treasury. The SMI Trust Fund has permanent indefinite authority.

SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and are matched by the Federal Government through the General Fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the *Social Security Act* authorizes appropriated funds to match SMI premiums collected and prescribes the ratio for the match as well as the method to fully compensate the Trust Fund if insufficient funds are available in the appropriation to match all premiums received in the fiscal year.

Medicare Supplementary Medical Insurance Trust Fund – Part D

The Medicare Supplementary Medical Insurance Trust Fund – Part D, (Prescription Drug Benefit) was established by the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (known as the *Medicare Modernization Act*, or *MMA*) *(P.L. 108-173)*. The Prescription Drug Benefit is available to all Medicare beneficiaries and provides a prescription drug benefit to those who opt into the program (beneficiaries eligible for Medicaid are automatically enrolled unless they have other credible drug coverage). The Prescription Drug Benefit is part of the SMI Trust Fund and is reported in the Medicare column of the financial statements where required. Drug plans are offered by insurance companies and other private companies approved by Medicare and are of two types: Medicare Prescription Drug Plans, which add coverage to fee-for-service Medicare and Medicare Advantage Prescription Drug Plans and other Medicare Health Plans in which drug coverage is offered as part of a benefit package that includes Part A and Part B services. Medicare helps employers and unions continue to provide retiree drug coverage that meets Medicare's standards through the Retiree Drug Subsidy. The Low Income Subsidy helps those with limited income and resources.

Medicare Integrity Program

The *Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104-191)* established the Medicare Integrity Program and codified the Medicare Integrity Program activities previously known as "payment safeguards." The HIPAA also established the Health Care Fraud and Abuse Control Account, which provides a dedicated appropriation for carrying out the Medicare Integrity Program. Through the Medicare Integrity Program, the HHS contracts with eligible entities to perform such activities as medical and utilization reviews, fraud reviews, cost report audits. In addition, the Department will educate providers and beneficiaries, with respect to payment integrity and benefit quality assurance issues. The Medicare Integrity Program is funded by the HI Trust Fund.

Revenue and Financing Sources

The HHS receives the majority of funding needed to support its discretionary 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 HHS. Other financing sources, such as donations and transfers of assets without reimbursements, are also recognized on the Consolidated Statement of Changes in Net Position.

Appropriations

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

Borrowing Authority

The HHS uses indefinite borrowing authority under the *Federal Credit Reform Act of 1990 (FCRA), (P.L. 101-508, as amended)* for its loan programs. Borrowing authority increases budgetary resources and enables costs to be financed by borrowing from Treasury. Any unobligated borrowing authority does not carry forward to the next fiscal year. The HHS has several existing programs with borrowing authority: the Health Care Loan Program and the Health Education Assistance Loan Program.

In FY 2010, HHS received borrowing authority under the *Patient Protection and Affordable Care Act (P.L. 111-148, § 1322)* to support the Consumer Operated and Oriented Plan (CO-OP) Program. The Act requires HHS to provide loans for start-up costs. This provision fosters the creation of qualified, non-profit health insurance issuers who will offer qualified health plans in the individual- and small-group markets of each State. These loans will be repaid in a manner consistent with State solvency and reserve requirements. These program awards are to be made no later than July 1, 2013.

- *Direct Loans*

The Health Care Infrastructure Improvement Program (enacted into law as part of the *Medicare Modernization Act of 2003, P.L. 108-173)* provides direct loans to hospitals or entities engaged in research of causes, prevention, and treatment of cancer. These entities are designated as cancer centers by the National Cancer Institute, or by the State legislature as the official cancer institute of the State. Such State designation must have occurred prior to December 8, 2003 to qualify for payment of capital costs for eligible projects.

- *Loan Guarantees*

The HHS administers guaranteed loan programs for the Health Center and the Health Education Assistance Loan Programs. Loans receivable represent defaulted guaranteed loans which have been paid to lenders under these programs and also include interest due to the HHS on the defaulted loans. The liabilities for loan guarantees are valued at the present value of the cash outflows from the HHS less the present value of related inflows. Due to the immateriality of these Direct Loans and Loan Guarantees, the related receivables and liabilities are reported in Other Assets and Other Liabilities, respectively.

Exchange Revenue

Exchange revenue is recognized when earned (i.e., when goods have been delivered or services have been rendered). These revenues reduce the cost of operations.

The HHS' pricing policy for 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.

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 HHS 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 Consolidated Statement of Changes in Net Position.

Non-Exchange Revenue

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 Consolidated Statement of Changes in Net

Position. Employment tax revenue collected under *FICA* and *SECA* is considered non-exchange revenue. See Medicare Hospital Insurance Trust Fund – Part A for descriptions of this revenue.

Imputed Financing Sources

In certain instances, the HHS' operating costs 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 Consolidated Statement of Net Cost and as an imputed financing source on the Consolidated Statement of Changes in Net Position.

Intragovernmental Transactions and Relationships

Intragovernmental transactions are transactions between Federal entities, meaning both the buyer and seller are Federal entities. Transactions with the public are transactions in which the buyer or seller of the goods or services is a non-Federal entity and the other party is a Federal entity.

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.

In the course of its operations, the HHS has relationships and financial transactions with numerous Federal agencies. The more prominent of these are with the SSA and the Treasury. The SSA determines eligibility for Medicare programs and also deducts Medicare Part B premiums from Social Security benefit payments and allocates those funds 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. Medicare Part D is primarily financed by the General Fund of the Treasury and beneficiary premiums.

Entity and Non-Entity Assets

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

Fund Balance with Treasury (FBWT)

The HHS maintains its available funds with the Treasury. The FBWT is available to pay current liabilities and finance authorized purchases. Cash receipts and disbursements are processed by the Treasury, and the HHS FBWT accounts are reconciled with those of Treasury on a regular basis.

Custodial Activity

Following OMB Circular A-136 guidance, the HHS now reports custodial activities on its Balance Sheet. However, the HHS does not prepare a separate Statement of Custodial Activity since custodial activities are incidental to its operations and the amounts collected are immaterial.

The ACF receives funding from the Internal Revenue Service for outlay to the States for child support. This funding represents delinquent child support payments withheld from Federal tax refunds. The FDA custodial activity involves collections of civil monetary penalties (CMP) assessed by the Department of Justice on behalf of FDA. Penalties are assessed for violations in areas such as illegally manufactured, marketed, and distributed animal food and drug products. The CDC custodial activity consists of collections of interest on outstanding receivables and funds received from debts in collection status.

Investments, Net

The HHS invests entity Medicare Trust Fund balances in excess of current needs in U.S. securities. The Treasury acts as the fiscal agent for the U.S. Government's investments in securities. Section 1817 for the HI Trust Fund and Section 1841 for the SMI Trust Fund of the *Social Security Act* require that Trust Funds not necessary to meet current expenditures be invested in interest-bearing obligations, or in obligations guaranteed as to both principal and interest by the U.S. Government. The cash receipts collected from the public, for the earmarked funds, are deposited with the Treasury, which uses the cash for general government purposes. Treasury securities are issued by Bureau of Public Debt to the HI and SMI Trust Funds as evidence of their receipt and are an asset to the Trust Funds and a liability of the Treasury. The Federal Government does not set aside assets to pay future benefits or other expenditures associated with the HI or SMI Trust Funds.

The Treasury securities provide the HI and SMI Trust Funds with authority to draw upon the U.S. Treasury to make future benefit payments or other expenditures. When the Trust Funds require redemption of these securities to make expenditures, the government finances the expenditures by (a) raising taxes, (b) raising other receipts, (c) borrowing from the public or repaying less debt, or (d) curtailing other expenditures. This is the same way that the Government finances all expenditures.

The Treasury securities issued and redeemed to the HI and SMI Trust Funds are Non-Marketable (Par Value) securities. These investments are carried at face value as determined by Treasury. Interest income is compounded semiannually (June and December) by Treasury and at year end is adjusted to include an accrual for interest earned from July 1 to September 30 (See Note 4).

The Vaccine Injury Compensation Trust Fund, an earmarked trust fund similar to the HI and SMI Trust Funds, invests in Non-Marketable Market Based securities issued by Bureau of Public Debt in the form of One Day Certificates and Market-Based Bills, Notes and Bonds.

The NIH Gift Funds are invested in Non-Marketable Market Based Bills issued by the Bureau of Public Debt. Funds are invested for either a 90 day or 180 day period based on the need for funds – no provision is made for unrealized gains or losses on these securities since it is the HHS' intent to hold investments to maturity.

The *Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3)* established a Child Enrollment Contingency Fund to cover shortfalls in funding for the States' Children's Health Insurance Program (CHIP). The *Affordable Care Act* extended the availability of the fund through 2015. This fund is invested in Non-Marketable Market-Based Bills issued by Bureau of Public Debt. These investments will be redeemed as funds are needed by the States to cover short-term shortfalls in the program.

Accounts Receivable, Net

Accounts Receivable, Net 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 less an allowance for uncollectible amounts. Intragovernmental accounts receivable arise generally from the provision of reimbursable work to other Federal agencies and no allowance for uncollectible amounts is established as they are considered fully collectible. Accounts receivable from the public are primarily composed of provider and beneficiary overpayments, Medicare Prescription Drug overpayments, Medicare premiums, and Medicaid audit disallowances.

Accounts Receivable are presented net of an allowance for uncollectible amounts. The allowance is based on past collection experience and an analysis of outstanding balances. For Medicare accounts receivable, the HHS calculates the allowance for uncollectible amounts based on the collection activity and the age of the debt for the most current fiscal year, while taking into consideration the average uncollectible percentage for the preceding five years. The Medicaid accounts receivable has been recorded at a net realizable amount based on historical analyses of actual recoveries and the rate of disallowances found in favor of the States.

Advances to Grantees and Accrued Grant Liability

The HHS awards grants to various grantees and provides advance payments to meet grantees' cash needs to carry out the HHS programs. Advance payments are recorded as "Advances to Grantees" and are liquidated upon grantees' reporting expenditures on the quarterly *Federal Financial Report*. In some instances, grantees incur expenditures before drawing down funds that, when claimed, would reduce the

"Advances to Grantees" account to a negative balance. An "Accrued Grant Liability" occurs when the accrued grant expenses exceed the outstanding advances to grantees.

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

For "Grants Subject to Grant Expense Accrual," commonly referred to as "non-block grants," grantees draw funds (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 expenditure 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 the HHS components and other Federal entities. Inventories Held for Sale are valued at historical cost using the weighted average valuation method for the PSC inventories and using the moving average valuation method for the NIH inventories.

Operating Materials and Supplies include pharmaceuticals, biological products, and other medical supplies used to provide medical services and conduct medical research. They are recorded as assets when purchased and are expensed when consumed. Operating Materials and Supplies are valued at historical cost using the first-in/first-out (FIFO) cost flow assumption.

Stockpile Materials are held in reserve to respond to local and national emergencies. The HHS maintains several stockpiles for emergency response purposes, which include the Strategic National Stockpile (SNS), Vaccines for Children (VFC) and Avian Influenza (H5N1). The pre-pandemic H5N1 Avian Influenza vaccine stockpile is held in reserve to respond to an avian pandemic declaration. The stockpile contains several million doses of vaccine in bulk which is stored and maintained for possible use. Project BioShield has increased the preparedness of the nation by procuring medical countermeasures that include anthrax vaccine, anthrax antitoxins, botulinum antitoxins, and blocking and decorporation agents for a radiological event. The cost value of the stockpile is vast and the importance of the vaccine stockpile is incalculable. All stockpiles are valued at historical cost, using various cost flow assumptions, including the FIFO for SNS and specific identification for VFC and Avian Influenza.

General Property, Plant and Equipment (PP&E), Net

The General PP&E consists of buildings, structures, and facilities used for general operations; land acquired for general operating purposes; equipment; assets under capital lease; leasehold improvements; construction-in-progress; and internal use software. The basis for recording purchased PP&E is full cost, including all costs incurred to bring the PP&E to a form and location suitable for its intended use, and is shown net of accumulated depreciation.

The cost of PP&E acquired under a capital lease is the amount recognized as a liability for the capital lease at its inception; or when acquired through a donation is the estimated fair market value when acquired. The cost of PP&E transferred from other Federal entities is the transferring entity's net book value. 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 Statement of Federal Financial Accounting Standards (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. The estimated useful life for internal use software is three to ten years for amortization purposes. The HHS begins amortization when the internal use software is placed in use. Capitalized costs include all direct and indirect costs.

The HHS' capitalization threshold for internal use software costs for appropriated fund accounts is $1 million and the 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 consists of stewardship land whose physical properties resemble those of General PP&E that are traditionally capitalized in the financial statements. Based on SFFAS No. 29, *Heritage Assets and Stewardship Land*, and due to the immateriality of these assets, the HHS does not report a related amount on the balance sheet.

The HHS' stewardship assets support the day-to-day operations of providing health care to American Indians and Alaskan Natives in remote areas of the country where no other facilities exist.

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

The HHS asset accountability reports differentiate Indian Trust land parcels from General PP&E situated thereon. The Required Supplementary Information (RSI) section provides additional information 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 HI 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: (a) new budget authority, (b) spending authority from offsetting collections, (c) recoveries of expired budget authority, (d) unobligated balances of budgetary resources at the beginning of the year, and (e) permanent indefinite appropriation or borrowing authority.

Liabilities Not Covered by Budgetary Resources

Sometimes funding has not yet been made available through Congressional appropriation or current earnings. The major liabilities in this category include employee annual leave earned but not taken, and amounts billed by the Department of Labor (DOL) for the *Federal Employees' Compensation Act (FECA) of 1916 (5 U.S.C. 751)* disability payments. Also included in this category is the actuarial *FECA* liability determined by DOL but not yet billed.

Accounts Payable

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

Fiduciary Activities

Effective FY 2009, the SFFAS No. 31, *Accounting for Fiduciary Activities* requires Federal entities to distinguish the information relating to fiduciary activities of the Federal entity from all other activities. The fiduciary activities are those Federal Government activities that relate to the collection or receipt, and the subsequent management, protection, accounting, investment and disposition of cash or other assets in which non-Federal individuals or entities have an ownership interest that the Federal Government must uphold. The HHS does not have reportable activities as defined by SFFAS No. 31.

Accrued Payroll and Benefits

Accrued Payroll and Benefits consists of salaries, wages, leave and benefits earned by employees but not disbursed at the end of the reporting period. A liability for annual and other vested compensatory leave is accrued as earned and reduced when taken. At the end of each fiscal year, the balance in the accrued annual leave liability account is adjusted to reflect current pay rates. Annual leave earned but not taken is considered an unfunded liability since it will be funded from future appropriations when it is actually taken by employees. Sick leave and other types of leave are not accrued and are expensed when taken. Intragovernmental Accrued Payroll and Benefits consists primarily of the HHS *FECA* liability.

Entitlement Benefits Due and Payable

Entitlement Benefits Due and Payable represents a liability for Medicare and Medicaid owed to the public for medical services incurred but not reported (IBNR) as of the end of the reporting period. The Medicare and Medicaid programs are the largest entitlement programs in the HHS.

Medicare

The Medicare liability is developed by the CMS Office of the Actuary 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 approved for payment by the Medicare contractors for which checks have not yet been issued.

(c) Checks 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.

(e) An estimate of retroactive settlements of cost reports submitted to the Medicare contractors by health care providers.

The HHS develops estimates for medical costs IBNR using an actuarial process that is consistently applied, centrally controlled, and automated. The actuarial models consider factors such as time from date of service to claim receipt, claim backlogs, medical care professional contract rate changes, medical care consumption, and other medical cost trends. The HHS estimates liabilities for physician, hospital, and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies. Each period, the HHS re-examines previously established medical cost payable estimates based on actual claim submissions and other changes in facts and circumstances. As the liability estimates recorded in prior periods become more exact, the HHS adjusts the amount of the estimates, and includes the changes in estimates in medical costs in the period in which the change is identified. In every reporting period, the HHS operating results include the effects of more completely developed Medicare benefits payable estimates associated with previously reported periods.

Medicaid

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

The American Recovery and Reinvestment Act of 2009 (Recovery Act, P.L. 111-5) provides additional Federal funding for the States through a temporary increase in the Federal Medical Assistance Percentages through the first quarter of FY 2011. *P.L. 111-226* extended this additional assistance, at phased down levels, through the third quarter of FY 2011. *P.L.111-226*, Title II, Subtitle A - State Fiscal Relief and Other Provisions, Sec. 201, extends this additional assistance, at phased down levels, through the third quarter of FY 2011.

Federal Employee and Veterans' Benefits

The HHS administers the Public Health Service (PHS) Commissioned Corps Retirement System (authorized by the *Public Health Service Act*, *P.L. 78-410*), a defined noncontributory benefit plan, for its active duty officers, retiree annuitants and survivors. The plan does not have accumulated assets, and funding is provided entirely on a pay-as-you-go basis by Congressional appropriation. The HHS records the present value of the Commissioned Corps pension and post-retirement health benefits.

The liability for Federal Employee and Veterans' Benefits also includes a liability for actual and estimated future payments for workers' compensation pursuant to the *FECA*. The *FECA* provides income and medical cost protection to Federal employees injured on the job or who sustained a work-related occupational disease, and 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: (a) actual claims paid by the DOL but not yet billed to agencies and (b) an estimated liability for future benefit payments as a result of past events such as death, disability, and medical costs.

Most HHS employees participate in the Civil Service Retirement System (CSRS), a defined benefit plan, or the Federal Employees' Retirement System (FERS), a defined benefit and contribution plan. For employees covered under CSRS, the Department contributes a fixed percentage of pay. Most employees hired after December 31, 1983, are automatically covered by the FERS. For employees covered under FERS, the Department contributes the employer's matching share for Social Security and Medicare Insurance. FERS offers a Thrift Savings Plan into which the Department automatically contributes one percent of employee pay and matches the first 3 percent of employee contributions dollar for dollar. Each dollar of the employee's next 2 percent of basic pay is matched 50 cents on the dollar.

The Office of Personnel Management is the administering agency for both of these benefit plans and, thus, reports CSRS and FERS assets, accumulated plan benefits, and unfunded liabilities applicable to Federal employees. Therefore, the HHS does not recognize any liability on its Consolidated Balance Sheet for pensions, other retirement benefits, and other post-employment benefits of its Federal employees with the exception of the PHS Commissioned Corps. The HHS does, however, recognize an expense in the Consolidated Statement of Net Cost and an imputed financing source for the annualized unfunded portion of pension and post-retirement benefits in the Consolidated Statement of Changes in Net Position. Gains or losses from changes in assumptions in the PHS Commissioned Corps retirement benefits are recognized at year end.

Contingencies

A loss contingency is an existing condition, situation, or set of circumstances involving uncertainty as to possible loss to the HHS. 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*, contains the criteria for recognition and disclosure of contingent liabilities.

The HHS and its components could be parties to various administrative proceedings, legal actions, and claims brought by or against it. With the exception of pending, threatened, or potential litigation, a contingent liability is recognized when a past transaction or event has occurred, a future outflow or other sacrifice of resources is more likely than not to occur, and the related future outflow or sacrifice of resources is measurable. For pending, threatened, or potential litigation, a contingent liability is recognized

when a past transaction or event has occurred, a future outflow or other sacrifice of resources is likely to occur, and the related future outflow or sacrifice of resources is measurable.

Statement of Social Insurance

The SOSI presents the projected 75-year actuarial present values of the income and expenditures of the HI and SMI Trust Funds. Future expenditures are expected to arise from the health care payment provisions specified in current law for current and future program participants and from associated administrative expenses. Actuarial present values are computed on the basis of the intermediate set of assumptions specified in the *Annual Report of the Medicare Board of Trustees*. These assumptions represent the Trustees' best estimate of likely future economic, demographic, and health care-specific conditions. The projected potential future income and expenditures under current law are not included in the accompanying Consolidated Balance Sheet, Statements of Net Cost, and Changes in Net Position, or Combined Statement of Budgetary Resources.

In order to make projections regarding the future financial status of the HI and SMI Trust Funds, various assumptions have to be made. As stated previously, the estimates presented here are based on the assumption that the Trust Funds will continue to operate under the law in effect August 5, 2010. In addition, the estimates depend on many economic, demographic, and health care-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 are drawn from the Social Security and Medicare Trustees Reports for 2010. 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.

American Recovery and Reinvestment Act of 2009

The *American Recovery and Reinvestment Act of 2009* (*Recovery Act, P.L. 111-5)* was signed into law on February 17, 2009. It was an extraordinary response to an economic crisis that included measures to modernize our nation's infrastructure, enhance energy independence, expand educational opportunities, preserve and improve affordable health care, provide tax relief, and protect those in greatest need.

The *Recovery Act* provides an estimated $141 billion to the HHS from 2009 through 2019, to fund Health Information Technology, Comparative Effectiveness Research, Prevention and Wellness, Scientific Research, Social Services, and Medicaid relief to the States. For further information concerning HHS obligations and expenditures related to the *Recovery Act*, see Note 27.

Affordable Care Act of 2010

During FY 2010, President Obama signed health insurance reform legislation giving Americans more control over their health care. The *Patient Protection and Affordable Care Act (P.L. 111-148)* and the *Health Care and Education Reconciliation Act (P.L. 111-152)* collectively referred to as the *Affordable Care Act* ensures that all Americans have access to quality, affordable health care, while significantly reducing long-term health care costs. Further information is available at http://www.healthcare.gov/.

For FY 2010, the *Affordable Care Act* included appropriated funding to the HHS for approximately 34 provisions. Of the 34 provisions, Congress appropriated approximately $18.7 billion for 32 provisions, and such sums as may be necessary for two provisions. This amount includes funding that was appropriated in FY 2010 to be available for one or multiple years and excludes amounts appropriated to other Departments or Agencies. Congress also authorized, but did not appropriate, funding for over 100 provisions in FY 2010.

Under the *Affordable Care Act*, the HHS was authorized to execute several new programs, which include: Qualified High Risk Pool for Pre-existing Conditions, Early Retiree Reinsurance Programs, American Health Benefit Exchanges (the "Exchanges"), Consumer Operated and Oriented Plan (CO-OP) Program, and the *Community Living Assistance Services and Support (CLASS) Act*. A brief description of these programs and their impact on the HHS financial statements is presented below.

Qualified High Risk Pool for Pre-existing Conditions

This plan is also known as the Pre-existing Condition Insurance Plan Program and offers coverage to uninsured Americans who have been unable to obtain health coverage because of a pre-existing health condition. Plans are administered through two processes: supporting State-run programs, or providing insurance coverage directly to individuals in States where States do not run their own programs. This program was established to enable coverage until the Exchanges programs are operational. Congress appropriated $5 billion for the life of this interim program.

The *Affordable Care Act* provides the HHS Secretary significant authorities to ensure the financial sustainability of this program, including, under Section 1101 Paragraph (g) (2), the authority to eliminate deficits under the program if available funds are less than estimated expenses. The Secretary also has the authority under Paragraph (g) (4) to stop taking applications to comply with funding limitations. This program ends on January 1, 2014. For FY 2010, the HHS recognized a liability at September 30 to cover the anticipated subsidy costs associated with applications received prior to year end.

Early Retiree Reinsurance Program

Under the *Affordable Care Act*, the HHS established a temporary reinsurance program to reimburse a portion of the employer cost of providing health insurance coverage for early retirees. Under the Act, limitations on the amounts of such reimbursements per claim have been established. Congress appropriated $5 billion for the life of this program. The Act authorizes the HHS Secretary to stop taking applications for participation in the program based on the availability of funding. On June 29, 2010 the HHS began accepting applications from employers. The program permits approved applicants to submit for reimbursement expenses incurred after June 1, 2010. As a result, the HHS recognized a liability at September 30, 2010 for those anticipated reimbursement requests. The program is scheduled to terminate on January 1, 2014.

American Health Benefit Exchanges

The HHS will provide grants to the States to establish American Health Benefit Exchanges, better known as Health Benefit Insurance Exchanges. These grants are to be made by the HHS to the States “not later than one (1) year after the date of enactment.” Thus, the HHS is required to make the initial grants by March 23, 2011. As of September 30, 2010, the HHS had no liability under this program.

Consumer Operated and Oriented Plan (CO-OP) Program

The CO-OP Program was established to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans to the individual and small group markets in each State. Under this program, the HHS provides assistance to persons applying to become qualified, nonprofit health insurance issuers through loans to assist in meeting start-up costs, and grants to assist the applicant meet State solvency requirements. In accordance with regulations to be developed by HHS not later than July 1, 2013, as well as legislative requirements, loans shall be repaid within five years and the grants repaid in 15 years, considering State reserve requirements and solvency regulations. Congress appropriated $6 billion to carry out this assistance program under the *Affordable Care Act*. At this time, the HHS does not anticipate awarding any loans or grants prior to FY 2012, and has no liability under this program. The loans and grants must be awarded before July 1, 2013.

Community Living Assistance Services and Support (CLASS) Act

The *CLASS Act* establishes a national voluntary insurance program for purchasing community living assistance services and supports in order to 1) provide individuals with functional limitations with tools that will allow them to maintain their personal and financial independence and live in the community through a new financing strategy for community living assistance services and supports; 2) establish an infrastructure that will help address the nation’s community living assistance services and supports needs; 3) alleviate burdens on family caregivers; and 4) address institutional bias by providing a financing mechanism that supports personal choice and independence to live in the community. This program has not been implemented as of September 30, 2010, and the financial statements do not reflect any impact of the program at this time.

Note 2. Entity and Non-Entity Assets

(in Millions)	2010	2009
Intragovernmental:		
Fund Balance with Treasury	$ 19	$ 29
Accounts receivable	6	14
Total Intragovernmental	25	43
Accounts receivable	21	21
Total Non-Entity Assets	46	64
Total Entity Assets	563,693	562,716
Total Assets	$ 563,739	$ 562,780

Note 3. Fund Balance with Treasury

(in Millions)	2010	2009
Fund Balance with Treasury		
Trust Funds	$ 2,265	$ 3,525
Revolving Funds	954	989
Appropriated Funds	177,852	156,469
Other Funds	1,164	979
Total	$ 182,235	$ 161,962
Status of Fund Balance with Treasury		
Unobligated Balance		
Available	$ 48,880	$ 41,108
Unavailable	10,445	9,270
Obligated Balance not yet Disbursed	175,361	165,061
Non-Budgetary Fund Balance with Treasury	(52,451)	(53,477)
Total	$ 182,235	$ 161,962

Other Funds include balances in deposit, suspense and related non-spending accounts. The Unobligated Balance includes funds that are restricted for future use and not apportioned for current use of $24.4 billion and $3.7 billion as of September 30, 2010 and September 30, 2009, respectively. The restricted amount is primarily for the *Affordable Care Act* programs, Children's Health Insurance Program, CMS Program Management, State Grants and Demonstrations, and the *Recovery Act* Health Information Technology Program. In FY 2010 the HHS received $18.7 billion under the *Affordable Care Act* of which $16 billion is restricted for future use. The Non-Budgetary FBWT negative balances reported for September 30, 2010 and September 30, 2009, are primarily due to CMS Medicare Trust Funds temporarily precluded from obligation.

Note 4. Investments, Net

(in Millions)	2010 Cost	Unamortized Discount	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 350,457	$ -	$ 4,046	$ 354,503	$ 354,503
Non-Marketable: Market-Based	5,098	249	32	5,379	5,379
Total, Intragovernmental	$ 355,555	$ 249	$ 4,078	$ 359,882	$ 359,882

(in Millions)	2009 Cost	Unamortized Discount	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 371,466	$ -	$ 4,369	$ 375,835	$ 375,835
Non-Marketable: Market-Based	5,046	207	28	5,281	5,281
Total, Intragovernmental	$ 376,512	$ 207	$ 4,397	$ 381,116	$ 381,116

The HHS investments consist primarily of Medicare Trust Fund earmarked investments. Medicare Non-Marketable: Par Value Bonds are carried at face value and have maturity dates ranging from June 30, 2011, through June 30, 2025, with interest rates ranging from 3.25 percent to 6.5 percent. Medicare Non-Marketable: Par Value Certificates of Indebtedness mature on June 30, 2011, with interest rates ranging from 2.125 percent to 2.5 percent.

Securities held by the Vaccine Injury Compensation Trust Fund will mature in fiscal years 2010 through 2018. The Market-Based Notes paid from 3.125 percent to 5.0 percent during October 1, 2009, to September 30, 2010, and October 1, 2008, to September 30, 2009. The Market-Based Bonds pay 9.125 percent through FY 2018.

The Market Based Bills held in the NIH gift funds during the fiscal year ended September 30, 2010, yielded from 0.04 percent to 0.32 percent depending on the date purchased and the time to maturity.

The non-earmarked investments held by the CHIP Child Enrollment Contingency Fund in the amount of $2.1 billion as of September 30, 2010, are short term Non-Marketable Market-Based Bills purchased at a discount which are fully amortized at the maturity date.

Note 5. Accounts Receivable, Net

(in Millions)	Accounts Receivable Principal	Interest Receivable	Penalties, Fines, & Admin Fees Receivable	Accounts Receivable, Gross	Allowance	Net HHS Receivables
2010						
Intragovernmental						
Entity	$ 1,131	$ -	$ -	$ 1,131	$ -	$ 1,131
Non-Entity	6	-	-	6	-	6
Total	$ 1,137	$ -	$ -	$ 1,137	$ -	$ 1,137
With the Public						
Entity						
Medicare	$ 5,801	$ 2	$ -	$ 5,803	$ (1,426)	$ 4,377
Other	3,738	-	3	3,741	(745)	2,996
Non-Entity	46	9	-	55	(34)	21
Total	$ 9,585	$ 11	$ 3	$ 9,599	$ (2,205)	$ 7,394
2009						
Intragovernmental						
Entity	$ 898	$ -	$ 1	$ 899	$ -	$ 899
Non-Entity	14	-	-	14	-	14
Total	$ 912	$ -	$ 1	$ 913	$ -	$ 913
With the Public						
Entity						
Medicare	$ 4,859	$ -	$ -	$ 4,859	$ (1,852)	$ 3,007
Other	3,123	-	3	3,126	(650)	2,476
Non-Entity	12	46	-	58	(37)	21
Total	$ 7,994	$ 46	$ 3	$ 8,043	$ (2,539)	$ 5,504

Accounts receivable are composed of various program related overpayments and other recoverable payments. The increase in the Medicare accounts receivable with the public is primarily attributable to the Medicare Prescription Drug (MPD) Program. The MPD accounts receivable of $1.4 billion ($0.3 billion in FY 2009) consists of amounts due CMS after completion of the Part D payment reconciliation for calendar year 2009.

Note 6. Inventory and Related Property, Net

(in Millions)	2010	2009
Inventory Held for Sale:		
Inventory Held for Current Sale	$ 34	$ 13
Operating Materials and Supplies:		
Operating Materials and Supplies Held for Use	15	86
Operating Materials and Supplies Reserved for Future Use	282	434
Total Operating Materials and Supplies	297	520
Stockpile Materials Held for Emergency or Contingency	5,746	5,071
Inventory and Related Property, Net	$ 6,077	$ 5,604

Note 7. General Property, Plant and Equipment, Net

(in Millions)	Depreciation Method	Estimated Useful Lives	2010 Acquisition Cost	2010 Accumulated Depreciation	2010 Net Book Value
Land & Land Rights	-	-	$ 51	$ -	$ 51
Construction in Progress	-	-	592	-	592
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	5,349	(2,012)	3,337
Equipment	Straight Line	3-20 Yrs	1,644	(926)	718
Internal Use Software	Straight Line	5-10 Yrs	1,059	(602)	457
Assets Under Capital Lease	Straight Line	1-20 Yrs	132	(52)	80
Leasehold Improvements	Straight Line	*Life of Lease	49	(21)	28
Totals			$ 8,876	$ (3,613)	$ 5,263

(in Millions)	Depreciation Method	Estimated Useful Lives	2009 Acquisition Cost	2009 Accumulated Depreciation	2009 Net Book Value
Land & Land Rights	-	-	$ 51	$ -	$ 51
Construction in Progress	-	-	665	-	665
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	5,000	(1,858)	3,142
Equipment	Straight Line	3-20 Yrs	1,515	(943)	572
Internal Use Software	Straight Line	5-10 Yrs	1,002	(499)	503
Assets Under Capital Lease	Straight Line	1-20 Yrs	136	(53)	83
Leasehold Improvements	Straight Line	*Life of Lease	49	(18)	31
Totals			$ 8,418	$ (3,371)	$ 5,047

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

Note 8. Other Assets

(in Millions)	2010	2009
Intragovernmental		
Advances to Other Federal Entities	$ 99	$ 92
With the Public		
Travel Advances & Emergency Employee Salary Advances	3	6
Cash and Other Monetary Assets	-	357
Other	1,649	2,179
Total With the Public	$ 1,652	$ 2,542

Other Assets with the public primarily consist of $1.0 billion, as of September 30, 2010 ($1.6 billion in FY 2009), of prepayment advances outstanding related to the CMS SMI Part D Program.

Note 9. Liabilities Not Covered by Budgetary Resources

(in Millions)	2010	2009
Intragovernmental		
Accrued Payroll and Benefits	$ 61	$ 40
Other	890	621
Total Intragovernmental	951	661
Accounts Payable	1	-
Federal Employee and Veterans' Benefits (Note 11)	9,985	9,690
Accrued Payroll and Benefits	554	517
Contingencies (Note 14)	6,079	4,048
Other	56	71
Total Liabilities Not Covered by Budgetary Resources	$ 17,626	$ 14,987
Total Liabilities Covered by Budgetary Resources	81,587	79,380
Total Liabilities	$ 99,213	$ 94,367

Note 10. Entitlement Benefits Due and Payable

(in Millions)	2010	2009
Medicare	$ 45,007	$ 46,772
Medicaid	27,215	24,977
Other	490	469
Totals	$ 72,712	$ 72,218

Medicare benefits payable consists of a $39.7 billion estimate ($39.6 billion in FY 2009) of Medicare services incurred, but not paid as of September 30, 2010, calculated by the CMS Office of the Actuary.

Medicare Advantage and Prescription Drug Program benefits payable consists of $2.4 billion ($2.5 billion in FY 2009) for amounts owed to plans relating to risk and other payment related adjustments, $0.9 billion in FY 2010 ($2.6 billion in FY 2009) owed to plans after the completion of the Prescription Drug payment reconciliation, and $0.1 billion for amounts owed to beneficiaries that have qualified for the Part D coverage gap as of the end of the fiscal year.

The Medicare Retiree Drug Subsidy (RDS) consists of a $1.9 billion estimate ($2.1 billion in FY 2009) of payments to plan sponsors of retiree prescription drug coverage incurred but not paid as of September 30, 2010. As part of the *Medicare Modernization Act (MMA)*, the RDS program makes subsidy payments available to sponsors of retiree prescription drug coverage. The program is designed to strengthen employer- and union-based retiree prescription drug plans.

Medicaid benefits payable of $27.2 billion as of September 30, 2010 ($25.0 billion in FY 2009) is an estimate of the net Federal share of expenses that have been incurred by the States but not yet reported to the HHS. This estimate incorporates claim activity tracked under *Recovery Act* of $4.0 billion ($3.2 billion in FY2009). An estimated CHIP benefits payable of $0.4 billion has been recorded as of September 30, 2010 ($0.4 billion in FY 2009) for the net Federal share of expenses that have been incurred by the States but not yet reported to the HHS.

Note 11. Federal Employee and Veterans' Benefits

(in Millions)	2010	2009
With the Public		
Liabilities Not Covered by Budgetary Resources		
PHS Commissioned Corp Pension Liability	$ 9,075	$ 8,817
PHS Commissioned Corp Post-retirement Health Benefits	651	619
Workers' Compensation Benefits (Actuarial *FECA* Liability)	259	254
Total, Federal Employee and Veterans' Benefits	$ 9,985	$ 9,690

Public Health Service (PHS) Commissioned Corps

The HHS administers the PHS Commissioned Corps Retirement System for 6,540 active duty officers and 5,872 retiree annuitants and survivors. As of September 30, 2010, the actuarial accrued liability for the retirement benefit plan was $9.7 billion, of which $0.7 billion was for non-Medicare coverage.

On October 14, 2008, the Federal Accounting Standards Advisory Board issued Statement of Federal Financial Accounting Standards (SFFAS) No. 33. This standard covers Federal Pensions, Other Retirement Benefits (ORB) and Other Post Employment Benefits (OPEB), previously covered by SFFAS No.5, and is effective for fiscal years beginning after September 30, 2009.

In FY 2010, this new standard affects the selection of discount rates used for present value measurements of Federal employee pension, ORB and OPEB liabilities. The Commission Corp Retirement System and Post-Retirement Benefits are not funded. Therefore, the standard indicates the discount rate should be based on long-term assumptions, for marketable securities (such as Treasury marketable securities) of similar maturity to the period over which the payments are to be made. The discount rates should be matched with the expected timing of the associated expected cash flow. A single discount rate may be used for all the projected cash flows, if the resulting present value is not materially different than the resulting present value using multiple rates.

The significant assumptions used in the calculation of the pension and medical program liability, as of September 30, 2010, and September 30, 2009, were:

	2010	2009
Interest on Federal securities	5.16 percent	5.75 percent
Annual basic pay scale increase	3.25 percent	3.75 percent
Annual inflation	2.50 percent	3.00 percent

The following shows key valuation results as of September 30, 2010 and 2009, in conformance with the actuarial reporting standards set forth in the SFFAS No. 5, *Accounting for Liabilities of the Federal Government* and SFFAS No. 33, *Pensions, Other Retirement Benefits, and Other Postemployment Benefits: Reporting the Gains and Losses from Changes in Assumptions and Selecting Discount Rates and Valuation Dates*. The valuation is based upon the current plan provisions, membership data collected as of June 30, 2010, and actuarial assumptions. The September 30, 2010 valuation includes an increase in liabilities of $290 million resulting from an increase in costs offset by actuarial gain from changes in assumptions and experience. Volatility of the discount rate significantly affects the liabilities for these benefits. Therefore, to mitigate the impact of this volatility, SFFAS No. 33 also provides for these of historical average rates to prevent the undue influence of current or near term rates.

(in Millions)	2010	2009
Beginning Liability Balance	$ 9,436	$ 8,462
Expense		
Normal Cost	235	183
Interest on the liability balance	527	496
Actuarial (Gain)/Loss		
From experience	(101)	169
From assumption changes		
Change in discount rate assumption	850	315
Change in inflation/salary increase assumption	(720)	-
Change in Others	(106)	191
Net Actuarial (Gain)/Loss	(77)	675
Total expense	685	1,354
Less amounts paid	(395)	(380)
Ending Liability Balance	$ 9,726	$ 9,436

Workers' Compensation Benefits

The actuarial liability for future workers' compensation benefits includes the expected liability for death, disability, medical, and miscellaneous costs for approved compensation cases, plus a component for incurred but not reported claims. The liability utilizes historical benefit payment patterns to predict the ultimate payment related to that period. 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 as of September 30, 2010 and September 30, 2009 appear below.

FY 2010	FY 2009
3.653% in Year 1	4.223% in Year 1
4.300% in Year 2 and thereafter	4.715% in Year 2 and thereafter

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

FY	COLA	CPIM
2010	N/A	N/A
2011	2.23%	3.45%
2012	1.13%	3.43%
2013	1.70%	3.64%
2014	1.90%	3.66%
2015	1.93%	3.73%

Note 12. Accrued Grant Liability

(in Millions)	2010	2009
Grant Advances Outstanding (before year end grant accrual)	$ 20,202	$ 17,427
Less: Estimated Accrual for Amounts Due to Grantees	(24,406)	(21,467)
Net Grant Liability	$ (4,204)	$ (4,040)

Note 13. Other Liabilities

	2010		2009	
(in Millions)	Intra-governmental	With the Public	Intra-governmental	With the Public
Accrued Payroll & Benefits	$ 139	$ 907	$ 111	$ 851
Advances from Others	591	369	474	160
Deferred Revenue	-	409	-	392
Capital Lease Liability (Note 15)	72	22	74	23
Custodial Liabilities	745	21	469	35
Other	25	1,354	54	608
Consolidated HHS Totals	$ 1,572	$ 3,082	$ 1,182	$ 2,069

Note 14. Contingencies and Commitments

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. 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.

(in Millions)	2010	2009
Medicaid Audit and Program Disallowances	$ 5,391	$ 3,793
Vaccine Injury Compensation Program	688	255
Total Contingencies	$ 6,079	$ 4,048

Medicaid Audit and Program Disallowances

The Medicaid amount for FY 2010 of $5.4 billion ($3.8 billion in FY 2009) consists of Medicaid audit and program disallowances of $0.9 billion ($1 billion in FY 2009) and of $4.5 billion ($2.8 billion in FY 2009) 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 the HHS. The HHS will be required to pay these amounts if the appeals are decided in favor of the States. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a State. There are also outstanding reviews of the State expenditures in which a final determination has not been made.

Vaccine Injury Compensation Program (VICP)

The VICP is administered by HRSA and provides compensation for vaccine-related injury or death. The $688 million ($255 million in FY 2009) VICP liability represents the estimated future payment value of injury claims outstanding for VICP as of September 30, 2010.

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 1991 (P.L. 101-150)*. The total payments related to cancelled appropriations are estimated at $1.3 billion and $1.5 billion as of September 30, 2010 and 2009, respectively.

Appeals at the Provider Reimbursement Review Board

Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. However, historical cases that have been appealed and settled by the PRRB are considered in the development of the actuarial Medicare incurred, but not reported (IBNR) liability, resulting in a projected liability for the 7,833 cases (7,984 in FY 2009) remaining on appeal as of September 30, 2010. In FY 2010, a total of 1,384 new cases were filed (2,312 in FY 2009). The PRRB rendered decisions on 144 cases in FY 2010 (93 in FY 2009); and 1,395 additional cases (1,947 in FY 2009) were dismissed, withdrawn, or settled prior to an appeal hearing. The PRRB receives no information on the value of these cases that are settled prior to a hearing.

Note 15. Leases

Capital Leases

The HHS has entered into various capital leases with private entities and with the General Services Administration (GSA) for office and warehouse space. Lease terms vary from 1 to 30 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 7, General Property, Plant and Equipment.

Summary of Net Assets under Capital Lease

(in Millions)	2010	2009
Land and Building	$ 132	$ 136
Accumulated Amortization	(52)	(53)
Assets under Capital Lease	$ 80	$ 83

Future Minimum Payments

(in Millions)	2010	2009
Year 1	$ 11	$ 12
Year 2	10	10
Year 3	10	10
Year 4	10	10
Year 5	11	10
Later Years	91	103
Total Minimum Lease Payments	143	155
Imputed Interest	(49)	(58)
Total Capital Lease Liability	$ 94	$ 97

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 non-cancellable 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.

Future Minimum Payments

(in Millions)	2010	2009
Year 1	$ 383	$ 344
Year 2	379	380
Year 3	377	382
Year 4	355	359
Year 5	377	317
Later Years	1,217	1,002
Total Operating Lease Liability	$ 3,088	$ 2,784

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

	2010						
(in Millions)	Education Training & Social Services	Health	Medicare	Income Security	OPDIV Combined Totals	Intra-HHS Eliminations	Consolidated Totals
Gross Cost	$ 137	$ 5,428	$ 863	$ 43	$ 6,471	$ (2,161)	$ 4,310
Earned Revenue	(26)	(3,240)	(16)	(20)	(3,302)	2,085	(1,217)
Net Cost, Intragovernmental	$ 111	$ 2,188	$ 847	$ 23	$ 3,169	$ (76)	$ 3,093
With the Public							
Gross Cost	$ 15,282	$ 351,482	$ 507,112	$ 42,452	$ 916,328	$ -	$ 916,328
Earned Revenue	-	(1,888)	(60,797)	(8)	(62,693)	-	(62,693)
Net Cost, With the Public	$ 15,282	$ 349,594	$ 446,315	$ 42,444	$ 853,635	$ -	$ 853,635
Totals							
Gross Cost	$ 15,419	$ 356,910	$ 507,975	$ 42,495	$ 922,799	$ (2,161)	$ 920,638
Earned Revenue	(26)	(5,128)	(60,813)	(28)	(65,995)	2,085	(63,910)
Net Cost of Operations	$ 15,393	$ 351,782	$ 447,162	$ 42,467	$ 856,804	$ (76)	$ 856,728

	2009						
(in Millions)	Education Training & Social Services	Health	Medicare	Income Security	OPDIV Combined Totals	Intra-HHS Eliminations	Consolidated Totals
Gross Cost	$ 157	$ 5,169	$ 777	$ 36	$ 6,139	$ (2,077)	$ 4,062
Earned Revenue	(27)	(3,419)	(10)	(2)	(3,458)	1,847	(1,611)
Net Cost, Intragovernmental	$ 130	$ 1,750	$ 767	$ 34	$ 2,681	$ (230)	$ 2,451
With the Public							
Gross Cost	$ 13,098	$ 320,781	$ 486,580	$ 40,498	$ 860,957	$ -	$ 860,957
Earned Revenue	(1)	(2,179)	(57,322)	(1)	(59,503)	-	(59,503)
Net Cost, With the Public	$ 13,097	$ 318,602	$ 429,258	$ 40,497	$ 801,454	$ -	$ 801,454
Totals							
Gross Cost	$ 13,255	$ 325,950	$ 487,357	$ 40,534	$ 867,096	$ (2,077)	$ 865,019
Earned Revenue	(28)	(5,598)	(57,332)	(3)	(62,961)	1,847	(61,114)
Net Cost of Operations	$ 13,227	$ 320,352	$ 430,025	$ 40,531	$ 804,135	$ (230)	$ 803,905

During FY 2010, the Health and Medicare budget functions experienced growth of 9.8% ($31.4 billion) and 4.0% ($17.1 billion), respectively. The growth in the Health budget function is primarily attributable to normal increases in Entitlement Benefits of $13.9 billion, and *Recovery Act* expenditures of $8.2 billion, which includes $6 billion for the extension of the Federal Medical Assistance Percentage. The growth in Medicare is primarily attributed to an increase in the HI and SMI benefits of $8.6 billion and $5.0 billion, respectively. There was also an increase in Part D benefits of approximately $6.6 billion and a reduction in the net cost related to an increase in the SMI premiums of $3.1 billion.

Note 17. Exchange Revenue

The HHS recognizes its revenue from exchange transactions when goods and services are provided. Total exchange revenue was $64 billion and $61 billion through September 30, 2010 and September 30, 2009, respectively. The HHS' exchange revenue consists primarily of Medicare premiums collected from beneficiaries. The HHS also charges user fees and collects revenues related to reimbursable agreements with other government entities.

Note 18. Apportionment Categories of Obligations Incurred

	2010		
(in Millions)	Direct	Reimbursable	Total
Category A (Distributed by Quarter)	$ 102,622	$ 7,106	$ 109,728
Category B (Restricted and Distributed by Activity)	610,334	490	610,824
Exempt from Apportionment	479,053	-	479,053
Total Obligations Incurred	$ 1,192,009	$ 7,596	$ 1,199,605

	2009		
(in Millions)	Direct	Reimbursable	Total
Category A (Distributed by Quarter)	$ 158,031	$ 6,785	$ 164,816
Category B (Restricted and Distributed by Activity)	507,428	536	507,964
Exempt from Apportionment	462,145	-	462,145
Total Obligations Incurred	$ 1,127,604	$ 7,321	$ 1,134,925

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

Note 19. 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. 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.

All Trust Fund receipts collected by the HHS during the fiscal year are reported as new budget authority in the Combined Statement of Budgetary Resources. The portion of the 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 Statement of Budgetary Resources and, therefore, is not classified as budgetary resources in the fiscal year collected. However, all such excess receipts are assets of the Trust Funds and currently become available for obligation as needed. The entire Trust Fund balances in the amount of $300.5 billion as of September 30, 2010, and $320.1 billion as of September 30, 2009 are included as Investments in the Consolidated Balance Sheet.

The NIH Funds consist of the following:

(a) The revolving and management funds available for centralized research support services and administrative activities.

1. Revolving funds are no-year funds available until expended.
2. The management fund is available for two fiscal years.

(b) The Gift Funds consist of the Conditional, Unconditional, and Patient Emergency Funds, and are also available until expended.

1. The Unconditional Gift Fund is available for any authorized purpose in the performance of NIH functions.

2. The Conditional Gift Fund is restricted to a specific purpose determined by the donor.

3. The Patient Emergency Fund is intended solely for the benefit of patients.

(c) The CRADA funds received are available for the performance of the contractual agreement, and are available for the term of the agreement.

(d) Royalty funds are available for obligation for two fiscal years after the fiscal year in which the funds are received. These funds are available for a variety of purposes, such as rewards to scientific, engineering, and technical employees of the laboratory; education and training of employees; and payment of expenses incidental to the administration of intellectual property by the entity.

The NIH is not authorized to spend the Gift 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.

Note 20. Explanation of Differences between the Statement of Budgetary Resources (SBR) and the Budget of the United States Government

The *FY 2011 President's Budget*, with actual amounts for FY 2010, has not yet been published, and, therefore, no comparisons can be made between FY 2010 amounts presented in the SBR with amounts reported in the Actual column of the *President's Budget*. The *FY 2012 President's Budget* is expected to be released in February 2011, and may be obtained from the Office of Management and Budget's website http://www.whitehouse.gov/omb/budget or from the Government Printing Office.

The *Budget of the United States Government, FY 2011 – Appendix* was used as the reference for the HHS total budgetary resources amount. Information contained in the "Federal Programs by Agency and Account" in the FY 2011 Analytical Perspectives volume of the *Budget of the United States Government* was used as the reference for the net outlays (gross outlays less offsetting collections) amount in the following reconciliation of the SBR to the *President's Budget* for FY 2009.

	2009			
(in Millions)	Budgetary Resources	Obligations Incurred	Offsetting Receipts	Net Outlays (Gross Outlays less Offsetting Collections)
Statement of Budgetary Resources	$ 1,185,303	$ 1,134,925	$ 284,292	$ 1,081,555
Unobligated Balances – Not Available	(5,623)	-	-	-
Other	(2,457)	(1,800)	22	(740)
Budget of the U.S. Government	$ 1,177,223	$ 1,133,125	$ 284,314	$ 1,080,815

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 differences primarily consist of activities performed by the HHS for the Department of Homeland Security (DHS) for Project Bioshield. The resources, obligations and outlays are reported on the HHS' SBR and included in the DHS *President's Budget*. The Other amounts in Obligations Incurred also consist of obligations for expired accounts that are appropriately reported on the SBR but not included in the *President's Budget*.

Note 21. 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.

Note 22. Undelivered Orders at the End of the Period

Undelivered Orders include grants that have been issued and obligated but not yet drawn down by the grantee, and goods and services ordered that have not been received. The HHS reported $99.9 billion of budgetary resources obligated for undelivered orders as of September 30, 2010, and $91.5 billion as of September 30, 2009.

Note 23. Earmarked Funds

Medicare is the largest earmarked fund group managed by the Department and is presented in a separate column in the schedule below. The Medicare programs include: (a) the Medicare Hospital Insurance (HI) Trust Fund, (b) the Medicare Supplementary Medical Insurance (SMI) Trust Fund, (c) the Medicare Prescription Drug Benefit – Part D, and (d) the Medicare Integrity Program. See Note 1 for a description of each fund's purpose and how the HHS accounts for and reports the fund. Portions of the Program Management appropriation have been allocated to the HI and SMI Trust Funds. SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and are matched by the Federal Government through the General Fund Appropriation, Payments to the Health Care Trust Funds.

The standard monthly SMI premium per beneficiary was $96.40 from October 1, 2009, through December 31, 2009, and $110.50 for January 1, 2010, through September 30, 2010. However, as a result of the zero cost-of-living adjustment (COLA) for Social Security beneficiaries effective for December 2009, about three-fourths of Part B enrollees are "held harmless" and do not have to pay the higher premium amount in 2010. New beneficiaries enrolling on January 1, 2010, and beyond, enrollees subject to an income-related additional premium, and individuals who do not have their premiums deducted from their Social Security benefit, including Medicare-Medicaid "dual-eligible beneficiaries," must pay a monthly premium based on the standard premium of $110.50. (Premiums for dual-eligible beneficiaries are paid by the State Medicaid programs.)

(in Millions)	2010 Medicare	2010 Other	2010 Total
Balance Sheet as of September 30, 2010			
Fund Balance with Treasury	$ 1,996	$ 1,217	$ 3,213
Investments	354,503	3,261	357,764
Other Assets	6,073	172	6,245
Total Assets	$ 362,572	$ 4,650	$ 367,222
Entitlement Benefits Due and Payable	$ 45,007	$ -	$ 45,007
Other Liabilities	2,342	864	3,206
Total Liabilities	47,349	864	48,213
Unexpended Appropriations	1,776	(101)	1,675
Cumulative Results of Operations	313,447	3,887	317,334
Total Liabilities and Net Position	$ 362,572	$ 4,650	$ 367,222
Statement of Net Cost For the Period Ended September 30, 2010			
Gross Program Costs	$ 507,975	$ 909	$ 508,884
Less: Earned Revenues	60,813	1,099	61,912
Net Cost of Operations	$ 447,162	$ (190)	$ 446,972
Statement of Changes in Net Position For the Period Ended September 30, 2010			
Net Position Beginning of Period	$ 336,342	$ 3,961	$ 340,303
Non-Exchange Revenue	201,482	298	201,780
Other Financing Sources	224,561	(663)	223,898
Net Cost of Operations	(447,162)	190	(446,972)
Change in Net Position	(21,119)	(175)	(21,294)
Net Position End of Period	$ 315,223	$ 3,786	$ 319,009

(in Millions)	2009 Medicare	2009 Other	2009 Total
Balance Sheet as of September 30, 2009			
Fund Balance with Treasury	$ 3,265	$ 1,100	$ 4,365
Investments	375,835	3,168	379,003
Other Assets	5,689	92	5,781
Total Assets	$ 384,789	$ 4,360	$ 389,149
Entitlement Benefits Due and Payable	$ 46,772	$ -	$ 46,772
Other Liabilities	1,675	399	2,074
Total Liabilities	48,447	399	48,846
Unexpended Appropriations	3,590	(98)	3,492
Cumulative Results of Operations	332,752	4,059	336,811
Total Liabilities and Net Position	$ 384,789	$ 4,360	$ 389,149
Statement of Net Cost For the Period Ended September 30, 2009			
Gross Program Costs	$ 487,357	$ 327	$ 487,684
Less: Earned Revenues	57,332	842	58,174
Net Cost of Operations	$ 430,025	$ (515)	$ 429,510
Statement of Changes in Net Position For the Period Ended September 30, 2009			
Net Position Beginning of Period	$ 354,907	$ 3,552	$ 358,459
Non-Exchange Revenue	213,177	342	213,519
Other Financing Sources	198,283	(448)	197,835
Net Cost of Operations	(430,025)	515	(429,510)
Change in Net Position	(18,565)	409	(18,156)
Net Position End of Period	$ 336,342	$ 3,961	$ 340,303

Note 24. Statement of Social Insurance Disclosures (Unaudited)

The Statement of Social Insurance (SOSI) presents the projected 75-year actuarial present values 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 Medicare Board of Trustees*. These assumptions represent the Trustees' best estimate of likely future economic, demographic, and health care-specific conditions.

The SOSI projections are based on current law, and reflect the effects of the *Patient Protection and Affordable Care Act,* as amended by the *Health Care and Education Reconciliation Act of 2010*. This legislation, referred to collectively as the "*Affordable Care Act*" contains roughly 165 provisions affecting the Medicare program by reducing costs, increasing revenues, improving certain benefits, combating fraud and abuse, and initiating a major program of research and development.

The *Affordable Care Act* improves the financial outlook for Medicare substantially; however, the full effects of some of the new law's provisions on Medicare are not known at this time, with the result that the projections are much more uncertain than normal, especially in the long-range future. It is important to note that the substantially improved results for HI and SMI Part B depend, in part, on the long-range feasibility of lower increases in Medicare payment rates to most categories of health care providers, as mandated by the *Affordable Care Act*. Moreover, in the context of today's health care system, these adjustments would probably not be viable indefinitely into the future. As a result, the actual future costs for Medicare are likely to exceed those shown by the current-law projections shown in the SOSI. Please see Note 25 for further information on the impact of the *Affordable Care Act*.

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. The Trustees' projections are based on the current Medicare laws, regulations, and policies in effect on August 5, 2010, and do not reflect any actual or anticipated changes subsequent to that date. The present values are calculated by discounting the future annual amounts of non-interest income and expenditures (including benefit payments as well as administrative expenses) at the projected average rates of interest credited to the HI Trust Fund. HI income includes the portion of *FICA* and *SECA* payroll taxes allocated to the HI Trust Fund, the portion of Federal income taxes paid on Social Security benefits that is allocated to the HI Trust Fund, and receipts from fraud and abuse control activities. SMI income includes premiums paid by, or on behalf of, beneficiaries and general revenue contributions made on behalf of beneficiaries. Fees related to brand-name prescription drugs, required by the *Affordable Care Act*, are included as income for Part B of SMI, and transfers from State governments are included as income for Part D of SMI. Since all major sources of income to the Trust Funds are reflected, the actuarial projections can be used to assess the financial condition of each Trust Fund.

The Part A present values in the SOSI exclude the income and expenditures for the roughly one percent of beneficiaries who are 65 or over, but are "uninsured" because they do not meet the normal insured status or related requirements to qualify for entitlement to Part A benefits. The primary purpose of the SOSI is to compare the projected future costs of Medicare with the program's scheduled revenues. Since costs for the uninsured are separately funded either through general revenue appropriations or through premium payments, the exclusion of such amounts does not materially affect the financial balance of Part A. In addition, such individuals are granted coverage outside of the social insurance framework underlying Medicare Part A. For these reasons, it is appropriate to exclude their income and expenditures from the statement of social insurance.

Actuarial present values of estimated future income (excluding interest) and estimated future expenditures are presented for three different groups of participants: (1) current participants who have not yet attained eligibility age; (2) current participants who have attained eligibility age; and (3) new entrants, those who are expected to become participants in the future. With the exception of the 2007 projections presented, 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. For the 2007 projections, the "closed group" of individuals includes individuals who are at least 18 at the start of the projection period. 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 values of all future HI (Part A) and SMI (Parts B and D) expenditures and of all future non-interest income for the next 75 years.

The SOSI also presents the net present values of future net cash flows for each fund, which are calculated by subtracting the actuarial present value of future expenditures from the actuarial present value of future income. The existence of an actuarial deficit for the HI Trust Fund indicates that, under these assumptions as to economic, demographic, and health care cost trends for the future, HI income is expected to fall short of expenditures over the next 75 years. Neither Part B nor Part D of SMI has similar problems because each account is automatically in financial balance every year due to its statutory financing mechanism.

In addition to the actuarial present value of the estimated future excess of income (excluding interest) over expenditures for the open group of participants, 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 ages 15 through 64 (18 through 64 in the case of the 2007 projections). 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 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. Please see Note 25 below for important information on the further uncertainty, resulting from the provisions in the *Affordable Care Act*, associated with the current-law projections presented in the SOSI. In order to make projections regarding the future financial status of the HI and SMI Trust Funds, various assumptions have to be made. As stated previously, the estimates presented here are based on the assumption that the Trust Funds will continue to operate under the law in effect on August 5, 2010. In addition, the estimates depend on many economic, demographic, and health care-specific assumptions, including changes in per beneficiary health care cost, wages, 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 based on current law, used in the projections of Medicare spending displayed in this section, are included in the following table. The assumptions underlying the 2010 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2010. Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The projected beneficiary cost increases summarized below reflect the overall impact of these more detailed assumptions. Detailed information, similar to that denoted within Table 1, for the prior years is publicly available on the CMS website at: www.cms.hhs.gov/CFOReport/.

Table 1: Significant Assumptions and Summary Measures
Used for the Statement of Social Insurance 2010

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		Real-
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	interest rate[9]
2010	2.08	1,215,000	784.4	3.1	5.1	2.0	2.3	1.1	3.8	4.3	0.9
2020	2.05	1,125,000	723.8	1.1	3.9	2.8	2.2	3.5	5.0	7.3	2.9
2030	2.01	1,085,000	661.8	1.2	4.0	2.8	2.1	4.7	4.8	5.9	2.9
2040	2.00	1,050,000	606.8	1.2	4.0	2.8	2.2	4.8	4.5	5.3	2.9
2050	2.00	1,035,000	558.6	1.2	4.0	2.8	2.1	3.9	4.1	5.1	2.9
2060	2.00	1,030,000	516.4	1.1	3.9	2.8	2.1	3.7	4.1	4.8	2.9
2070	2.00	1,025,000	479.1	1.1	3.9	2.8	2.1	3.6	3.9	4.6	2.9
2080	2.00	1,025,000	446.1	1.2	4.0	2.8	2.1	3.3	3.8	4.4	2.9

[1]Average number of children per woman.

[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 Trustees Reports.

Table 2: Significant Ultimate Assumptions Used for the Statement of Social Insurance, FY 2010 - 2006

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[9]
FY 2010	2.0	1,025,000	446.1	1.2	4.0	2.8	2.1	3.3	3.8	4.4	2.9
FY 2009	2.0	1,025,000	458.2	1.1	3.9	2.8	2.1	4.4	4.3	4.3	2.9
FY 2008	2.0	1,025,000	476.8	1.1	3.9	2.8	2.1	4.4	4.3	4.4	2.9
FY 2007	2.0	900,000	496.8	1.1	3.9	2.8	1.9	4.3	4.3	4.3	2.9
FY 2006	2.0	900,000	497.6	1.1	3.9	2.8	1.9	4.3	4.3	4.3	2.9

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

[2]Includes legal immigration, net of emigration, as well as other, non-legal, immigration. For 2008-2010, the ultimate level of net legal immigration was increased from 600,000 to 750,000 persons per year. In addition, the method for projecting annual net other immigration was changed and it now varies throughout the projection period. So for 2008-2010, the assumption presented is the value assumed in the year 2080. For 2006-2007, the ultimate assumption is displayed and 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. Except for minor fluctuations, the ultimate assumption is reached within the first 10 years of the projection period.

[5]Average annual wage in covered employment. Except for minor fluctuations, 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 each 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 still relatively new (having begun operations in January 2006), with relatively little actual program data currently available. The actual 2006 through 2010 bid submissions by the private plans offering this coverage, together with actual data on beneficiary enrollment and program spending through 2009, have 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.

Note 25. *Affordable Care Act* and SMI Part B Physician Payment Update Factor (Unaudited)

The *Affordable Care Act* improves the financial outlook for Medicare substantially; however, the full effects of some of the new law's provisions on Medicare are not known at this time, with the result that the projections are much more uncertain than normal, especially in the longer-range future. For example, the *Affordable Care Act* initiative for aggressive research and development has the potential to reduce Medicare costs in the future; however, as specific reforms have not yet been designed, tested, or evaluated, their ability to reduce costs cannot be estimated at this time, and thus no specific savings have been reflected in the projections for the initiative.

Another important example involves lower payment rate updates to most categories of Medicare providers in 2011 and later. These updates will be adjusted downward by the increase in productivity experienced in the economy overall. Since the provision of health services tends to be labor-intensive and is often customized to match individuals' specific needs, most categories of health providers have not been able to improve their productivity to the same extent as the economy at large. Over time, the productivity adjustments mean that the prices paid for health services by Medicare will grow about 1.1 percent per year more slowly than the increase in prices that providers must pay to purchase the goods and services they use to provide health care services. Unless providers could reduce their cost per service correspondingly, through productivity improvements, or other steps, they would eventually become unwilling or unable to treat Medicare beneficiaries.

It is possible that providers can improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. Similarly, the implementation of payment and delivery system reforms, facilitated by the *Affordable Care Act* research and development program, could help constrain cost growth to a level consistent with the lower Medicare payments. These outcomes are far from certain, however. Many experts doubt the feasibility of such sustained improvements and anticipate that over time the Medicare price constraints would become unworkable and that Congress would likely override them, much as they have done to prevent the reductions in physician payment rates otherwise required by the sustainable growth rate formula in current law.

The reductions in provider payments reflected in these updates, if implemented for all future years as required under current law, could have secondary impacts, for beneficiary access to care; utilization, intensity and quality of services; and other factors. These possible impacts are speculative, and at present there is no consensus among experts as to their potential scope. Further research and analysis will help to better inform this issue and may enable the development of specific projections of secondary effects under current law in the future.

The SOSI projections must be based on current law. Therefore, the productivity adjustments are assumed to occur in all future years, as required by the *Affordable Care Act*. In addition, reductions in Medicare payment rates for physician services, totaling 30 percent over the next three years, are assumed to be implemented as required under current law, despite the virtual certainty that Congress will continue to override these latter reductions. Therefore, it is important to note that the actual future costs for Medicare are likely to exceed those shown by these current-law projections.

Illustrative Scenario

The Medicare Board of Trustees, in their annual report to Congress, references an alternative scenario to illustrate, where possible, the potential understatement of Medicare costs and projection results. This alternative scenario assumes that the productivity adjustments are gradually phased out over the 15 years, starting in 2020, and that the physician fee reductions are overridden. These examples were developed for illustrative purposes only; the calculations have not been audited; no endorsement of the illustrative alternative to current law by the Trustees, CMS, or the Office of the Actuary should be inferred; and the examples do not attempt to portray likely or recommended future outcomes. Thus, the illustrations are useful only as general indicators of the substantial impacts that could result from future legislation affecting the productivity adjustments and physician payments under Medicare and of the broad range of uncertainty associated with such impacts. The table below contains a comparison of the Medicare 75-year present values of income and expenditures under current law with those under the alternative scenario illustration.

Medicare Present Values *(in Billions)*		
	Current law (unaudited)	Illustrative Alternative Scenario[1,2] (unaudited)
Income		
Part A	$14,408	$14,408
Part B	17,737	28,284
Part D	9,715	9,715
Expenditures		
Part A	17,090	21,745
Part B	17,737	28,284
Part D	9,715	9,715
Income Less Expenditures		
Part A	(2,683)	(7,337)
Part B	0	0
Part D	0	0

[1]These amounts are not presented in the 2010 Trustees' Report.

[2]At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare Trust Fund projections that differ from current law. No endorsement of the illustrative alternative to current law by the Trustees, CMS, or the Office of the Actuary should be inferred.

As expected, the differences between the current-law projections and the illustrative alternative are substantial, although both represent a sizeable improvement in the financial outlook for Medicare compared to law in effect prior to the *Affordable Care Act*. This difference in outlook serves as a compelling reminder of the importance of developing and implementing further means of reducing health care cost growth in the coming years. All Part A fee-for-service providers are affected by the productivity adjustments, so the current law projections reflect an estimated 1.1 percent reduction in annual Part A cost growth each year. If the productivity adjustments were gradually phased out, as illustrated under the alternative scenario, the present value of Part A expenditures is estimated to be roughly 27 percent higher than the current-law projection. As indicated above, the present value of Part A income is unchanged under the alternative scenario.

The Part B expenditure projections are significantly higher under the alternative scenario than under current law, both because of the assumed gradual phase-out of the productivity adjustments and the assumption that the scheduled physician fee reductions would be overridden and based on annual increases in the Medicare Economic Index. The productivity adjustments are estimated to affect more than half of Part B expenditures at the time their phase-out is assumed to begin. Similarly, physician fee schedule services are assumed to be roughly 30 percent higher under the alternative scenario than under current law at that time. The combined effect of these two factors results in a present value of Part B expenditures under the alternative scenario that is approximately 59 percent higher than the current-law projection.

The Part D projections are unaffected under the alternative projection because the services are not impacted by the productivity adjustments or the physician fee schedule reductions.

The extent to which actual future Part A and Part B costs exceed the projected current-law amounts due to changes to the productivity adjustments and physician payments depends on both the specific changes that might be legislated and on whether Congress would pass further provisions to help offset such costs. As noted, these examples only reflect hypothetical changes to provider payment rates.

It is likely that in the coming years Congress will consider, and pass, numerous other legislative proposals affecting Medicare. Many of these will 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 26. Reconciliation of Net Cost of Operations (Proprietary) to Budget *(in Millions)*

	2010	2009
RESOURCES USED TO FINANCE ACTIVITIES:		
BUDGETARY RESOURCES OBLIGATED		
Obligations Incurred	$ 1,199,605	$ 1,134,925
Spending Authority from Offsetting Collections and Recoveries	(31,221)	(26,339)
Obligations Net of Offsetting Collections and Recoveries	1,168,384	1,108,586
Offsetting Receipts	(303,977)	(284,292)
Net Obligations	864,407	824,294
OTHER RESOURCES		
Net Non-Budgetary Resources Used to Finance Activities	554	427
Total Resources Used to Finance Activities	864,961	824,721
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	7,249	21,396
Resources That Fund Expenses Recognized in Prior Periods	3	17
Budgetary Offsetting Collections and Receipts That Do Not Affect Net Cost of Operations	(110)	(89)
Resources That Finance the Acquisition of Assets or Liquidations of Liabilities	903	1,565
Other Resources or Adjustments to Net Obligated Resources That Do Not Affect Net Cost of Operations	1,468	1,138
Total Resources Used to Finance Items Not Part of the Net Cost of Operations	9,513	24,027
Total Resources Used to Finance the Net Cost of Operations	855,448	800,694
COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD		
Components Requiring or Generating Resources in Future Periods	483	3,686
Components Not Requiring or Generating Resources	797	(475)
Total Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period	1,280	3,211
NET COST OF OPERATIONS	$ 856,728	$ 803,905

Note 27. *American Recovery and Reinvestment Act* Obligations and Net Outlays *(in Millions)*

	2010	2009	Inception to September 30, 2010
OBLIGATIONS	$ 59,800	$ 46,512	$ 106,312
NET OUTLAYS	$ 55,248	$ 33,048	$ 88,296

These funds were distributed among most of the HHS' responsibility segments and required new processes to be developed or modified within a very short timeframe to ensure compliance with the *Recovery Act* and OMB regulations.