Department of Health and Human Services

FY 2011 Agency Financial Report

November 15, 2011

FY 2011 Agency Financial Report

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INTRODUCTION

Purpose of This Report

Our fiscal year 2011 *Agency Financial Report* provides fiscal and high-level performance results that enable the President, Congress, and American people to assess our accomplishments for the reporting period October 1, 2010, through September 30, 2011. This report provides an overview of our programs, accomplishments, challenges, and management's accountability for the resources entrusted to us. We have prepared this report in accordance with the requirements of the Office of Management and Budget's Circular A-136*, Financial Reporting Requirements.*

How This Report is Organized

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

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

Section II: Financial Reports contains a message from the Chief Financial Officer, the independent audit reports, the financial statements and notes, required supplementary stewardship information, and required supplementary information.

Section III: Other Accompanying Information includes other annually required reports, *Improper Payments Elimination and Recovery Act (Public Law 111-204)* reporting details, the management report on final action, the summary of financial statement audit and management assurance findings, the Office of Inspector General's summary of top management challenges and our response to those challenges.

We Welcome Your Comments

Thank you for your interest in the Department of Health and Human Services. We welcome your comments and questions regarding this *Agency Financial Report* and appreciate any suggestions for reader improvements. Please contact us at hhsdeputycfo@hhs.gov or at:

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MESSAGE FROM THE SECRETARY

Kathleen Sebelius

I am pleased to issue this year's *FY 2011 Agency Financial Report* for the Department of Health and Human Services.

Our Department's mission is to improve the health and well-being of all Americans through effective health and human services and by fostering sound, sustained advances in care, research, public health and social services. We fulfill that mission every day by providing millions of children, families, and seniors with access to high-quality health care, by helping people find jobs and parents find affordable childcare, by keeping food safe and infectious diseases at bay, and by pushing the boundaries of how we diagnose and treat disease.

This year, we saw the enactment of the *FDA Food Safety Modernization Act* (*Public Law (P.L.) 111-353*) and the *Healthy Hunger-Free Kids Act* (*P.L. 111-296*), two new laws that help us give Americans more control over their health care. The *FDA Food Safety Modernization Act* gives HHS the opportunity to work with public and private partners and build a new system of food safety oversight – one focused on applying the best available science and good common sense. The *Healthy Hunger-Free Kids Act* is a significant step forward in our effort to help America's children thrive and grow to be healthy adults by tackling child hunger and obesity rates around the country.

I am proud of our continued work on health reform. The *Affordable Care Act* (*P.L. 111-148* and *111-152*) is delivering on its promise of better care, better health and lower costs for all Americans.

In FY 2011, we had a number of significant accomplishments.

Transforming Health Care

Thanks to the *Affordable Care Act*, millions of Americans, including Americans with Medicare, are already enjoying better access to health care. 18.9 million Americans with Medicare have received free preventive services and their prescription drug premiums remain low. In addition, Medicare beneficiaries, who fall into the Medicare Part D coverage gap or "donut hole" are receiving discounts on their covered name brand prescriptions, saving almost $1 billion. And, we've done all this while adding seven years of solvency to the Medicare Trust Fund.

Advancing Scientific Knowledge and Innovation

The *Affordable Care Act* also funded therapeutic discovery tax credits and grants for small bio-technology companies with big potential in nearly every State, and the District of Columbia. These companies are producing new therapies for unmet medical needs, reducing health care costs by targeting chronic disease, and advancing the development of new treatments for cancer. In addition, these tax credits and grants will help our small business and entrepreneurs invest, innovate, and strengthen our economy far into the future.

Advancing the Health, Safety, and Well-Being of Americans

We continue to drive the goals set out by the *Affordable Care Act's* National Quality Strategy by supporting local, State and national efforts to transform our health care system away from a focus on sickness and disease to one focused on prevention and wellness. This stops small health problems from becoming big ones and reduces costs in our system.

Increasing Efficiency, Transparency, and Accountability of Our Programs

During fiscal year (FY) 2011, we improved 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. The auditors did not express an opinion on the Statement of Social Insurance, derived from information from the annual

report of the Medicare trust funds. The FY 2011 Statement of Social Insurance projections contained in this report incorporate the effects of the *Affordable Care Act*, prepared in accordance with the standards issued by the Federal Accounting Standards Advisory Board, and reflect current law.

We are committed to responsible management and accountability of taxpayer dollars. We are transparent in our activities with honest disclosure of potential conflicts of interest and no tolerance for waste or abuse. The first of its kind in government, our Program Integrity Initiative takes a comprehensive, proactive approach to programmatic challenges, and assessing and mitigating risks associated with our programs. Our initial efforts have established a strong foundation for ensuring taxpayer dollars are spent effectively, efficiently, and for their intended purpose.

As required by the *Federal Managers' Financial Integrity Act of 1982 (FMFIA)* and the Office of Management and Budget's Circular A-123, *Management's Responsibility for Internal Control,* we also evaluated our internal controls and financial management systems. We found only one material weakness in the Department related to Information Systems Controls and Security. This weakness, which we are committed to eliminating in the future, also constitutes a system non-conformance under Section 4 of the *FMFIA*. This is an improvement over prior year's, as we have focused efforts to improve our financial report's and are no longer required to identify this as a weakness.

The Department of Health and Human Services manages one of the largest budgets in the world and improves the health and lives of Americans every day. Our accomplishments are not possible without the dedication and commitment of our employees and the strong support of our State, local, and non-profit partners. I am proud of the incredible work this Department does to improve the health and well-being of all Americans, especially those who are least able to help themselves.

/Kathleen Sebelius/

Kathleen Sebelius
Secretary
November 15, 2011

Section I: Management's Discussion and Analysis

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AGENCY FINANCIAL REPORT ACKNOWLEDGEMENT

We present our fiscal year (*FY) 2011 Agency Financial Report*. This report is presented in conformity with the Office of Management and Budget's Circular A-136, *Financial Reporting Requirements*. The *FY 2011 Annual Performance Report* and the *FY 2013 Congressional Budget Justification* will be available in February 2012, as will the *Summary of Performance and Financial Information*. These reports will be available on our Web site at www.hhs.gov at that time We believe this format provides the reader and decision-makers more transparent and enhanced financial and performance reporting.

MISSION AND ORGANIZATIONAL STRUCTURE

Our mission is to enhance the health and well-being of Americans by providing for effective health and human services, and by fostering sound, sustained advances in the sciences, underlying medicine, public health, and social services.

Our vision is to provide the building blocks that Americans need to live healthy, successful lives. We fulfill our mission and vision daily by providing millions of children, families, and seniors with access to high-quality health care, helping people find jobs, assisting parents to find affordable childcare, keeping the food on Americans' shelves safe, and pushing the boundaries of how we diagnose and treat disease. Each HHS component contributes to our mission and vision as follows:

- The Administration for Children and Families (ACF) is responsible for federal programs that promote the economic and social well-being of families, children, individuals, and communities.
- The Administration on Aging (AoA) is responsible for developing a comprehensive, coordinated, and cost-effective system of home- and community-based services that help elderly individuals maintain health and independence in their homes and communities. The AoA serves as the primary federal focal point and advocacy agent for older Americans via State and local area agency networks on aging, as well as providing grants to States, Tribal organizations, and other community services.
- The Agency for Healthcare Research and Quality (AHRQ) improves the quality, safety, efficiency, and effectiveness of health care for all Americans. The AHRQ fulfills this mission by conducting health services research in order to identify the most effective ways to organize, manage, finance, and deliver high-quality health care, reduce medical errors, and improve patient safety.
- The Agency for Toxic Substances and Disease Registry (ATSDR) serves the public by using the best science, taking responsive public health actions, and providing trusted health information to prevent harmful exposures or disease-related exposures to toxic substances.
- The Centers for Disease Control and Prevention (CDC) collaborates to create the expertise, information, and tools that people and communities need to protect their health – through health promotion; prevention of disease, injury and disability; and preparedness for new health threats.
- The Centers for Medicare and Medicaid Services (CMS) administers public insurance programs, which serve as the primary sources of health care coverage for seniors and a large population of medically vulnerable individuals, and act as a catalyst for enormous changes in the availability and quality of health care for all Americans. In addition to these programs, CMS has the responsibility to ensure effective, up-to-date health care coverage, and promote quality care for beneficiaries. CMS also has responsibility with helping implement many provisions of the *Affordable Care Act* such as the establishment of the Consumer Operated and Oriented Plan (CO-OP), which will foster the creation of qualified non-profit health insurance issuers to offer competitive health plans in the individual and small group markets.
- The Food and Drug Administration (FDA) is responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation. The FDA is also responsible for advancing the public health by helping to speed innovations that make medicines and foods effective, affordable, and safe; and helping the public get the accurate, science-based information they need to use medicines and foods to improve their health.

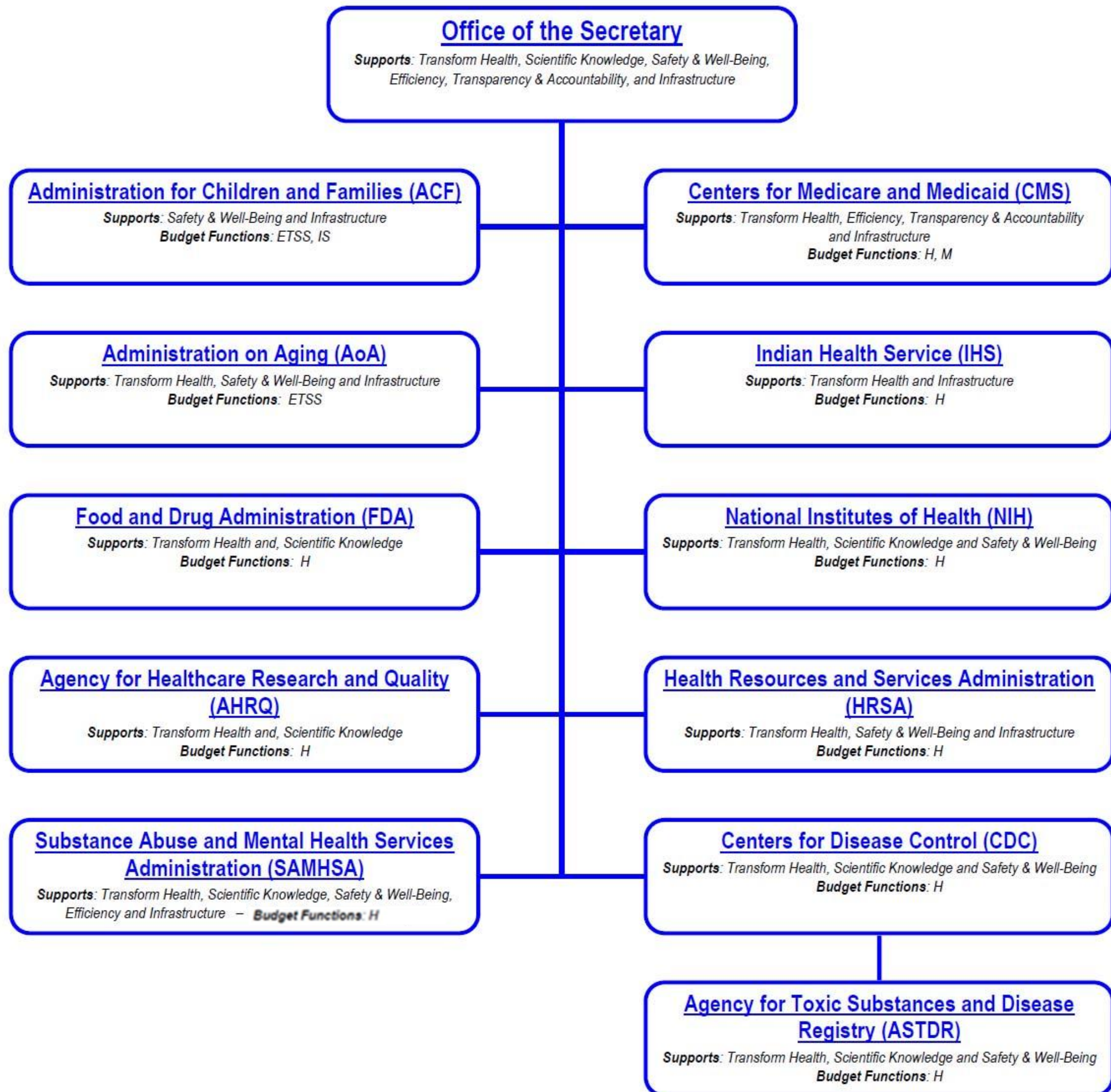
- The Health Resources and Services Administration (HRSA) is responsible for improving health care, and achieving health care equity through access to quality services, a skilled health workforce and innovative programs. The HRSA focuses on uninsured, underserved, and special needs populations in its goals and program activities.
- The Indian Health Service (IHS) raises the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.
- The National Institutes of Health (NIH) are the stewards of medical and behavioral research for the nation. The NIH promotes science in pursuit of fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to extend healthy life and reduce the burdens of illness and disability.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) is responsible for reducing the impact of substance abuse and mental illness on America's communities. The SAMHSA accomplishes its mission by providing leadership, developing service capacity, communicating with the public, setting standards; and improving practice in communities and in primary and specialty care settings.

Our Secretary leads our components to provide a wide range of services and benefits to the American people.

In addition, the following staff offices report directly to the Secretary, and support the operating components in carrying out our mission. They are:

- Office of the Assistant Secretary for Administration
- Office of the Assistant Secretary for Financial Resources
- Office of the Assistant Secretary for Health
- Office of the Assistant Secretary for Legislation
- Office of the Assistant Secretary for Planning and Evaluation
- Office of the Assistant Secretary for Public Affairs
- Office of the Assistant Secretary for Preparedness and Response
- Center for Faith-Based and Neighborhood Partnerships
- Departmental Appeals Board
- Office for Civil Rights
- Office on Disability
- Office of the General Counsel
- Office of Global Affairs
- Office of Health Reform
- Office of the Inspector General
- Office of Intergovernmental Affairs
- Office of Medicare Hearings and Appeals
- Office of the National Coordinator for Health Information Technology
- Office of Security and Strategic Information

On the next page, we present our organizational chart, which consists of the Office of the Secretary, including the noted staff offices, and 10 operating components, and further details concerning each component's role in the accomplishment of our overall mission and strategic goals, incorporating those of the staff offices. To find further information regarding our organization, components, and programs, visit our Web site at www.hhs.gov.



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

STRATEGIC GOALS

We strive for continuous improvement, enhancing the health and well-being of Americans. We achieve our vision for a healthier and more hopeful America through leadership in medical sciences, and public health and human services programs.

We accomplish our mission through several hundred programs and initiatives covering a wide spectrum of activities, serving the American public at every stage of life. We are responsible for approximately a quarter of all federal expenditures[1] and administer more grant dollars than all other federal agencies combined. Our FY 2011 direct budget authority was approximately $900 billion. Through our programs and other activities, we work closely with State, local, U.S. Territory and Tribal governments, and the private sector to improve the health and well-being of Americans.

Many of our programs meet the objectives of the *Affordable Care Act* (*P.L. 111-148* and *P.L.111-152*) and the *American Recovery and Reinvestment Act (P.L. 111-5) (Recovery Act).* For specific information on these statutory programs, see www.hhs.gov/recovery and www.recovery.gov.

Every three years, we update our strategic plan, which describes our work to address complex, multifaceted, and ever-evolving health and human service issues. An agency strategic plan is one of three main elements required by the *Government Performance and Results Act of 1993 (P.L. 103-62) (GPRA)*. Our *FY 2010 – 2015 Strategic Plan* (*Strategic Plan*) defines our mission, goals, and the means by which we will measure our progress in addressing specific national problems, needs or challenges related to our mission over the course of five years.

Last year we updated our *Strategic Plan* for FY 2010 through 2015. The plan contains our five updated strategic goals related to each of our operating components, and is summarized below.

The primary responsibility for our strategic efforts, by component, is included in our organizational chart on the Page I-3. The *FY 2010 – 2015 Strategic Plan* is available at www.hhs.gov/secretary/about/priorities/priorities.html.

Each of our operating and staff divisions contributed to the development of our *Strategic Plan*. The planning process emphasized creating alignment between the long-range *Strategic Plan* and required annual *GPRA* reporting in our *Congressional Budget Justifications* and the *Summary of Performance and Financial Information*, which together fulfill our annual performance reporting requirements.

We discuss highlights of our FY 2011 activities in the *Strategic Goal Highlights* section, which follows on Page I-6. Information related to changes in our performance results reporting is included in the next section.

Strategic Plan FY 2010 – 2015

Goal 1. *Strengthen Health Care.* Make coverage more secure and affordable, while promoting high-value, effective care.

Goal 2. *Advance Scientific Knowledge and Innovation.* Improve patient care, food safety, and medical product safety through scientific discovery, innovation for shared solutions, and investment in the regulatory sciences.

Goal 3. *Advance the Health, Safety, and Well-Being of the American People.* Ensure the health, safety and well-being of our people through improved accessibility and quality of supportive services, promotion of prevention and wellness, reduction of infectious diseases, and protection of health and safety during emergencies.

Goal 4. *Increase Efficiency, Transparency, and Accountability of HHS Programs.* Ensure program integrity and responsible stewardship of resources by fighting fraud and working to eliminate improper payments. Improve the health and well-being of the American people by providing and leveraging available data. Promote sustainability by improving HHS environmental, energy, and economic performance.

Goal 5. *Strengthen the Nation's Health and Human Service Infrastructure and Workforce.* Enhance the ability and capacity of the health care workforce, strengthen the nation's human service workforce, and improve national, State, local, and Tribal surveillance and epidemiology capacity.

[1] Calculated using data from the *FY 2011 President's Budget,* Historical Table 4.2 *Outlays by Agency*

SUMMARY OF DEPARTMENT OF HEALTH AND HUMAN SERVICES PERFORMANCE RESULTS

We managed, through our 10 Operating Divisions and 19 Staff Divisions, over 300 programs in FY 2011, affecting the health, safety, and welfare of every American. Detailed information about each of our programs and the associated performance measures can be found at: www.hhs.gov/budget.

We gauge our success through hundreds of performance measures. Information on our performance measures is included in the *On-line Performance Appendices* (available at: www.hhs.gov/budget). We do not yet have FY 2011 data for many program measures due to the expected data lag resulting from the timing of the reporting requirements for our grantees.

In FY 2011, HHS began implementing the newly reauthorized *Government Performance and Results Modernization Act* (*P.L. 111–352*). Accordingly, HHS evaluated performance reporting and consolidated the Department's 18 performance reports into a consolidated report that includes 134 representative performance measures. The FY 2011 *Summary of Performance and Financial Information*, available in February 2012, will provide a complete presentation and analysis.

Strategic Goal Highlights

We accomplish our strategic goals by managing hundreds of programs across several disciplines. As a major grant-making agency, our grantees significantly influence our outcomes. We publicly report our progress toward achievement of our mission and strategic goals through the performance measures contained in our *On-Line Performance Appendices* (at www.hhs.gov/budget).

More than 60 percent of these measures track outcomes. An example of an outcome measure is the percentage of eligible hospitals receiving meaningful use of health-information, technology incentive payments. Approximately 33 percent of our performance measures track the output with which we provide our services. These measures reflect our success in attaining our goals. An example of an output measure is the increase in the number of public health laboratories monitoring influenza virus resistance to antiviral drugs. The remaining 7 percent of our performance measures track the efficiency with which we provide our goods and services. An example of this would be optimizing utilization of home and community services for seniors and their families.

Detailed performance results will be available in our *FY 2011 Annual Performance Report*, in our *FY 2013 Congressional Justification*, during February 2012, downloadable at www.hhs.gov/budget. In addition, a synopsis of performance information will be contained in the *FY 2011 Summary of Performance and Financial Information*, also available at www.hhs.gov in February 2012.

The accomplishments described below, relate to our five strategic goals and represent highlights of our accomplishments. These selected accomplishments demonstrate progress toward the achievement of our mission and strategic goals. For a discussion of our financial and program challenges, please see *Looking Ahead*, included later in this section, on Page I-30.

Strategic Goal 1: Strengthen Health Care

Giving Americans More Control Over Their Health Care – *Affordable Care Act*

On March 23, 2010, President Obama signed the *Affordable Care Act*. The law requires comprehensive health insurance reform that rolls out over four years and beyond, with most changes taking place by 2014. The Center for Consumer Information and Insurance Oversight, established in FY 2011, will administer many of the new programs mandated by the *Affordable Care Act*. These programs transitioned from the HHS Office of the Secretary (where initial implementation was managed), to the Centers for Medicare and Medicaid Services.

The *Affordable Care Act* also includes a series of Medicare reforms that will generate billions of dollars in savings for Medicare and strengthen the care Medicare beneficiaries receive. The new law protects guaranteed benefits for all current Medicare beneficiaries, and provides new benefits and services to seniors that will help keep them healthy. The law also includes provisions that will improve the quality of care; develop and promote new models of care delivery; appropriately price services; modernize our health system; and fight waste, fraud, and abuse.

Under the *Affordable Care Act*, HHS was authorized to execute several new programs, including: Pre-existing Conditions Insurance Program, Early Retiree Reinsurance Program (ERRPs), Affordable Insurance Exchanges (the "Exchanges"), the Consumer Operated and Oriented Plan (CO-OP) Program, and Accountable Care Organizations (ACOs). The Pre-existing

Conditions Insurance Program offers affordable coverage to uninsured Americans with a pre-existing condition who have been unable to obtain health coverage.

We also established the ERRP to reimburse a portion of the employer cost of providing health insurance coverage to early retirees. We also provide grants to the States, U.S. Territories, and the District of Columbia to establish the Exchanges.

In addition, the CO-OP Program was established to foster the creation of qualified non-profit health insurance issuers to offer qualified health plans to individual and small group markets in each State and U.S. Territory. Finally, the ACOs are one way that doctors, hospitals, and other health care providers can work together to better coordinate care for patients. This coordination helps improve the health and quality of care, and lower costs for Americans. Health care providers can join ACOs to integrate and coordinate services in return for a share of any savings to the Medicare program.

Promoting Better Health, Quality Care for Americans with the National Quality Strategy

We released the *National Strategy for Quality Improvement in Health Care* (*National Quality Strategy*). The strategy was called for under the *Affordable Care Act* and is the first effort to create priorities to guide local, State, and national efforts for the improvement of the quality of health care in the United States.

The *National Quality Strategy* promotes quality health care focused on the needs of patients, families, and communities. At the same time, the strategy will move the system to work better for doctors and other health care providers – reducing administrative burdens and helping them collaborate for the improvement of care. We also continue to move forward with efforts to measure and improve health and health care quality. The strategy presents three priorities for the health care system:

- **Better Care:** Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.
- **Healthy People and Communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.
- **Affordable Care:** Reduce the cost of quality health care for individuals, families, employers, and government.

To achieve these priorities, the strategy establishes six priorities, to focus efforts of public and private partners. Those priorities are:

- Making care safer by reducing harm caused in the delivery of care;
- Ensuring that each person and family is engaged as partners in their care;
- Promoting effective communication and coordination of care;
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease;
- Working with communities to promote wide use of best practices to enable healthy living; and

- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

Providing Health Coverage to Early Retirees and Their Families

Many large and small businesses, State and local governments, educational institutions, non-profit organizations, and unions joined the Early Retiree Reinsurance Program. Sponsors began receiving reimbursements for their early retirees' medical claims in the fall of 2010.

Created by the *Affordable Care Act* as another bridge to the new health insurance exchanges in 2014, the Early Retiree Reinsurance Program provides $5 billion in financial assistance to employers and unions to help them maintain coverage for early retirees ages 55 and older who are not yet eligible for Medicare.

Businesses and other employers and unions accepted into the program will receive reimbursement for medical claims of their early retirees and their spouses, surviving spouses, and dependents. Savings can reduce employer or union health care costs, provide premium or out-of-pocket relief to workers, retirees, and their families.

The program ends January 1, 2014, when early retirees will be able to choose from additional coverage that will be available in the State-based health insurance exchanges. HHS set up a Web site, www.ERRP.gov, where sponsors can submit information to qualify early retirees, spouses, surviving spouses, and dependents for claims reimbursements.

Implementing a New Strategic Framework to Improve the Health Status of Individuals with Multiple Chronic Conditions

We issued a new *Strategic Framework on Multiple Chronic Conditions* (*Strategic Framework*) — an innovative private-public sector collaboration to coordinate responses to a growing challenge.

More than a quarter of all Americans — and two out of three older Americans — have multiple chronic conditions, and treatment for these individuals accounts for 66 percent of the country's health care budget. These numbers should rise as the number of older Americans increases.

The new *Strategic Framework* expects to reduce the risks of complications and improve the overall health status of individuals with multiple chronic conditions by fostering change within the system; facilitating research to improve oversight and care, and providing more information and better tools to help health professionals – as well as patients – learn how to better coordinate and manage care.

The management of multiple chronic conditions has major cost implications for both the country and individuals. Increased spending on chronic diseases is a key factor driving the overall growth in spending in the Medicare program. Individuals with multiple chronic conditions also face increased out-of-pocket costs for their care, including higher costs for prescriptions and support services.

HHS has taken action to improve the health of individuals with multiple chronic conditions by awarding more than $100 million in grants, including counseling and care transition programs, to help meet the challenge of improving the lives of Americans with chronic conditions, especially our older population. For more information about the new HHS Strategy on Multiple Chronic Conditions, go to www.hhs.gov/ash/initiatives/mcc/.

Supporting Innovations in Information Technology with the Health Indicators Warehouse

We launched a new web portal providing important health and health care indicator data to support innovations in information technology. The Health Indicators Warehouse represents a vast collection of health and health care indicators along with new web technologies to support automated data services. Health indicators are measurable characteristics that describe the health of a population (e.g., life expectancy, mortality, disease incidence or prevalence, or other health states); determinants of health (e.g., health behaviors, health risk factors, physical

environments, and socio-economic environments); and health care access, cost, quality, and use. Depending on the measure, a health indicator may be defined for a specific population, place, political jurisdiction, or geographic area.

HHS featured the resource as an important step toward addressing data transparency and the agency's commitment to its *Open Government Plan* and the *Community Health Data Initiative*.

The Health Indicators Warehouse includes over 1,000 health indicators derived from over 170 different data sources. The health indicator data sets and the web tools provided by the warehouse should support technology development, leading to a wide array of applications and data services. For more information about the Health Indicators Warehouse, visit www.healthindicators.gov.

Improving the Quality of Hospital Care and Reducing Health Care Costs

We launched a new initiative that rewards hospitals for the quality of care they provide to people with Medicare and may help reduce health care costs. Authorized by the *Affordable Care Act*, the *Hospital Value-Based Purchasing Program* marks the beginning of an historic change in how Medicare pays hospitals. For the first time, 3,500 hospitals across the country will be paid for inpatient acute care services based on care quality, not just the quantity of the services they provide.

This initiative helps support the goals of the *Partnership for Patients*, a new public private partnership that helps improve the quality, safety, and affordability of health care for all Americans. *The Partnership for Patients* has the potential, over the next three years, to save 60,000 lives and save up to $35 billion in health care costs, including up to $10 billion for Medicare. For more information about *Partnership for Patients* visit www.healthcare.gov/compare/partnership-for-patients/index.html.

Beginning in FY 2013, a portion of hospital payments will be based on their overall performance on quality measures shown to improve clinical processes of care and patient satisfaction.

The initial measures to determine quality in the *Hospital Value-Based Purchasing Program* focus on how closely hospitals follow best clinical practices and how well hospitals enhance patients' experiences of care and will be expanded to include measures of outcomes and efficiency. When hospitals follow these types of proven best practices, patients receive higher quality care. For a fact sheet on the *Hospital Value-Based Purchasing Program*, including a link to the quality measures, visit www.healthcare.gov/news/factsheets/2011/04/valuebasedpurchasing04292011a.html.

Strategic Goal 2: Advance Scientific Knowledge and Innovation

Supporting Groundbreaking Biomedical Research

We collaborated with the U.S. Department of the Treasury to award $1 billion in new *Therapeutic Discovery Project Program* tax credits and grants created by the *Affordable Care Act*. This program will help nearly 3,000 small biotechnology companies in nearly every State and the District of Columbia produce new and cost-saving therapies, support good jobs, and increase U.S. competitiveness.

The Therapeutic Discovery Project Program targets projects that show significant potential to produce new therapies, address unmet medical needs, reduce the long-term growth of health care costs, or develop new treatments for cancer. The allocation of the tax credit also reflects which projects show the greatest potential to create and sustain high-quality, high-paying jobs, and will advance our competitiveness in the fields of life, biological, and medical sciences. Today, the biotechnology industry employs 1.3 million workers, and the industry continues to be a key growth engine for our economy.

Developing New Flu Vaccine Technology

We awarded significant contracts for advanced development of new types of flu vaccines, and new ways to make flu vaccines known as next-generation recombinant influenza vaccines. In addition, we are collaborating with a contractor for the development of a long-acting single-dose antiviral.

One contractor is working with us to develop new technology to produce vaccines using insect cells to express influenza proteins and create virus-like particles that stimulate a strong immune response in humans. Another contractor is working with us to develop a recombinant influenza-vaccine technology based on combining influenza and bacteria proteins to stimulate strong immune response to protect against the flu.

In addition, we are working closely with another contractor to develop a dry powder inhaler that provides a single dose full treatment antiviral as opposed to the currently approved antiviral drugs requiring five days of twice-daily dosings to be effective against viruses. All contractors will conduct clinical safety and efficacy studies to optimize and validate their manufacturing processes needed to obtain licensing from us in order to use the new technologies in manufacturing flu vaccine in the U.S.

These next-generation recombinant influenza vaccines supported in early stages by us, will complement currently available and other new influenza vaccines. They are part of a national pandemic vaccine preparedness strategy, which includes the advanced development of new types influenza vaccines, as well as expanding and diversifying domestic influenza vaccine production, and establishing and testing stockpiles of pre-pandemic vaccine. In addition, the recombinant flu vaccine may enhance pandemic vaccine manufacturing surge capacity in the U.S. For more information about the national influenza preparedness strategy, visit www.phe.gov. Information about the flu is available at www.flu.gov.

Supporting Development of New Drugs to treat Radiation Injury

We awarded two contracts for advanced development of drugs to treat gastro-intestinal (GI) tract injuries associated with acute radiation syndrome. The contracts are part of continuing efforts to develop diagnostic tools and drugs to protect health, and save lives in a radiological or nuclear emergency. When the GI tract is exposed to high levels of radiation it becomes inflamed, and the drugs studied under these contracts may prevent or decrease that inflammation.

Both contracts fund studies to determine if the drugs are effective when administered 24 or more hours after radiation exposure. The studies are the next step in the drug development process, and necessary before proceeding to clinical trials and pivotal efficacy studies.

Strategic Goal 3: Advance the Health, Safety and Well-Being of the American People

Unveiling New Interactive Video to Prevent Health Care Associated Infections

As part of a wider effort that works closely with public- and private-sector partners to improve the quality, safety, and affordability of health care for all, we released *Partnering to Heal: Teaming Up Against Healthcare-Associated Infection.* This video is an interactive computer-based video-simulation training program. This training program helps support the goals of the *Partnership for Patients*; a new public-private partnership that helps improve the quality, safety and affordability of health care for all Americans.

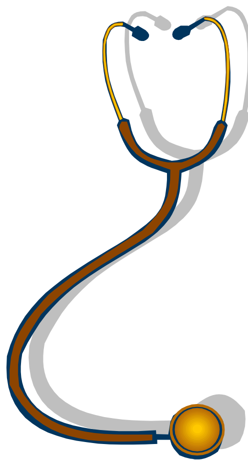
Healthcare-associated infections harm many patients, causing injury and raising costs. On average, 1 in 3 patients admitted to a hospital suffers a medical error or adverse event, and at any given time about 1 in every 20 patients is affected by an infection related to hospital care. On average, 1 in 7 Medicare beneficiaries is harmed in the course of care, costing the government an estimated $4.4 billion every year.

We set a goal of decreasing preventable hospital-acquired conditions by 40 percent (compared with 2010 rates) by the end of 2013. Achieving this

goal should result in approximately 1.8 million fewer injuries and patient illnesses, with more than 60,000 lives saved over the next three years. The *Partnership for Patients* has the potential to save up to $35 billion in health care costs.

To help address this public health challenge, we developed *Partnering to Heal*. This training program permits viewers to "become" one of five characters who can make decisions that impact health risks, and then view the results of those decisions and learn from the outcomes.

Partnering to Heal is for students in the health professions, early-career clinicians, and other health care personnel, as well as patients and families to help prevent infections acquired in hospitals and other health care settings.

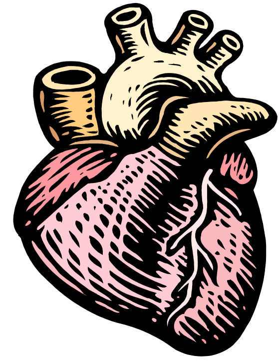


Available online at no cost, *Partnering to Heal* promotes a team-based approach to reducing preventable infections and deaths in the United States. It teaches viewers how to prevent the most prevalent hospital-acquired infections by sharing knowledge of universal and isolation precautions to take in health care settings. The *Partnering to Heal* training video is available at www.hhs.gov/partneringtoheal. For more information on *Partnership for Patients, visit* www.HealthCare.gov/center/programs/partnership.

Launching the Nation's New Health Promotion and Disease Prevention Agenda

We unveiled *Healthy People 2020*, a national framework for public health prevention consisting of 10-year goals and objectives for health promotion and disease prevention. In addition, we announced "*myHealthyPeople*," a new challenge for technology application developers.

For the past 30 years, *Healthy People* has been committed to improving the quality of our nation's health by producing a framework for public health prevention priorities and actions.



Chronic diseases, such as heart disease, cancer, and diabetes are responsible for 7 out of every 10 deaths among Americans each year, and account for 75 percent of the nation's health spending. Many risk factors that contribute to the development of these diseases are preventable.

The *Healthy People* initiative is based upon the principle that setting national objectives and monitoring progress can motivate action. In just the last decade, preliminary analyses indicate that the country has either progressed toward or met 71 percent of the *Healthy People* targets.

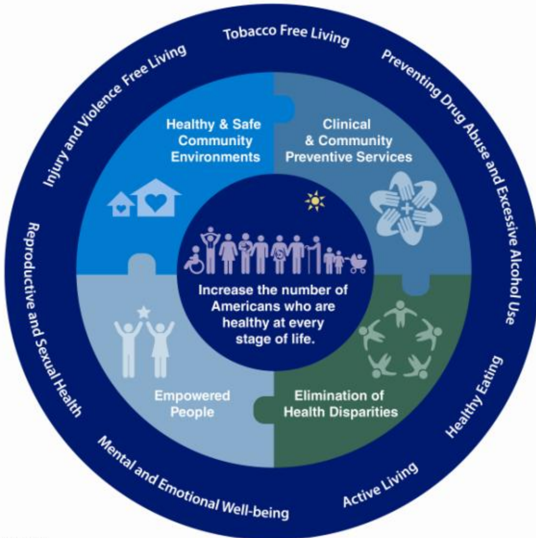
Healthy People 2020 resulted from an extensive stakeholder feedback process. It integrates input from public health and prevention experts, a wide range of federal, State and local government officials, a consortium of more than 2,000 organizations, and perhaps most importantly, the public. More than 8,000 comments were considered in drafting a comprehensive set of *Healthy People 2020* objectives. Based on this input, a number of new topic areas are included in the new initiative, including:

- Adolescent Health
- Blood Disorders and Blood Safety
- Dementias, including Alzheimer's Disease
- Early and Middle Childhood
- Genomics
- Global Health
- Health-Related Quality of Life and Well-Being
- Healthcare-Associated Infections
- Lesbian, Gay, Bisexual and Transgender Health
- Older Adults
- Preparedness
- Sleep Health
- Social Determinants of Health

We also launched a newly redesigned Healthy People Web site that allows users to tailor information to their needs and explore evidence-based resources for implementation, located at: www.healthypeople.gov. For more information about *myHealthyPeople*, go to www.challenge.gov.

Creating a National Prevention Strategy

Members of the National Prevention, Health Promotion, and Public Health Council (National Prevention Council, or NPC) released the *National Prevention and Health Promotion Strategy (National Prevention Strategy)*, a comprehensive plan that will help increase the number of Americans who are healthy at every stage of life.



The *National Prevention Strategy*, as called for under the *Affordable Care Act*, recognizes that good health comes not just from receiving quality medical care, but also from clean air and water, safe worksites and healthy foods. The strategy was developed by the NPC, which is composed of 17 federal agencies who consulted with outside experts and stakeholders.

The *National Prevention Strategy* includes actions that public-and private-partners can take to help Americans stay healthy and fit and improve our nation's prosperity. The strategy outlines four strategic directions that, together, are fundamental to improving the nation's health. The four strategic directions are: (i) building healthy, safe community environments; (ii) expanding quality preventive services in both clinical and community setting; (iii) empowering people to make healthy choices; and (iv), eliminating health disparities.

For additional information on the *National Prevention Strategy* and the NPC, visit www.HealthCare.gov/center/councils/nphpphc.

Initiating a New Comprehensive Tobacco Control Strategy

We initiated a new comprehensive tobacco control strategy that includes new bolder health warnings on cigarette packages and advertisements. We unveiled nine graphic health warnings required to appear on every pack of cigarettes sold in the U.S. and in every cigarette advertisement. This bold measure will help prevent children from smoking, encourage adults who do to quit, and ensure every American understands the dangers of smoking.

The warnings (a) represent the most significant changes to cigarette labels in more than 25 years; (b) will affect everything from packaging to advertisements; and (c) are required on all cigarette packs, cartons, and ads no later than September 2012. For more information on graphic warning labels, visit www.fda.gov/cigarettewarnings.

Launching a New Consumer-Focused Immunization Web site

We unveiled an innovative new Web site to help parents and other consumers learn about the most effective way to protect themselves and their children from infectious diseases and learn about immunization. Vaccines.gov (www.vaccines.gov) brings together the best in federal resources on vaccines and immunizations to provide consumers with easy-to-understand health information specifically for their needs.

Vaccines.gov is the first government Web site devoted to providing consumer information about vaccines and immunization, combining content and expertise from agencies across HHS. It is the result of unprecedented collaboration among federal health and communications experts to offer on-line content about vaccines and immunizations based on consumer needs.

The site includes content about vaccine recommendations, the diseases that vaccines prevent, important information for getting vaccinated, and tips on travel health. It also links consumers with resources in their States to learn about vaccine requirements for school or child care entry and local community information.

In the coming year, Vaccines.gov will expand to include information from other government Departments and will include a Spanish version of the Web site. Along with new content on vaccine

recommendations and infectious disease outbreaks, Vaccines.gov will undergo continuous testing to ensure consumer needs and questions remain addressed.

Combating Viral Hepatitis

We released *Combating the Silent Epidemic of Viral Hepatitis: Action Plan for the Prevention, Care and Treatment of Viral Hepatitis (Viral Hepatitis Action Plan)*, a comprehensive action plan for the prevention, care, and treatment of Viral Hepatitis. The plan is part of our commitment to ensure the prevention of new viral hepatitis cases, as well as ensuring that persons already infected are tested, kept informed about their infection, and are provided with counseling, care, and treatment.

An estimated 3-5.5 million persons are living with viral hepatitis in the U.S. As many as 65-75 percent of these persons do not know they are infected and are not receiving care or treatment, which places them at greater risk for severe, even fatal, complications from the disease, and puts millions more at risk for infection.

Though virtually unknown to the general public, at-risk populations, and policymakers, hepatitis is the leading infectious cause of death, claiming the lives of 12-15 thousand Americans each year.

The *Viral Hepatitis Action Plan* engages participating agencies, federal and external partners in the following six action steps, which correspond to recommendations made by the Institute of Medicine (IOM) in 2010 to improve the prevention of viral hepatitis and the care and treatment provided to infected persons:

- Educating Providers and Communities to Reduce Health Disparities;
- Improving Testing, Care, and Treatment to Prevent Liver Disease and Cancer;
- Strengthening Surveillance to Detect Viral Hepatitis Transmission and Disease;
- Eliminating Transmission of Vaccine-Preventable Viral Hepatitis;
- Reducing Viral Hepatitis Caused by Drug-Use Behaviors; and
- Protecting Patients and Workers from Health-Care Associated Viral Hepatitis.

To learn more about the *Viral Hepatitis Action Plan*, visit www.aids.gov/hepatitis.

Strategic Goal 4: Increase Efficiency, Transparency, and Accountability of HHS Programs

Fighting Fraud, Strengthening Medicare, and Protecting Taxpayer Dollars within the U.S. Health Care System

The *Affordable Care Act* takes landmark steps forward to fight health care fraud, waste, and abuse by providing critical new tools to improve and enhance the Administration's continuing efforts to prevent and detect fraud, and crack down on individuals who attempt to defraud the Medicare, Medicaid, and Children's Health Insurance Programs as well as private insurance. For example, the President has committed to cutting the improper payment rate in the Medicare Fee-for-Service program in half by 2012.

The *Affordable Care Act* fights fraud in the health care system by providing an additional $350 million over the next ten years through the Health Care Fraud and Abuse Control Account. The *Act* toughens sentencing for criminal activity, enhances screenings and enrollment requirements, encourages increased sharing of data across government, expands over-payment recovery efforts, and provides greater oversight of private insurance abuses.

The *Affordable Care Act* also includes tools and resources to help States reduce improper payments through the establishment of Recovery Audit contractors. Over the next five years, HHS projects its newly established *Medicaid Recovery Audit Contractor Program* will save $2.1 billion, of which $910 million is returned to the appropriate States. This comes as our *Medicare Recovery Audit Contractor Program* completes its second year of national use. It is largely self-funded, paying independent auditors a contingency fee out of any improper payments they recover that took place in the previous three years. The *Medicare Recovery*

Audit Contractor Program is on pace to increase the amount of Medicare over-payments recovered by nearly 800%, from roughly $75 million in 2010, to nearly $670 million in 2011.

CMS, working in conjunction with the HHS OIG, are taking steps to increase accountability and decrease the presence of fraudulent providers. CMS is acquiring state-of-the-art fraud fighting analytic tools to prevent wasteful and fraudulent payments in the Medicare, Medicaid and the Children's Health Insurance Programs. These tools will integrate many of the CMS' pilot programs into the *National Fraud Prevention Program* and complement the work of the joint HHS and the U.S. Department of Justice Health Care Fraud Prevention and Enforcement Action Team (HEAT). CMS, like other health care payers, will take anti-fraud actions before a claim is paid, stopping payments to "false fronts" identified through sophisticated predictive modeling analysis.

In addition, the HHS OIG introduced a new booklet for medical students called *A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud Abuse.* The booklet will go out to medical schools across the country. It explains the laws that apply to physicians so they can comply with federal law, avoid liability, and spot signs of potential fraud. The *Roadmap* is available at oig.hhs.gov/fraud/PhysicianEducation.To learn more about HEAT visit www.stopmedicarefraud.gov.

Enhancing Program Integrity to Ensure Taxpayer Dollars Are Used Effectively

HHS launched the Program Integrity Initiative (Initiative) in May 2010. The first of its kind in federal government, the Initiative takes a comprehensive look at the challenges facing HHS programs, and promotes a proactive approach to addressing programmatic vulnerabilities. Within the first year, HHS made substantive progress, most notably in communicating the importance of program integrity and establishing a strong foundation for the Initiative.

The essence of program integrity is ensuring taxpayer dollars are used effectively, efficiently, and for their intended purpose. It involves enhancing program integrity both in HHS' internal operations and by HHS' external partners. Program integrity is not new; HHS programs have always operated with integrity. But what is new is that we are reexamining all operations and processes using a standardized, enterprise-wide risk management approach; and we're leveraging our best practices and responses to cross cutting issues across all HHS Divisions.

HHS has made progress in building the infrastructure for the Initiative, both at an HHS governance level and at the Operating and Staff Division (Division) level. At the top of the governance structure is the Secretary's Council on Program Integrity. Membership is comprised of all Division heads. Reporting to that body is the Program Integrity Coordinating Council (PICC), comprised of senior leaders who report directly to their Division head. During this year, the PICC has undertaken a number of activities and has provided strategic direction to the Initiative.

There has also been considerable activity at the Division level. Prior to the Initiative's launch, Divisions varied in the way they approached program integrity. For example, some Divisions considered program integrity inherent to their business operations, while other Divisions had an established program integrity structure. Regardless, since the Initiative's launch all Divisions have increased their focus on program integrity in some manner. Some have chosen to concentrate on internal operations while others have focused on their external partners. The Divisions have all made progress building program integrity awareness.

While the Department has made substantive progress during this first year, much more work remains. Over the coming years the Divisions will continue to assess their programs using the standardized, enterprise-wide risk management approach. As the relationships within and among the various new teams mature, HHS will share best practices on a Department-wide basis. We are excited about the progress made and are looking forward to the future as the Department builds upon these successes and continues to instill program integrity into every aspect of HHS' culture to achieve its mission with unprecedented accountability for taxpayer funds.

Combating Abuse and Neglect in the Nation's Long-Term Care Facilities

In a move aimed at combating abuse and neglect in the nation's long-term care facilities, we awarded more than $34 million to 14 States to design comprehensive applicant criminal

background check programs for jobs involving direct patient care.

Created by the *Affordable Care Act*, the new *National Background Check Program* will help identify "best practices" for long-term care providers to determine whether a job seeker has any kind of criminal history or other disqualifying information that could make him or her unsuitable to work directly with residents. Funding for this program is $160 million, which is available through September 2012.

The national background check for each prospective direct, patient care employee must include a criminal history search of both State and federal abuse and neglect registries and databases, such as the Nurse Aide Registry or FBI files. Long-term care facilities or providers covered under the program include nursing facilities, home health agencies, hospice providers, long-term care hospitals, and intermediate-care facilities for persons with mental retardation, and other entities that provide long-term care services. E-mail questions about the *National Background Check Program* to Background_Checks@cms.hhs.gov.

Imposing a $4.3 Million Civil Money Penalty for Violations of the HIPAA Privacy Rule

We imposed a civil money penalty (CMP) of $4.3 million for violations of the *Privacy Rule of the Health Insurance Portability and Accountability Act of 1996* (*HIPAA Privacy Rule*). This represented the first CMP issued by HHS for a covered entity's violations

We found that a health care company violated 41 patients' rights by denying them access to their medical records when requested between September 2008 and October 2009. These patients individually filed complaints, initiating investigations of each complaint. The *HIPAA Privacy Rule* requires that a covered entity provide a patient with a copy of their medical records within 30 (and no later than 60) days of the patient's request.

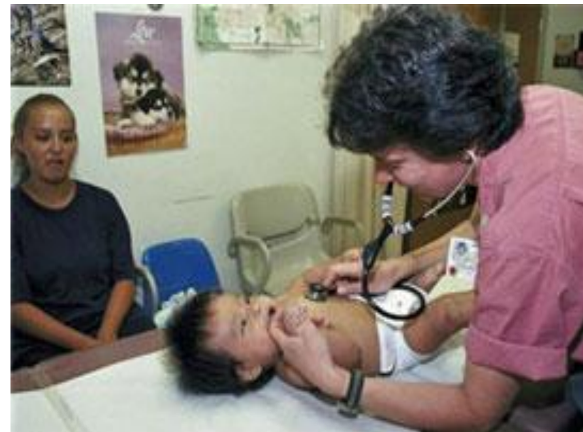
The CMP for these violations was $1.3 million. During the investigations, the health care company also refused to respond to demands to produce the records and failed to cooperate with investigations of the complaints, resulting in an additional CMP of $3 million.

Individuals who believe a covered entity violated their (or someone else's) health information privacy rights, or committed another violation of the *HIPAA Privacy Rule* may file a complaint at www.hhs.gov/ocr/privacy/hipaa/complaints/index.html.

Strategic Goal 5: Strengthen the Nation's Health and Human Services Infrastructure and Workforce

Fostering Tribal Relationships through the Secretary's Tribal Advisory Committee

HHS Secretary Kathleen Sebelius established a new Secretary's Tribal Advisory Committee and signed the Department's revised *Tribal Consultation Policy*. The advisory committee signals a new level of attention to government-to-government relationship between HHS and Indian Tribal governments.



The advisory committee's primary purpose is to seek consensus, exchange views, share information, provide advice and recommendations; or facilitate any other interaction related to intergovernmental responsibilities or administration of HHS programs, including those that arise explicitly or implicitly under statute, regulation or Executive Order. Priorities discussed by the committee include:

- Improvement of delivery of preventive services to close the health disparities gap for American Indians and Alaska Natives;
- Working together more effectively to provide social services to families;
- Providing additional technical assistance for and better access to federal grants; and,
- Promoting government-to-government relationships.

Web sites with more information include www.hhs.gov/intergovernmental/tribal/tcp.html and www.hhs.gov/intergovernmental/tribal/.

Bolstering the Primary Care Workforce in Medically Underserved Communities

We announced the launch of the new application cycle for the National Health Service Corps (NHSC) Loan Repayment Program (http://nhsc.hrsa.gov/). The NHSC offers primary care medical, nursing, dental, and mental health clinicians up to $60,000 to repay student loans in exchange for two years of service at health care facilities in medically underserved areas.

This year's investment in the program includes $290 million from the *Affordable Care Act*, and seeks to address shortages in the primary health care workforce and translates into greater access to health care for those who might otherwise go without. A total of $1.5 billion is scheduled to be funded under this program.

For the first time, clinicians may apply to the NHSC loan repayment program online where they will find tutorials and additional information to assist in the application process. Eligible disciplines include: physician, dentist (general or pediatric), psychiatrist, nurse practitioner (primary care), certified nurse-midwife, physician assistant, dental hygienist, psychologist (health service), licensed clinical social worker, psychiatric nurse specialist, marriage and family therapist, licensed professional counselor.

Strengthening the Nursing Workforce

We announced $71.3 million in grants to expand nursing education, training and diversity. Nursing workforce development programs, reauthorized by the *Affordable Care Act* and administered by HHS' Health Resources and Services Administration, are the primary source of federal funding for nursing education and workforce development. These programs bolster nursing education at all levels, from entry-level preparation through the development of advanced practice nurses. They also prepare faculty to teach the nation's future nursing workforce.

Creating Community Health Centers to Increase Access to Affordable, Cost-Effective, and High-Quality Care

For more than 45 years, community health centers have delivered comprehensive, high-quality preventive and primary health care to patients regardless of their ability to pay. During that time, community health centers have become the essential primary care medical home for millions of Americans, including some of the nation's most vulnerable populations. The *Affordable Care Act* established the Community Health Center fund that provides $11 billion over five years for the operation, expansion, and construction of health centers throughout the nation.

Today, more than 1,100 community health centers operate over 8,100 service delivery sites, providing care to approximately 19.5 million patients in every State, the District of Columbia, and U.S. Territories. This network of community health centers has created one of the largest safety net systems of primary and preventive care in the country with a true national impact.

The quality of care at community health centers often surpasses that provided by other primary care providers. A programmatic emphasis on quality improvement, as well as community-responsive and culturally appropriate care, has also translated into impressive reductions in health disparities for patients in community health centers, which also reduce costs to health systems. The model of care at community health center has shown reductions in the use of more costly providers of care, such as emergency departments and hospitals.

Community health centers emphasize coordinated primary and preventive services or a "medical home" that promotes reductions in health disparities for low-income individuals, racial and ethnic minorities, rural communities, and other

underserved populations. Community health centers place emphasis on the coordination and comprehensiveness of care, the ability to manage patients with multiple health care needs, and the use of key quality improvement practices, including health information technology.

The community health center model also overcomes geographic, cultural, linguistic and other barriers through a team-based approach to care that includes physicians, nurse practitioners, physician assistants, nurses, dental providers, midwives, behavioral health care providers, social workers, health educators, and many others.

Rooted in a commitment to community-based, patient-centered care, community health centers continue to focus on comprehensive services that meet the varying needs of their patient populations including: disease management and coordination; prevention and patient education activities; and outreach.

To learn more about the Community Health Center Program, visit bphc.hrsa.gov/about/index.html. To find a health center in your area, visit findahealthcenter.hrsa.gov.

Analysis of Financial Statements and Stewardship Information

The financial statements were prepared in accordance with federal accounting standards and audited by the independent accounting firm of Ernst & Young LLP under the direction of our Inspector General. The *Chief Financial Officers Act of 1990 (P.L. 101-576)* requires the preparation and audit of these statements, which are part of our efforts for continuous improvement of financial management. The production of accurate and reliable financial information is necessary for making sound decisions, assessing performance, and allocating resources. Section II of the report presents our audited financial statements and notes.

Table 1: Summary of Financial Condition Trends

(in Billions)

	FY2007	FY2008	FY2009	FY2010	FY2011	Increase (Decrease)	% Change
Total Assets	**$ 503.8**	**$ 529.3**	**$ 562.8**	**$ 563.7**	**$ 532.9**	**$ (30.8)**	**(5.5) %**
Fund Balance with Treasury	114.8	124.3	162.0	182.2	166.9	(15.3)	(8.4) %
Investments, Net	365.9	385.4	381.1	359.9	325.4	(34.5)	(9.6) %
Other Assets	23.1	19.6	19.7	21.6	40.6	19.0	88.0 %
Total Liabilities	**$ 81.9**	**$ 86.6**	**$ 94.4**	**$ 99.2**	**$ 104.9**	**5.7**	**5.7 %**
Accounts Payable	1.0	1.0	1.1	1.6	1.2	(.4)	(25.0) %
Entitlement Benefits Due and Payable	61.5	65.9	72.2	72.7	80.9	8.2	11.3 %
Accrued Grant Liabilities	3.9	3.9	4.0	4.2	4.5	.3	7.1 %
Federal Employee and Veterans Benefits	8.4	8.8	9.7	10.0	10.2	.2	2.0 %
Other Liabilities	7.1	7.0	7.4	10.7	8.1	(2.6)	(24.3) %
Net Position	**$ 421.9**	**$ 442.7**	**$ 468.4**	**$ 464.5**	**$ 428.0**	**$ (36.5)**	**(7.9) %**
Total Liabilities and Net Position	**$ 503.8**	**$ 529.3**	**$ 562.8**	**$ 563.7**	**$ 532.9**	**$ (30.8)**	**(5.5) %**

Limitations of the Principal Financial Statements

The principal financial statements in Section II of this report have been prepared to report our financial position and results of operations, pursuant to the requirements of 31 U.S.C. §3515 (b). Although the statements have been prepared from our books and records in accordance with generally accepted accounting principles for federal entities and the formats prescribed by the OMB, the statements are in addition to the financial reports used to monitor and control budgetary resources, which are prepared from the same books and records.

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 us with resources and budget authority.

Financial Condition: What is Our Financial Picture?

Table 1 above, summarizes trend information concerning components of our financial condition as of September 30 each year – assets, liabilities, and net position. The Consolidated Balance Sheet, found in Section II of this report, presents a snapshot of our financial condition as of September 30, 2011, compared to FY 2010, and displays assets, liabilities and net position.

Another presentation of our financial picture is our Consolidated Statement of Net Cost, also found in Section II, with further detailed presentations, which can be found in Section III. Year over year summary changes for each of these statements are discussed in the following sections and provided in greater detail in the Notes found in Section II of this report.

Assets: What Do We Own and Manage?

Assets represent the value of what we own and manage. Our total assets were $532.9 billion on September 30, 2011. This amount represents a decrease of $30.8 billion or 5.5 percent below last year's assets. This $30.8 billion decrease in assets is primarily attributable to a decrease in Net Investments of $34.5 billion for the Medicare Trust Funds. In addition, the Fund Balance with Treasury declined by $29.2 billion related to disbursements for Medicaid ($16.6 billion), *Recovery Act* ($8.0 billion), *Affordable Care Act* ($2.4 billion), and the National Stockpile ($2.2 billion).

However, there was an off-setting increase in Fund Balance with Treasury for the *Affordable Care Act* for the CMS and HRSA programs ($6.5 billion and $2.8 billion, respectively), Medicare (SMI $3.7 billion; HI -$0.4 billion), CHIP ($1.3 billion), and SMI Accounts Receivable of $4.0 billion. There was also an increase related to Advances for the Medicare Advantage and Prescription Drug plan in the amount of $15.0 billion.

The federal government does not set aside assets to pay future benefits associated with Medicare. Treasury securities (our Net Investments) are earmarked assets for the Medicare program. Trust fund holdings not necessary to meet current expenditures are invested in interest-bearing U.S. Treasury securities. The securities held by the Medicare Trust Fund provide the authority to make expenditures. As a result, our Net Investments declined $34.5 billion in FY 2011 for Medicare. This decrease in the investment was necessary to meet the cash requirements related to Medicare, primarily for the Hospital Insurance program in the amount of $34.0 billion. Although *Federal Insurance Contributions Act* (*FICA*) and *Self Employment Contributions Act* (*SECA*) contributions, or revenues, are beginning to grow following the national recession, the Hospital Insurance investments continue to decrease as expenses exceed revenues.

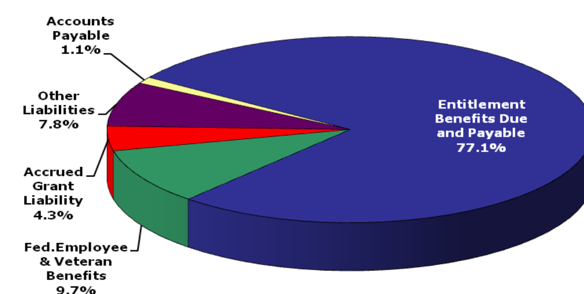
We have experienced a slight change in the overall composition of our assets in FY 2011 compared to FY 2010. The Fund Balance with Treasury and Net Investments together currently comprise 92.4 percent of our total assets compared to 96.2 percent at the end of FY2010. The remaining FY 2011 assets, totaling $40.6 billion or 7.6 percent, consists of: Accounts Receivable; Inventory and Related Property; Property, Plant, and Equipment; Advances; and Other Assets. In FY 2010, Other Assets represented 3.8 percent of our total assets. This change in asset composition is directly related to an increase in advance payments by the Centers for Medicare and Medicaid Services for the Medicare Advantage and Prescription Drug plans for services provided in October 2011.

Liabilities: What Do We Owe?

Our liabilities, or amounts that we owe from past transactions or events, were $104.9 billion on September 30, 2011. This represents an increase of $5.7 billion, or 5.7 percent above the last year's liabilities.

Entitlement Benefits Due and Payable to the public from the Medicare and Medicaid insurance programs was $80.9 billion on September 30, 2011, compared to $72.7 billion at the end of FY 2010. These amounts represent 77.1 percent and 73.3 percent of our liabilities in FY 2011 and FY 2010, respectively. The year-over-year change represents an $8.2 billion or 11.3 percent change from FY 2010. This change is primarily due to increases in the estimates of expenses incurred, but not yet recorded for the Hospital Insurance and Supplementary Medical Insurance programs. In addition, we have an offsetting $2.6 billion decrease in Other Liabilities, which relates primarily to a decrease in Contingent Liabilities for Medicaid reimbursement of State plan amendments.

Figure 1: FY 2011 Liabilities by Type



Consistent with federal accounting standards, we recognize the responsibility for future program participants of Medicare as a social insurance program, rather than a pension program. Accordingly, we have not recognized a liability for future payments to current and future program participants. The estimated long-term cost for Medicare is included in the Statement of Social Insurance (SOSI) and discussed further later in

this report; and a more extensive discussion is provided in the associated Financial Statement Notes in Section II of this report.

Ending Net Position: What Have We Done Over Time?

Our net position represents the difference between assets and liabilities. Changes in our net position results from changes that occur within the cumulative results of operations and unexpended appropriations. At the end of FY 2011, our net position was $428.0 billion, a decrease of $36.5 billion, or 7.9 percent from FY 2010. Of the $428.0 billion, $297.6 billion was for earmarked funds compared to $319.0 billion in FY 2010, and $130.4 billion for all other funds compared to the FY 2010 ending balance of $145.5 billion.

The decrease of $36.5 billion was principally due to a decrease of $24.0 billion in earmarked cumulative results of operations, and $17.9 billion decrease in unexpended appropriations for all other Departmental funds. Net position is the sum of the cumulative results of operations since inception and unexpended appropriations, those appropriations provided to HHS that remain unused at the end of the fiscal year.

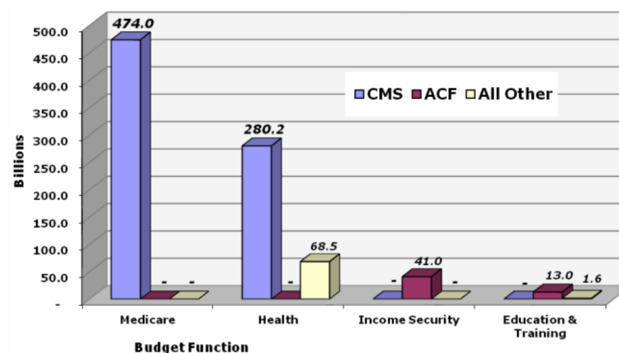
Net Cost of Operations: What Are Our Sources & Uses of Funds?

Our net cost of operations represents the difference between the costs incurred by our programs less associated revenues. We receive the majority of our funding through Congressional appropriations and reimbursement for the provision of goods or services to other federal agencies. Our Net Cost of Operations for the year ended September 30, 2011, totaled $878.1 billion.

Figure 2 depicts our FY 2011 Net Cost of Operations by major budget function and significant components. The majority of FY 2011 net costs relate to Medicare ($474.0 billion) and Health ($348.7 billion) programs, or more than 93 percent of our annual net costs. During FY 2011, the Medicare budget function experienced growth of 6.0 percent ($26.8 billion) and Health decreased 0.9 percent ($3.1 billion).

The growth in the Medicare budget function is primarily attributable to the normal increases in Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) benefits of $12.5 billion and $14.3 billion, respectively.

Figure 2: FY 2011 Net Cost of Operations



The FY 2011 Net Cost represents an increase of $21.4 billion or 2.5 percent more than the FY 2010 Net Cost. Approximately 86 percent of the Net Cost of Operations ($753.7 billion) relates to Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and other health programs managed by the Centers for Medicare and Medicaid Services.

Table 2 below depicts our Net Cost of Operations by major component for the last five years.

Table 2: Net Cost of Operations
(in Billions)

	2007	2008	2009	2010	2011	$ Change	% Change
Responsibility Segments							
Centers for Medicare and Medicaid Services (CMS) Gross Cost	$ 612.4	$ 657.9	$ 749.0	$ 789.7	$ 817.4	$ 27.7	3.5 %
CMS Exchange Revenue	(50.3)	(54.1)	(57.3)	(60.7)	(63.7)	(3.0)	4.9 %
CMS Net Cost of Operations	562.1	603.8	691.7	729.0	753.7	24.7	3.4 %
Other Segments:							
Other Segments Gross Cost of Operations	105.4	108.4	116.0	130.9	128.2	(2.7)	(2.1) %
Exchange Revenue	(2.9)	(3.1)	(3.8)	(3.2)	(3.8)	(0.6)	18.8 %
Other Segments Net Cost of Operations	102.5	105.3	112.2	127.7	124.4	(3.3)	(2.6) %
Net Cost of Operations	**$ 664.6**	**$ 709.1**	**$ 803.9**	**$ 856.7**	**$ 878.1**	**$ 21.4**	**2.5 %**

Budget Resources
What Were Our Resources and the Status of Funds?

The Combined Statement of Budgetary Resources provides information on availability of budgetary resources and the status at the end of the year. FY 2011 total resources were $1.3 trillion, representing an increase of $56.4 billion, or 4.5 percent, over FY 2010. Fiscal year 2011 obligations of $1.3 trillion increased $63.9 billion, or 5.3 percent, over FY 2010. Our year-end resources were $51.8 billion, of which $7.4 billion are not yet available for expenditure as of September 30, 2011. Total net outlays (cash disbursed for the Department's obligations) of $891.5 billion increased $37.4 billion or 4.4 percent from FY 2010 net outlays of $854.1 billion.

Statement of Social Insurance

Effective for FY 2011, we implemented the new provisions for the Federal Accounting Standards Advisory Board (FASAB) Statement of Federal Financial Accounting Standard Number 37 – *Social Insurance: Additional Requirements for Management Discussion and Analysis (MD&A) and Basic Financial Statements*[2]. The SOSI is a principle statement and presents the 75-year actuarial present value of the income and expenditures of the Medicare trust funds. Future expenditures are expected to arise from the formulae specified in current law for current and future program participants. This projection is considered important information regarding the potential future cost of the program.

These projected potential future obligations under current law are not included in the Consolidated Balance Sheet, Statements of Net Cost and Changes in Net Position, or Combined Statement of Budgetary Resources.

The SOSI presents the following estimates:

- The present value of future income (income excluding interest) to be received from or on behalf of current participants who have attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income to be received from or on behalf of current participants who have not yet attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income less future cost for the closed group, which represents all current participants who attain age 15 or older in the first year of the projection period, plus the assets in the combined HI and SMI Trust Funds as of the beginning of the valuation period;
- The present value of income to be received from or on behalf of future participants and the cost of providing benefits to those same individuals;

[2] On April 5, 2010, FASAB issued SFFAS No. 37, which amended SFFAS No. 17, *Accounting for Social Insurance*, to provide more transparent financial reporting to the public.

- The present value of future income less future cost for the open group, which represents all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program, plus the assets in the combined HI and SMI Trust Funds as of the beginning of the valuation period; and
- The present value of future cashflows for all current and future participants over the next 75 years (open group measure as of January 1, 2011) decreased from -$2.7 trillion, determined as of January 1, 2010, to -$3.3 trillion, determined as of January 1, 2011.

Including the combined HI and SMI Trust Fund assets increases the present value, as of January 1, 2011, of future cashflow for all current and future participants -$2.9 trillion for the 75-year valuation period. The comparable closed group of participants, including the combined HI and SMI Trust Fund assets, is -$7.7 trillion.

Hospital Insurance Trust Fund Solvency

Pay-as-you-go Financing

The Hospital Insurance (HI) Trust Fund is deemed to be solvent as long as assets are sufficient to finance program obligations. Such solvency is indicated, for any point in time, by the maintenance of positive Trust Fund assets. In recent years, current expenditures have exceeded program income for the HI program, and thus, the HI Trust Fund assets have been declining. The following table shows that HI Trust Fund assets, expressed as a ratio of the assets at the beginning of the fiscal year to the expenditures for the year. This ratio has steadily dropped from 149 percent at the beginning of FY 2007 to 106 percent at the beginning of FY 2011.

Trust Fund Ratio Beginning of Fiscal Year[3]					
	2007	**2008**	**2009**	**2010**	**2011**
HI	149%	139%	134%	124%	106%

[3] Assets at the beginning of the year to expenditures during the year.

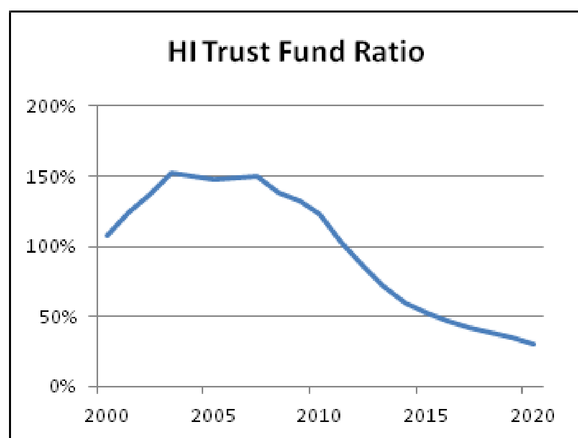
Short-Term Financing

The HI Trust Fund is deemed adequately financed for the short term when actuarial estimates of Trust Fund assets for the beginning of each calendar year are at least as large as program obligations for the year. Estimates in the *2011 Trustees Report* indicate that the HI Trust Fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the *2011 Trustees Report*, the HI Trust Fund ratio is estimated to steadily decline to about 31 percent by the beginning of calendar year 2020. From the end of 2010 to the end of 2020, assets are expected to decline by 60 percent, from $272 billion to $108 billion.

Long-Term Financing

HI financing is not projected to be sustainable over the long term with the tax rates and expenditure levels projected in current law. Program cost will exceed total income in all years of the 75-year projection period. In 2024, the HI Trust Fund will be exhausted according to the projections by the CMS Office of the Actuary. Under current law, when the HI Trust Fund is exhausted, full benefits cannot be paid on a timely basis. Tax revenues are projected to be sufficient to support 90 percent of projected expenditures after the HI Trust Fund exhaustion in 2024, declining to 88 percent of projected expenditures in 2085.

The primary reasons for the projected long-term inadequacy of financing under current law relate to the fact that the ratio of the number of workers paying taxes relative to the number of beneficiaries eligible for benefits drops from 3.4 in 2010 to about 2.0 by 2085. In addition, health care costs continue to rise faster than the taxable wages used to support the program. In present value terms, the 75-year shortfall is $3.3 trillion, which is 0.7 percent of taxable payroll and 0.3 percent of the Gross Domestic Product (GDP) over the same period.



Significant uncertainty surrounds the estimates for the SOSI. In particular, the actual future values of demographic, economic, and programmatic factors are likely to be different from the near term and ultimate assumptions used in the projections. For more information, please refer to the Required Supplementary Information in Section II of this report.

Supplementary Medical Insurance Trust Fund Solvency

The Supplementary Medical Insurance (SMI) Trust Fund consists of two accounts – Part B and Part D. In order to evaluate the financial status of the SMI Trust Fund, each account needs to be assessed individually, since financing rates for each part are established separately, their program benefits are quite different in nature, and there is no provision for transferring assets.

While differences between the two accounts exist, the financing mechanism for each part is similar in that the financing is determined on a yearly basis. The Part B account is generally financed by premiums and general revenue-matching appropriations determined annually to cover projected program expenditures and to provide a contingency for unexpected program variation. The Part D account is financed by premiums, general revenues, and transfers from State governments.

Unlike the Part B account, Part D has a flexible, general-revenue appropriation, which means that general revenues cover the remaining cost of providing Part D benefits, thereby eliminating the need to maintain a normal contingency reserve.

Since both the Part B and Part D programs are financed on a yearly basis, from a program perspective, there is no unfunded liability in the short- or long-range. Therefore, in this financial statement the present value of estimated future excess of income over expenditures for current and future participants over the next 75 years is $0. However, from a government-wide perspective, general fund transfers as well as interest payments to the Medicare Trust Funds and asset redemption, represent a draw on other federal resources for which there is no earmarked source of revenue from the public. Hence, from a government-wide perspective, the corresponding estimate of future income over expenditures for the 75-year projection period is -$21.3 trillion.

Even though from a program perspective, the unfunded liability is $0, there is concern over the rapid cost of the SMI program as a percent of GDP. In 2010, SMI expenditures were 1.89 percent of GDP. By 2085, SMI expenditures are projected to grow to 4.13 percent of the GDP.

The following table presents key amounts from the CMS financial statements for fiscal years 2009 through 2011.

TABLE OF KEY MEASURES [4]
BASED ON THE CMS FINANCIAL STATEMENTS FOUND IN SECTION III
(IN BILLIONS)

	2011	2010	2009
Net Position (end of fiscal year)			
Assets	$ 424.2	$ 430.7	$ 435.5
Less Total Liabilities	$ 87.5	$ 80.5	$ 77.7
Net Position (assets net of liabilities)	$ 336.7	$ 350.2	$ 357.8
Change in Net Position (end of fiscal year)			
Net Costs	$ 754.1	$ 728.7	$ 691.5
Total Financing Sources	$ 730.4	$ 709.5	$ 681.6
Change in Net Position	$ (23.7)	$ (19.2)	$ (9.9)
Statement of Social Insurance (calendar year basis)			
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), current year valuation	$ (3,252)	$ (2,683)	$ (13,770)
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), prior year valuation	$ (2,683)	$ (13,770)	$ (12,737)
Change in present value	$ (569)	$ 11,087	$ (1,033)

[4] The table or other singular presentation showing the measures described above. Although, the closed group measure is not required to be presented in the table or other singular presentation, the HHS presents the closed group measure and open group measure.

Statement of Changes in Social Insurance Amounts

The Statement of Changes in Social Insurance Amounts (SCSIA) reconciles the change (between the current valuation period and the prior valuation period) in the present value of future tax income less future cost for current and future participants (the open group measure) over the next 75 years. This reconciliation identifies those components of the change that are significant and provides reasons for the changes.

The present value as of January 1, 2011, would have decreased by $112 billion due to advancing the valuation date by one year and including the additional year 2085. Similarly, changes in the projection base and demographic assumptions, further decreased the present value of future cashflows by $531 billion and $112 billion, respectively.

However, (1) legislative changes, (2) changes in economic data, assumptions, and methods, and (3) changes in programmatic data, assumptions, and methods revisions in assumptions each increased the present value of future cashflows by about $185 billion. For further explanation, please refer to Notes 21, 22, and 23 of Section II.

Required Supplementary Information

As required by SFFAS No. 17 (as amended by SFFAS No. 37), we have included information about the Medicare Trust Funds – HI and SMI. The RSI presents the required long-range, cashflow projections, the long-range projections of the ratio of contributors to beneficiaries (dependency ratio), and the sensitivity analysis illustrating the effect of the changes in the most significant assumptions on the actuarial projections and present values.

SFFAS No. 37 does not eliminate or otherwise affect SFFAS No. 17 requirements for the supplementary information, except that the actuarial projections of annual cashflow in nominal dollars are no longer required. As such, it will not be reported in the RSI. The RSI assesses the sufficiency of future budgetary resources to sustain program services and meet program obligations as they come due. The information is drawn from the *2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation for the financial and actuarial status of the Medicare Trust Funds.

SYSTEMS, LEGAL COMPLIANCE, AND MANAGEMENT ASSURANCES

Systems

Our overall goals for financial management systems focus on ensuring effective internal controls, sound financial management practices, systems integration, and the ability to produce timely and reliable financial and performance data for reporting. Management's priority is to quickly and effectively address weaknesses identified in audits, and self-evaluations or assessments of our financial management controls, systems, and processes.

Improving our financial management practices requires the ability to maintain sound systems, processes, and controls that ensure transparency and accountability; provide useful management information; and meet the requirements of federal laws, regulation, and authoritative guidance. We seek to comply with federal financial management systems requirements, including the:

- *Federal Managers' Financial Integrity Act of 1982 (P.L. 97-255)*
- *Chief Financial Officers Act of 1990 (P.L. 101-576)*
- *Government Management Reform Act of 1994 (P.L. 103-356)*
- *Federal Financial Management Improvement Act of 1996 (P.L. 104-208)*
- *Clinger-Cohen Act of 1996 (P.L. 104-106)*
- *Federal Information Security Management Act of 2002 (P.L. 107-347)*
- OMB Regulations related to these laws.

This Section provides an overview of our current key systems, processes and controls.

Goals and Strategies

Our financial system is a web-based, commercial off-the-shelf product, which serves as the foundation for integrated financial management across our organization. This system requires a unified approach for enhancing financial management, business processes and system performance by eliminating duplication, streamlining processes, producing meaningful consolidated reports, and establishing a common infrastructure across the enterprise.

Our current financial system is comprised of three major components: the Healthcare Integrated General Ledger Accounting System supporting the Centers for Medicare and Medicaid Services; the National Institutes of Health Business System supporting the National Institutes of Health; and the Unified Financial Management System (UFMS) serving the rest of our organization. In FY 2011, we completed our financial management system with the implementation of our Consolidated Financial Reporting Solution. This tool enables us to systematically consolidate information from the three base components and further develop, enhance and improve our consolidated management reporting efforts.

Our financial management goals seek to provide decision-makers with timely, accurate, and useful financial and program information; and ensure appropriate and effective use of our limited resources. We continue to improve financial management and reporting through standardizing, streamlining, and integrating our financial management information to ensure the integrity, transparency and accountability of our information.

We established the Financial Management System Program (FMSP), which will provide central management direction and oversight of financial management systems improvements across the Department. This program is also intended to facilitate and foster collaboration between business owners and information technology professionals, and to optimize and improve utilization of our investments.

Required System Control Reviews

We currently serve many federal agencies outside of the Department. In our role as service provider, we are required to have Statement on Standards for Attestation Engagements (SSAE) No. 16 examinations, which provide our serviced customers an assessment of our system controls by service organization. The SSAE No. 16 replaced the Statement on Auditing Standard (SAS) No. 70 reviews previously required.

These independent examinations of our internal controls were completed for our service providers for FY 2011 under the guidelines of the American Institute of Certified Public Accountants' SSAE No. 16. This examination reports on management's representation of and the operational effectiveness of those controls at service organizations when those controls are likely to be relevant to user entities' internal control over financial reporting.

During FY 2011, independent auditors performed SSAE No. 16 examinations on the Program Support Center's (PSC) Payment Management System (PMS) and the National Institutes of Health's Center for Information Technology (CIT) service organizations for periods from October 1, 2010, to June 30, 2011.

In the examiner's opinion, the management descriptions of PMS and CIT were fairly stated, and the controls tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives achieved during that period, with the exception of the change control process within the Program Support Center's Payment Management System, as noted by the examiners. We have addressed the situation and are developing further enhancement plans to improve the services provided by the PSC and CIT.

Legal Compliance

Anti-Deficiency Act

As noted in our FY 2010 *Agency Financial Report*, we indicated HHS was investigating potential reportable violations. During FY 2011, we completed our investigation and identified reportable violations. As required by the *Anti-Deficiency Act*, we notified all appropriate authorities of such violations. HHS management has taken, and continues to take, all necessary steps to prevent future violations.

Among other steps, the Department has revised its acquisition guidance, improved business processes, conducted Department-wide appropriation law training, launched a robust, web-based appropriation law knowledge repository, and is conducting procurement management and internal control reviews to validate continued compliance with appropriation law.

With respect to other possible issues, we are working through investigations, and further assessment is necessary. We remain fully committed to resolving these matters appropriately and complying with all aspects of the law.

Improper Payments Reporting

The *Improper Payments Elimination and Recovery Act (IPERA, P.L. 111-204)*, signed into law on July 22, 2010, amends the *Improper Payments Information Act of 2002 (IPIA, P.L. 107-300)* and repeals the *Recovery Auditing Act (Section 831, Defense Authorization Act of 2002, P.L. 107-107)*. The *IPERA*, like *IPIA*, requires each federal agency to annually review all programs and activities that it administers and identify all such programs and activities that may be susceptible to improper payments. For high-risk programs, the *IPERA* requires that we report improper payment estimates and various other related data. In addition, the *IPERA* significantly increases our recovery auditing efforts, by expanding the definition of payments recovered to include program payments. Section III of this report contains detailed information on our *IPIA* and *IPERA* activities.

Our FY 2011 *Improper Payments Information Act* Report includes a discussion of the following information, as required by *the Improper Payments Information Act of 2002* (*IPIA*), as amended by the *Improper Payments Elimination and Recovery Act of 2010 (IPERA),* OMB Circulars A-136 and A-123, Appendix C.

HHS has conducted risk assessments on 23 additional high-dollar programs. In the most recent review cycle, all 23 of these programs were deemed non-high-risk programs. We are in the process of incorporating improper payment risk assessment requirements into another risk assessment tool. This integrated approach will result in increased efficiency for our programs without compromising the assessment process.

HHS has shown tremendous leadership in the improper payments arena. We have been publishing an error rate for Medicare Fee-for-Service (FFS) since FY 1996, reporting Foster Care and Head Start error rates since FY 2004. We are reporting a composite error rate for the Medicare Prescription Drug program for the first time. HHS continues to implement corrective action plans to reduce future error rates.

HHS holds agency managers, beginning with leadership and cascading down through senior executives (including component heads) to the lowest accountable program official, for progress on this initiative.

Table 1 in the Improper Payments Reporting Section shows our results, and associated notes, for the current year (CY) 2011, the prior year (PY) 2010, as well as the targets for the years 2012 through 2014.

Management Assurance

Department-wide Assurance Statement

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

As required by OMB Circular A-123, *Management's Responsibility for Internal Control*, HHS has evaluated its internal control and financial management systems to determine whether these objectives are being met. Accordingly, HHS provides a qualified statement of reasonable assurance that its internal control and financial systems meet the objectives of FMFIA. This statement is qualified due to the following material weakness (noted in Table 1), which also constitutes a non-conformance under Section 4 of *FMFIA*:

Information System Controls and Security

Internal Control over Financial Reporting

HHS conducted its assessment of the effectiveness of internal control over financial reporting, which includes safeguarding of assets and compliance with applicable laws and regulations, in accordance with the requirements of Appendix A, OMB Circular A-123, *Management's Responsibility for Internal Control*. Based on the results of this assessment, HHS provides reasonable assurance that internal controls over financial reporting as of June 30, 2011, were operating effectively and no material weaknesses were identified in the design or operation of the internal control over financial reporting.

Internal Control over Operations and Compliance

HHS conducted its assessment of internal control over the effectiveness and efficiency of operations and compliance with applicable laws and regulations, in accordance with OMB Circular A-123, *Management's Responsibility for Internal Control*. Based on the results of this evaluation, HHS identified one material weakness in its internal control over the effectiveness and efficiency of operations under Section 2 of FMFIA relating to the Department's information system controls and security (identified above), which also constitutes a non-conformance under Section 4 of FMFIA as of September 30, 2011. Other than this exception, noted above and described in Table 1, the Department provides reasonable assurance that internal controls over operations and compliance with applicable laws and regulations as of September 30, 2011, were operating effectively and no other material weaknesses were identified in the design or execution of the internal controls over operations and compliance.

/Kathleen Sebelius/

Kathleen Sebelius
November 15, 2011

Table 1

Summary of Material Weakness and System Non-Conformance

Control Area	FMFIA Section 2			FMFIA Section 4
	Operations (As of 9/30/2011)	Compliance (As of 9/30/2011)	Financial Reporting (As of 6/30/2011)	System Non-Conformance
Information System Controls and Security	X	–	–	X

Information System Controls and Security

HHS continues to acknowledge an internal control weakness related to system security, including general and application controls in our financial management systems. Although no one financial management system had a material weakness, the pervasive nature of the findings across our organization leads management to conclude that these findings warrant classification as a material weakness. In FY 2011, significant progress has been made in the remediation of the financial management systems' findings. However, the financial management systems are not yet in substantial conformance with the *Federal Financial Management Improvement Act* (FFMIA) and its associated regulatory guidelines, as established by the appropriate governing bodies with respect to overall system security as of September 30, 2011. Due to the sensitive nature of information security controls, detailed findings and corrective actions are submitted separately through the governance of the *Federal Information Security Management Act* (*FISMA*).

Table 2

Corrective Action Plan and Impact of Material Weaknesses

The following table lists the corrective action dates for the control weaknesses and the impacts of the material weaknesses on the Financial Statements.

Material Weakness	Corrective Action Date	Impact of Material Weakness on Financial Statements
Information System Controls and Security	FY 2012	Sufficient compensating controls exist through manual efforts that the risk of misstating the Financial Statements is mitigated.

Other Management Information and Initiatives

Grants Management

We are the principal federal agency for protecting the health of all Americans and providing essential human services to those in need. As the largest federal agency, the nation's largest health insurer, and the largest grant-making agency, HHS represents more than a quarter of all federal outlays and administers more grant dollars than all other federal agencies combined. We manage an array of grant programs in basic and applied science, public health, income support, child development, and health and social services. Through these programs, we awarded nearly 93,000 grants totaling more than $372 billion in FY 2010.

Collectively, these programs are our primary means to achieve our Strategic Goals and objectives, and are described in our Strategic Plan for fiscal years 2010 to 2015. To achieve our goals, we form partnerships with other federal departments; State, local, and Tribal governments; academic institutions; hospitals; the business community; non-profit and volunteer organizations including faith- and community-based organizations; foreign countries; and international organizations. The primary funding vehicle used in these partnerships is a grant. Grants are financial assistance awards that provide support or stimulation to accomplish a public purpose authorized by federal statute. The primary beneficiary under a grant or cooperative agreement is the public, as opposed to the government.

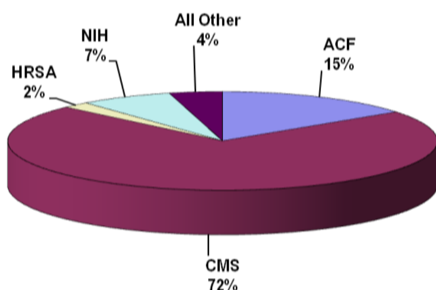
The Division of Grants (within the Office of Grants and Acquisition Policy and Accountability), in addition to providing Department-wide policy oversight and guidance for our grant portfolio, has primary responsibility for two systems that support our grant activity. The Tracking Accountability in Government Grants System (TAGGS), a comprehensive Department-wide database designed to track our obligated grant awards at the transaction level on behalf of our operating divisions, offers full search capabilities (taggs.hhs.gov) for all of our awards, including grants and cooperative agreements. TAGGS supports our compliance with *The Federal Funding Accountability and Transparency Act of 2006 (P.L. 109-282)* by collecting agency grant data and transmitting the data to the federal web site, www.USASpending.gov.

We also continue to serve as the managing partner for www.Grants.gov, which is the federal government's central portal for the public to find and apply for federal assistance awards. Government wide, by the end of FY 2010, www.Grants.gov posted 4,443 grant opportunities and processed approximately 253,312 grant applications. We posted 1,210 grant opportunities on www.Grants.gov and processed more than 157,000 applications.

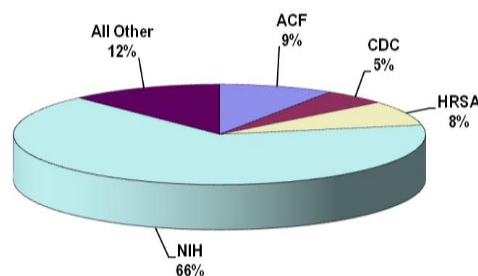
We manage several types of grants including formula, block, entitlement, and discretionary. As was the case in prior years, the largest number of grant awards were discretionary (93 percent of total grant volume awarded), yet most of the dollars associated with our grants were awarded through formula, block, or entitlement grants (86 percent of the total dollars awards).

The data presented in this section are based on the latest available at the time of this report. The majority of our total FY 2010 grant dollars were awarded by the Centers for Medicare and Medicaid Services (71.6 percent) and the Administration for Children and Families (14.9 percent). By volume, the National Institutes of Health awarded 65.6 percent of the grants, whereas the Administration for Children and Families awarded 9.3 percent.

FY10 Grant Dollars by Component



FY10 Grant Volume by Component



Looking Ahead To 2012 Management Challenges And High-Risk Areas

Financial Management Challenges

We are the largest agency in the federal government. Our FY 2011 direct budget authority in excess of $900 billion represents more than a quarter of all federal expenditures. We are one of the largest financial organizations in the world. Our total net cost of operations is almost double the revenues of the largest *Fortune 500* companies. The sheer magnitude and size, combined with the diverse nature of our operating components, constantly challenge our efforts to standardize and improve financial and program management across our organization. We have found that a cohesive, coordinated, and unified approach makes these challenges less difficult to overcome, as discussed further in the Strategic Planning Section below.

Health Reform Implementation

We have been entrusted with the responsibility for implementing many major provisions of the historic *Affordable Care Act*. Reforming health care is a key goal of the Administration. We established a structure of cross-component and cross-functional subject matter working groups to promote effective collaboration during the implementation phase to ensure goals are met.

In conjunction with our health reform efforts, the Office of Consumer Information and Insurance Oversight (OCIIO) was established in FY 2010, to implement the new private health insurance provisions of the *Affordable Care Act*. This office was responsible for initially standing up the programs in FY 2010. In January 2011, the Secretary determined that this office would be best able to execute its mission if transitioned to the Centers for Medicare and Medicaid Services.

As required by the *Affordable Care Act*, the Department initiated a comprehensive analysis of the *Community Living Assistance Services and Supports (CLASS)* program. Experts across HHS undertook a methodical and comprehensive analysis of the statute and plan design options. We broadly considered how to design potential benefit structures and reviewed those designs carefully to determine if they meet the twin tests of solvency and consistency with the law. Despite our best analytical efforts, we do not see a viable path forward for *CLASS* implementation at this time.

Financial Management Modernization Projects

The commercial-off-the-shelf (COTS) financial accounting system we currently have in place, originally customized for us 10 years ago is now fully integrated. We recently implemented our consolidating reporting solution, which allows us visibility into the data from three systems and six sets of accounting center records. In order to ensure it remains an effective tool for the Department, we must continue our efforts to maintain and improve our financial management, transparency and accountability.

We have several programs in development to further enhance the system we have and to assist us improving our transparency and reporting capabilities. Our initial efforts are to support our decision-makers and ensure they have timely, accurate, and useful program and financial information.

Consolidation Financial Reporting System Improvements

This project leverages the recent completion of our Hyperion reporting tool. The completion of the reporting tool is already providing us visibility previously unavailable at the Department level.

We are working to develop a suite of managerial reports to support operational managers in their efforts to manage the funds entrusted to them. We are beginning this effort in a phased approach. We are designing the initial reporting based on one accounting center's structure, at which point we will migrate the solution to the other accounting centers as appropriate. This approach allows us to develop and provide an initial solution and mitigate risk in both development and the roll-out of the solution. This system is also the foundation for our second improvement strategy for developing a business intelligence tool as discussed in the next section.

Dashboard and Business Intelligence

The Dashboard and Business Intelligence project addresses a critical gap identified by the Department. This project is a key short-term, high-impact recommendation from an earlier assessment process; it received the highest priority rating from key members of the assessment team and senior level stakeholders. The scope of this project is to (1) define a Department-wide reporting strategy, and (2) to implement a Business Intelligence tool previously piloted by the Food and Drug

Administration (FDA). This project is expected to leverage work performed by FDA and the consolidated reporting system.

This reporting and business intelligence tool will allow us to utilize program data and integrate it with financial data that is verified, validated, and audited. The ultimate outcome is that business intelligence information will be provided at a series of levels: program, office or divisional, and Departmental.

This solution seeks not only to improve managerial and decision-making reporting and support, but consolidates the vast array of available information from a large number of disparate reporting systems currently used across the Department today.

Recovery Act Challenges and Opportunities

The unprecedented accountability and transparency requirements of the *Recovery Act* continue to pose important opportunities and challenges for us. We have made significant strides in the development of sophisticated financial systems. However, much work remains to standardize the information across our entity such that the consolidation of information can be performed systematically and provide more timely, informative reports to our stakeholders.

Strategic Planning

During FY 2011, our CFO Community continues to use the critical lessons learned from prior activities to support Administration and Departmental priorities. We are working to ensure that we can provide appropriate transparency for funds provided under the *Affordable Care Act* and all other appropriations.

We continue to conduct business in a collaborative and cross-organizational manner, promote accountability for all of our programs and ensure that our initiatives support our missions and fiscal responsibilities.

Our key initiative for FY 2011 was the collaborative efforts to enhance our financial management and reporting such that we have eliminated the Department's audit identified material weakness in Financial Reporting. This required a coordinated effort in the implementation of our Consolidated Financial Reporting System.

This integration of our three key accounting systems provides the foundation for data availability and improves our ability to provide consolidated information at more detailed levels and more timely. The success of this effort required not only cross-functional collaboration, but also cross-Departmental collaboration. We produced our quarterly and annual financial statements from this system during FY 2011, and anticipate further enhancement of our management reporting during FY 2012.

In addition, we continued our focus upon those objectives identified in FY 2007 and demonstrated significant progress on many of the efforts during FY 2011, such that we closed many information technology findings, improved business processes and financial management activities that we are now utilizing the integrated system more effectively.

Program Challenges

The breadth of essential human services we deliver to fulfill the President's vision of a healthier, safer, and more hopeful America creates a number of management challenges. To ensure effective stewardship of the taxpayer's resources, we are committed to make improvements related to these challenges.

We are committed to meeting our stewardship responsibilities under the *Affordable Care Act* to ensure that our programs operate efficiently and effectively, while protecting the dollars entrusted to us from fraud and abuse. To achieve this, we will implement clear and effective communication with program beneficiaries, private citizens, and health care industry stakeholders to maintain, develop and oversee our grant and loan programs. We will collaborate with partners to respond to vulnerabilities in current federal health care programs.

Although we made great progress during FY 2011, we must continue our current efforts to sustain positive outcomes and augment them with new, innovative strategies to continue to improve the nation's health and well-being.

A *Summary of Top Management Challenges Identified by the Inspector General* follows this section. We present the full text of the Inspector General's assessment and our management's response to these challenges in Section III, Other Accompanying Information. Additionally, Section III includes further information concerning our efforts and actions to resolve Office of Inspector General audit findings in the FY 2011 *Management's Report on Final Action*.

Summary of Top Management Challenges Identified by the Inspector General

1. Implementing the *Affordable Care Act*

Under the *Affordable Care Act*, the Department is implementing and administering new programs involving billions of dollars in grants, loans, and benefits payments. In addition, the *Affordable Care Act* enacted numerous changes and additions to existing programs.

Challenges include:

- The Department must assume responsibility for implementing and administering these new and existing programs, and overseeing *Affordable Care Act* funding throughout. Many programs also require close coordination with federal and State partners. Ongoing implementation and operational challenges include the magnitude, complexity, and novelty of programs; compressed implementation timelines; and marketplace dynamics; and
- Focusing on integrity in these programs is essential to ensuring that they operate with economy, efficiency, and are free from fraud, waste, and abuse.

2. Preventing and Detecting Medicare and Medicaid Fraud

Perpetrators of schemes to defraud Medicare and Medicaid range from criminals who masquerade as health care providers and suppliers but who do not provide legitimate services or products, to Fortune 500 companies that pay kickbacks to physicians in return for referrals. Fraud is a crime of deception, and perpetrators design their schemes to avoid detection.

Challenges include:

- Effectively using provider enrollment and payment suspension authorities against those providers and suppliers that have exploited weaknesses to commit fraud;
- Managing the Department’s expanding use of data analysis; and
- Excluding individuals and entities who commit fraud and abuse to protect the programs and their beneficiaries.

3. Identifying and Reducing Improper Payments

Improper payments cost the federal government billions of dollars annually.

OMB has assigned “high error” designation to 14 HHS programs.

In FY 2010, the Department reported improper payments totaling more than $70 billion in Medicare FFS, Medicare Advantage and Medicaid; the Administration for Children and Families (ACF) also administers programs susceptible to improper payments, and it estimated that the Child Care program’s national error rate for 2010 equaled 13 percent. ACF programs accounted for $1 billion in improper payments in 2010.

Challenges include:

- Intensifying efforts to eliminate payment error, waste, fraud, and abuse in major programs administered by the federal government, including the Department’s health care programs, while continuing to ensure that federal programs serve and provide access to their intended beneficiaries.

4. Patient Safety and Quality of Care

As a purchaser of health care for over 100 million Americans, HHS faces challenges in ensuring the quality of care rendered to program beneficiaries. Despite increased attention to patient safety, quality problems persist.

For example, OIG has found that 13.5 percent of hospitalized Medicare beneficiaries suffered harm from an adverse event during their hospital stay. Forty-four percent of these adverse events were preventable and caused by care failures such as medical error, substandard care, or inadequate monitoring.

Challenges include:

- Preventing the overmedication of beneficiaries in nursing homes; and
- Licensing and qualifying of health care providers across all settings of care.

<table>
<tr>
<th>5. Integrity and Security of Information Systems and Data</th>
<th>6. Availability and Quality of Data for Effective Program Oversight</th>
<th>7. Oversight of CMS Program and Benefit Integrity Contractors</th>
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<tr>
<td>As health care providers modernize their medical recordkeeping and billing systems, adoption of electronic health records (EHRs) and other innovations offers tremendous opportunity for improved patient care and more efficient practice management.

Challenges include:

• Protecting the privacy and security of data should be prioritized as growing quantities of personal medical information are stored in electronic format; and

• Ensuring the integrity of incentive payments to encourage providers to adopt electronic prescribing and recordkeeping technologies, which includes making certain recipients truly qualify for incentive payments, and that payment policies effectively promote adoption of desirable technological practices.</td>
<td>The Department and OIG rely heavily on the availability and completeness of data to ensure that the over 300 departmental programs are operating as intended and to help identify instances of fraud, waste, and abuse. Each program compiles an enormous amount of data on beneficiaries, providers, drugs, equipment and supplies, the delivery of services, and the quality of care. When these data are unavailable, are incomplete, or contain inaccuracies, program oversight and monitoring activities are hindered.

Challenges include:

• Ensuring Medicaid program data are current, available, complete, and accurate;

• Ensuring Medicare program data are complete and accurate;

• Making certain data collected for public health and human services programs data are timely, complete, accurate, and available for oversight purposes; and

• Improving quality of data received through data exchanges with other Departments as needed.</td>
<td>With an ever-growing reliance on contractors to identify, prevent, and respond to fraud, abuse, and improper payments in the Medicare and Medicaid programs, CMS must conduct adequate oversight and monitoring.

Challenges include:

• Ensuring CMS' contracts, statements of work, and task orders contain adequate controls, including clear roles and responsibilities and performance measures;

• Questioning poor and/or inconsistent performance among contractors; and

• Collecting sufficient information to monitor contractor activities and conducting regular and meaningful reviews of contractor performance.</td>
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8. ***Ensuring Integrity In Health Care Benefits Delivered By Private Plans***	9. **Avoiding Waste in Health Care Pricing Methodologies**	10. **Grants Management and Administration of Contract Funds**
Medicare Advantage, the Part D Prescription Drug Benefit, and Medicaid Managed Care are administered by private health care plans, operating within parameters established by the federal (and for Medicaid, also the State) government. Effective administration and oversight of these programs requires extensive coordination and information sharing among the federal and State governments, private health care plans, subcontractors, health care providers, and third-party payers. Challenges include: • Ensuring the accuracy of payments to private plans; • Ensuring the plans' implementation of effective program integrity standards; and • Ensuring plans implement adequate consumer protections.	The federal government must act as a prudent purchaser of health care to ensure access to quality care without wasteful spending. Payment methodologies must be designed to reimburse providers and suppliers fairly for appropriate care and to respond to changes in the health care marketplace. Certain Medicare and Medicaid payment methodologies are misaligned with the current health care market. Challenges include: • Monitoring Medicare and Medicaid prescription drug payments to ensure payment methodology are aligned with the current health care market; • Ensuring Medicare fee schedule payments for certain types of durable medical equipment bear resemblance to market prices; and • Ensuring monitoring and updating eligibility for enhanced payments under the Medically Underserved/Health Professional Shortage Areas program.	HHS is the largest grant-making organization in the federal government. In FY 2010, the Department awarded approximately $370 billion in grants. The *American Recovery and Reinvestment Act* (*Recovery Act*) provided an additional $31.8 billion for the temporary expansion of these (non-Medicaid/CHIP) programs for fiscal years (FY) 2009 and 2010. Finally, the *Affordable Care Act* appropriated billions of dollars in additional grant funding through FY 2019. HHS is also the third largest contracting agency in the federal government; in 2010, HHS awarded $19.1 billion in contracts. Oversight and management of both new and continuing grant programs is crucial to the Department's mission and to the health and well-being of the public. Challenges include: • Monitoring of grants and contracts management because of the size and scope of grant and contract expenditures; and • Ensuring the appropriate use of grants and contract funds through increased transparency and accountability, which includes training and sharing best practices.

<table>
<tr><th>11. Ensuring the Safety of the Nation's Food Supply</th><th>12. Oversight of the Approval, Safety, and Marketing of Drugs and Devices</th><th>13. Oversight and Enforcement of HHS Ethics Programs</th></tr>
<tr><td>CDC estimates that each year roughly 1 in 6 Americans (or 48 million people) gets sick, 128,000 are hospitalized, and 3,000 die of foodborne diseases. FDA is responsible for ensuring the safety of much of the Nation's food supply. During a food emergency, FDA is responsible for finding the contamination source and overseeing the removal by manufacturers of these products from the market. The Food Safety Modernization Act (FSMA) signed into law in January 2011, provides FDA important new authorities to better protect the Nation's food supply.

Challenges include:

• Ensuring that food recall inefficiencies, inadequate food facility inspections, and recordkeeping issues do not impair the ability to effectively resolve food emergencies; and

• Effectively implementing FSMA.</td><td>The Department, through the FDA, is responsible for ensuring that all drugs, biologics, and medical devices are safe and effective. The Department must also ensure that once a drug, biologic, or device has been approved for use, it is marketed appropriately.

Challenges include:

• Overseeing the safety of drugs, biologics, and medical devices. In particular the ability to ensure the timeliness of drug application reviews, the adequate monitoring of adverse-event reporting of medical devices, and the prevention of off-label marketing of drugs, biologics, and medical devices; and

• Ensuring that participants in both pre- and post-marketing clinical trials are protected from significant risk.</td><td>Conflicts of interest in the health care system generally, and specifically in the Department, have been the subject of scrutiny by Congress, the medical community and the media. With a heightened focus on transparency in the federal government and the need to use resources efficiently and appropriately, it is imperative that the Department ensures that internal and external stakeholders (i.e., grantees, employees) are free from conflicts of interest or other ethics

Challenges include:

• Overseeing ethics considerations in grants and contracts management and research and regulatory oversight;

• Ensuring that federal employees are not compromised by conflicts of interest when performing their official duties (employees cannot participate in official matters in which they and related parties have a financial interest); and

• Monitoring potential conflict-of-interest issues related to non-federal entities and participants in our programs (grantees, clinical investigators, contractors).</td></tr>
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Section II: Financial Reports

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 in using 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 $900 billion in fiscal year (FY) 2011, we are one of the largest, most complex financial organizations in the world. Through collaboration, our CFO community manages financial accountability, transparency, compliance, and risk across the Department by maximizing resources to drive results.

This *Agency Financial Report* represents our accountability report for FY 2011. We will issue the *FY 2011 Annual Performance Report*, the *Congressional Budget Justification*, and the *Summary of Performance and Financial Information* in February, 2012. During FY 2011, the Department successfully sustained and improved upon its standards for reporting and management controls. We have refined our reporting processes and successfully performed our annual, 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 2011, 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 2011 Statement of Social Insurance projections contained in this report incorporate the effects of the *Affordable Care Act*, and are prepared in accordance with the new requirements of the standards issued by the Federal Accounting Standards Advisory Board, and reflect current law. Please refer to Section II of this *Agency Financial Report* for further information.

The FY 2011 independent audit report on controls indentifies one remaining material weakness pertaining to Information Systems Controls and Security. This result is a major improvement over our prior year's results. We have successfully improved our financial management over the past three years, and our auditors have acknowledged improvement in our report by reducing one of the two material weaknesses (Financial Reporting) from the FY 2010 report. Our successful implementation of the Consolidated Financial Reporting System (CFRS) significantly augments our financial reporting capabilities. Our improved financial reporting status and the augmentation of our systems reflect management's continuous commitment and determination for financial management improvement.

During FY 2011, CFO executives throughout the Department have worked together as a community to ensure our stewardship is transparent through continued accountability for *Recovery* and *Affordable Care Act* funds. We remain committed toward resolving the remaining system-control and security issues, and maintaining full accountability, transparency, and effective stewardship.

Finally, I want to thank our employees and partners who work daily 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 taking our ambitious agenda for the future into 2012.

/Ellen G. Murray/

Ellen G. Murray
Assistant Secretary for Financial Resources, and
Chief Financial Officer
November 15, 2011

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Audit Reports

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

NOV 14 2011

TO: The Secretary
Through: DS ________
COS ________
ES ________

FROM: Inspector General

SUBJECT: Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2011 (A-17-11-00001)

This memorandum transmits the independent auditors' reports on the Department of Health and Human Services (HHS) fiscal year (FY) 2011 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 (1) consolidated balance sheet as of September 30, 2011 and 2010, and the related consolidated statements of net cost and changes in net position; (2) the combined statement of budgetary resources for the years then ended; and (3) the statement of social insurance as of January 1, 2011 and 2010, and the related statement of changes in social insurance amounts. 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 the Office of Management and Budget (OMB) Bulletin 07-04, as amended, *Audit Requirements for Federal Financial Statements.*

Results of the Independent Audit

Based on its audit, E&Y found that the FY 2011 HHS consolidated balance sheet and the related consolidated statements of net cost and changes in net position and combined statement of budgetary resources were presented fairly, in all material respects, in conformity with accounting principles generally accepted in the United States of America. As presented in Note 21 to the financial statements, E&Y was unable to determine whether the statement of social insurance as of January 1, 2011 and 2010, and the related statement of changes in social insurance amounts were presented fairly because of various actuarial uncertainties. Many of these uncertainties were reported by the Chief Actuary in the *2011 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 with respect to the financial reporting. Under the

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standards established by the American Institute of Certified Public Accountants, E&Y identified a material weakness in HHS's financial information management systems and a significant deficiency in its financial reporting systems, analyses, and oversight:

- *Financial Information Management Systems*—E&Y acknowledged significant progress has been made in the remediation of the financial management systems' findings from previous years. For example, HHS issued policies to facilitate the remediation and implementation of automated tools to address conflicts in segregation of duties. These achievements and other progress were significant and resulted in the conclusion that application general controls for the new Consolidated Financial Reporting System (CFRS) and the procurement system, HHS Consolidated Acquisitions Solution, are designed effectively. However, many of the successes were not achieved in time to have an impact on the overall conclusions for the fiscal year ended September 30, 2011. Although plans are in place to remediate most of the deficiencies remaining on the other significant systems, including the two primary general ledger applications, difficult work remains to achieve the remediation. E&Y identified issues in the security management program and in the maturity and integration of a sound configuration management program. These remaining unremediated deficiencies continue to constitute a material weakness in internal control.
- *Financial Reporting Systems, Analyses, and Oversight*—During the FY 2011 audit, E&Y noted HHS management had stepped up its initiatives to improve its processes and controls over financial reporting. For example, HHS implemented CFRS to automatically and consistently consolidate financial information from HHS's three financial systems: the Unified Financial Management System, the National Institutes of Health Business System, and the Healthcare Integrated General Ledger Accounting System. Nonetheless, the audit identified internal control weaknesses in financial systems and processes, including lack of integrated financial management systems and insufficient analysis of certain significant accounts that impaired HHS's ability to report timely financial information. While steps have been taken to improve financial reporting systems, HHS'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 and other requirements. HHS's lack of an integrated financial management system continues to impair its ability to support and analyze account balances reported in a timely fashion. Because weaknesses continue to exist in the financial management systems, management must compensate for the weaknesses by strengthening manual and other internal controls to ensure that errors and irregularities are detected in a timely manner.

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;
- monitoring the progress of the audit;

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- examining audit documentation including those related to the review of internal controls over financial reporting;
- reviewing the auditors' reports; and
- reviewing the HHS *FY 2011 Agency Financial Report*.

E&Y is responsible for the attached reports 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 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.

We also noted that CMS management revised its methodology for the Medicare fee-for-service improper payment estimate to adjust for the effects of the receipt of late documentation and denied claims overturned on appeal. While we have suggested to management that including an adjustment for overturned Medicare claim payment denials could improve its estimates of reported errors, we have not yet had time to review the adjusted data and related methodology. Under the Improper Payments Elimination and Recovery Act (P.L. No. 111-204), we are required to issue a report on compliance with the Improper Payments Information Act of 2002 and as part of that report will assess the accuracy and completeness of agency improper payment reporting.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Gloria L. Jarmon, Deputy Inspector General for Audit Services, at (202) 619-3155 or through e-mail at Gloria.Jarmon@oig.hhs.gov. Please refer to report number A-17-11-00001.

/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

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 (HHS) as of September 30, 2011 and 2010, and the related consolidated statements of net cost and changes in net position, and the combined statements 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 statements of social insurance as of January 1, 2011 and 2010 and the related statement of changes in social insurance amounts. These financial statements are the responsibility of HHS' management. Our responsibility is to express an opinion on these financial statements based on our audits. The statement of social insurance as of January 1, 2007, was audited by other auditors whose report dated November 14, 2007, expressed an unqualified opinion on that statement.

Except as discussed in the following paragraphs with respect to the accompanying statements of social insurance as of January 1, 2011 and 2010 and the related statement of changes in social insurance amounts, 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 HHS' 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 HHS' 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 21 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

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Report of Independent Auditors

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may be material. Projections of Medicare costs are sensitive to assumptions about future decisions by policymakers and about the behavioral responses of consumers, employers, and health care providers as policies, incentives, and the health care sector change over time. 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 22 to the financial statements, with respect to the estimates for the CMS social insurance program presented as of January 1, 2011 and 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 statements of social insurance as of January 1, 2011 and 2010 and the related statement of changes in social insurance amounts.

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 HHS social insurance program as of January 1, 2011 and 2010 and the related changes in the social insurance program.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of HHS as of September 30, 2011 and 2010, 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 14, 2011, on our consideration of HHS' 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.

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Report of Independent Auditors

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Our audits were conducted for the purpose of forming an opinion on the 2011 and 2010 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 14, 2011

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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*

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 (HHS or the Department) as of and for the year ended September 30, 2011, and we were engaged to audit the statement of social insurance as of January 1, 2011, and the related statement of changes in social insurance amounts, and have issued our Report of Independent Auditors, therein dated November 14, 2011. 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, 2011 and the related statement of changes in social insurance amounts. 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. We consider the deficiency related to Financial Information Management Systems to be a material weakness.

A significant deficiency is a deficiency or a combination of deficiencies in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. We consider the deficiency related to Financial Reporting Systems, Analyses, and Oversight to be a significant deficiency.

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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.

Material Weakness

Financial Information Management Systems

HHS intensified its efforts in fiscal year (FY) 2011 to improve the controls within its information technology (IT) infrastructure and financial application systems. Specifically, we noted a significant increase in attention among the non-Centers for Medicare and Medicaid Services (CMS) operating divisions (OPDIVs) to address the existing tools, policies, and practices related to controls over information security and application configuration for financial systems. The following summarizes some of the improvements achieved by the non-CMS OPDIVs that resulted from this increased attention:

- Implementation of the Consolidated Financial Reporting System (CFRS), a Hyperion consolidating reporting module, to automate the preparation of Department-level consolidated and individual OPDIV financial statements.
- Adoption of a single Windows Active Directory (AD) domain allowing a unified network source for system scanning, patch management, and asset accountability.
- Implementation of an automated system to enhance the Unified Financial Management System (UFMS) user activity monitoring process.
- Issuance of policies to facilitate remediation and implementation of automated tools to refine and remediate segregation of duties (SoD) conflicts among IT users.
- Update of the Department's policy for Information Systems Security and Privacy to align it with the latest National Institute of Standards and Technology (NIST) guidance.
- Completion of system certification and accreditation documentation for various applications.

These achievements were significant and resulted in our conclusion that application general controls for two key financial systems, CFRS and HHS Consolidated Acquisition Solution (HCAS), are designed effectively. However, many of the successes were not achieved in time to have an impact on the overall conclusions for the fiscal year ended September 30, 2011. Although plans are in place to remediate most of the deficiencies remaining on the other significant systems, including the two primary general ledger applications, UFMS and NIH Business System (NBS), difficult work remains to achieve the remediation, and the remaining unremediated deficiencies as summarized below continue to constitute a material weakness in internal control.

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Report on Internal Control

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The following deficiencies in IT controls were identified during our procedures.

Non-CMS OPDIV Financial Information Management Systems

The security management program, as required by the Federal Information Security Management Act (FISMA) of 2002, provides a framework 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. Without a fully integrated security management program, design and implementation of security controls may be inadequate; user roles and responsibilities may be unclear; and management, operational and technical controls may be inconsistently implemented. Such conditions will lead to insufficient protection of sensitive or critical resources. Our procedures identified the following issues:

- Vulnerability Management—The Department's current vulnerability assessment tool lacked the capability to assess the various operating systems that exist at HHS. In addition, this tool provided inaccurate baseline configuration compliance results. Without an effective vulnerability assessment tool, deviations and unauthorized changes in the systems cannot be detected and could result in data being compromised or manipulated. As a result, the Department is in the process of transitioning to a new vulnerability management software.
- Background Investigation—HHS Information Security Program (ISP) Policy requires suitability background investigations to be completed and favorably adjudicated prior to allowing access to sensitive Departmental systems and networks. However, two OPDIVs did not comply with this policy and granted personnel network access without either the fingerprint or background investigation.
- Remote Access—Users access the HHS 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 HHS network.
- Penetration Testing—Major grants web application contained multiple system vulnerabilities that pose significant risk to the data. This resulted from application developers not following secure coding methodology.
- Application User Access Management—For some users, access to UFMS; HCAS; Information for Management, Planning, Analysis and Coordination (IMPACII); and Enterprise Human Resource and Payroll (EHRP) was not appropriately reviewed, recertified, or removed.
- Password Management—During FY 2010, HHS modified the password expiration requirement; however, system configurations for UFMS, HCAS, IMPACII, and EHRP were not modified system configurations in compliance with the new HHS password expiration policy. UFMS and EHRP used generic shared system IDs or had multiple IDs associated to accounts. Sharing of user IDs eliminates personal accountability for any system activity. In addition, Grants Administration, Tracking and Evaluation System (GATES) system password complexity did not comply with HHS standards.

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- Security Management—Annual security assessments for UFMS and HCAS were not performed timely.

Non-CMS OPDIV Application Security Management

Elements of sound configuration management (CM) programs ensure that only authorized and fully tested software is placed in operation, software and hardware are updated, information systems are monitored, patches are applied to systems to protect against known vulnerabilities, and emergency changes are documented and approved. These controls, which limit and monitor access to powerful programs and sensitive files associated with computer operations, are important in providing reasonable assurance that access controls and the operations of systems and networks are not compromised. For the majority of the significant financial applications, the framework of a sound CM program exists; however, the CM program had not fully matured nor been integrated.

- Infrastructure Change Management – CM exceptions were identified at NIH Centers for Information Technology (CIT). More specifically, CIT did not perform comparisons of UNIX system changes to the baseline configuration standards. CIT has implemented Tripwire to monitor critical system files; however, no evidence showed that the monitoring was being performed.
- Application Change Management – CM processes for UFMS, NBS, HCAS, GATES, and EHRP were insufficient to ensure only properly authorized changes were implemented into production systems. For UFMS as an example, as noted above, Audit Vault has been installed since May 2011 and the audit logs are being reviewed. Prior to May, however, no such logging capability existed. In addition, management is in the process of working with business and IT personnel to refine its monitoring process. As in the case for NBS, unlike UFMS, management does not have the automated capability to monitor for system changes.
- Segregation of Duties – Access assignments were excessive for UFMS, NBS, IMPACII, HCAS, GATES, EHRP, and CFRS 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, for UFMS, HCAS, GATES, EHRP, and CFRS applications, developer(s) had full access to both development and production systems.

Other deficiencies that warrant attention include the following:

- Audit Logging and Monitoring - IMPACII system upgraded the database to Oracle 11g which resulted in substantial amount of detailed audit logs. Due to the volume of data being logged, auditing option was revised to failed login attempts only. This setting is not in compliance with HHS policy.

Non-CMS OPDIV Recommendations:

HHS should continue to increase its focus on remediating the remaining deficiencies. The following are some specific items to consider:

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- Establish a consistent vulnerability management program based on the newly selected tool and operational processes that will allow the Department to effectively secure and operate the various IT operating systems such as Windows, UNIX, databases, and network devices.
- Require suitability background investigations to be completed and favorably adjudicated for personnel prior to allowing access to sensitive Departmental systems and networks.
- Continue to implement two-factor authentication for all remote access to the HHS network. Furthermore, HHS should work to implement an effective remote access program that appropriately controls remote access to systems, including controls in place to monitor compliance with anti-virus and patch management requirements.
- Assess the security of all Internet web servers for system vulnerabilities and implement a secure coding methodology.
- Continue to review and verify that user access to critical financial applications is properly granted and to recertify or remove access on a periodic basis. In addition, password controls should be implemented consistent with HHS policy.
- Enhance their overall configuration process, including putting an enhanced focus on consistently executing detective reviews, the review of Tripwire changes and monitoring of baselines.
- Continue to test, track, and authorize all system changes planned for release into the live environment. For example for UFMS, system owner should collaborate with Financial Enterprise Systems Management (FESM), Information Security Branch (ISB) and business process owners to develop and implement a policy and procedure outlining key activities and events within UFMS to be monitored on a regular basis, frequency of monitoring, assignment of responsibilities and the appropriate documentation required. This policy should be in accordance with and address HHS information security controls and applicable guidance. For NBS, management should implement a tool to enable them to produce a system generated list of changes related to an object.
- Continue to identify, assess, modify, and monitor SoD to ensure the minimum restricted privileged access is granted to system users for all systems listed above. Here are the specific recommendations for UFMS, NBS, and GATES:
    - For UFMS, management has finalized a standard operating procedure (SOP) which outlines how SoD conflicts are to be evaluated, documented, and reviewed. System owner should collaborate with FESM and the UFMS user community to clearly document what constitutes a SoD conflict within UFMS, and work with the users to resolve conflicts existing within the system.
    - For NBS, management should continue to resolve "Intra" conflicts where the focus is on SoD conflicts within a role and the "Inter" conflicts where users have been assigned multiple roles, which creates the conflicts.

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- For GATES, management should design and implement a plan to revise the SoD matrix to include a comprehensive set of responsibilities that would allow for clear identification of conflicts.

CMS Financial Information Management Systems

During FY 2011, CMS further improved its internal controls over information technology and continues to take proactive steps to improve information security and software and systems configuration management at Central Office and its Medicare fee-for-service business partners, principally Fiscal Intermediaries (FIs), Carriers, Medicare Administrative Contractors (MACs), and Enterprise Data Centers (EDCs), collectively referred to as Medicare fee-for-service contractors.

Specifically, the change control process at Central Office was further formalized in FY 2011 through the use of change control boards for Central Office-managed applications, enterprise IT vulnerability management was enhanced through the implementation of new technologies that permits active vulnerability monitoring on a continuous basis, and a structured approach for accreditation and acceptance of information systems was introduced.

However, because of the complexity, age, and size of the information systems used to process Medicare fee-for-service claims, the use of multiple processes to accomplish similar tasks such as configuration management and the number of connections between the Central Office and its contractors, CMS continues to experience a lack of consistent adherence to management control processes and procedures over the software used to process Medicare fee-for-service claims. In addition, further centralization of its change management program for the Medicare fee-for-service application programs occurred without adequate corresponding oversight procedures or integration strategies. Remediation of prior control deficiencies has been particularly slow and additional deficiencies were identified during the current year. These conditions may result in incomplete and inaccurate processing of transactions, causing an impact on the integrity and completeness of data used to prepare CMS' financial statements. The following sections provide more specifics regarding our information technology controls findings with a substantial majority of the findings relating to the oversight or operation of the Medicare fee-for-service claims processing systems.

CMS' Systems Environment Overview

CMS manages national health-care related programs, of which Medicare fee-for-service is the largest; other programs include Medicare Advantage (Part C), the Prescription Drug (Part D), Medicaid, and the Children's Health Insurance Program (CHIP). CMS' Central Office provides overall direction for these programs using a variety of information systems. Substantially all of CMS' Medicare fee-for-service claims and related data are processed under a decentralized business model by geographically dispersed contractors using complex and extensive information systems operations. These operations support a number of Medicare fee-for-service application systems that are intended to assure consistency in administering the Medicare fee-for-service activities, in addition to processing, accounting for, and reporting Medicare fee-for-service expenditures and related assets and liabilities. Internal controls over these operations are essential to manage the integrity, confidentiality, and reliability of

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Medicare fee-for-service data and application programs and to reduce the risk of errors, fraud or other illegal acts.

For Medicare fee-for-service claims, CMS has contracted with commercial insurance and technology organizations for claims administration/processing, claims payment and audit/reimbursement services. CMS has centralized its ongoing principal data processing needs into three separate EDCs.

CMS maintains multiple Medicare fee-for-service claims processing systems depending on the type of claim. These systems include the Fiscal Intermediary Standard 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 and each of these is maintained by a contracted system software maintainer. The maintenance of these systems is coordinated by CMS.

In addition to the Medicare fee-for-service systems previously noted, the important financial systems managed by the CMS Central Office include the Healthcare Integrated General Ledger Accounting System (HIGLAS), the Financial Accounting and Control System (FACS), the Medicare Advantage and Prescription Drug System (MARx), the Medicaid Budget & Expenditure System / State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), and the National Claims History (NCH).

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 fee-for-service contractors. CMS communicates the requirements of their information assurance program through the requirements of the BPSSM; monitoring compliance with the BPSSM is accomplished through CMS' ongoing 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 CMS' systems. Central Office and contractor personnel are required to receive annual security awareness training.

CMS principally monitors its Medicare fee-for-service contractors' compliance with its standards through the following processes:

- Reports issued annually on the controls MACs placed in operation and tested to conclude on the operating effectiveness issued by independent auditors in accordance with the AICPA's Statement on Auditing Standards No. 70, *Service Organizations;*
- Annual evaluations of the implementation of information security requirements outlined in Section 912 of the Medicare Modernization Act of 2003;
- Annual reviews are performed to meet the requirements of the 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 financial systems;

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- 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; and
- CMS is subject to various Federal information security and application software management guidelines. Primary guidance is provided by the National Institute of Standards and Technology (NIST). An independent assessment of CMS' compliance with the NIST guidance is in part accomplished through the performance of an annual review conducted by the Department of Health and Human Services (HHS) Office of Inspector General (OIG) under the *Federal Information Security Management (FISMA) Act of 2002.*

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

The continued and growing complexity of the government health care business environment, coupled with the ongoing evolution of technology and related vulnerabilities, pose a significant challenge to CMS. The mainframe-centric Medicare fee-for-service claims systems that CMS uses to process data are aging and may be increasingly difficult to maintain when integrating future changes in the program.

CMS Configuration Management

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

CMS Medicare Fee-for-Service

CMS has contracted with several system software maintainers to provide application software development and testing support for the majority of the systems used to process Medicare fee-for-service claims. These maintainers provide services for the shared systems that include application development, system documentation, training and testing. The MACs that use the shared systems are responsible for the configuration of programmed edits (for example, 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. The complexity of managing changes as a result of new or revised Medicare fee-for-service policies and other management directives issued by CMS impacts the overall integrity of the claims process.

Change requests for the shared systems are formulated and developed as a result of numerous events, including medical policy revisions issued by CMS' medical staff based on legislative mandates, national trends, historical analysis, implementation of new or revised business processes to efficiently manage the significant volume of claims processed by CMS every day, and the implementation of new processing technologies.

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Because of the complexity and size of the shared systems, the system software maintainers perform the initial program design and coding. CMS coordinates the change control activities for the updates to the shared systems. Integration testing is performed to determine whether modified software components are operating in accordance with CMS' requirements and to verify that unexpected or unintended changes to the shared systems do not occur. Through the EDCs, these changes are applied to the shared systems for the individual MACs at least quarterly.

During FY 2011, CMS completed its transition to a new single testing contractor. However, CMS did not ensure that sufficient controls were in effect at the completion of the transition. As a result of our procedures, numerous control deficiencies were identified at the single testing contractor as it relates to the business models being used to implement CMS' activities. Examples of configuration management deficiencies observed included:

- Testing of shared system change requests by the single testing contractor was neither complete nor successful but the changes were implemented.
- CMS approvals were not consistently obtained prior to the change being implemented.
- Changes to programs may be made after the final testing is performed just prior to implementation.

Configuration management is increasingly dependent on and significantly impacted by information security controls. However, we found that the single testing contractor did not have adequate information security controls. For example:

- The required system security plan was not current or complete and did not reflect an assessment of risks that the single testing contractor faces in its role supporting CMS.
- Reviews of access rights of user accounts for propriety were not performed or not documented.
- Evidence that vulnerability scans were performed was not retained, unapproved wireless technologies were identified, and laptop computers were not encrypted.

Some of these deficiencies are a result of a compressed schedule to implement numerous change requests across the broad range of claims systems and are indicative of the complexity faced by CMS in its daily business activities and the need for assigning priorities to tasks. Also, the MACs may implement certain local changes provided they are compliant with CMS' directives. We found, however, that local changes to Medicare fee-for-service data edits were not always documented or approved by CMS. However, as a result of these deficiencies, CMS may not be able to ensure the accuracy, completeness, or overall integrity of the shared systems.

CMS Enterprise-Wide

In addition to the shared systems, CMS has implemented configuration and change control processes for other Central Office systems that affect Part C, Part D, Medicaid, and CHIP programs. However, we found deficiencies in these processes. Some examples include:

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- Some Central Office applications did not have adequate segregation of duties as it relates to implementing new program code; further, documentation for authorization, testing and approval of changes was not retained.
- CMS has developed a process requiring Interface Control Documents (ICDs) for its major applications, but these are not standardized in content and not used by all relevant programming groups.

CMS Information Security – Medicare Fee-for-Service

Information security controls are fundamental to the integrity of any information system, including configuration management. Such controls, including active monitoring of security events for proper assessment and timely remediation, properly designed and implemented controls, can help manage risks to critical data. These controls include physical and logical access restrictions to protect against unauthorized usage of CMS resources, including programs and data files.

CMS has developed policies that are designed to comply with and are consistent with Federal information security standards. However, the implementation of these policies is affected by the size and complexity of the Medicare fee-for-service environment and available resources. As a result, in addition to the previously cited deficiencies herein, an inconsistent and incomplete execution of CMS' directives and guidance was observed. These information security vulnerabilities relate primarily to Medicare fee-for-service activities and may lessen the ability of CMS to provide secure and reliable processing systems. Examples of these deficiencies include:

- System security plans were incomplete and not always current.
- Information security software for multiple contractors was not configured in accordance with CMS-required standards which are based on NIST guidance.
- Systems software used to implement shared system changes was not configured for adequate segregation of duties.
- Vulnerabilities in system configurations for contractor networks used to transport Medicare fee-for-service data were identified.
- Enterprise-wide vulnerability management software results are being collected but not consistently reviewed.
- Users had the ability to directly update Medicare fee-for-service data without a business justification for such access. In addition, direct data access to alter Medicare fee-for-service data was granted to users who were designated as application developers and outside subcontractors.
- Not all Medicare fee-for-service contractors performed periodic reviews of user access to sensitive data and the related application systems.

Recommendations

CMS should continually assess the governance and oversight across its organizational units charged with responsibility for the configuration management and information security of its

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Medicare fee-for-service systems and data. Such an approach will require continued and active communication and integration of efforts by the OFM, the Office of Information Services (OIS) and the Center for Medicare (CM).

An improved governance-based approach should result in strengthened control and oversight processes that will enhance the overall integrity of CMS' information systems. Examples of such oversight processes that should be improved include:

- Proactive monitoring of Medicare fee-for-service contractor compliance with its directives for data access and controlling changes to the shared systems;
- Reviewing and evaluating identified deficiencies and instances of non-compliance with stated CMS policies, including the documentation of conclusions and evaluating their impact on the financial statements.

Specific to the implementation of a governance-based model at CMS consisting of separate but related control activities relative to configuration management and information security, we recommend that:

- Appropriate segregation of duties be established in all systems that support CMS' programs, including Medicare fee-for-service claims and related financial processing at the FIs, Carriers, MACs, and EDCs to prevent excessive or inappropriate access. In addition, access to all systems should be periodically assessed to ensure that access remains appropriate and no incompatible duties exist.
- Compliance detection systems for the timely implementation and activation of new Medicare fee-for-service claims edits are monitored timely and appropriate system corrections are made for identified errors.
- All application changes to CMS software systems, including the Medicare fee-for-service shared systems, and related support systems managed by the Central Office, are documented, and tested timely, adequately and completely.
- System interfaces are identified and ICDs are consistently completed and used for all of CMS' significant 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.

In addition, CMS should implement enhanced information security policies and techniques developed by OIS for all of CMS' information systems, including:

- Consistent, current and complete system security plans prepared by all system owners and the Medicare fee-for-service MACs, EDCs and system software maintainers.
- Continued implementation of new system security management activities at the Central Office and the Medicare fee-for-service contractors in accordance with CMS' policies, related monitoring procedures, and timely remediation of identified errors.
- Continued and expanded oversight of the Medicare fee-for-service contractors' use of newer technologies, including wireless.

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Significant Deficiency

Financial Reporting Systems, Analyses, and Oversight

Overview

Beginning in the late 1990s, significant issues have continued to be identified in HHS' financial management processes and systems. The passage of significant legislation and other challenges, including numerous antiquated legacy systems, resource limitations, and the decentralized nature and complexities within the organization have impacted the pace of progress. During our FY 2011 audit, we noted that management had stepped up its initiatives in improving its processes and controls. As part of these initiatives, HHS has implemented new processes, upgraded its various legacy systems, improved communication, developed new guidance, and provided training to its personnel to address these issues. HHS management indicated that the progress noted in FY 2011 was the result of over three years of efforts to address hundreds of noted issues. For example, during FY 2011, HHS indicated that progress had been made in many areas, including:

- Implementation of the Consolidated Financial Reporting System (CFRS). The CFRS is a systematic process of consolidating consistently formatted financial information from HHS' three financial systems (UFMS, NBS, and HIGLAS). The system has also provided a universe of data for department-level data mining and analysis.
- Enhanced financial management processes at the Indian Health Service to improve coordination and cooperation of area offices and headquarters, ensure timely reconciliations of account balances, reduction of unreconciled differences, enhancement of financial analysis processes at the area offices, and the introduction of goals in executive performance plans to support progress at the entity.
- Enhanced reconciliation processes throughout the Department reducing the amount of outstanding differences.
- Initiatives to review outstanding undelivered orders and to complete procedures to close out contracts and grants timely.
- Updates of certain financial policies and procedures to document updated processes within HHS.
- Revisions to its acquisition guidance, improvements in business processes, appropriation law training for several thousand employees department-wide, development and launching of a robust, web-based appropriation law knowledge repository, and performance of procurement management and internal control reviews to validate continued compliance with appropriation law.
- Completion of remediation procedures for hundreds of existing weaknesses from various evaluations by the completion of corrective action plans.
- Improvements to certain system controls, as discussed above, and the implementation of audit tools to monitor whether user duties are appropriately segregated.

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As part of our FY 2011 audit, we noted significant improvements in financial management processes. For example: our procedures noted fewer unexplained differences and unsupported adjustments, more timely preparation of reconciliations, more detailed analyses of financial data at the departmental level, and improvements in the closeout of older obligations. Additionally, we noted a more timely compilation of OPDIV trial balances and fewer inconsistencies between OPDIVs with the implementation of the CFRS system. With the level of improvements noted in FY 2011 on the overall financial management environment, we were able to report a significant deficiency related to Financial Reporting, Systems, Analyses and Oversight as compared to reporting a material weakness in FY 2010.

However, through the end of FY 2011, HHS and its operating division management's review and the results of our testing of internal control continued to identify internal control weaknesses in financial systems and processes for producing financial statements, including lack of integrated financial management systems and insufficient analysis of certain significant accounts which impaired HHS' ability to report timely financial information. In many cases, the progress noted above and related processes continued to be developed throughout FY 2011 and will require additional refinements in FY 2012. Within the context of the approximately $900 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 systemic issues that must continue to be resolved.

Lack of Integrated Financial Management System

In FY 2004, HHS 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 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 2012.
- 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 three to five 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, HHS' financial management systems are not compliant with the Federal Financial Management

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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 HHS' and its OPDIVs' abilities to adequately support and analyze account balances reported in a timely fashion.

Although HHS implemented a commercial off-the-shelf product, approved by the former Joint Financial Management Improvement Program (JFMIP), HHS' accounting systems lack integration and do not conform to the requirements. HHS' management has identified configuration issues that result in incorrect 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 significant progress was made with the implementation of the CFRS during FY 2011, over five thousand manual journal vouchers in excess of $596 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 and internal controls over manual vouchers were found to be operating effectively, including supervisory reviews and properly maintained documentation to support each entry, many of these entries should be configured as routine systematic entries within the systems. HHS' management indicated that it has developed corrective actions to reduce the number of manual entries in future years. For NBS financial statement closing entries, although the entry is recorded in NBS for financial statement preparation purposes, the entry may be recorded in aggregate and reversed until such time that either the routine process captures the activity or the entries are carried forward to the next reporting period. During our audit of NIH balances affected by the October 1, 2010 conversion to the CFRS system, we identified over $300 million in differences between September 30, 2010 ending balances and October 1, 2010 beginning balances. Management indicated that they believe they have corrected the difference on a go-forward basis. Further, due to the timing of the NIH closing procedures, and the complexities of recording the grant accrual in the NBS, NIH management made a decision not to record its fourth quarter accrual. As a result, the September 30, 2011, financial statements were understated by approximately $568 million.

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- CMS continues their efforts to implement a web-based accounting system, HIGLAS, that will integrate the CMS contractors' standard claims processing system and eventually replace FACS (currently, HIGLAS has been placed "on top" of FACS). Although CMS is preparing financial statements using HIGLAS, the majority of the financial transactions and journal vouchers still are recorded within the current mainframe-based financial system. As a result, full functionality of HIGLAS has not been implemented nor has it been investigated to determine the effectiveness of the system and whether HIGLAS is capable of consolidating, or has the ability to consolidate, the financial data from the contractors and Central Office. In addition, there is no letter of credit or cash management module that currently exists within HIGLAS at Central Office that monitors the Medicare contractors' draws. The Medicare contractors' accounts receivable balances are recorded at Central Office through the manual journal voucher process.

  There are a number of system interventions and manual adjustments or reconciliations to properly categorize the information in accordance with the financial statement and disclosure requirements in OMB Circular No. A-136. The creation of the periodic financial statements is largely system dependent. The information security controls over FACS are weak, primarily due to the lack of segregation of duties that continue to exist between the business and information security administration functions within the Office of Financial Management (OFM). OFM has assigned personnel the function of system and security administrators, and these personnel also are able to grant access to the FACS application to perform and process business transactions. Information security controls are fundamental to the integrity of any information system to protect against unauthorized usage of financial data. CMS is aware of the noted shortcomings within FACS but does not plan to make changes to this system as it will be decommissioned by fiscal year 2013.

- Not all Medicare contractors have implemented HIGLAS, including the contractors responsible for the DME contracts, 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. The accuracy of the financial 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.

- As discussed in further detail above, 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 OIG engagements. Finally, HHS 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 and Analysis of the Department's FY 2011 Annual Financial Report.

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- 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 HHS 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.
- The NIH's NBS system utilizes systematic table-driven entries when a standard routine transaction occurs. During our testing, we noted that NIH did not identify several incorrect transactions timely when a table-driven entry caused a transaction to post incorrectly. The entry recorded collections in the current year even though the funds had been collected in a previous year.
- Within a decentralized complex organization like HHS, 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, 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. Additionally, there is limited program, OPDIV, and/or consolidated department level financial data available. Management indicated that with the introduction of CFRS and its future implementation of the Oracle Business Intelligence system, it is working to improve upon its readily available information to support its day-to-day activities and to address potential requests from Congress, OMB, the President, and other entities.

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

Financial Analysis and Oversight

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 HHS' ability to report accurate financial information on a timely basis. Consistent with prior years, during FY 2011, we found that certain controls were not consistently 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 still required further improvements. The following represent specific areas we noted that need enhanced periodic reconciliation and analysis procedures:

- Fund Balance with Treasury (FBWT) – As reported in prior years, on a monthly basis, HHS is responsible for reconciling approximately 500 Treasury appropriation symbols. As of June 30, 2011, the general ledger and Treasury's records differed by more than an approximate absolute value of $500 million. This primarily relates to differences that were not adequately researched and cleared from the Suspense Account Reconciliation. This difference is significantly less than the $3 billion difference identified at June 30, 2010 by our prior year audit. 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 time frame.

- 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 21st, 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 or fully supported. In our review of the OPDIV level financial statements, we identified approximately $886 million in differences that could not be identified. Finally, we noted that sufficient reviews of the compiled financial statements and related footnotes did not identify certain mistakes in a timely fashion. For example, during our review of the September 30, 2011 financial statements, we identified several mistakes in the manually-calculated footnotes related to elimination and undelivered order amounts.

- Procurement Activities – In our FY 2010 Report on Internal Control, we reported that during FY 2008, the Senior Procurement Executive of the HHS 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, HHS Acquisition Regulation 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 identified significant compliance concerns including a misunderstanding of the above appropriation-related guidance and its applicability to planning, awarding and funding HHS contracts. On July 14, 2011, HHS reported in a letter to the President that it had identified and declared multiple instances of violations of 31 U.S.C. 1341, *the Anti-Deficiency Act*, as a result of this review. As part of its remediation efforts, HHS continues to review its future and past procurement activities for potential violations. During FY 2011, several other potential violations have been identified. We understand that the Department is committed to notifying the appropriate authorities of violations of the *Anti-Deficiency Act* and will take the necessary actions to prevent future problems:

Policies and Procedures

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 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. It is our understanding that the Department and its OPDIVs are currently updating their financial management procedures.

CMS Medicaid Oversight

The Medicaid program is designed to reimburse the various state programs for the Federal share of claim payments. CMS approves each state's budget (the authorized amount) on a quarterly or annual basis. The state draws against their authorized amounts, funds representing the Federal share of claims paid. The state has to support its draws by supplying CMS with a certified report of actual expenditures. The certification of the actual expenditures by the states, the review by CMS and determination of any adjustments required to the draw, is to occur within the succeeding two quarters (180 days). The grant awards are reconciled on an annual basis and any over or under draws by the states become a accounts receivable or payable on CMS financial statements.

In connection with the grant finalization process, the authorized amount (provided by the budget process), the draws made (provided by the Payment Management System (PMS), the Department of Health and Human Services' operation used to provide the bank-like services for the states) and the actual certified expenditures incurred (provided by the states' Chief Financial Officer) for the grant year are reviewed and analyzed by CMS. When the state's draws exceed the actual certified expenditures, the state owes that amount to CMS. Conversely, when the state draws are less than the actual certified expenditures, CMS owes that amount to the state. The program is intended to reimburse the state for those certified expenditures that have been made by the state. Therefore, states should have receivable or payable balances only related to differences in estimating the portion of current claims reimbursable by Medicaid or for disallowances or adjustments to the listing of certified expenditures.

As of September 30, 2011, a $1.3 billion accounts receivable and a $1.8 billion accounts payable balance were recorded in the CMS financial statements related to the Medicaid program, some of which dates back to FY 2009 and prior. Our analyses of the grant award finalization identified the following weaknesses or vulnerabilities in the Medicaid program related to the financial reporting process:

- There is no effective monitoring of the state's draws compared to the related expenditures until the grant award is finalized.
- There is not a timely settlement of the receivables and payables with the state after the annual grant award has been finalized as certain receivables and payables that were recorded in the prior year have yet to be resolved (either collected or paid).
- The grant close out process within the Payment Management System (PMS) is not performed timely.
- The states have access to draw or transfer funds from open PMS accounts, even those for which CMS has finalized the grant awards.
- Accounts receivable and payable balances were not identified timely because of the two quarter lag in finalizing actual state certified expenditures nor are these items recorded in detail within a Medicaid receivable or payable subsidiary ledger.
- The accounting analysis performed to identify and record the payable or receivable balances are not reviewed or corroborated by Medicaid management.

CMS Financial Management Analysis Function

Critical or new accounting matters identified within CMS require a robust analysis and review process, including meaningful collaboration with Centers and Offices, timely summarization of considerations and conclusions and documentation of the significant accounting matters through a series of white papers. The white papers supporting the conclusions on several critical accounting matters were not prepared timely, not all aspects of the accounting matters were considered or whether conclusions on prior year matters remain appropriate. The dispersed nature of the environment leaves CMS vulnerable to delays in the financial management implications of issues being recognized and addressed and creates a challenge to gather and analyze the information from across the organization to complete the required white papers timely. Additional examples include:

- Effective April 1, 2011, the Center for Consumer Information and Insurance Oversight (CCIIO) was transferred from the HHS' Office of the Secretary to CMS. Although the transfer took place on April 1, policies that analyzed the accounting for the transfer, including accrual methodologies for two CCIIO programs, were not finalized by the September 30, 2011 year end closing. The transfer was not fully analyzed by CMS to verify that the balances recorded were complete and accurate. Additionally, because the reporting infrastructure was already established, the transactions continued to be administered by HHS' Program Support Center. The Program Support Center provided the period ending balances to CMS and CMS records this financial information with only limited review, analysis and corroboration of the financial information.

- Statement of Federal Financial Accounting Standards No. 37, *Additional Requirements for Management's Discussion and Analysis and Basic Financial Statements*, required CMS to present a Statement of Changes in Social Insurance Amounts (SCSIA) and additional required disclosures. This Statement was issued in April 2010. Although a complex area, the SCSIA and additional required disclosures were not finalized by the September 30, 2011 year end closing, while the changes were evaluated as part of the 2011 Trustees Report.

CMS does not ensure that the legal accrual is recorded in accordance with generally accepted accounting principles in the United States nor did CMS follow its own stated policy in assessing contingencies or potential accruals. In FY 2011, one instance where CMS did not follow its stated policy, which resulted in CMS not identifying a potential accrual in the prior year, and although that accrual would have been assessed as a remote likelihood of occurrence in that year, the potential contingency was not identified by CMS.

Consistent with the prior years, 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 (unpaid claims) but not reported liability. The Medicaid EBDP is a significant liability on the FY 2011 financial statements. CMS is not able to validate its methodology by using a claims-based approach and continues to rely on its estimation process (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.

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 and regional offices may be summarized, including an example for each category, as follows: (i) review or monitoring function was established but was not performed or effective or the policies and procedures are not properly designed and implemented (for example, an $800 million difference identified during the audit between the Medicaid liabilities and entitlement benefits due and payable); and (ii) the review or monitoring function was not performed timely (for example, the monthly NCH validation process, which compares the NCH paid claims to the Medicare contractor reported draws).

A strong control environment not only ensures accountability but provides oversight and reasonable assurance over the financial reporting process. Improvements can be made in the way the Centers and Offices coordinate, collaborate and communicate with OFM to understand the impact of their program transactions and ultimately corroborate the impact is properly reflected in the financial statements.

<u>CMS Business Partner Risk Management</u>

CMS administers an extensive internal control program to protect the Agency's resources from fraud, waste and mismanagement. CMS 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 Part C and Part D programs.

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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 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 fee-for-service contractors include provisions that require the Medicare contractor to develop and follow objectives established by CMS. Through the established procedures, the Medicare contractors are required to a) periodically certify to the completeness and accuracy of the financial information transmitted, b) document specific objectives and maintain supporting documentation for review and audit, and c) provide monthly shared system reports and related support for reported amounts. Through its A-123, SAS 70 and regional office processes, CMS tests and monitors the Medicare contractors' compliance with its policies and procedures, established controls and the accuracy of financial reporting.

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 the issues are timely remediated by the Medicare contractors. As CMS continues its efforts to transition to HIGLAS and to implement the provisions of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (combined known as ACA), there will be greater significance placed on monitoring the Medicare and other contractors, accentuating not only the value but also the consequences, to the Agency. During our audit activities, we identified weaknesses in financial reporting oversight, and noted the following examples.

- Neither CMS nor the Medicare contractors were able to provide a system-generated subsidiary ledger for the amounts payable to providers or beneficiaries (or amounts owed to CMS) for certain ancillary accounts (for example, refunds payable) 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 or substantiate these account balances on a periodic basis. Certain balances presented were comprised of both receivable and payable amounts, which ultimately reduced the account balance without a clear understanding if that right of offset was appropriate. Although these account balances generally are not significant, these balances are not being monitored or reviewed to ensure that the balances are properly and timely resolved.
- Undelivered Medicare Summary Notices (MSNs) returned to the Medicare contractor 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 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.

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 claim data, if material, should be detected in the annual Comprehensive Error Rate Testing (CERT) process and in the Payment Error Rate Measurement (PERM) process for Medicaid. Similar processes are used to monitor improper payments for Part C and Part D plans. 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. Timeliness of the availability of the error rate reports to the public is critical to the Agency's efforts to provide transparency and accountability. The FY 2010 CERT report has not been issued to date, due to the review process performed by other Federal agencies, and the FY 2010 PERM report was only recently issued. Similarly, the timeliness of finalizing the error rates for Part C and Part D continues to be a challenge.

We reviewed the error analyses and these analyses quantify the overall challenges that CMS has regarding improper payments. Our audit procedures also consider the activities performed by OIG and others for Part C, Part D and other programs. Findings, such as the timeliness of the plan audits and the accumulation of the Prescription Drug Event (PDE) data, are inherent risks of the programs. The error rate review processes, methodologies and calculations continue to evolve and certain provisions of ACA require additional monitoring and recovery activities. Any changes implemented may impact comparability of information on an annual basis and the transparency and accountability of the process. In addition, ensuring that a fully reconciled population of claims is subject to testing is an important starting point in the development of PERM error rates and the reconciliation of such populations continue to be an area of focus.

Statement of Social Insurance (SOSI)

The Statement of Social Insurance (SOSI) for CMS presents a long-term projection of the present value 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 SCSIA presents the changes in the open group measure from the end of the previous reporting period and reconciles the change between the current and prior period valuation. 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.

In FY 2010, the passage of the ACA 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 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 experienced in FY 2010 regarding the projections continued in FY 2011 and certain matters were called into question, and as a result, 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, 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 current law SOSI projections, as presented, are subject to ongoing uncertainty this year and may not reflect management's reasonable estimate of the ultimate cash flows of the social insurance program, is discussed in the footnotes to the FY 2011 Statements of Social Insurance.

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 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. 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 have been taken within CMS that will assist in narrowing areas of concern, including the appointment of public trustees and a panel of advisors to assist in reviewing the projections and related assumptions. Although the work of the panel of advisors was not completed for the FY 2011 SOSI presentation and Trustees Report development, these measures will assist CMS during the refinement of future projections and in considering the

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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.

Recommendations

We recommend that HHS 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 HHS:

- Continue to focus on 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 devise short-term and long-term resolutions to systematic and integration issues that complicate use of UFMS and NBS. HHS 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 to personnel to ensure consistent application of policies among the various Operating Divisions and Headquarters.
- 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.
- Complete its implementation of the Oracle Business Intelligence and expansion of the CFRS to provide for more timely and up-to-date financial and business information.
- Continue its review of procurement activities to resolve issues related to the Anti-Deficiency Act.

Additionally, in regard to CMS, we recommend that CMS 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 CMS implement the following:

- Efforts to continuously monitor the state Medicaid draws and perform grant oversight activities should be improved. Routine and timely review of the draws would ensure that the states do not overdraw funds. Medicaid grant awards should be finalized timely and settled on a periodic basis. CMS should ensure that the grant close out process occurs timely and consistently within PMS to eliminate any erroneous draws to grant awards with remaining authority.

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- Accounts receivable and payable Medicaid balances should be identified and recorded timely. A subsidiary ledger should be generated to validate the propriety of ending balances on a periodic basis and to understand the change in the respective balances. The information within the analyses and the corresponding subsidiary ledger should be reviewed and approved by the program management.
- Further enhance its process to develop, document and validate the new critical accounting matters that are identified during the year, including timeliness, accuracy and completeness of the white papers. Prepare required presentations and disclosures to ensure adequate time for analysis and feedback from key stakeholders.
- Ensure that the legal accrual is recorded in accordance with generally accepted accounting principles in the United States.
- 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 approximately $26.1 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 or information being gathered by the Center for Program Integrity to calculate the average days outstanding or sample the largest states and determine if information is available for subsequent analysis.
- Delegate to and ensure that the Centers or Offices provide robust analytical analyses to OFM on a periodic basis 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 organization.
- Establish a periodic organizational-wide financial statement review process to enhance the financial reporting process, address or identify transactions that require cross-functional input and ensure financial statements are accurate and complete.
- Revise and enhance the design of the financial review guidance provided to regional offices and Medicare contractors to incorporate more analyses and scrutiny in the review of the financial information.
- As CMS transitions to HIGLAS, challenge the policies and procedures to determine if the implementation has impacted the financial reporting and internal control processes (for example, generate and reconcile the subsidiary ledgers, MSNs and HIGLAS reporting). If current methods are impacted, provide updated guidance and communication to the contractor to incorporate the changes.
- Develop a system-generated subsidiary ledger or use analytical tools to create a detailed schedule of the outstanding amounts payable to providers or beneficiaries for certain Medicare contractor ancillary accounts (for example, refunds payable) as of the balance sheet date (month or quarter end). The subsidiary ledger should be reviewed, analyzed and adjusted to ensure that the provider balances are properly supported and recorded. The subsidiary ledger should be reconciled to the general ledger on a periodic basis.

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- Continue to enhance 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 identify anomalies to begin investigations of the root causes of the errors and prevention, mitigation and recovery plans. Continue efforts to further develop the eligibility process to ensure only appropriate parties participate.
- Assess and prioritize the findings from the OIG and other program reviews performed, implement the recommended changes and modify the internal control processes to hold plan sponsors more accountable for the findings identified. The financial management groups should monitor the programs and their activities to identify the appropriate financial statement impact and disclosure.
- Continue to implement an integrated financial management system for use by CMS and the Medicare contractors to promote consistency and reliability in accounting and financial reporting and assess the capability of and implement the full functionality of HIGLAS while working towards decommissioning FACS.
- 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 and FY 2011 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, CMS should consider the following.
    - Efforts initiated late in FY 2010 and continued in FY 2011 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 co-develop 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.

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Report on Internal Control

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STATUS OF PRIOR YEAR FINDINGS

In the reports on the results of the FY 2010 audit of the HHS 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 2011 Status**
Financial Reporting Systems, Analyses, and Oversight	• Lack of Integrated Financial Management System • Financial Analysis and Oversight • Management Corrective Actions	Sufficient progress noted; material weakness downgraded to significant deficiency.
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 HHS 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 HHS' 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 HHS, OMB, GAO, and Congress. This report is not intended to be and should not be used by anyone other than these specified parties.

/Ernst & Young LLP/

November 14, 2011

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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*

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 (HHS) as of and for the year ended September 30, 2011, and we were engaged to audit the statement of social insurance as of January 1, 2011 and the related statement of changes in social insurance amounts, and have issued our Report of Independent Auditors thereon dated November 14, 2011. 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, 2011 and the related statement of changes in social insurance amounts. 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 HHS' 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 HHS.

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.

During fiscal year (FY) 2011, HHS' management declared several violations to certain provisions of the Anti-Deficiency Act (P.L. 101-508 and OMB Circular A-11). Currently, HHS is investigating several additional potential violations of that Act.

Additionally, the Improper Payments Information Act (IPIA) of 2002 and the Improper Payment Eliminations and Recovery Act (IPERA) of 2011 (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 it continues to make progress, HHS is currently not in full compliance with the requirements of the Acts.

Under FFMIA, we are required to report whether HHS' financial management systems substantially comply with federal financial management systems requirements, applicable

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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 HHS' 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, HHS has not yet completed the implementation of the Healthcare Integrated General Ledger Accounting System (HIGLAS) general ledger system. Additionally, HHS continues to resolve certain legacy system issues within the National Institutes of Health's (NIH) Business System (NBS). As a result, NIH's NBS is not capturing certain transactions correctly in accordance with the Treasury Standard general ledger requiring ad hoc inquiries to adjust accounting records.
- During fiscal year 2011, thousands of manual journal vouchers were required to be recorded in UFMS/NBS 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.
- 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.
- Although progress was noted, 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, HHS 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.
- Currently, 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. Additionally, there is limited program, operating divisions, and/or consolidated department level financial data available.

* * * * *

Our Report on Internal Control dated November 14, 2011, 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 FMFIA, and our

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Report on Compliance and Other Matters

Page 3

recommendations related to the specific issues presented. It is our understanding that management agrees with the facts as presented and that relevant comments from HHS' management responsible for addressing the noncompliance are provided in their letter dated November 14, 2011. We did not audit management's comments and, accordingly, we express no opinion on them. Additionally, HHS 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 General of the HHS, OMB, and Congress. This report is not intended to be and should not be used by anyone other than these specified parties.

Ernst & Young LLP

November 14, 2011

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DEPARTMENT'S RESPONSE TO THE AUDIT

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

NOV 14 2011

To: Daniel R. Levinson, Inspector General

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

Subject: FY 2011 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. We generally concur with the findings identified in the draft Report on Internal Control. The final reports will be included in our FY 2011 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, 2011, AND 2010
(IN MILLIONS)

	2011	2010
Assets (Note 2)		
Intra-governmental		
Fund Balance with Treasury (Note 3)	$ 166,855	$ 182,235
Investments, Net (Note 4)	325,443	359,882
Accounts Receivable, Net (Note 5)	1,020	1,137
Advances (Note 8)	29	99
Total Intra-governmental	493,347	543,353
Accounts Receivable, Net (Note 5)	10,908	7,394
Inventory and Related Property, Net (Note 6)	6,546	6,077
General Property, Plant, and Equipment, Net (Note 7)	5,657	5,263
Advances (Note 8)	16,090	1,312
Other	332	340
Total Assets	**$ 532,880**	**$ 563,739**
Stewardship PP&E (Note 1)		
Liabilities (Note 9)		
Intra-governmental		
Accounts Payable	$ 649	$ 906
Other (Note 13)	1,100	1,572
Total Intra-governmental	1,749	2,478
Accounts Payable	547	673
Entitlement Benefits Due and Payable (Note 10)	80,882	72,712
Accrued Grant Liability (Note 12)	4,485	4,204
Federal Employee & Veterans' Benefits (Note 11)	10,219	9,985
Contingencies & Commitments (Note 14)	3,623	6,079
Other (Note 13)	3,412	3,082
Total Liabilities	**104,917**	**99,213**
Net Position		
Unexpended Appropriations - Earmarked funds	4,236	1,675
Unexpended Appropriations - Other funds	122,558	140,468
Unexpended Appropriations, Total	126,794	142,143
Cumulative Results of Operations - Earmarked funds	293,362	317,334
Cumulative Results of Operations - Other funds	7,807	5,049
Cumulative Results of Operations, Total	301,169	322,383
Total Net Position	**427,963**	**464,526**
Total Liabilities & Net Position	**$ 532,880**	**$ 563,739**

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, 2011, AND 2010
(IN MILLIONS)

	2011	2010
Responsibility Segments		
Centers for Medicare & Medicaid Services (CMS)		
Gross Cost	$ 817,383	$ 789,713
Exchange Revenue (Note 16)	(63,686)	(60,717)
CMS Net Cost of Operations	753,697	728,996
Other Segments:		
Administration for Children and Families (ACF)	54,027	56,369
Administration on Aging (AoA)	1,569	1,530
Agency for Healthcare Research and Quality (AHRQ)	553	86
Centers for Disease Control and Prevention (CDC)	10,407	10,482
Food and Drug Administration (FDA)	3,144	3,130
Health Resources and Services Administration (HRSA)	8,523	9,222
Indian Health Service (IHS)	5,240	5,262
National Institutes of Health (NIH)	34,406	33,776
Office of the Secretary (OS)	5,033	6,720
Program Support Center (PSC)	1,817	1,063
Substance Abuse and Mental Health Services Administration (SAMHSA)	3,581	3,362
Other Segments Gross Cost of Operations before Actuarial Gains and Losses	128,300	131,002
Actuarial (Gains) and Losses Commissioned Corp Retirement and Medical Plan	(82)	(77)
Other Segments Gross Cost of Operations after Actuarial Gains and Losses	128,218	130,925
Exchange Revenue (Note 16)	(3,782)	(3,193)
Other Segments Net Cost of Operations	124,436	127,732
Net Cost of Operations	**$ 878,133**	**$ 856,728**

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, 2011
(IN MILLIONS)

	2011			
	Earmarked Funds	**All Other Funds**	**Eliminations**	**Consolidated Total**
Cumulative Results of Operations:				
Beginning Balances	$ 317,334	$ 5,049	$ -	$ 322,383
Budgetary Financing Sources:				
Appropriations Used	242,151	405,173	-	647,324
Non-exchange Revenue				
Non-exchange Revenue - Tax Revenue	192,341	-	-	192,341
Non-exchange Revenue - Investment Revenue	15,736	4	-	15,740
Non-exchange Revenue - Other	2,469	-	-	2,469
Donations and Forfeitures of Cash and Cash Equivalents	56	-	-	56
Transfers-in/out without Reimbursement	(3,809)	2,373	-	(1,436)
Other (+/-)	(1)	(32)	-	(33)
Other Financing Sources (Non-Exchange):				
Donations and Forfeitures of Property	-	5	-	5
Transfers-in/out Without Reimbursement (+/-)	(4)	23	-	19
Imputed Financing	41	687	(127)	601
Other (+/-)	6	(173)	-	(167)
Total Financing Sources	448,986	408,060	(127)	856,919
Net Cost of Operations (+/-)	472,958	405,302	(127)	878,133
Net Change	(23,972)	2,758	-	(21,214)
Cumulative Results of Operations	**293,362**	**7,807**	-	301,169
Unexpended Appropriations				
Beginning Balances	1,675	140,468	-	142,143
Budgetary Financing Sources				
Appropriations Received	245,950	417,471	-	663,421
Appropriations Transferred in/out	-	(294)	-	(294)
Other Adjustments	(1,238)	(29,914)	-	(31,152)
Appropriations Used	(242,151)	(405,173)	-	(647,324)
Total Budgetary Financing Sources	2,561	(17,910)	-	(15,349)
Total Unexpended Appropriations	4,236	122,558	-	126,794
Net Position	**$ 297,598**	**$ 130,365**	**$ -**	**$ 427,963**

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
Non-exchange 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
COMBINED STATEMENT OF BUDGETARY RESOURCES
FOR THE YEARS ENDED SEPTEMBER 30, 2011, AND 2010
(IN MILLIONS)

	2011	2010
Budgetary Resources:		
Unobligated Balance, Brought Forward, October 1:	$ 59,325	$ 50,378
Recoveries of Prior Year Unpaid Obligations	25,808	17,682
Budget Authority		
Appropriation	1,247,791	1,194,294
Spending Authority from Offsetting Collections		
Collected	13,267	9,038
Change in Receivables from Federal Sources	(28)	290
Change in Unfilled Customer Orders		
Advance Received	(410)	279
Without Advance from Federal Sources	(230)	(102)
Previously Unavailable	385	293
Expenditure Transfers from Trust Funds	7,962	4,034
Subtotal	1,268,737	1,208,126
Non-expenditure Transfers, Net, Anticipated and Actual	(589)	(663)
Temporarily not available pursuant to Public Law	(746)	(11,296)
Permanently not available	(37,202)	(5,297)
Total Budgetary Resources	$ 1,315,333	$ 1,258,930
Status of Budgetary Resources:		
Obligations Incurred (Note 17)		
Direct	$ 1,256,150	$ 1,192,009
Reimbursable	7,382	7,596
Subtotal	1,263,532	1,199,605
Unobligated Balances Available		
Apportioned	44,169	48,526
Exempt from Apportionment	265	354
Subtotal	44,434	48,880
Unobligated Balances Not Available	7,367	10,445
Total Status of Budgetary Resources	$ 1,315,333	$ 1,258,930
Change in Obligated Balance:		
Obligated Balance, Net		
Unpaid Obligations, brought forward, October 1	$ 182,540	$ 171,739
Uncollected Customer Payments from Federal Sources, brought forward, October 1	(7,179)	(6,678)
Total Unpaid Obligated Balance, Net	175,361	165,061
Obligations Incurred, Net	1,263,532	1,199,605
Gross Outlays	(1,231,449)	(1,171,122)
Recoveries of Prior Year Unpaid Obligations, Actual	(25,808)	(17,682)
Change in Uncollected Customer Payments from Federal Sources	(3,462)	(501)
Obligated Balance, Net, End of Period		
Unpaid Obligations	188,534	182,540
Uncollected Customer Payments from Federal Sources	(10,360)	(7,179)
Total, Unpaid Obligated Balance, Net, End of Period	178,174	175,361
Net Outlays		
Gross Outlays	1,231,449	1,171,122
Offsetting Collections	(17,193)	(13,038)
Distributed Offsetting Receipts	(322,724)	(303,977)
Net Outlays	**$ 891,532**	**$ 854,107**

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, 2011, AND PRIOR BASE YEARS
(IN BILLIONS)

			Estimates from Prior Years		
	2011 (unaudited)	**2010** (unaudited)	**2009**	**2008**	**2007**
Current Participants:					
Actuarial present value for the 75-year projection period from or on behalf of:					
Those who, in the starting year of the projection period, have attained eligibility age:					
Income (excluding interest)	$ 3,079	$ 2,866	$ 2,729	$ 2,568	$ 2,572
Expenditures	5,961	5,459	5,695	5,315	5,186
Income less Expenditures	(2,882)	(2,593)	(2,967)	(2,746)	(2,614)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	27,615	26,259	28,815	27,778	25,372
Expenditures	32,814	30,974	40,634	38,841	35,042
Income less Expenditures	(5,199)	(4,715)	(11,819)	(11,063)	(9,669)
Actuarial present value of estimated future income (excluding interest) less Expenditures (closed-group measure)	(8,081)	(7,308)	(14,786)	(13,809)	(12,284)
Combined Medicare Trust Fund assets at start of period	344	381	381	368	338
Actuarial present value of estimated future income (excluding interest) less Expenditures plus Trust Fund assets at start of period	(7,737)	(6,927)	(14,405)	(13,441)	(11,945)
Future Participants:					
Actuarial present value for the 75-year projection period:					
Income (excluding interest)	13,300	12,735	12,991	12,698	12,065
Expenditures	8,471	8,109	11,976	11,625	12,074
Income less Expenditures	4,829	4,626	1,016	1,073	(9)
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less Expenditures	(3,252)	(2,683)	(13,770)	(12,737)	(12,292)
Combined Medicare Trust Fund assets at start of period	344	381	381	368	338
Actuarial present value of estimated future income (excluding interest) less Expenditures plus Trust Fund assets at start of period	$ (2,908)	$ (2,302)	$ (13,390)	$ (12,369)	$ (11,954)

Totals do not necessarily equal the sum of the 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” is 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.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
STATEMENT OF SOCIAL INSURANCE (*CONTINUED*)
75-YEAR PROJECTION AS OF JANUARY 1, 2011, AND PRIOR BASE YEARS
(IN BILLIONS)

		Estimates from Prior Years			
	2011	**2010**	**2009**	**2008**	**2007**
	(unaudited)	(unaudited)			
Actuarial present value for the 75-year projection period of estimated future Income (excluding interest) received from or on behalf of: (Notes 21 and 22)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 7,581	$ 7,216	$ 6,348	$ 6,320	$ 5,975
SMI Part B	13,595	12,688	16,323	14,932	12,112
SMI Part D	6,438	6,355	6,144	6,527	7,285
Have attained eligibility age (age 65 and over)					
HI	262	248	209	202	178
SMI Part B	2,122	1,972	1,924	1,785	1,648
SMI Part D	695	646	595	581	746
Those expected to become participants					
HI	7,260	6,944	5,451	5,361	4,870
SMI Part B	3,223	3,077	4,909	4,480	4,460
SMI Part D	2,817	2,714	2,632	2,856	2,735
All current and future participants					
HI	15,104	14,408	12,008	11,883	11,023
SMI Part B	18,940	17,737	23,156	21,197	18,221
SMI Part D	9,950	9,715	9,371	9,964	10,766
Actuarial present value for the 75-year projection period of estimated future Expenditures for or on behalf of: (Notes 21 and 22)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	12,887	12,032	18,147	17,365	15,639
SMI Part B	13,489	12,587	16,342	14,949	12,130
SMI Part D	6,438	6,355	6,144	6,527	7,273
Have attained eligibility age (age 65 and over)					
HI	2,923	2,648	2,958	2,747	2,558
SMI Part B	2,343	2,166	2,142	1,986	1,834
SMI Part D	695	646	595	581	794
Those expected to become participants					
HI	2,546	2,411	4,673	4,506	5,118
SMI Part B	3,108	2,984	4,672	4,262	4,257
SMI Part D	2,817	2,714	2,632	2,856	2,699
All current and future participants					
HI	18,356	17,090	25,778	24,619	23,315
SMI Part B	18,940	17,737	23,156	21,197	18,221
SMI Part D	9,950	9,715	9,371	9,964	10,766
Actuarial present values for the 75-year projection period of estimated future excess of Income (excluding interest) over Expenditures (Notes 21 and 22)					
HI	$ (3,252)	$ (2,683)	$(13,770)	$ (12,737)	$ (12,292)
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 21 and 22)					
HI	$ (3,252)	$ (2,683)	$(13,770)	(12,737)	$ (12,292)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Trust fund assets at start of period					
HI	272	304	321	312	300
SMI Part B	71	76	59	53	38
SMI Part D	1	1	1	3	1
Actuarial present value for the 75-year projection period of estimated future excess of Income (excluding interest) and Trust Fund assets at start of period over Expenditures (Notes 21 and 22)					
HI	$ (2,980)	$ (2,378)	$(13,449)	$ (12,425)	$ (11,993)
SMI Part B	71	76	59	53	38
SMI Part D	1	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.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
STATEMENT OF CHANGES IN SOCIAL INSURANCE AMOUNTS (UNAUDITED)
MEDICARE HOSPITAL AND SUPPLEMENTARY MEDICAL INSURANCE
(IN BILLIONS)

	Actuarial Present Value Over the Next 75 Years (open group measure)			Combined HI and SMI Trust Fund Account Assets	Actuarial Present Value of Estimated Future Income (excluding interest) Less Expenditures Plus Combined Trust Fund Assets
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures		
Total Medicare *(Note 23)*					
As of January 1, 2010	$ 41,860	$ 44,543	$ (2,683)	$ 381	$ (2,302)
Reasons for change					
Change in the valuation period	1,952	2,063	(112)	(49)	(160)
Change in projection base	(1,069)	(538)	(531)	11	(519)
Changes in the demographic assumptions	(67)	44	(112)	-	(112)
Changes in economic and health care assumptions	1,299	1,115	185	-	185
Changes in law	19	19	-	1	1
Net changes	2,134	2,703	(569)	(37)	(606)
As of January 1, 2011	$ 43,993	$ 47,245	$ (3,252)	$ 344	$ (2,908)
HI - Part A *(Note 23)*					
As of January 1, 2010	$ 14,408	$ 17,090	$ (2,683)	$ 304	$ (2,378)
Reasons for change					
Change in the valuation period	611	723	(112)	(32)	(143)
Change in projection base	(427)	103	(531)	(1)	(531)
Changes in the demographic assumptions	(151)	(40)	(112)	-	(112)
Changes in economic and health care assumptions	664	479	185	-	185
Changes in law	-	-	-	-	-
Net changes	696	1,265	(569)	(32)	(602)
As of January 1, 2011	$ 15,104	$ 18,356	$ (3,252)	$ 272	$ (2,980)
SMI - Part B *(Note 23)*					
As of January 1, 2010	$ 17,737	$ 17,737	$ -	$ 76	$ 76
Reasons for change					
Change in the valuation period	807	807	-	(16)	(16)
Change in projection base	(552)	(552)	-	12	12
Changes in the demographic assumptions	123	123	-	-	-
Changes in economic and health care assumptions	806	806	-	-	-
Changes in law	19	19	-	1	1
Net changes	1,203	1,203	-	(4)	(4)
As of January 1, 2011	$ 18,940	$ 18,940	$ -	$ 71	$ 71
SMI - Part D *(Note 23)*					
As of January 1, 2010	$ 9,715	$ 9,715	$ -	$ 1	$ 1
Reasons for change					
Change in the valuation period	534	534	-	(1)	(1)
Change in projection base	(90)	(90)	-	-	-
Changes in the demographic assumptions	(39)	(39)	-	-	-
Changes in economic and health care assumptions	(170)	(170)	-	-	-
Changes in law	-	-	-	-	-
Net changes	234	234	-	-	-
As of January 1, 2011	$ 9,950	$ 9,950	$ -	$ 1	$ 1

Totals do not necessarily equal the sum of the rounded components.
The accompanying "Notes to the Financial Statements" are an integral part of these statements

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NOTES TO THE PRINCIPAL FINANCIAL STATEMENTS FOR THE YEARS ENDED SEPTEMBER 30, 2011 AND 2010

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 eleven 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 Officer (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 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 250 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.

Use of Estimates in Preparing Financial Statements

Preparation of financial statements in accordance with accounting principles generally accepted in the United States are based on the selection of accounting policies and the application of significant accounting estimates, some of which require management to make significant assumptions. Further, the estimates are based on current conditions that may change in the future. Actual results could differ materially from the estimated amounts. The financial statements include information to assist in understanding the effect of changes in assumptions to the related information.

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.

The Department 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.

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

Reclassifications and Adjustments

Certain FY 2010 balances have been reclassified to conform to FY 2011 financial statement presentations, the effects of which are immaterial. Also during 2011, the Department implemented a consolidated reporting solution. As a result, immaterial balances were reclassified in both the Statement of Changes in Net Position and the Statement of Budgetary Resources.

Earmarked Funds

Earmarked funds are financed by specifically identified revenues, often supplemented by other 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. 74-271 of 1935, 49 Stat. 620, now codified as 42 U.S.C. Ch 7, Section 1895i, 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) is 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 (Ch 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 self-employment 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 is 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 generally 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. 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, and cost report audits. In addition, the Department educates 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 user fees. 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).

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.

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 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 and grants to assist the applicant to meet State solvency requirements. 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 federal legislation and State solvency and reserve requirements. These program awards are to be made no later than July 1, 2013. There was no loan activity in FY 2011.

- *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 researching the 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 results when HHS provides a good or service to another entity and 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 should result in no profit or loss for the HHS. 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 revenue receipts by federal agencies are processed through the Treasury 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-in/out Without Reimbursement to other government agencies on the HHS Consolidated Statement of Changes in Net Position.

Non-Exchange Revenue

Non-exchange revenue results 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 separately reported in the Consolidated Statement of Changes in Net Position. Employment tax revenue collected under *FICA* and *SECA* is considered non-exchange 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 are identifiable to the HHS and directly attributable to the Department's operations and 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.

Intra-governmental Transactions and Relationships

Intra-governmental transactions are transactions between federal entities, meaning both the buyer and seller are federal entities. Transactions with the public are transactions in which either the buyer or seller of the goods or services is a non-federal entity.

If a federal entity purchases goods or services from another federal entity and sells them to the public, the exchange revenue is classified as with the public, but the related costs would be classified as intra-governmental. The purpose of the classifications is to enable the federal government to provide consolidated financial statements, and not to match public and intra-governmental revenue with costs incurred to produce public and intra-governmental revenue.

In the course of operations, the HHS has relationships and financial transactions with numerous federal agencies. The more prominent of these relationships 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 assets held by the reporting entity, but not available for use. HHS has non-entity assets that are comprised of delinquent child support payments for the Child Support Enforcement Program, which are withheld from federal tax refunds, and interest accrued on over-payments 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

In accordance with guidance set forth in OMB Circular A-136, the HHS 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 the FDA. Penalties are assessed by the FDA for violations in areas such as illegally manufactured, marketed, and distributed animal food and drug products. The CDC custodial activity consists of the collection 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. Sections 1817 and 1841 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 for the Trust Funds and a corresponding 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 semi-annually (June and December) by Treasury and at fiscal yearend 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- 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 provide additional funding to States that experience shortfalls in their Children's Health Insurance Programs (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 on public receivables. Intra-governmental accounts receivable result from the provision of reimbursable work to other federal agencies; no allowance for uncollectible amounts is established as they are considered fully collectible. Accounts Receivable, Net from the public is primarily composed of provider and beneficiary over-payments, Medicare Prescription Drug over-payments, Medicare premiums, State phased-down contributions, and Medicaid over-payments and audit disallowances.

Accounts Receivable, Net from the public 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 have 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 Funds (SSFs) 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 SSF's inventories and using the moving average valuation method for the NIH SSF's 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 H5N1 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 H5N1.

General Property, Plant, and Equipment, Net

The General Property, Plant, and Equipment (PP&E), Net 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 presented 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, is 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 fund accounts is $500 thousand. Costs below the threshold levels are expensed. 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 IHS 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; (e) permanent indefinite appropriation; and (f) 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 the 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. Intra-governmental 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.

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 non-contributory 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 three percent of employee contributions dollar for dollar. Each dollar of the employee's next two percent of basic pay is matched at fifty 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 Statement of Social Insurance (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 May 13, 2011. 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 2011*. 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

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 $138 billion to the HHS from 2009 through 2021, to fund Health Information Technology, Comparative Effectiveness Research, Prevention and Wellness, Scientific Research, Social Services, and Medicaid relief to the States.

Affordable Care Act

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/.

Under the *Affordable Care Act*, the HHS was authorized to execute several new programs, which include: Pre-existing Condition Insurance Plan Program; Early Retiree Reinsurance Program; and the Consumer Operated and Oriented Plan (CO-OP) Program. A brief description of these programs and their impact on the financial statements is presented below.

Pre-existing Condition Insurance Plan Program

This program 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. The HHS recognized a liability at September 30, 2011, 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, 2011, for anticipated reimbursement requests. The program is scheduled to terminate on January 1, 2014.

Consumer Operated and Oriented Plan (CO-OP) Program

The CO-OP Program was established to foster the creation of qualified non-profit 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 organizations applying to become qualified, non-profit 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*. The *Department of Defense and Full-Year Continuing Appropriations Act of 2011 (P.L. 112-10)* included a $2.2 billion rescission of the CO-OP budget authority. As of September 30, 2011, HHS does not award any loans or grants, and currently has no liability under this program. The loans and grants must be awarded before July 1, 2013.

Note 2. Entity and Non-Entity Assets

(in Millions)	2011	2010
Intra-governmental:		
Fund Balance with Treasury	$ 11	$ 19
Accounts receivable	13	6
Total Intra-governmental	24	25
Accounts receivable	16	21
Total Non-Entity Assets	40	46
Total Entity Assets	532,840	563,693
Total Assets	$ 532,880	$ 563,739

Note 3. Fund Balance with Treasury

(in Millions)	2011	2010
Fund Balance with Treasury		
Trust Funds	$ 6,370	$ 2,265
Revolving Funds	1,175	954
Appropriated Funds	158,927	177,852
Other Funds	383	1,164
Total	$ 166,855	$ 182,235
Status of Fund Balance with Treasury		
Unobligated Balance		
Available	$ 44,434	$ 48,880
Unavailable	7,367	10,445
Obligated Balance not yet Disbursed	178,174	175,361
Non-Budgetary Fund Balance with Treasury	(63,120)	(52,451)
Total	$ 166,855	$ 182,235

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 $19.0 billion and $24.4 billion as of September 30, 2011 and September 30, 2010, 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 2011, the HHS received $28.9 billion in direct appropriations under the *Affordable Care Act*, of which $15.3 billion is restricted for future use.

The Non-Budgetary FBWT negative balances reported for September 30, 2011, and 2010, are primarily due to CMS Medicare Trust Funds temporarily precluded from obligation.

Note 4. Investments, Net

(in Millions)	2011				
	Cost	Amortized (Premium) Discount	Interest Receivable	Investments, Net	Market Value Disclosure
Intra-governmental Securities					
Non-Marketable: Par Value	$ 316,386	$ -	$ 3,586	$ 319,972	$ 319,972
Non-Marketable: Market-Based	5,552	(111)	30	5,471	5,471
Total, Intra-governmental	$ 321,938	$ (111)	$ 3,616	$ 325,443	$ 325,443

(in Millions)	2010				
	Cost	Amortized (Premium) Discount	Interest Receivable	Investments, Net	Market Value Disclosure
Intra-governmental Securities					
Non-Marketable: Par Value	$ 350,457	$ -	$ 4,046	$ 354,503	$ 354,503
Non-Marketable: Market-Based	5,419	(72)	32	5,379	5,379
Total, Intra-governmental	$ 355,876	$ (72)	$ 4,078	$ 359,882	$ 359,882

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, 2013, through June 30, 2026, with interest rates ranging from 2.5 percent to 6.5 percent. Medicare Non-Marketable: Par Value Certificates of Indebtedness mature on June 30, 2012, with an interest rate of 1.875 percent.

Securities held by the Vaccine Injury Compensation Trust Fund will mature in fiscal years 2011 through 2018. The Market-Based Notes paid from 3.125 percent to 4.75 percent during October 1, 2010 to September 30, 2011 and 3.125 percent to 5.0 percent during October 1, 2009 to September 30, 2010. 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, 2011, yielded from 0.02 percent to 0.22 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, 2011, 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)	2011 Accounts Receivable Principal	Interest Receivable	Penalties, Fines, & Admin Fees Receivable	Accounts Receivable, Gross	Allowance	Net HHS Receivables
Intra-governmental						
Entity	$ 1,007	$ -	$ -	$ 1,007	$ -	$ 1,007
Non-Entity	13	-	-	13	-	13
Total	$ 1,020	$ -	$ -	$ 1,020	$ -	$ 1,020
With the Public						
Entity						
Medicare	$ 8,920	$ -	$ -	$ 8,920	$ (1,434)	$ 7,486
Other	3,905	10	3	3,918	(512)	3,406
Non-Entity	34	5	-	39	(23)	16
Total	$ 12,859	$ 15	$ 3	$ 12,877	$ (1,969)	$ 10,908

(in Millions)	2010 Accounts Receivable Principal	Interest Receivable	Penalties, Fines, & Admin Fees Receivable	Accounts Receivable, Gross	Allowance	Net HHS Receivables
Intra-governmental						
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

Accounts receivable are composed of various program related over-payments 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 $3.8 billion ($1.4 billion in FY 2010) consists of amounts due to CMS after completion of the Part D payment reconciliation for CY 2010 in the amount of $2.2 billion and the Coverage Gap Discount in the amount of $1.6 billion.

Note 6. Inventory and Related Property, Net

(in Millions)	2011	2010
Inventory Held for Sale:		
Inventory Held for Current Sale	$ 10	$ 34
Operating Materials and Supplies:		
Operating Materials and Supplies Held for Use	451	15
Operating Materials and Supplies Reserved for Future Use	-	282
Total Operating Materials and Supplies	451	297
Stockpile Materials Held for Emergency or Contingency	6,085	5,746
Inventory and Related Property, Net	**$ 6,546**	**$ 6,077**

Note 7. General Property, Plant, and Equipment, Net

(in Millions)	Depreciation Method	Estimated Useful Lives	2011 Acquisition Cost	2011 Accumulated Depreciation	2011 Net Book Value
Land & Land Rights	-	-	$ 52	$ -	$ 52
Construction in Progress	-	-	740	-	740
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	5,592	(2,125)	3,467
Equipment	Straight Line	3-20 Yrs	1,785	(954)	831
Internal Use Software	Straight Line	5-10 Yrs	1,123	(660)	463
Assets Under Capital Lease (Note 15)	Straight Line	1-20 Yrs	133	(56)	77
Leasehold Improvements	Straight Line	*Life of Lease	50	(23)	27
Totals			**$ 9,475**	**$ (3,818)**	**$ 5,657**

(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 (Note 15)	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**

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

Note 8. Advances

(in Millions)	2011	2010
Intra-governmental		
Advances to Other Federal Entities	$ 29	$ 99
With the Public		
Travel Advances & Emergency Employee Salary Advances	2	3
Other	16,088	1,309
Total With the Public	**$ 16,090**	**$ 1,312**

Advances with the public primarily consist of advance payments issued for the Medicare Advantage and Prescription Drug plans on September 30, 2011, in the amount of $14,889 million for services that will be provided in FY 2012 ($5,220 million from the HI Trust Fund, $4,820 million from the SMI Trust Fund, and $4,849 million from Medicare Prescription Drug Program).

Note 9. Liabilities Not Covered by Budgetary Resources

(in Millions)	2011	2010
Intra-governmental		
Accrued Payroll and Benefits	$ 58	$ 61
Other	974	890
Total Intra-governmental	1,032	951
Accounts Payable	-	1
Federal Employee and Veterans' Benefits (Note 11)	10,219	9,985
Accrued Payroll and Benefits	576	554
Contingencies and Commitments (Note 14)	3,623	6,079
Other	1,352	56
Total Liabilities Not Covered by Budgetary Resources	$ 16,802	$ 17,626
Total Liabilities Covered by Budgetary Resources	88,115	81,587
Total Liabilities	**$ 104,917**	**$ 99,213**

Note 10. Entitlement Benefits Due and Payable

(in Millions)	2011	2010
Medicare	$ 54,292	$ 45,007
Medicaid	26,069	27,215
Other	521	490
Totals	**$ 80,882**	**$ 72,712**

Medicare benefits payable consists of a $47.7 billion estimate ($39.7 billion in FY 2010) of Medicare services incurred, but not paid as of September 30, 2011, calculated by the CMS Office of the Actuary.

Medicare Advantage and Prescription Drug Program benefits payable consists of $1.9 billion in FY 2011 ($2.4 billion in FY 2010) for amounts owed to plans relating to risk and other payment-related adjustments, $2.1 billion in FY 2011 ($0.9 billion in FY 2010) owed to plans after the completion of the Prescription Drug payment reconciliation, and $0.1 billion in FY 2011 ($0.1 billion in FY 2010) 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 $2.6 billion estimate ($1.9 billion in FY 2010) of payments to plan sponsors of retiree prescription drug coverage incurred but not paid as of September 30, 2011. As part of the *Medicare Modernization Act*, 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 $26.1 billion as of September 30, 2011 ($27.2 billion in FY 2010) 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 $1.1 billion ($4.0 billion in FY 2010). An estimated CHIP benefits payable of $0.5 billion has been recorded as of September 30, 2011, ($0.4 billion in FY 2010) 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)	2011	2010
With the Public		
Liabilities Not Covered by Budgetary Resources		
PHS Commissioned Corp Pension Liability	$ 9,365	$ 9,075
PHS Commissioned Corp Post-retirement Health Benefits	585	651
Workers' Compensation Benefits (Actuarial *FECA* Liability)	269	259
Total, Federal Employee and Veterans' Benefits	**$ 10,219**	**$ 9,985**

Public Health Service (PHS) Commissioned Corps

The HHS administers the PHS Commissioned Corps Retirement System for 6,426 active duty officers and 6,036 retiree annuitants and survivors. As of September 30, 2011, the actuarial accrued liability for the retirement benefit plan was $10.0 billion, of which $0.6 billion was for non-Medicare coverage of the Post Retirement Medical Plan.

On October 14, 2008, the FASAB issued 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 2011 and 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 cashflow. A single discount rate

may be used for all the projected cashflows, 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, 2011, and September 30, 2010, were:

	2011	2010
Interest on federal securities	5.03 percent	5.16 percent
Annual basic pay scale increase	3.22 percent	3.25 percent
Annual inflation	2.47 percent	2.50 percent

The following shows key valuation results as of September 30, 2011, and 2010, 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, 2011, and actuarial assumptions. The September 30, 2011, valuation includes an increase in liabilities of $224 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 the use of historical average rates to prevent the undue influence of current or near term rates.

(in Millions)	2011	2010
Beginning Liability Balance	$ 9,726	$ 9,436
Expense		
Normal Cost	233	235
Interest on the liability balance	479	527
Actuarial (Gain)/Loss		
From experience	(154)	(101)
From assumption changes		
Change in discount rate assumption	155	850
Change in inflation/salary increase assumption	(46)	(720)
Change in Others	(37)	(106)
Net Actuarial (Gain)/Loss	(82)	(77)
Total expense	630	685
Less amounts paid	(406)	(395)
Ending Liability Balance	**$ 9,950**	**$ 9,726**

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, 2011 and September 30, 2010 appear below.

FY 2011	FY 2010
3.535% in Year 1	3.653% in Year 1
4.025% in Year 2 and thereafter	4.300% 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
2011	N/A	N/A
2012	2.10%	3.07%
2013	2.53%	3.62%
2014	1.83%	3.66%
2015	1.93%	3.73%
2016	2.00%	3.73%

Note 12. Accrued Grant Liability

(in Millions)	2011	2010
Estimated Accrual for Amounts Due to Grantees	$ 23,735	$ 24,406
Offsetting Grant Advances	(19,250)	(20,202)
Net Grant Liability	**$ 4,485**	**$ 4,204**

Note 13. Other Liabilities

	2011		2010	
(in Millions)	*Intra-governmental*	*With the Public*	*Intra-governmental*	*With the Public*
Accrued Payroll & Benefits	$ 107	$ 924	$ 139	$ 907
Advances from Others	292	84	591	369
Deferred Revenue	-	456	-	409
Capital Lease Liability (Note 15)	66	21	72	22
Custodial Liabilities	822	30	745	21
Other	(187)	1,897	25	1,354
Consolidated HHS Totals	**$ 1,100**	**$ 3,412**	**$ 1,572**	**$ 3,082**

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)	2011	2010
Medicaid Audit and Program Disallowances	$ 3,016	$ 5,391
Vaccine Injury Compensation Program	607	688
Total Contingencies	**$ 3,623**	**$ 6,079**

Medicaid Audit and Program Disallowances

The Medicaid amount for FY 2011 of $3.0 billion ($5.4 billion in FY 2010) consists of Medicaid audit and program disallowances of $1.0 billion ($0.9 billion in FY 2010) and of $2.0 billion ($4.5 billion in FY 2010) 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 $0.6 billion ($0.7 billion in FY 2010) VICP liability represents the estimated future payment value of injury claims outstanding for VICP as of September 30, 2011.

Obligations Related to Canceled 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 canceled pursuant to the *National Defense Authorization Act of 1991 (P.L. 101-150)*. The total payments related to canceled appropriations are estimated at $1.1 billion and $1.3 billion as of September 30, 2011, and 2010, 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 6,683 cases (7,833 in FY 2010) remaining on appeal as of September 30, 2011. In FY 2011, a total of 821 new cases were filed (1,384 in FY 2010). The PRRB rendered decisions on 122 cases in FY 2011 (144 in FY 2010); and 1,863 additional cases (1,395 in FY 2010) 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)	2011	2010
Land and Building	$ 133	$ 132
Accumulated Amortization	(56)	(52)
Assets under Capital Lease	$ 77	$ 80

Future Minimum Payments

(in Millions)	2011	2010
Year 1	$ 10	$ 11
Year 2	10	10
Year 3	10	10
Year 4	10	10
Year 5	11	11
Later Years	80	91
Total Minimum Lease Payments	131	143
Imputed Interest	(44)	(49)
Total Capital Lease Liability	**$ 87**	**$ 94**

Operating Leases

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-cancelable 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)	2011	2010
Year 1	$ 553	$ 383
Year 2	546	379
Year 3	537	377
Year 4	379	355
Year 5	326	377
Later Years	1,079	1,217
Total Operating Lease Liability	**$ 3,420**	**$ 3,088**

Note 16. Revenue

Consolidated Gross Cost and Earned Revenue by Budget Function Classification

2011

(in Millions)	Education Training & Social Services	Health	Medicare	Income Security	OpDiv Combined Totals	Intra-HHS Eliminations	Consolidated Totals
Intra-governmental							
Gross Cost	$ 122	$ 5,571	$ 868	$ 34	$ 6,595	$ (2,463)	$ 4,132
Earned Revenue	(34)	(3,408)	(18)	(28)	(3,488)	2,336	(1,152)
Net Cost, *Intra-governmental*	$ 88	$ 2,163	$ 850	$ 6	$ 3,107	$ (127)	$ 2,980
With the Public							
Gross Cost	$ 14,450	$ 349,347	$ 536,630	$ 41,040	$ 941,467	$ -	$ 941,467
Earned Revenue	3	(2,837)	(63,475)	(5)	(66,314)	-	(66,314)
Net Cost, *With the Public*	$ 14,453	$ 346,510	$ 473,155	$ 41,035	$ 875,153	$ -	$ 875,153
Total							
Gross Cost	$ 14,572	$ 354,918	$ 537,498	$ 41,074	$ 948,062	$ (2,463)	$ 945,599
Earned Revenue	(31)	(6,245)	(63,493)	(33)	(69,802)	2,336	(67,466)
Total Net Cost of Operations	**$ 14,541**	**$ 348,673**	**$ 474,005**	**$ 41,041**	**$ 878,260**	**$ (127)**	**$ 878,133**

2010

(in Millions)	Education Training & Social Services	Health	Medicare	Income Security	OpDiv Combined Totals	Intra-HHS Eliminations	Consolidated Totals
Intra-governmental							
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, *Intra-governmental*	$ 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
Total							
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)
Total Net Cost of Operations	**$ 15,393**	**$ 351,782**	**$ 447,162**	**$ 42,467**	**$ 856,804**	**$ (76)**	**$ 856,728**

Exchange Revenue

The HHS recognizes its revenue from exchange transactions when goods and services are provided. Total exchange revenue was $67 billion and $64 billion through September 30, 2011, and 2010, 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 17. Apportionment Categories of Obligations Incurred and Undelivered Orders

(in Millions)	2011 Direct	2011 Reimbursable	2011 Total
Category A (Distributed by Quarter)	$ 94,512	$ 6,960	$ 101,472
Category B (Restricted and Distributed by Activity)	634,981	422	635,403
Exempt from Apportionment	526,657	-	526,657
Total Obligations Incurred	**$ 1,256,150**	**$ 7,382**	**$ 1,263,532**

(in Millions)	2010 Direct	2010 Reimbursable	2010 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**

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*.

Undelivered Orders include obligations that have been issued but are not yet drawn down, and goods and services ordered that have not been received. HHS reported $95.1 billion of budgetary resources obligated for undelivered orders as of September 30, 2011, and $99.9 billion as of September 30, 2010.

Note 18. 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, for other new obligations in the year of appropriation and for adjustments to valid obligations for five subsequent years.

All Trust Fund receipts collected by 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 become available for obligation as needed. The entire Trust Fund balances in the amount of $260.7 billion as of September 30, 2011, and $300.5 billion as of September 30, 2010, 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 gift. 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 19. Explanation of Differences between the Statement of Budgetary Resources (SBR) and the Budget of the United States Government

The *FY 2012 President's Budget*, with actual amounts for FY 2011, has not yet been published, and, therefore, no comparisons can be made between FY 2011 amounts presented in the SBR with amounts reported in the Actual column of the *President's Budget*. The *FY 2013 President's Budget* is expected to be released in February 2012, and may be obtained from the Office of Management and Budget's Web site http://www.whitehouse.gov/omb/budget, or from the Government Printing Office.

The HHS reconciled the amounts of the FY 2010 column on the SBR to the actual amounts for FY 2010 from the Appendix in the *FY 2012 President's Budget* for budgetary resources, obligations incurred, offsetting receipts and net outlays (gross outlays less offsetting collections) as presented below.

	2010			
(in Millions)	Budgetary Resources	Obligations Incurred	Distributed Offsetting Receipts	Net Outlays (Gross Outlays less Offsetting Collections)
Statement of Budgetary Resources	$ 1,258,930	$ 1,199,605	$ 303,977	$ 1,158,084
Unobligated Balances – Not Available	(3,430)	-	-	-
Other	(1,102)	(610)	65	117
Budget of the U.S. Government	**$ 1,254,398**	**$ 1,198,995**	**$ 304,042**	**$ 1,158,201**

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 include expired authorities which are appropriately reported on the SBR but not included in the *President's Budget*.

Note 20. 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 SMI 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 generally 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 $110.50 from October 1, 2010, through December 31, 2010, and $115.40 for January 1, 2011, through September 30, 2011. However, as a result of the zero cost-of-living adjustment (COLA) for Social Security beneficiaries effective for January 1, 2011, about three-fourths of Part B enrollees are "held harmless" and are not required to pay the higher premium amount in 2011, as in prior years. New beneficiaries enrolling on January 1, 2011, 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 $115.40. (Premiums for dual-eligible beneficiaries are paid by the State Medicaid programs.)

	2011		
(in Millions)	Medicare	Other	Total
Balance Sheet as of September 30, 2011			
Fund Balance with Treasury	$ 6,130	$ 1,513	$ 7,643
Investments	319,972	3,377	323,349
Other Assets	23,604	1,060	24,664
Total Assets	$ 349,706	$ 5,950	$ 355,656
Entitlement Benefits Due and Payable	$ 54,292	$ -	$ 54,292
Other Liabilities	2,217	1,549	3,766
Total Liabilities	56,509	1,549	58,058
Unexpended Appropriations	4,335	(99)	4,236
Cumulative Results of Operations	288,862	4,500	293,362
Total Liabilities and Net Position	$ 349,706	$ 5,950	$ 355,656
Statement of Net Cost For the Period Ended September 30, 2011			
Gross Program Costs	$ 537,498	$ 302	$ 537,800
Less: Earned Revenues	63,493	1,349	64,842
Net Cost of Operations	$ 474,005	$ (1,047)	$ 472,958
Statement of Changes in Net Position			
For the Period Ended September 30, 2011			
Net Position Beginning of Period	$ 315,223	$ 3,786	$ 319,009
Non-Exchange Revenue	210,169	377	210,546
Other Financing Sources	241,810	(809)	241,001
Net Cost of Operations	(474,005)	1,047	(472,958)
Change in Net Position	(22,026)	615	(21,411)
Net Position End of Period	**$ 293,197**	**$ 4,401**	**$ 297,598**

(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**

Note 21. Statement of Social Insurance (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. As with all of the assumptions underlying the Trustees' financial projections, the Medicare-specific assumptions are reviewed annually and updated based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. Such a review is currently in progress. Please see Note 22 below for further information on the 2010-2011 Medicare Technical Review Panel (the Panel).

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*, which is referred to collectively as the *Affordable Care Act*. The *Affordable Care Act* improves the financial outlook for Medicare substantially; however, the full effects of some of the law's provisions on Medicare are not known at this time, with the result that the projections are very uncertain, 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 providers, as mandated by the *Affordable Care Act*. Without fundamental change in the current delivery system, these

adjustments would probably not be viable indefinitely. Please see Note 22 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 May 13, 2011, 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 transfers from the general fund of the Treasury 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 1 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 expenditure 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 expenditure 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 expenditures and of all future non-interest income for the next 75 years. The SOSI also presents the net present values of future net cashflows, which are calculated by subtracting the actuarial present value of future expenditures from the actuarial present value of future income. The HI Trust Fund is expected to have an actuarial deficit indicating 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, the SOSI also sets forth the same 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 22 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 May 13, 2011. In addition, the estimates depend on many economic, demographic, and health care-specific assumptions, including changes in per beneficiary health care cost, wages, and the consumer price index (CPI), fertility rates, mortality rates, immigration rates, and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period. The assumed growth rates for per beneficiary health care costs vary throughout the projection period.

The most significant underlying assumptions, 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 2011 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2011. 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 Web site at: http://www.cms.hhs.gov/CFOReport/.

Table 1: Significant Assumptions and Summary Measures Used for the Statement of Social Insurance 2011

					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]*
2011	2.07	895,000	766.5	2.9	4.1	1.2	2.7	2.3	3.7	3.1	1.5
2020	2.05	1,195,000	707.8	1.1	3.9	2.8	2.1	3.3	5.5	6.5	2.9
2030	2.02	1,115,000	648.7	1.2	4.0	2.8	2.2	4.6	4.9	5.7	2.9
2040	2.00	1,070,000	596.6	1.2	4.0	2.8	2.2	4.9	4.5	5.4	2.9
2050	2.00	1,050,000	550.8	1.2	4.0	2.8	2.2	3.9	4.1	5.1	2.9
2060	2.00	1,040,000	510.5	1.1	3.9	2.8	2.1	3.7	4.1	4.8	2.9
2070	2.00	1,030,000	474.9	1.1	3.9	2.8	2.1	3.6	3.9	4.6	2.9
2080	2.00	1,030,000	443.2	1.2	4.0	2.8	2.1	3.3	3.7	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 projections presented in the Statement of Social Insurance are based on various economic and demographic assumptions. The values for each of these assumptions move from recently experienced levels or trends toward long-range ultimate values. These ultimate values assumed for the current year and prior four years are summarized in 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 2011-2007

					Annual Percentage Change in:						
								Per Beneficiary Cost[8]			
									SMI		
	Fertility Rate[1]	Net Immigration[2]	Mortality Rate[3]	Real-Wage Differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real Interest Rate[9]
FY 2011	2.0	1,030,000	443.2	1.2	4.0	2.8	2.1	3.3	3.7	4.4	2.9
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

[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 2008-2011, 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 2008-2011, the assumption presented is the value assumed in the year 2080. For 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 2011 bid submissions by the private plans offering this coverage, together with actual data on beneficiary enrollment and program spending through 2010, 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 22. *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 law's provisions on Medicare are not known at this time, with the result that the projections are very uncertain, 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 could 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. The feasibility of such sustained improvements is debatable. Without fundamental changes in current health care delivery systems and payment mechanisms, the Medicare price constraints would probably become unworkable, in which case 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 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 very 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.

Because knowledge of the potential long-range effects of the productivity adjustments, delivery and payment innovations, and certain other aspects of the *Affordable Care Act* is so limited, in August 2010, the HHS Secretary, working on behalf of the Board of Trustees, established an independent panel of expert actuaries and economists to review the assumptions and methods used by the Trustees to make projections of the financial status of the Trust Funds. The members of the Panel were selected in October 2010 and began their deliberations in November. They were asked to focus their immediate attention on the long-range Medicare expenditure growth rate assumption. In its interim report, the Panel found that the long-range Medicare growth rate assumptions used in the 2010 report for the current-law projections were not unreasonable in light of the provisions of the *Affordable Care Act*. The Panel recommended the continued use of a supplemental analysis, similar to the illustrative alternative projection in the 2010 Trustees Report, for the purpose of illustrating the higher Medicare costs that would result if the reduction in physician payment rates and the productivity adjustments to most other provider payment updates are not fully implemented as required under current law.[5]

The Panel members noted the extreme difficulty involved in developing long-range Medicare cost growth assumptions, due to the many uncertainties that surround not only the long-term evolution of the U.S. health care system but also the system's interaction with the provisions of the *Affordable Care Act*. The trustees will continue their efforts, with the assistance of the Panel, to develop possible improvements to the cost growth assumptions underlying the 2010 Medicare Trustees Report.

[5]The *Interim Report of the Technical Review Panel on the Medicare Trustees Report* is available at http://aspe.hhs.gov/health/medpanel/2010/interim1103.shtml.

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, an almost 30 percent reduction in Medicare payment rates for physician services in January 2012 is assumed to be implemented as required under current law, despite the virtual certainty that Congress will continue to override this reduction. 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, when possible, the potential understatement of Medicare costs and projection results. This alternative scenario assumes that the productivity adjustments are gradually phased out over the 16 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)	*Alternative scenario[1, 2] (Unaudited)*
Income		
Part A	$15,104	$15,104
Part B	18,940	28,744
Part D	9,950	9,950
Expenditures		
Part A	18,356	23,640
Part B	18,940	28,744
Part D	9,950	9,950
Income less expenditures		
Part A	(3,252)	(8,536)
Part B	-	-
Part D	-	-

[1]These amounts are not presented in the 2011 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 sizable improvement in the financial outlook for Medicare compared to the laws 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 29 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 assumed 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 52 percent higher than the current-law projections.

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 23. Statement of Changes in Social Insurance Amounts (Unaudited)

The Statement of Changes in Social Insurance Amounts (SCSIA) reconciles the change (between the current valuation and the prior valuation) in the (1) present value of future income (excluding interest) for current and future participants; (2) present value of future expenditures for current and future participants; (3) present value of future non-interest income less future expenditures for current and future participants (the open group measure) over the next 75 years; (4) the assets of the combined Medicare Trust Funds; and (5) present value of future non-interest income less future expenditures for current and future participants over the next 75 years plus the assets of the combined Medicare Trust Funds. The reconciliation identifies several components of the change that are significant and provides reasons for the changes.

Because of the financing mechanism for Parts B and D of Medicare, any change to the estimated expenditures has the same effect on estimated total income, and vice versa. Therefore, any change has no impact on the future net cashflow. In order to enhance the presentation, the changes in the present values of income and expenditures are presented separately.

The five changes considered in the Statement of Changes in Social Insurance Amounts are, in order:

- Changes in the valuation period;
- Changes in the projection base;
- Changes in demographic assumptions;
- Changes in economic and health care assumptions; and
- Changes in law.

All estimates in the table are presented as incremental to the prior change. As an example, the present values shown for demographic assumptions, represent the additional effect that these assumptions have, once the effects from the change in the valuation period and projection base have been considered.

Assumptions Used for the Statement of Changes in Social Insurance Amounts

The present values included in the Statement of Changes in Social Insurance Amounts are for the current and prior years and are based on various economic and demographic assumptions used for the intermediate assumptions in the Trustees Reports for those years. Table 1 of Note 21 summarizes these assumptions for the current year.

Present values as of January 1, 2010, are calculated using interest rates from the intermediate assumptions of the 2010 Trustees Report. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, and demographic assumptions are determined using the interest rates under the intermediate assumptions of the 2010 Trustees Report. Since interest rates are economic assumptions, the estimates of the present values of changes in economic assumptions are presented using the interest rates under the intermediate assumptions of the 2011 Trustees Report.

Changes in the Valuation Period

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2010-84) to the current valuation period (2011-85) is measured by using the assumptions for the prior valuation period and applying them, in the absence of any other changes, to the current valuation period. Changing the valuation period removes a small negative net cashflow for 2010 and replaces it with a much larger negative net cashflow for 2085. The present value of future net cashflow (including or excluding the combined Medicare Trust Fund assets at the start of the period) was therefore decreased (made more negative) when the 75-year valuation period changed from 2010-84 to 2011-85. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming all values projected in the prior valuation for the year 2010 are realized. The change in valuation period decreased the level of assets in the combined Medicare Trust Funds.

Changes in the Projection Base

Actual income and expenditures in 2010 were different than what was anticipated when the 2010 Trustees Report projections were prepared. Part A income was lower than estimated and Part A expenditures were higher than anticipated, due to the impacts of the economic recession. Part B total income and expenditures were lower than estimated based on actual experience. For Part D, actual income and expenditures were both slightly lower than prior estimates. The net impact of the Part A, B, and D projection-base changes is a slight decrease in the future net cashflow. Actual experience of the Medicare Trust Funds between January 1, 2010 and January 1, 2011 is incorporated in the current valuation and is slightly more than projected in the prior valuation.

Changes in Demographic Assumptions

The demographic assumptions used in the Medicare projections are the same as those used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (SSA).

The ultimate demographic assumptions for the current valuation period are the same as those for the prior valuation period. However, the starting demographic values were changed.

- The inclusion of final mortality data for 2007 results in lower starting death rates and faster near-term declines in death rates at older ages for the current valuation period.
- Revised historical estimates of net other immigration and final data on legal immigration for 2009 are also used in the current valuation. Based on estimates from the Department of Homeland Security for 2007 and 2008, and due to the weak U.S. economy since 2008, net other immigration levels for 2007 – 2010 are assumed negative for the current valuation period. These levels are significantly lower than the positive estimates used in the prior valuation period.
- Birth rates projected through 2026 are slightly lower in the current valuation; preliminary birth data 2008 and 2009 was lower than expected for the prior valuation.

These changes have little impact on the present values of future expenditures and income.

Changes in Economic and Health Care Assumptions

The economic assumptions used in the Medicare projections are the same as those used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (SSA).

The ultimate economic assumptions for the current valuation period are the same as those for the prior valuation period. However, the starting economic values and near-term economic growth rate assumptions were changed. The economic recovery has been slower than was assumed for the prior valuation period.

- For the current valuation period, HI taxable earnings are considerably lower for the starting year, 2010, than were projected for the prior valuation period. The projected level of taxable earnings grows more slowly through 2017 for the current valuation period.
- Unemployment rates are slightly higher over the first few years of the projection for the current valuation period.
- The interest rates assumed in the short-range period are lower for the current valuation period.

Inclusion of each of these economic revisions decrease the present value of future net cashflow.

The health care assumptions are specific to the Medicare projections. The following health care assumptions were changed in the current valuation.

- Utilization rates for certain hospitals were lowered.
- Components of price updates for hospitals were increased.
- Components of price updates for home health agency services were lowered.
- Slightly lower residual assumptions for certain Part B services in the short-range period.
- Slight refinement in the Part B application of the *Affordable Care Act* multifactor productivity adjustments in the long-range period, which lowers expenditures.
- The utilization assumed for beneficiaries assumed to switch from Medicare Advantage to fee-for-service was lowered.
- The utilization assumed for beneficiaries assumed to switch from fee-for-service to Medicare Advantage was increased.
- Assumed utilization of skilled nursing facility and home health agency services was increased.
- Reduction in the projected growth in prescription drug spending in the U.S.

These changes had a net positive impact on the future net cashflow for total Medicare. For Part A, these changes resulted in a net increase to the present value of both income and expenditures, with an overall increase on the future net cashflow. For Part B, these changes increased the present value of expenditures (and also income). On the other hand, the above-mentioned changes lowered the present value of expenditures (and also income) for Part D.

Changes in Law

Although Medicare legislation was enacted since the prior valuation date, most of the provisions have a negligible impact on the present value of the 75-year income, expenditures, and net cashflow. However, the enacted changes to the physician payment update very slightly increased the present value of both income and expenditures, but had no effect on the 75-year present value of future net cashflow.

Note 24. Reconciliation of Net Cost of Operations (Proprietary) to Budget *(in Millions)*

	2011	2010
Resources Used to Finance Activities:		
Budgetary Resources Obligated		
Obligations Incurred	$ 1,263,532	$ 1,199,605
Spending Authority from Offsetting Collections and Recoveries	(46,369)	(31,221)
Obligations Net of Offsetting Collections and Recoveries	1,217,163	1,168,384
Distributed Offsetting Receipts	(322,724)	(303,977)
Net Obligations	894,439	864,407
Other Resources		
Net Non-Budgetary Resources Used to Finance Activities	458	554
Total Resources Used to Finance Activities	**894,897**	**864,961**
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	10,504	7,249
Resources That Fund Expenses Recognized in Prior Periods	158	3
Budgetary Offsetting Collections and Receipts That Do Not Affect Net Cost of Operations	(921)	(110)
Resources That Finance the Acquisition of Assets or Liquidations of Liabilities	861	903
Other Resources or Adjustments to Net Obligated Resources That Do Not Affect Net Cost of Operations	2,260	1,468
Total Resources Used to Finance Items Not Part of the Net Cost of Operations	12,862	9,513
Total Resources Used to Finance the Net Cost of Operations	**882,035**	**855,448**
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	(3,493)	483
Components Not Requiring or Generating Resources	(409)	797
Total Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period	(3,902)	1,280
Net Cost of Operations	**$ 878,133**	**$ 856,728**

REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

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INVESTMENT IN HUMAN CAPITAL

For the Year Ended September 30, 2011

(in Millions)

Responsibility Segment Program	2011	2010	2009	2008	2007
Administration for Children and Families					
Administration on Developmental Disabilities	$ 11	$ 9	$ 10	$ 8	$ 8
Health Resources and Services Administration					
Scholarships and Loans	761	691	447	400	582
National Institutes of Health					
Research Training and Career Development	1,920	1,915	1,862	1,792	1,756
Totals	**$ 2,692**	**$ 2,615**	**$ 2,319**	**$ 2,200**	**$ 2,346**

Investments in Human Capital are expenses incurred by federal education and training programs for the public, which are intended to maintain or increase national productive capacity. Three operating divisions of the Department conduct education and training programs under this category: Administration for Children and Families (ACF), National Institutes of Health (NIH), and Health Resources and Services Administration (HRSA).

Administration for Children and Families

The ACF is able to estimate Investment in Human Capital for the Administration for Developmental Disabilities (ADD) using existing data collection activities. Under ADD, 41 grants are anticipated to be awarded for Projects of National Significance (PNS). As of September 30, 2011, all of the 41 PNS grants have been awarded for FY 2011. PNS grants are awarded to public or private, non-profit institutions to enhance the independence, productivity, integration and inclusion into the community of people with developmental disabilities. These monies also support the development of national and State policy to serve this community. Grants awarded total $11 million as of September 30, 2011.

Health Resources and Services Administration

The National Health Service Corps (NHSC) is a network of 10,000 primary care providers and 17,000 sites working in communities with limited access to care across the country. To support their service, the NHSC provides clinicians with financial support in the form of loan repayment and scholarships.

To increase the diversity of the health professions workforce and the number of providers working in underserved communities, HRSA makes grant funding to schools, which in turn provide scholarships and low-interest loans to disadvantaged students with financial need. Many of the students who benefit from these programs are from racial and ethnic minorities under-represented in the health workforce, including African Americans, Latinos, and American Indians and Alaska Natives – groups that comprise 25 percent of the U.S. population, but less than 10 percent of many health professionals.

National Institutes of Health

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

INVESTMENT IN RESEARCH AND DEVELOPMENT

As of September 30, 2011

(in Millions)

Responsibility Segments	Basic	Applied	Develop-mental	2011 Total	2010	2009	2008	2007	Grand Total
ACF	$ -	$ 7	$ -	$ 7	$ 9	$ 16	$ 25	$ 16	$ 73
AHRQ	333	-	-	333	263	203	184	198	1,181
CDC	-	457	-	457	465	755	440	563	2,680
FDA	51	-	7	58	48	36	67	40	249
NIH	19,741	13,161	-	32,902	31,342	27,889	27,302	26,131	145,566
Totals	**$ 20,125**	**$ 13,625**	**$ 7**	**$33,757**	**$ 32,127**	**$ 28,899**	**$28,018**	**$ 26,948**	**$149,749**

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

Administration for Children and Families

The ACF oversees research and development programs that contribute to a better understanding of how to improve the economic and social well-being of families and children, so that they may lead healthier and more productive lives.

Agency for Healthcare Research and Quality (AHRQ)

The AHRQ is the lead federal agency charged with improving the quality, safety, efficiency, and effectiveness of health care for all Americans. AHRQ supports health services research that will improve the quality of health care and promote evidence-based decision making.

Centers for Disease Control and Prevention (CDC)

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

Food and Drug Administration (FDA)

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

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

The FDA Research Grants Program is a grants program whose purpose is to assist public and non-public institutions and for-profit organizations to establish, expand, and improve research, demonstration, education, and information dissemination activities concerned with a wide variety of FDA areas.

National Institutes of Health (NIH)

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

REQUIRED SUPPLEMENTARY INFORMATION

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COMBINING STATEMENT OF BUDGETARY RESOURCES

For the Year Ended September 30, 2011

(in Millions)

	CMS					
	Medicare HI	Medicare SMI	Medicaid	CMMI	Other Agency Budgetary Accounts[6]	Agency Combined Totals
Budgetary Resources:						
Unobligated Balance, Brought Forward, Oct 1	$ -	$ -	$ 17,000	$ 5	$ 42,320	$ 59,325
Recoveries of Prior Year Unpaid Obligations	501	347	20,027	-	4,933	25,808
Budget Authority	274,222	236,347	285,985	10,000	462,183	1,268,737
Non-expenditure Transfers, Net, Anticipated & Actual	(142)	(150)	(3,937)	-	3,640	(589)
Temporarily not available pursuant to Public Law	(27)	(32)	-	-	(687)	(746)
Permanently not available (-)	(2)	(1)	(26,680)	-	(10,519)	(37,202)
Total Budgetary Resources	**$ 274,552**	**$ 236,511**	**$ 292,395**	**$ 10,005**	**$ 501,870**	**$ 1,315,333**
Status of Budgetary Resources:						
Obligations Incurred	$ 274,552	$ 236,511	$ 291,883	$ 95	$ 460,491	$ 1,263,532
Unobligated Balances – Available	-	-	-	9,910	34,524	44,434
Unobligated Balances – Not Available	-	-	512	-	6,855	7,367
Total Status of Budgetary Resources	**$ 274,552**	**$ 236,511**	**$ 292,395**	**$ 10,005**	**$ 501,870**	**$ 1,315,333**
Relationship of Obligations to Outlays:						
Obligated Balance, Net	$ 23,422	$ 22,184	$ 27,887	$ -	$ 101,868	$ 175,361
Obligations Incurred, Net (+/-)	274,552	236,511	$ 291,883	95	460,491	1,263,532
Less: Gross Outlays	(265,280)	(234,285)	(272,017)	(11)	(459,856)	(1,231,449)
Less: Recoveries of Prior Year Unpaid Obligations	(501)	(347)	(20,027)	-	(4,933)	(25,808)
Change in Uncollected Customer Payments	-	-	-	-	(3,462)	(3,462)
Obligated Balance, Net, End of Period	32,193	24,063	27,726	84	94,108	178,174
Net Outlays	**$ 237,826**	**$ (61,935)**	**$ 271,185**	**$ 11**	**$ 444,445**	**$ 891,532**

Summary of Other Agency Budgetary Accounts

	Budgetary Resources	Status of Budgetary Resources	Net Outlays
ACF	$ 52,861	$ 52,861	$ 53,267
AoA	1,520	1,520	1,555
AHRQ	407	407	112
CDC	11,585	11,585	10,516
CMS	361,705	361,705	320,334
FDA	3,999	3,999	2,002
HRSA	10,470	10,470	8,764
IHS	6,574	6,574	4,432
NIH	35,643	35,643	34,269
OS	11,587	11,587	5,266
PSC	1,722	1,722	512
SAMHSA	3,797	3,797	3,416
Totals	**$ 501,870**	**$ 501,870**	**$ 444,445**

[6] "Other Agency Budgetary Accounts" includes the budgetary accounts of the 11 HHS agencies other than CMS, as well as the remaining budgetary accounts not reported by CMS under Medicare and Medicaid. This includes budgetary resources of $4.0 billion and net outlays of $3.8 billion for the Vaccine for Children Program which are appropriated to the Medicaid program and transferred to the CDC.

DEFERRED MAINTENANCE

For the Years Ended September 30, 2011, and 2010

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

Category of Asset (in Millions)	Condition	Estimated Cost to Return to Acceptable Condition	
		2011	2010
General PP&E			
Buildings	1 - 4	$ 1,976	$ 1,940
Equipment	3 - 4	13	12
Other Structures	1 - 4	30	34
Total		**$ 2,019**	**$ 1,986**

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

STEWARDSHIP PROPERTY, PLANT, AND EQUIPMENT

As of September 30, 2011

The HHS has Indian Trust Lands that are considered a type of property, plant, and equipment (PP&E) for stewardship reporting purposes. Indian Trust Lands are those lands that do not meet the definition of stewardship land (i.e., land other than those acquired for or used in connection with general [capitalized] PP&E), but have always been held by IHS as separate and distinct, because of the government's long-term trust responsibility. All Trust Lands, when no longer needed by 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.

For the purpose of Statements of Federal Financial Accounting Standards No. 29, *Heritage Assets and Stewardship Land*, heritage assets are any real property assets that are individually listed on the National Register of Historic Places. As of September 30, 2011, IHS has no individually listed properties.

The IHS accountability reports differentiate Indian Trust Land parcels from general PP&E situated thereon. The IHS Trust Land balances are removed from the HHS FY 2011 Balance Sheet and reported as Stewardship Assets - Indian Trust Lands.

The Distribution of Stewardship Assets by Type and Area, as of September 30, 2011, is summarized below:

Distribution of Stewardship Assets by Type and Area

	Indian Trust Lands	
	Number of Sites	Total Hectares
Aberdeen	9	75
Albuquerque	4	4
Bemidji	2	9
Billings	7	48
Navajo	35	255
Oklahoma City	1	2
Phoenix	12	17
Portland	3	1
Tucson	5	12
Total	78	423

SOCIAL INSURANCE

As of September 30, 2011

Medicare, the largest health insurance program in the country, has helped fund medical care for the nation's aged and disabled for over four decades. A brief description of the provisions of Medicare's Hospital Insurance (HI, or Part A) Trust Fund and Supplementary Medical Insurance (SMI, or Parts B and D) Trust Fund is included in this financial report.

The Required Supplementary Information (RSI) contained in this section is based on current law and is presented in accordance with the requirements of the Federal Accounting Standards Advisory Board (FASAB). Included are descriptions of the long-term sustainability and financial condition of the program and a discussion of trends revealed in the data.

RSI material is generally drawn from the *2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare Trust Funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

As was the case with last year's report, the projections shown here incorporate 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*," contained 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 for alternative provider payment mechanisms, health care delivery systems, and other changes intended to improve the quality of health care and reduce its costs to Medicare.

The *Affordable Care Act* improved the financial outlook for Medicare substantially, mainly as a result of permanent price update reductions for most fee-for-service providers, substantial reductions in payments to private health plans, and an increase in the Part A payroll tax rate for high-income earners. 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. These outcomes are far from certain, however. The feasibility of such sustained improvements is debatable. Without fundamental changes in current health care delivery systems and payment mechanisms, the Medicare price constraints would probably become unworkable, in which case 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. However, the effects of some of the law's provisions on Medicare are not known at this time, with the result that the projections are very uncertain, especially in the longer-range future.

As stated previously, the projections in this section are drawn from the annual Medicare Trustees report, which must be based on current law. In addition, the FASAB rules governing the SOSI also require use of projections based on current law. Accordingly, the permanent payment update reductions are assumed to occur in all future years, as required by the *Affordable Care Act*. In addition, an almost 30-percent reduction in Medicare payment rates for physician services is assumed to be implemented in 2012 as required under current law, despite the virtual certainty that Congress will override the reduction.

In view of the factors described above, it is important to note that the actual future costs for Medicare are likely to exceed those shown by the current-law projections. Therefore, 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. At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare Trust Fund projections under this theoretical alternative to current law. No endorsement of the illustrative alternative to current law by the Trustees, CMS, or the Office of the Actuary should be inferred. Additional information on this theoretical alternative to current law is provided in Note 22 in these financial statements, and in an auxiliary memorandum prepared by the CMS Office of the Actuary at the request of the Board of Trustees. Printed copies of the Trustees Report and auxiliary memorandum may be obtained from the CMS Office of the Actuary (410-786-6386) or can be downloaded from http://www.cms.hhs.gov/ReportsTrustFunds/.

ACTUARIAL PROJECTIONS

HI Cashflow as a Percentage of Taxable Payroll

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

Chart 1 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. Prior to the 2006 Trustees Report, the long range increase in average expenditures per beneficiary was assumed to equal growth in per capita gross domestic product (GDP) plus 1 percentage point. Beginning with the 2006 report, the Board of Trustees adopted a refinement of these long-range growth assumptions. The refinement provides a smoother and more realistic transition from current Medicare cost growth rates, which have been significantly above the level of GDP growth, to the ultimate assumed level of GDP plus zero percent for the indefinite future. This same approach was used to establish "baseline" long-range growth rate assumptions for the 2010 Medicare Trustees Report, prior to the incorporation of the provisions in the *Affordable Care Act*.

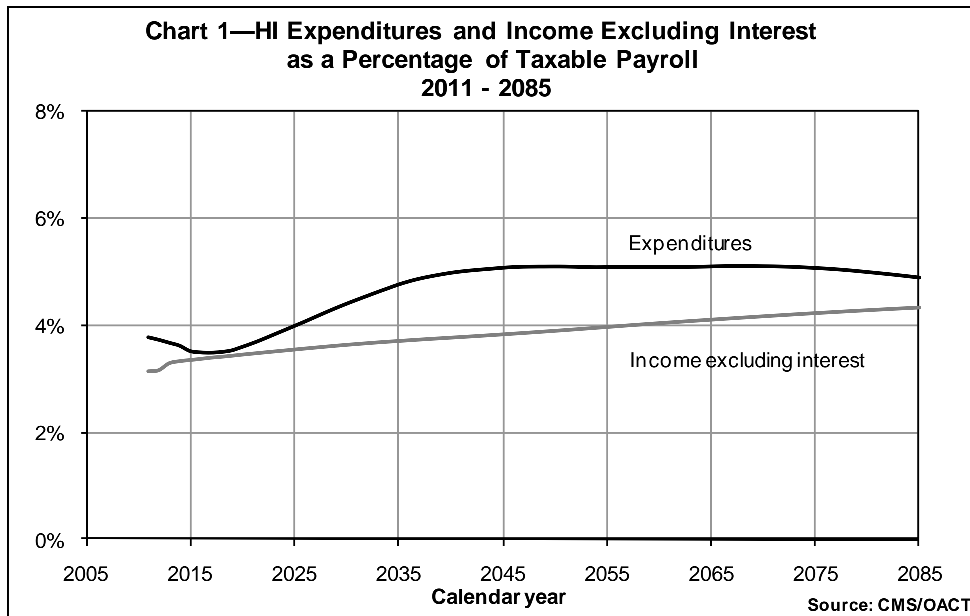
For the 2011 Medicare Trustees Report, the long-range Medicare cost growth assumptions are identical to the ones used by the Trustees in their 2010 report. Under the Office of the Actuary's economic model, in 2035 the pre-*Affordable Care Act* growth rate for all Medicare services is assumed to be about 1.3 percentage points above the rate of GDP growth for that year (before demographic impacts). This differential gradually declines to about 0.8 percentage point in 2055 and to less than 0.3 percentage point in 2085. Compared to a constant "GDP plus 1 percent" assumption, the pre-*Affordable Care Act* baseline growth assumption is initially higher, but subsequently lower.

In order to incorporate the effects of the permanent Medicare price update reductions required by the *Affordable Care Act*, adjustments were made to the per capita growth rates produced by the economic model for Parts A and B[7]. Since all Part A fee-for-service providers are affected, the assumed adjustment in each year is the full update reduction (1.1 percent).

For SMI Part B, only certain provider categories—for example, outpatient hospitals, ambulatory surgical centers, diagnostic laboratories, and most other non-physician services—are affected by the price update reductions. Accordingly, these services are subject to the same assumed long-range growth rate as Part A services. In contrast, Part B physician expenditures per beneficiary are increased at approximately the rate of per capita GDP growth, as required by the sustainable growth rate formula in current law. All other Part B outlays, which constitute an estimated 12.0 percent of total Part B expenditures in 2020, have an assumed average growth rate of per capita GDP plus 1 percent (adjusted by the economic model), as determined for the pre-*Affordable Care Act* "baseline" growth trend.

Based on these projections, the Medicare Trustees apply a formal test of "long-range close actuarial balance." The HI Trust Fund fails this test, as it has for many years.

[7] The price update reductions do not affect Part D, and therefore the growth assumption for this account continues to be based on the pre-*Affordable Care Act* baseline growth of GDP plus 1 percent, as adjusted by the economic model.



Since the standard HI payroll tax rates are not scheduled to change in the future under present law, most payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. Under the *Affordable Care Act*, however, high-income workers will pay an additional 0.9 percent of their earnings above $200,000 (for single workers) or $250,000 (for married couples filing joint income tax returns) in 2013 and later. Because these income thresholds are not indexed, over time an increasing proportion of workers will become subject to the additional HI tax rate, and consequently total HI payroll tax revenues will increase steadily as a percentage of taxable payroll. Income from taxation of benefits will also increase as a greater proportion of Social Security beneficiaries become subject to such taxation, since the income thresholds determining taxable benefits are not indexed for price inflation. Thus, as Chart 1 shows, the income rate is expected to gradually increase over current levels.

As indicated in Chart 1, the cost rate will initially decline as the economy recovers from the recent recession and as the savings provisions of the *Affordable Care Act* take effect. Subsequently, the cost rate will increase significantly due to retirements of those in the baby boom generation and continuing health services cost growth. The effect of these factors will be largely offset in 2045 and later under current law by the accumulating effect of the reduction in provider price updates, which will reduce annual HI cost growth by an estimated 1.1 percent per year. If the slower price updates were not feasible in the long range and were phased out during 2020-2035, then the HI cost rate would be 5.3 percent in 2035 and 9.4 percent in 2085[8]. These levels are about 10 percent and 90 percent higher, respectively, than the current-law estimates under the intermediate assumptions, illustrating the very strong impact of the market basket reductions scheduled in current law.

HI and SMI Cashflow as a Percentage of GDP

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

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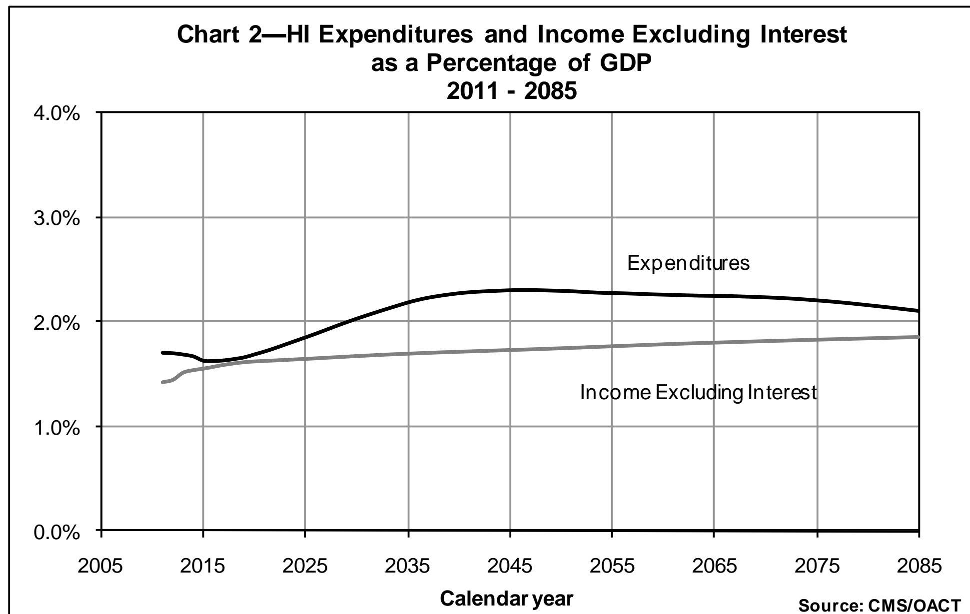
[8] At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare Trust Fund projections under this theoretical alternative to current law, which assumes that (i) physician payment rates would be updated using the Medicare Economic Index, rather than through the sustainable growth rate (SGR) process; and (ii) the productivity adjustments would be gradually phased out starting in 2020. No endorsement of the illustrative alternative to current law by the Trustees, CMS, or the Office of the Actuary should be inferred.

- *HI*

Chart 2 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2010, the expenditures were $247.9 billion, which was 1.7 percent of GDP. This percentage is projected to increase steadily through 2046 and then decrease throughout the remainder of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the Illustrative alternative projections,[9] HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 4.0 percent in 2085.



- *SMI*

Because of the Part B and Part D financing mechanism in which income mirrors expenditures, it is not necessary to test for long-range imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and federal general revenue payments.

Chart 3 shows projected total SMI (Part B and Part D) expenditures and premium income as a percentage of GDP. As in the projections for HI, the assumed long-range increase in average expenditures per beneficiary incorporates the effects of the *Affordable Care Act*. The growth rates are estimated year by year for the next 10 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 11 to 25 is assumed to grade smoothly into the long-range assumption described previously.

Under the intermediate assumptions, annual SMI expenditures were $274.9 billion, or about 1.9 percent of GDP, in 2010. Then, in about 25 years, they would grow to roughly 3.4 percent of GDP and to approximately 4.1 percent by the end of the projection period. Total SMI expenditures in 2085 would be 6.6 percent of GDP under the illustrative alternative projection mentioned previously.

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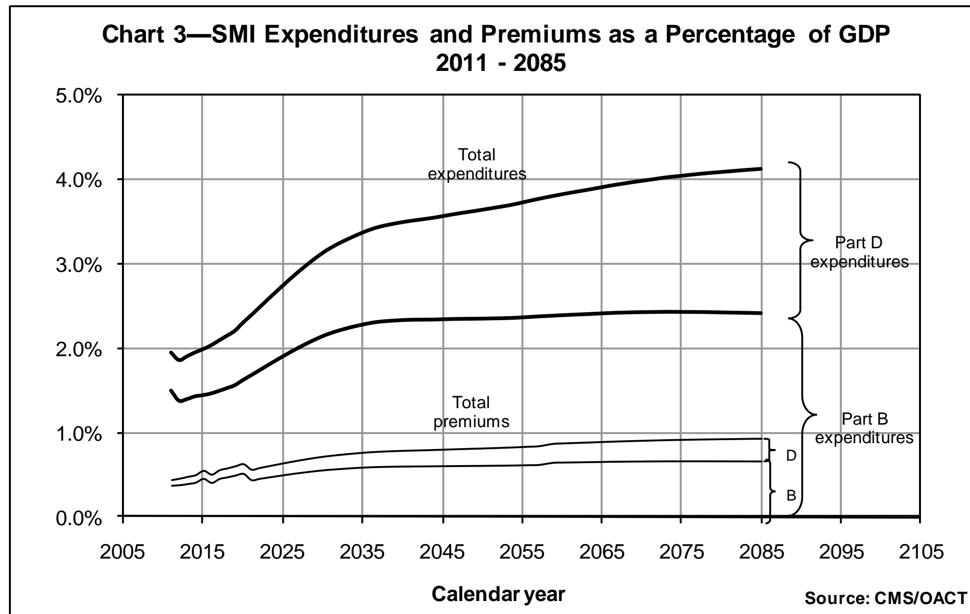
[9] At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare Trust Fund projections under this theoretical alternative to current law, which assumes that (i) physician payment rates would be updated using the Medicare Economic Index, rather than through the sustainable growth rate (SGR) process; and (ii) the productivity adjustments would be gradually phased out starting in 2020. No endorsement of the illustrative alternative to current law by the Trustees, CMS, or the Office of the Actuary should be inferred.



To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time. In fact, average per-beneficiary costs for Part B and Part D benefits are projected to increase after 2011 by about 4.4 percent annually. The associated beneficiary premiums - and general revenue financing - would increase by approximately the same rate. The special State payments to the Part D account are set by law at a declining portion of the States' forgone Medicaid expenditures attributable to the Medicare drug benefit. The percentage was 90 percent in 2006, phasing down to 75 percent in 2015 and later. Then, after 2015, the State payments are also expected to increase faster than GDP.

Worker-to-Beneficiary Ratio

- *HI*

Another way to evaluate the long-range outlook of the HI Trust Fund is to examine the projected number of workers per HI beneficiary. Chart 4 illustrates this ratio over the next 75 years. For the most part, current benefits are paid for by current workers. The retirement of the baby boom generation will therefore be financed by the relatively smaller number of persons born after the baby boom. In 2010, every beneficiary had 3.4 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.3 workers per beneficiary. The projected ratio continues to decline until there are just 2.0 workers per beneficiary by 2085.

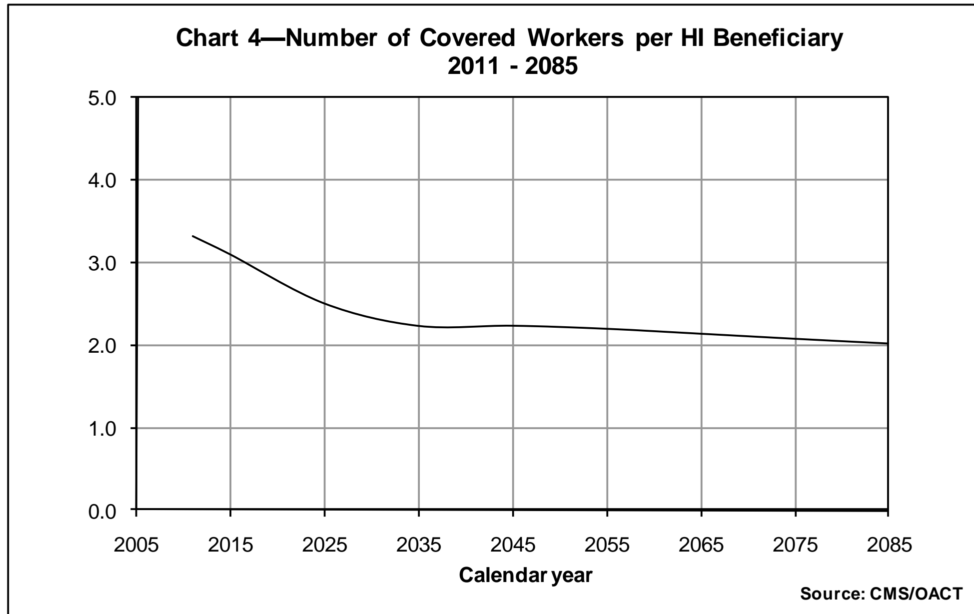


Chart 4—Number of Covered Workers per HI Beneficiary
2011 - 2085
5.0
4.0
3.0
2.0
1.0
0.0
2005
2015
2025
2035
2045
2055
2065
2075
2085
Calendar year
Source: CMS/OACT

Sensitivity Analysis

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

To illustrate the sensitivity of the long-range projections and determine the impact on the HI actuarial present values, six of the key assumptions were varied individually.[10] The assumptions varied are the health care cost factors, real-wage differential, consumer price index (CPI), real-interest rate, fertility rate, and net immigration.[11]

For this analysis, the intermediate economic and demographic assumptions in the *2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund*s are used as the reference point. Each selected assumption is varied individually to produce three scenarios. All present values are calculated as of January 1, 2011, and are based on estimates of income and expenditures during the 75-year projection period.

Charts 5 through 10 show the present value of the estimated net cashflow for each assumption varied. Under all three scenarios the present values initially increase, as the effects of the *Affordable Care Act* result in Trust Fund surpluses, and then decrease until about 2040 when they start to increase (or become less negative) once again. This pattern occurs in part because of the discounting process used for computing present values, which is used to help interpret the net cashflow deficit in terms of today's dollar. In other words, the amount required to cover this deficit, if made available and invested today, begins to decrease at the end of the 75-year period, reflecting the long period of interest accumulation that would occur. The pattern is also affected by the accumulating impact of the lower Medicare price updates over time and the greater proportion of workers who will be subject to the higher HI payroll tax rate, as noted above.

Health Care Cost Factors

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

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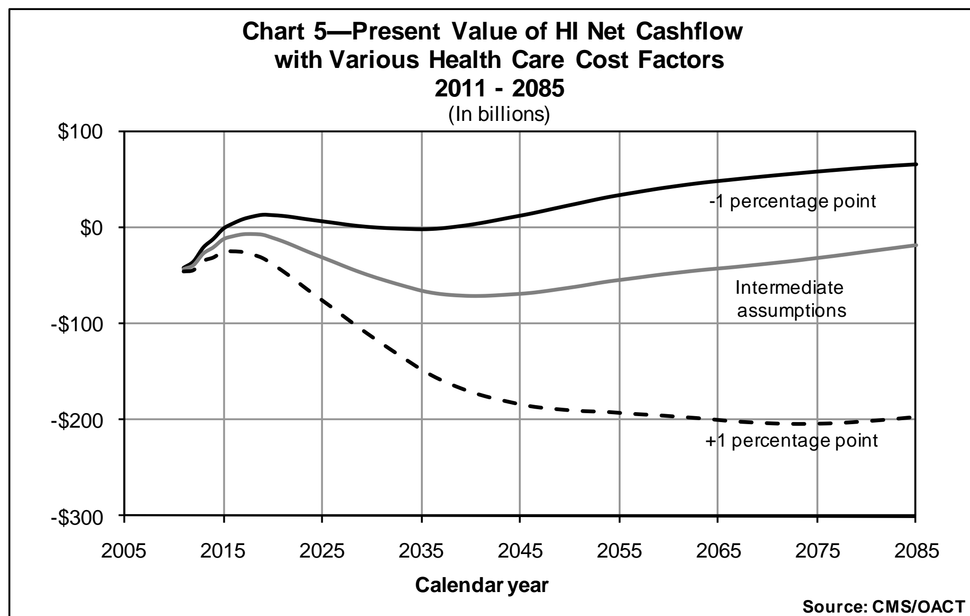
[10] Sensitivity analysis is not done for Parts B or D of the SMI Trust Fund due to the financing mechanism for each account. Any change in assumptions would have a negligible impact on the net cashflow, since the change would affect income and expenditures equally.

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

Table 1—Present Value of Estimated HI Income Less Expenditures under Various Health Care Cost Growth Rate Assumptions			
Annual Cost/Payroll Relative Growth Rate	−1 percentage point	Intermediate assumptions	+1 percentage point
Income Minus Expenditures (in Billions)	$ 1,917	$ (3,252)	$ (11,445)

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $5,169 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases substantially, by $8,193 billion.

Chart 5 shows projections of the present value of the estimated net cashflow under the three alternative annual growth rate assumptions presented in Table 1.



This assumption has a dramatic impact on projected HI cashflow. The present value of the net cashflow under the ultimate growth rate assumption of 1 percentage point lower than the intermediate assumption actually becomes a surplus and remains positive throughout the entire period, due to the improved financial outlook for the HI Trust Fund as a result of the *Affordable Care Act*. Several factors, such as the utilization of services by beneficiaries or the relative complexity of services provided, can affect costs without affecting tax income. As Chart 5 indicates, the financial status of the HI Trust Fund is extremely sensitive to the relative growth rates for health care service costs.

Real-Wage Differential

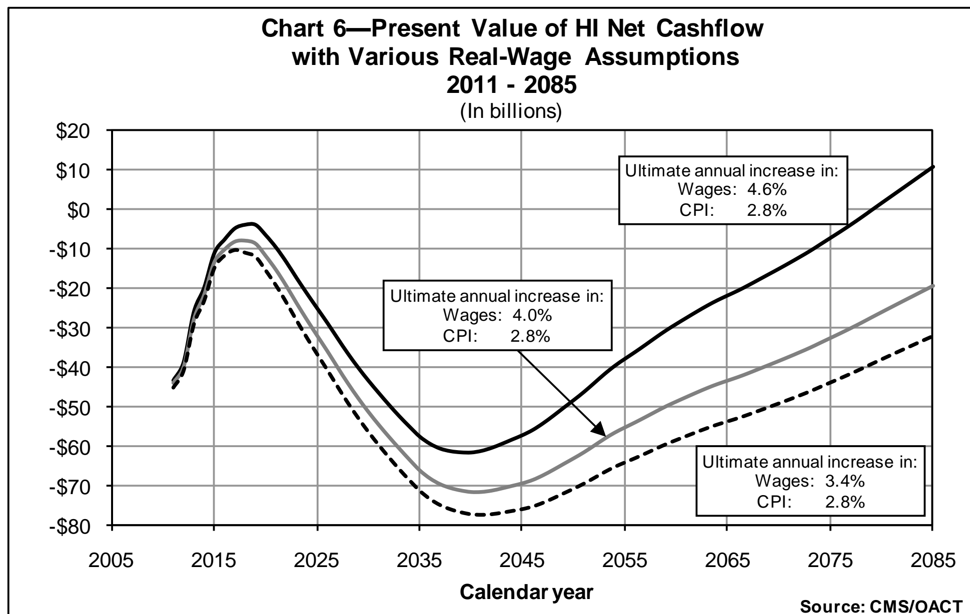
Table 2 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.6, 1.2, and 1.8 percentage points.[12] In each case, the ultimate CPI increase is assumed to be 2.8 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.4, 4.0, and 4.6 percent, respectively.

Table 2—Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions

Ultimate Percentage Increase in Wages – CPI	3.4 – 2.8	4.0 – 2.8	4.6 – 2.8
Ultimate Percentage Increase in Real-Wage Differential	0.6	1.2	1.8
Income Minus Expenditures (in Billions)	$ (3,819)	$ (3,252)	$ (2,156)

As indicated in Table 2, for a half-point increase in the ultimate real-wage differential assumption, the deficit - expressed in present-value dollars - decreases by approximately $910 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about $470 billion.

Chart 6 shows projections of the present value of the estimated net cashflow under the three alternative real-wage differential assumptions presented in Table 2.



As illustrated in Chart 6, faster real-wage growth results in smaller HI cashflow deficits, when expressed in present-value dollars. A higher real-wage differential immediately increases both HI expenditures for health care and wages for all workers. There is a full effect on wages and

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[12] The real-wage differential is the difference between the percentage increases in the average annual wage in covered employment and the average annual CPI.

payroll taxes, but the effect on benefits is only partial, since not all health care costs are wage-related. Prior to the *Affordable Care Act*, the deficit was increased under the higher real-wage assumptions on a present-value basis, since the dollar impact on expenditures was higher than the dollar impact on income. This is not the case this year because, compared to pre-*Affordable Care Act* projections, expenditures are substantially reduced as a result of the continued payment update reductions for all HI fee-for-service providers, and income is higher due to the additional HI tax rate for high-income earners. This reversal in the direction of the impact of higher real-wage growth illustrates a limitation of the use of present-value cashflows as a measure of financial status; in practice, faster real-wage growth always improves the financial status of the HI Trust Fund, regardless of whether there is a small or large imbalance between income and expenditures. Also, as noted previously, the closer financial balance for the HI Trust Fund under the *Affordable Care Act* depends critically on the long-range feasibility of the lower Medicare price updates for hospitals and other HI providers. There is a strong likelihood that certain of these changes will not be viable in the long range.

Consumer Price Index

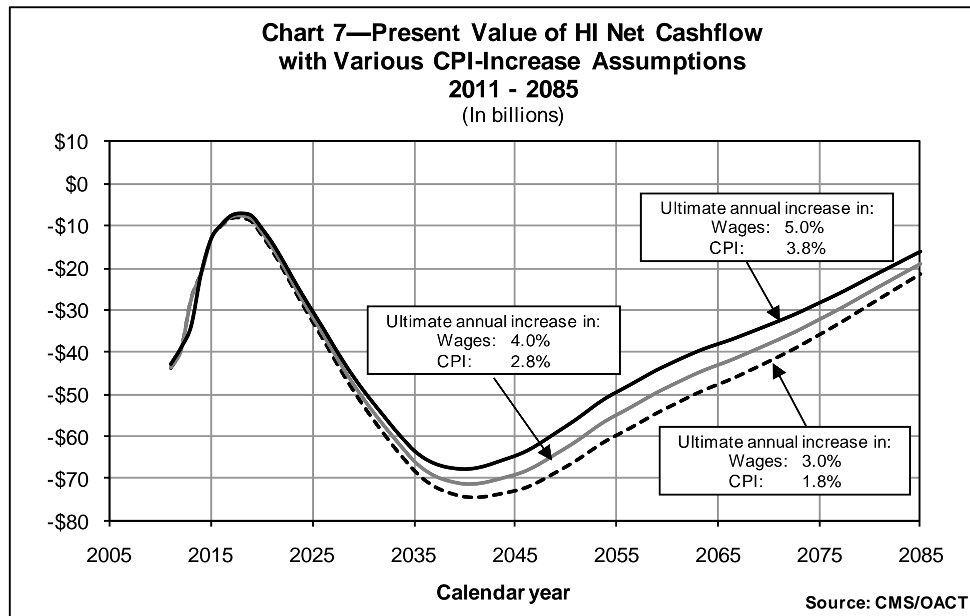
Table 3 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 1.8, 2.8, and 3.8 percent. In each case, the ultimate real-wage differential is assumed to be 1.2 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.0, 4.0, and 5.0 percent, respectively.

Table 3—Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions

Ultimate Percentage Increase in Wages − CPI	3.0 − 1.8	4.0 − 2.8	5.0 − 3.8
Income Minus Expenditures (in Billions)	$ (3,478)	$ (3,252)	$ (3,006)

Table 3 demonstrates that if the ultimate CPI-increase assumption is 1.8 percent, the deficit increases by $226 billion. On the other hand, if the ultimate CPI-increase assumption is 3.8 percent, the deficit decreases by $246 billion.

Chart 7 shows projections of the present value of net cashflow under the three alternative CPI rate-of-increase assumptions presented in Table 3.



As Chart 7 indicates, this assumption has a small impact when the cashflow is expressed as present values. The relative insensitivity of the projected present values of HI cashflow to different levels of general inflation occurs because inflation tends to affect both income and costs in a similar manner. In present value terms, a smaller deficit results under high-inflation conditions because the present values of HI expenditures are not significantly different under the various CPI scenarios, but under high-inflation conditions the present value of HI income increases as more people become subject to the additional 0.9 percent HI tax rate required by the *Affordable Care Act* for workers with earnings above $200,000 or $250,000 (for single and joint income-tax filers, respectively). Since the thresholds are not indexed, additional workers become subject to the additional tax more quickly under conditions of faster inflation, and vice-versa.

Real-Interest Rate

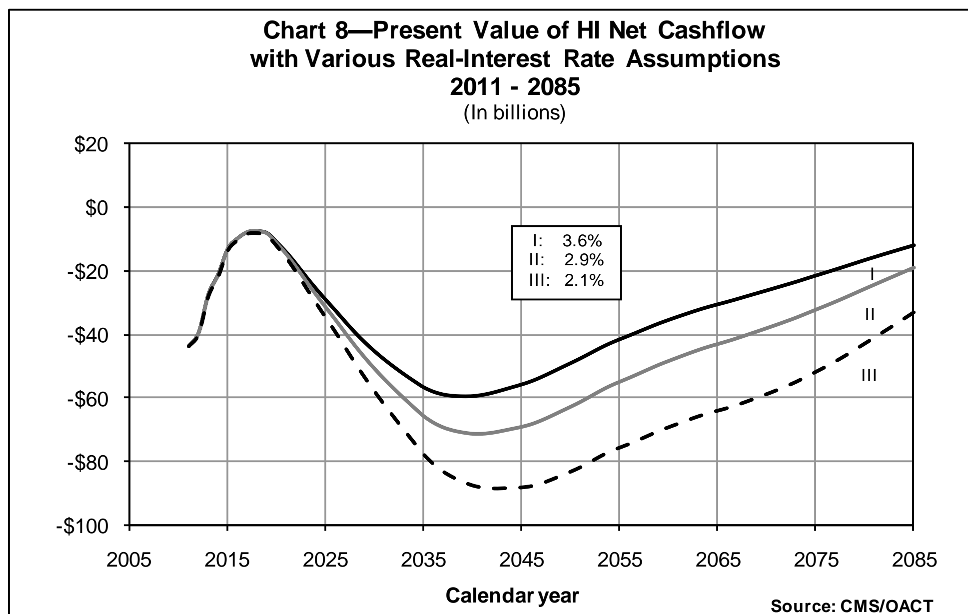
Table 4 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-interest assumptions: 2.1, 2.9, and 3.6 percent. In each case, the ultimate annual increase in the CPI is assumed to be 2.8 percent, resulting in ultimate nominal annual yields of 4.9 5.7, and 6.4 percent, respectively.

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

Ultimate Real-Interest Rate	2.1 percent	2.9 percent	3.6 percent
Income Minus Expenditures (in Billions)	$ (4,293)	$ (3,252)	$ (2,589)

As illustrated in Table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $110 billion.

Chart 8 shows projections of the present value of the estimated net cashflow under the three alternative real-interest assumptions presented in Table 4.



As shown in Chart 8, the projected HI cashflow when expressed in present values is fairly sensitive to the interest assumption. This is not an indication of the actual role that interest plays in HI financing. In actuality, interest finances very little of the cost of the HI Trust Fund because, under the intermediate assumptions, the fund is projected to be relatively low and exhausted by 2024. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), resulting in a smaller overall net present value.

Compared to past reports, however, the sensitivity of present values to different real-interest rate assumptions is substantially reduced as a result of the *Affordable Care Act*. Under this legislation, annual deficits would decrease due to the compounding effects of the price update reductions for HI fee-for-service providers. Discounting a relatively level series by high or low interest factors has much less effect than when the series is increasing rapidly, as with the pre-*Affordable Care Act* projections.

Fertility Rate

Table 5 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.7, 2.0, and 2.3 children per woman.

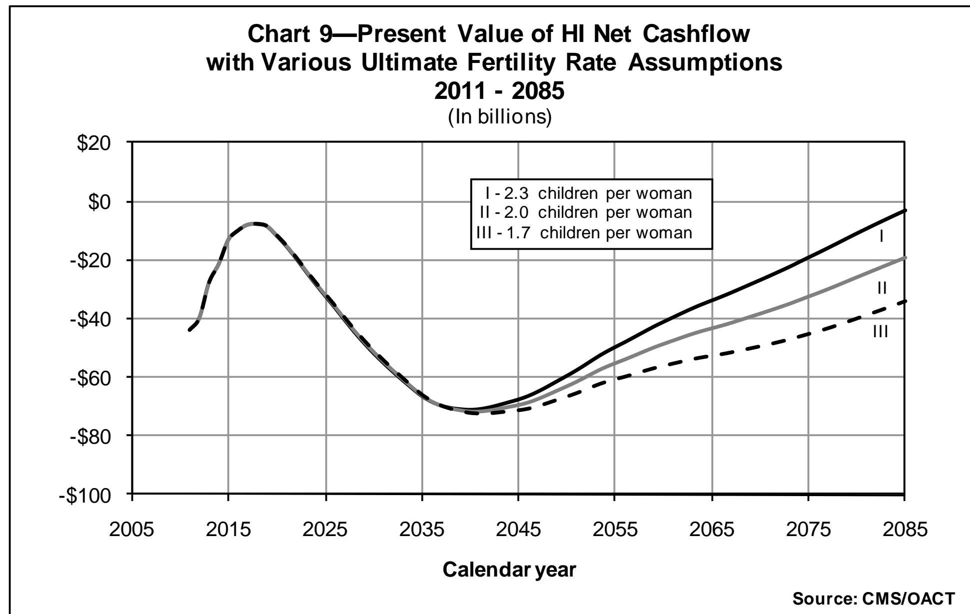
Table 5—Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

Ultimate Fertility Rate[1]	1.7	2.0	2.3
Income Minus Expenditures (in Billions)	$ (3,623)	$ (3,252)	$ (2,874)

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

As Table 5 demonstrates, for an increase of 0.3 in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately $370 billion.

Chart 9 shows projections of the present value of the net cashflow under the three alternative fertility rate assumptions presented in Table 5.



As Chart 9 indicates, the fertility rate assumption has a fairly large impact on projected HI cashflows. This result is different than in past reports mainly due to the additional HI tax on high-income earners required by the *Affordable Care Act*. Under the higher fertility rate assumptions, there will be additional workers in the labor force after 20 years, as in past reports, but their impact on future HI taxes will be relatively greater, since many will become subject to the additional HI tax, thereby lowering the deficit proportionately more on a present-value-dollar basis. Under the lower fertility rate assumptions, on the other hand, there will be fewer workers in the workforce with a smaller number subject to the additional tax, in turn raising the HI deficit. It is important to point out that if a longer projections period was used, the impact of a fertility rate change would be more pronounced.

Net Immigration

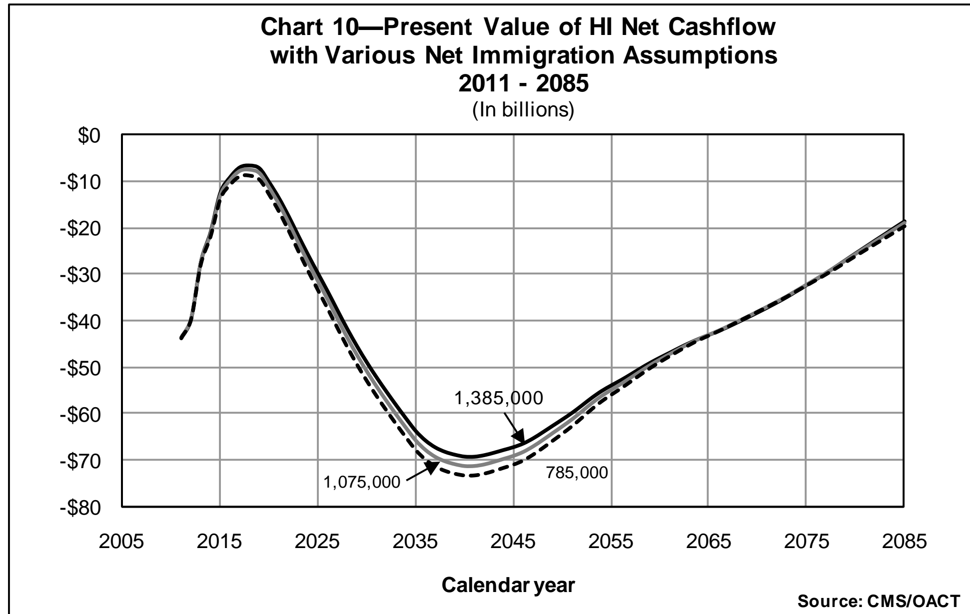
Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative average annual net immigration assumptions: 785,000 persons, 1,075,000 persons, and 1,385,000 persons per year.

Table 6—Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions

Average Annual Net Immigration	785,000	1,075,000	1,385,000
Income Minus Expenditures (in Billions)	$ (3,327)	$ (3,252)	$ (3,169)

As indicated in Table 6, if the average annual net immigration assumption is 785,000 persons, the deficit - expressed in present-value dollars - increases by $75 billion. Conversely, if the assumption is 1,385,000 persons, the deficit decreases by $83 billion.

Chart 10 shows projections of the present value of net cashflow under the three alternative average annual net immigration assumptions presented in Table 6.



As illustrated in Chart 10, higher net immigration results in smaller HI cashflow deficits. Since immigration tends to occur most often among people at working ages, who work and pay taxes into the HI system, a change in the net immigration assumption affects revenues from payroll taxes almost immediately. However, the impact on expenditures occurs later as those individuals age and become beneficiaries.

Prior to the *Affordable Care Act*, the deficit was increased under the higher-net immigration assumptions, since the cost of HI benefits for the additional participants was substantially greater than their HI taxes. This is not the case this year because, compared to pre-*Affordable Care Act* projections, expenditures are substantially reduced as a result of the continued payment update reductions for all HI fee-for service providers, and income is higher due to the additional HI tax for high-income earners. As shown in the SOSI, the value of the additional HI payroll taxes paid by new participants in the future, on average, will be greater than the cost of their benefits, assuming that the lower HI price updates can be continued indefinitely. As noted previously, there is a significant likelihood that the reduction in Medicare provider payment updates will not be feasible in the long range.

TRUST FUND FINANCES AND SUSTAINABILITY

HI

The financial status of the HI Trust Fund was substantially improved by the lower expenditures and additional tax revenues instituted by the *Affordable Care Act*. However, the fund is now estimated to be exhausted in 2024, 5 years earlier than was shown in last year's report, and it is not adequately financed over the next 10 years. HI taxable earnings in 2010 were lower than previously estimated, and the rate of growth in these earnings is projected to accelerate and to exceed last year's growth assumptions in 2011-2019. HI expenditures in 2010 were close to the previous estimate, but the projected level grows more rapidly than shown in last year's report because of the projected faster growth in earnings. HI expenditures have exceeded income annually since 2008 and are projected to continue to do so through the short-range period until the fund becomes exhausted in 2024. The shortfalls can be met with increasing reliance on the redemption of Trust Fund assets, thereby adding to the draw on the federal budget. In the absence of corrective legislation, a depleted HI Trust Fund would initially produce payment delays but would very quickly lead to a curtailment of health care services to beneficiaries. In practice, Congress has never allowed a Medicare or Social Security Trust Fund to become fully depleted.

It is important to note that the improved outlook for the HI Trust Fund depends in part on the feasibility of the provider payment update reductions. There is a significant likelihood, however, that these providers would not be able to reduce their cost growth rates sufficiently during this period to match the slower increases in Medicare payments per service, and in this case they would eventually become unable to continue providing health care services to Medicare beneficiaries. If such a situation occurred, and Congress overrode the payment update reductions, then actual costs would be higher and the HI Trust Fund would be depleted somewhat sooner.

The HI Trust Fund remains out of financial balance in the long range. Bringing the fund into actuarial balance over the next 75 years under the intermediate assumptions would require significant increases in revenues and/or reductions in benefits. These changes are needed partially as a result of the impending retirement of the baby boom generation. If the reductions to HI provider price updates could be not continued in the long run, then the actuarial deficit would be much greater.

SMI

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

The financing established for the Part B account for calendar year 2011 is adequate to cover 2011 expected expenditures and to maintain the financial status of the account in 2011 at a satisfactory level. The Part B cost projections are understated as a result of the substantial reductions in physician payments that would be required under current law and are further understated if the reductions in future price updates for most other Part B providers are not viable. Actual future Part B costs will depend on the steps that Congress might choose to take to address these situations.

No financial imbalance is anticipated for the Part D account, since the general revenue subsidy for this benefit is drawn on a daily, as-needed basis. The projected Part D costs shown in this section are somewhat lower than previously estimated, due to slightly better-than-expected experience of the Part D plans in 2010 and lower assumed growth rates for prescription drug expenditures in the U.S. overall.

For both the Part B and Part D accounts, beneficiary premiums and general revenue transfers will be set to meet expected costs each year. Such financing, however, would have to increase faster than the economy to match expected expenditure growth under current law. A critical issue for the SMI Trust Fund continues to be the impact of the past and expected rapid growth of SMI costs, which place gradually increasing demands on beneficiaries, the federal budget, and society at large.

Medicare Overall

The *Medicare Modernization Act* requires the Board of Trustees to determine whether the difference between Medicare outlays and "dedicated financing sources" is projected to exceed 45 percent of total Medicare outlays within the next 7 fiscal years (2011-2017).[13] This difference is expected to exceed 45 percent of total expenditures in fiscal year 2011, which is the first year of the 7-year test period. Consequently, the Trustees issued a determination of projected "*excess general revenue Medicare funding,*" as required by law. Similar determinations were made in their 2006-2010 annual reports to Congress. With this sixth consecutive finding, another "Medicare funding warning" is triggered this year, indicating that the general revenues provided to Medicare under current law are becoming a substantial proportion of total program costs. This finding requires the President to submit to Congress, within 15 days after the release of the next budget, proposed legislation to respond to the warning. Congress is then required to consider this legislation on an expedited basis.[14] This requirement helps to call attention to Medicare's impact on the federal budget.

The Medicare financial projections shown in this section represent a substantial, but very uncertain, improvement over those prior to 2010 as a result of the *Affordable Care Act*. In the long range, much of this improvement depends on the feasibility of the legislation's downward adjustments to future increases in Medicare prices for most categories of health care providers. These projections continue to demonstrate the need for timely and effective action to address the remaining financial challenges facing Medicare - including the projected exhaustion of the HI Trust Fund, this fund's long-range financial imbalance, and the issue of rapid growth in Medicare expenditures. Furthermore, if the lower prices payable for health services under Medicare are overridden, the financial challenges in the long range would be much more severe. In their 2011 annual report to Congress, the Medicare Boards of Trustees emphasized the seriousness of these concerns and urged the nation's policy makers to take "*prompt action … to address these challenges.*" They also stated: "*Consideration of … further reforms should occur in the near future.*"

[13] Dedicated Medicare financing sources include HI payroll taxes; income from taxation of Social Security benefits; State transfers for the prescription drug benefit; premiums paid under Parts A, B, and D; fees allocated to Part B related to brand-name prescription drugs; and any gifts received by the Medicare Trust Funds.

[14] In January 2009, the House of Representatives passed a resolution (H. Res.5, section 3(e)) stating that section 803 of the Medicare Modernization Act, governing action required by the House in response to a funding warning, would not apply to the 111th Congress.

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Section III: Other Accompanying Information

Section III: Other Accompanying Information

This section contains other financial information, HHS' detailed *Improper Payments Information Act of 2002 Report*, summary of financial statement audit and management assurance findings, the HHS Inspector General's summary of the most significant management and performance challenges facing the Department, and the Department's response to the Inspector General's assessment.

OTHER FINANCIAL INFORMATION

CONSOLIDATING BALANCE SHEET BY BUDGET FUNCTION

As of September 30, 2011
(in Millions)

	Education, Training & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals
Assets (Note 2)							
Intra-governmental							
Fund Balance with Treasury (Note 3)	$ 8,840	$ 139,376	$ 6,130	$ 12,509	$ 166,855	$ -	$ 166,855
Investments, Net (Note 4)	-	5,471	319,972	-	325,443	-	325,443
Accounts Receivable, Net (Note 5)	37	1,851	62,548	13	64,449	(63,429)	1,020
Advances (Note 8)	-	380	90	-	470	(441)	29
Total Intra-governmental	8,877	147,078	388,740	12,522	557,217	(63,870)	493,347
Accounts Receivable, Net (Note 5)	-	3,421	7,486	1	10,908	-	10,908
Inventory and Related Property, Net (Note 6)	-	6,546	-	-	6,546	-	6,546
General Property, Plant, and Equipment, Net (Note 7)	-	5,294	363	-	5,657	-	5,657
Advances (Note 8)	-	81	16,009	-	16,090	-	16,090
Other	-	332	-	-	332	-	332
Total Assets	**$ 8,877**	**$ 162,752**	**$ 412,598**	**$ 12,523**	**$ 596,750**	**$ (63,870)**	**$ 532,880**
Stewardship PP&E (Note 1)							
Liabilities (Note 9)							
Intra-governmental							
Accounts Payable	$ 5	$ 154	$ 63,537	$ -	$ 63,696	$ (63,047)	$ 649
Other (Note 13)	29	1,047	846	1	1,923	(823)	1,100
Total Intra-governmental	34	1,201	64,383	1	65,619	(63,870)	1,749
Accounts Payable	17	530	-	-	547	-	547
Entitlement Benefits Due and Payable (Note 10)	-	26,590	54,292	-	80,882	-	80,882
Accrued Grant Liability (Note 12)	897	2,979	-	609	4,485	-	4,485
Federal Employee and Veterans Benefits (Note 11)	5	10,201	13	-	10,219	-	10,219
Contingencies and Commitments (Note 14)	-	3,623	-	-	3,623	-	3,623
Other (Note 13)	22	2,651	713	26	3,412	-	3,412
Total Liabilities	**975**	**47,775**	**119,401**	**636**	**168,787**	**(63,870)**	**104,917**
Net Position							
Unexpended Appropriations - Earmarked funds	-	(99)	4,335	-	4,236	-	4,236
Unexpended Appropriations - Other funds	7,900	102,777	-	11,881	122,558	-	122,558
Unexpended Appropriations, Total	**7,900**	**102,678**	**4,335**	**11,881**	**126,794**	**-**	**126,794**
Cumulative Results of Operations - Earmarked funds	-	4,500	288,862	-	293,362	-	293,362
Cumulative Results of Operations - Other funds	2	7,799	-	6	7,807	-	7,807
Cumulative Results of Operations, Total	**2**	**12,299**	**288,862**	**6**	**301,169**	**-**	**301,169**
Total Net Position	**7,902**	**114,977**	**293,197**	**11,887**	**427,963**	**-**	**427,963**
Total Liabilities and Net Position	**$ 8,877**	**$ 162,752**	**$ 412,598**	**$ 12,523**	**$ 596,750**	**$ (63,870)**	**$ 532,880**

CONSOLIDATED BALANCE SHEET BY OPERATING DIVISION

As of September 30, 2011

(in Millions)

	ACF	AoA	AHRQ	CDC	CMS	FDA	HRSA	IHS	NIH	OS	PSC	SAMHSA	Agency Consolidated Totals	Intra-HHS Eliminations	HHS Consolidated Totals
Assets (Note 2)															
Intra-governmental															
Fund Balance with Treasury (Note 3)	$ 20,704	$ 646	$ 611	$ 7,145	$ 74,517	$ 2,417	$ 8,386	$ 2,099	$ 35,442	$ 11,909	$ 183	$ 2,796	$ 166,855	$ -	$ 166,855
Investments, Net (Note 4)	-	-	-	-	322,065	-	3,352	-	26	-	-	-	325,443	-	325,443
Accounts Receivable, Net (Note 5)	17	32	-	27	516	19	15	41	-	347	353	129	1,496	(476)	1,020
Advances (Note 8)	-	-	-	56	91	10	25	2	244	3	1	39	471	(442)	29
Total Intra-governmental	20,721	678	611	7,228	397,189	2,446	11,778	2,142	35,712	12,259	537	2,964	494,265	(918)	493,347
Accounts Receivable, Net (Note 5)	1	-	-	3	10,527	170	4	181	2	13	7	-	10,908	-	10,908
Inventory and Related Property, Net (Note 6)	-	-	-	2,288	-	1	2	13	34	4,202	6	-	6,546	-	6,546
General Property, Plant, and Equipment, Net (Note 7)	-	-	-	1,436	389	414	1	1,066	2,036	313	2	-	5,657	-	5,657
Advances (Note 8)	-	-	-	8	16,083	-	-	(2)	1	-	-	-	16,090	-	16,090
Other	-	-	-	-	-	9	323	-	-	-	-	-	332	-	332
Total Assets	**$ 20,722**	**$ 678**	**$ 611**	**$ 10,963**	**$ 424,188**	**$ 3,040**	**$ 12,108**	**$ 3,400**	**$ 37,785**	**$ 16,787**	**$ 552**	**$ 2,964**	**$ 533,798**	**$ (918)**	**$ 532,880**
Stewardship PP&E (Note 1)															
Liabilities (Note 9)															
Intra-governmental															
Accounts Payable	$ 5	$ 1	$ 2	$ -	$ 651	$ 18	$ 31	$ 3	$ 30	$ 18	$ -	$ 2	$ 761	$ (112)	$ 649
Other (Note 13)	28	1	70	116	882	16	49	357	52	210	2	123	1,906	(806)	1,100
Total Intra-governmental	33	2	72	116	1,533	34	80	360	82	228	2	125	2,667	(918)	1,749
Accounts Payable	17	-	7	61	-	2	79	26	276	46	21	12	547	-	547
Entitlement Benefits Due and Payable (Note 10)	-	-	-	-	80,882	-	-	-	-	-	-	-	80,882	-	80,882
Accrued Grant Liability (Note 12)	1,407	98	16	297	-	7	365	29	2,230	47	-	(11)	4,485	-	4,485
Federal Employee and Veterans Benefits (Note 11)	5	-	-	35	13	24	20	79	60	17	9,953	13	10,219	-	10,219
Contingencies and Commitments (Note 14)	-	-	-	-	3,016	-	607	-	-	-	-	-	3,623	-	3,623
Other (Note 13)	47	2	16	146	2,001	236	88	219	415	199	36	7	3,412	-	3,412
Total Liabilities	1,509	102	111	655	87,445	303	1,239	713	3,063	537	10,012	146	105,835	(918)	104,917
Net Position															
Unexpended Appropriations - Earmarked funds	-	-	-	-	4,335	(98)	-	-	(1)	-	-	-	4,236	-	4,236
Unexpended Appropriations - Other funds	19,225	555	501	6,745	42,093	(1,938)	7,676	1,303	32,022	11,552	30	2,794	122,558	-	122,558
Unexpended Appropriations, Total	19,225	555	501	6,745	46,428	(2,036)	7,676	1,303	32,021	11,552	30	2,794	126,794	-	126,794
Cumulative Results of Operations - Earmarked funds	-	-	-	40	288,862	1,279	2,759	25	393	-	-	4	293,362	-	293,362
Cumulative Results of Operations - Other funds	(12)	21	(1)	3,523	1,453	3,494	434	1,359	2,308	4,698	(9,490)	20	7,807	-	7,807
Cumulative Results of Operations, Total	(12)	21	(1)	3,563	290,315	4,773	3,193	1,384	2,701	4,698	(9,490)	24	301,169	-	301,169
Total Net Position	19,213	576	500	10,308	336,743	2,737	10,869	2,687	34,722	16,250	(9,460)	2,818	427,963	-	427,963
Total Liabilities and Net Position	**$ 20,722**	**$ 678**	**$ 611**	**$ 10,963**	**$ 424,188**	**$ 3,040**	**$ 12,108**	**$ 3,400**	**$ 37,785**	**$ 16,787**	**$ 552**	**$ 2,964**	**$ 533,798**	**$ (918)**	**$ 532,880**

NET COST OF TOP 20 PROGRAMS
For The Year Ended September 30, 2011 and 2010
(in Millions)

HHS Program	HHS Net Cost ($) FY 2011	HHS Net Cost ($) FY 2010	Rank by ($) FY 2011	Rank by ($) FY 2010	Budget Function	HHS Component Responsible for Program
Medicare	$ 474,005	$ 447,162	1	1	Medicare	CMS
Medicaid	268,116	272,995	2	2	Health	CMS
Research	34,807	33,476	3	3	Health	NIH
Temporary Assistance to Needy Families	19,003	20,307	4	4	Education, Training & Social Services / Income Security	ACF
Children's Health Insurance Program (CHIP)	8,689	7,968	5	6	Health	CMS
Head Start	8,362	8,262	6	5	Education, Training & Social Services / Income Security	ACF
Child Welfare	7,945	7,883	7	7	Education, Training & Social Services / Income Security	ACF
Child Care	5,957	5,972	8	8	Education, Training & Social Services / Income Security	ACF
Infectious Diseases	5,696	5,970	9	9	Health	CDC
Low-Income Home Energy Assistance	4,424	4,599	10	11	Education, Training & Social Services / Income Security	ACF
Health Insurance Reform	4,327	692	11	122	Health	CMS & OS
Child Support Enforcement	4,285	4,408	12	12	Education, Training & Social Services / Income Security	ACF
Primary Care	3,375	3,103	13	13	Health	HRSA
Clinical Services	2,285	2,188	14	15	Health	IHS
HIV/AIDS Programs	2,069	2,448	15	14	Health	HRSA
Social Services Block Grant	1,763	1,991	16	16	Education, Training & Social Services / Income Security	ACF
Substance Abuse Prevention and Treatment Block Grant	1,690	1,727	17	17	Health	SAMHSA
Public Health and Social Services	1,595	5,057	18	10	Health	OS
State and Community Based Services	1,428	1,395	19	19	Education, Training & Social Services	AoA
Health Promotion	1,264	1,193	20	20	Health	CDC
Total, Top 20 Programs	**861,085**	**838,796**				
All Other HHS Programs	17,048	17,932			Various Functions	Various Components
Total Net Costs	**$ 878,133**	**$ 856,728**				

SUPPLEMENTAL STATEMENT OF NET COST
For The Years Ended September 30, 2011, and 2010
(in Millions)

	2011			
		Inter-Agency Eliminations		
Responsibility Segments	**Agency Consolidated Totals**	**Costs (-)**	**Earned/Exchange Revenues (+) ***	**Consolidated Totals**
ACF	$ 54,010	$ (46)	$ 4	$ 53,968
AoA	1,572	(6)	4	1,570
AHRQ	175	(17)	398	556
CDC	10,067	(176)	388	10,279
CMS	754,145	(465)	17	753,697
FDA	2,034	(169)	36	1,901
HRSA	8,702	(256)	32	8,478
IHS	3,912	(223)	147	3,836
NIH	34,822	(888)	193	34,127
OS	4,680	(244)	469	4,905
PSC	728	83	508	1,319
SAMHSA	3,413	(56)	140	3,497
Net Cost of Operations	**$ 878,260**	**$ (2,463)**	**$ 2,336**	**$ 878,133**

	2010			
		Inter-Agency Eliminations		
Responsibility Segments	**Agency Consolidated Totals**	**Costs (-)**	**Earned/Exchange Revenues (+) ***	**Consolidated Totals**
ACF	$ 56,331	$ (13)	$ 51	$ 56,369
AoA	1,529	(2)	5	1,532
AHRQ	57	(361)	13	(291)
CDC	10,356	(378)	200	10,178
CMS	728,704	(6)	298	728,996
FDA	2,153	(26)	140	2,267
HRSA	9,158	(24)	151	9,285
IHS	4,390	(33)	55	4,412
NIH	33,476	(188)	921	34,209
OS	6,513	(342)	191	6,362
PSC	738	(631)	30	137
SAMHSA	3,399	(157)	30	3,272
Net Cost of Operations	**$ 856,804**	**$ (2,161)**	**$ 2,085**	**$ 856,728**

* Eliminations for non-exchange revenue are reported in the Statement of Changes in Net Position

CONSOLIDATING STATEMENT OF NET COST BY BUDGET FUNCTION
For The Year Ended September 30, 2011
(in Millions)

Responsibility Segments	Education, Training, & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra-HHS Eliminations Cost (-)	Intra-HHS Eliminations Revenue	Consolidated Totals
ACF	$ 12,969	$ -	$ -	$ 41,041	$ 54,010	$ (46)	$ 4	$ 53,968
AoA	1,572	-	-	-	1,572	(6)	4	1,570
AHRQ	-	175	-	-	175	(17)	398	556
CDC	-	10,067	-	-	10,067	(176)	388	10,279
CMS	-	280,140	474,005	-	754,145	(465)	17	753,697
FDA	-	2,034	-	-	2,034	(169)	36	1,901
HRSA	-	8,702	-	-	8,702	(256)	32	8,478
IHS	-	3,912	-	-	3,912	(223)	147	3,836
NIH	-	34,822	-	-	34,822	(888)	193	34,127
OS	-	4,680	-	-	4,680	(244)	469	4,905
PSC	-	728	-	-	728	83	508	1,319
SAMHSA	-	3,413	-	-	3,413	(56)	140	3,497
Net Cost of Operations	**$ 14,541**	**$ 348,673**	**$ 474,005**	**$ 41,041**	**$ 878,260**	**$ (2,463)**	**$ 2,336**	**$ 878,133**

GROSS COST AND EXCHANGE REVENUE
For The Year Ended September 30, 2011
(in Millions)

Responsibility Segments	Intra-governmental Gross Cost Combined	Intra-governmental Gross Cost Eliminations	Intra-governmental Gross Cost Consolidated	Intra-governmental Less: Exchange Revenue Combined	Intra-governmental Less: Exchange Revenue Eliminations	Intra-governmental Less: Exchange Revenue Consolidated	With the Public Gross Cost	With the Public Less: Exchange Revenue	Consolidated Net Cost of Operations
ACF	$ 144	$ (46)	$ 98	$ (58)	$ 4	$ (54)	$ 53,929	$ (5)	$ 53,968
AoA	14	(6)	8	(6)	4	(2)	1,561	3	1,570
AHRQ	42	(17)	25	(396)	398	2	528	1	556
CDC	871	(176)	695	(506)	388	(118)	9,712	(10)	10,279
CMS	978	(465)	513	(20)	17	(3)	816,870	(63,683)	753,697
FDA	941	(169)	772	(62)	36	(26)	2,372	(1,217)	1,901
HRSA	320	(256)	64	(34)	32	(2)	8,459	(43)	8,478
IHS	587	(223)	364	(329)	147	(182)	4,876	(1,222)	3,836
NIH	1,602	(888)	714	(360)	193	(167)	33,692	(112)	34,127
OS	755	(244)	511	(579)	469	(110)	4,522	(18)	4,905
PSC	139	83	222	(915)	508	(407)	1,513	(9)	1,319
SAMHSA	204	(56)	148	(225)	140	(85)	3,433	1	3,497
Totals	**$ 6,597**	**$ (2,463)**	**$ 4,134**	**$ (3,490)**	**$ 2,336**	**$ (1,154)**	**$ 941,467**	**$ (66,314)**	**$ 878,133**

IMPROPER PAYMENTS INFORMATION ACT REPORT

1.0 Overview

Our FY 2011 *Improper Payments Information Act* Report includes a discussion of the following information, as required by *the Improper Payments Information Act of 2002* (IPIA) and as amended by the *Improper Payments Elimination and Recovery Act of 2010 (IPERA),* OMB Circular A-136 and OMB Circular A-123, Appendix C.

- Program Descriptions (Section 1.10)
- Risk Assessments (Section 2.0)
- Statistical Sampling Process (Section 3.0)
- Corrective Action Plans (Section 4.0)
- Recovery Auditing Reporting (Section 5.0 has been re-located to Section 12.0)
- Accountability in Reducing and Recovering Improper Payments (Section 6.0)
- Information Systems and Other Infrastructure (Section 7.0)
- Mitigation Efforts Related to Statutory or Regulatory Barriers (Section 8.0)
- Progress and Achievements (Section 9.0)
- Improper Payment Reduction Outlook (Section 10.0)
- Program Specific Reporting Information (Section 11.0)
  - Medicare Fee-for-Service (FFS) Program (Section 11.10)
  - Medicare Advantage (Section 11.20)
  - Medicare Prescription Drug Benefit (Section 11.30)
  - Medicaid (Section 11.40)
  - Children's Health Insurance Program (Section 11.50)
  - Temporary Assistance for Needy Families (Section 11.60)
  - Foster Care (Section 11.70)
  - Head Start (Section 11.80)
  - Child Care (Section 11.90)
- Recovery Auditing Reporting (Section 12.0)

1.10 Program Descriptions

The following is a brief description of the nine programs that will be discussed in this report.

1) Medicare Fee-for-Service (Medicare Parts A and B) - A federal health insurance program for: people age 65 or older, people younger than age 65 with certain disabilities, and people of all ages with End-Stage Renal Disease.
2) Medicare Advantage (Medicare Part C) - A federal health insurance program that allows beneficiaries to receive their Medicare benefits through a private health plan.
3) Medicare Prescription Drug Benefit (Medicare Part D) - A federal prescription drug benefit program for Medicare beneficiaries.
4) Medicaid - A joint federal/State program, administered by the States that provides health insurance to certain low income individuals.
5) Children's Health Insurance Program (CHIP) - A joint federal/State program, administered by the States that provides health insurance for qualifying children.
6) Temporary Assistance for Needy Families (TANF) - A joint federal/State program, administered by the States that provides time-limited assistance to needy families with children to promote work, responsibility and self-sufficiency.
7) Foster Care - A joint federal/State program, administered by the States for children who need placement outside their homes in a foster family home or a child care facility.
8) Head Start - A federal program that provides comprehensive developmental services for America's low-income, preschool children ages three to five and their families.
9) The Child Care Development Fund (CCDF) - A joint federal/State program, administered by the States that provides child care financial assistance to low-income working families.

2.0 Risk Assessments

In addition to the 9 programs deemed by OMB to be susceptible to significant improper payments, HHS has conducted risk assessments on 23 additional high-dollar programs. *IPERA* and OMB Circular A-123, Appendix C requires HHS to perform risk assessments once every 3 years on these programs. In the most recent review cycle, all 23 of these programs were deemed non-high-risk programs. The most recent round of assessments we completed in FY 2010. We are in the process of incorporating improper payment

risk assessment requirements into another risk assessment tool. This integrated approach will result in increased efficiency for our programs without compromising the assessment process.

3.0 Statistical Sampling Process

The statistical sampling process conducted to estimate the improper payment rate for each program identified in our program description section is discussed in the Program-Specific Reporting Information section. All seven programs that are reporting error rates used a statistical contractor. Unless otherwise stated in the Program-Specific Reporting Information section. All programs also comply with *IPIA* guidance requiring that all estimates be based on the equivalent of a statistically valid random sample of sufficient size to yield an estimate with a 90-percent confidence interval of plus or minus 2.5 percentage points around the estimate of the percentage of erroneous payments.

3.10 Net Error Rate Presentation

OMB Circular A-136 allows agencies to report net error rates in addition to gross error rates, for the first time in the *FY 2011 AFR*.

The gross error rate is calculated by adding over-payments and under-payments and is the official program error rate.

The net error rate is calculated by subtracting under-payments from over-payments, thus reflecting the overall estimated monetary loss to the program.

See the chart, following Section 10.0, for each programs' gross and net error rates.

4.0 Corrective Action Plans

Corrective Action Plans for reducing the estimated rate of improper payments for each program are included in the Program-Specific Reporting Information section. There are two important aspects to the corrective action plans: (1) setting aggressive, but realistic, goals and targets and (2) achieving the targets according to the timetable in the plan. Corrective action plans are reviewed each year to ensure that they are focused on the root causes of the errors and that the targets are being met. If targets are not being met, remediation will take place that may include employing new strategies, adjusting staffing and other resources, and possibly revising targets.

4.10 Corrective Actions for Grants

HHS verifies that grantee organizations have procedures in place to ensure that sub-recipients operate in compliance with applicable policies. The provisions of OMB Circular A-110 are be applied to sub-recipients performing work under awards if such sub-recipients are institutions of higher education, hospitals or other non-profit organizations. State and local government sub-recipients are subject to the provisions of regulations implementing the grants management common rule, "*Uniform Administrative Requirements for Grants and Cooperative Agreements to State and Local Governments*," published at *53 Federal Register 8034* (3/11/88). The grantees are required to have internal methods and systems to monitor the expenditures and accounting practices of sub-recipients. Grantees also monitor the use of funds at the sub-recipient organization and use detailed reports from internal financial systems. Grantees should demonstrate the use of a standardized approach to addressing fiscal inconsistencies at sub-recipient sites, along with a strategy for addressing the issues.

5.0 Recovery Auditing/Payment Recapture Reporting

For ease and clarity of presentation, this section has been moved to the end of the report or Section 12.0.

6.0 Accountability in Reducing and Recovering Improper Payments

HHS has shown tremendous leadership in the improper payments arena. We have been publishing an error rate for Medicare Fee-for-Service (FFS) since FY 1996, which was one of the first error rates published across government. HHS has also been reporting Foster Care and Head Start error rates since FY 2004. This year, we are reporting a composite error rate for the Medicare Prescription Drug program for the first time. HHS continues to implement corrective action plans to reduce future error rates.

In addition, HHS management performance plan objectives hold agency managers, beginning with leadership and cascading down through HHS Senior Executives (including component heads) to the lowest accountable program official, responsible for achieving progress on this initiative. As part of the semi-annual and annual performance evaluation, HHS Senior Executives and program officials are evaluated on the progress the agency achieves toward this and other goals.

7.0 Information Systems and Other Infrastructure

Reporting requirements related to information systems and other infrastructure are discussed by

program within the Program-Specific Reporting Information section.

8.0 Mitigation Efforts Related to Statutory or Regulatory Barriers

Reporting requirements related to whether there are any statutory or regulatory barriers to reducing improper payments are discussed by program within the Program - Specific Reporting Information section.

9.0 Progress and Achievements

9.10 FY 2011 Progress

HHS currently has nine programs that have been deemed risk susceptible: Medicare Fee-for-Service, Medicare Advantage, Medicare Prescription Drug Benefit, Medicaid, Children's Health Insurance Program (CHIP), Temporary Assistance for Needy Families (TANF), Head Start, Child Care, and Foster Care.

HHS works with OMB to put approved measurement plans in place for all risk-susceptible programs as well as a corrective action plan with OMB-approved targets for all programs that have established baseline measurements.

9.20 Achievements

9.21 Improving Program Integrity in Medicare and Medicaid

Medicare:

Section 302 of the *Tax Relief and Health Care Act of 2006* required HHS to implement the Medicare Fee-for-Service (FFS) Recovery Audit program in all 50 States no later than January 1, 2010. In February 2009, HHS awarded contracts to four Recovery Auditors. Each Recovery Auditor is responsible for identifying and correcting improper payments in approximately 25 percent of the country.

In FY 2011, the Medicare FFS Recovery Audit program demanded approximately $961.3 million and recovered $797.4 million in over-payments. FY 2011 recoveries were 958 percent higher than recoveries in the implementation years of FY 2009 and FY 2010, combined. The Recovery Auditors focused their reviews on short hospital stays and claims for durable medical equipment.

This is consistent with HHS' focus to lower the Medicare error rate. HHS expects that implementation of certain corrective actions will lower collections for some types of claims; however, collections will remain stable or increase slightly as Recovery Auditors continue to expand their reviews to other claim types. HHS continues to monitor the Recovery Audit program and makes continuous improvements to activities, such as, the appeal process, feedback to providers, and systems. HHS is also focused on taking the findings identified by the Recovery Auditors and putting actions into place to prevent future improper payments. For example, in FY 2011, HHS released four Provider Compliance Newsletters that provided detailed information on 31 findings identified by the Recovery Auditors. HHS also implemented local and/or national system edits to automatically prevent improper payments.

Section 6411 of the *Affordable Care Act* expanded the Recovery Audit program to Medicare Parts C and D. HHS solicited comments on innovative strategies to the implement the Medicare Part C and D Recovery Audit program on December 27, 2010. HHS implemented the Medicare Part D Recovery Audit Contractor (RAC) program in September 2011.

Medicaid:

Section 6411 of the *Affordable Care Act* requires States to establish Medicaid RAC programs. HHS required States to submit State plan amendments by December 31, 2010, on how they would establish their RAC program. Medicaid RACs will be paid by each State on a contingency basis. They will review Medicaid provider claims to identify and recover over-payments and identify under-payments made for services provided under Medicaid State plans and Medicaid waivers.

HHS published a final rule titled, "Medicaid Program: Recovery Audit Contractors" in the *Federal Register* on September 16, 2011, that implemented Section 6411(a) of the *Affordable Care Act*. This final rule requires States to initiate Recovery Audit programs in an effort to identify and recoup improper payments in the Medicaid programs. This final rule aligns the Medicaid RAC requirements to existing Medicare requirements, where feasible, and provides each State the flexibility to tailor its program where appropriate.

9.22 Head Start Signed Statement Template Form and Monitoring Visit Procedure Changes

HHS has developed a standard signed statement template form for Head Start, which was made

available to all grantees in FY 2009. Although OMB clearance (OMB 0907-0374) was obtained in FY 2010, the use of the form is optional, but grantees are strongly encouraged to use it. The standard signed statement form helps guide grantees on the type of information they need to collect from prospective families during the enrollment process and provides them with a structure for recording this information.

In the past, HHS has typically provided grantees with notice before conducting monitoring or other onsite visits. HHS is now increasing its use of unannounced visits in an effort to ensure the reviewers are seeing how the programs normally operate.

9.23 Public Assistance Reporting Information System

The Public Assistance Reporting Information System (PARIS) is a federal/State partnership with all 50 States, the District of Columbia and Puerto Rico that provides State public assistance agencies detailed information and data to assist them in maintaining program integrity and detecting/deterring improper payments in their TANF, Medicaid, Workers' Compensation, Child Care and Supplemental Nutrition Assistance Program "SNAP" (formerly known as Food Stamps) programs.

PARIS has a Board of Directors comprised of a key technical support representative from HHS (*ex-officio* non-voting member) and nine elected State technical and program representatives. The Board provides support to State Public Assistance Agencies by disseminating information, processes, techniques, and activities to maximize the technical abilities of States' systems and staff performing PARIS-related activities.

HHS and the Department of Defense have formed a partnership to further the goals of the PARIS project. Defense's Manpower Data Center (DMDC) provides computer resources to support PARIS development and operation. HHS contributes to this effort by establishing Computer Matching Agreements and coordinating the quarterly matches (November, February, May, and August) with all participating parties.

There is no cost to States to participate in PARIS. DMDC produces a match file using the Social Security Number as the key match indicator. States are expected to verify the matched individual's continued eligibility for benefits in their State, and take whatever case action is appropriate. Eleven States have reported savings of $423,992,088 as a result of PARIS. More information can be found on the PARIS Web site at www.acf.hhs.gov/paris.

9.24 Medicare Prescription Drug Benefit Program (Part D)

HHS is reporting, for the first time, a composite error rate for the Medicare Prescription Drug Benefit, or Part D. Medicare Part D is a federal program that subsidizes the costs of prescription drugs for Medicare beneficiaries in the United States. It was enacted as part of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (*MMA*) and went into effect on January 1, 2006. The rate reported in the FY 2011 AFR is based on Calendar Year 2009 data. For more information on how this rate was developed and calculated, see Section 11.30 of this report.

10.0 Improper Payment Reduction Outlook FY 2010 through FY 2014

The chart on the following page shows our *IPIA* results for the current year (CY) 2011, the prior year (PY) 2010, as well as the targets for the years 2012 through 2014. For each year we show, for each program, outlays for that fiscal year (FY), the error rate or future target (IP%), and the dollars paid improperly (IP$). In addition, for the CY we have also included the amount of over-payments (CY Over-payments) and under-payments (CY Under-payments), as well as the net error rate (CY Net Rate IP%) and the corresponding over-payments, when available. Table notes are defined in Section 10.1, after the table.

TABLE 1
IMPROPER PAYMENT REDUCTION OUTLOOK
FY 2010 - FY 2014
(in Millions)

Program or Activity	PY Outlays $	PY IP %	PY IP $	CY Outlays $	CY IP %	CY IP $	CY Over payment $	CY Under payment $	CY Net IP %	CY Net IP $	CY+1 Est. Outlays $	CY+1 IP %	CY+1 IP $	CY+2 Est. Outlays $	CY+2 IP %	CY+2 IP $	CY+3 Est. Outlays $	CY+3 IP %	CY+3 IP $
Medicare FFS	326,400 Note (a)	9.1 Note (1)	29,700	336,378 Note (b)	8.6 Note (1)	28,810	28,039	772	8.1	27,266	364,449 Note (c)	5.4 Note (2)	19,680	384,112	5.0	19,210	418,989	4.8	20,110
Medicare MC	96,437 Note (d)	14.1	13,600	112,215 Note (e)	11.0	12,390	9,040	3,350	5.1	5,690	118,329 Note (f)	10.4	12,310	128,522	9.8	12,600	123,623	9.2	11,370
Medicare Drug	58,822 Note (g)	N/A	N/A	53,162 Note (h)	3.2	1,709	1,604	105	2.8	1,498	62,528 Note (i)	3.2	2,000	76,259	3.1	2,360	82,029	3.0	2,460
Medicaid	239,012 Note (j)	9.4	22,500	269,241 Note (k)	8.1 Note (3)	21,900	21,448	453	7.8	20,995	262,433 Note (l)	7.4	19,420	281,077	6.4	17,990	343,872	6.0	20,630
CHIP	8,909 Note (m)	N/A	N/A	8,993	N/A Note (4)	N/A	N/A	N/A	N/A	N/A	9,612	N/A	N/A	10,287	N/A	N/A	11,037	N/A	N/A
TANF	17,320	N/A	N/A	17,026	N/A Note (5)	N/A	N/A	N/A	N/A	N/A	16,867	N/A	N/A	16,867	N/A	N/A	16,729	N/A	N/A
Head Start	7,234	1.7	123	7,235	0.6 Note (6)	44.1	44.1	-	N/A Note (7)	N/A	8,100	0.6	48.6	8,100	0.6	48.6	8,100	0.6	48.6
Foster Care	1,483	4.9	72.7	1,374	5.3	72.1	62.9	9.2	3.9	54	1,270	4.5	57.2	1,244	4.3	53.5	1,230	4.0	49.2
Child Care	6,091	13.3	810	5,677	11.2	638	580	58	9.2	522	5,774	10.8	624	5,747	9.9	569	5,745	9.6	552

Note: In the CY columns the IP percentage, when multiplied by the outlays, will not produce the exact total in the IP $ cell. This is a result of using rounded numbers in the table for presentation purposes. Other rows may not add perfectly, also due to rounding.

Note: The Current Year (CY) CY+1, CY+2 and CY+3 estimated dollars paid improperly (IP$) is calculated based on the target error rate and estimated outlays for each year, respectively. However, it is important to note that the measurement periods for each program vary. Therefore, the future outlay estimates presented may not be the actual amounts against which the target error rates will be applied to compute the dollars paid improperly in future years. To illustrate, the CY outlays for Medicaid, $269,241 million, is based on actual FY 2010 claims data, as explained in Note (k), whereas the CY+1 outlays of $262,433 million reflects the FY 2012 estimated outlays. When determining the amount of dollars paid improperly next year, the error rate will be applied to the FY 2011 claims data.

10.10 Improper Payment Reduction Outlook Notes

(a) – PY benefit outlays for Medicare FFS are from the November 2010 Improper Medicare FFS Payments Report (based on claims from April 2009 – March 2010).

(b) – CY benefit outlays for Medicare FFS are from the November 2011 Improper Medicare FFS Payments Report (based on claims from January 2010 – December 2010).

(c) – Medicare FFS CY+1, CY+2, CY+3 benefit outlay numbers are based on the FY 2012 Midsession Review (Medicare Benefit Outlays current law (CL)).

(d) – Medicare Advantage PY benefit outlays reflect 2008 Part C payments, as reported in the FY 2010 Medicare Part C Payment Error Final Report.

(e) – Medicare Advantage CY benefit outlays reflect 2009 Part C payments, as reported in the FY 2011 Medicare Part C Payment Error Final Report.

(f) – Medicare Advantage CY+1, CY+2, CY+3 benefit outlay numbers are based on the FY 2012 Midsession Review (Medicare Benefit Outlays (CL)).

(g) – Medicare Prescription Drug Benefit PY outlays reflect 2008 Part D payments as reported in the FY 2010 Medicare Part D Payment Error Final Report (h) – Medicare Prescription Drug Benefit CY outlays reflect 2009 Part D payments as reported in the FY 2011 Medicare Part D Payment Error Final Report.

(h) – Medicare Prescription Drug Benefit CY outlays reflect 2009 Part D payments as reported in the FY 2011 Medicare Part D Payment Error Final Report.

(i) - Medicare Prescription Drug Benefit CY+1, CY+2, CY+3 benefit outlay numbers are based on the FY 2012 Midsession Review (Medicare Benefit Outlays (CL)).

(j) - Medicaid PY benefit outlays for Medicaid are from the FY 2010 Medicaid Annual Error Rate Report (based on FY 2009 claims).

(k) – Medicaid CY benefit outlays for Medicaid are from the FY 2011 Medicaid Annual Error Rate Report (based on FY 2010 claims).

(l) – Medicaid CY+1, CY+2, CY+3 benefit outlay numbers are based on the FY 2012 Midsession Review (Medicaid Net Benefit Outlays (CL), excluding CDC Program Vaccine for Children obligations).

(m) – CHIP PY, CY, CY+1, CY+2, CY+3 benefit outlays are based on the FY 2012 Midsession Review (CHIP Total Benefit Outlays with *CHIPRA* Bonus and Health Care Quality Provisions (CL)).

(1) - Beginning with the FY 2011 Agency Financial Report (AFR), HHS refined its error rate estimation methodology to reflect activity related to the receipt of additional documentation and the outcome of appeal decisions that routinely occur after the cut-off date for the published AFR. The refined estimation methodology is based on analyses of actual appeal results and the submission of late documentation received after the cut-off date for FY 2009 and FY 2010 claims. HHS developed an estimate for FY 2011 modeled after the FY 2010 actual results. Therefore, the error rate results and targets for all years presented in the chart have been adjusted to reflect this revised estimation methodology. Without this adjustment, the FY 2011 error rate would have been 9.9 percent or $33.3 billion and the FY 2010 rate, as reported in the FY 2010 AFR, was 10.5 percent or $34.4 billion. These improvements provide a more accurate estimate of improper payments in the Medicare FFS program.

(2) - Based on this new estimation methodology, HHS calculated an adjusted FY 2009 error rate of 10.8 percent. As a result, HHS has adjusted its FY 2012 (CY+1) and FY 2013 (CY+2) targets from 6.2 percent and 5.8 percent respectively, as reported in the FY 2010 AFR, to 5.4 percent and 5.0 percent, respectively

(3) - HHS calculated and is reporting the three-year weighted average national Medicaid error rate that includes data reported in the *AFR* for FYs 2009, 2010, and 2011. The weighted national Medicade error component rates are as follows: Medicaid FFS: 2.7 percent, Medicaid managed care: 0.3 percent; and Medicaid eligibility: 6.1 percent. However, as required under Section 601 of the *Children's Health Insurance Program Reauthorization Act of 2009* (*CHIPRA P.L. 111-3*), HHS published a final rule on August 11, 2010, which required the eligibility reviews to be consistent with the State's eligibility verification policy rather than reviewing eligibility against a uniform methodology, which was done in the past. Based on current regulations, certain cases from FYs 2009-2010 would no longer be considered as errors. After publication of the final rule States were allowed to review cases under the new methodology.

(4) – The Payment Error Rate Measurement final rule (75 FR 48816), the methodology used to measure the Medicaid and Children's Health Insurance Program, was published on August 11, 2010, and became effective September 10, 2010. This final rule implements provisions from the *Children's Health Insurance Program Reauthorization Act of 2009* (*CHIPRA*) with regard to the PERM program. Section 601 of *CHIPRA* prohibits HHS from calculating or publishing any national or State-specific error rates for CHIP until six months after the new PERM final rule is effective. HHS did not report a national error rate for CHIP in the FY 2009 or FY 2010 *AFR.* Due to the timing of the published PERM final rule, HHS is not reporting a national error rate for CHIP in the FY 2011 *AFR*. HHS will publish a CHIP error rate in FY 2012 *AFR*. Due to the recent publication of the PERM final rule, setting out-year target rates for CHIP is not applicable at this time.

(5) - The TANF program is not reporting an error rate for FY 2011. Statutory limitations prohibit HHS from requiring States to participate in a TANF improper payment measurement. Despite statutory limitations, HHS continues to explore options that will allow for a future error rate measurement.

(6) – HHS is engaged in a number of efforts to reduce erroneous determinations in the Head Start eligibility process and to improve our detection and measurement of errors. The FY 2011 study showed that more programs are maintaining copies of source documentation used to determine eligibility status. As a result, the FY 2011 error rate of 0.6 is significantly lower than the FY 2010 error rate of 1.7. Therefore, HHS will maintain its FY 2011 rates as the out-year targets.

(7) – The Head Start program did not calculate a net error rate.

11.0 Medicare Fee-for-Service Program

11.10 Medicare Fee-for-Service Program - A federal health insurance program for: people age 65 or older, people under age 65 with certain disabilities, and people of all ages with End-Stage Renal Disease.

11.11 Medicare FFS Statistical Sampling Process

The Medicare Fee-for-Service (FFS) improper payment estimate is calculated under the Comprehensive Error Rate Testing (CERT) Program.

The Medicare FFS error rate for FY 2011 is 8.6 percent, or $28.8 billion. The FY 2011 net error rate is 8.1 percent, or $27.3 billion. The net error rate is calculated by subtracting under-payments from over-payments, thus reflecting the overall estimated monetary loss to the program.

Beginning with the *FY 2011 AFR*, HHS refined its error rate estimation methodology to reflect activity related to the receipt of additional documentation and the outcome of appeal decisions that routinely occur after the cut-off date for the published AFR. Taking into account appeals and late documentation, provides a more accurate estimate of improper payments in the Medicare FFS program. Without this change in estimation methodology, the FY 2011 error rate would have been 9.9 percent, or $33.3 billion.

For consistency and comparison purposes, HHS has recalculated the Medicare FFS error rates for FY 2009 and FY 2010 based on analyses of actual appeal results and the submission of late documentation received after the cut-off date for FY 2009 and FY 2010 claims. The FY 2009 reported rate was 12.4[15] percent and the adjusted rate is 10.8 percent. The FY 2010 reported rate was 10.5 percent and the adjusted rate is 9.1 percent. When comparing the adjusted rates, the Medicare FFS error rate has declined 0.5 percent from FY 2010.

The Medicare FFS improper payment methodology begins with a random sample of claims. This year approximately 50,000 claims were sampled. For each sampled claim, HHS obtains medical records from providers and additional claim detail from its shared systems. This information is reviewed for compliance with Medicare coverage, coding and billing rules. When a provider does not provide the requested medical record documentation or the information submitted does not meet the Medicare requirements, the claim is counted as an error.

11.12 Medicare FFS Corrective Action Plans

The primary causes of improper payments, as identified in the FY 2011 Medicare FFS Improper Payments report, were insufficient documentation errors (Administrative and Documentation), medically unnecessary services (Authentication

[15] The HHS *2009 Agency Financial Report* (*AFR*) reported the Medicare FFS error rate as 7.8 percent, or $24.1 billion in improper payments. This rate reflected a combination of two different review methodologies to determine errors: 1) the old review process, accounting for the majority of the FY 2009 reviews; and 2) the new review process that implemented a more stringent review methodology. Since the new review process was to be used going forward, HHS estimated an adjustment to the FY 2009 error rate for comparison purposes. The adjusted FY 2009 rate was 12.4 percent.

and Medical Necessity), and to a lesser extent, coding errors (Administrative and Documentation). When the errors are analyzed based on the setting in which the service took place, the data shows that the most improper payments are due to medically unnecessary errors for inpatient hospital services.

Physicians and durable medical equipment suppliers contribute substantially to the amount of improper payments due to insufficient documentation. Incorrect coding errors are most prevalent in physician services.

HHS developed an Error Rate Reduction Plan (ERRP) that outlines actions the agency will implement in an effort to prevent and reduce improper payments for all categories of error.

Of particular importance are three demonstrations that HHS is implementing to prevent and reduce improper payments:

- First, HHS will further encourage private companies to catch wasteful spending before it happens by expanding the use of Recovery Audit Contractors in the Medicare program. Last year, private companies recovered hundreds of millions of taxpayer dollars by finding improper payments that have already been paid out. The agency will now allow private companies to review claims before they are paid, which will prevent improper payments from occurring in the first place.
- Second, HHS will test a change in hospital billing policies that would allow some hospitals to rebill for inpatient claims that would have been more appropriately treated in the outpatient settings. These errors account for over 20 percent of all Medicare improper payments.
- Third, HHS will test a change in payment policies for power mobility devices which have historically seen an extremely high error rate. Reports from the Office of Inspector General found that the error rate for standard and complex power wheelchairs was 80 percent in 2007. The agency will institute a demonstration program in 7 states to test whether a pre-payment review, followed later by a prior authorization program, can reduce fraud and improper payments for power mobility devices.

Administrative and Documentation Errors - Corrective Actions:

HHS has implemented safeguards to better ensure that only legitimate providers and suppliers receive Medicare payments:

- HHS published a final rule with comment titled, “Medicare, Medicaid and Children’s Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers” on February 2, 2011. This final rule implemented many of the program integrity provisions in the *Affordable Care Act*, including the requirement that State Medicaid programs terminate a provider or supplier who has been terminated from another State Medicaid program or from Medicare.
- HHS partnered with the Department of Justice (DOJ) to host Health Care Fraud Prevention Summits in four cities during FY 2011: Brooklyn, NY; Boston, MA; Detroit, MI; and Philadelphia, PA. These summits bring together a wide array of federal, State and local partners, beneficiaries, and providers to discuss innovative ways to eliminate fraud across the U.S. health care system.
- HHS has awarded five of the seven contracts required to complete the realignment of the Zone Program Integrity Contractors (ZPICs) with the Medicare Administrative Contractors (MACs). The seven zones were created to target fraud “hot spots” in the United States.
- HHS issued a request for proposals for an automated screening solution in July 2011 that will support the revalidation of 1.5 million providers, as required by the *Affordable Care Act*. HHS awarded the contract on September 30, 2011. The enrollment screening solution will automate the multiple database checks that are currently manual, increasing the accuracy of results and decreasing application processing time.
- HHS, in collaboration with California provider groups, law enforcement, and the Senior Medicare Patrol, hosted a series of events in September 2011, across the State, to educate physicians on medical identity theft and other fraud related topics and how to protect their professional and medical identity from fraud.
- HHS published a final rule titled “Home Health Prospective Payment System Rate Update” that implemented the face-to-face encounter requirements for Medicare home health benefits on November 17, 2010, as required by Section 6407 of the *Affordable Care Act*.
- HHS continues to improve the Medicare FFS error rate measurement program to ensure that providers and suppliers submit the

required documentation. Such improvements includes:

- HHS continued DME, Part A and Part B Medicare Administrative Contractor (MAC) provider outreach and education task forces during FY 2011. These task forces consist of contractor medical review professionals that meet regularly to develop strategies for provider education in error prone areas. The groups have written informational articles that are distributed on an as-needed basis to promote education among providers. These articles are maintained on the publically available Medical Learning Network (MLN).
- When a supplier is contacted for documentation, HHS notifies the ordering provider that they may be contacted by the supplier.
- HHS conducts calls with contractors and sends notices to providers and suppliers advising them of special studies being conducted in areas at high risk for improper payments. Information is provided regarding the documentation requests the provider or supplier may receive and what information and records are required to be provided.
- HHS revises the medical record request letters, as needed, to clarify the components of the medical record that are required for a CERT review.
- HHS contacts third party providers to request documentation when the billing provider indicated that a portion of the medical record is possessed by a third party. For example, a third party provider may be a physician who orders a power wheelchair, but the supplier submits the claim.
- HHS regularly calls providers to make additional attempts at collecting medical documentation to ensure insufficient documentation errors are accurate.

- HHS and its contractors conduct ongoing education to inform providers about the importance of submitting thorough and complete documentation. This involves national training sessions, individual meetings with providers with high error rates, presentations at industry association meetings, and the dissemination of educational materials.

Authentication and Medical Necessity Errors - Corrective Actions:

- HHS updates its review manuals, as needed, to clarify requirements for reviewing documentation. These clarifications promote uniform interpretation of the policies across all medical review entities involved in the Medicare FFS program.
- HHS is implementing the Electronic Submission of Medical Documentation (ESMD) into the CERT review process to create greater program efficiencies; allow quicker response time to documentation requests; and provide better communication between the provider and supplier, the CERT contractors, and HHS.
- HHS developed Comparative Billing Reports (CBRs) to help non-hospital providers analyze their administrative claims data. CBRs compare a provider's billing pattern for a specific procedure, or service, to their peers on a State and national level. HHS also developed the Program for Evaluating Payment Patterns Electronic Report (PEPPER). The PEPPER allows inpatient hospital providers to analyze their billing patterns through a comparison to other inpatient hospitals in their State and in the nation.
- HHS is developing a Program Vulnerability Tracking System (PVTS) that will track and analyze vulnerabilities identified by internal and external sources, including the National Fraud Prevention program, the Recovery Auditors, and the Office of Inspector General.
- HHS is conducting probe samples on providers to identify potential problem areas. Based on the probe results, HHS takes corrective actions, such as increased or more targeted pre-payment or post-payment reviews.
- HHS is increasing and improving medical review through the detection of and focus on services, supplies, providers, and suppliers that are at high risk for improper payments.
- HHS will allow Recovery Auditors to review additional provider types and will closely monitor the decisions made by the Recovery Auditors.
- HHS requires the Carriers, FIs, and MACs to develop Error Rate Reduction Plans (ERRP) that identify the specific causes of the improper payments in their jurisdiction and outline corrective actions.
- HHS requires the Carriers, FIs, and MACs to review and validate the CERT results for their jurisdiction to determine the education

outreach and review strategies needed to reduce improper payments.

- HHS developed medically unlikely auto-deny edits to catch those services where the level billed exceeds a number that would be clinically reasonable. HHS updates these edits quarterly.
- HHS implemented a National Fraud Prevention System (FPS) on June 30, 2011, as required by the *Small Business Jobs Act of 2010*. The FPS is an innovative risk scoring technology that applies proven predictive models to nationwide Medicare Fee-for-Service claims on a pre-payment basis. The risk-scores identify highly suspect claims, and help target resources to the areas of Medicare's greatest risk. Additionally, all Medicare ZPICs are assigned tasks through this single, integrated system.

11.13 Medicare FFS Improper Payment Recovery

The actual over-payments identified in the FY 2011 Medicare FFS Improper Payments Report were $5,821,154. The identified over-payments are to be recovered by the Medicare contractors via the standard payment recovery methods. As of the report publication date, Medicare contractors reported collecting $5,358,617, or 92 percent of the actual over-payment dollars identified in the report.

HHS has been able to recover 83 percent of the identified Medicare over-payments over the last five years. See Section 12.0 for further information on payment recovery.

11.14 Medicare FFS Information Systems and Other Infrastructure

HHS has the information systems and other infrastructure it needs to reduce improper Medicare FFS payments to the levels targeted. HHS' systems have the ability to identify developing and continuing aberrant billing patterns based upon a comparison of local payment rates with national rates. The systems at both the Medicare contractor level and the central office level are tied together by a high-speed secure network that allows rapid transmission of large data sets between systems. No other systems or infrastructure are needed at this time.

11.15 Medicare FFS Statutory or Regulatory Barriers That Could Limit Corrective Actions

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

11.16 Medicare FFS Best Practices

The following best practices have been incorporated into the overall CERT process to ensure the highest degree of efficiency for the program:

- CERT offers many educational forums for providers and suppliers to gain additional knowledge about the CERT program. Such educational resources include several CERT-related Web sites, a toll-free CERT contractor customer service line, CERT provider outreach calls, and on-line reference materials.
- HHS holds weekly calls with all CERT contractors to facilitate communication, solve problems, and to improve the CERT process.
- CERT collaborates with other review contractor entities, such as the MACs and Recovery Auditors, to clarify unclear policies, in an effort to ensure review consistency.

11.20 Medicare Advantage or Medicare Part C - A Medicare health insurance program that allows beneficiaries to receive their Medicare benefits through a private health plan.

11.21 Part C Medicare Advantage Statistical Sampling Process

The FY 2011 Medicare Part C Composite Payment Error Rate is based on calendar year (CY) 2009 payments and combines two component payment error measures: the Medicare Advantage Prescription Drug (MARx) Payment Error (MPE) estimate and the Risk Adjustment Error (RAE) estimate.

The Medicare Part C error rate for FY 2011 is 11.0 percent, or $12.4 billion. The FY 2011 error rate represents a decrease of 3.1 percentage points from the FY 2010 estimate. The net error rate for FY 2011 is 5.1 percent, or $5.7 billion. The net error rate is calculated by subtracting under-payments from over-payments, thus reflecting the overall estimated monetary loss to the program.

The Part C MPE estimate captures errors in prospective Part C payments caused by errors in the transfer of data, interpretation of data, and payment calculations in the MARx system. The FY 2011 methodology consists of:

- Selection of a random sample of beneficiaries for whom HHS made payments to plans for each month of CY 2009;
- Computation of the prospective payment error amount for sampled beneficiaries; and

- Extrapolation of the sample payment error to the population, resulting in a Part C gross payment error amount.

For FY 2011, the MPE rate is 0.2 percent.

The RAE estimate captures payment errors due to the application of incorrect beneficiary risk scores. The primary component of a beneficiary's risk score is based on clinical diagnoses submitted by plans. If diagnoses submitted to HHS by the plans are not supported by medical records, the risk scores will be inaccurate and result in payment errors. The RAE estimate is based on medical record reviews conducted under HHS' annual Risk Adjustment Data Validation (RADV) process, where unsupported diagnoses are identified and corrected risk scores are calculated.

The FY 2011 RAE methodology consists of:

- Selection of a stratified random sample of beneficiaries for whom a risk adjusted payment was made in CY 2009, where the strata are high, medium, and low risk scores;
- Medical record review of the diagnoses submitted by plans for the sampled beneficiaries;
- Calculation of beneficiary-level payment error for the sample; and
- Extrapolation of the sample payment error to the population subject to risk adjustment, resulting in a Part C gross payment error amount.

For FY 2011, the RAE rate is 11.0 percent.

The FY 2011 Part C composite payment error amount is the sum of the MPE and RAE gross payment error amounts described above. The Part C composite payment error rate is this sum divided by the CY 2009 total final Part C payments.

11.22 Medicare Advantage Corrective Action Plans

The root cause of improper payments in the Medicare Part C program reported in FY 2011 is administrative and documentation errors. The majority of the payment error estimate was insufficient documentation to support the diagnoses submitted by the plans, as measured by the RAE. The remainder of the payment error in the program is related to transfer of data, interpretation of data, and payment calculations within the MARx payment system, as reflected in the MPE estimate. HHS is taking steps to address the error measured by both the MPE and RAE. The error rate estimate for both the MPE and RAE decreased this year and HHS exceeded the FY 2011 Part C target error rate.

For the MPE error estimate, HHS will continue to routinely implement payment controls in the MARx payment system to ensure accurate and timely payments, including monthly payment validation and authorization processes. MARx payment errors are corrected and payment adjustments are made on a flow basis, including payment adjustments applied as part of the final Part C risk score reconciliation. These steps have been successful, as the MPE rate has declined from that reported in the *FY 2009 Agency Financial Report.*

For the RAE error estimate, HHS has implemented three key initiatives, described below, as part of its corrective action plan: Contract-level audits; physician outreach; and Medicare Advantage (MA) organization guidance and training.

- Contract-Level Audits: HHS is proceeding with the Risk Adjusted Data Validation (RADV) contract-level audits for the purposes of recovering over-payments. RADV verifies, through medical record review, the accuracy of enrollee diagnoses submitted by MA organizations for risk adjusted payment. RADV audits are HHS' primary corrective action to recoup improper payments. HHS also expects that payment recovery will have a sentinel effect on the quality of risk adjustment data submitted for payment as MA organizations recognize the potential financial impact.
- Physician Outreach: HHS has begun a program that enhances physician understanding of the way HHS pays MA organizations and the payment methodology impact on physicians. The focus of this effort is to improve medical record documentation prepared by physicians to support risk adjustment diagnoses.
- Medicare Advantage Organization Guidance and Training: HHS conducts national training sessions for MA organizations that provide comprehensive information on submitting accurate risk adjustment data. Additionally, HHS has been developing a method for identifying risk adjustment diagnoses that are more likely to be associated with payment error. This study has been examining the reasons these diagnoses are problematic. HHS has used and will continue to use these findings to conduct outreach, education and provide guidance to MA organizations.

11.23 Medicare Advantage Program Improper Payment Recovery

The MARx payment system error rate is based on an analysis of prospective payments. MARx payment system errors are fixed continuously throughout the payment year. The resulting payment adjustments are regularly corrected in the MARx system, including payment adjustments due to the final Part C risk score reconciliation. Therefore, recovery of MPE errors occurs as part of the routine operation of the MARx payment system.

Regarding the risk adjustment error reported in FY 2011, the Medical Record Review was based on a national sample of beneficiaries and no payment recovery has been conducted at this point. However, HHS is proceeding with the RADV audits for the purposes of recovering over-payments.

11.24 Medicare Advantage Information Systems and Other Infrastructure

HHS has the information systems and other infrastructure needed to reduce improper Medicare Part C payments. HHS uses the following internal Medicare systems to make and validate the Part C payments: the Medicare Beneficiary Database, the Risk Adjustment System, the Health Plan Management System, and the MARx payment system. No other systems or infrastructure are needed at this time.

11.25 Medicare Advantage Statutory or Regulatory Barriers that could limit Corrective Actions

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

11.26 Medicare Advantage Program Best Practices

HHS has taken several steps to ensure payment accuracy in the Medicare Advantage program. HHS performs a monthly evaluation of the MARx payment system, as represented in the MPE estimate, which has lead to system refinement and more accurate prospective payments to plans.

11.30 Medicare Prescription Drug Benefit or Part D - A federal prescription drug benefit program for Medicare beneficiaries.

11.31 Part D Statistical Sampling Process

In FY 2011, HHS is reporting, for the first time, a composite error estimate for the Medicare Prescription Drug Program (Part D), based on CY 2009 payments. The FY 2011 Part D Composite Payment Error Rate combines five component payment error measures: the Medicare Advantage Prescription Drug (MARx) Payment Error (MPE) estimate; the Payment Error relating to Low Income Subsidy status (PELS); the Payment Error Related to Incorrect Medicaid Status (PEMS); the Payment Error Related to Prescription Drug Event Data Validation (PEPV); and the Payment Error related to Direct and Indirect Remuneration (PEDIR). FY 2011 is the first year PEDIR has been measured.

The Medicare Part D error rate for FY 2011 is 3.2 percent, or $ 1.7 billion. The net error rate for FY 2011 is 2.8 percent, or $1.5 billion. The net error rate is calculated by subtracting under-payments from over-payments, thus reflecting the overall estimated monetary loss to the program.

The FY 2011 Part D composite payment error amount is the sum of the payment error amounts for the five component measures described below divided by the CY 2009 total final Part D payments.

The Part D MPE estimate captures errors in prospective Part D payments caused by errors in the transfer of data, interpretation of data, and payment calculations in the MARx system. The FY 2011 methodology consists of:

- Selection of a random sample of beneficiaries for whom HHS made payments to plans, for each month of CY 2009.
- Computation of the prospective payment error amount for sampled beneficiaries.
- Extrapolation of the sample payment error to the population, resulting in a Part D gross payment error amount.

For FY 2011, the MPE rate is 0.08 percent.

The Part D PELS estimate captures payment errors due to inconsistent HHS data on beneficiary low-income subsidy (LIS) status and the related low income cost sharing subsidy (LICS) payments. The payment error may occur when a State Medicaid agency or the Social Security Administration (SSA) submit to HHS' systems an update on a beneficiary's level of LIS after a Prescription Drug Event (PDE) record has been accepted. The FY 2011 PELS methodology consists of:

- Identification of the population subject to PELS in CY 2009.
- For this population, computation of beneficiary-level differences between LICS payments based on LIS status in the accepted PDE record generated on the date of service and the corrected LICS payments based on

LIS status in HHS' systems at the time of reconciliation.

- Program-level computation of: (1) the gross payment amount in error (the absolute difference between actual and corrected LICS payments for accepted PDE records), and (2) the PELS rate.

For FY 2011, the PELS rate is 0.14 percent.

The Part D PEMS estimate captures payment errors due to incorrect assignment of Medicaid status, which results in incorrect LIS-related payments. Full benefit dually-eligible beneficiaries (those eligible for Medicare and Title XIX benefits -- comprehensive health benefits and/or the Medicare Savings Program) are also eligible for the Part D full LIS. If a beneficiary were incorrectly assigned Medicaid eligibility, all or part of HHS' LIS-related payment to the Part D plan would be in error. The FY 2011 PEMS estimate is based on the FY 2009 national Medicaid active eligibility case error rate determined by another HHS *IPIA* error rate measurement programs, the Payment Error Rate Measurement (PERM) program. For the PEMS estimate, the PERM eligibility error rate (representing incorrect status for the entire Medicaid population) is assumed to be a proxy for the eligibility error rate for a subset of Medicaid beneficiaries, those also eligible for Medicare. The PEMS rate reflects over-payments only. The FY 2011 PEMS methodology consists of:

- Application of the PERM eligibility active case error rate to 100 percent of dual-eligible beneficiaries, by dividing them into three groups: (1) those who would remain eligible for the Part D full LIS even without dual eligible status; (2) those who would become eligible for the Part D partial LIS; and (3) those who would no longer be LIS-eligible.
- Beneficiaries with a PELS error were excluded from receiving a PEMS-related error to avoid the over-estimation of payment error.
- Computation of: (1) the PEMS gross payment error amount as the sum of the LIS payment amounts in error for the three groups, and (2) the PEMS rate.

For FY 2011, the PEMS rate is 0.66 percent.

The Part D PEPV estimate captures errors in payment due to invalid and/or inaccurate PDE records that result in adjustments to the benefit phase assignment of beneficiaries' PDE records, thus changing Part D LICS and reinsurance payments. The FY 2011 PEPV methodology consists of:

- Validation of a statistically valid sample of PDE records using hard copy prescriptions and claim detail documentation submitted by plan sponsors and the creation of a corrected PDE record for all sampled records with discrepancies.
- Imputation of PDE sample validation findings onto the PDE records for a random five percent sample of the Part D population.
- Calculation of a payment error estimate for the sample of beneficiaries. A simulation process measures the change in LICS and reinsurance payments as they relate to the changes in gross drug costs.
- Extrapolation of the sample payment error to the entire Part D population resulting in a PEPV gross payment error amount and PEPV rate.

For FY 2011, the PEPV rate is 2.18 percent.

The Part D PEDIR estimate captures error in the final Part D program payment due to incorrect total Direct and Indirect Remuneration (DIR) amounts reported by Part D plans to HHS. DIR refers to all rebates, subsidies, or other price concessions from any source (e.g., manufacturers) that serve to decrease the costs incurred by the Part D plan (directly or indirectly) for the Part D drug. The FY 2011 PEDIR methodology consists of:

- Determination of DIR error amounts for a CY 2008 sample of plans by identifying discrepancies between the total DIR amount reported for a plan for a year and the total DIR amount validated for that plan through HHS' financial audits of the plans.
- Extrapolation of DIR error from the sample to the CY 2009 population of plans.
- Conversion of DIR error amounts into payment error by recalculating reinsurance, risk sharing, and final reconciliation payments for each plan in the population.
- The payment reconciliation amount in error (the difference between the original and corrected Part D payment reconciliation amount) is summed for all plans, resulting in a program-wide PEDIR gross payment error amount and rate.

Payment Error related to DIR (PEDIR) is a plan-level estimate because DIR is reported to HHS at the plan level. The other four components of the composite error rate are PDE/beneficiary-level estimates. Combining these different units of analysis poses complex technical and statistical

challenges in calculating a confidence interval for the composite rate. Each component independently meets the OMB precision requirements. The four PDE/beneficiary-level measures (MPE, PELS, PEMS, and PEPV) combined into a four-component composite measure also meets the precision requirement (without PEDIR).

For FY 2011, the PEDIR rate is 0.15 percent.

11.32 Corrective Action Plan

The root cause of improper payments in the Part D program reported in FY 2011 is administrative and documentation errors.

For the MPE component, HHS will continue to routinely implement payment controls in the MARx payment system to ensure accurate and timely payments, including monthly payment validation and authorization processes. MARx payment errors are corrected and future payment adjustments are made on a flow basis, including the payment adjustments applied to the final Part D risk score reconciliation.

For the PEMS component, the corrective action steps identified in Medicaid Section 11.42 will assist in reducing the PEMS error estimate because this component is driven by the PERM findings.

HHS will conduct more in-depth analyses on the PELS error estimate to further describe the PELS population and assist in identifying subsequent steps that could be taken to address improper payment issues. Further, HHS will provide additional guidance to Part D sponsors to update beneficiary LIS status prior to reconciliation.

Going forward, HHS plans to continue the national training sessions for Medicare Prescription Drug Benefit Plans that provide comprehensive information on all aspects of Part D payment and data submission requirements, including sessions focusing on improvements in PDE record submission, which is reflected in the PEPV error rate estimate.

To assist plans with improved DIR reporting in the future, HHS is requiring plans to submit DIR amounts by National Drug Code (NDC).

11.33 Medicare Prescription Drug Benefit Improper Payment Recovery

The MARx payment system error rate, or MPE, is based on analysis of prospective payments. MARx payment system errors are fixed on a flow basis throughout the payment year. The resulting payment adjustments are also implemented on a flow basis in the MARx system, including the round of payment adjustments due to the final Part D risk score reconciliation. Therefore, recovery of MPE errors occurs on a flow basis as part of the routine operation of the MARx payment system.

Regarding the PEMS estimate, application of the national Medicaid active case eligibility error rate to Part D payments does not allow HHS to identify which dual eligible beneficiaries actually had incorrect Medicaid status. Thus, it is not possible to identify any beneficiary-level payments for which HHS could pursue payment recovery.

Regarding the PEPV error, the PDE validation reported in FY 2011 was based on a national sample of PDEs and the imputation of these results onto the Part D population, therefore payment errors cannot be linked to specific beneficiaries for payment recovery purposes.

Regarding the PELS estimate, further investigation must be done to better understand the inconsistencies identified by this analysis in order to determine how to conduct payment recovery.

Regarding the PEDIR error, the original data used to develop the FY 2011 error rate was based on CY 2008 audits. Plans submit updates to their reported DIR amounts on a flow basis. As a result, HHS expects to update the CY 2008 Part D reconciliation in CY 2012 and payment recoveries will be addressed at that time.

11.34 Medicare Prescription Drug Benefit Information Systems and Other Infrastructure

HHS has the information systems and other infrastructure needed to reduce improper Medicare Prescription Drug Benefit payments. HHS uses the following internal Medicare systems to make and validate the Part D payments: the Medicare Beneficiary Database, the Risk Adjustment System, the Health Plan Management System, the MARx payment system, and the Integrated Data Repository. No other systems or infrastructure are needed at this time.

11.35 Medicare Prescription Drug Benefit Statutory or Regulatory Barriers that could limit Corrective Actions

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

11.36 Medicare Prescription Drug Benefit Program Best Practices

HHS has taken several steps to ensure payment accuracy in the Medicare Prescription Drug program.

- Monthly validation of the MARx generated prospective payments, as represented in the MPE estimate, has led to system refinement and robust monitoring of prospective payments to plans.
- Outreach to plans before and during the PEPV data collection and validation process provides an open forum for improving instructions for data submission. In addition, extending the collection period has allowed for increased response rates and decreased improper payment estimates over time.

11.40 Medicaid - A joint federal/State program, administered by the States that provides health insurance to certain low income individuals.

11.41 Medicaid Statistical Sampling Process

The Payment Error Rate Measurement (PERM) program uses a 17 State three-year rotation for measuring Medicaid improper payments. To select the 17 States for the three-year cycle, States were ranked by size based on their past federal Fee-for-Service (FFS) expenditures and grouped into three major strata with 17 States in each stratum. The expenditure data showed that nine States represent the major portion (approximately 50 percent) of total federal FFS expenditures. To get a precise estimate for the national rate, it was important to make these nine high-expenditure States their own stratum. Therefore, the 17 States in Strata - 1 were further divided into two substrata – Strata - 1A (consisting of the nine States with the highest federal FFS expenditures) and Strata - 1B (consisting of the eight remaining high-expenditure States). The States were sampled such that three States were selected from Strata - 1A each year. Given the criterion that each State be sampled exactly once over a three-year cycle, each stratum will have one year in which only five States are sampled. That is, the pattern will resemble the sample distribution shown in Table 1.

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

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

Medicaid improper payments are estimated on a federal fiscal year basis and measure three component error rates: FFS, managed care, and eligibility. HHS, through its use of federal contractors, measures the FFS and managed care components and States perform the eligibility component measurement.

FFS and Managed Care Component:

States submit quarterly adjudicated claims data from which a randomly selected sample of FFS claims and managed care claims are drawn each quarter. Each selected FFS claim is subjected to a medical and data processing review. Managed care claims are subject only to a data processing review. For States reporting in FY 2011, the average FFS sample size was 540 claims and the average managed care sample size was 280 claims per State.

Eligibility Component:

For the entire 12 months of FY 2011, States conducted an eligibility review on a randomly selected sample of between 216 and 523 active cases and between 132 and 350 negative cases. The difference in sample sizes is based on the State’s historical eligibility error rate data.

- Active cases contain information on a beneficiary who is enrolled in the Medicaid program in the month that eligibility is reviewed.
- Negative cases contain information on a beneficiary who applied for benefits and was denied, or whose program benefits were terminated based on the State agency’s eligibility determination in the month that eligibility is reviewed.

HHS calculated two error rates for active cases, the payment error rate and the case error rate.

- The payment error rate is calculated using the weighted dollar values of payments made for services provided to beneficiaries who were ineligible for the program, or received a service that was not included in the beneficiary’s benefit package, divided by the weighted dollar value of claims for the sample of beneficiaries each month, (i.e., weighted dollars in error over total weighted dollars in the sample). HHS combines the State reported eligibility component payment error rates to develop a national eligibility error rate for Medicaid.
- The case error rate is calculated by dividing the weighted number of ineligible beneficiaries by the total weighted number of beneficiaries in the sample. HHS calculates only a case error rate for negative cases, because no payments were made. For the active and

negative case error rates, the errors are not dollar weighted, but they are sample weighted by stratum within a month.

Calculations and Findings:

All payment error rate calculations for the Medicaid program (the FFS component, managed care component, eligibility component, and national Medicaid error rate) are based on the ratio of estimated dollars of improper payments to the estimated dollars of total payments. Individual State error rate components are combined to calculate the national component error rates. The national Medicaid program error rate is calculated by combining the individual State error rates. National component error rates and the Medicaid program error rate are weighted by State size, so that a State with a $10 billion program "counts" 10 times more toward the national rate than a State with a one billion dollar program. The national program error rate represents the combination of Medicaid FFS, Medicaid managed care, and Medicaid eligibility error rates. A small correction factor ensures that Medicaid eligibility errors do not get "double counted."

HHS calculated and is reporting the 3-year weighted average national error rate that includes data from FYs 2009, 2010, and 2011. The three-year rolling error rate is 8.1 percent or $21.9 billion. The net error rate for FY 2011 is 7.8 percent, or $21 billion. The net error rate is calculated by subtracting under-payments from over-payments, thus reflecting the overall estimated monetary loss to the program.

The weighted national component error rates are as follows: Medicaid FFS - 2.7 percent; Medicaid managed care - 0.3 percent; and Medicaid eligibility - 6.1 percent. Within the Medicaid eligibility error rate, the active case error rate is 8.2 percent and the negative case error rate is 4.9 ercent. Note, as required under Section 601 of the *Children's Health Insurance Program Reauthorization Act of 2009* (*CHIPRA P.L. 111-3*), HHS published a final rule on August 11, 2010, effective September 30, 2010, which requires the eligibility reviews to be consistent with the State's eligibility verification policy rather than reviewing eligibility against a uniform methodology, which was done in the past. After publication of the final rule States were allowed to review cases under the new methodology. Based on current regulations, certain cases from FYs 2009-2010 would no longer be considered errors.

Medicaid Corrective Action Plans

States reviewed for the FY 2011 AFR measurement were the same States reviewed for the FY 2008 AFR. The re-measurement of this group reflects the impact of effective corrective action plans implemented after the last measurement. The error rate for this group of States dropped from 10.5 percent in FY 2008 to 6.7 percent in FY 2011, causing the three-year rolling error rate to decrease. The greatest improvement was made in the FFS component which dropped from 8.9 percent to 3.6 percent. Most States focused on provider education and communication which greatly reduced FFS documentation errors.

Overall, the majority of the FY 2011 errors were a result of cases reviewed for eligibility that were either not eligible or their eligibility status could not be determined, thus they were considered errors (verification errors). The most common cause of cases in error for the Medicaid FFS medical review was insufficient documentation (Administrative and Documentation errors).

For FY 2011, the most common causes of improper payments were:

- Verification:
  - Eligibility Errors
  - Pricing error
  - Non-covered service
- Administrative and Documentation:
  - Insufficient documentation
  - No documentation
- Authentication and Medical Necessity:
  - Number of units error
  - Diagnosis coding error Policy violation
  - Procedure coding error

HHS works closely with States to develop State-specific Corrective Action Plans (CAPs). States are responsible for implementing, monitoring, and evaluating the effectiveness of their CAPs. HHS received CAPs from all States whose Medicaid programs were measured and reported in FY 2010. States continue to take steps to reduce errors identified during the measurement.

Because much of the error rate in the past was due to missing or insufficient documentation, the majority of States focused on provider education and communication methods to improve the providers' responsiveness and timeliness. These methods included provider training sessions; meetings with provider associations; notices, bulletins and provider alerts; provider surveys; improvements and clarifications to written State policies emphasizing documentation

requirements; and performing more provider audits.

States focus their efforts on major causes of error where HHS and the State can identify clear patterns. For example, States have found that particular provider types, such as pharmacies or long-term care facilities, repeatedly fail to comply with documentation requirements and may find that a targeted corrective action for these providers is cost-effective and likely to reduce future improper payments. When States have pricing and logic errors occur in their processing system, they work to ensure that those systems are fixed to avoid improper payments.

For eligibility errors, specific corrective action strategies implemented by the States to reduce errors have included leveraging technology and available databases to obtain eligibility verification information without client contact; providing additional caseworker training, particularly in areas determined by the PERM review to be error-prone; and providing additional eligibility policy resources through a consolidated manual and web-based training.

In addition to the development, execution, and evaluation of the State-specific CAPS, HHS has also made significant efforts to lower error rates:

- A significant portion of medical review errors result from providers failing to submit necessary documentation. It is possible that some of these claims are accurate, but HHS could not verify their validity in the absence of sufficient documentation. The claims are therefore considered to be fully in error. HHS increased its efforts to reach out to providers and to obtain medical records to help resolve this problem. HHS also gives States more information on the potential impact of these documentation errors and more time for the States to work with providers to resolve them.
- For the second year, HHS has sponsored a series of provider open forum calls in the fall of 2011 for all States in the next PERM review cycle. HHS also enhanced the PERM Web site with up-to-date information, included a separate web page for providers, and an email account for providers to communicate directly with HHS.
- HHS developed PERM+, a new method for States to submit claims data for the PERM review. PERM+ makes claims data submission easier for States and condenses the PERM audit timeline. To test this new method, HHS conducted a PERM+ pilot with selected States. The pilot was successful as it decreased the burden and time for the PERM+ pilot States to produce the initial data request and improved the accuracy of the PERM universe. HHS is incorporating this approach beginning with the FY 2011 PERM cycle that will be reported in the FY 2012 AFR.
- Previously, the PERM sampling and review methodology required individual service-level claims. States struggled to provide documentation for payments not made or stored at the beneficiary level (aggregate payments). HHS developed an aggregate payment methodology that, if appropriate, allows aggregate payments to be submitted and sampled for PERM. HHS conducted an aggregate payment pilot with States to test this methodology. The pilot was successful and showed that the methodology can be applied consistently across States while maintaining statistical validity. The pilot was completed in FY 2010 and HHS is incorporating the aggregate payment methodology beginning with the FY 2011 PERM cycle that will be reported in the FY 2012 AFR.
- HHS conducts national best practice calls to facilitate idea sharing and lessons learned among the States in order to decrease improper payments. The first call was conducted in May 2010, and calls are conducted quarterly. States present their corrective action success stories in decreasing improper payment so other States can implement similar initiatives. All States, as well as PERM staff, Medicaid and CHIP Regional Office staff, and Medicaid Integrity staff attend.
- HHS conducts post-CAP onsite visits or webinars with the States. The first round of onsite visits or webinars began in April 2011 and concluded in June 2011. HHS plans to conduct these meetings annually. These meetings entail collaboration with the Medicaid Integrity Group (MIG), Regional Offices (ROs), and the PERM team. The information covered during each meeting included a recap of the previous PERM cycle, the disclosure of improper payment trends, the strategies for success in the upcoming PERM cycle, a discussion of State specific eligibility issues, a review of previous CAPs submitted, a discussion of upcoming PERM initiatives, an overview of the various HHS workgroups, and a summary of applicable OIG audits.
- HHS published a final rule with comment titled, "Medicare, Medicaid and Children's

Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" on February 2, 2011. This final rule implemented many of the program integrity provisions in the Affordable Care Act, including the requirement that State Medicaid programs terminate a provider or supplier who has been terminated from another State Medicaid program or from Medicare. HHS believes this rule will contribute to decreasing improper payments.

- Section 6411 of the *Affordable Care Act* requires States to establish Medicaid RAC programs and HHS published a final rule titled, "Medicaid Program: Recovery Audit Contractors" in the *Federal Register* on September 16, 2011, implementing this section. This final rule aligned the Medicaid RAC requirements to existing Medicare requirements, where feasible, and provides the State flexibility to tailor its program where appropriate. HHS required States to submit State plan amendments by December 31, 2010, on how they will establish their RAC program. Medicaid RACs will be paid by each State on a contingency basis. They will review Medicaid provider claims to identify and recover over-payments and identify under-payments made for services provided under Medicaid State plans and Medicaid waivers.
- HHS published a proposed rule for public comment on the face-to-face documentation requirements for Medicaid home health services and medical supply benefit on July 12, 2011, as required by Section 6407 of the Affordable Care Act.
- As an additional program corrective action, HHS formed a State systems workgroup to address individual State system problems that may cause payment errors. The workgroup includes representatives from HHS and State staff.

11.43 Medicaid Program Improper Payment Recovery

For FY 2009, HHS identified $1,095,473 in Medicaid Improper Payments.

For FY 2010, HHS identified $784,877 in Medicaid Improper Payments.

For FY 2011, HHS identified $1,743,563 in Medicaid Improper Payments.

HHS works closely with States to recover over-payments identified from the fee-for-service and managed care claims sampled and reviewed.

The recoveries of Medicaid improper payments are governed by Section 1903(d)(2) of the *Social Security Act* and related regulations at Part 433, Subpart F under which States must return the federal share of over-payments. States reimburse HHS for the federal share on the Medicaid CMS-64 expenditure report.

Section 6506, of the *Affordable Care Act* allows States up to one year from the date of discovery of an over-payment for Medicaid services to recover, or to attempt to recover, such over-payment before making an adjustment to refund the federal share of the over-payment.

HHS is implementing a Medicaid Recovery Audit program, as required by section 6411(a) of the Affordable Care Act. As HHS designs the program, we are drawing from the lessons learned from the Medicare FFS Recovery Audit Program. HHS issued a State Medicaid Director letter in October 2010, that offered initial guidance on the implementation of Medicaid Recovery Audit Contractors and published the final rule titled, "Medicaid Program: Recovery Audit Contractors" in the *Federal Register* on September 16, 2011.

See Section 12.0 for further information on payment recovery.

11.44 Medicaid Information Systems and Other Infrastructure

Since Medicaid payments occur at the State level, information systems and other infrastructure needed to reduce Medicaid improper payments would need to be implemented at the State level. PERM faced many challenges with State payment systems that had paper only and aggregate claims; changes in information systems at the State level during the course of the measurement cycle; and a wide variation of system designs and capabilities. HHS has been active in encouraging and supporting States in their efforts to modernize and improve State Medicaid Management Information Systems (MMIS). Such improvements will produce greater efficiencies in the PERM measurement and strengthen program integrity. The State systems workgroup consisting of State and HHS representatives meets regularly to identify and discuss State system vulnerabilities and the impact on the measurement of improper payments. In addition, HHS developed a methodology to measure aggregate claims that have been incorporated into the PERM processes.

HHS is developing a comprehensive plan to modernize the Children's Health Insurance

Program (CHIP) and Medicaid data systems. The primary goal of this plan is to leverage technologies to create an authoritative and comprehensive Medicaid and CHIP data structure so that HHS can provide more effective oversight of its programs. The plan will also result in a reduction of State burden and the availability of more robust data for the PERM measurement.

HHS is also developing the Medicaid and CHIP Business Information Solutions (MACBIS) system. MACBIS will allow States to submit timely claims data submission to HHS. HHS will use this data for the Medicaid improper payment measurement and to satisfy other HHS requirements. Through the use of MACBIS, HHS will not only acquire higher quality data, but will also reduce State data requests.

11.45 Medicaid Statutory or Regulatory Barriers that could limit Corrective Actions

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

11.46 Medicaid Program Best Practices

Based on lessons learned through previous PERM cycles and in an effort to address challenges faced by the States, HHS continues the pre-cycle aspect of the PERM measurement. The pre-cycle phase occurs prior to the first submission of data and allows HHS to disseminate information on changes in the program and to conduct individual orientation and education sessions with the States. The following additional measures have been incorporated into the overall process:

- States receive further education on the PERM process through HHS-initiated cycle calls and Web site activity.
- HHS has designated a cycle manager as the lead for a fiscal year measurement and the main point of contact at HHS for that year.
- HHS utilizes dashboards, a compilation of the contractors' and States' work, to monitor the progress of the measurement. The dashboards enable HHS to monitor problems in the measurement early and provide assistance to resolve issues that could delay the measurement progress.
- HHS published the PERM Manual (internet only) in January 2011 to offer States day-to-day operating instructions, policies, and procedures based on statutes, regulations, guidelines, models, and directives.
- The use of biweekly all-contractor meetings has been employed to facilitate communication and problem solving between HHS and its contractors to improve the PERM process.
- For States having difficulty providing complete data, HHS has provided on-site technical assistance. HHS published the Medicaid Integrity Manual (an internet-only manual) on September 23, 2011. This is the first time various forms of guidance to State Medicaid programs have been consolidated into one easy-to-use location. HHS continues to offer training to State Medicaid program officials through the Medicaid Integrity Institute (MII). The MII provides a unique opportunity for HHS to offer substantive training, technical assistance, and support to States in a structured learning environment.
- *CHIPRA* required HHS to review the requirements of the MEQC and PERM programs and coordinate the implementation of the requirements to reduce redundancies between the measurements. Beyond what was proposed in the August 2010 final rule, HHS is exploring options to further coordinate and consolidate the requirements of Section 1903(u) of the Medicaid statute for Medicaid Eligibility Quality Control (MEQC) with the requirements of *PERM*. The eventual goal is to allow one measurement to meet the quality control requirements of MEQC and the improper payment requirements of PERM. Harmonization would benefit States by reducing workload for conducting eligibility reviews, providing meaningful results for corrective actions, and allowing HHS to recover identified erroneous payments based on Medicaid eligibility determinations.
- HHS is exploring what changes will be needed for PERM in light of *Affordable Care Act* implementation, particularly with regard to the significant changes in Medicaid eligibility determination required by the *Act*.

11.50 Children's Health Insurance Program (CHIP) - A joint federal/State program administered by the States that provides health insurance for qualifying children.

11.51 CHIP Statistical Sampling Process

On August 11, 2010, as part of enhanced efforts to reduce improper payments in federal programs, HHS issued the final regulations (PERM final rule) that fully implements improvements to the Payment Error Rate Measurement (PERM) program for Medicaid and the Children's Health Insurance Program (CHIP). Section 601 of the *Children's Health Insurance Program*

Reauthorization Act of 2009 (*CHIPRA P.L. 111-3*) prohibited HHS from calculating or publishing any national or State-specific error rates for CHIP until six months after a new PERM final rule was in effect. As a result, HHS did not report a national error rate for CHIP in the FY 2009 or FY 2010 AFR. Due to the timing of the PERM final rule, HHS is not reporting a national error rate for CHIP in the FY 2011 *AFR*. However, HHS will publish a CHIP error rate in the FY 2012 *AFR*.

Prior to the passage of *CHIPRA* and the statutory requirement prohibiting the calculation or publication of a CHIP error rate, Medicaid and CHIP employed the same State sampling process. HHS determined that CHIP can be measured in the same States selected for Medicaid review each fiscal year with a high probability that the CHIP error rate will meet the *IPIA* required confidence and precision levels. Since CHIP and Medicaid will be measured in the selected States in the same year, each State will be measured for CHIP once and only once every three years. For detailed information on the State sampling process implemented prior to passage of *CHIPRA*, please refer to Section 11.41, Medicaid Statistical Sampling Process.

CHIP improper payments will be estimated on a federal fiscal year basis and will measure three component error rates: FFS, managed care, and eligibility. HHS, through its use of federal contractors, measures the FFS and managed care components and States perform the eligibility component measurement.

11.52 CHIP Corrective Action Plans

Since HHS is not reporting a national CHIP FY 2011 error rate, the affected States were not required to submit a corrective action plan.

States will submit and implement corrective action plans after we report a CHIP error rate in FY 2012. That corrective action plan will include the following:

- Data analysis - an analysis of the findings to identify where and why errors are occurring.
- Program analysis - an analysis of the findings to determine the causes of errors in program operations.
- Corrective action planning - steps taken to determine cost-effective actions that can be implemented to correct error causes.
- Implementation - plans to operationalize the corrective actions, including milestones and a timeframe for achieving error reduction.
- Monitoring and evaluation – assessment of whether the corrective actions are in place and are effective at reducing or eliminating error causes.

HHS will monitor States' implemented corrective actions to determine whether the actions are effective and whether milestones are being reached.

11.53 CHIP Program Improper Payment Recovery

For FY 2011, no improper payments were identified for the CHIP program as explained in Section 11.51.

The recoveries of CHIP improper payments are governed by Section 2105(e) of the *Social Security Act* and related regulations at Part 457, Subpart B under which States must return the federal share of over-payments. States reimburse HHS for the federal share on the CHIP CMS-21 expenditure report. As of January 2010, States report PERM recoveries separately on the CMS-21 making recoveries easier for HHS to track.

Section 2105(c)(6)(B) of the *Social Security Act* incorporated the over-payment requirements of Section 1903(d)(2) for CHIP. Section 6506 of the *Affordable Care Act* allows States up to one year from the date of discovery of an over-payment for services to recover, or to attempt to recover, such over-payment before making an adjustment to refund the federal share of the over-payment.

11.54 CHIP Information Systems and Other Infrastructure

Since CHIP payments occur at the State level, information systems and other infrastructure needed to reduce CHIP improper payments would need to be implemented at the State level. PERM faced many challenges with State payment systems that had paper-only and aggregate claims; changes in information systems at the State level during the course of the measurement cycle; and a wide variation of system designs and capabilities. HHS has been active in encouraging and supporting States in their efforts to modernize and improve State Medicaid Management Information Systems (MMIS). Such improvements will produce greater efficiencies in the PERM measurement and strengthen program integrity. The State systems workgroup consisting of State and HHS representatives meets regularly to identify and discuss State system vulnerabilities and the impact on the measurement of improper payments. In addition, HHS developed a methodology to measure aggregate claims that have been incorporated into the PERM processes.

HHS is developing a comprehensive plan to modernize the CHIP and Medicaid data systems. The primary goal of this plan is to leverage technologies to create an authoritative and comprehensive Medicaid and CHIP data structure so that HHS can provide more effective oversight of its programs. The plan will also result in a reduction of State burden and the availability of more robust data for the PERM measurement.

HHS is also developing the Medicaid (MACBIS) system, which will allow States to submit timely claims-data submissions to HHS. HHS will use this data for the Medicaid improper payment measurement and to satisfy other HHS requirements. Through the use of MACBIS, HHS will not only acquire higher quality data, but will also reduce State data requests.

11.55 CHIP Statutory or Regulatory Barriers that could limit Corrective Actions

Section 601 of *the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3)* prohibited HHS from calculating or publishing any national or State-specific error rates for CHIP until six months after a new PERM final rule was in effect. The new final rule for PERM became effective September 10, 2010; therefore, for FY 2009 and FY 2010, HHS did not report a national CHIP error rate. However, HHS will begin the CHIP measurement in FY 2011 and report an error rate in the FY 2012 AFR.

11.56 CHIP Best Practices

This section is not currently applicable because HHS is not reporting a CHIP error rate in FY 2011.

11.60 Temporary Assistance for Needy Families (TANF) - A joint federal/State program administered by the States that provides time-limited assistance to needy families with children to promote work, responsibility and self-sufficiency.

11.61 TANF Statistical Sampling Process

Statutory limitations prohibit HHS from requiring States to participate in a TANF improper payment measurement. As a result, the TANF program is not reporting an error rate for FY 2011. Despite statutory limitations, HHS continues to explore options that will allow for a future error rate measurement.

11.62 TANF Corrective Action Plans

Since TANF is a State-administered program, corrective actions that could help reduce improper payments would have to be implemented at the State level. The TANF statute prohibits HHS from requiring State TANF agencies to implement and report on corrective actions. Despite the limitations, HHS has submitted letters to all TANF States with recommendations for potential corrective actions based on past reviews done by the OIG. The reviews show that the primary causes of error are ineligible recipients, incorrect payment amounts, and insufficient documentation. States may employ these recommendations voluntarily in their corrective action efforts to reduce future improper payments.

11.63 TANF Improper Payments Recovery

Statutory limitations prohibit HHS from requiring States to participate in a TANF improper payment measurement. As a result, the TANF program is not reporting an error rate for FY 2011, or any results from improper payment recoveries. Despite statutory limitations, HHS continues to explore options that will allow for a future error rate measurement.

11.64 TANF Information Systems and Other Infrastructure

Since TANF payments occur at the State level, information systems and other infrastructure needed to reduce TANF improper payments would need to be implemented at the State level. States utilize the Public Assistance Reporting Information System (PARIS), the National Directory of New Hires (NDNH), and the Income and Eligibility Verification System (IEVS), to help ensure that improper payments are minimized. No other systems or infrastructure are needed at this time.

11.65 TANF Statutory or Regulatory Barriers

Statutory limitations prohibit HHS from requiring States to participate in a TANF improper payment measurement.

11.66 TANF Program Best Practices

We encourage States to stress the importance of payment accuracy for TANF cases and seriously consider measures that will reduce the incidence of erroneous payments in their States. Actions that may prove beneficial in this area include but are not limited to:

- Conduct local office quality control reviews at both the initial intake and redetermination stages of case development for basic assistance eligibility and payment processes.
- Consider payment accuracy as proper case documentation measures or elements of staff performance.
- Develop and maintain a reminder system for critical follow-up actions on cases such as responding to reports of non-cooperation with

child support, IEVS "hits", redeterminations of eligibility, or failure to fulfill work requirements.

- Establish a process for the collection of TANF over-payments from the applicable recipients.
- Periodically remind TANF recipients of their responsibility to accurately report income, resources, and other family circumstances to the local TANF agency on a timely basis.
- Conduct training on investigative interviewing techniques for intake workers and case managers.
- Perform periodic "checks" of case records, paying particular attention to documentation that includes a current application and facts supporting income, household composition, participation in work activities, and cooperation with child support enforcement.
- Establish and monitor internal procedures to ensure that TANF payments are adjusted on a timely basis when family circumstances change and affect case eligibility or the amount of payment. Use National Directory of New Hires (NDNH) information to verify the eligibility of adult TANF recipients residing in the State and once the information is verified, it can be used to modify benefits or close the case if the individual is not eligible for assistance. States using NDNH information have reported that it has been a valuable tool in improving payment accuracy. By using NDNH information, States have uncovered previously unknown employment, improved TANF program integrity by evaluating benefit accuracy, and even uncovered identity theft.

11.70 Foster Care - A joint federal/State program administered by the States for children who need placement outside their homes in a foster family home or a child care facility.

11.71 Foster Care Statistical Sampling Process

There have been no changes to the statistical sampling process for Title IV-E Foster Care during the current year. Under the regulatory review promulgated at *45 CFR 1356.71*, Foster Care Eligibility Reviews are conducted systematically in each State (the 50 States, the District of Columbia and Puerto Rico) every three years. During these reviews, a team comprised of federal and State staff review 80 cases selected from the State's *Title IV-E* Foster Care population to determine a State's level of compliance in meeting the federal eligibility requirements for the Foster Care program and to validate the accuracy of a State's claim for federal reimbursement of Foster Care maintenance payments. Each regulatory review identifies the number of error cases and amount of payment errors, as determined from the review of a sample drawn from the State's overall *Title IV-E* caseload for its six-month Period Under Review (PUR). The sample is a random sample drawn from the universe of cases having at least one *Title IV-E* Foster Care maintenance payment during the PUR. An error case is defined as a case in which a *Title IV-E* Foster Care maintenance payment is made on behalf of an ineligible child during the PUR. Payment errors may include payments for error cases, payments made for non-error cases which failed to meet an eligibility criterion outside the PUR, and payments for services not covered by *Title IV-E* or its regulatory provisions (e.g. therapy). Payment errors associated with under-payments are also identified during the reviews. If any over-payment errors are identified during a primary review, HHS imposes a disallowance in the total amount of all identified over-payment errors.

HHS employs a 10 percent error threshold to determine the level of State compliance in meeting the federal requirements in the Foster Care program. If during a primary review, in which 80 cases are reviewed, four or fewer cases are found to be in error, HHS can be 91 percent certain that no more than 10 percent of the entire population of *Title IV-E* Foster Care cases will be in error. If, however, during a primary review a State exceeds the error threshold because more than four cases are found to be in error, (a) HHS takes a disallowance as described above, (b) the State is required to develop and implement a Program Improvement Plan (PIP) and, (c) following PIP implementation (which generally is completed within a year), the State is subjected to a secondary review where 150 cases are selected for review. If a State exceeds the error threshold for the case and dollar error rates in a secondary review, the State is assessed an additional extrapolated disallowance, which is equal to the lower limit of a 90 percent confidence interval for the State Foster Care population's total dollars in error during the six-month PUR. The extrapolation increases geometrically the resulting disallowance. Since FY 2000, HHS has systematically conducted more than 170 regulatory Foster Care reviews, with nearly 16,000 Foster Care cases reviewed.

The Foster Care error rate and national estimates of improper payments are calculated each year using data collected in the most recent eligibility review for each of 50 States, the District of Columbia, and Puerto Rico. Since each State is reviewed every three years, each year's

"composite sample" of data from 52 State reviews incorporates new review data for about one-third of the States. While each State sample represents a distinct six-month PUR, the national "composite" sample reflects a composite PUR. Consequently, the resulting error rate is referred to as a "rolling" estimate, since about one-third of the review data are replaced with new data each year. To arrive at the national estimates of improper payments and payment error rate, data from each State review sample are used to develop an estimate of State improper payments for the PUR. This estimate considers both under- and over-payments in accordance with the *IPIA*. State estimates are then aggregated to estimate national improper payments for the composite PUR. The national estimate is divided by the sum of payments received during respective PURs to determine the national payment error rate for the program. Each annual estimate since FY 2008 has reflected a shift from a case-based estimation to a refined dollar-based methodology for estimating State improper payments. Continued application of the new, refined methodology to eligibility review data for this year indicates that, for FY 2011, the Foster Care estimated national payment error rate is 5.3% percent, or $72.1 million. The net error rate is 3.9 percent, or $54 million. The net error rate is calculated by subtracting under-payment from over-payments, thus reflecting the overall estimated monetary loss to the program.

This year's error rate represents a slight increase compared to the FY 2010 error rate of 4.9 percent; however, current performance still represents a decrease of nearly 50 percent from the baseline rate of 10.33 percent. The slight increase in the error rate since FY 2010 appears to stem from higher error rates in three of the States reviewed in this year that are in the top third of States in terms of program size. Consequently, the increase in their error rates had a substantial impact on the overall program rate. Conversely, although over half of States reviewed demonstrated improved error rate performance (i.e., lower error rates), most of the improvements were relatively small, so they had minimal impact on the national rate.

11.72 Foster Care Corrective Action Plans

All payment errors in the *Title IV-E* Foster Care Program are "Administrative and Documentation" errors because they all reflect incorrect classifying or processing of payments by State agencies or third parties who are not the beneficiaries. Thus, all corrective action plans are targeted to improving processing of *Title IV-E* claims by State and local agencies. Corrective action plans instituted by HHS to address improper payments in the Foster Care program have been designed to help States address those payment errors (e.g., under-payments) that have contributed most to improper payments made by the *Title IV-E* program to State agencies.

In FY 2011, the most common payment errors made by States involving *Title IV-E* Foster Care funds included the following:

- Ineligible payment (e.g., therapy or unallowable transportation costs) (19 percent of errors);
- Under-payments (15 percent of errors);
- Provider not licensed or approved (14 percent of errors);
- Not AFDC eligible at time of removal (10 percent of errors);
- Criminal records check not completed (9 percent of errors); and
- Duplicate or excessive maintenance payments to providers (7 percent of errors).

Together these six items account for over 85 percent of the payment errors for Foster Care. The overall frequency of all types of payment errors in the composite Foster Care sample (i.e., across all States) increased by about 10 percent from FY 2010 to FY 2011. This increase was primarily attributed to increases in ineligible payments (e.g., payment for transportation costs unallowable for reimbursement as foster care maintenance costs) and, to a lesser extent, duplicate or excessive payments. Payment errors related to lack of court orders involving contrary to welfare determinations also increased after a 5-year downward trend, however, half of that increase occurred in a single State.

It is of interest to note that in our efforts to reduce improper payments, the overall number of payment errors has dropped substantially and the composition of error types identified has changed as well. When reporting commenced in FY 2004, the most prevalent errors were errors associated with the requirement for a judicial determination in finalizing the permanency plan. However, these errors have been reduced from a frequency of 286 in FY 2004 to only 28 in FY 2011.

The slight increase in payment errors in FY 2011 highlights the importance of maintaining diligence in corrective action efforts. Key features of HHS's corrective action strategies include the following:

- HHS conducts on-site and post-site review activities to effectively validate the accuracy of a State's claim for reimbursement of

payments made on behalf of children and their Foster Care providers. Specific feedback is provided on-site to the State agency to directly impact the proper and efficient administration and implementation of the State's *Title IV-E* Foster Care program. Further, a comprehensive report is issued to the State agency to confirm the final findings of the on-site review. The final report serves as the basis for the development of a Program Improvement Plan (PIP) for States that exceed the error threshold.

- States are required to develop and execute State-specific PIPs that target corrective action to the root cause of payment errors in the State. The PIP is developed by State staff in consultation with federal staff and is required to include:

  (1) Specific goals or outcomes for program improvement;

  (2) Measurable action steps required to correct each identified weakness or deficiency;

  (3) A target date for completing each action step;

  (4) A description of how progress will be evaluated by the State and reported to HHS, including the frequency and format of the evaluation procedures; and

  (5) A description of how the State will report to HHS when an action step has been achieved.

- The PIP is designed to lead to measurable changes in State program operations and is required to identify the specific action steps developed to attain the desired outcomes and correct program deficiencies. Each action strategy has a projected completion date that will not extend more than one year from the date the PIP is approved by HHS. This assures that proper attention is given to correcting deficiencies in a timely manner. HHS believes that the development and implementation of the PIP is the key to identifying the reasons why cases are in error and motivating States to correct the identified problems. Requiring States to implement PIPs has proven to be an effective solution in addressing eligibility errors as reflected in the decrease in the national error rate since FY 2004.

- HHS provides onsite training and technical assistance to States to develop and implement program improvement strategies.

- HHS works toward heightening judicial awareness and monitoring of reviews. In past years, three of the six most frequently occurring errors have involved the judiciary. In FY 2011, none of the six most frequent payment errors involved the judiciary. HHS continues to share the results of the Foster Care reviews with judicial organizations and offers training and technical assistance to educate and inform the judiciary in areas pertaining to their role directly impacting the State agency's performance on the eligibility factors.

- HHS works closely with the Court Improvement Program in States where judges require training and court orders warrant modification to maintain the gains in reducing improper payments related to the judiciary.

- HHS conducts secondary reviews (as applicable) and takes appropriate disallowances consistent with the review findings. HHS's expectation is that these disallowances, in conjunction with the development and implementation of the PIP, will serve as strong encouragement to the States to improve their programs to the extent that when a secondary review is conducted they will be determined to be in substantial compliance.

- HHS provides technical guidance to ensure reliable identification of under-payments by

  (1) Discussing any under-payments identified during a *Title IV-E* eligibility review at the exit conference with State agency senior management;

  (2) Identifying under-payments in final reports issued to States following Title IV-E eligibility reviews; and

  (3) Including language in the *Title IV-E Foster Care Eligibility Review Guide* clarifying what constitutes an "under-payment" to ensure that federal and State agency staff accurately identify under-payments.

- Also, HHS provides training and technical assistance tailored to assist States and Tribes in improving their child welfare systems and to conform to outcomes and systemic factors identified in the results of the regulatory Foster Care monitoring reviews. The aim is to refine their management and operations, expand organizational capacity, and foster effective and consistent practice while improving outcomes for children, youth, and families.

Through implementation of its comprehensive corrective action plan, HHS reduced the national Foster Care error rate below target levels and demonstrated steady progress in reducing the error rate in FY 2005, FY 2006, and FY 2007. The error rate decreased from 10.33 percent in FY 2004 (baseline) to 8.6 percent (FY 2005) to 7.68 percent (FY 2006) to 3.3 percent (FY 2007). Although the rate increased in FY 2008 to 6.42 percent, that change still represented a reduction of the rate by over one-third since establishing the baseline for FY 2004. In addition, the FY 2008 error rate estimate reflected a transition from a case-based estimation to a refined dollar-based methodology for estimating State improper payments.

In FY 2009, the error rate decreased to 4.7 percent. Although in FY 2010 and FY 2011 the program error rate increased by about one quarter percent each year, the *Title IV-E* Foster Care program continues to maintain a payment error rate that is about half the baseline rate. In comparison to the baseline rate of 10.33 percent, the FY 2011 payment error rate is 5.3 percent. Examination of the relative contributions of over-payments and under-payments indicates that the overall program improper payments error rate of 5.3 percent is comprised of a 4.6 percent over-payment rate and a 0.7 percent under-payment rate, producing a net error rate of 3.9 percent.

Applying the program payment error rate to program maintenance payments for FY 2011 yields an estimate of gross annual improper payments (i.e., over-payments *plus* under-payments) of $72.1 million. Consideration of the over-payment and under-payment error rates indicates that this $72.1 million in improper payments includes estimated annual over-payments of $63.92 million and under-payments of $9.2 million. Thus, estimated net annual improper payments (i.e., over-payments *less* under-payments) are $54 million for the *Title IV-E* Foster Care program.

11.73 Foster Care Improper Payment Recovery

As a result of conducting Foster Care eligibility reviews in 16 States during the 12-month period between August 2010 and July 2011, HHS has recovered over $2.3million in *Title IV-E* improper payments. The funds recovered are comprised of $1,605,113 in disallowed maintenance payments and $655,774 in disallowed administrative payments.

The recovery of improper payments through eligibility reviews is most aptly classified as occurring through *post-payment reviews*. The Foster Care program does not systematically track cost recovery through the Office of Inspector General reviews and Single Audit Reports; however, such information has been obtained from HHS reports generated as part of the audit clearance process. Specifically, audit findings where the audit has been closed and a recommended cost recovery has been sustained for the Title IV-E Foster Care program were identified and tabulated.

These amounts are in addition to amounts identified through the eligibility reviews and are presumed as recovered in the fiscal year, when the audit is closed.

Recoveries of improper payments through audits can include *Title IV-E* Foster Care maintenance assistance payments, administration, and training and automated systems development costs.

See Section 12.0 for further information on payment recovery.

11.74 Foster Care Information Systems and Other Infrastructure

HHS uses the Adoption and Foster Care Analysis and Reporting System for the regulatory reviews. Utilizing this existing source of data reduces the burden on States to draw their own samples, promotes uniformity in sample selection, and employs the database in a practical and beneficial manner.

Since Foster Care payments occur at the State level, information systems and other infrastructure needed to reduce Foster Care improper payments would need to be implemented at the State level. No other systems or infrastructure are needed at this time.

11.75 Foster Care Statutory or Regulatory Barriers that could limit Corrective Actions

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

11.76 Foster Care Best Practices

Since the inception of its improper payment reporting, HHS has maintained a diligent focus on improper payment identification and reduction efforts in the Foster Care program. Refinements to the error rate methodology have included steps to ensure systematic examination and consideration of under-payments in eligibility reviews and modifying data retention practices to permit shifting from case-based extrapolation to dollar-based extrapolation.

Concurrent with these efforts to continually refine its identification and reporting on improper

payments, HHS has worked successfully to reduce improper payments across the Foster Care program. Working on dual fronts with States to improve administrative procedures for tracking and documenting eligibility and with the judiciary to support adherence to requirements for timely and thoroughly documented case hearings and court orders has yielded reductions in eligibility errors and resulting improper payments nearly each year since baseline reporting in FY 2004. The payment error rate has been reduced from a baseline rate of 10.33 percent of payments in FY 2004 to a rate of 5.3 percent in FY 2011. Furthermore, in the years since baseline reporting commenced, the *Title IV-E* Foster Care program has recovered a total of $14.5 million in improper payments.

In addition to the ongoing efforts to address improper payments outlined above, in FY 2011 the Foster Care program has continued to lay the groundwork for and move towards future implementation of a new methodology to review administrative payments for *Title IV-E* Foster Care (i.e., Administrative Cost Review, or ACR). In FY 2011, HHS conducted two pilot tests of the ACR methodology and shared the findings with the participating States for their consideration and implementation in improving the administrative cost allocation and the assignment to Title IV-E Foster Care. Additional pilot tests are scheduled for FY 2012.

11.80 Head Start - A federal program that provides comprehensive developmental services for America's low-income, preschool children ages three to five and their families.

11.81 Head Start Statistical Sampling Process

HHS is legislatively required to perform reviews of each Head Start program every three years and at the end of the program's first year of service. The Erroneous Payments (EP) study occurs simultaneously with a programs' scheduled triennial monitoring or first year review and includes a review of eligibility documentation. As required by *45 CFR 1305.4(c)*, *(d)*, and *(e)*, programs must verify family income, state the child's eligibility to participate in the program, and include within the child's file a signed statement identifying which documents were used to establish income eligibility. In addition, in May 2010 HHS issued a program instruction that emphasized the requirements of *1305.4(c)*, *(d)*, and *(e)*, and recommended programs use the signed statement designed by HHS and retain copies of eligibility documentation.

The objective of the Head Start EP study is to produce a national level error rate of enrolled children who are ineligible for Head Start or Early Head Start services according to Head Start's income eligibility guidelines. Improper payments in the Head Start program are defined as more than the allowed percentage of children enrolled whose family income exceeds the income eligibility guidelines.

The design of the sample for the Erroneous Payments study of Head Start programs is a three-stage sample process. The first stage of the sample selection is to identify programs scheduled for review. The second stage of the sample selection process is to select the programs to be reviewed through a stratified random sample, where programs were divided into five stratums by size of enrollment. The number of programs sampled within each stratum is roughly proportional to the number of children represented in each stratum.

The third stage of the sample selection process occurs when the EP Reviewer is onsite. The EP Reviewer selects the records to be reviewed using a systematic sampling scheme.

In FY 2011, 51 programs were sampled and a total of 11,726 child files were examined. The FY 2011 error rate is 0.6 percent, or $43.4 million.

11.82 Head Start Corrective Action Plans

The statistical analysis indicates that approximately 99 percent of the FY 2011 Head Start Erroneous Payments error rate is due to administrative, documentation and verification errors. Since 99 percent of the error rate is due to administrative, documentation and verification errors, HHS is concentrating its efforts on instructing and training its employees to reduce these correctable errors.

In May 2010, HHS issued a Program Instruction (*ACF-PI-HS-10-02*), reminding programs that they are required to verify family income before determining a child is eligible to participate in the program. The Program Instruction also encouraged programs to maintain copies of the eligibility documents with the eligibility verification form in the child's official record and to provide annual training to employees responsible for determining and verifying income eligibility.

HHS also developed a standard signed statement template form for Head Start. Although OMB clearance (*OMB 0907-0374*) was obtained in FY 2010, the use of the form is optional, but grantees are strongly encouraged to use it. The standard signed statement form helps guide grantees on the type of information they need to

collect from prospective families during the enrollment process and provides them with a structure for recording this information.

In FY 2011, HHS expanded the Erroneous Payments study to review more files while onsite. In addition, during monitoring reviews for all programs, additional files are sampled to verify age and income eligibility requirements and information is collected on how many programs maintain source documentation with the child's record. If available, a review of source documentation will be used to better understand whether the program is accurately determining eligibility status. Maintaining source documentation is currently not a requirement.

11.83 Head Start Improper Payments Recovery

HHS has determined that no program reviewed as part of the FY 2011 Erroneous Payment study will be subject to a disallowance. However, HHS will continue to concentrate on improper payment recovery where necessary.

11.84 Head Start Information Systems and Other Infrastructure

HHS has the information systems and infrastructure needed to reduce improper Head Start payments to the levels that HHS has targeted. HHS has two systems in place that identify grantees that are not complying with Head Start's income eligibility requirements. First, all review reports are processed centrally by HHS as part of the Head Start monitoring process. Secondly, Head Start is using the Risk Management System, implemented in each region, to help identify and manage grantee compliance with eligibility requirements. Both systems allow HHS to identify grantees that fail to comply with income eligibility requirements. No other systems or infrastructure are needed at this time.

11.85 Head Start Statutory or Regulatory Barriers

Currently, HHS cannot require programs to maintain source documentation that supports the determination of income eligibility. An HHS Notice of Proposed Rulemaking, published on March 18, 2011, potentially will require grantees to maintain source documentation.

11.86 Head Start Program Best Practices

HHS continues to explore ways as to how to improve the Head Start error rate process and address the Administrative and Documentation errors.

11.90 Child Care - A Joint federal/State program, administered by the States that provides child care financial assistance to low-income working families.

11.91 Child Care Statistical Sampling Process.

There were no changes to the statistical sampling process. However, HHS renewed the Data Collection Forms and Instructions in October 2010. The new instructions streamlined the review process, removed errata, and provided more guidance to reviewers. The Child Care Improper Payments statistical sampling methodology may be found on the Office of Child Care Web site at: http://www.acf.hhs.gov/programs/ccb/ccdf/ipi/data_final/data_final.pdf.

The FY 2011 Child Care error rate is 11.2 percent, or $636 million. The net error rate for FY 2011 is 9.2 percent, or $522 million. The net error rate is calculated by subtracting under-payment from over-payments, thus reflecting the overall estimated monetary loss to the program.

11.92 Child Care Corrective Action Plans

Administrative and Documentation Errors accounted for an estimated 54 percent of the improper authorization for payment errors found in the Child Care Improper Authorizations review process. Errors were primarily due to missing or insufficient documentation. The most frequently cited reasons for errors due to missing or insufficient documentation included: (1) insufficient documentation of earned income, unearned income and income deductions; (2) insufficient documentation of the hours of care needed; (3) missing or incomplete documentation about the work/educational/ training activity of the head of household; and (4) while less common, States also cited lack of documentation for the child's immigration status; correct household size/composition; and qualifying provider documentation.

Verification Errors represented 46 percent of errors found in the reviews. For purposes of this report, Verification Errors were identified as those with a lack of information to verify portions of the case record. These consisted of the failure to apply policy correctly including:

(1) Income calculation errors (inability to determine income calculation method, failure to include all income, use of an incorrect monthly conversion factor);

(2) Incorrect computation of the hours of care needed;

(3) Co-pay calculations, including incorrect use of the fee schedule; and

(4) Data errors (entry, eligibility and "Begin Date" errors).

Corrective actions targeting both error types include efforts by both the States administering the program as well as HHS.

States' efforts include:

- Conducting ongoing case record reviews. Several States focused their attention on conducting reviews or re-reviews of local agencies deemed high risk and large agencies that have a greater probability of contributing files to the federal sample. Other actions included reviewing supporting documentation to ensure that all case action was taken properly; and sub recipient monitoring was conducted on all entities through validation reviews.
- Increasing program monitoring to incorporate performance improvement plans, increasing awareness through review of results, and targeted corrective actions to managers.
- Evaluating and revising program policies and procedures. For example, one State reported successfully identifying and implementing efficiencies for workload management.
- Additional training, policy clarification, calculation tools and checklists for workers to ensure accuracy in the application process.
- Modifying contracts with local agencies to include measures on payment accuracy rates, annual management reviews, and corrective action plans. Several States added performance results to contracts and included corrective actions as performance required. Financing systems to support eligibility determinations (including a client income calculator, a parent fee calculator, and verification requirements). Many grantees updated system edits to support tracking attendance, caseworker alerts for action items, and monitoring reports. Developing an aggressive training plan to provide one-on-one training for eligibility workers.
- Developing an aggressive training plan to assist eligibility workers in all facets of the eligibility determination process in order to reduce specific errors, such as, income calculation, co-payment and fee schedules, etc.

HHS corrective actions, for errors identified, include:

- Providing technical assistance, specifically designed to help States focus on staff training, eligibility determination procedures, documentation requirements, routine case reviews, and overall program administration. Assigning contracted technical assistance specialists to work with individual States on implementing the Error Rate Review process. This added support was in addition to the technical assistance provided through the HHS and its Regional Offices.
- Conducting on-site visits to assist States in the implementation of the Error Rate Review methodology. For example, one State that received technical assistance showed a marked reduction in the error rate as a result of federal technical assistance.
- Providing guidance to all grantees through the issuance of a Program Instruction which highlights Program Integrity, Financial Accountability, and Access to Child Care. It can be found on the Office of Child Care Web site at: http://www.acf.hhs.gov/programs/ccb/law/guidance/current/pi2010-06/pi2010-06.html.
- Facilitating the National Program Integrity Conference Call Series that highlights various topics including: detecting customer and provider fraud; monitoring sub-recipients; program integrity processes; identifying fraud before it occurs; an overview of the national error rate data; an inventory of child care information systems; and an overview of the Grantee Internal Control Self Assessment Instrument
- Revising the State CCDF Plan Pre-Print to require specific information regarding reducing administrative errors, fraud, waste, and abuse. State Plan summaries are made available to the public in the spring following the year of submission.
- Continuing to modify and add to the CCDF Accountability Framework (which includes the Error Rate Review process, monitoring audit processes, and addressing potential fraud, waste, and abuse).
- Delivering targeted technical assistance to States to meet their individual needs within a block grant format.
- Providing States with an opportunity for peer-to-peer sharing of both error causes and program improvements, in an effort to reduce and/or eliminate errors and improper payments.

- Planning technical assistance and training opportunities to encourage States to begin their next review early, through examining current policies and procedures and automating their case review tool.
- Determining additional means to ascertain data on the scope of administrative errors, fraud, waste, and abuse.
- Pilot testing the technical assistance tool *Grantee Internal Control Self-Assessment Instrument* with several States to help them assess their internal control system, identify areas of risk, develop mitigation strategies, and receive technical assistance as they implement corrections.

11.93 Child Care Program Improper Payment Recovery

The actual CCDF improper authorization for payments identified as part of the FY 2011 error rate is $765,491. Since the overall error rate is comprised of three review cycles, the improper authorizations for payment amounts are as follows for each cycle: Year One States $166,268; Year Two States $214,475; and Year Three States $384,748.

The FY 2011 review cycle represents the second time that Year One States have conducted the error rate measurement. In comparison to FY 2008, the last time these States were measured, the improper authorizations for payment amount declined by $9,342 (from $175,610 to $166,268).

Overall, Year One States expect to recover seven percent, or $11,576, of the $166,268 in improper authorizations for payment identified during the review. This estimate breaks down as follows: three Year One States expect to recover more than 60 percent of improper authorizations for payment; seven States expect to recover between 5 and 60 percent; and eight Year One States expect to recover none of the $88,007 in errors they identified in the sample cases. Since requesting over-payment collection information from States is not part of the current information collection process, requesting such information would be in violation of the Paperwork Reduction Act. HHS is in the process of determining the best method of obtaining this information for future AFR submissions.

The CCDF methodology distinguishes between authorizations for payment and actual payments made to providers. Therefore, the amount of improper authorizations for payment identified during the review process does not represent actual improper payments. In general, the amount of payments is lower, computed to be on average about 17 percent lower. Any actual improper payments related to a specific case that was included in the sample during the case review process will be recovered from States by HHS through the disallowance process as set forth at 45 CFR 98.86 of CCDF regulations.

States also may take their own action to pursue recovery from the appropriate party (e.g., client or child care provider), however pursuant to CCDF regulations at 45 CFR 98.60(i), States are required to recover child care payments that are the result of fraud. States have discretion as to whether to recover misspent funds that were not the result of fraud, such as in cases of administrative error. Improperly spent funds are subject to disallowance by HHS regardless of whether the State pursues recovery.

11.94. Child Care Program Information Systems and Other Infrastructure

Since CCDF program payments occur at the State level, information systems and other infrastructure needed to reduce CCDF improper payments would need to be implemented at the State level. State investments in information systems for administering the CCDF program vary widely and there are large disparities in the capacity and capabilities of State systems. The majority of States report having sufficient infrastructure to reduce improper payments to the level targeted as part of the Error Rate Review process.

While the majority of States have automated, State-wide systems and the necessary infrastructure to meet targets to reduce improper authorizations in their next reporting cycle, States have reported implementing a range of improvements to information systems including:

- Integrating systems to enhance the application for child care benefits and to build the child care authorization spreadsheet into the application system.
- Incorporating alerts into the child care application system to remind eligibility workers to check completeness and accuracy of case files.
- Enhancing child care information systems to include capacity for the automated calculation of authorization amounts, given family income, hours of care needed, provider payment rate and co-pay requirements.

11.95 Child Care Program Statutory or Regulatory Barriers.

No statutory or regulatory barriers that would limit corrective actions have been identified at this time.

11.96 Child Care Program Best Practices

The "best practices" or "lessons learned" most frequently cited by the Year One States, based on their experiences in two review cycles, include the following:

- *Centralized Case-Record Reading* - Centralizing case-record reading supported the re-review process through the consistency of policy interpretation and error definition and allowed for copying record materials, regular meetings of the reviewers to discuss issues, and the increasingly important management of operational costs.
- *Review Team Composition* - Several States utilized a smaller review team as a lesson learned from the prior review process. This facilitated more uniform interpretation of case-file information, but at times resulted in a larger burden on the review team. For some States, using the same review staff who were involved in the first review cycle and their quality control staff was a major benefit. In one case, a technical assistance site visit was requested to work with Quality Control and State program staff. The State mentioned in its final report that, as a result of the technical assistance provided, the State had a clear understanding of the federal review expectations and limitations and the error rate decreased significantly.
- *Starting the Planning Process Early* - All phases of the process (customizing the *Record Review Worksheet*, the record-review process, and resolving sampling problems) took longer than States expected. Starting the process earlier allowed time to react to the unexpected, such as sampling problems or delays, review-team issues or record-reading problems. Six Year One States began the process 10 to 14 months prior to the submission of the final report.
- *Re-evaluation of the Existing Monitoring Process* - In some States, the guidance for the review process will be rewritten to comply both with State audit procedures and the requirements outlined in the *State Improper Payments Data Collection Instructions*.
- *Automating the Record Review Worksheet* - During the first review cycle, four Year One States automated the *Record Review Worksheet*. The number of States increased to eight for the second cycle. As the first review cycle progressed and States automated the *Record Review Worksheet,* examples were shared with other States through technical assistance.
- *Involving Local Partners* - Involvement of local partners *(*for example, Child Care Resource and Referral agencies and department of social services county offices) simplifies the record-request process, affords the opportunity to produce missing information or explain actions by sharing preliminary review findings on error cases, and creates buy-in and accountability fo*r* reductions in improper authorizations for payment.

In addition, States that availed themselves of the technical assistance regarding sampling, error definition, and scope of review were the States that experienced fewer challenges.

12.0 Recovery Auditing/Reporting

From FY 2004 to FY 2006, HHS awarded a contingency fee contract to a recovery auditing firm to review $24 billon in contract payments made between FY 2002 to FY 2005. As previously reported, our recovery auditors have found the HHS payment systems to be without major program integrity issues. The auditors identified approximately $1.6 million in potential recoveries and HHS has recovered $74,401. We have not sought a contractor to attempt to recover funds beyond FY 2005 because our efforts to date have produced such small recoveries.

HHS is currently in the planning stages of new, but similar, efforts in this area, termed payment recapture, as described in IPERA and in OMB guidance. We have convened workgroups across HHS to assess how well our various payment systems are performing and hope to have a strategy in place in FY 2012.

In FY 2011, the Medicare FFS Recovery Audit program demanded approximately $961.3 million and recovered $797.4 million in over-payments nationwide. FY 2011 recoveries were 958 percent higher than recoveries in the implementation years of FY 2009 and FY 2010. The Recovery Auditors focused their reviews on short hospital stays and claims for durable medical equipment.

Finally, some of our programs have results to report in this area and those results are included below in the following tables. If a program is not listed on a certain table, it is because they do not yet have results in that area.

TABLE 3
PAYMENT RECAPTURE AUDIT REPORTING
FY 2011
(in Millions)

Type of Payment	Amount Subject to Review for CY Reporting	Actual Amount Reviewed and Reported (CY)	Amount Identified for Recovery (CY)	Amount Recovered (CY)	% of Amount Recovered out of Amount Identified (CY)	Amount Outstanding (CY)	% of Amount Outstanding out of Amount Identified (CY)	Amount Determined Not to be Collectable (CY)	% of Amount Determined Not to be Collectable out of Amount Identified (CY)	Amounts Identified for Recovery (PYs)	Amounts Recovered (PYs)	Cumulative Amounts Identified for Recovery (CY + PYs)	Cumulative Amounts Recovered (CY + PYs)	Cumulative Amounts Outstanding (CY+PYs)	Cumulative Amounts Determined Not to be Collectable (CY+PYs)
Medicare FFS Recovery Auditors	N/A	N/A	$961.3	$797.4	83	$163.9	17.1	N/A	N/A	$135.7	$75.4	$1,097.0	$872.8	$224.2	N/A
HHS-Contracts	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$1.5	$0.074	$1.5	$0.074	N/A	N/A

TABLE 4
PAYMENT RECAPTURE AUDIT TARGETS
FY 2011
(in Millions)

Type of Payment	CY Amount Identified	CY Amount Recovered	CY Recovery Rate (Amount Recovered / Amount Identified)	CY + 1 Recovery Rate Target	CY + 2 Recovery Rate Target	CY + 3 Recovery Rate Target
Medicare FFS Recovery Auditors	$961.3	$797.4	83	83.5	84	85

TABLE 5
AGING OF OUTSTANDING OVERPAYMENTS
FY 2011
(in Millions)

Type of Payment	CY Amount Outstanding (0 – 6 months)	CY Amount Outstanding (6 months to 1 year)	CY Amount Outstanding (over 1 year)
Medicare FFS Recovery Auditors	$59.9	$154	N/A*

*Currently, HHS does not separately track over-payments identified by the Medicare FFS Recovery Auditors after they are one year old. HHS is exploring a mechanism to meet this requirement..

TABLE 6
DISPOSITION OF RECAPTURED FUNDS
FY 2011
(in Millions)

Type of Payment	Agency Expenses to Administer the Program	Payment Recapture Auditor Fees	Financial Management Improvement Activities	Original Purpose	Office of Inspector General	Returned to Treasury
Medicare FFS Recovery Auditors	$47.5	$81.9	N/A	N/A*	N/A	N/A

*Currently, HHS does not separately track over-payments identified by the Medicare FFS Recovery Auditors after they are one year old. HHS is exploring a mechanism to meet this requirement..

TABLE 7
OVERPAYMENTS RECAPTURED OUTSIDE OF PAYMENT RECAPTURE AUDITS
FY 2011
(in Millions)

Agency Source	Amount Identified (CY)	Amount Recovered (CY)	Amount Identified (PY)	Amount Recovered (PY)	Cumulative Amount Identified (CY+PYs)	Cumulative Amount Recovered (CY+PYs)
Medicare FFS Error Rate Measurement	$5.8	$5.4	$5.1	$3.8	$10.9	$9.2
Medicare Contractors	$14,019.7	$10,256.4	$10,682.9	$9,149.0	$24,702.7	19,405.4
Medicare Part C	N/A	N/A	N/A	N/A	N/A	N/A
Medicare Part D	N/A	N/A	N/A	N/A	N/A	N/A
Medicaid Error Rate Measurement	$1.7	$0.1	$0.8	$0.6	$2.5	$0.7
Foster Care Eligibility Reviews = Post-Payment Reviews	$2.3	$2.3	$12.2	$ 12.2	$14.5	$14.5
Foster Care OIG Reviews	$115.9	$0.7	$182.0	$102.0	$297.9	$102.7
Foster Care Single Audits	$1.4	$0.2	$26.1	$26.1	$27.5	$26.3
Child Care-Single Audit	$2.4	-	$0.174	N/A	$0.802	N/A
Child Care-Error Rate Measurement	$0.2	-	$0.384	N/A	$0.552	N/A
Head Start- OIG Reviews	$0.3	$0.3	N/A	N/A	$0.3	$0.3
Head Start- Single Audits	$1.4	$0.7	N/A	N/A	$1.4	$0.7

MANAGEMENT REPORT ON FINAL ACTION
October 1, 2010 - September 30, 2011

Background

The Inspector General Act Amendments of 1988 (P.L. 100-504) require Departments and Agencies to report to Congress on the actions they have taken and the amount of funds recovered or saved in response to the Office of Inspector General's (OIG) audit recommendations. This annual management report provides the status of OIG A-133 audit reports in the Department and summarizes the results of actions taken to implement OIG audit recommendations during the reporting period. As part of the U.S. Chief Financial Officer Council's Streamlining Effort of FY 1996, the Management Report on Final Action has been incorporated in the Agency Financial Report.

Status of Audits in the Department

In general, HHS Agencies follow-up on OIG recommendations effectively and within regulatory time limits. The HHS Agencies usually reach a management decision within the 6-month period that is prescribed by P.L. 100-504 and OMB Circular A-50, *Audit Follow-up*. For the most part, they also complete their final actions on OIG reports, including collecting disallowed costs and carrying out corrective action plans, within a reasonable amount of time. However, the Department continues to monitor this area to improve procedures and ensure compliance with corrective action plans.

Departmental Conflict Resolution

In the event that HHS agencies and OIG staff cannot resolve differences on specific report recommendations, a conflict resolution mechanism is available. During FY 2011, there were no disagreements requiring the convening of the Conflict Resolution Council.

Final Action Tables and Departmental Findings

Table I – Management Action on Costs Disallowed in OIG Reports. Disallowed costs are those costs that are challenged by HHS because a grantee has violated a law, regulation, grant term, or condition.

The HHS Process

Four Key Elements to the HHS Audit Resolution and Follow-up Process

- The HHS Agencies have a lead responsibility for implementation and follow-up on OIG and independent auditor recommendations;
- The Assistant Secretary for Resources and Technology establishes policy and monitors HHS Agencies' compliance with audit follow-up requirements;
- The audit resolution process includes the ability to appeal disallowances administratively under such programs as Head Start, Foster Care and Medicaid pursuant to the Departmental Grant Appeals Board's regulations in 45 C.F.R. Part 16; and
- If necessary, the Conflict Resolution Council resolves conflicts between the HHS Agencies and the OIG.

- In FY 2011, HHS initiated Recovery Action, through collection, offset or other means, on 301 cases for a total of $721,946,595.
- In FY 2011, HHS completed Recovery Action, through collection, offset or other means, on 294 cases for a total of $477,523,234.
- As of September 30, 2011, HHS reports 198 outstanding balances over one year old totaling $2,331,592,613. Thirty-seven percent of these accounts receivable are currently being pursued for collection. These accounts receivable are owed by State and local governments (91), hospital and medical related organizations (63), non-profit organizations (18), Indian tribes (17), and educational institutions (9). A detailed list of reports over one year old with outstanding balances to be collected can be found at: http://www.hhs.gov/asfr/of/finpollibrary/financialpolicies/outstandingbalances2011.html.

TABLE I

Management Action on Costs Disallowed in OIG Reports

As of September 30, 2011

(in Thousands)

	Number	Disallowed Costs
A. Reports for which final action had not been taken by the commencement of the reporting period. See Note 1.	271	$2,555,231,561
B. Reports on which management decisions were made during the reporting period. See Note 2.	301	718,946,595
Subtotal (A + B)	572	3,274,178,156
C. Reports for which final action was taken during the reporting period:		
i. The dollar value of disallowed costs were recovered through collection, offset, property in lieu of cash, or otherwise.	294	477,523,234
ii. The dollar value of disallowed costs that were written off by management.	6	795,119
Subtotal (i + ii)	300	478,318,353
D. Reports for which no final action has been taken by the end of the reporting period. See Note 3.	274	$2,798,151,019

Notes:

1. Includes adjustments of amended disallowance and disallowance excluded from the previous reporting period.
2. Represents the amount of management concurrence with the OIG's recommendations. For this fiscal year, the OIG's reconciliation with the HHS Agencies showed a variance that represents the three organizations having different cut-off dates.
3. In addition to current unresolved cases, this figure includes audits over one year old with outstanding balances totaling $2,331,592,613 (e.g., audits under current collection schedule, or audits under administrative or judicial appeal).

TABLE II
Management Action on OIG Reports with Recommendations that Funds Be Put to Better Use
As of September 30, 2011
(in Thousands)

	Number	Disallowed Costs
A. Reports for which final action had not been taken by the commencement of the reporting period. See Note 1.	10	$12,844,176
B. Reports on which management decisions were made during the reporting period.	24	1,315,740,616
Subtotal (A + B)	34	1,328,584,792
C. Reports for which final action was taken during the reporting period:		
i. The dollar value of recommendations that were actually completed based on management action or legislative action.	24	1,219,311,272
ii. The dollar value of recommendations that management has subsequently concluded should not or could not be implemented or completed.	0	0
Subtotal (i + ii)	24	1,219,311,272
D. Reports for which no final action has been taken by the end of the reporting period.	10	$109,273,520
Notes: 1. Includes adjustments of amended disallowance and disallowance excluded from the previous reporting period.		

Table II – Management Action on OIG Reports with Recommendations that Funds Be Put to Better Use. "Funds to be put to better use" relates to those costs associated with cost avoidances, budget savings, etc.

- In FY 2011, HHS initiated action on $1,315,740,616 in OIG recommendations to put funds to better use.
- In FY 2011, HHS completed action on $1,219,311,272 in OIG recommendations to put funds to better use.

SUMMARY OF FINANCIAL STATEMENT AUDIT AND MANAGEMENT ASSURANCES

TABLE 1 SUMMARY OF FINANCIAL STATEMENT AUDIT					
Audit Opinion			Unqualified for Four Financial Statements. No Opinion Expressed on Statement of Social Insurance		
Restatement			No		
Material Weaknesses	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Ending Balance**
Financial Reporting, Systems, Analyses & Oversight	☑		☑		
Financial Management Information Systems	☑				☑
Total Material Weaknesses	*2*	*0*	*1*	*0*	*1*

Definition of Terms – Tables 1 and 2

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

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

Consolidated: The combining of two or more findings.

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

Ending: The agency's year-end balance.

TABLE 2
SUMMARY OF MANAGEMENT ASSURANCES

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

Statement of Assurance	Unqualified					
Material Weaknesses	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Reassessed**	**Ending Balance**
Financial Reporting Systems & Processes	☑		☑			
Total Material Weaknesses	***1***	***0***	***1***	***0***	***0***	***0***

Effectiveness of Internal Control over Operations (FMFIA #2)

Statement of Assurance	Qualified					
Material Weaknesses	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Reassessed**	**Ending Balance**
Information System Controls and Security	☑					☑
Total Material Weaknesses	***1***	***0***	***0***	***0***	***0***	***1***

Conformance with Financial Management System Requirements (FMFIA #4)

Statement of Assurance	Non-conformance					
Non-Conformances	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Reassessed**	**Ending Balance**
Financial Reporting Systems & Processes	☑		☑			
Information System Controls and Security	☑					☑
Total Non-Conformances	***2***	***0***	***1***	***0***	***0***	***1***

Compliance with *Federal Financial Management Improvement Act (FFMIA)*

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

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OIG TRANSMITTAL OF FY 2011 TOP MANAGEMENT AND PERFORMANCE CHALLENGES

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

NOV 10 2011

TO: The Secretary
Through: DS ________
COS ________
ES ________

FROM: Inspector General

SUBJECT: Top Management and Performance Challenges facing the Department of Health and Human Services in Fiscal Year 2011

This memorandum transmits the Office of Inspector General's (OIG) list of top management and performance challenges facing the Department of Health and Human Services (Department). The *Reports Consolidation Act of 2000*, *Public Law 106-531*, requires OIG to identify these management challenges, assess the Department's progress in addressing each challenge, and submit this statement to the Department annually.

The OIG's list of top management and performance challenges for FY 2011 includes the following:

1) Implementing the Affordable Care Act
2) Preventing and Detecting Medicare and Medicaid Fraud
3) Identifying and Reducing Improper Payments
4) Patient Safety and Quality of Care
5) Integrity and Security of Information Systems and Data
6) Availability and Quality of Data for Effective Program Oversight
7) Oversight of CMS Program and Benefit Integrity Contractors
8) Ensuring Integrity in Medicare and Medicaid Benefits Delivered by Private Plans
9) Avoiding Waste in Health Care Pricing Methodologies
10) Grants Management and Administration of Contract Funds
11) Ensuring the Safety of the Nation’s Food Supply
12) Oversight of the Approval, Safety, and Marketing of Drugs and Devices
13) Oversight and Enforcement of the Department’s Ethics Programs

Page 2 - The Secretary

OIG looks forward to continuing to work with the Department to identify and implement strategies to protect the integrity of the Department's programs and the well-being of the beneficiaries of these programs. If you have any questions or comments, please contact me, or your staff may contact Erin Bliss, Director of External Affairs, at (202) 205-9523 or Erin.Bliss@oig.hhs.gov.

/Daniel R. Levinson/

Daniel R. Levinson

Attachment

FY 2011 Top Management And Performance Challenges Identified By Office Of The Inspector General

Management Issue 1: Implementing the Affordable Care Act

Why This is a Challenge

The Department is implementing and administering new programs under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (ACA) involving billions of dollars in grants, loans, and benefits payments. These programs include the Affordable Insurance Exchanges, the Consumer Operated and Oriented Plan Program, the Pre-Existing Condition Insurance Plan, the Early Retiree Reinsurance Program, the Prevention and Public Health Fund, the Center for Medicare and Medicaid Innovation, and others. In addition, the ACA enacted numerous changes and additions to existing Department programs, including Medicare and Medicaid. Noteworthy examples include novel programs, such as the Medicare Shared Savings Program, designed to improve quality and reduce cost through health care delivery and payment reform.

Responsibility for implementing ACA provisions, administering new and changed programs, and/or overseeing ACA funding rests with components across the Department, including the Centers for Medicare & Medicaid Services (CMS), the Office of the Secretary, the Health Resources and Services Administration (HRSA), the Food and Drug Administration (FDA), the National Institutes of Health (NIH), the Administration on Aging, the Centers for Disease Control and Prevention (CDC), the Indian Health Service (IHS), the Agency for Healthcare Research and Quality, and the Office of Inspector General (OIG). Many programs require close coordination between the Department and other federal and State agencies. Additional ongoing implementation and operational challenges include the magnitude, complexity, and novelty of programs; compressed implementation timelines; and marketplace dynamics.

Focusing on integrity in these programs is essential to ensuring that they operate with economy and efficiency and are free from fraud, waste, and abuse. The Department and its partners must indentify and mitigate program vulnerabilities and prioritize oversight resources. The Department must also ensure that providers, insurers, employers, and program beneficiaries understand their rights, responsibilities, and obligations under the new law.

Progress in Addressing the Challenge

The Department and its partners have issued and are continuing to issue regulations and other guidance for ACA programs. The Department has made a range of resources available on its Web site to inform the public about these programs and is working with States and other entities to identify potential program vulnerabilities and set up guidelines and systems to mitigate risks. The Department has continued to fortify its infrastructure to support the implementation, administration, and oversight of new and expanded programs. OIG has provided technical assistance to CMS and other Department components to assist in indentifying and preventing program integrity vulnerabilities. Moreover, OIG plans to examine several ACA programs in fiscal year (FY) 2012, including, the Early Retiree Reinsurance Program, the Prevention and Public Health Fund, and ACA-funded Community Health Centers. Additional progress related to ACA is described elsewhere in these challenges.

What Needs To Be Done

The Department and its partners must be vigilant in identifying and addressing existing and emerging fraud, waste, and abuse risk areas in ACA-related programs. The Department should continue to apply lessons learned about accountability, transparency, compliance, and risk management from its American Reinvestment and Recovery Act (Recovery Act) and other program experiences to ACA implementation and oversight. The Department should also continue to train staff overseeing ACA grants and contracts on effective internal controls and best practices for preventing and detecting fraud, waste, and abuse. Data systems supporting ACA programs must be scrutinized for accuracy and completeness, as well as compliance with security and privacy rules. The Department, including OIG, should continue to implement the full complement of program integrity provisions in ACA and identify the most effective ways to use new oversight authorities and tools. The Department should continue its efforts to provide stakeholders with clear guidance about ACA programs.

Additional recommendations for addressing ACA-related vulnerabilities appear elsewhere in these challenges.

Key OIG Resources:

- Office of Inspector General Fiscal Year 2012 Work Plan: http://oig.hhs.gov/reports-and-publications/workplan/index.asp.

Management Issue 2: Preventing and Detecting Medicare and Medicaid Fraud

Why This is a Challenge

Perpetrators of schemes to defraud Medicare and Medicaid range from criminals who masquerade as bona fide health care providers and suppliers but who do not provide legitimate services or products to Fortune 500 companies that pay kickbacks to physicians in return for referrals. Fraud is a crime of deception, and perpetrators design their schemes to avoid detection. The Department faces multiple challenges in preventing and detecting these frauds, including:

- effectively using CMS's provider enrollment and payment suspension authorities against those providers and suppliers that have exploited weaknesses to commit fraud rather than provide legitimate patient care,
- managing the Department's expanding use of data analysis, and
- excluding individuals and entities from federal health care programs to protect the programs and beneficiaries.

Many of CMS's essential program integrity activities are carried out by contractors. (See Challenge 7, Oversight of CMS Program and Benefit Integrity Contractors, for more information.)

Progress in Addressing the Challenge

Enrollment and Payment. The ACA addressed many program vulnerabilities by authorizing rigorous enrollment and screening processes, enrollment moratoria, and payment suspension. In February 2011, CMS published a final rule implementing the ACA provisions concerning screening of providers and suppliers based on fraud risk. CMS's enhanced payment suspension authority took effect in March 2011.

Data analysis. Enhanced data analysis made possible the impressive enforcement results of the nine Medicare Fraud Strike Forces, which are part of the Health Care Fraud Prevention and Enforcement Action Team (HEAT). The strike forces are interagency teams of prosecutors and federal and local law enforcement that focus enforcement resources on geographic areas at high risk for fraud. CMS has made claims data available more quickly and efficiently by providing limited law enforcement access to real-time data and has increased the number of trained law enforcement users on the One Program Integrity tool. In June 2011, CMS implemented the Fraud Prevention System (FPS) to risk-score Medicare Fee-for-Service (FFS) claims prepayment and awarded a contract to IBM in July 2011 to develop and test new predictive models for inclusion in the FPS.

Accountability. CMS's imposition of payment suspensions is one example of the Department's increased focus on accountability. OIG is using its permissive exclusion authority to pursue exclusion of responsible corporate officers of sanctioned providers and suppliers that may otherwise view civil penalties and fines as the cost of doing business.

What Needs To Be Done

CMS's final rule on enrollment screening takes important steps toward preventing unscrupulous providers and suppliers from obtaining Medicare billing privileges. However, there are additional opportunities for CMS to strengthen the enrollment system, including adopting a more flexible screening approach, tailoring screening measures to fraud risks, and classifying reenrolling DME and home health providers as "high risk." Moreover, the Department must ensure that its response to program vulnerabilities captures not only improper payments but also fraud; to that end, the contractors on which it relies must be carefully selected and have the tools, training, resources, and incentive to appropriately address improper payments and make appropriate fraud referrals. (See Challenge 7, Oversight of CMS Program and Benefit Integrity Contractors, for additional information.)

The Department should continue to improve law enforcement's access to data—including real-time claims data—as well as create more robust data sets, which are critical to identifying and investigating fraud. OIG must also ensure that it has the capacity to handle the volume of new fraud referrals that can be expected from CMS's expansion into predictive modeling and that CMS and OIG coordinate closely on such referrals.

The Department should continue to focus on accountability for fraud. In addition, OIG will continue to use its permissive exclusion authority for responsible individuals and entities in appropriate cases and monitor its effect on recidivism.

Key OIG Resources:

- South Florida and Los Angeles Suppliers' Compliance With Medicare Standards: Results From Unannounced Visits. OEI-03-07-00150 (South Florida) and OEI-09-07-00550 (Los Angeles)
- Questionable Billing for Brand-Name Inhalation Drugs in South Florida. OEI-03-09-00530

- Press Release: Medicare Fraud Strike Force Charges 111 Individuals for More Than $225 Million in False Billing and Expands Operations to Two Additional Cities. http://www.hhs.gov/news/press/2011pres/02/20110217a.html
- OIG Testimony for Senate Finance Committee Hearing: Preventing Health Care Fraud: New Tools and Approaches to Combat Old Challenges. http://oig.hhs.gov/testimony/docs/2011/levinson_testimony_03022011.pdf

Management Issue 3: Identifying and Reducing Improper Payments

Why This is a Challenge

Improper payments are a significant problem, costing billions of dollars annually across federal programs. In November 2009, the President signed *Executive Order 13520, Reducing Improper Payments and Eliminating Waste in Federal Programs*, and in July 2010, the *Improper Payments Elimination and Recovery Act (IPERA)* was enacted. The purpose of the Executive Order and *IPERA* is to reduce improper payments by intensifying efforts to eliminate payment error, waste, fraud, and abuse in the major programs administered by the federal government, including the Department's health care programs, while continuing to ensure that federal programs serve and accessible by their intended beneficiaries.

In 2010, the Office of Management and Budget (OMB) designated 14 programs as "high error." CMS administers five of these high-error programs: Medicare FFS; Medicare Part D; Medicare Advantage; Medicaid; and the Children's Health Insurance Program (CHIP). For FY 2010, the Department reported improper payments totaling more than $70 billion in Medicare FFS, Medicare Advantage, and Medicaid. HHS's Administration for Children and Families (ACF) also administers programs susceptible to improper payments. For example, ACF estimated that its Child Care program's national error rate equaled 13 percent and ACF programs accounted for $1 billion in improper payments in 2010.

Improper payments are divided into four categories: unsupported services, medically unnecessary services, incorrect billings, and other noncovered cost or error types. These are the core payment issues within the Department. OIG has recently completed and has underway several reviews that focus on improper payments. One review identified over 700 providers that routinely had errors over a 4-year period (2005 through 2008).

Progress in Addressing the Challenge

The Department has taken actions to address some improper payment vulnerabilities. CMS uses the Comprehensive Error Rate Testing (CERT) program to measure the Medicare FFS error rate and as a guide in developing corrective actions to reduce improper payments. CMS analyzes the CERT improper payment data and uses the results to provide feedback to Medicare contractors to enhance their medical reviews, focus on high risk areas, and reduce improper payments. Also, Medicare's automated systems have edits in place to detect and reject payment for medical services that are physically impossible, such as a hysterectomy for a male beneficiary, and "medically unlikely," such as services claimed for which the quantity billed exceeds acceptable clinical limits.

CMS developed the Payment Error Rate Measurement (PERM) program to review improper payments for Medicaid and CHIP FFS claims, managed care claims, and beneficiary eligibility. Though causes of improper payments vary from State to State, PERM helps CMS identify trends and common errors across States. Based on PERM results, States are required to submit Corrective Action Plans (CAP) 90 days after they are notified by CMS of their error rates. Many States' CAPs focus on provider education to reduce improper payment rates.

CMS contracts with Recovery Auditors to help detect and correct past improper payments so that CMS can implement actions that will prevent future improper payments. CMS has made policy and manual changes and local system edits, and CMS Medicare Administrative Contractors have conducted local provider education.

CMS has also developed a methodology to estimate an error rate for its Medicare Advantage program and implemented processes and procedures to reduce administrative and documentation errors, the two most prevalent error types in the Medicare Advantage program. Additionally, ACF has also begun to measure error rates for its Child Care, Foster Care, and Head Start programs and provided staff to serve on OMB improper payments teams.

The Department is also examining techniques used by private sector entities to reduce improper payments. CMS is conducting data analysis and predictive modeling to identify improper claims in Medicare FFS and is considering requiring prior authorizations for certain services. CMS is also exploring ways to leverage existing compliance programs within the provider community to educate providers about payment vulnerabilities.

What Needs To Be Done

The Department should continue to develop error rates for additional programs to comply with IPERA requirements. Medicare Part D and CHIP are slated to have projected error rates in the 2011 and 2012 reporting periods, respectively.

Further, the Department should use historical improper payment data to identify the root causes of improper payments and develop, implement, and track a Department CAP. In addition, for Medicare FFS claims, CMS should also continue to monitor its payment systems to identify additional edits and prepayment reviews that could identify suspicious claims and prevent improper payments. The Department should continue to identify best practices in the private sector that it can use to avoid improper payments. It should also expand its provider education efforts around program requirements and improper payment vulnerabilities. (See Challenge 10, Grants Management and Administration of Contract Funds, for additional information regarding improper payments.)

Key OIG Resources

- Centers for Medicare & Medicaid Services' Use of Medicare Fee-for-Service Error Rate Data To Identify and Focus on Error-Prone Providers. A-05-08-00080
- Inappropriate Claims for Medicaid Personal Care Services. OEI-07-08-00430
- Independent Contractor's Review of Durable Medical Equipment Claims From the Fiscal Year 2008 Comprehensive Error Rate Testing Program. A-01-09-00500
- Questionable Billing for Brand-Name Inhalation Drugs in South Florida Under Medicare Part. OEI-03-09-00530

Management Issue 4: Patient Safety and Quality of Care

Why This is a Challenge

As a purchaser of health care for over 100 million Americans, the Department faces challenges in ensuring the quality of care rendered to federal health care program beneficiaries. Despite increased attention to patient safety, quality problems persist. According to the Joint Commission, 40 wrong-site surgeries are performed in U.S. hospitals and surgicenters every week. OIG has found that 13.5 percent of hospitalized Medicare beneficiaries suffered harm from adverse events during their hospital stays. Forty-four percent of these adverse events were preventable and were caused by care failures, such as medical error, substandard care, or inadequate monitoring. Other OIG work has raised concerns about overmedication of beneficiaries with antipsychotic drugs in nursing homes; more than 20 percent of antipsychotic drugs claims for Medicare patients in nursing homes exceeded Medicare limits on dose or duration. OIG has also identified concerns with the licensure and qualifications of health care providers across all settings of care. In addition, for more than 60 percent of claims, hospices did not meet federal requirements for establishing adequate plans of care.

OIG investigations have uncovered instances and systemic patterns of substandard care in nursing homes. Problems often include inadequate staffing resulting in substandard care, failure to provide adequate nutrition and hydration, patients' developing preventable or untreated pressure wounds (bedsores), and other serious deficiencies.

Progress in Addressing the Challenge

The Department has taken steps to improve quality of care and promote patient safety. These includes targeting specific populations, such as improving coordination of care for Medicare beneficiaries with multiple chronic conditions, as well as improving care for all beneficiaries. The Department has committed up to $1 billion in ACA funding to the Partnership for Patients Initiative, a public-private partnership designed to keep patients from becoming injured or sicker and to help patients heal without complication. Members of the partnership will identify specific steps they will take to reduce preventable injuries and complications in patient care. Two specific goals set by the partnership are to reduce hospital readmissions by 20 percent and reduce preventable harm to hospital patients by 40 percent.

The Department is implementing value-based purchasing (VBP) payment policies required by ACA, such as the policy establishing the new VBP program for hospitals that will include quality metrics, as well as other payment policies targeting improved quality, such as the hospital-acquired conditions policy. These policies provide incentives to deliver better care. The Department continues to promote the adoption of electronic health records (EHR) and electronic prescribing, which should improve quality of care, reduce medication errors, and otherwise promote patient safety. It established tools to help beneficiaries compare facility-specific quality indicators and inform their decisions regarding where to seek treatment. CMS is developing new programs, such as the Medicare Shared Savings Program, as well as demonstration programs sponsored by the new Center for Medicare and Medicaid Innovation, with potential to enhance provider accountability for quality of care and improve coordination of care and care transitions.

OIG has entered into corporate integrity agreements with several nursing homes and other health care providers, including hospitals, assisted-living facilities, and dental clinics, which include quality-monitoring provisions. CMS and OIG continue to work closely with law enforcement partners at the Department of Justice and through the Federal Elder Justice Interagency Working Group to pursue providers that subject elderly persons to abuse or neglect, to exchange ideas, and to promote policies advancing better care for the elderly.

What Needs To Be Done

The Department should continue to prioritize quality of care and patient safety and build upon its past efforts, including implementing the quality improvement provisions of the ACA and achieving the goals set by the Partnership for Patients. OIG has offered recommendations to assist the Department in this mission. For example, OIG suggested enhancements to nursing home oversight to ensure that Medicare does not pay nursing homes to overmedicate or otherwise inappropriately medicate beneficiaries. OIG also suggested enhancements to outpatient prescription drug claims that could help the Department ensure that Medicare and Medicaid beneficiaries receive only the drugs that are appropriate for their medical indications.

Further work also needs to be done to improve the quality of care rendered to patients in hospitals. For example, the Department could strengthen its hospital-acquired conditions policy, such as by improving compliance with present-on-admission coding rules and, if supported by evidence of effectiveness, expanding the list of hospital-acquired conditions. It should also continue denying payments for services of such low quality that they are virtually worthless and exclude providers that have rendered grossly substandard care, thereby preventing harm to additional beneficiaries. The Department must also ensure that health care professionals working in all sites of service, such as hospitals, nursing homes, school-based facilities, and even the beneficiaries' own homes, meet qualification and licensure requirements before they treat federal health care program beneficiaries.

Key OIG Resources

- Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries. OEI-06-09-00090
- Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents. OEI-07-08-00150
- Quality Improvement Organizations' Final Responses to Beneficiary Complaints. OEI-01-09-00620

Management Issue 5: Integrity and Security of Information Systems and Data

Why This is a Challenge

As health care providers modernize their medical recordkeeping and billing systems, the adoption of EHRs and other innovations offers tremendous opportunity for improved patient care and more efficient practice management. However, as growing quantities of personal medical information are stored in electronic format, protecting the privacy and security of these data should be prioritized. A series of OIG audits revealed that some hospitals lack sufficient security features, potentially exposing patients' electronic protected health information to unauthorized access. Vulnerabilities included unsecured wireless access, inadequate encryption, authentication failures, and other access control vulnerabilities.

Protecting beneficiaries' and providers' identifying information is critical because fraud perpetrators often use stolen beneficiary and/or physician identities to submit false claims to the programs. In one recent example, OIG investigated fraudulent medical clinics in California that used provider numbers of unaffiliated physicians to submit false claims to Medicare for medical equipment that the physicians did not order and for services that the physicians did not render. The perpetrators pleaded guilty to defrauding Medicare and the operation has been shut down.

Additionally, the Department must ensure the integrity of incentive payments to encourage providers to adopt electronic prescribing and EHRs. In particular, the Department must ensure that recipients of Medicare and Medicaid EHR incentives truly qualify for these payments and that these payment policies effectively promote adoption of desirable technological practices. OIG found that the lack of sufficient data limits State Medicaid agencies' ability to verify both eligibility requirements prior to payment and the completeness of those verifications. Between 2009 and 2021, the federal government will spend an estimated $20.6 billion on the Medicare and Medicaid EHR incentive programs.

Finally, EHRs should facilitate more accurate billing and support better quality of care, but when misused may promote fraudulent billing or wasteful or inappropriate care. For example, cut-and-paste features and auto-fill templates can reduce paperwork burdens, but can also be misused to fabricate information, which results in improper payments and leaves inaccurate and potentially dangerous information in the patient record. Similarly, well-designed decision support tools can help physicians select the best care for their

patients, but inappropriately designed decision support tools can drive overutilization of services and lower the quality of care.

Progress in Addressing the Challenge

The Department has promulgated various rules that address privacy and security of patient information, encourage health care providers to use EHRs, and ensure that record systems are interoperable and facilitate accurate and secure exchange of information between authorized users. The Department has provided guidance to help covered entities comply with privacy and security rules mandated by the Health Insurance Portability and Accountability Act of 1996 and pursued enforcement actions against entities that have failed to do so. The Department has also addressed, in limited ways, privacy and security matters in its regulations governing Medicare and Medicaid EHR incentive payments. The Department has implemented numerous recommendations to make its own electronic data more secure.

In addition, OIG has undertaken educational initiatives, including direct outreach by special agents and distribution of an identity theft brochure, to help beneficiaries and providers protect themselves from medical identity theft.

What Needs To Be Done

The Department needs to heighten its focus on oversight and enforcement of privacy and security protections to ensure that hospitals and other health care providers, as well as the Department's own contractors, effectively safeguard individuals' protected health information when stored in electronic formats. This should entail continued compliance reviews to ensure adoption of adequate privacy and security standards. The Department should also provide additional guidance on general information technology security standards and best practices the health care industry should adopt for EHRs. As providers begin claiming financial incentives for adoption of electronic record and prescribing technologies, strict oversight, including prepayment verification and postpayment auditing, will be essential.

Key OIG Resources

- Early Review of States' Planned Medicaid Electronic Health Record Incentive Program Oversight. OEI-05-10-00080
- Nationwide Rollup Review of the Centers for Medicare & Medicaid Services Health Insurance Portability and Accountability Act of 1996 Oversight. A-10-08-5069
- Audit of Information Technology Security Included in Health Information Technology Standards. A-18-09-30160

Management Issue 6: Availability and Quality of Data for Effective Program Oversight

Why This is a Challenge

The Department and OIG rely heavily on the availability and completeness of data to ensure that the over 300 departmental programs are operating as intended and to help identify instances of fraud, waste, and abuse. The Department's programs compile an enormous amount of data on beneficiaries, providers, drugs, equipment and supplies, the delivery of services, and the quality of care. When these data are unavailable, are incomplete, or contain inaccuracies, program oversight and monitoring activities are hindered. OIG work has shown challenges in the following areas:

Medicaid program data are not current, available, complete, and accurate. The Medicaid Statistical Information System (MSIS) is the only national database of Medicaid claims and beneficiary eligibility information. In a 2009 report, OIG found that MSIS data were an average of 1.5 years old when released to users for data analysis. Moreover, CMS does not enforce certain MSIS data requirements, such as the submission of managed care encounter data. To conduct necessary Medicaid oversight, OIG must sometimes request data directly from each State.

Medicare program data are not complete and accurate. CMS compiles voluminous amounts of data on, among other things, provider enrollment and ownership, medical care encounters, prescription drugs, claims and payment, and adverse actions taken against providers. OIG has found that while Medicare data are largely available for analysis and review, databases such as the Provider, Enrollment, Chain and Ownership System (PECOS); the Prescription Drug Event Database; and the Healthcare Integrity and Protection Data Bank are missing data and/or contain inaccurate information, resulting in limited usefulness for oversight purposes.

Public health and human services programs data are not timely, complete, accurate, and available for oversight purposes. The Department is responsible for ensuring that required entities report timely and accurate data on public health and human services programs to ensure that programs operate as intended and use data to help combat acute and chronic diseases and disabilities. However, OIG work has shown that databases such as the ACFs Program Information Report, FDA's Food Facility Registry and its National Drug Code Directory, HRSAs 340B covered-entity database, and HIS's Health Service Directory contain incomplete and inaccurate data.

Improved quality of data received through exchanges with other Departments is needed. OIG work has found that external databases have quality issues similar to those found in Department databases. For example, a recent audit report found that the Social Security Administration (SSA) does not always verify the day of death, which impedes the usefulness of data matches between the SSA Master Death File and the Department's National Claims History File. Addressing concerns about the quality of data received from other agencies will be increasingly important as the Department expands CMS's Integrated Data Repository under ACA to include claims and payment data from other agencies, such as the SSA, the Department of Veterans Affairs, and Department of Defense.

Progress in Addressing the Challenge

The Operating Divisions (OPDIVs) have taken or planned some steps to address data-related vulnerabilities identified by OIG. For instance, in response to OIG recommendations regarding FDA's National Drug Code Directory, FDA has implemented an electronic reporting system for drug product information that may encourage manufacturers to update their listings more frequently. In response to ACA requirements, CMS is revalidating all enrollment information for the approximately 1.5 million providers and suppliers currently in PECOS and plans to cross-check enrollment data to other referential sources to better ensure accuracy. CMS also intends to increase efforts to consistently enforce the federal reporting requirements for managed care encounter data and has committed to conducting a review of laws and regulations to identify areas in which it can strengthen reporting. CMS has acknowledged problems related to the availability, completeness, accuracy and timeliness of State Medicaid data and has launched various projects aimed at improvement.

What Needs To Be Done

To formulate a plan and take corrective action, the Department will need to review the vulnerabilities specific to each database. Until the Department makes all necessary data available and corrects specific instances of incomplete or inaccurate data, program oversight will be hindered. As the Department integrates other agencies' data, it will need to examine their validity before relying on them for oversight purposes.

Key OIG Resources

- MSIS Data Usefulness for Detecting Fraud, Waste, and Abuse. OEI-04-07-00240
- Medicaid Managed Care Encounter Data. OEI-07-06-00540
- Inaccurate Data in the Provider Enrollment, Chain, and Ownership System Individual Global Extract File. OEI-07-08-00181
- Invalid Prescriber Identifiers on Medicare Part D Drug Claims. OEI-03-09-00140

Management Issue 7: Oversight of CMS Program and Benefit Integrity Contractors

Why This is a Challenge

With an ever-growing reliance on contractors to identify, prevent, and respond to fraud, abuse, and improper payments in the Medicare and Medicaid programs, CMS must conduct adequate oversight and monitoring. CMS contracts with several entities, including Program Safeguard Contractors (PSC), Medicare Drug Integrity Contractors (MEDIC), Zone Program Integrity Contractors (ZPIC), and Recovery Audit Contractors (RAC), to perform many Medicare integrity functions. For Medicaid integrity, CMS relies largely on State-based programs, but also contracts with Medicaid Integrity Contractors. OIG work has revealed persistent problems with CMS's program and benefit integrity contractors and ongoing vulnerabilities in CMS's oversight. These challenges include:

Inadequate contracts. The Department must ensure that CMS's contracts, statements of work, and task orders contain adequate controls, including clear roles and responsibilities and performance measures. Without these, programs are at heightened risk of poor contractor performance and ineffectiveness. Contracts should also ensure that performance incentives align with the objectives to reduce fraud, waste, and abuse. OIG has found that RACs have disincentives for referring instances of suspected fraud because even though RACs are paid through contingency fees based on the amount of over-payments collected, in cases of suspected fraud, over-payments may not be collected while the cases are being investigated. Between 2005 and 2008, RACs identified more than $1.03 billion in Medicare improper payments; however, the RACs referred only two cases of potential fraud to CMS.

Questionable contractor performance. OIG work has documented poor and/or inconsistent performance among contractors. For example, OIG found that PSCs differed substantially in the number of new investigations and case referrals to law enforcement; some had only minimal activity in these primary workload categories. Also, most PSCs had minimal results from proactive data analysis. OIG also found that PSCs referred $835 million in over-payments to claims processors for collection in 2007; however, 2 of 18 PSCs accounted for 62 percent of this amount. OIG is examining PSCs' efforts to match Medicare and Medicaid data (known

as the Medi-Medi project) to identify trends and refer suspected fraud for investigation.

Insufficient CMS Oversight. CMS must collect sufficient information to monitor contractor activities and conduct regular and meaningful reviews of contractor performance. In examining early stages of the transfer of program integrity functions from PSCs and MEDICs to ZPICs, OIG found that workload data used by CMS to oversee ZPICs were not accurate or uniform. OIG has also found problems in CMS's efforts to evaluate contractor performance. CMS evaluations of PSCs' performance did not include sufficient information and were not completed in time for the results to be used during contract renewal determinations. (For related information, please see Challenge 2, Preventing and Detecting Medicare and Medicaid Fraud, and Challenge 6, Availability and Quality of Data for Effective Program Oversight.)

Progress in Addressing the Challenge

CMS has made some progress toward addressing these challenges, including providing additional training to RACs on the identification and referral of potential fraud and developing electronic systems to monitor fraud referrals. In September 2011, CMS published its final rule implementing Section 6411 of the *Affordable Care Act* and providing guidance to the States related to the funding, operation, and maintenance costs of Medicaid RACs. Effective January 1, 2012, States are required to contract with Medicaid RACs to audit Medicaid claims to identify under-payments and over-payments and to collect over-payments. The rule requires States to make referrals of suspected fraud and/or abuse to appropriate agencies. CMS anticipates working with States to develop metrics to measure the Medicaid RACs' performance. CMS is transitioning program integrity functions from PSCs and MEDICs to the ZPICs. The ZPICs will be responsible for ensuring the integrity of all Medicare-related claims under Parts A, B, C, and D and for coordinating the Medi-Medi data match program. CMS expects that the ZPIC contracting strategy will allow for the review of claims across all benefit categories and across geographic locations, which should result in improved contractor performance. In FY 2011, CMS began conducting quarterly onsite visits to the PSCs and ZPICs.

What Needs To Be Done

The ACA expanded the RAC program to encompass improper payments in Medicaid and Medicare Parts C and D. As CMS expands its use of contractors and as contractors' responsibilities grow, CMS must make continued improvements to address the above challenges. CMS should also monitor the extent to which contractor-led program and benefit integrity activities have brought about improvements and appropriate metrics exist to assess performance.

Key OIG Resources

- Recovery Audit Contractors' Fraud Referrals. OEI-03-09-00130
- Medicare Overpayments Identified by Program Safeguard Contractors. OEI-03-08-00031 Medicare's Program Safeguard Contractors: Activities to Detect and Deter Fraud and Abuse. OEI-03-06-00010
- Zone Program Integrity Contractors' Data Issues Hinder Effective Oversight. OEI-03-09-00520
- Medicare's Program Safeguard Contractors: Performance Evaluation Reports. OEI-03-04-00050

Management Issue 8: Ensuring Integrity in Medicare and Medicaid Benefits Delivered by Private Plans

Why This is a Challenge

Medicare Advantage, the Part D Prescription Drug Benefit, and Medicaid Managed Care are administered by private health care plans, operating within parameters established by the federal government (and, for Medicaid, the State governments). Most Medicare beneficiaries are enrolled in Part D plans, and as of December 2009, 24 percent of beneficiaries were enrolled in Medicare Advantage. Major enrollment growth for Medicare Parts C and D is anticipated in the years following FY 2012 as the baby boomer generation becomes eligible for Medicare. As of June 2008, 72 percent of all Medicaid beneficiaries were enrolled in some type of managed care delivery system. Effective administration and oversight of these programs require extensive coordination and information sharing between the federal and State governments, private health care plans, subcontractors, health care providers, and third-party payers. The Department must ensure the accuracy of payments to private plans, the plans' implementation of effective program integrity safeguards, and their implementation of adequate consumer protections.

Medicare and Medicaid make capitated payments to private health care plans to deliver a specified set of benefits to qualified beneficiaries. Although specific payment methodologies vary by program, in general, private plans submit bids to CMS or the States related to their expected costs for the upcoming plan year. The standard per beneficiary payment rate is usually risk-adjusted (increased or decreased) based on the health characteristics of individual enrolled beneficiaries. However, OIG has found that some Part D plans have submitted inaccurate and incomplete information in their bids

and that CMS's review of Part D bids has been inadequate. As a result, Medicare has made higher payments to plans and beneficiaries have paid higher premiums than they would have if plans' bids had been more accurate. In addition, some Medicare Advantage plans have submitted inaccurate beneficiary health data used to calculate risk-adjustment payments, resulting in inflated Medicare payments.

In some States, Medicaid managed care plans are subject to limits on their administrative costs relative to their direct costs. OIG investigations have revealed that some Medicaid managed care plans have manipulated their finances and inflated their direct health care costs to circumvent these limits.

CMS and the States must also monitor private plans to ensure that they have implemented effective program safeguards. Private plans share risk with the government and have incentives to detect and prevent fraud; however, not all plans have done so effectively. For example, we have found deficiencies in Part D plans' compliance with program requirements including maintaining adequate compliance plans, monitoring to prevent payments on behalf of deceased beneficiaries, and paying claims with invalid prescriber numbers.

Finally, the Department must ensure that beneficiaries have sufficient access to the services that plans have agreed to provide, have accurate information about coverage and costs to make informed choices, and are protected from illegal or coercive marketing tactics and other inappropriate activities.

Progress in Addressing the Challenge

CMS has strengthened its oversight of Part D plans' compliance with program requirements and implementation of compliance plans by conducting audits and promoting effective compliance programs. It has also issued guidance to plans to identify and review drug claims with invalid prescriber identification numbers. CMS has also issued guidance and clarification regarding Medicare Advantage and Part D plans' responsibility to train all providers on ways to avoid fraud, waste, and abuse. In August 2011, CMS hosted its first annual program integrity conference and plans to deploy fraud, waste, and abuse training for Part C and Part D.

In 2010, CMS began implementing a broad set of Medicaid initiatives focused on assessing and improving States' performance in meeting regulatory requirements and ensuring that managed care systems deliver accessible, available and appropriate services to Medicaid beneficiaries. These initiatives include updating regulatory compliance checklists, developing new tools to assess the readiness of States to implement managed care, and disseminate written policy guidance to States and health plans.

What Needs To Be Done

Ensuring the accuracy of payments to private plans remains a challenge, and CMS should strengthen its oversight of bids and risk adjustment payments. CMS must also continue to monitor plans' implementation of integrity safeguards, provision of covered services to all eligible beneficiaries, and compliance with marketing rules. CMS will also need to oversee plans' compliance with medical loss ratios and ensure that plans are not inflating their direct health care costs.

Key OIG Resources:

- Concerns With Rebates in the Medicare Part D Program. OEI-02-08-00050
- Invalid Prescriber Identifiers on Medicare Part D Drug Claims. OEI-03-09-00140
- Medicare Prescription Drug Sponsors' Training on Fraud, Waste, and Abuse. OEI-01-10-00060
- Review of Florida's Children's Health Insurance Program Experience Adjustment and Refund Submission Reports. A-04-10-06123

Management Issue 9: Avoiding Waste in Health Care Pricing Methodologies

Why This is a Challenge

The federal government must act as a prudent purchaser of health care to ensure access to quality care without wasteful spending. Payment methodologies must be designed to reimburse providers and suppliers fairly for appropriate care and to respond to changes in the health care marketplace. However, certain Medicare and Medicaid payment methodologies are misaligned with the current health care market.

Medicare and Medicaid prescription drug payments raise such concerns. State Medicaid agencies lack accurate information about pharmacies' costs to purchase drugs, typically relying upon inaccurate and unreliable published prices to estimate pharmacy costs. As a result, Medicaid payments to pharmacies for drugs often significantly exceed pharmacies' costs for those drugs. Although drug manufacturer rebates to State Medicaid agencies present opportunities for savings, these savings are not always realized. For example, OIG found that manufacturers avoided paying billions of dollars in rebates related to increases in their drug prices by modifying existing drugs and treating them as new drugs. Further, for brand-name drugs, Medicaid is entitled to an additional rebate when the price of a drug rises faster than the rate of inflation. However,

generic drugs are not subject to these additional rebates, a missed savings opportunity. Finally, beneficiaries who are eligible for both Medicaid and Medicare Part D (dual eligibles) receive their drug benefits through Medicare Part D. This shift may result in higher net costs for dual eligibles' drugs because the rebates that Part D plans have negotiated with drug manufacturers are lower than those mandated for Medicaid.

Like Medicaid drug reimbursement, Medicare fee-schedule payments for certain types of durable medical equipment (DME) bear little resemblance to market prices. For example, Medicare reimbursed suppliers approximately $17,000 for individual wound therapy pumps that suppliers, on average, purchased for $3,600. The Medicare payment rate had not been lowered as more wound pump models and manufacturers entered the market and competition drove prices down.

OIG also reviewed the effects of a regulatory change in how Medicare pays skilled nursing facilities (SNF) for certain types of therapy in 2011. CMS intended the change to be budget neutral; however, we indentified a $2.1 billion increase in payments to SNFs because SNFs changed their billing patterns in unexpected ways.

Failure to monitor and update eligibility for enhanced payments under the Medically Underserved/Health Professional Shortage Areas program (MUA/HPSA) also results in waste. This program provides enhanced Medicare payments, among other incentives, to attract providers to medically underserved areas to improve health care access. However, HRSA has not updated the criteria for qualifying as an MUA or a HPSA and does not systematically redetermine whether the shortages have been alleviated in designated areas. Thus, some locations receive enhanced funding despite no longer meeting the criteria.

The challenges and opportunities in meeting the objective of better price alignment and waste reduction are complex and are evolving, particularly as the Department is moving to paying for health care based on value rather than volume of care delivered and to linking payment to quality and health outcomes. (See Challenge 1, Implementing the Affordable Care Act, for additional information.)

Progress in Addressing the Challenge

With respect to prescription drugs, provisions of the ACA increased Medicaid drug rebates and are intended to prevent manufacturers of brand-name drugs from circumventing payment of additional rebates on alternate versions of existing drugs. CMS is also developing alternative drug price benchmarks through a monthly retail price survey so that States will have more accurate estimates of drug costs to use for their pharmacy reimbursement.

With respect to DME, the Department has implemented the Competitive Bidding Program for certain DME, which is intended to achieve savings by better aligning reimbursement with market prices. OIG has identified excessive fee-schedule payments for oxygen concentrators and power wheelchairs, whose prices are now subject to competitive bidding. We will monitor competitive bidding to determine whether it addresses our pricing concerns. The Department is also moving forward with several value-based purchasing initiatives.

In July 2011, CMS announced a final rule reducing Medicare SNF payments in FY 2012 to correct for the unintended spike in payment levels and better align Medicare payments with costs.

What Needs To Be Done

Overall, the Department must take steps to better ensure that Medicare and Medicaid payments are economical and respond timely to changes in the marketplace, including seeking new authority where needed to implement pricing changes.

Other specific actions include CMS's continuing to work with States to more accurately reimburse pharmacies for drugs, ensuring that drug manufacturers are meeting their Medicaid rebate obligations, and monitoring the Competitive Bidding Program and updating it as needed. Also, HRSA should update the HPSA and MUA criteria, as needed; and review designations periodically; and remove the designations from locations that no longer face health care shortages. Finally, the Department must be vigilant in the implementation and oversight of its new VBP programs.

Key OIG Resources

- Medicaid Brand-Name Drugs: Rising Prices Are Offset by Manufacturer Rebates. OEI-03-10-00260
- Higher Rebates for Brand-Name Drugs Result in Lower Costs for Medicaid Compared to Medicare Part D. OEI-03-10-00320
- Medicare Payments for Newly Available Generic Drugs. OEI-03-09-00510
- Review of Generic Drug Price Increases. A-06-07-00042
- Status of the Rural Health Clinic Program, OEI-05-03-00170
- Review of Additional Rebates for Brand-Name Drugs With Multiple Versions, A-06-09-00033

Management Issue 10: Grants Management and Administration of Contract Funds

Why This is a Challenge

HHS is the largest grant-making organization in the federal government, and its funding of health and human services programs touches the lives of almost all Americans. In FY 2010, the Department awarded approximately $370 billion in grants, approximately 30 percent of which funded programs other than Medicaid and CHIP. The Recovery Act provided an additional $31.8 billion for the temporary expansion of these (non-Medicaid/CHIP) programs for FYs 2009 and 2010. Finally, the ACA appropriated billions in additional grant funding. HHS is also the third largest contracting agency in the federal government; in 2010, HHS awarded $19.1 billion in contracts.

Oversight and management of both new and continuing grant programs is crucial to the Department's mission and to the health and well-being of the public. However, our audits of grantees have found internal control deficiencies, problems with financial stability, inadequate organizational structures, inadequate procurement and property management policies, and inadequate personnel policies and procedures. Additionally, in recent reviews of Head Start grantees, we found significant health and safety violations.

Increased concerns by Congress and the Administration regarding transparency of and accountability for agency expenditures is creating heightened scrutiny over the administration of grant and contract dollars. Ongoing oversight by the Recovery and Accountability Transparency Board (RATB) and the results of a recent survey by the Council of the Inspectors General on Integrity and Efficiency on the use of suspension and debarment at federal agencies underscore the importance of vigorous oversight. For example, the Government Accountability Office found that the Department views suspension and debarment as an underused tool and is committed to instituting a more vigorous process, which includes training and sharing best practices.

With respect to contracts, we have focused on NIH's use of appropriations to fund 21 longer term contracts. We found a number of instances of improper funding of these contracts that have resulted in potential violations of the *Antideficiency Act* (*ADA*).

Progress in Addressing the Challenge

To conduct Recovery Act oversight, OIG worked closely with OPDIVs to perform risk analyses of grantees eligible for Recovery Act funding. In most cases, our recommendations were adopted and high risk grantees did not receive funding or were subject to heightened scrutiny. Additionally, the Department's grant recipients are nearly 100 percent compliant in required reporting to the RATB. With respect to grants oversight, HHS continues to make progress in educating grants management officials. The Department hosted a two-day symposium in April 2011 for all of its acquisition and grants officers. OIG has also been hosting grant training focused on fraud, waste, and abuse for Department grants officers. With respect to systemic contract funding problems, the Department, as required by law, reported multiple violations of the Antideficiency Act; issued detailed policy guidance; and developed and mandated a Department-wide appropriations law training course for all budget, finance, program, and contracting officials.

What Needs To Be Done

The OPDIVs need to continue to be vigilant in monitoring ACA, Recovery Act, and other grant awards. Additionally, through our grants management training efforts, we have found that each OPDIV has a great deal of autonomy over how it oversees its grants and that processes for taking grant actions differ. The processes across the Department should be more consistent. With respect to contract funding, the Department has advised "[w]e are heavily focused on preventing new violations, but in terms of old contracts that are on-going, we're taking legally appropriate actions to ensure that there are no further violations of the ADA." The OIG continues to recommend that the Department correct the improper funding of contracts that resulted in appropriations violations and continue to ensure that appropriate officials attend mandated training, that future contracts are funded properly, and that policy guidance is consistently followed.

Key OIG Resources

- Most Early Head Start Teachers Have the Required Credentials, But Challenges Exist. OEI-05-10-00240
- Review of the District of Columbia Department of Parks and Recreation's Compliance with Health and Safety Regulations for Head Start Programs. A-03-09-00363
- Appropriations Funding of National Institute of Allergy and Infectious Diseases Contract N01-AI-15416 with the University of California at San Francisco. A-03-10-03120

Management Issue 11: Ensuring the Safety of the Nation's Food Supply

Why This is a Challenge

CDC estimates that each year roughly 1 in 6 Americans (or 48 million people) gets sick, 128,000 are hospitalized, and 3,000 die of food-borne diseases. FDA is responsible for ensuring the safety of much of the Nation's food supply. During a food emergency, FDA is responsible for finding the contamination source and overseeing the removal by manufacturers of these products from the market. Yet, recent OIG reports found that food recall inefficiencies, inadequate food facility inspections, and recordkeeping issues impair FDA's ability to effectively resolve food emergencies. These challenges may be exacerbated in the case of imported foods, which have increased significantly in volume and variety in recent years.

In reviews of food safety recalls, we found that FDA did not often follow its own procedures for ensuring that the recall process operated efficiently and effectively. Further, FDA's procedures for monitoring recalls were not always adequate.

Our work has also found that FDA conducts food facility inspections infrequently - many food facilities went 5 years or longer without an FDA inspection. Furthermore, FDA took action against less than half of food facilities after the agency found conditions that warranted its most severe inspection classification. FDA relies increasingly upon States to conduct food facility inspections under contract; OIG is examining the effectiveness of FDA's oversight of these inspections.

Food facilities' failure to comply with FDA's recordkeeping requirements impedes the Department's ability to ensure the safety of the Nation's food supply. We found that 59 percent of selected food facilities did not comply with FDA's record-keeping requirements. We also found that 5 percent failed to register with FDA as required. Of those that did register, almost half failed to provide accurate and complete information.

The Food Safety Modernization Act (FSMA), signed into law in January 2011, provides FDA important new authorities to better protect the Nation's food supply. However, challenges exist in implementing these new authorities.

Progress in Addressing the Challenge

The Department has made progress in addressing the safety of imported food. FDA opened field offices in China, India, and Costa Rica to conduct more inspections and work with local officials to improve the safety of foods exported to the United States. FDA expanded its inspections capacity by increasing its staff by more than 700 investigators between FY 2007 and FY 2009 and by an additional 274 staff in FY 2010. FDA also deployed the PREDICT system, which is a risk-based screening tool for imported foods. As of August 23, 2011, 11 of 16 import districts were using the PREDICT screening tool. In September 2009, FDA required food facilities to report to a new registry all instances in which a food might cause serious health consequences and to investigate the causes of any adulteration reported. FDA has implemented www.foodsafety.gov, which provides food safety information for consumers. FDA is also developing the Petnet system, which will provide information on pet item recalls.

FDA has also made progress streamlining its jurisdiction by increasing its interagency coordination. For example, FDA partners with the National Oceanic and Atmospheric Administration to develop, validate, and use new chemical tests to detect oil residues and dispersants in seafood. Additionally, FDA partnered with the U.S. Department of Agriculture, States, and localities to improve the food safety system, including implementing a national egg inspection plan, which has a goal of inspecting 600 of the Nation's largest egg facilities by the end of calendar year 2011.

What Needs To Be Done

The Department and FDA should act quickly to implement FSMA to better protect the Nation's food supply. FSMA addresses many of OIG's recommendations; however we continue to recommend that FDA vigorously use its new authorities to remedy identified weaknesses in its inspections and recall procedures. FDA should also ensure that States properly conduct contracted food facility inspections.

OIG will continue to oversee the Department's management of food safety issues. In ongoing work, OIG is examining food facility compliance with requirements of FDA's Reportable Food Registry, FDA oversight and operations related to imported pet food and feed products, and the extent of FDA's testing of human food for contamination.

Key OIG Resources

- Review of the Food and Drug Administration's Monitoring of Imported Food Recalls. A-01-09-01500
- FDA Inspections of Domestic Food Facilities.OEI-02-08-00080

- FDA's Food Facility Registry. OEI-02-08-00060
- Traceability in the Food Supply Chain. OEI-02-06-00210
- OIG Testimony on the Safety of the Nation's Food Supply. http://oig.hhs.gov/testimony/docs/2010/FDA_inspections_testimony5-6-10.pdf

Management Issue 12: Oversight of the Approval, Safety, and Marketing of Drugs and Devices

Why This is a Challenge

The Department, through FDA, is responsible for ensuring that all drugs, biologics, and medical devices are safe and effective. The Department must also ensure that once a drug, biologic, or device has been approved for use, it is marketed appropriately. However, OIG work has revealed weaknesses in FDA's ability to adequately oversee the safety of drugs, biologics, and medical devices. In particular, we have found vulnerabilities in FDA's ability to ensure the timeliness of drug application reviews; the adequate monitoring of adverse-event reporting for medical devices; and the prevention of off-label marketing of drugs, biologics, and medical devices. In addition, as a result of expanded authorities under the ACA to approve biosimilars (generic biologics), FDA will need to develop a plan to implement these new authorities without exacerbating its backlog for drug approvals. Ensuring that participants in clinical trials are protected from significant risk presents an additional challenge to the Department both during the initial approval process and after drugs, devices, and biologics are approved by FDA when post-marketing trials are conducted.

Progress in Addressing the Challenge

FDA has taken actions to address some of the vulnerabilities related to timely review of generic drug applications, including issuing a final rule and providing guidance on what to include in generic drug applications. FDA also developed a new database to more effectively review and follow up on adverse-event reports for medical devices.

FDA has an ongoing Human Subject Protection/Bioresearch Monitoring Initiative tasked with modernizing the regulation of clinical trials across the spectrum of a product's lifecycle. FDA also has a Good Clinical Practice (GCP) Initiative with the European Medicines Agency underway that will permit the use of limited resources through joint inspections. The goal of this effort is to establish a mechanism for sharing information regarding applications and inspections while providing FDA with an enhanced understanding of health systems, medical practice, and regulatory requirements in foreign countries.

OIG is also working with law enforcement partners to investigate and prosecute drug and device manufacturers that engage in illegal marketing or conduct unauthorized clinical trials. For example, in November 2010, Synthes, Incorporated (Synthes), and its subsidiary, Norian Corporation, pleaded guilty to conducting clinical trials of a medical device without FDA authorization. Both companies agreed to pay the maximum criminal monetary penalties. They had conducted unauthorized clinical trials of Synthes's medical devices in surgeries to treat vertebral compression fractures of the spine, despite an FDA-cleared label warning against this use for this device and in the face of serious medical concerns about the safety of the devices when used in the spine. In another case, Novartis Pharmaceutical Corporation agreed to pay $422.5 million and enter into a corporate integrity agreement with OIG to resolve civil liability resulting from Novartis' violations of the Anti-Kickback statute and criminal and civil liability resulting from Novartis' marketing and promotion practices for Trileptal, an epilepsy medication, for a variety of conditions that were not approved by FDA.

What Needs To Be Done

The Department needs to focus on reducing off-label promotion, which may put patients in harm's way and may increase fraudulent claims for payment by federal health care programs. OIG is increasingly using its administrative authorities to sanction individuals and entities that engage in fraud and abuse in the pharmaceutical and medical device industries.

Key OIG Reports

- FDA's Generic Drug Review Process. OEI-04-07-00280
- Adverse Event Reporting for Medical Devices. OEI-01-08-00110
- FDA's Oversight of Clinical Trials. OEI-01-06-00160

Management Issue 13: Oversight and Enforcement of the Department's Ethics Programs

Why This is a Challenge

Conflicts of interest in the health care system generally, and specifically in the Department, have been the subject of scrutiny by Congress, the medical community, and the media. With a heightened focus on transparency in the federal government and the need to use resources efficiently and appropriately, the Department must ensure that internal and external stakeholders (e.g., employees, grantees) are free of conflicts of interest or other ethics concerns. However, results

of our work indicate that the Department can do more to ensure that ethics vulnerabilities are identified and addressed.

OIG work has found that the Department provides limited oversight of conflicts of interest of FDA clinical investigators, NIH grantees, and federal employees. For example, in a 2011 report, we found that 56 percent of the HHS employees' conflict-of-interest waivers reviewed were not documented as recommended in government-wide federal ethics regulations, guidance, and the Secretary's instructions. In another review, we found that only 70 of 156 responding NIH grantee institutions had written policies and procedures for addressing institutional conflicts of interest (these policies are not required by law). Increased reliance on contract personnel raises additional conflict concerns. For instance, we found inappropriate use of contractor personnel at the CDC (i.e., contractors' supervising federal employees). To ensure public trust in Department programs and operations, the Department must be steadfast in its oversight and enforcement responsibilities regarding ethics matters.

Progress in Addressing the Challenge

CDC has taken significant steps to improve the process for granting waivers for identified conflicts of interest to Special Government Employees (SGE). CDC now ensures that SGEs' Confidential Financial Disclosure Reports are complete before certifying them. CDC also has a policy for tracking SGEs' compliance with ethics requirements, including recusal procedures for upcoming meetings in which an SGE might have a conflict.

FDA has also taken steps to address identified vulnerabilities related to its clinical investigators. FDA now requires companies applying to market drugs, devices, and biologics (sponsors) to submit a complete list of clinical investigators and either certify the absence of a financial conflict of interest or disclose the nature of the financial arrangement to FDA for each clinical investigator. Additionally, FDA updated the *Compliance Program Guidance Manual* chapter on clinical investigator inspections to help ensure that clinical investigators submit required financial information to sponsors.

Similarly, NIH has taken actions to address conflict-of-interest vulnerabilities identified among NIH grantees. For instance, NIH published a final rule on August 25, 2011, revising 1995 regulations covering financial conflicts of interest for investigators. It addresses a number of issues related to promoting objectivity in research and addresses our recommendation to require grantee institutions to provide details regarding the nature of financial conflicts of interest and the ways in which they are managed, reduced, or eliminated.

What Needs To Be Done

OIG has recommended that NIH develop regulations governing institutional conflicts of interest, but the final rule does not address our concerns regarding institutional conflicts. Instead, in the final rule NIH States that "[w]e continue to believe that further careful consideration is necessary before PHS [Public Health Service] regulations could be formulated that would address the subject of institutional conflict of interest…." OIG continues to recommend that NIH issue regulations requiring institutions to have a written policy on institutional conflicts. This would provide consistency and clarity to institutions.

The Office of the General Counsel should provide guidance to OPDIVs and Staff Divisions and ensure that they document conflict-of-interest waivers in accordance with the Secretary's guidance. FDA and CDC should continue to build upon the actions they have undertaken to improve oversight of clinical investigators and SGEs.

Key OIG Resources

- Institutional Conflicts of Interest at NIH Grantees (OEI-03-09-00480)
- CDC's Ethics Program for Special Government Employees on Federal Advisory Committees (OEI-04-07-002600)
- The Food and Drug Administration's Oversight of Clinical Investigators' Financial Information, OEI-05-07-00730.

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DEPARTMENT'S RESPONSE TO THE OIG TOP MANAGEMENT AND PERFORMANCE CHALLENGES

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

To: Daniel R. Levinson, Inspector General

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

Subject: FY 2011 Top Management and Performance Challenges Identified by the Office of the Inspector General

This memorandum is in response to OIG's *FY 2011 Top Management and Performance Challenges*, which summarized the top management and performance challenges that the Department has faced over recent years.

We concur with OIG's findings concerning the HHS top management and performance challenges. In response to OIG's report, we are providing the attached table, which includes a brief summary of the top management challenges, management's response, and future plans to address these challenges during FY 2012.

Our management is committed to working toward resolving these challenges, and looks forward to continued collaboration with OIG to improve the health and well-being of the American people through our efforts.

FY 2011 Top Management and Performance Challenges Summary

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
1. Implementing the Affordable Care Act	The Department and its partners have issued and are continuing to issue regulations and other guidance for ACA programs. The Department has made a range of resources available on its Web site to inform the public about these programs. The Department has also continued to strengthen its internal infrastructure to support the implementation and administration of new and expanded programs. OIG has provided technical assistance to CMS and other Department components to assist in indentifying and preventing program integrity vulnerabilities. Moreover, OIG will begin planned work addressing several ACA programs in FY 2012.	HHS is vigilant in identifying and addressing existing and emerging fraud, waste, and abuse areas in ACA-related programs. We continue to work with States and other entities to identify potential program vulnerabilities and set up guidelines and systems to mitigate risks and address identified vulnerabilities. We also agree that successful implementation of new programs requires clear and effective communications with stakeholders. CMS and other Department components have also implemented training programs to enhance our communication and project monitoring to help ensure a robust program integrity effort is established.	The OIG and the Department will work together to ensure we meet our ACA responsibilities. We understand the importance and need for systems supporting ACA programs to be accurate and complete, as well as compliant with security and privacy rules. We will continue to work with the OIG to implement the full complement of program integrity provisions in ACA and assess the most effective ways to use new oversight authorities and tools.

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
2. Preventing and Detecting Medicare and Medicaid Fraud	ACA addressed many program vulnerabilities by authorizing rigorous enrollment and screening processes, enrollment moratoria, and payment suspension. In February 2011, CMS published a final rule implementing ACA provisions concerning provider and supplier screening based on fraud risk. CMS' enhanced payment suspension authority took	CMS agrees there are additional opportunities for strengthening the enrollment system. CMS' final rule on enrollment screening enhances HHS' ability to detect provider and suppliers that are intent on defrauding the Medicare and Medicaid programs. In addition, CMS will conduct continuous screening through an automated screening process on all	CMS will strive to enhance its detection and prevention efforts. It will also continue to work with its partners to respond to health care waste, fraud, and abuse, and consider areas for future improvement that potentially create significant programmatic threats to the Medicare and Medicaid programs.

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
	effect in March 2011. Enhanced data analysis made possible the impressive enforcement results of the nine Health Care Fraud Prevention and Enforcement Action Team Medicare Fraud Strike Forces - interagency teams of prosecutors and federal and local law enforcement - that focus enforcement resources in geographic areas at high risk for fraud. CMS has made data available more quickly and efficiently by providing limited law enforcement access to real-time data. In June 2011, CMS implemented the Fraud Prevention System (FPS) to risk score Medicare Fee-for-Service (FFS) prepayment claims and awarded a contract to develop and test predictive modeling for inclusion in FPS. OIG is pursuing exclusion actions against responsible corporate officers of sanctioned providers and suppliers who may otherwise view civil penalties and fines as the cost of doing business.	providers and suppliers. On a quarterly basis, Provider, Enrollment, Chain and Ownership System (PECOS) data will be screened with referential databases to identify any potential changes that may have been made without being reported to CMS. The number of trained law enforcement users on the One Program Integrity (PI) tool will also be increased to fight potential fraud. The purpose of One PI is to establish an enterprise resource as a single source of information for all CMS fraud, waste, and abuse activities. The project will, for the first time, provide streamlined, centralized access and analysis for standardized Medicaid data across multiple States, integrated with data from Medicare Parts A, B, and D.	

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
3. Identifying and Reducing Improper Payments	CMS has taken actions to address some improper payment vulnerabilities. The Comprehensive Error Rate Testing (CERT) program measures the Medicare FFS error rate.	CMS strives to eliminate improper payments in the Medicare program, to maintain the Medicare trust funds, and protect beneficiaries. It redefined the CERT process and	CMS will continue to take measures to develop error rates for additional programs to comply with the Improper Payments and Elimination Recovery Act (IPERA)

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
	CMS uses CERT in developing corrective actions and providing feedback to contractors. In Medicaid and CHIP, the Payment Error Rate Measurement (PERM) program reviews improper payments. PERM helps CMS identify trends and common errors across States. CMS contracts with Recovery Auditors to help detect and correct past improper payments in Medicare. In response, CMS has made changes in its policies and manuals as well as local system edits and conducted local provider education. CMS is examining techniques used in the private sector to reduce improper payments and is considering requiring prior authorizations for certain services. CMS is also exploring ways to leverage existing compliance programs within the provider community to educate providers about payment vulnerabilities. CMS has developed a methodology to estimate an error rate for Medicare Advantage. ACF has begun to measure error rates in the Child Care, Foster Care, and Head Start programs and serves on OMB's improper payments team.	called for more strict enforcement of its policies. In Medicaid and CHIP programs, CMS is dedicated to eliminating improper payments by using data obtained through PERM and making changes in areas that show programmatic weaknesses by initiating corrective actions. CMS also works with State representatives and others stakeholders to continue collaborative education and outreach plans focusing on payment vulnerabilities.	requirements. CMS will also continue to monitor payment systems for activity that could identify suspicious claims and prevent improper payments. In addition, it will identify best practices in the private sector that it can use to avoid improper payments. CMS will also expand its provider education around program requirements and vulnerabilities as part of its commitment to lowering improper payments.

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
4. Patient Safety and Quality of Care	HHS has taken steps to improve quality of care and promote patient safety. HHS committed $1 billion to the Partnership for Patients Initiative, a public-private partnership designed to keep patients from getting injured or sicker and to help patients heal without complication. Members of the partnership will identify steps they will take to reduce preventable injuries and complications in patient care. HHS has implemented value-based purchasing payment policies required by the ACA, such as a new program for hospitals that includes quality metrics, as well as other payment policies targeting improved quality. The Department continues to promote the use of electronic health records (EHR) and electronic prescribing to improve quality of care, reduce medication errors, and otherwise promote patient safety. CMS and OIG are working closely with the Federal Elder Justice Interagency Working Group to pursue providers that abuse or neglect elderly persons and to promote policies advancing better care for the elderly.	The Partnership for Patients has set two ambitious goals for all U.S. hospitals: 1) reduce preventable all-cause harm by 40 percent; and 2) reduce hospital readmissions by 20 percent. The time period to achieve these reductions is 2010 to 2013. Nine specific types of adverse events or hospital-acquired conditions (HACs) have been identified that every hospital should be working to prevent. Changes in clinical practice are necessary to reduce the adverse events or HACs, and it is unrealistic to expect dramatic deductions in harm if hospitals and health systems are not provided tools and resources to make changes. The Department has provided technical assistance to hospitals and health systems to actually implement interventions and improvement strategies to make effective changes at the point of care.	The Department will continue to implement programs, and work with providers to enhance patient safety and the quality of care in the health care delivery system by promoting the use of electronic health records. We will also continue efforts to establish Statewide programs that engage local practitioners and provider communities. The current HHS National Action Plan to Prevent Heathcare-Associated Infections (HAIs) is using State-based collaboratives comprising State Health Departments, State Hospital Associations, State Patient Safety Organizations, and Quality Improvement Organizations to implement and promote the adoption of safe practices to eliminate HAIs. The quality improvement/technical assistance efforts for this initiative will build on and expand this existing infrastructure and will expand further to include the new Hospital Engagement Contractors, which will be coordinated by CMS's Centers for Medicare and Medicaid Innovation (CMMI) as part of the Partnership for Patients initiative.

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
5. Integrity and Security of Information Systems and Data	The Department has promulgated various rules that address privacy and security of patient information, that encourage the use of EHRs, and that ensure that record systems are interoperable and facilitate accurate and secure exchange of information. HHS has provided guidance to help covered entities comply with the rules of the Health Insurance Portability and Accountability Act of 1996 and pursued enforcement actions against entities that have failed to do so. HHS has also addressed, in limited ways, privacy and security matters in its regulations governing Medicare and Medicaid EHR incentive payments. Additionally, the Department has implemented numerous security recommendations to make its own electronic data more secure.	HHS remains committed to protecting the privacy of electronic health records (EHRs), and established the Office of the Chief Privacy Officer (OCPO) within the Office of the National Coordinator for Health IT (ONC) to focus on privacy and security activities when it come to the adoption of EHRs. OCPO has initiated significant programs aimed at protecting privacy by, among other things, raising awareness and understanding of a provider's responsibilities to secure EHRs, as specified in HIPPA. HHS has developed privacy and security criteria for Meaningful Use incentives and provided technical expertise on breach prevention. We also continually monitor feedback from our claims administration contractors to identify opportunities to reduce vulnerability to making improper payments, to enhance the accuracy of payments, and to make other improvements to make electronic data more secure.	ONC and the Department will continue to protect the privacy and integrity of EHRs. We will fund multiple provider training modules, in addition to investigating technical solutions aimed to make security compliance easier and more automated for providers. We will also partner with external and internal stakeholders to develop security monitoring protocols and identify potential areas for improving formal guidance. Finally, OCPO is developing a campaign to inculcate security awareness with the objective of having attention to privacy and security made a routine part in the development of grants and procurements.

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
6. Availability and Quality of Data for Effective Program Oversight	The Department has taken limited steps to address data-related vulnerabilities identified by OIG.	We agree with the OIG and have made progress responding to vulnerabilities to strengthen the integrity of data we rely on to	The Department and its components remain committed to addressing data-related vulnerabilities specific to each database to ensure

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
	FDA has implemented an electronic reporting system for drug product information that may encourage manufacturers to update their listings in the National Drug Code Directory more frequently. In response to ACA requirements, CMS is revalidating all enrollment information for the approximately 1.5 million providers and suppliers currently in the Provider Enrollment, Chain, and Ownership System (PECOS) and plans to cross-check enrollment data with other sources to ensure accuracy. CMS also intends to increase efforts to enforce federal reporting requirements for managed care encounter data and has committed to conducting a review of laws and regulations to identify areas in which it can strengthen reporting. CMS has acknowledged problems related to the availability, completeness, accuracy, and timeliness of State Medicaid data and has launched various projects aimed at improvement.	ensure our programs are operating as intended, and to help identify instances of fraud, waste, and abuse. CMS understands the importance of accurate data for Medicare, Medicaid, and CHIP. For example, as for the Medicare program, CMS is now embarking on revalidating all enrollment information for the approximately 1.5 million providers and suppliers currently in the PECOS. In addition, steps are being taken to consider the extent to which data should be added to the IDR to comply with the provisions of the ACA. Efforts are also underway to assess and improve the availability, completeness, accuracy, and timeliness of State data for Medicaid and CHIP.	that our over 300 programs are operating as intended. Specifically, CMS intends to continue its efforts to improve the availability, completeness, accuracy, and timeliness of data for Medicaid.

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
7. Oversight of CMS Program and Benefit Integrity Contractors	CMS has made some progress toward addressing these challenges, including providing additional training to Recovery Audit Contractors (RAC)	CMS agrees that contractor oversight is essential to protecting the Medicare program requirements. This includes developing performance metrics,	CMS will continue its efforts to provide proactive contractor oversight that is an essential element to protecting the Medicare

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
	on the identification and referral of potential fraud and developing electronic systems to monitor fraud referrals. In September 2011, CMS published its final rule implementing Section 6411 of the *Affordable Care Act* and providing guidance to States relating to the funding, operations, and maintenance costs of Medicaid RACs. Effective January 1, 2012, States are required to contract with Medicaid RACs to audit Medicaid claims to identify underpayments and overpayments and to collect overpayment. The rule requires States to make referrals of suspected fraud and/or abuse to appropriate agencies. CMS anticipates working with States to develop metrics to measure the Medicaid RACs' performance. CMS is transitioning program integrity functions from Program Safeguard Contractors (PSC) and Medicare Drug Integrity Contractors to the Zone Program Integrity Contractors (ZPIC). The ZPICs will be responsible for ensuring the integrity of all Medicare-related claims under Parts A, B, C, and D and for coordinating the Medi-Medi data match program. CMS expects that the ZPIC contracting strategy will allow for the review of claims across all benefit categories and across geographic locations. In FY 2011, CMS began conducting quarterly onsite visits to	continuous monitoring of contractor performance, conducting performance evaluations, and refining metrics. CMS continues to train, evaluate, and assess its' RACs, PSCs, MEDICS, and ZPICs to help ensure consistent performance among contractors and proper oversight of Medicare. The use of RACs remains a valuable piece in the identification of improper payments, and CMS has increased reviews by RACs to ensure potential fraud cases are referred to the OIG.	program. The use of RACs will continue to play a vital role in identifying potential fraud cases. CMS also looks forward to continuing its relationship with the OIG by further refining and improving the referral process to ensure more timely and accurate referrals.

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
	the PSCs and ZPICs..		

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
8. Ensuring Integrity in Medicare and Medicaid Benefits Delivered by Private Plans	CMS has strengthened its oversight of Part D plans. It has taken steps to improve Part D plans' compliance with program requirements and implementation of compliance plans by conducting audits and promoting effective compliance programs. It has issued guidance to plans to identify and review drug claims with invalid prescriber identification numbers. In August 2011, CMS held its first annual program integrity conference for Parts C and D. In 2010, CMS began implementing a broad set of Medicaid initiatives focused on assessing and improving States' performance in meeting regulatory requirements and ensuring that managed care systems deliver accessible, available, and appropriate services to Medicaid beneficiaries.	CMS agrees that addressing potential fraud, waste, and abuse are key obligations of the private insurers that participate in the Part C and Part D Medicare programs. It is also committed to assuring that all Medicaid beneficiaries have access to high quality care in all service delivery settings, and agrees that oversight of health plans providing Medicaid benefits is of critical importance.	CMS will continue to explore new ways of measuring effectiveness in our Part D compliance programs through audits, reviews, and qualitative and quantitative analysis. It has continually taken the necessary actions to improve the accuracy of payments to private plans, the plans' implementation of effective program integrity safeguards, and their implementation of adequate consumer protections by modifying and improving our audits and reviews of the plans. CMS believes that the combination of these approaches will, over time, achieve a new level of accountability for managed care plans and providers and ultimately result in higher quality, more cost-effective care for beneficiaries.

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
9. Avoiding Waste in Health Care Pricing Methodologies	Provisions of the ACA increased Medicaid drug rebates and are intended to prevent manufacturers of brand-name drugs from avoiding paying additional rebates on alternate versions of	CMS agrees it needs to ensure better access to quality care in an economical manner. It is taking great measures to enact the provisions of the ACA and ensure that Medicare and Medicaid	With the passage of the ACA, CMS will continue to collect additional data, convene technical expert panels, and conduct data analysis to implement the requirements of the

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
	existing drugs. CMS is also developing alternative drug price benchmarks through a monthly retail price survey so that States will have more accurate estimates of drug costs to use for their pharmacy reimbursement. HHS has implemented the Competitive Bidding Program for certain DME, which is intended to achieve savings by better aligning reimbursement with market prices. OIG has identified excessive fee schedule payments for oxygen concentrators and power wheelchairs, whose prices are now subject to competitive bidding. We will monitor competitive bidding to determine whether it addresses our pricing concerns.	payments are economical, and are taking the necessary steps to respond timely to changes in the marketplace. This includes seeking new authority, where needed, to implement pricing changes. For example, CMS has begun developing an alternative benchmark for States to consider when setting their reimbursement methodology. CMS also announced plans to expand Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. The program's goal is to save billions of dollars for people with Medicare and other taxpayers – while preserving access to quality items and services from qualified suppliers.	ACA. CMS also expects to develop a National Average Drug Acquisition Cost as well as continue to work with State Medicaid agencies to assist in potential cost-saving initiatives. It addition, it will be proactive in monitoring the implementation of the DMEPOS Competitive Bidding Program to ensure that beneficiaries maintain access to high-quality products and services at competitive costs.

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
10. Grants Management and Administration of Contract Funds	With respect to oversight of Recovery Act grants, OIG worked closely with HHS operating divisions to perform risk analyses of grantees eligible for Recovery Act funding. In most cases, our recommendations were adopted and high risk grantees did not receive funding or were subject to heightened scrutiny. With respect to grants oversight generally, HHS continues to make	The Department agrees that proper and accountable oversight and management of both new and continuing grant programs are crucial to the mission and to the health and well being of the public. HHS initiated a Department-wide effort to update and revamp its Agency Grant Award Administration Manual to promote greater consistency in the implementation of grants administration policy,	HHS will continue its efforts to oversee its grants and acquisition management practices, update acquisition and grant related policies, and ensure greater accountability and transparency in its programs. HHS will also continue to coordinate closely with stakeholders and our leadership regarding all pertinent ADA corrective actions – which will

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
	progress in educating grants management officials. The Department hosted a two-day symposium in April 2011 for all of its acquisition and grants officers. OIG has also been hosting grant training focused on fraud, waste, and abuse for HHS grants officers. With respect to contract funding, the Department has advised "[w]e are heavily focused on preventing new violations, but in terms of old contracts that are on-going, we're taking legally appropriate actions to ensure that there are no further violations of the ADA." The OIG continues to recommend that the Department correct the improper funding on contracts that resulted in appropriations violations and continue to ensure that appropriate officials attend mandated training, that future contracts are funded properly, and that policy guidance is consistently followed.	processes and business practices. To address ADA violations, we took several actions that included providing appropriation law training, and developed an "HHS Reference Tool for Contract Funding, Formation and Appropriations Law Compliance," which is designed to help the HHS' finance, budget, program and contracting communities: (a) have a better understanding of contract funding and formation strategies; and (b) foster compliance with federal appropriation laws, regulations, and policies.	include conducting on-going reviews to verify continued compliance with appropriations-law related requirements.

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
11. Ensuring the Safety of the Nation's Food Supply	The Department has made progress in addressing the safety of imported foods. For example, FDA opened field offices in China, India, and Costa Rica to conduct more inspections and work with local officials to improve the safety of food exported to	Food safety is a core public health issue and FDA remains committed to ensuring its regulated products are safe and secure. Through the Food Safety Modernization Act of 2010 (FSMA), signed into law in January 2011, significant progress has been made with regard to	FDA will continue to implement FSMA and the challenges associated with transforming the food safety program. It will expand partnerships with government partners and private sector stakeholders to focus more on preventing food safety problems

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
	the United States. FDA expanded its inspections capacity by adding more than 700 investigators between FY 2007 and FY 2009 and 274 more in FY 2010. FDA also deployed the PREDICT system, which is a risk-based screening tool for imports. In September 2009, FDA also required food facilities to report to a new registry all instances in which food might cause serious health consequences and to investigate the causes of any adulteration reported.	streamlining jurisdiction, and improving interagency coordination through work with the Food Safety Working Group and other stakeholders. FDA is improving its recall implementation, expanding its inspectional capacity, and has implemented the national egg inspection plan. In addition to these efforts, FDA began its deployment of the PREDICT system, which provides a risk-based screening tool for imports.	rather than reacting to them after they occur. This includes the development of regulations and guidance that serve as important prevention-focused tools that guide food safety efforts at each step of the process.

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
12. Oversight of the Approval, Safety, and Marketing of Drugs and Devices	FDA has taken actions to address some of the vulnerabilities related to timely review of generic drug applications, including issuing a final rule and providing guidance on what to include in generic drug applications. FDA also developed a new database to more effectively review and follow up on adverse-event reports for medical devices. FDA has an ongoing Human Subject Protection/Bioresearch Monitoring Initiative tasked with modernizing the regulation of clinical trials across the spectrum of a product's lifecycle. FDA also has a Good Clinical Practice Initiative with the European Medicines Agency	FDA implemented the Medical Product Safety Network (MedSun), whose goal is to work collaboratively with the clinical community to identify, understand, and solve problems with the use of medical devices. FDA continues to expand the availability of high-quality generic drug products and provide consumers and health care providers with information on both safety and effectiveness.	FDA will continue to monitor the ever-increasing amount of medical product promotion that occurs each year. It will maintain its multifaceted and collaborative approach to oversight of human subject protections, while expanding its training of employees in foreign posts, to help draw upon the experience and resources of foreign regulatory authorities in these areas.

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
	underway that will permit the use of limited resources through joint inspections. OIG is also working with law enforcement partners to investigate and prosecute drug and device manufacturers that engage in illegal marketing or conduct unauthorized clinical trials.		

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
13. Oversight and Enforcement of HHS Ethics Programs	HHS has taken several actions to improve its oversight and enforcement of ethics programs. Among them, CDC has taken significant steps to improve the process for granting waivers to SGEs by improving oversight of confidential financial disclosure reporting and through its policy for tracking SGEs' compliance with ethics requirements, including recusal procedures. In August 2011, NIH published a final rule revising 1995 regulations covering financial conflicts of interest for investigators. It addresses OIG's recommendation to require grantee institutions to provide details regarding the nature of financial conflicts of interest and the ways in which they are managed, reduced, or eliminated.	The Office of the General Counsel (OGC) Ethics Division has responsibility for administering the Department's ethics program as it pertains to HHS employees (including SGEs). It is committed to increased oversight and improvement of the conflict of interest review and waiver process for federal employees, which are included as part of its audits/program reviews.	The OGC Ethics Division will continue to work with all Department components to ensure that waiver documents issued to SGE employees are legally effective and meet a level of clarity and transparency that is consistent with applicable law. Planned efforts include issuance of additional guidance, instruction and training, development of sample templates, and increased pre-clearance by OGC of draft instruments prepared by component ethics programs.

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Glossary

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GLOSSARY

ACRONYM	DESCRIPTION
ACF	Administration for Children and Families
AFR	Agency Financial Report
AHIC	American Health Information Community
AHRQ	Agency for Healthcare Research and Quality
AIDS	Acquired Immunodeficiency Syndrome
AoA	Administration on Aging
AMP	Average Manufacturer Price
ASA	Assistant Secretary for Administration
ASFR	Assistant Secretary for Financial Resources
ASH	Assistant Secretary for Health
ASL	Assistant Secretary for Legislation
ASPA	Assistant Secretary for Public Affairs
ASPE	Assistant Secretary for Planning and Evaluation
ASPR	Assistant Secretary for Preparedness and Response
ATSDR	Agency for Toxic Substances and Disease Registry
BARDA	Biomedical Advanced Research and Development Authority
CAS	Carotid Artery Stenting
CBO	Congressional Budget Office
CCB	Child Care Bureau
CCDF	Child Care Development Fund
CDC	Centers for Disease Control and Prevention
CEA	Carotid Endarterectomy
CERT	Comprehensive Error Rate Testing
CFBNP	Center for Faith-Based and Neighborhood Partnerships
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CFRS	Consolidated Financial Reporting System
CHIP	Children's Health Insurance Program
CHIPRA	*Children's Health Insurance Program Reauthorization Act of 2009*
CIA	Corporate Integrity Agreement
CIT	Center for Information Technology
CLABSI	Central Line-Associated Bloodstream Infections
CLASS	*Community Living Assistance Services and Support Act*

ACRONYM	**DESCRIPTION**
CMP	Civil Monetary Penalties
CMS	Centers for Medicare and Medicaid Services
COLA	Cost of Living Adjustment
COTS	Commercial-off-the-shelf
CPG	Compliance Program Guidance
CPI	Consumer Price Index
CPIM	Consumer Price Index-Medical
CPPW	Communities Putting Prevention to Work
CRADA	Cooperative Research and Development Agreement
CSRS	Civil Service Retirement System
CY	Current Year
DAB	Departmental Appeals Board
DAEO	Designated Agency Ethics Officer
DC	District of Columbia
DHS	Department of Homeland Security
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DOJ	Department of Justice
DOL	Department of Labor
DSH	Disproportionate Share Hospital
E&M	Evaluation and Management
EHR	Electronic Health Records
EY	Ernst & Young LLP
FASAB	Federal Accounting Standards Advisory Board
FBWT	Fund Balance with Treasury
FCA	False Claims Act
FDA	Food and Drug Administration
FECA	*Federal Employees' Compensation Act*
FERS	Federal Employees' Retirement System
FFMIA	*Federal Financial Management Improvement Act of 1996*
FFS	Fee-for-Service
FICA	*Federal Insurance Contributions Act*
FIFO	First-in/first-out
FISMA	*Federal Information Security Management Act of 2002*
FMFIA	*Federal Managers' Financial Integrity Act of 1982*
FUL	Federal Upper Limit

ACRONYM	**DESCRIPTION**
FMAP	Federal Medical Assistance Percentage
FMSP	Financial Management System Program
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GDP	Gross Domestic Product
GMRA	*Government Management Reform Act of 1994*
GPRA	*Government Performance and Results Act of 1993*
GSA	General Services Administration
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HEW	Department of Health, Education and Welfare (now HHS)
HHAs	Home Health Agencies
HHS	Department of Health and Human Services
HI	Hospital Insurance
HIGLAS	Healthcare Integrated General Ledger Accounting System
HIPAA	*Health Insurance Portability and Accountability Act of 1996*
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health Act
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
H5N1	Avian Influenza
IBNR	Incurred But Not Reported
IEVS	Income Eligibility Verification System
IGA	Intergovernmental Affairs
IHCIA	*Indian Health Care Improvement Act*
IHS	Indian Health Service
IPERA	*Improper Payments Elimination and Recovery Act of 2010*
IPIA	*Improper Payments Information Act of 2002*
IT	Information Technology
J3	Jurisdiction 3
LICS	Low Income Cost Sharing Subsidy
LIPS	Low Income Premium Subsidy
LIS	Low-Income Subsidy
LLP	Limited Liability Partnership
MA	Medicare Advantage
MACs	Medicare Administrative Contractors

ACRONYM	**DESCRIPTION**
MARx	Medicare Advantage Prescription Drug
MC	Managed Care
MEDIC	Medicare Drug Integrity Contractors
MMA	*Medicare Prescription Drug, Improvement and Modernization Act of 2003*
MPD	Medicare Prescription Drug
MMIS	Medicaid Management Information Systems
MPE	MARx Payment Error
MSIS	Medicaid Statistical Information Systems
N/A	Not Applicable
NBS	NIH Business Systems
NCI	National Cancer Institute
NDMS	National Disaster Medical System
NDNH	National Directory of New Hires
NHIN	Nationwide Health Information Network
NIH	National Institutes of Health
NPI	National Provider Identification
NPRM	Notice of Proposed Rulemaking
OACT	Office of the Actuary
OCIIO	Office of Consumer Information and Insurance Oversight
OCR	Office for Civil Rights
OD	Office on Disability
OER	Office of Extramural Research
OGC	Office of the General Counsel
OGE	Office of Government Ethics
OGHA	Office of Global Health Affairs
OHR	Office of Health Reform
OIG	Office of the Inspector General
OMB	Office of Management and Budget
OMHA	Office of Medicare Hearings and Appeals
ONC	Office of the National Coordinator for Health Information Technology
OPDIV	Operating Division
OPEB	Other Post Employment Benefits
ORB	Other Retirement Benefits
OS	Office of the Secretary
PAHPA	*Pandemic and All-Hazards Preparedness Act*
PARIS	Public Assistance Reporting Information System
PCIP	Pre-Existing Condition Insurance Plan

ACRONYM DESCRIPTION

PDE .... Prescription Drug Event
PELS............. Payment Error related to Low-Income Subsidy
PEMS............ Payment Error related to incorrect Medicaid Status
PEPFAR .... President's Emergency Plan for AIDS Relief
PEPV............. Prescription Drug Event Validation
PERM............ Payment Error Rate Measurement
PHS.............. Public Health Service
PIP............... Program Improvement Plan
P.L. .... Public Law
PP&E .... Property, Plant and Equipment
PPS .... Prospective Payment System
PRRB .... Provider Reimbursement Review Board
PSC.............. Program Support Center or Program Safeguard Contractor
PUR.............. Period Under Review
PY .... Prior Year
QI .... Qualifying Individual
QIO.............. Quality Improvement Organization
QRIS............. Quality Rating and Improvement Systems
RAC.............. Recovery Audit Contractor
RADV............ Risk Adjustment Data Validation
RAE .... Risk Adjustment Error
RATB .... Recovery Accountability and Transparency Board
RDS .... Retiree Drug Subsidy
RFR .... Reportable Food Registry
RSI............... Required Supplementary Information
RSSI............. Required Supplementary Stewardship Information
SAMHSA .... Substance Abuse and Mental Health Services Administration
SAS.............. Statement on Auditing Standards
SBR .... Statement of Budgetary Resources
SECA .... Self-Employment Contribution Act of 1954
SFFAS........... Statement of Federal Financial Accounting Standards
SGE .... Special Government Employees
SHARP .... Strategic Health IT Advanced Research Projects
SLEP............. Shelf Life Extension Program
SLV .... School-Located Vaccination

ACRONYM	DESCRIPTION
SMI	Supplementary Medical Insurance
SNF	Skilled Nursing Facility
SNS	Strategic National Stockpile
SOSI	Statement of Social Insurance
SSA	Social Security Administration
SSN	Social Security Number
STAFFDIV	Staff Division
TAGGS	Tracking Accountability in Government Grants System
TANF	Temporary Assistance for Needy Families
Treasury	Department of the Treasury
UFMS	Unified Financial Management System
UPIN	Unique Physician Identification Number
U.S.	United States
VFC	Vaccines for Children
VICP	Vaccine Injury Compensation Program
ZPIC	Zone Program Integrity Contractor

Laws, Regulations, and Guidance

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LAWS, REGULATIONS, & GUIDANCE

SHORT TITLE **LONG TITLE** *(each title is linked to an official government source)*

P.L. .... Public Law
OMB .... Office of Management and Budget
U.S.C. .... United States Code

P.L. 59-384................. Food, Drug, Cosmetic Act

P.L. 74-271................. Social Security Act of 1935

P.L. 78-410................. 42 U.S.C. Ch 6A (Public Health Service Act)

P.L. 93-502................. 5 U.S.C. Ch 5 § 552 (Freedom of Information Act of 1974)

P.L. 93-579................. Privacy Act of 1974

P.L. 96-88 .... Department of Education Organization Act of 1979

P.L. 97-255................. Federal Managers' Financial Integrity Act of 1982

P.L. 97-414................. Orphan Drug Act

P.L. 100-235............... Computer Security Act of 1987

P.L. 100-496............... Prompt Payment Act as Amended (1996)

P.L. 100-504............... Inspector General Act Amendments of 1988

P.L. 101-150............... National Defense Authorization Act of 1991

P.L. 101-508 § 500 .... Federal Credit Reform Act of 1990 (FCRA)

P.L. 101-576............... Chief Financial Officer (CFO) Act of 1990

P.L. 102-589............... Cash Management Improvement Act of 1990 (As Amended)

P.L. 103-62................. Government Performance and Results Act

P.L. 103-66................. Omnibus Reconciliation Act of 1993

P.L. 103-356............... Government Management Reform Act of 1994

P.L. 103-13................. Paperwork Reduction Reauthorization Act of 1986

P.L. 104-106............... Clinger-Cohen Act of 1996

P.L. 104–134............... Debt Collection Improvement Act of 1996

P.L. 104-191............... Health Insurance Portability and Accountability Act of 1996 (HIPAA)

P.L. 104-191............... 42 U.S.C. Ch 7, Section 1395i (Federal Hospital Insurance Trust Fund)

P.L. 104-208............... Federal Financial Management Improvement Act of 1996 (FFMIA)

P.L. 105-206............... Internal Revenue Service Restructuring and Reform Act of 1998

P.L. 105-277 § 1701...... Government Paperwork Elimination Act of 1998

P.L. 106-107............... Federal Financial Assistance Management Improvement Act of 1999

P.L. 106-246 §2403....... Rehabilitation Act Amendments of 1998 (Workforce Investment Act)

P.L. 106-531............... Reports Consolidation Act of 2000

P.L. 107-204............... Sarbanes Oxley Act of 2002

P.L. 107-289............... Accountability of Tax Dollars Act of 2002

P.L. 107-300............... Improper Payments Information Act of 2002

P.L. 107-347 .... *Federal Information Security Management Act of 2002 (FISMA - Title III of the E-Government Act of 2002)*

P.L. 108-173 .... *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (a.k.a. *Medicare Modernization Act*, or *MMA*)

P.L. 109-222 .... *Tax Increase Prevention and Reconciliation Act of 2005*

P.L. 111-3.................. *Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)*

P.L. 111-5.................. *American Recovery and Reinvestment Act of 2009 (ARRA or Recovery Act)*

P.L. 111-240 .... *Small Business Jobs Act of 2010*

P.L. 111-148, § 1322..... *Patient Protection and Affordable Care Act*

P.L. 111-148, § 8001..... *Community Living Assistance Services and Support (CLASS) Act*

P.L. 111-152 .... *Health Care and Education Reconciliation Act of 2010*

P.L. 111-296 .... *Healthy-Hunger Free Kids Act*

P.L. 112-10................. *Department of Defense and Full-Year Continuing Appropriations Act, 2011*

OMB Circular A-11......... *Preparation, Submission and Execution of the Budget*

OMB Circular A-50......... *Audit Follow-Up*

OMB Circular A-123....... *Management's Responsibility for Internal Control*

OMB Circular A-127....... *Financial Management Systems*

OMB Circular A-130....... *Management of Federal Information Resources*

OMB Circular A-136....... *Financial Reporting Requirements*

5 U.S.C. 751 .... *Federal Employees' Compensation Act of 1916 (FECA)*

26 U.S.C. Ch 21........... *Federal Insurance Contributions Act (FICA)*

26 U.S.C. Ch 2............. *Self Employment Contributions Act (SECA) of 1954 (§1401 through §1403)*

31 U.S.C. Ch 15 § 1535 . *Economy Act*

31 U.S.C. Ch 31........... *Anti-Deficiency Act (§ 1341, 1342, 1349-1351, and 1511-1519)*

44 U.S.C. Ch 31 § 3101 . *Federal Records Act of 1950*

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