



Department of Health and Human Services

FY 2012 Agency Financial Report

November 15, 2012

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MESSAGE FROM THE SECRETARY



I am pleased to present the *FY 2012 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 manage one of the largest budgets in the world and improve the health and lives of Americans every day. We administer more grant dollars than all other federal agencies combined.

Kathleen Sebelius Our programs are as diverse as the people that we serve. And whether it's providing millions of children, families and seniors with access to high-quality health care or exploring new frontiers of biomedical research, it's our obligation to make the investments that will reach the most people, build most effectively on our partners' efforts and lead to the biggest gains in health and opportunity for the American people. In the process, we are committed to responsibly managing every dollar in our budget.

As the Secretary of HHS, I recognize that we are accountable, above all, to the American Public. Our financial statement audit is one of the best tools the American people have to assess our financial information. 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 FY 2012 Statement of Social Insurance and Statement of Changes in Social Insurance Amounts which reflect current law as presented in the 2012 Medicare Trustees' Report.

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 one material weakness in the Department related to Information Systems Controls and Security and one material noncompliance with *Improper Payments Information Act* related to error rate measurement. We have already begun taking actions to improve our financial reports and systems. Further details concerning these weaknesses and planned corrective actions may be found in the Management Discussion and Analysis section of our report.

None of our accomplishments would be 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 work we do and the progress we have made. We are delivering on our promise of providing better care, helping Americans achieve better health and lowering the costs of health care for all Americans.

/Kathleen Sebelius/
Kathleen Sebelius
Secretary
November 15, 2012

ABOUT THE AGENCY FINANCIAL REPORT

The Department of Health and Human Services (HHS or the Department) Fiscal Year (FY) 2012 *Agency Financial Report* (AFR) provides fiscal and summary performance results that enable the President, Congress and the American people to assess our accomplishments for the reporting period October 1, 2011, through September 30, 2012. 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 (OMB) Circular A-136, *Financial Reporting Requirements*. This document consists of three primary sections:



Management's Discussion and Analysis

The Management's Discussion and Analysis (MD&A) section provides an overview of the entire report. The MD&A presents an overview of performance and financial highlights for FY 2012. It also discusses HHS' compliance with legal and regulatory requirements, its summary of audit and management assurances and gives a brief look ahead to FY 2013.



Financial Section

The Financial Section includes the Department's financial statements and the Independent Auditor's report. It also contains the Notes to the Principal Financial Statements, Required Supplementary Stewardship Information and Required Supplementary Information.



Other Accompanying Information

Other Accompanying Information contains the Office of Inspector General's (OIG) FY 2012 assessment of management challenges facing the Department, as well as a glossary and legal regulations relevant to this AFR.

Agency Financial Report Acknowledgement

We present our FY 2012 AFR, which conforms to OMB Circular A-136, *Financial Reporting Requirements*. The *Annual Performance Report* and the *FY 2014 Congressional Budget Justification* will be available in February 2013, as will the *Summary of Performance and Financial Information*. These reports will be available on our website at <http://www.hhs.gov> at that time. We believe this format provides the readers and decision-makers more transparent and enhanced financial and performance reporting.

We Welcome Your Comments

Thank you for your interest in the Department of Health and Human Services. The FY 2012 AFR is available at <http://www.hhs.gov>. We welcome your comments and questions regarding this *Agency Financial Report* and appreciate any suggestions. Please contact us at hhsdeputycfo@hhs.gov or at:

Department of Health and Human Services
Office of Finance/OFPR
Mail Stop 522D
200 Independence Avenue, S.W.
Washington, DC 20201

MANAGEMENT'S DISCUSSION AND ANALYSIS



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ABOUT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

HHS is the United States (U.S.) Government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.



Mission Statement

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.

HHS represents almost a quarter of all federal outlays and it administers more grant dollars than all other federal agencies combined. As the Nation's largest health insurer, HHS' Medicare program handles more than one billion claims per year. Medicare and Medicaid, together, provide health care insurance for one in four Americans.

HHS works closely with state and local governments, and many HHS-funded services are provided at the local level by state or county agencies, or through private sector grantees. Twelve operating divisions (OPDIVs) administer more than 300 programs, covering a wide spectrum of activities. In addition to the services they deliver, HHS programs provide for equitable treatment of beneficiaries nationwide and enable the collection of national health and other data.

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 OPDIV 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. For more information, please visit: <http://www.acf.hhs.gov>.

The Administration for Community Living (ACL) is responsible for providing national leadership and direction to plan, manage, develop and raise awareness of comprehensive and coordinated systems of long-term services and support that enable older Americans and individuals with disabilities to maintain their health and independence in their homes and communities. We reorganized during FY 2012 and established ACL to carry out functions previously performed by the Administration on Aging, the Office of Disability and the Administration on Development Disabilities. For more information, please visit: <http://www.hhs.gov/acl>.

The Agency for Healthcare Research and Quality (AHRQ) improves the quality, safety, efficiency and effectiveness of health care for all Americans. AHRQ fulfills this mission by conducting health services research in order to identify the most effective ways to organize, manage, finance, deliver high quality health care, reduce medical errors and improve patient safety. For more information, please visit: <http://www.ahrq.gov>.

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. For more information, please visit: <http://www.atsdr.cdc.gov>.

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 to promote quality care for beneficiaries. CMS also is responsible for helping to implement many provisions of the *Affordable Care Act (ACA)* such as with the establishment of the Consumer Operated and Oriented Plan (CO-OP). This plan will foster the creation of qualified non-profit health insurance issuers to offer competitive health plans in the individual and small group markets. For more information, please visit: <http://www.cms.gov>.

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. For more information, please visit: <http://www.cdc.gov>.

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. FDA is also responsible for advancing the public health by helping to speed innovations that make medicines and foods effective, affordable and safe. Additionally, it helps the public get the most accurate, science-based information it needs to use medicines and foods to improve its health. For more information, please visit: <http://www.fda.gov>.

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. HRSA focuses on uninsured, underserved and special needs populations in its goals and program activities. For more information, please visit: <http://www.hrsa.gov>.

The Indian Health Service (IHS) is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally recognized tribes grew out of the special government-to-government relationship between the Federal Government and Indian tribes. This relationship, established in 1787, is based on Article I, Section 8 of the Constitution and has been given form and substance by numerous treaties, laws, Supreme Court decisions and Executive Orders. IHS is the principal federal health care provider and health advocate for Indian people, with the goal of raising Indian health status to the highest possible level. The IHS provides a comprehensive health service delivery system for approximately 1.9 million American Indians and Alaska Natives who belong to 566 federally recognized tribes in 35 States. For more information, please visit: <http://www.ihs.gov>.

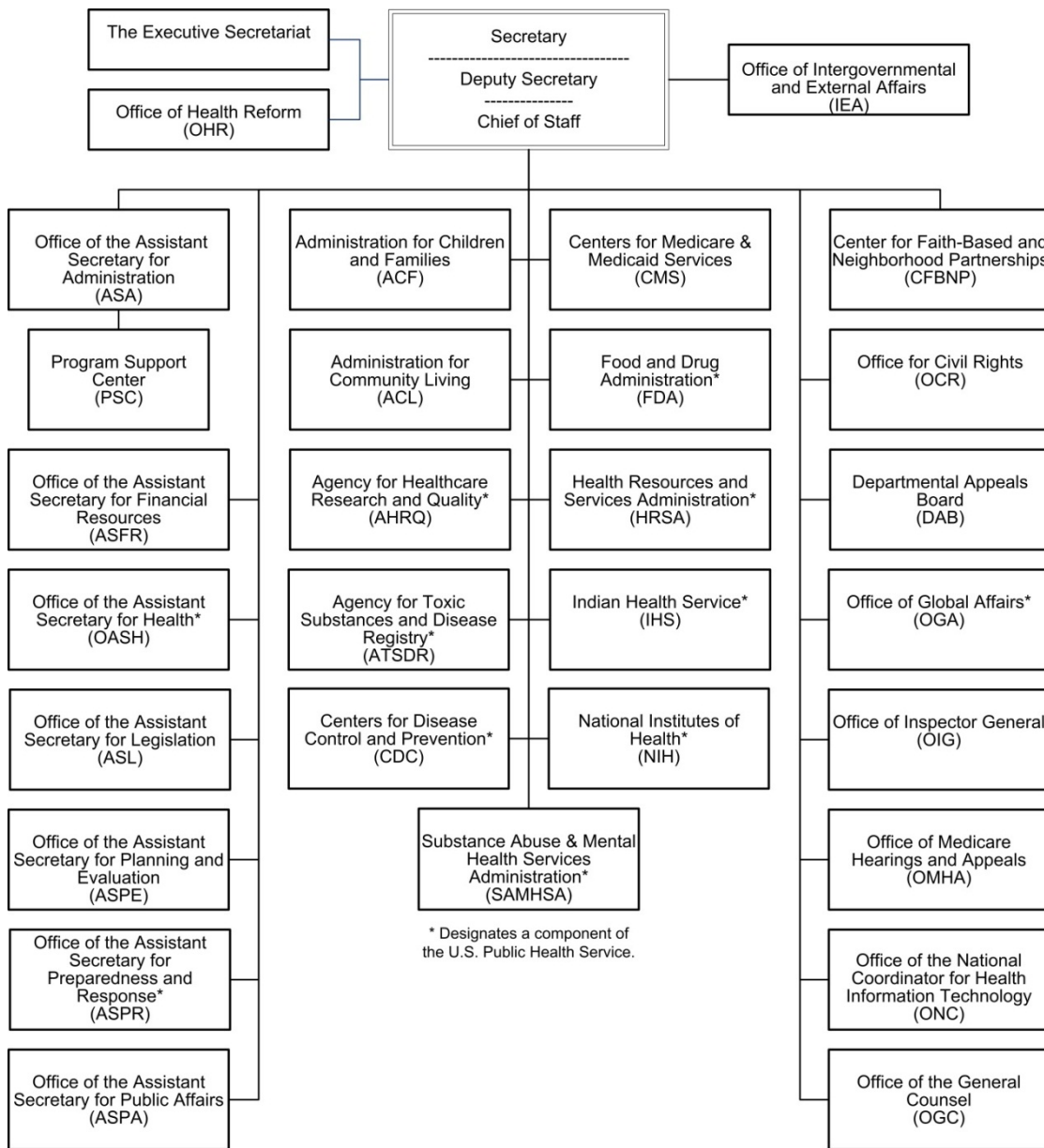
The National Institutes of Health (NIH) is the steward of medical and behavioral research for the nation. NIH promotes science in pursuit of fundamental knowledge about the nature and behavior of living systems. It also utilizes the application of that knowledge to extend healthy life and reduce the burdens of illness and disability. For more information, please visit: <http://www.nih.gov>.

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. SAMHSA accomplishes its mission by providing leadership, developing service capacity, communicating with the public, setting standards and improving practice in communities, primary and specialty care settings. For more information, please visit: <http://www.samhsa.gov>.

The Office of the Secretary (OS), with our Secretary, leads our components to provide a wide range of services and benefits to the American people. In addition, the following staff divisions (STAFFDIVs) report directly to the Secretary, managing programs and supporting the operating components in carrying out our mission. They are:

- Office of the Assistant Secretary for Administration <http://www.hhs.gov/asa/>
- Office of the Assistant Secretary for Financial Resources <http://www.hhs.gov/asfr/>
- Office of the Assistant Secretary for Health <http://www.hhs.gov/ash/>
- Office of the Assistant Secretary for Legislation <http://www.hhs.gov/asl/>
- Office of the Assistant Secretary for Planning and Evaluation <http://www.aspe.hhs.gov/>
- Office of the Assistant Secretary for Public Affairs <http://www.hhs.gov/aspa/>
- Office of the Assistant Secretary for Preparedness and Response <http://www.phe.gov/preparedness/>
- Center for Faith-Based and Neighborhood Partnerships <http://www.hhs.gov/partnerships/>
- Departmental Appeals Board <http://www.hhs.gov/dab/>
- Office for Civil Rights <http://www.hhs.gov/ocr/>
- Office of the General Counsel <http://www.hhs.gov/ogc/>
- Office of Global Affairs <http://www.globalhealth.gov/>
- Office of Inspector General <http://www.oig.hhs.gov/>
- Office of Intergovernmental External Affairs <http://www.hhs.gov/intergovernmental/>
- Office of Medicare Hearings and Appeals <http://www.hhs.gov/omha/>
- Office of the National Coordinator for Health Information Technology <http://www.healthit.hhs.gov/>

Below, we present our organizational chart, which consists of the Office of the Secretary <http://www.hhs.gov/secretary/> and the noted STAFFDIVs and OPDIVs. To find further information regarding our organization, components and programs, visit our website at <http://www.hhs.gov>.



PERFORMANCE GOALS, OBJECTIVES AND RESULTS

Health and Human Services Performance Results



In FY 2012, HHS continued improving its performance management processes in alignment with the *Government Performance and Results Modernization Act*. This activity supports our mission to enhance the health and well-being of Americans. HHS' performance management efforts during FY 2012 have reinforced progress while finding efficiencies.

Performance Management Process Milestones

Every four years, HHS updates its Strategic Plan which describes its 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* and the *Government Performance and Results Modernization Act*. An agency strategic plan defines its missions, goals and the means by which it will measure its progress in addressing specific national problems, needs or mission-related challenges over a five year period. Each HHS OPDIV and STAFFDIV contributes to the development of the Strategic Plan (available at <http://www.hhs.gov/secretary/about/priorities/priorities.html>), as reflected in goals, objectives, strategies, evaluations and performance indicators. This plan outlines five Strategic Goals as follows:

1. Strengthen Health Care
2. Advance Scientific Knowledge and Innovation
3. Advance the Health, Safety and Well-Being of the American People
4. Increase Efficiency, Transparency and Accountability of HHS Programs
5. Strengthen the Nation's Health and Human Services Infrastructure and Workforce

Aligned with these goals, we established six new Priority Goals for FY 2012-2013 with quarterly performance reviews between HHS component staff and leadership. These goals align to the Strategic Goals as noted above and include efforts to:

1. Increase the number of health centers certified as Patient Centered Medical Homes (PCMH)
2. Improve patient safety
3. Improve health care through meaningful use of Health Information Technology (HIT)
4. Improve the quality of early childhood education
5. Reduce cigarette smoking
6. Reduce food-borne illness in the population

These new Priority Goals were selected based on their importance to the HHS mission and crosscutting characteristics. Each of these priority goals directly supports the HHS Strategic Plan and has met significant milestones in FY 2012.



Progress toward HHS priorities is measured using data-driven review and analysis. This focus promotes active management engagement across HHS, which ensures continued alignment to the Performance and Strategic Plans. We support and coordinate performance management efforts across HHS through engagement across the Federal

Performance Management Community and sharing of best practices. Further growth of the Performance Officers network will support and coordinate performance management efforts throughout HHS.

Detailed performance results will be available in February 2013, in our FY 2012 *Annual Performance Report* and our FY 2014 *Congressional Budget Justification*. In addition, a synopsis of performance information will be contained in the FY 2012 *Summary of Performance and Financial Information*. These documents will be available at <http://www.hhs.gov> in February 2013.

The accomplishments below highlight our results by each of the five HHS Strategic Goals along with additional successes linked to other HHS performance measures.

Strategic Goal One: Strengthen Health Care

HHS is responsible for implementing many of the health reform changes in the ACA. These changes include working to strengthen and modernize health care to improve patient outcomes. It also promotes efficiency and accountability, ensures patient safety, encourages shared responsibility and works toward high-value health care. In addition to addressing these responsibilities, HHS is improving access to culturally competent, quality health care for uninsured, underserved, vulnerable, older and special needs populations.



Goal One Key Results:

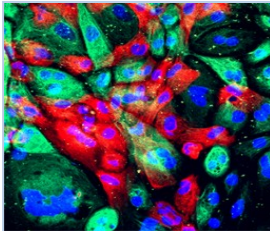
- CMS' Quality Improvement Organizations (QIOs) completed recruitment for hospitals around the country. CMS' QIOs recruited 165 hospitals for hospital-acquired central line-associated bloodstream infections reduction across 17 States including 234 intensive-care units (ICUs) and 151 non-ICUs. For catheter-associated urinary tract infections, 675 hospitals were recruited across all 50 States, the District of Columbia (DC), Puerto Rico and the Virgin Islands which include 857 ICUs and 782 non-ICUs. This effort directly supports meeting the goal of reducing central line-associated bloodstream infections by 25 percent and catheter-associated urinary tract infections by 20 percent by September 2013.
- The Health Center Program supports a national network of health centers that provides access to comprehensive, culturally competent, quality primary health care services to medically underserved communities and vulnerable populations. The program supports the advancement and acceleration of quality improvement efforts across the Nation's health centers. By June 2012, 11.4 percent of health centers had at least one site recognized as a PCMH, a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes. An additional 369 health center grantees initiated surveys to become PCMH recognized. This progress supports the goal of increasing the proportion of health centers that are nationally recognized as a PCMH from 1 to 25 percent by September 2013.



- By September 2012, over 150,000 providers received payments for successful adoption or meaningful use of Electronic Health Records (EHR) exceeding HHS' September 2013 target of 140,000 providers. Communications, outreach and assistance led to this increase and support HHS' overall strategy to transform and modernize the health care system. This transformation is realized through the use of electronic data to improve health care quality, reduce unnecessary costs, decrease paperwork, expand access to affordable care, improve population health and support reformed payment structures, while protecting a patient's privacy and security.



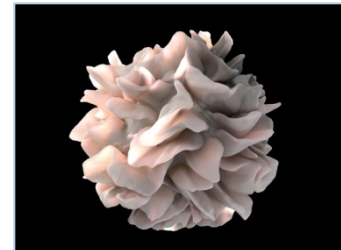
Strategic Goal Two: Advance Scientific Knowledge and Innovation



HHS must expand its scientific understanding of how to best advance health care, public health, human services, biomedical research and the availability of safe medical and food products. Among these efforts, HHS will prioritize the identification, implementation and rigorous evaluation of new approaches in science, health care, public health and human services that reward efficiency, effectiveness and sustainability.

Goal Two Key Results:

- The NIH Molecular Libraries Program (MLP) made exceptional progress toward making freely available to researchers the results of 300 high-throughput biological assays screened against a library of 300,000 unique compounds. Further, the MLP exceeded the FY 2012 performance target by depositing chemical structure and biological data for 294 small molecule probes in PubChem (a database of chemical molecules) since the program began. By disseminating results of the high-throughput biological assays, chemical optimization campaigns and probes in PubChem, the MLP has enabled mining of one of the largest sets of publicly available chemical biological information. This innovative program is expected to provide a scientific resource that will accelerate the discovery of protein functions that control critical processes such as development, aging and disease.
- In FY 2012, AHRQ once again exceeded their target for making Effective Health Care Program products available for use by clinicians, consumers and policymakers. These products aim to provide evidence on the effectiveness, benefits and harms of different treatment options for diverse audiences.



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



Over the past few decades, the Nation has made substantial advancements in ensuring the public health, safety and well-being of the American people, but there is still more to be done. Poverty, teen pregnancy, family disruptions, violence and trauma continue to be pervasive, harmful and costly public health problems in the U.S. HHS is working to implement evidence-based strategies to strengthen families and to improve outcomes for children, adults and communities. Underlying each objective and strategy is a focus on prevention.

Goal Three Key Results:

- FDA, in partnership with CDC, aims to reduce the rate of *Salmonella Enteritidis* cases from 2.6 per 100,000 to 2.1 per 100,000 by the end of 2013. FDA completed key performance milestones including inspections and improving methodologies for generating estimates for *Salmonella Enteritidis*.
- In 2012, the direct medical costs of child maltreatment, in caring for trauma, fractures, joint injuries and acute medical needs are estimated between \$2.9 billion and \$4.2 billion per year.^{1,2} ACF, as part of its efforts to improve the social-emotional well-being of trauma-exposed children, issued five demonstration grants titled “Integrating Trauma-Informed and Trauma-Focused Practice in Child Protective Service Delivery” to build the capacity of the child welfare and services workforce to deliver evidence-based treatments to children. ACF selected an additional nine grantees for an “Initiative to Improve Access to Needs-Driven, Evidence-Based/Evidence-informed Mental and Behavioral Health Services in Child Welfare.” These selections support the implementation of evidence-based or evidence-informed screening, assessment, case planning and service array reconfiguration practices.
- HHS is collaborating to achieve the goal of reducing cigarette smoking, the leading cause of preventable deaths in the U.S. To date, FDA conducted over 80,000 retail inspections and issued approximately 3,000 warning letters, most of which were violations to retailers relating to selling tobacco products to minors. As part of HHS’ comprehensive tobacco control strategy, NIH worked closely with CDC’s expanded eHealth (electronic health) and mHealth (mobile health) activities to increase the scope and reach of tobacco cessation resources, as well as to launch Smokefree Teen mobile and online resources to help teens quit cigarette smoking, with mobile tools available in Spanish.



¹ Gelles, RJ & Perlman, S (2012) Estimated Annual Cost of Child Abuse and Neglect. Chicago, IL: Prevent Child Abuse America.

² Fang, X., Brown, DS, Florence, CS, & Mercy, JA (2012) The economic burden of child maltreatment in the US and implications for prevention. *Child Abuse & Neglect*, 36(2), 156-165.

- High quality early childhood programs are critical to preparing children for success in school and are assessed through implementing Quality Improvement Rating Systems (QIRS). ACF established seven high quality benchmarks for QIRS implementation to encourage states to improve the quality of child care and other early childhood programs. In FY 2011, 17 states had QIRS that met these high quality benchmarks. Although the final number of states meeting all seven benchmarks for FY 2012 is not yet available, ACF measures the number of states that are making progress toward the benchmarks throughout the year to measure performance in relation to the FY 2012 target. Through technical assistance and other support from ACF, an additional 15 states have demonstrated significant progress by meeting at least five (of the seven) quality benchmarks thus far. This progress represents meaningful progress toward meeting the goal of 25 states meeting all quality benchmarks in FY 2013.



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



As the largest grant-awarding agency in the Federal Government and the Nation's largest health insurer, HHS places a high priority on ensuring the integrity of its investments. Its responsibilities are driven by complex scientific and technological issues that require sophisticated analyses of rapidly growing amounts of information. Promoting program integrity and increasing transparency of HHS' efforts requires the expertise of staff across HHS, working both independently and in close collaboration.

Goal Four Key Results:

- CMS continued to measure and work to reduce improper payments made under the Medicare Fee-For-Service (FFS), Part C (Medicare Advantage) and Part D programs. In FY 2012, CMS reduced the improper payment error rate in Medicare FFS from 8.6 percent to 8.5 percent and in Part D from 3.2 percent to 3.1 percent. The Part C error rate rose slightly from 11.0 percent to 11.4 percent.
- As part of their efforts to improve the Foster Care error rate in FY 2012, ACF issued a program instruction for the State Court Improvement Program with specific requirements for grantees to demonstrate collaboration with the title IV-B/IV-E foster care program agency in addressing the title IV-E Foster Care Eligibility Review findings. This program was created to prevent the unnecessary placement of children from low-income families. These requirements are used to calculate the percent of claims that were made on behalf of eligible children. As a result of this instruction, all 50 States, Puerto Rico and DC submitted applications detailing how the courts would participate in the title IV-E foster care eligibility review process, including program improvement plans.



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



Currently, areas in the Nation face shortages of critical healthcare workers such as primary care physicians, nurses, behavioral health and long-term care workers. These areas also face shortages of public health and human service professionals. HHS is addressing many of these workforce issues through implementation of the ACA.

Goal Five Key Results:

- In FY 2012, CDC assigned 160 Public Health Associates to public health agencies in 36 states, two tribal areas, one territory and DC as part of a two-year training program to prepare for future public health-related careers. These associates serve on the frontlines of the public health system to provide infectious disease investigation, environmental health surveillance, individual and community education and support for emergency responses to outbreaks. These outbreaks include food-borne diseases, seasonal diseases like influenza and natural disasters that put communities at high risk for disease infection. CDC also supported 552 fellows, 346 (63 percent) of whom were in state and local field assignments.



- The National Health Service Corps (NHSC) addresses the nationwide shortage of health care providers in Health Professional Shortage Areas (HPSAs). It does so by providing recruitment and retention incentives in the form of scholarship and loan repayment support to health professionals committed to a career in primary care and service to underserved communities. In FY 2012, due to this effort, 9,908 providers met the primary care needs of nearly 10.4 million patients in underserved communities targeting HPSAs of greatest need. The NHSC field strength indicates the number of providers fulfilling active service obligations with the NHSC in underserved areas, in exchange for scholarship or loan repayment support.



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* requires the preparation and audit of these statements, which are part of our efforts for continuous improvement of financial management. Accurate, timely and reliable financial information is necessary for making sound decisions, assessing performance and allocating resources. The Financial Section of the report presents our audited financial statements and notes.

Summary of Financial Condition Trends

(in Billions)

	2008	2009	2010	2011	2012	\$ Change	% Change
Total Assets	\$ 529.3	\$ 562.8	\$ 563.7	\$ 532.9	\$ 530.7	(2.2)	(0.4)
Fund Balance with Treasury	124.3	162.0	182.2	166.9	197.3	30.4	18.2
Investments, Net	385.4	381.1	359.9	325.4	306.4	(19.0)	(5.8)
Other Assets	19.6	19.7	21.6	40.6	27.0	(13.6)	(33.5)
Total Liabilities	\$ 86.6	\$ 94.4	\$ 99.2	\$ 104.9	\$ 99.5	(5.4)	(5.1)
Accounts Payable	1.0	1.1	1.6	1.2	1.1	(0.1)	(8.3)
Entitlement Benefits Due and Payable	65.9	72.2	72.7	80.9	72.5	(8.4)	(10.4)
Accrued Grant Liability	3.9	4.0	4.2	4.5	3.7	(0.8)	(17.8)
Federal Employee and Veterans' Benefits	8.8	9.7	10.0	10.2	11.0	0.8	7.8
Other Liabilities	7.0	7.4	10.7	8.1	11.2	3.1	38.3
Net Position	\$ 442.7	\$ 468.4	\$ 464.5	\$ 428.0	\$ 431.2	3.2	0.7
Total Liabilities and Net Position	\$ 529.3	\$ 562.8	\$ 563.7	\$ 532.9	\$ 530.7	(2.2)	(0.4)

Financial Condition: What is Our Financial Picture?

The table above summarizes trend information concerning components of our financial condition as of September 30 each year. The Consolidated Balance Sheet, found in the Financial Section of this report, presents our financial condition as of September 30, 2012, compared to September 30, 2011 and displays assets, liabilities and net position.

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

Assets: What Do We Own and Manage?

Assets represent the value of what we own and manage. Our total assets were \$530.7 billion on September 30, 2012. This amount represents a decrease of \$2.2 billion or 0.4 percent less than last year's assets. This \$2.2 billion decrease in assets is primarily attributable to a decrease in Net Investments of \$19.0 billion mainly for the

Medicare Trust Funds and a decrease in Advance payments of \$14.9 billion dollars for payments made to the Medicare Advantage and Prescription Drug Plans.

However, the assets included an offsetting increase in Fund Balance with Treasury in FY 2012 compared to FY 2011 of \$30.4 billion (\$197.3 billion and \$166.9 billion, respectively). The increase is primarily attributable to Medicare Hospital Insurance (HI) in the amount of \$1.0 billion, Supplementary Medical Insurance (SMI) in the amount of \$16.1 billion and an increase to Medicaid in the amount of \$19.7 billion dollars.

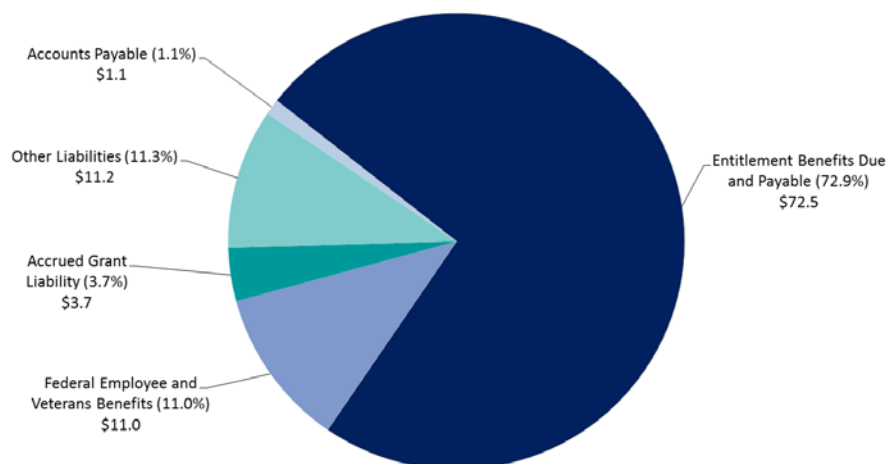
The Federal Government does not set aside assets to pay future benefits associated with Medicare. Treasury securities (our Net Investments) are earmarked assets for the Medicare program. Trust fund holdings not necessary to meet current expenditures are invested in interest-bearing U.S. Treasury securities. The securities held by the Medicare Trust Fund provide the authority to make expenditures. As a result, our Net Investments declined by \$19.0 billion in FY 2012 for Medicare. The investment decreased to meet the cash requirements related to Medicare, primarily for the HI program in the amount of \$18.0 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 HI investments continue to decrease as expenses exceed revenues.

We have experienced a slight change in the overall composition of our assets in FY 2012 compared to FY 2011. The Fund Balance with Treasury and Net Investments together currently comprise 94.9 percent of our total assets compared to 92.4 percent at the end of FY 2011. The remaining FY 2012 assets, totaling \$27.0 billion or 5.1 percent, consists of: Accounts Receivable; Inventory and Related Property; Property, Plant and Equipment; Advances; and Other Assets, compared to FY 2011, which represented 7.6 percent of our total assets. This change in asset composition is directly related to a decrease in advance payments by CMS for the Medicare Advantage and Prescription Drug plans for services provided in October 2012.

Liabilities: What Do We Owe?

Our liabilities, or amounts that we owe from past transactions or events, were \$99.5 billion on September 30, 2012. This represents a decrease of \$5.4 billion, or 5.1 percent less than the FY 2011 liabilities.

Figure 1: FY 2012 Liabilities by Type
(in Billions)



Entitlement Benefits Due and Payable to the public from the Medicare and Medicaid insurance programs decreased from \$80.9 billion on September 30, 2011 to \$72.5 billion on September 30, 2012. The year-over-year change represents an \$8.4 billion or 10.4 percent change from FY 2011.

Entitlement Benefits Due and Payable represents 72.9 percent and 77.1 percent of our total liabilities in FY 2012 and FY 2011, respectively, which is primarily due to a decrease in the estimates of expenses incurred, but not yet recorded for the HI and SMI programs. In addition, we have an offsetting \$3.1 billion increase in Other Liabilities, which includes activities such as an increase in Contingent Liabilities for Medicaid reimbursement of State plan amendments and IHS Tribal Contract Support Cost Litigations.

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 later in this section. A more extensive discussion is provided in the Notes to the Financial Statements in the Financial Section 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 result from changes that occur within the Cumulative Results of Operations and Unexpended Appropriations. Our net position increased by \$3.2 billion (0.7 percent), from \$428.0 billion in FY 2011 to \$431.2 billion in FY 2012. The \$431.2 billion includes \$287.4 billion for earmarked funds (compared to \$297.6 billion in FY 2011) and \$143.7 billion for FY 2012 for all other funds (compared to the FY 2011 ending balance of \$130.4 billion).

The FY 2012 increase of \$3.2 billion includes an increase of \$16.2 billion in earmarked unexpended appropriations, \$13.2 billion in unexpended appropriations for all other funds and \$0.1 billion in cumulative results of operations for all other funds. The increase was offset by a decrease of \$26.4 billion in earmarked cumulative results of operations. Net position is the sum of the cumulative results of operations since inception and unexpended appropriations which represent those appropriations provided to HHS that remain unused at the end of the fiscal year.

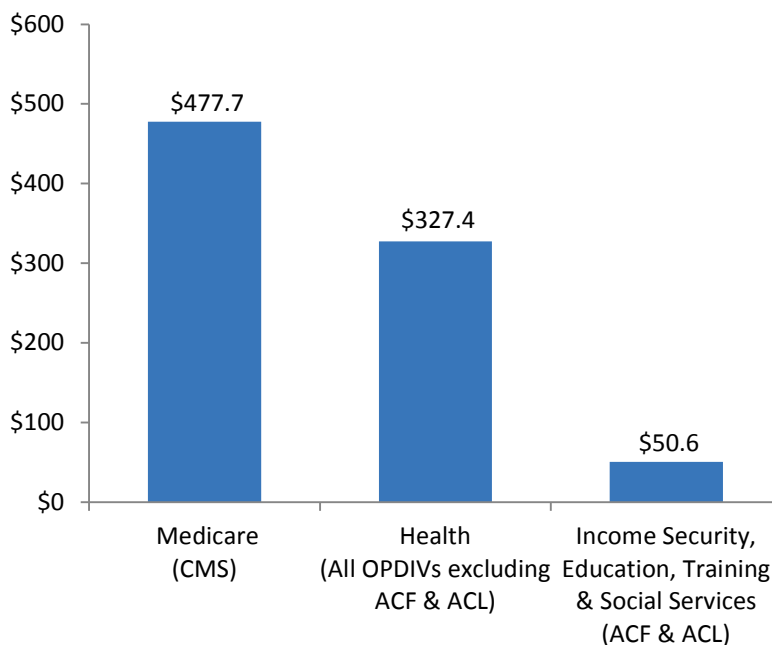
Net Cost of Operations: What Are Our Sources and Uses of Funds?

Our net cost of operations represents the difference between the costs incurred by our 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, 2012, totalled \$855.5 billion.

Figure 2 on the next page depicts our FY 2012 Combined Net Cost of Operations by major budget function and significant components. The majority of FY 2012 net costs relate to Medicare (\$477.7 billion) and Health (\$327.4 billion) programs, or more than 94 percent of our annual net costs. During FY 2012, the Medicare budget function experienced growth of 0.8 percent (\$3.7 billion) and Health decreased 6.1 percent (\$21.3 billion).

The growth in the Medicare budget function is primarily attributable to an increase in SMI of \$9.6 billion offset by a decrease in HI of \$5.9 billion.

Figure 2: FY 2012 Combined Net Cost of Operations by Budget Function
(in Billions)



The FY 2012 Net Cost represents a decrease of \$22.6 billion or 2.6 percent less than the FY 2011 Net Cost of Operations. Approximately 86.2 percent of the Net Cost of Operations (\$737.2 billion) relates to Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and other health programs managed CMS. The Table below depicts our Net Cost of Operations by major component for the last five years.

Net Cost of Operations
(in Billions)

	2008	2009	2010	2011	2012	\$ Change	% Change
Responsibility Segments							
CMS Gross Cost	\$ 657.9	\$ 749.0	\$ 789.7	\$ 817.4	\$ 802.3	(15.1)	(1.8)
CMS Exchange Revenue	(54.1)	(57.3)	(60.7)	(63.7)	(65.1)	(1.4)	2.2
CMS Net Cost of Operations	603.8	691.7	729.0	753.7	737.2	(16.5)	(2.2)
Other Segments:							
Other Segments Gross Cost of Operations	108.4	116.0	130.9	128.2	121.5	(6.7)	(5.2)
Exchange Revenue	(3.1)	(3.8)	(3.2)	(3.8)	(3.2)	0.6	(15.8)
Other Segments Net Cost of Operations	105.3	112.2	127.7	124.4	118.3	(6.1)	(4.9)
Net Cost of Operations	\$ 709.1	\$ 803.9	\$ 856.7	\$ 878.1	\$ 855.5	(22.6)	(2.6)

Budgetary and Non-Budgetary Resources: What Were Our Resources and the Status of Funds?

The Combined Statement of Budgetary Resources provides information on availability of budgetary and non-budgetary resources at the end of the year. FY 2012 total resources were \$1.3 trillion, representing a decrease of \$25.5 billion, or 1.9 percent, over FY 2011. HHS received \$3.2 billion in borrowing authority under the *Federal Credit Reform Act of 1990* to support the CO-OP Program. FY 2012 total obligations of \$1.2 trillion decreased by \$57.7 billion, or 4.6 percent, less than FY 2011. Our year-end resources were \$84.0 billion, of which \$8.7 billion are not yet available for expenditure as of September 30, 2012. Total net outlays (cash disbursed for HHS' obligations) of \$848.2 billion decreased by \$43.3 billion or 4.9 percent from FY 2011 net outlays of \$891.5 billion.

Statement of Social Insurance

The SOSI presents the 75-year actuarial present value of the income and expenditures of the HI and SMI trust funds. Future expenditures are expected to arise from the formulas specified in current law for current and future program participants. This projection is considered to be 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:

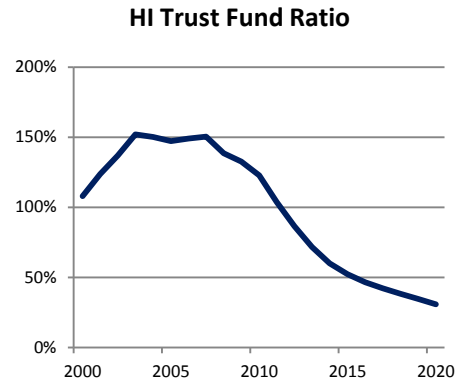
- The present value of future income (excluding interest) to be received from or on behalf of current participants who have attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income to be received from or on behalf of current participants 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;
- 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) decreased from \$(3.3) trillion, determined as of January 1, 2011, to \$(5.6) trillion, determined as of January 1, 2012.

Including the combined HI and SMI Trust Fund assets increases the present value, as of January 1, 2012, of future cashflows for all current and future participants to \$(5.3) trillion for the 75-year valuation period. The comparable closed group of participants, including the combined HI and SMI Trust Fund assets, is \$(9.9) trillion.

Hospital Insurance Trust Fund Solvency

Pay-as-you-go Financing

The 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 139.0 percent at the beginning of FY 2008 to 94.0 percent at the beginning of FY 2012.



	Trust Fund Ratio ³				
	2008	2009	2010	2011	2012
HI	139.0%	134.0%	124.0%	106.0%	94.0%

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 2012 Trustees Report indicate that the HI Trust Fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the 2012 Trustees Report, the HI Trust Fund ratio is estimated to steadily decline to about 32.0 percent by the beginning of calendar year 2021. From the end of 2011 to the end of 2021, assets are expected to decline by 50.0 percent, from \$244 billion to \$119 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 87.0 percent of projected expenditures after the HI Trust Fund exhaustion in 2024, declining to 69.0 percent of projected expenditures in 2086.

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

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

from 3.43 in 2011 to about 2.1 by 2086. 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 \$5.5 trillion, which is 1.4 percent of taxable payroll and 0.6 percent of 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: Social Insurance* disclosures required by the Federal Accounting Standards Advisory Board (FASAB).

Supplementary Medical Insurance Trust Fund Solvency

The 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 expenditures less income for the 75-year projection period is \$(21.6) 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 2011, SMI expenditures were 1.97 percent of GDP. By 2086, SMI expenditures are projected to grow to 4.02 percent of the GDP.

The following table presents key amounts from CMS' basic financial statements for FYs 2010 through 2012.

Table of Key Measures⁴
Based on the CMS Financial Statements⁵
(in Billions)

	2012	2011	2010
<i>Net Position (end of fiscal year)</i>			
Assets	\$ 424.8	\$ 424.2	\$ 430.7
Less Total Liabilities	80.5	87.5	80.5
Net Position (assets net of liabilities)	<u>\$ 344.3</u>	<u>\$ 336.7</u>	<u>\$ 350.2</u>
<i>Change in Net Position (end of fiscal year)</i>			
Net Costs	\$ 737.8	\$ 754.1	\$ 728.7
Total Financing Sources	710.8	730.4	709.5
Change in Net Position	<u>\$ (27.0)</u>	<u>\$ (23.7)</u>	<u>\$ (19.2)</u>
<i>Statement of Social Insurance (calendar year basis)</i>			
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	\$ (5,581)	\$ (3,252)	\$ (2,683)
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	<u>(3,252)</u>	<u>(2,683)</u>	<u>(13,770)</u>
Change in present value	<u>\$ (2,329)</u>	<u>\$ (569)</u>	<u>\$ (11,087)</u>

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, 2012, would have decreased by \$125 billion due to advancing the valuation date by one year and including the additional year 2086. Similarly, changes in the demographic and economic and health care assumptions further decreased the present value of future cashflows by \$97 billion and \$2,546 billion, respectively. However, projection base and legislative changes increased the present value of future cashflows by \$286 billion and \$153 billion, respectively. For further explanation, please refer to Note 24, *Statement of Changes in Social Insurance Amounts* of the Financial Section.

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 CMS presents the closed group measure and open group measure.

⁵ Available at <http://www.cms.gov>.

Required Supplementary Information

As required by the Statement of Federal Financial Accounting Standards (SFFAS) Number 17 (as amended by SFFAS Number 37), CMS has included information about the Medicare trust funds – HI and SMI. The Required Supplementary Information presents required long-range cash-flow 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. The SFFAS Number 37 does not eliminate or otherwise affect the SFFAS Number 17 requirements for the supplementary information, except that actuarial projections of annual cashflows in nominal dollars are no longer required. Accordingly, it will not be reported in the Required Supplementary Information. The Required Supplementary Information 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 *2012 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.

Limitations of the Principal Financial Statements

The principal financial statements in the Financial Section of this report have been prepared to report our financial position and results of operations, pursuant to the requirements of 31 U.S. Code (U.S.C.) §3515 (b). Although the statements have been prepared from our books and records in accordance with generally accepted accounting principles (GAAP) 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 HHS with resources and budget authority.

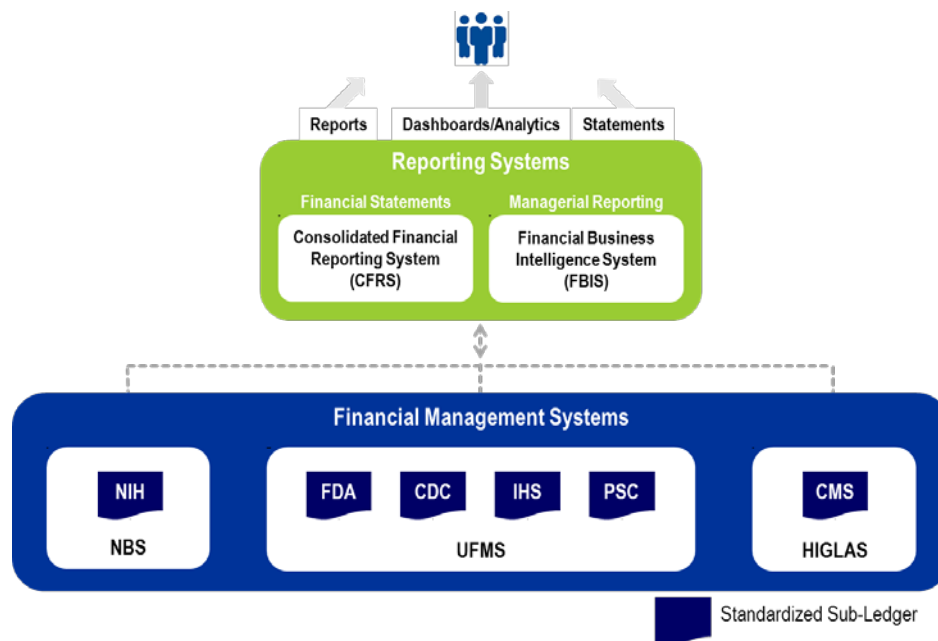
The Required Supplementary Information section is unique to Federal financial reporting. This section is required under OMB Circular A-136, *Financial Reporting Requirements*.

SYSTEMS, LEGAL COMPLIANCE AND INTERNAL CONTROLS

SYSTEMS

HHS financial management systems are designed to support effective internal controls and to produce accurate, reliable and timely financial information. Our current financial systems portfolio, referred to as “Global UFMS” hereinafter, is depicted in the image below:

Global Unified Financial Management System (Global UFMS)



Global UFMS and its major components are described below.

1. The financial management systems component (shown above in the Financial Management Systems layer), consists of three financial management and accounting systems that offer HHS a platform for effectively processing and tracking its financial and accounting transactions, while meeting the unique business needs of the users. The specific systems are shown below:
 - UFMS is the integrated financial management system with four standardized sub-ledgers (one for each of the OPDIVs shown above and with the Program Support Center (PSC) supporting six OPDIVs and sixteen STAFFDIVs);
 - The Healthcare Integrated General Ledger Accounting System (HIGLAS) at CMS serves 15 Medicare Administrative Contractors (MACs) processing medical payments with its single standardized sub-ledger; and
 - The National Institutes of Health Business System (NBS) serves 27 separate research institutes supporting health research, an integral part of the HHS mission, with its single standardized sub-ledger.

Built upon a web-based commercial off-the-shelf solution, these three systems allow us to reliably execute financial management procedures and business processes over a common infrastructure across the enterprise.

2. The reporting systems component of Global UFMS (shown above in the Reporting Systems layer) consists of two reporting solutions that accept data from the financial management systems and facilitate reconciliation, financial analysis and management reporting. The specific systems are shown below:
 - The Consolidated Financial Reporting System (CFRS), implemented during FY 2011, enables us to systematically consolidate information from the three financial management systems. It generates the formal, HHS-wide consolidated financial statements and other managerial reports on a consistent, timely and reliable basis.
 - The Enterprise Financial Business Intelligence System (FBIS), which we are implementing in phases with the first phase rolled out during FY 2012, will offer expanded financial reporting functionality to a larger user base by mid FY 2013. This system provides management reports and business analytics that will facilitate the delivery of data across all financial systems. Its purpose is to provide analytic tools used by strategic decision makers within HHS. FBIS is currently integrated with the financial management systems via extract files, but it will be integrated directly with UFMS, thereby providing for full access and drill-down capabilities to the financial and accounting data that it stores.

Because of their tight integration with UFMS, both reporting systems are thought of as sub-systems to UFMS, not just as components of Global UFMS.

Our primary goals for Global UFMS are to consistently strengthen internal controls, to maintain data integrity and transparency and to report reliable financial information on a timely basis. In addition, a management priority is continual systems improvement, accomplished by addressing weaknesses identified in audits and by performing self-evaluations and assessments of our financial management controls, systems and processes.

These objectives align with the requirement to abide by all relevant federal laws, regulations and authoritative guidance. In addition, we seek to comply with the federal financial management systems requirements and related OMB regulations, such as those listed below:

- *Federal Managers' Financial Integrity Act*
- *Chief Financial Officers Act*
- *Government Management Reform Act*
- *Federal Financial Management Improvement Act*
- *Clinger-Cohen Act of 1996*
- *Federal Information Security Management Act*

In line with the goals described above and anticipating the need to meet new business and reporting demands, we are in the preliminary phases of devising a Department-wide financial systems improvement strategy and are developing a high-level roadmap to execute the strategy incrementally over time. The improvement strategy is intended to maintain the Department's secure and reliable environment, while further leveraging our financial systems investments. As part of implementing this strategy, we will standardize financial data across HHS to improve data integrity and expand the use of business intelligence incrementally to further enhance financial management reporting, strengthen internal controls and facilitate effective strategic and tactical decision-making.

As part of the financial systems improvement strategy, we are also establishing Department-wide governance to provide oversight of the financial management systems portfolio as it continues to evolve. This governance will ensure efficient execution of project responsibilities and Department-wide coordination of project activities.

LEGAL COMPLIANCE

Anti-Deficiency Act

As noted in our FY 2011 AFR, HHS investigated potential reportable violations. During FY 2012, 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.

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

Federal Financial Management Improvement Act

In 1982, Congress enacted the *Federal Managers' Financial Integrity Act* (FMFIA). Under FMFIA, federal agencies must provide reasonable assurances that agencies have established internal accounting and administrative controls to prevent waste or misuse of agency funds or property and to assure the accountability of assets, including conformance of the agency's accounting system with government-wide standards. The FMFIA also requires a plan and schedule for correction of any weaknesses identified in the report.

In 1996, Congress enacted the *Federal Financial Management Improvement Act* (FFMIA). FFMIA expanded upon FMFIA by requiring that agencies implement and maintain financial management systems that comply substantially with federal financial management systems, applicable federal accounting standards and the standard U.S. General Ledger at the transaction level.

The key reason for our lack of compliance with FFMIA is the material weakness related to system security controls that is described in the Statement of Assurance section. This section also describes the corrective action plan that we will execute to resolve this weakness, as we continue working towards our goal of making Global UFMS fully compliant with FFMIA. Our multi-faceted effort also encompasses improvements to all of our financial management and reporting systems as well as enhanced policies and procedures.

The following briefly describes our accomplishments during FY 2012.

UFMS and its Related Reporting Systems

We carefully reviewed our weaknesses related to UFMS and its related reporting systems and are in the process of developing corrective action plans. As part of this effort, we improved our policies and procedures and emphasized the need to fully implement them. Further, to minimize HHS' challenges with timing and recognition of key financial transactions, we leveraged CFRS by moving from a quarterly close process to one with monthly cycles, in order to improve the timeliness and reliability of our financial statements.

As mentioned in the "Systems" section above, we implemented FBIS, which provides users with HHS financial reporting and business analytics capabilities using data from our distinct financial management systems and other

data sources. In addition to enabling enhanced strategic decision-making, these new capabilities provide the following benefits to HHS:

- Improves data integrity and reduces manual review efforts;
- Consolidates and reconciles data sourced from different systems;
- Strengthens internal controls to ensure that errors and irregularities are detected in a timely manner; and
- Provides the tools that can be used to validate, verify and analyze accounting data.

UFMS' compliance with FFMIA will be further improved once FBIS is directly integrated with UFMS during FY 2013, since this will facilitate the ability to support and analyze reported account balances in a timely fashion. Global UFMS has already benefitted from FBIS in terms of FFMIA compliance, even with its reliance on data extracts.

HIGLAS

HIGLAS is a single, integrated dual-entry accounting system that standardizes and centralizes federal financial accounting and replaces the existing accounting/payment systems for Medicare and Medicaid. Although Medicare contractors' claims processing systems were operating effectively in adjudicating healthcare claims in the past, before the phased rollout of HIGLAS, the systems were not designed to meet the requirements of a dual entry general ledger accounting system. As a result, they did not meet the provisions of the FFMIA.

Following the guidance of the OMB Circular A-130, *Management of Federal Information Resources*, CMS acquired a commercial off-the-shelf product. As a result, in FY 2010, CMS made significant progress toward FFMIA compliance and now considers its financial systems to be integrated in accordance with OMB Circular A-127, *Financial Management Systems*, highlighting the following data regarding HIGLAS (current as of September, 2012).

- A total of 99.5 percent of total CMS program payments (Medicare, Medicaid and CHIP are accounted for in HIGLAS.
- Since being implemented in May 2005, HIGLAS has processed more than 4.0 billion financial transactions and processed over 150.9 million payments worth \$1.4 trillion.

HIGLAS will continue to enhance CMS' oversight of claims administration contractor financial operations and the accounting and reporting of other CMS activities, while providing high quality, timely data for decision making and performance measurement.

NBS

NBS is a fully integrated financial, property, acquisition and logistics management system that supports NIH's core administrative and financial operations. NBS fosters NIH's mission through the provision of secure, accurate and timely business transaction capabilities that enable the NIH scientific community and supporting organizations to acquire needed assets, goods and services. It also provides accurate source information that facilitates knowledgeable decision making by the NIH management community regarding budgets, finance, acquisitions and property management. Overall, the NBS supports HHS' goal of "achieving excellence in management practices" through accountability and transparency. NBS management is actively remediating application security management audit findings related to change management, segregation of duties and audit log monitoring.

Collectively, these improvements have significantly enhanced our financial management systems' compliance with FFMIA. However, management will continue to improve policies and implement corrective action on any deficiencies identified.

Improper Payments Reporting

The *Improper Payments Elimination and Recovery Act (IPERA)*, signed into law on July 22, 2010, amends the *Improper Payments Information Act (IPIA)*. The IPIA requires each federal agency to review all programs and activities that it administers and identify all such programs and activities that may be susceptible to significant improper payments. For programs that are identified as susceptible to significant improper payments (known as high-risk programs), it also requires that each agency report improper payment estimates and various other related information. In addition, the IPIA as amended by IPERA significantly increases our recovery auditing efforts by expanding the definition of payments recovered to include program payments. The Other Accompanying Information section of this report contains detailed information on our improper payment activities.

HHS has shown tremendous leadership in the improper payments arena. HHS has published an error rate for Medicare FFS since FY 1996 and reported Foster Care and Head Start error rates since FY 2004. In addition, this year we are also reporting an improper payment estimate for CHIP for the first time since FY 2008.

HHS continues to face challenges in developing an improper payment estimate for the Temporary Assistance for Needy Families (TANF) program. Due to statutory limitations, HHS is unable to compel states to collect the information needed to conduct an improper payment measurement. When legislation is considered to reauthorize TANF, HHS plans to work with Congress to include changes that would allow for reliable error rate measurement. HHS continues to encourage states to implement corrective actions to reduce and prevent improper payments.

Table 1 in the Improper Payments Reporting Section (found in the Other Accompanying Information section of this report) shows our results and associated notes, for the current year (CY) 2012, the prior year (PY) 2011, as well as the targets for the years 2013 through 2015.

INTERNAL CONTROLS

FMFIA and OMB Circular A-123, *Management's Responsibility for Internal Control* requires agencies to evaluate and report on the effectiveness of internal controls in place to ensure effectiveness and efficiency of operation, compliance with applicable laws and regulations and reliable financial reporting. HHS has completed these very rigorous assessments since FY 2006.

Managers throughout HHS are responsible for ensuring that effective internal controls are implemented in their areas of responsibility. Senior management throughout HHS provides assurance statements annually concerning the effectiveness and efficiency of internal controls within programs, the reliability of internal controls over financial reporting and compliance with applicable laws and regulations. The HHS Risk Management Financial Oversight Board (RMFOB) assesses all senior management assurances and provides the Secretary with a recommendation to sign the Agency's Statement of Assurance.

HHS continues to strengthen our internal controls assessment process to be more effective so that management can identify risks and make timely corrective actions. The HHS FY 2012 self-assessment, as well as the financial statement audit, identified one material weakness, which also constitutes a non-conformance under FMFIA Section 4 and one material non-compliance, which are respectively: (1) Information System Controls and Security and (2) Error Rate Measurement.

HHS believes that maintaining integrity and accountability in all programs and operations is critical to our mission and demonstrates responsible stewardship over assets and resources. It also promotes responsible leadership, ensures the effective delivery of high quality services to our customers and maximizes desired program outcomes.

STATEMENT OF ASSURANCE



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

The Department of Health and Human Services' (HHS or the Department) management is responsible for establishing and maintaining effective internal control and financial management systems that meet the objectives of the FMFIA and 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 the *Federal Managers' Financial Integrity Act*. This statement is qualified due to one material weakness which also constitutes a non-conformance under Section 4 of FMFIA and one material noncompliance with the *Improper Payments Information Act* (IPIA):

1. Information System Controls and Security
2. Error Rate Measurement

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, 2012, were operating effectively and no material weaknesses were found 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, which also constitutes a non-conformance under Section 4 of FMFIA and one material noncompliance with IPIA related to error rate measurement, as of September 30, 2012. Other than the exceptions (identified above), the Department provides reasonable assurance that internal controls over operations and compliance with applicable laws and regulations as of September 30, 2012, were operating effectively and no other material weaknesses were found in the design or execution of the internal controls over operations and compliance.

/Kathleen Sebelius/
Kathleen Sebelius
Secretary
November 15, 2012

Summary of Material Weaknesses and System Non-Conformances

Control Area	FMFIA Section 2			FMFIA Section 4
	Operations (as of 9/30/2012)	Compliance (as of 9/30/2012)	Financial Reporting (as of 6/30/2012)	Systems Non-Conformance
1. Information System Controls and Security	✓	-	-	✓
2. Error Rate Measurement	-	✓	-	-

1. Information System Controls and Security

HHS acknowledges an internal control weakness related to system security, including general and application controls in our financial management systems and other information security weaknesses identified through the *Federal Information Security Management Act* (FISMA) annual review process. 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. While we have made progress in the remediation of the financial management systems' finding, our systems are not yet in substantial conformance with FFIA and its associated regulatory guidelines, as established by the appropriate governing bodies with respect to overall system security as of September 30, 2012.

2. Error Rate Measurement

We did not find a material weakness in our controls over compliance. However, we did find one process limitation relating to the Temporary Assistance for Needy Families (TANF) program that led to an instance of material non-compliance with IPIA. The TANF program is not reporting an error rate for FY 2012. Statutory limitations prohibit HHS from requiring States to participate in a TANF improper payment measurement. When legislation is considered to reauthorize TANF, HHS plans to work with Congress to include changes that would allow for reliable error rate measurement.

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
1. Information System Controls and Security	FY 2015	Sufficient compensating controls exist through manual efforts that the risk of misstating the Financial Statements is mitigated.
2. Error Rate Measurement	TBD ⁶	While error rate measurements do not directly impact HHS' financial statements, we are unable to report in our AFR an estimate of improper payments for TANF, as required.

The range of challenges resulting in our IT material weakness will require additional work beyond FY 2012 to address. In FY 2013, we will continue our efforts to remediate our IT material weakness by establishing a joint CFO-CIO partnership to develop a corrective action plan. This partnership will expand ongoing efforts of the CIO, CISO, and CFO to address the issues underlying our IT material weakness. We will identify high risk areas and key drivers for HHS' financial systems, mixed financial systems and associated IT infrastructure. We plan to form various cross-cutting teams, led by executive sponsors. The executive sponsors of each of these teams will be accountable to the Risk Management Financial Oversight Board to drive results and establish effective, operational controls to reduce risk.

⁶ HHS is limited with respect to corrective actions it can take to develop an error rate for TANF. However, when legislation is considered to reauthorize TANF, HHS plans to work with Congress to include changes that would allow for a reliable error rate measurement.

**TABLE 1
SUMMARY FINANCIAL STATEMENT AUDIT**

Audit Opinion		Unqualified for Four Financial Statements. No Opinion Expressed on Statement of Social Insurance and Statement of Changes in Social Insurance Amounts			
Restatement		No			
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Ending Balance
Financial Reporting, Systems, Analyses & Oversight	-	-	-	-	-
Financial Management Information Systems	✓	-	-	-	✓
Total Material Weaknesses	1	0	0	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
<i>Total Material Weaknesses</i>	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>

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	✓	-	-	-	-	✓
Error Rate Measure	0	✓	-	-	-	✓
Total Material Weaknesses	1	1	0	0	0	2

Conformance with Financial Management System Requirements (FMFIA #4)						
Statement of Assurance	Non-conformance					
Non-Conformances	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
Information System Controls and Security	✓	-	-	-	-	✓
Total Non-Conformances	1	0	0	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	
3. USSGL at Transaction Level	No	

LOOKING AHEAD TO 2013

Management Challenges and High-Risk Areas

HHS is committed to improving the Nation's health and well-being while simultaneously contributing to deficit reduction. Plans for FY 2013 support the Administration's challenging, yet complementary, goals of investing in the future while establishing a sustainable fiscal outlook through reductions to lower priority areas, reducing duplication and increasing administrative efficiencies. The activities discussed in the next sections highlight the size and scope of the challenges faced across HHS and diverse nature of the efforts to meet these challenges across our operating components.

Health Reform Implementation

Effective implementation of the ACA is central to the improved fiscal outlook and well-being of the Nation. Affordable Insurance Exchanges (Exchanges) will provide improved access to insurance coverage for millions of Americans. FY 2013 will be a critical year for building the infrastructure and initiating the many business operations critical to enabling Exchanges to begin operation on January 1, 2014. The expansion of health insurance coverage for millions of low-income individuals who were previously not eligible for coverage also begins in 2014, and CMS will continue outreach efforts with states to ensure states are prepared for this deadline.

Additionally, HHS' investment in health centers will provide significantly increased access to quality care. Health Centers are a key component of the Nation's health care safety net. This investment will provide Americans in underserved areas, both rural and urban, with access to comprehensive primary and preventive health care services.

Quality and Prevention

FY 2013 plans support critical reforms in Head Start and Child Care quality improvement efforts that, when taken together with the Race to the Top Early Learning Challenge, are key elements of the Administration's broader education reform agenda designed to improve our Nation's competitiveness by helping every child enter school ready for success. This agenda includes continuing implementation of new regulations that require grantees that do not meet high quality benchmarks to compete for continued funding. It also introduces efforts to measure the quality of individual childcare programs through a rating system or another system of quality indicators. These initiatives focus on continuous quality improvement and provide low-income children access to high quality early education settings that support children's learning, development and success.

Also, domestic Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) activities will support treatment to people living with HIV/AIDS in the U.S., improve adherence to medications and support prevention programs in states and communities. CDC's domestic HIV/AIDS prevention activities will support grants to health departments to reduce new HIV infections, identify previously unrecognized HIV infections and improve health outcomes. The activities will continue supporting research, surveillance, evaluation and implementation of high-impact prevention programs among HIV risk populations consistent with the National HIV/AIDS Strategy.

Research and Innovation

FY 2013 plans continue the priority to invest in innovative biomedical and behavioral research at NIH that advances medical science to improve health while spurring economic growth. NIH continues generating discoveries that are opening new avenues for disease treatment and prevention and revolutionizing patient care. In FY 2013, NIH will seek to take advantage of such discoveries by investing in basic research on the fundamental causes and mechanisms of disease, accelerating discovery through new technologies, advancing translational sciences and encouraging new investigators and new ideas.

HHS is committed to advancing the use of HIT and promoting EHRs as tools to improve both the health of individuals and the health care system as a whole, through the Office of the National Coordinator for Health Information Technology (ONC). Furthermore, through the *Health Information Technology for Economic and Clinical Health Act* (HITECH) provisions of the *American Recovery and Reinvestment Act*, CMS will continue providing hospitals and medical professionals who participate in Medicare and Medicaid with substantial incentive payments for the adoption and meaningful use of EHRs. By encouraging providers to modernize their systems, this investment will improve the quality of care and protect patient safety.

Strategy and Program Integrity

The ACA directed HHS to develop a national strategy to improve health care services delivery, patient health outcomes and population health. The Department's National Strategy for Quality Improvement in Health Care (the Strategy) highlights three broad aims: Better Care, Healthy People and Communities and Affordable Care. Since publishing the Strategy, HHS has focused on gathering additional input from private partners and aligning new and existing HHS activities with the Strategy. HHS will enhance the Strategy by incorporating input from stakeholders and developing metrics to measure progress toward achieving the Strategy's aims and priorities. The Strategy is already serving as a blueprint for quality improvement activities across the country.

Program integrity continues as a top priority in FY 2013. Planned investment supports the continued reduction of the Medicare FFS improper payment rate, investments in prevention focused, data driven initiatives like predictive modeling; and HHS-Department of Justice Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiatives, including Medicare Strike Force teams and fighting pharmaceutical fraud. Additionally, Durable Medical Equipment (DME) Competitive Bidding will continue competitive pricing, while ensuring access to quality medical equipment from accredited suppliers, which will save Medicare billions over ten years and help millions of Medicare beneficiaries save in out-of-pocket costs.

HHS' continued efforts across health reform implementation in coordination with quality and prevention activities and investing in research and innovation have resulted in various positive outcomes in FY 2012 and these efforts in FY 2013 will continue meaningful gains in health and opportunity for the American people.

A *Summary of Top Management Challenges Identified by the Inspector General* follows in the Other Accompanying Information section, and includes the full text of the HHS' OIG assessment. Additionally, the Other Accompanying Information section includes further information concerning our efforts and actions to resolve OIG audit findings in the FY 2012 *Management's Report on Final Action*.