



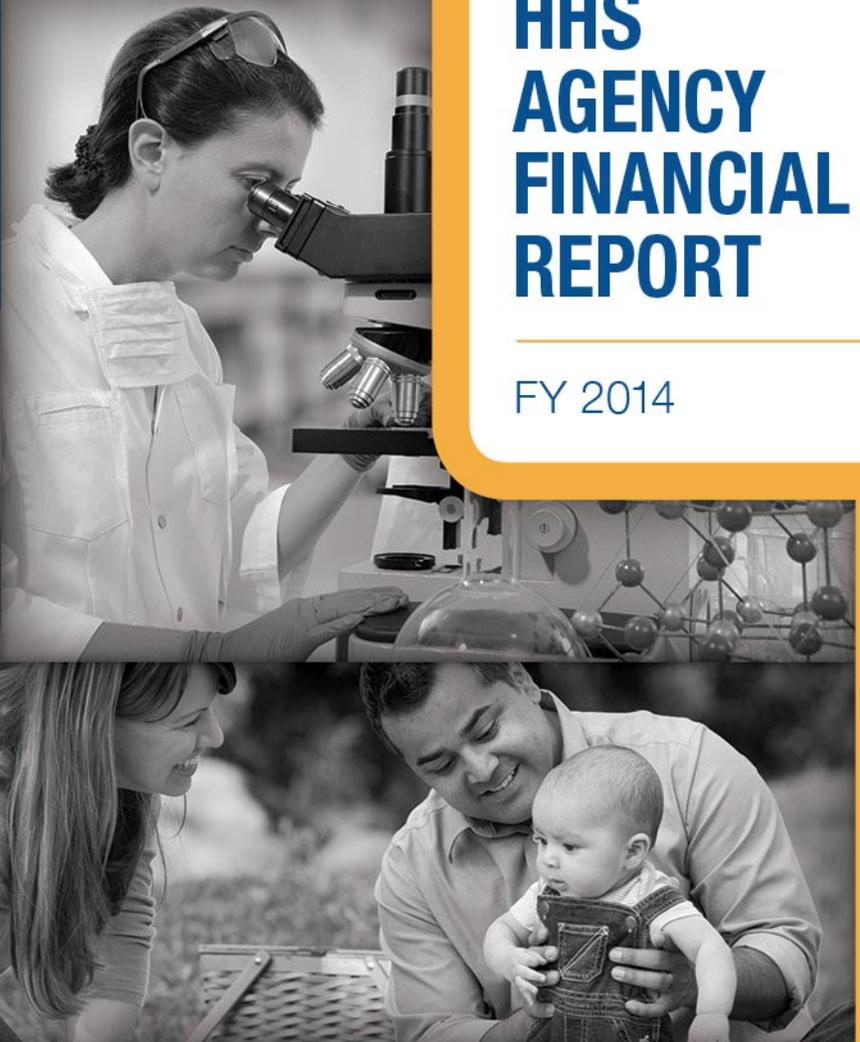
IT WAS ONCE SAID THAT
THE MORAL TEST OF GOVERNMENT
IS HOW THAT GOVERNMENT TREATS
THOSE WHO ARE IN THE DAWN OF LIFE,
THE CHILDREN; THOSE WHO ARE IN
THE TWILIGHT OF LIFE, THE ELDERLY;
AND THOSE WHO ARE IN
THE SHADOWS OF LIFE, THE SICK,
THE NEEDY AND THE HANDICAPPED.

HUBERT H. HUMPHREY



HHS AGENCY FINANCIAL REPORT

FY 2014





U.S. Department of Health and Human Services

ADMINISTRATION FOR
CHILDREN & FAMILIES



National Institutes
of Health



One Department, One Mission, One HHS!

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MESSAGE FROM THE SECRETARY



Sylvia M. Burwell

Mission/Introduction

The mission of the U.S. Department of Health and Human Services (HHS) is to ensure every American has access to the building blocks of healthy and productive lives. At HHS, we believe in building bridges, relationships, and strong teams with the talent and focus necessary to deliver results. We believe in managing well, in transparency, and in delivering impact on behalf of the people we serve.

I'm pleased to present HHS's Fiscal Year (FY) 2014 Agency Financial Report (AFR). The report illustrates how we manage our resources, highlights our major accomplishments, and outlines our plans to address the challenges we face. At HHS, we're dedicated to meeting the high standards of government reporting and accountability. This year, for the first time, the Department received the Association of Government Accountants' *Certificate of Excellence in Accountability Reporting* for our FY 2013 AFR, and we're committed to upholding these standards of excellence in the future.

Financial Management

As responsible stewards of the public resources that the American taxpayers and the Congress entrust to us, we practice fiscal responsibility and transparency. One of the best tools to assess our financial information is our departmental financial statement audit. This year, we obtained an unmodified (clean) opinion on the Consolidated Balance Sheet, Statement of Net Cost, Statement of Changes in Net Position, and the Combined Statement of Budgetary Resources. Based on our internal assessments and the auditor's report, I believe that our financial and performance data are reliable and complete. For the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts, the auditors disclaimed providing an opinion. The disclaimer was primarily due to the uncertainties surrounding provisions of the *Affordable Care Act* and the impact of potential changes in law that would impact underlying assumptions of financial projections. These statements were developed based upon current law using information from the *2014 Medicare Trustees Report*, as required by standards issued by the Federal Accounting Standards Advisory Board. The Financial Section of this report includes more detailed information.

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 identified one material weakness, which also constitutes a non-conformance under Section 4 of FMFIA, and one material noncompliance, which are respectively: (1) Information System Controls and Security and (2) Error Rate Measurement. Management continues efforts to improve our financial reports and systems. The Management's Discussion and Analysis section of this report includes further details.

HHS Building Progress

Delivery System Reform

Over the last four years, the *Affordable Care Act* rolled out comprehensive health insurance reform. When you consider the law through the lens of access, affordability, and quality, the evidence reflects that the *Affordable Care Act* is working. Examples of the impact over the past four years include:

- **Access.** The number of uninsured adults decreased by 10.3 million adults since 2013. More than 7.3 million people signed up for Marketplace plans, paid their premiums, and accessed quality, affordable

coverage. Another 8.7 million enrolled in Medicaid or CHIP since the beginning of Open Enrollment (as of August 2014) – an increase of 15 percent compared to average monthly signups before October 1, 2013. Three million Americans under the age of 26 gained coverage under their parent’s plans.

- **Affordability.** 70 percent of Americans with Marketplace insurance plans feel they can now afford care if they get sick, and a majority say their premiums are easy to afford. Across the board, health care price inflation is at the lowest level in 50 years.
- **Quality.** Americans are pleased by the quality of care they’re receiving. In one recent survey, more than 3 in 4 newly insured consumers expressed satisfaction with their coverage. And from 2012 to 2013, there were 150,000 fewer unnecessary hospital readmissions.

We will continue to improve, and have been challenged by the Office of Inspector General in our FY 2014 Top Management Challenges to do so. We are committed to making progress and we will work with the American people across all sectors. We have a four-part strategy moving forward:

- Improving access and affordability through the Marketplace. In order to make sure that Americans continue to access affordable choices, we have to get HealthCare.gov right. We are prioritizing the most important items and areas to improve, giving ourselves the appropriate amount of time for testing, and focusing on security.
- Improving quality for patients and spending every dollar wisely. We are changing incentives to move from a volume-based to a more impact-based system. We are investing in tools that expand our capacity to change. We are improving the flow of information, so doctors can spend more time with patients and less time doing paperwork, and so they can coordinate more effectively with one another.
- We are expanding access by expanding Medicaid. We are working to bring more states into the fold on Medicaid expansion.
- We are partnering with organizations across the country to help consumers understand how to use their existing and new coverage, including the role of prevention and wellness.

Unaccompanied Children

The growth in unaccompanied children over the last three years has risen from an estimated 6,600 children in FY 2011 to 58,000 children in FY 2014. The influx of unaccompanied children across our border is the result of complex human tragedies. Although there are no easy answers to this issue, I am confident that we can work together to care for the unaccompanied children in a way that honors the values of the American people while at the same time enforcing the law and dissuading children from undertaking this dangerous journey. HHS has a role in providing care to these children and we seek to minimize the time they initially spend in U.S. Customs and Border Protection (CBP) custody. To do this, HHS is pursuing two key strategies: (1) reducing the amount of time that children remain in our care before being placed with a sponsor (typically a parent or other relative) who can care for them safely and appropriately while their immigration case is processed; and (2) expanding our shelter capacity, both in standard shelters and temporary shelters for use during an influx. Additionally, in May and early June, HHS established temporary emergency shelters on three military bases to help relieve the backlog of children in CBP custody at the border. The Administration for Children and Families (ACF) provides grant funding to organizations to operate standard shelters around the country to care for these children until they can be placed with an appropriate sponsor, while awaiting immigration proceedings. We have made progress in both areas, though significant work remains. Americans can be proud of the work carried out through partnerships between government entities, the military, and communities.

Global Health Security

A consequence of a more interconnected world is the increasing opportunities for human, animal, and zoonotic diseases to emerge and spread globally. The thousands of lives lost to Ebola are a tragic and solemn reminder of

why global health security must remain a top priority. Through global partnerships and a strong whole-of-government U.S. response, we will bring the epidemic under control. The HHS contribution includes the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the Food and Drug Administration (FDA), the Office of the Assistant Secretary for Preparedness and Response (ASPR), and the Office of Global Affairs (OGA). Efforts include:

- CDC is working to make sure health care providers, public health workers, and others in this country enlist in extra precautions to ensure protocols are being met. CDC is also working abroad and at home to coordinate our national response. In the most impacted countries, CDC is helping to establish and equip emergency operations infrastructure and train local staff, including surveillance, contact tracing, health education, and testing of Ebola cases. CDC is partnering with ministries of health and humanitarian groups in affected countries, the United Nations, the World Health Organization, and U.S. agencies and hospitals across the country.
- NIH is working to develop an Ebola vaccine and recently began clinical trials using an expedited process. NIH is also aiding the efforts of private sector and university researchers pursuing the development of Ebola vaccines.
- FDA expedited the review of investigational New Drug Applications to speed along the process of relevant medical products in development, and also authorized a diagnostic test developed by the Department of Defense to detect the Ebola virus.
- ASPR is working with foreign governments, non-government organizations and industry partners to support expediting the development of Ebola drugs and vaccines.
- OGA is helping coordinate our current response to the World Health Organization effort.

Delivering Impact to Meet Our Challenges

The HHS Inspector General identified 10 performance challenges that present opportunities for improvement. These challenges range from overseeing the Health Insurance Marketplace, safeguarding privacy and data security, to protecting HHS grants and contract funds from fraud, waste and abuse. Greater detail of how HHS is addressing these challenges can be found in the Other Information Section under *FY 2014 Top Management and Performance Challenges Identified by the Office of Inspector General*.

The hardworking Americans who rely on our Department as they look to obtain the building blocks of healthy and productive lives are our “bosses.” We believe in managing well. We believe in transparency and we believe in impact – impact for the American people. We’re here to fight for affordability, access and quality. When we tackle a problem at HHS, I make sure that we set out a very clear definition of impact from the beginning: *What do we hope to accomplish and who do we hope to accomplish it for?*

I appreciate the talent of our employees and the relationships we have built with our state, local and nonprofit partners. None of our accomplishments would be possible without them. We will continue to build and strengthen relationships with anyone and everyone who shares our passion for impact and progress while helping Americans obtain the building blocks of healthy and productive lives.

/Sylvia M. Burwell/

Sylvia M. Burwell
Secretary
November 13, 2014

ABOUT THE AGENCY FINANCIAL REPORT

The Department of Health and Human Services (HHS or the Department) Fiscal Year (FY) 2014 *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, 2013, through September 30, 2014. 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. Specifically, the MD&A presents an overview of performance and financial highlights for FY 2014. It also discusses HHS's compliance with legal and regulatory requirements, a summary of audit and management assurances and gives a brief look ahead to FY 2015.



Financial Section

The Financial Section includes the Report of the Independent Auditors, the Department's Principal Financial Statements, Notes to the Principal Financial Statements, Required Supplementary Stewardship Information, and Required Supplementary Information.



Other Information

The Other Information section contains additional financial information including the Schedule of Spending, the Office of Inspector General's FY 2014 assessment of management challenges facing the Department, a Management Report on Final Action and the Improper Payments Information Act Report, as well as appendices to this AFR.

The Department has chosen to produce an AFR and *Annual Performance Report and Performance Plan*. In February 2015, additional reports that will be available on the Department's website (<http://www.hhs.gov/budget>) include:

1. FY 2014 *HHS Summary of Performance and Financial Information*
2. FY 2016 *Annual Performance Report and Performance Plan*
3. FY 2016 *Congressional Budget Justification*

Certificate of Excellence in Accountability Reporting

In May 2014, HHS received the Certificate of Excellence in Accountability Reporting (CEAR) from the Association of Government Accountants (AGA) for its FY 2013 *Agency Financial Report*. The CEAR Program was established by the AGA, in conjunction with the Chief Financial Officers Council, to further performance and accountability reporting. Receiving the CEAR Award represents a significant accomplishment for a federal agency. FY 2013 marks the first year the Department received this prestigious award.



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In this Section:

- About the Department of Health and Human Services
- Performance Goals, Objectives, and Results
- Systems, Legal Compliance, and Internal Controls
- Management Assurances
- Looking Ahead to FY 2015
- Analysis of Financial Statements and Stewardship Information

Management Discussion and Analysis

The Management's Discussion and Analysis (MD&A) section provides an overview of the entire report. Specifically, the MD&A presents an overview of performance and financial highlights for FY 2014. It also discusses HHS's compliance with legal and regulatory requirements, a summary of audit and management assurances and gives a brief look ahead to FY 2015.



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, providing essential human services, and promoting economic and social well-being for individuals, families, and communities, including seniors and individuals with disabilities. HHS represents almost a quarter of all federal outlays and administers more grant dollars than all other federal agencies combined. HHS's Medicare program is the nation's largest health insurer, handling more than one billion claims per year. Medicare and Medicaid together provide health care insurance for one in four Americans.

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 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. The HHS Office of the Secretary (OS) and its 11 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. 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. ACF programs aim to empower families and individuals to increase their economic independence and productivity, and encourage strong, healthy, supportive communities that have a positive impact on quality of life and the development of children. 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. For more information, please visit: <http://www.hhs.gov/acl>.



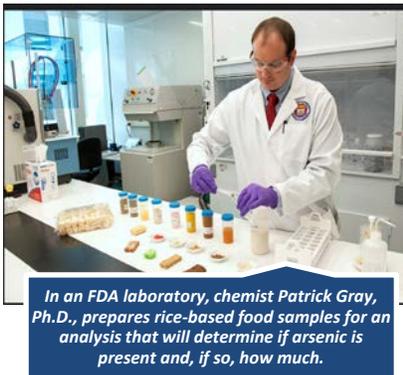
Women participating in an exercise program at an ACL senior center in Portsmouth, VA.

The Agency for Healthcare Research and Quality's (AHRQ) mission is to conduct 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. This mission is supported by focusing on 1) improving health care quality, 2) making health care safer, 3) increasing accessibility, and 4) improving health care affordability, efficiency, and cost transparency. For more information, please visit: <http://www.ahrq.gov>.

The Agency for Toxic Substance and Disease Registry (ATSDR) is charged with the prevention of exposure to toxic substances and the prevention of the adverse health effects and diminished quality of life associated with exposure to hazardous substances from waste sites, unplanned releases, and other sources of pollution present in the environment. For more information, please visit: <http://www.atsdr.cdc.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. CDC works to protect America from health, safety and security threats, both foreign and domestic. Whether diseases start at home or abroad, are chronic or acute, curable or preventable, human error or deliberate attack, CDC fights disease and supports communities and citizens to do the same. For more information, please visit: <http://www.cdc.gov>.

The Centers for Medicare and Medicaid Services (CMS) administers public insurance programs that serve as the primary sources of health care coverage for seniors and a large population of medically vulnerable individuals. CMS acts 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 is also responsible for helping to implement many provisions of the *Affordable Care Act*, such as the establishment of the Consumer Operated and Oriented Plan (CO-OP). This plan fosters 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>.



In an FDA laboratory, chemist Patrick Gray, Ph.D., prepares rice-based food samples for an analysis that will determine if arsenic is present and, if so, how much.

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 more effective, safer, and more affordable and by helping the public get the accurate, science-based information they need to use medicines and foods to maintain and improve their health. FDA also has responsibility for regulating the manufacturing, marketing, and distribution of tobacco products to protect the public health and to reduce tobacco use by minors.

Finally, FDA plays a significant role in the nation's counterterrorism capability. FDA fulfills this responsibility by ensuring the security of the food supply and by fostering development of medical products to respond to deliberate and naturally emerging public health threats. For more information, please visit: <http://www.fda.gov>.

The Health Resources and Services Administration (HRSA) is responsible for improving access to health care by strengthening the health care workforce, building healthy communities and achieving health equity. HRSA's programs provide health care to people who are geographically isolated, economically or medically vulnerable. 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. IHS is the principal federal health care provider and health advocate for the Indian people, with the goal of raising Indian health status to the highest possible level. IHS provides a comprehensive health service delivery system for approximately 2.2 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/>.



Let's Move! in Indian Country (coordinated by IHS) works to prevent childhood obesity in American Indian and Alaska Native children.

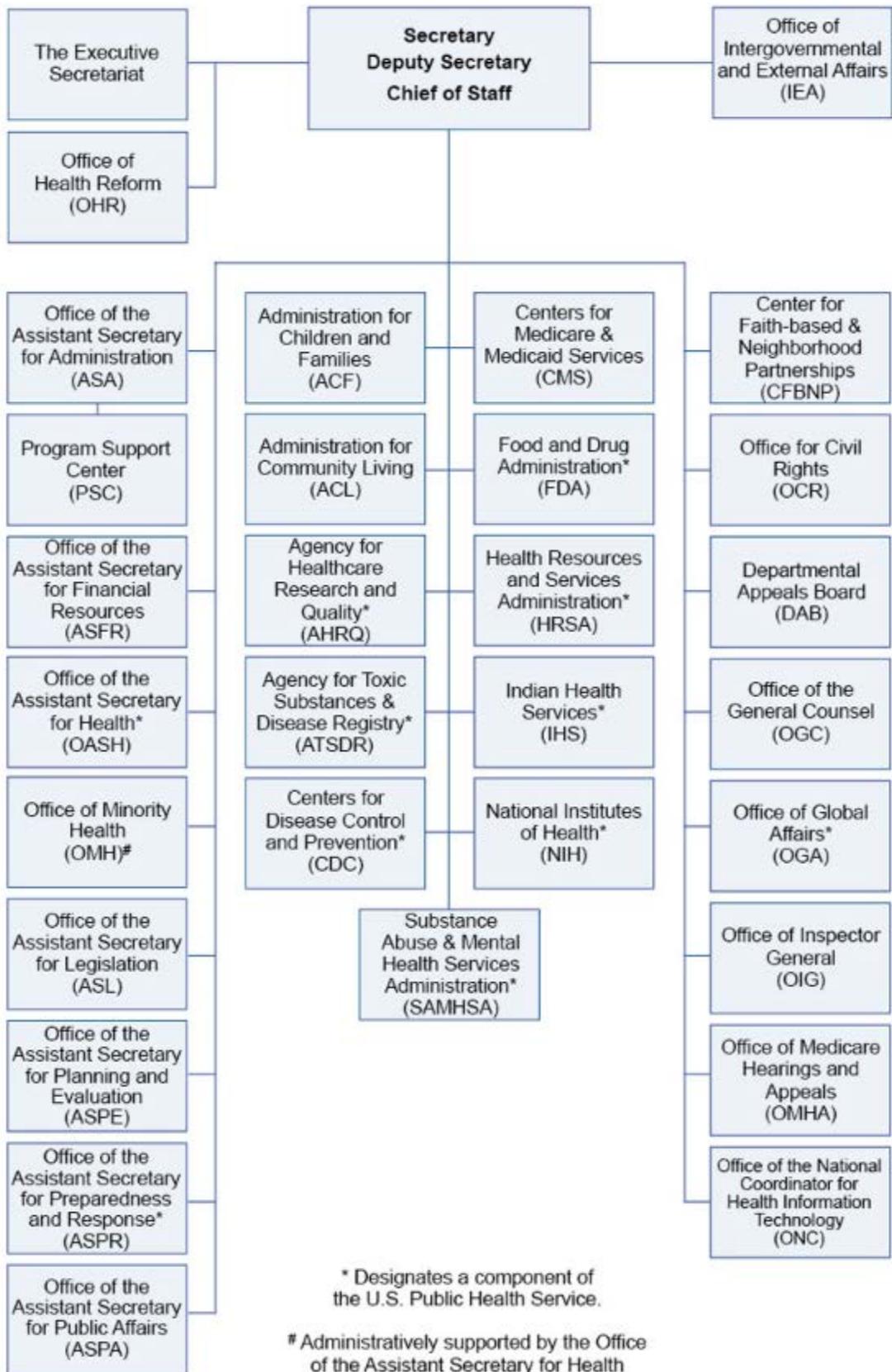
The National Institutes of Health (NIH) seeks fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability. For more information, please visit: <http://www.nih.gov>.

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 behavioral health practice in communities, and both primary and specialty care settings. For more information, please visit: <http://www.samhsa.gov>.

The Office of the Secretary (OS), with the Secretary, leads HHS and its 11 OpDivs 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 OpDivs in carrying out our mission. The StaffDivs are:

- Immediate Office of the Secretary (IOS) <http://www.hhs.gov/about/foa/osleadership>
 - The Executive Secretariat
 - Office of Health Reform (OHR)
- Office of the Assistant Secretary for Administration (ASA) <http://www.hhs.gov/asa>
 - Program Support Center (PSC) <http://www.hhs.gov/asa/psc>
- Office of the Assistant Secretary for Financial Resources (ASFR) <http://www.hhs.gov/asfr>
- Office of the Assistant Secretary for Health (OASH) <http://www.hhs.gov/ash>
- Office of the Assistant Secretary for Legislation (ASL) <http://www.hhs.gov/asl>
- Office of the Assistant Secretary for Planning and Evaluation (ASPE) <http://www.aspe.hhs.gov>
- Office of the Assistant Secretary for Public Affairs (ASPA) <http://www.hhs.gov/aspa>
- Office of the Assistant Secretary for Preparedness and Response (ASPR) <http://www.phe.gov/preparedness>
- Center for Faith-Based and Neighborhood Partnerships (CFBNP) <http://www.hhs.gov/partnerships>
- Departmental Appeals Board (DAB) <http://www.hhs.gov/dab>
- Office for Civil Rights (OCR) <http://www.hhs.gov/ocr>
- Office of the General Counsel (OGC) <http://www.hhs.gov/ogc>
- Office of Global Affairs (OGA) <http://www.globalhealth.gov>
- Office of Inspector General (OIG) <http://www.oig.hhs.gov>
- Office of Intergovernmental and External Affairs (IEA) <http://www.hhs.gov/intergovernmental>
- Office of Medicare Hearings and Appeals (OMHA) <http://www.hhs.gov/omha>
- Office of Minority Health (OMH) <http://minorityhealth.hhs.gov>
- Office of the National Coordinator for Health Information Technology (ONC) <http://www.healthit.gov/newsroom/about-onc>

On the next page, 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/about/foa>.



PERFORMANCE GOALS, OBJECTIVES, AND RESULTS

Health and Human Services Performance Results

HHS continues to improve its performance management processes in alignment with the *Government Performance and Results Modernization Act*. HHS executes Priority Goals through collaboration across the Department leading to improvements in each goal. Additionally, the knowledge gained in these collaborations and during our data-driven reviews has supported the development of our Priority Goals. HHS performance initiatives, including Priority Goals, continue to influence plans and policies as demonstrated in the Department's Strategic Plan which guides our future efforts.

HHS also continues to engage with individuals across the federal performance management community to implement best practice and refine our processes. These refinements and lessons learned have also influenced future plans and are represented in the FY 2014 - FY 2015 Priority Goals which HHS has developed. The most recent data and completed accomplishments as well as future actions on Priority Goals can also be found at <http://www.performance.gov>. The site provides information on what measures and milestones HHS uses to track progress toward these goals.

In addition to the HHS Strategic Goals and the HHS Priority Goals, HHS reported data on 135 key performance measures in their FY 2015 *HHS Annual Performance Report and Performance Plan*. These measures represent important issue areas being addressed by the health care and human services communities. These measures present a powerful tool in improving HHS operations and help to advance an effective, efficient and productive government. HHS regularly collects and analyzes performance data to inform decisions. While HHS does not yet have FY 2014 data available for all measures due to the lag associated with data collection and reporting, HHS's Operating and Staff Divisions constantly strive to find lower-cost ways to achieve positive impacts, in addition to sustaining and fostering the replication of effective and efficient government programs.

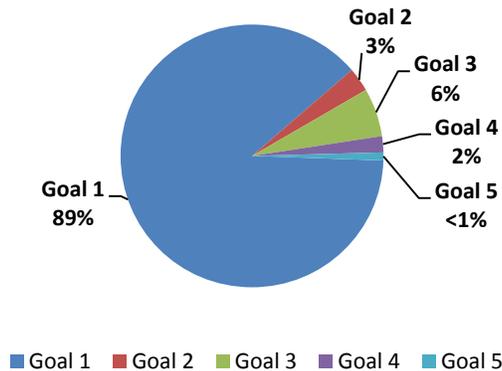
Looking Back at FY 2013 Performance

It is helpful to look at how HHS invests resources toward fulfilling the Department's mission through its strategic goals. In FY 2013, HHS focused on five strategic goals:

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

As shown in the FY 2013 *HHS Summary of Performance and Financial Information*, the chart on the next page provides the breakdown of the HHS FY 2013 budget by strategic goal. Although HHS funding here is broken down into strategic goals, many of the programs in HHS are crosscutting in nature and support a number of strategic goals.

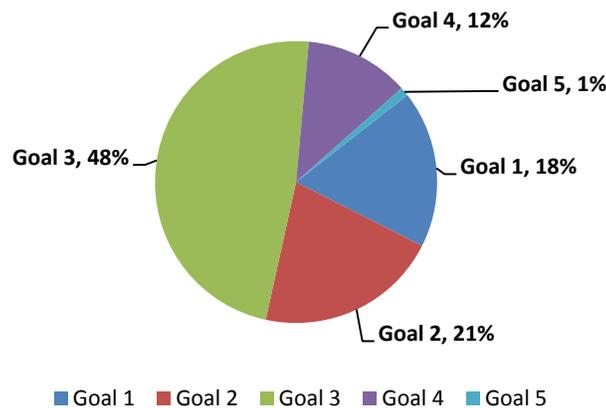
Total FY 2013 HHS Budget



The total resources available to spend in FY 2013 were \$1.3 trillion. The majority of the Department’s funding was primarily associated with Goal 1 because of the large amount of money invested in delivering quality care and services through Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP). For FY 2013, of the five strategic goals, 89 percent was spent on Goal 1, 3 percent on Goal 2, 6 percent on Goal 3, 2 percent on Goal 4, and less than 1 percent on Goal 5.

The chart below demonstrates the HHS FY 2013 budget spent \$386 billion after subtracting the costs of Medicare, Medicaid, and CHIP. Of the five strategic goals excluding Medicare, Medicaid, and CHIP, 18 percent was spent on Goal 1, 21 percent on Goal 2, 48 percent on Goal 3, 12 percent on Goal 4, and 1 percent on Goal 5.

FY 2013 HHS Budget Excluding Medicare, Medicaid CHIP



Similar information on FY 2014 strategic goals resource allocation will be published in the FY 2014 *HHS Summary of Performance and Financial Information*, available in February 2015 on the Department’s website (<http://www.hhs.gov/budget>). A detailed breakdown of FY 2014 spending by HHS activity and budget function is available now in the Other Information section of this report.

Performance Management Process Milestones

In FY 2014, HHS released a new strategic plan outlining how the Department will emphasize program performance to support the Department’s mission of protecting the health of all Americans, providing essential human services, and promoting economic and social well-being for individuals, families, and communities, including seniors, and individuals with disabilities. These efforts are shown through the successes of the near-term HHS Priority Goals and the innovative and results-oriented solutions developed and delivered throughout the Department. Furthermore, the alignment of Department activities to the HHS Strategic Plan provides the framework to simultaneously address current issues and prepare to meet future challenges. This Plan is available at <http://www.hhs.gov/secretary/about/priorities/priorities.html> and outlines four Strategic Goals:

1. Strengthen health care
2. Advance scientific knowledge and innovation
3. Advance the health, safety, and well-being of the American people
4. Ensure efficiency, transparency, accountability, and effectiveness of HHS programs

The table below lists alphabetically the primary OpDivs that contribute to each Strategic Goal.

1. Strengthen Health Care
Administration for Community Living (ACL) Agency for Healthcare Research and Quality (AHRQ) Centers for Disease Control and Prevention (CDC) Centers for Medicare and Medicaid Services (CMS) Food and Drug Administration (FDA) Health Resources and Services Administration (HRSA) Indian Health Services (IHS) National Institutes of Health (NIH) Substance Abuse and Mental Health Services Administration (SAMHSA)
2. Advance Scientific Knowledge and Innovation
Administration for Children and Families (ACF) Administration for Community Living (ACL) Agency for Healthcare Research and Quality (AHRQ) Centers for Disease Control and Prevention (CDC) Food and Drug Administration (FDA) National Institutes of Health (NIH) Substance Abuse and Mental Health Services Administration (SAMHSA)
3. Advance the Health, Safety and Well-being of the American People
Administration for Children and Families (ACF) Administration for Community Living (ACL) Agency for Healthcare Research and Quality (AHRQ) Centers for Medicare and Medicaid Services (CMS) Centers for Disease Control and Prevention (CDC) Food and Drug Administration (FDA) Health Resources and Services Administration (HRSA) Indian Health Services (IHS) National Institutes of Health (NIH) Substance Abuse and Mental Health Services Administration (SAMHSA)
4. Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs
Every Operating Division has responsibility within this goal.

With collaboration from stakeholders throughout the Department, HHS is pursuing five Priority Goals for FY 2014-2015, which contribute toward the achievement of our Strategic Goals. These efforts have supported significant improvements in near-term outcomes and advanced progress toward longer-term, outcome-focused strategic objectives. These Priority Goals include efforts to:

1. Improve patient safety
2. Improve health care through meaningful use of Health Information Technology
3. Improve the quality of early childhood education
4. Reduce cigarette smoking
5. Reduce food-borne illness in the population

Performance Results

The performance results in this section represent key measures and performance highlights demonstrating progress toward each HHS Strategic Goal. In February 2015, additional performance measures and trends are available in related reports on the Department's website (<http://www.hhs.gov/budget>). These reports include:

- FY 2014 HHS Summary of Performance and Financial Information
- FY 2016 Annual Performance Report and Performance Plan
- FY 2016 Congressional Budget Justification

The accomplishments and performance trends below, including progress on HHS Priority Goals, underscore HHS's dedication to sustained performance improvement, and emphasis on working to meet the Department's four Strategic Goals. Targets presented within the graphs represent performance expectations based on a number of factors and may not exceed the previous years' results, although they may represent an improvement over previous years' targets. The results displayed in bold and marked with an asterisk (*) within each Strategic Goal indicate targets that were met or exceeded for the applicable period. Some results were not available at the time of this report due to the lag associated with data collection requirements. The target is displayed to show planned progress, with results expected in FY 2015.

Strategic Goal One: Strengthen Health Care



National Cancer Institute's Bradford Wood, M.D., and Peter Pinto, M.D., perform a prostate biopsy at the NIH Clinical Center in Bethesda, Maryland.
(Photo Credit Rhoda Bear)

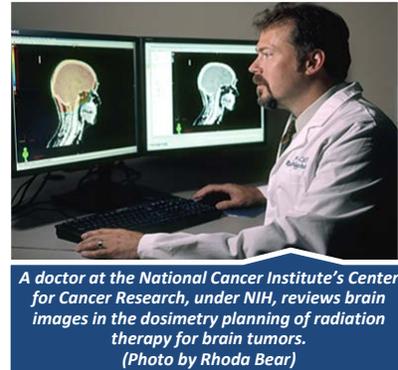
HHS continues to drive the effort to strengthen and modernize health care to improve patient outcomes. Through its programs, HHS also promotes efficiency and accountability, ensures patient safety, encourages shared responsibility, and works toward high-value health care. In addition to addressing these responsibilities, HHS is improving access to culturally competent, quality health care for uninsured, underserved and vulnerable populations.

HHS's efforts in patient safety as well as health care quality are reflected in the improve patient safety Priority Goal (<http://www.performance.gov/content/improve-patient-safety>), in order to reduce Healthcare-Associated Infections (HAIs). These infections can lead to significant morbidity and mortality, with tens

of thousands of lives lost each year. During the FY 2012-2013 Priority Goal period, HHS efforts focused on two of these infections: central line-associated bloodstream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI). Despite the continual CLABSI reductions seen throughout the 2012-2013 Priority Goal period,

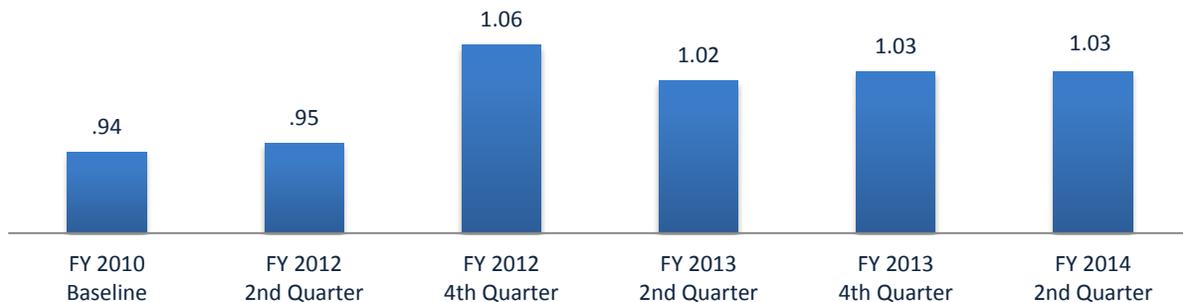
HHS fell short of the final target, which was a 25 percent reduction in CLABSI or a final standard infection ratio (SIR) of 0.51. Although CLABSI reduction was not retained in the FY 2014-2015 Priority Goal, this effort is closely monitored and will continue to be publicly reported elsewhere by HHS. The reduction of CAUTI in hospitals is now the singular focus of the FY 2014-2015 Priority Goal.

Leveraging the combined programmatic efforts within HHS, including AHRQ, CDC, CMS and OASH, the Improve Patient Safety Priority Goal is working to reduce CAUTI by 10 percent in hospitals nationwide by the end of FY 2015. This is measured over the FY 2013 SIR of 1.03. The final SIR of the previous Priority Goal period (1.03) was higher than the 2010 baseline (.94). Although the SIR increased, knowledge gained during this period has led to better data tracking and monitoring as well as new approaches in the Intensive Care Units (ICUs) based on identified potential barriers. Lessons learned were also used to focus HHS efforts, including targeting the hospitals with the highest excess number of CAUTIs.



HHS program efforts that help health care partners achieve this goal include the AHRQ's Comprehensive Unit-based Safety Program (CUSP), CDC's development and maintenance of the National Healthcare Safety Network (NHSN), CMS's Quality Improvement Organizations (QIO) and Partnership for Patients initiative, and strategic direction and support from OASH, including the National Action Plan to Prevent HAIs.

*Standardized Infection Ratio of Catheter-Associated Urinary Tract Infections
HHS Priority Goal- Improve Patient Safety
(* result met or exceeded target)*



At the heart of HHS's strategy to strengthen and modernize health care is the use of data to improve health care quality, reduce unnecessary health care costs, decrease paperwork, expand access to affordable care, improve population health, and support reformed payment structures. The nation's health information technology infrastructure enables the flow of information to power these critical efforts that can help facilitate the types of fundamental changes in access and health care delivery proposed in the *Affordable Care Act*. A key step in this strategy is to provide incentive payments to eligible providers serving Medicare and Medicaid beneficiaries who adopt and meaningfully use certified electronic health records (EHR) technology. The improvement of health care through meaningful use of health information technology (<http://www.performance.gov/content/improve-health-care-through-meaningful-use-health-information-technology>) continues as a Priority Goal for the FY 2014-2015 period, with a goal of 425,000 incentive payments by the end of 2015. HHS will also begin tracking participating hospitals and professionals that are eligible to attest to Medicare and Medicaid EHR Incentive Program Stage 2 meaningful use milestones and will report this data beginning in 2015. Providers must demonstrate Stage 1

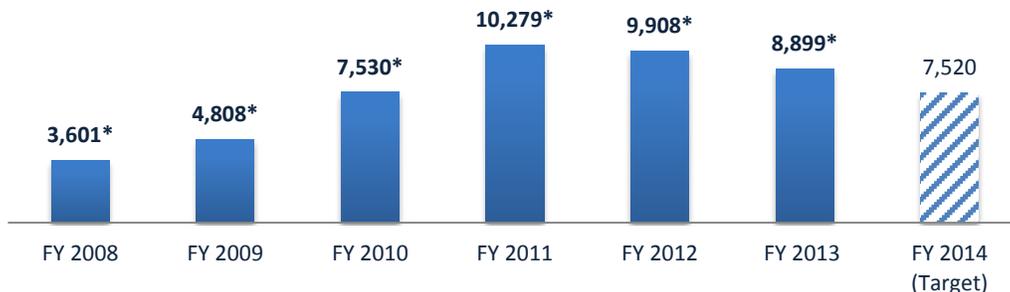
meaningful use before attesting to Stage 2. Please note that while information has been available quarterly, targets have generally been set on an annual basis.

*Number of Eligible Providers who Receive an Incentive Payment from
CMS Medicare and Medicaid Electronic Health Records Incentive Programs
HHS Priority Goal- Improve Health Care through Meaningful Use of Health Information Technology
(* result met or exceeded target)*



The National Health Service Corps (NHSC) addresses the nationwide shortage of health care providers 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. More than 45,000 primary care medical, dental, mental, and behavioral health professionals have served in the NHSC since its inception. The 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. In FY 2013, the NHSC field strength was 8,899. The annual field strength is dependent upon funding levels and programmatic policy decisions that allocate funding between the scholarship and loan repayment programs. NHSC loan repayors are immediately counted in the annual field strength, while NHSC scholars are not counted until completion of training. The FY 2015 President’s budget request includes *Affordable Care Act*, discretionary, and new mandatory funding to substantially grow the NHSC field strength to expand access to primary care services in underserved communities and vulnerable populations in high need urban and rural communities across the country.

*Field Strength of the NHSC, as Measured by the Number of Providers Fulfilling Active Service Obligations in
Exchange for Scholarship and Loan Repayment Agreements
(* result met or exceeded target)*



As an indicator of the number of health care organizations using AHRQ-supported tools to improve patient safety, AHRQ relies in part on the Hospital Survey of Patient Safety (HSOPS). Some organizations that use the survey voluntarily submit their data to a comparative database for aggregation. In 2013, data from 653 hospitals, 934 medical offices, and 40 nursing homes were available in the database. It is anticipated that as many as 1,750 organizations will have submitted information to the HSOPS comparative database by 2015. Interest in other

AHRQ tools and resources has also remained strong, as evidenced by on-going participation in informational webinars, electronic downloads, and orders placed for various products.

*Number of Users of Research Using AHRQ-Supported Research Tools to Improve Patient Safety Culture
(* result met or exceeded target)*



Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers who come together voluntarily to provide coordinated high quality care to the Medicare patients. This coordinated care helps ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors. Leveraging the innovative model of ACOs is a key part of promoting health care cost savings through the *Affordable Care Act*. While data collection on a number of ACO-related measures began only in 2013, early results are encouraging. The number of Medicare beneficiaries who have been aligned with ACOs in FY 2014 was 5,652,270, exceeding the target by over 50,000. The number of physicians participating in an ACO in FY 2014 was 163,549, exceeding the target by over 30,000.

Strategic Goal Two: Advance Scientific Knowledge and Innovation



NIH supported researchers are developing a powered robotic prosthesis that senses a person's next move and provides powered assistance to achieve a more natural gait.

HHS is expanding its scientific understanding of how best to advance health care, public health, human services, biomedical research, and to ensure the availability of safe medical and food products. Chief among these efforts is the identification, implementation, and rigorous evaluation of new approaches in science, health care, public health, and human services that encourage efficiency, effectiveness, sustainability, and sharing or translating that knowledge into better products and services.

AHRQ's Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) is an evidence-based teamwork system used to improve communication and teamwork skills among health care professionals as a way to improve patient safety. The system, developed jointly by the Department of Defense (DOD) and AHRQ, has spread to all 50 states, now reaching an estimated 30 percent of U.S. hospitals, including small critical access hospitals. Over 8,000 master trainers have received TeamSTEPPS training through AHRQ and DOD. These master

trainers, on average, have trained an additional 50 front line health care professionals for an estimated national grand total of over 350,000.

The use and dissemination of data is a priority for the Department. ASPR is using big data and technology, specifically geographic information systems, to enhance the ability to link, visualize, and analyze the multi-dimensional realities of disasters and translate that data into actionable information at the state, local, and

community level. FDA has launched openFDA, an initiative designed to spur innovation, advance regulatory science and empower decision-making by providing software developers, researchers, consumers, and health professionals easy access to high-value FDA public data. The initial pilot will cover datasets defined into three broad focus areas: Adverse Events, Product Recalls, and Product Labeling.

SAMHSA launched two mobile apps in FY2014 to provide information resources and tools regarding two key behavioral health issues – disaster response and bullying prevention. In February 2014, SAMHSA launched the Behavioral Health Disaster Response mobile app to support first responders in times of natural or man-made disasters. This app enables first responders to access and share behavioral health resources, with those most in need, during and after deployment. In August of 2014, SAMHSA also launched the KnowBullying app. This app helps parents and caregivers engage in meaningful conversations with their children about bullying. It includes strategies for different age groups to prevent bullying. Parents and caregivers also learn about warning signs and to recognize if their child is engaging in bullying, being bullied, or witnessing bullying. The apps are tagged to allow SAMHSA to see screens/pages visitors view, clicks on outbound links, device type and other traditional web metrics. Within seven months of launch, the Disaster mobile app has been downloaded over 8,250 times. Within two months of launch, the KnowBullying app has been downloaded almost 5,000 times.



A father and son handle 3D-printed virus models at the NIH 2014 USA Science & Engineering Festival.

Three new research awards (totaling up to \$19.4 million over five years) will address the growing proportion of the U.S. population that has multiple chronic medical conditions. These milestone-driven, phased awards are funded through NIH's Health Care Systems (HCS) Research Collaboratory, which engages health care systems as research partners in conducting large-scale clinical studies. It is estimated that 3 in 4 adults over age 65 and 1 in 15 children suffer from two or more chronic medical conditions--such as diabetes mellitus, chronic kidney disease, hypertension, and chronic pain. As patients develop more chronic conditions, they are likely to use more health care services and suffer negative outcomes, such as unnecessary hospitalizations, adverse drug reactions, declining functional status, and mortality. Health care systems, which include health maintenance organizations and other large integrated care settings, serve large populations of patients. Through these new collaborative research projects, NIH is better able to conduct large-scale and cost-effective clinical research on multiple chronic conditions within the settings where patients are already receiving their care.

Since 1980, CDC has developed international Field Epidemiology Training Programs (FETPs) serving 94 countries that have graduated over 3,100 epidemiologists. Through FETPs, CDC helps establish a network of disease detectives around the globe that are the first line of defense in detecting and responding to outbreaks in their respective countries as well as neighboring countries. In FY 2013, FETP graduates and residents led 345 outbreak investigations, and CDC's Global Disease Detection Centers responded to 268 disease outbreaks. On average, over 80 percent of FETP graduates work within their Ministry of Health after graduation and many assume key leadership positions, such as the National Director of Tuberculosis program and National Director of Chronic Disease program in the Dominican Republic. In FY 2013, CDC met its target of bringing on 300 new FETP residents to increase global health ministries' ability to detect and respond to outbreaks.

*Capacity of Epidemiology and Laboratory within Global Health Ministries through FETP
As measured by the Number of New Residents
(* result met or exceeded target)*

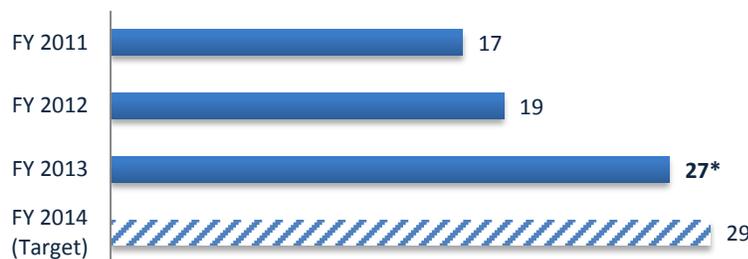


Strategic Goal Three: Advance the Health, Safety, and Well-Being of the American People

HHS strives to promote the health, economic, and social well-being of children, people with disabilities, and older adults while improving wellness for all. To meet this goal, the Department is employing evidence-based strategies to strengthen families and to improve outcomes for children, adults, and communities. Underlying each objective and strategy associated with this goal is a focus on prevention.

The improve the quality of early childhood education Priority Goal (<http://www.performance.gov/content/improve-quality-early-childhood-education>) calls for actions to improve the quality of programs for children of low-income families, namely Head Start and Child Care. For the Child Care program, the aim is to increase the number of states with Quality Rating and Improvement Systems (QRIS) that meet the seven high-quality benchmarks for child care and other early childhood programs developed by HHS, in coordination with the Department of Education. QRIS is a mechanism used to improve the quality of child care available in communities and increase parents’ knowledge and understanding of the child care options available to them. Through the end of FY 2013, 27 states had a QRIS that met high-quality benchmarks, exceeding the goal of 25 states. States made several changes to their QRIS, such as opening eligibility to family child care providers, expanding from a pilot program to statewide, and implementing new consumer education efforts.

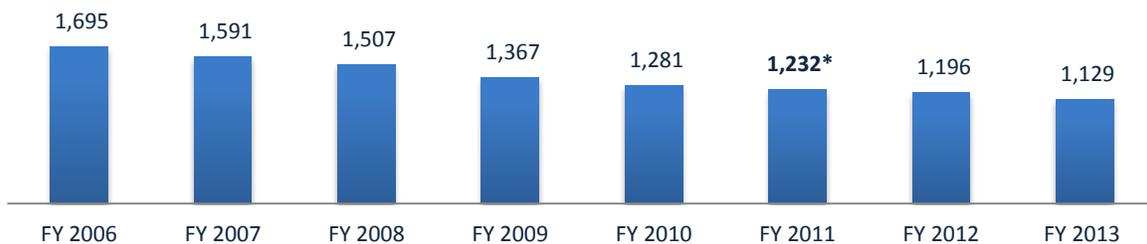
*Number of States Implementing QRIS that are Meeting the QRIS High-Quality Benchmarks
HHS Priority Goal- Improve the Quality of Early Childhood Education
(* result met or exceeded target)*



Smoking and secondhand smoke kill an estimated 480,000 people in the U.S. each year. For every smoker who dies from a smoking-attributable disease, another 30 live with a serious smoking-related disease. Smoking costs the U.S. \$133 billion in medical costs and \$156 billion in lost productivity each year. While smoking among adults in the U.S. has decreased significantly from a decade ago, the decline in adult smoking rates has slowed, concurrent with reductions in state investments in tobacco control programs. In addition, the coordinated efforts

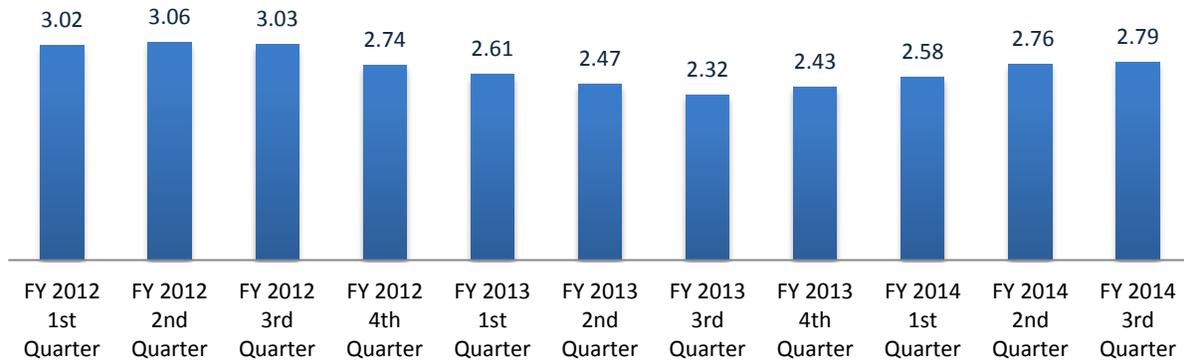
of the Priority Goal to reduce tobacco use (<http://www.performance.gov/content/reduce-combustible-tobacco-use>) have resulted in reductions in adult cigarette consumption, based on FY 2013 results (reported in June 2014). In the 2014-2015 iteration of this Priority Goal, HHS is focused on a new measure of smoking-- annual per capita adult combustible tobacco consumption in the U.S. This new measure focuses on all combustibles, not just cigarettes, as a way to ascertain broader trends in tobacco use among adults. Data on this new measure will be available following FY 2014. The data represented below captures the most recent results from the measure used during the previous FY 2012-2013 Priority Goal period.

Annual Per Capita Cigarette Consumption by Adults in the United States
HHS Priority Goal- Reduce Cigarette Smoking
 (* result met or exceeded target)



Salmonella is the leading known cause of bacterial foodborne illness and death in the U.S. Each year in the U.S., Salmonella causes an estimated 1.2 million illnesses and between 400 and 500 deaths. Salmonella serotype enteritidis (SE), a subtype of Salmonella, is now the most common type of salmonella in the U.S. and accounts for approximately 20 percent of all salmonella cases in humans, and reducing its prevalence is an HHS Priority Goal to reduce foodborne illness in the population (<http://www.performance.gov/content/reduce-foodborne-illness-population>). The most significant sources of foodborne SE infections are shell eggs (FDA-regulated) and broiler chickens (USDA-regulated). Therefore, reducing SE illness from shell eggs is the most appropriate FDA strategy for reducing illness from SE. Preventing Salmonella infections depends on actions taken by regulatory agencies, the food industry, and consumers to reduce contamination of food, as well as actions taken for detecting and responding to outbreaks. CDC estimated that, for 2007-2009, 40 percent of domestically-acquired, foodborne SE illnesses were from eating shell eggs and 28 percent of total SE illnesses (foodborne, non-foodborne, and international travel-associated) were from shell eggs. CDC completed an evaluation of a "food product" model to estimate annual change in percentage of SE illnesses from shell eggs, but determined that necessary data about contamination of shell eggs was not available. CDC concluded that this model could not be used unless new sources of egg data were obtained. Therefore, as of January 2014, CDC began collecting exposure data from persons with SE infection in FoodNet sites, a network that conducts surveillance for infections diagnosed by laboratory testing of samples from patients. CDC will conduct a preliminary evaluation of this data to assess its quality and determine its usefulness in updating CDC's exposure model for estimating the proportion of total SE illnesses attributable to shell eggs during 2014-2015.

Rate of Salmonella Enteritidis Illness in the Population
HHS Priority Goal- Reduce Food-Borne Illness in the Population
 (* result met or exceeded target)



One of SAMHSA’s goals in its Strategic Initiative on Recovery Support is to ensure that permanent housing and supportive services are available for individuals with mental and substance use disorders. A way to meet this goal is to ensure that the most vulnerable individuals who experience chronic homelessness receive access to sustainable permanent housing, treatment, and recovery supports through grant funds and mainstream funding sources. A measure of the effectiveness of this effort is to determine overall health status, both physical and emotional health, from the consumer’s perception of his or her recent functioning. Following the initial 13 percentage point increase from FY 2008 to FY 2009, the percentage has consistently remained over 60 percent since, and FY 2013 progress supports continued sustained performance. A lack of funding due to sequestration and other budget restrictions led to no new grants being awarded in FY 2012, which impacted trends in this area.

Percentage of Adults Receiving Homeless Support Services who Report Positive Functioning at 6 Month Follow-up
 (* result met or exceeded target)



Head Start has shown a steady increase in the number of Head Start teachers with an Associate of Arts (AA), Bachelor of Arts (BA), or other advanced degree in early childhood education, supported by plans to improve the qualifications of staff. Based on the most recent data (as of early FY 2014), 94.6 percent of Head Start teachers (42,527 out of 44,973) had an AA degree or higher, missing the target of 100 percent but improving significantly since 2008. Additionally, 66 percent of Head Start teachers have a BA degree or higher, which far exceeds the statutory requirement of 50 percent.

*Percentage of Head Start Teachers with AA, BA, Advanced Degree, or Other Degree
in a Field Related to Early Childhood Education
(* result met or exceeded target)*



ACL’s Administration on Aging (AoA) Family Caregiver Support Services enables family members who have a loved one with disabilities or conditions that require assistance to use an array of supportive services, including respite care, information and assistance, support groups, and training. Caregivers are frequently under substantial strain with the responsibilities of caring for their ill relatives while also caring for children or other family members while employed. Since 2008, Family Caregiver Support Services clients have rated services good to excellent consistently above the target level of 90 percent. Nearly 90 percent of respondents reported that the services helped them to be a better caregiver, and nearly three quarters report feeling less stressed due to the services.

Strategic Goal Four: Ensure Efficiency, Transparency, Accountability, and Effectiveness 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 expenditures. HHS manages hundreds of programs in basic and applied science, public health, income support, child development, and health and social services, which award over 75,000 grants annually. The Department has robust processes in place to manage the resources and information employed to support programs and activities.

One of CMS’s key goals is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable, and necessary services provided to eligible beneficiaries. Paying correctly the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable dollars. The primary cause of improper payments is Documentation and Administrative Errors, in large part due to insufficient documentation. Other notable causes include Authentication and Medical Necessity Errors, caused by medically unnecessary services, and to a lesser extent, incorrect diagnosis coding. Between FY 2009 and FY 2012, the improper payment rate consistently improved. Data from FY 2013 indicates an increase in this improper payment rate and efforts are currently in progress to investigate and resolve the drivers causing this increase.



The HHS Office for Civil Rights (OCR) in action at the Oakland Pride weekend in Oakland, California.

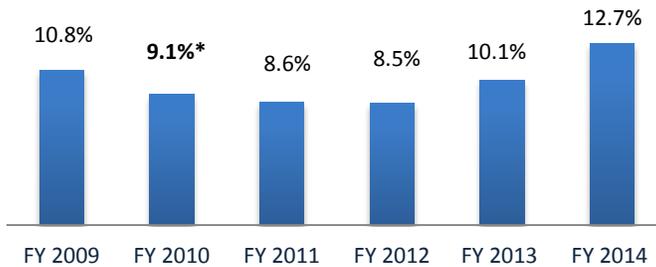
For Medicaid, the Payment Error Rate Measurement (PERM) program uses a 17 state three-year rotation for measuring improper payments, so the FY 2014 rate is based on measurements conducted in FYs 2012, 2013, and 2014. To reduce the national Medicaid error rates, states are required to develop and submit corrective action

plans targeting root causes of error. The current FY 2014 error rate is 6.7 percent. Additional information is available in Section III - Improper Payments Information Act Report.

Estimate of the Payment Error Rate in the Medicaid Program
 (* result met or exceeded target)



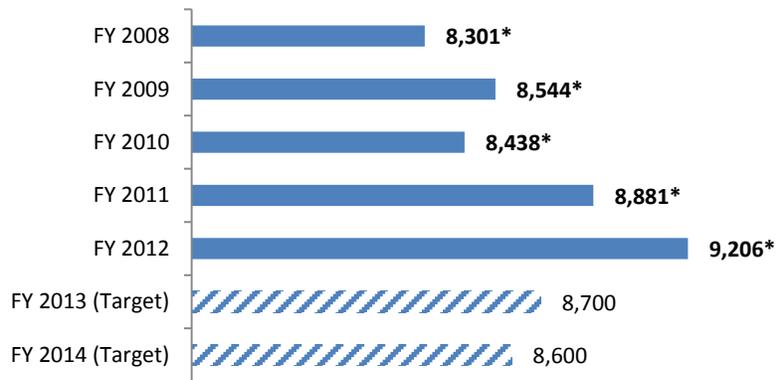
Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program
 (* result met or exceeded target)



A foundation of ACL’s program success is access to Home and Community-based Services. In FY 2012, the Aging Services Network served 9,206 clients per million dollars of *Older Americans Act* funding exceeding the target of 8,600. Performance has largely trended upward and performance targets have been consistently achieved. This reflects the success of ongoing initiatives to improve program management and expand options for home and community-based care. Aging and Disability Resource Centers (ADRCs), along with increased commitments and partnerships at the state and local levels, have all had positive impacts on program efficiency. Between FY 2007 and FY 2012 performance has improved by 10.5 percent, without the benefit of adjustment for inflation. The targeted number of clients served is expected to be maintained or slightly increased between FY 2013 and FY 2016.



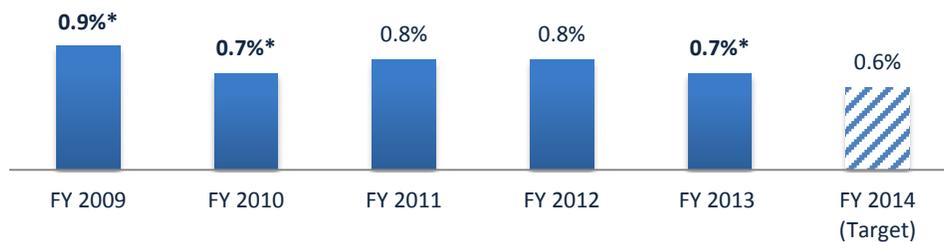
*Number of Clients Served by the Home and Community-Based Services, including Nutrition and Caregiver Services, per Million Dollars of Title III Older Americans Act Funding
(* result met or exceeded target)*



ACF’s Head Start program works to ensure that the maximum number of children are served and that federal funds are used appropriately and efficiently by measuring under-enrollment across programs. Since Head Start grantees range in size from super-grantees with multiple delegate agencies serving up to 20,000 children to individual centers that serve as few as 15 children, a national under-enrollment rate better captures the under-enrollment than the proportion of grantees that meet under-enrollment targets. An un-enrolled space or vacancy in Head Start is defined as a funded space that is vacant for over 30 days.

The most recent data available indicate that, during the FY 2012-2013 program year, Head Start grantees had, on average, not enrolled 0.7 percent of the children they were funded to serve, continuing steady improvement in this area. Further improvements are expected in FY 2014 resulting from continued program support and technical assistance.

*Decrease in the Under-Enrollment Rate of Head Start Programs; Increased Number of Children Served Per Dollar
(* result met or exceeded target)*



Cross-Agency Priority Goals

HHS contributes to Cross-Agency Priority Goals with other federal agencies. For example, the Department contributes significantly to the mission-related Science, Technology, Engineering and Mathematics (STEM) and Service Members and Veterans Mental Health Cross-Agency Priority Goals. We are also maximizing federal spending through participation in the Shared Services, and Benchmark and Improve Mission-Support Operations efficiency goals. For more information on HHS’s contributions to Cross-Agency Priority Goals and progress, refer to <http://www.performance.gov/cap-goals-list>.

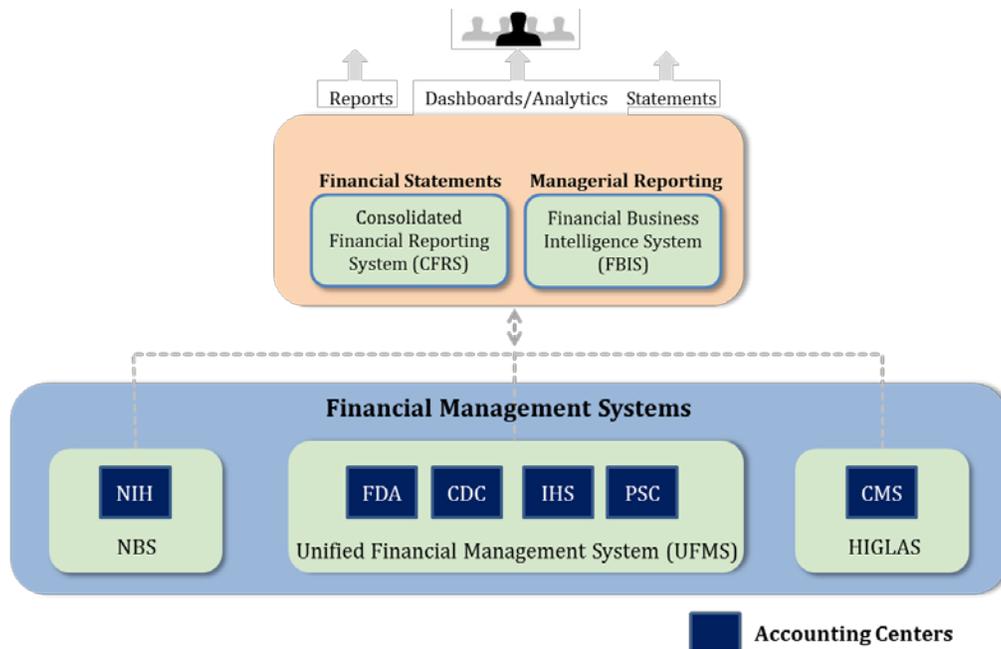
SYSTEMS, LEGAL COMPLIANCE, AND INTERNAL CONTROLS

Systems

Current Financial 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 is depicted in the image below:

HHS Financial Management System Environment



The HHS Financial Management System Environment and its major components are described below.

The financial management systems component (shown above in the Financial Management Systems layer), consists of three financial management 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. Built upon a web-based commercial off-the-shelf (COTS) solution, these three systems allow HHS to reliably execute financial management procedures and business processes over a common infrastructure across the enterprise. The specific systems are shown below:

- Unified Financial Management System (UFMS) supports HHS's health care delivery mission and is responsible for its regulatory functions. It is an integrated financial management system with four standardized accounting centers (one for each of the OpDivs shown above, with the PSC supporting five OpDivs and the OS). UFMS, along with the Healthcare Integrated General Ledger Accounting System (HIGLAS) and the National Institutes of Health Business System (NBS) (described below), provides the accounting and financial backbone for managing the Department's \$1.4 trillion in budgetary resources.

- HIGLAS at CMS serves the Medicare Administrative Contractors (MACs) that process medical payments; supports accounting for Medicaid and Children’s Health Insurance Program (CHIP) grants; generates the CMS Financial Statements; and handles all vendor payments, payables, and receivables.
- NBS fosters NIH’s mission through the provision of business transaction capabilities that enable the NIH scientific community and supporting organizations to acquire needed assets, goods and services. It serves 27 separate research institutes and centers supporting health research, an integral part of the HHS mission.

The reporting systems component of HHS Financial Management System Environment (shown in the Reporting Systems layer of the diagram at the top of this section) consists of two reporting solutions: Consolidated Financial Reporting System (CFRS) and Financial Business Intelligence System (FBIS). These reporting systems accept data from the financial management systems and facilitate reconciliation, financial analysis and reporting, as well as management reporting. These reporting systems are described in more detail below:

- CFRS enables HHS to systematically consolidate information from the three financial management systems. It generates the HHS-wide consolidated financial statements and other managerial reports on a consistent, timely, and reliable basis and meets regulatory reporting requirements.
- FBIS gathers information from the three financial management systems into a business intelligence platform for integrated, timely, and accurate reporting and analysis. HHS is implementing FBIS in phases, with the third phase rolled out during the fourth quarter of FY 2014. FBIS delivers actionable data to all levels of the user community. HHS leadership primarily accesses this data using executive dashboards and scorecards for strategic decision making, whereas others rely on operational reports, alerts, ad hoc queries, and drill-down capabilities for making tactical decisions and to support their transactional processing responsibilities. FBIS is currently integrated directly with UFMS and indirectly to HIGLAS and NBS, thereby providing access to the financial and accounting data of these systems.

The primary goals for HHS’s Financial Management System Environment are to consistently strengthen internal controls, to maintain data integrity, increase data transparency, and to report reliable financial information on a timely basis. In addition, it is an HHS priority to ensure continual systems improvement by addressing identified weaknesses through improved management oversight of the monitoring 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, HHS seeks to comply with federal financial management systems requirements such as those listed below:

- *Federal Managers’ Financial Integrity Act of 1982*
- *Chief Financial Officers Act of 1990*
- *Government Management Reform Act of 1994*
- *Federal Financial Management Improvement Act of 1996*
- *Clinger-Cohen Act of 1996*
- *Federal Information Security Management Act of 2002*
- *OMB directives related to these laws*

Financial Systems Strategy, Opportunities and Challenges

In line with the goals described above and anticipating the need to meet new regulatory and reporting demands, HHS is in the process of executing a Department-wide financial systems improvement strategy that it developed in FY 2012 for both the Financial Systems Improvement Program (FSIP) and Financial Business Intelligence Program (FBIP).

The most critical component of this multi-year initiative addresses the need to upgrade the three financial management systems as part of FSIP, since the software vendor will end its support for the software version HHS is currently operating in December 2015. In early 2014, HHS initiated the effort to upgrade these systems in order to maintain a secure and reliable systems environment, while also protecting its investment. As part of the upgrade effort, which we expect to complete in FY 2016, HHS will also implement data standards that will improve fiscal transparency and accountability, enhance the accuracy of financial reporting, and reduce the need for burdensome and manual reconciliations across the Department. Another key component of FSIP is the pursuit of sharing initiatives, such as the standardization of accounting treatment across systems, the transitioning of the financial management systems environment to a Cloud infrastructure design, and the use of shared acquisition contracts. Concurrently with FSIP, HHS plans to continue executing FBIP in phases to expand the use of business intelligence, with the goals of further enhancing financial management information and reporting, as well as facilitating effective decision making.

To support both FSIP and FBIP, HHS has created a strong governance foundation in FY 2014. HHS established a Financial Governance Board (FGB) to address at an enterprise level the financial management areas of common concern among the OpDivs, including financial policies and procedures, financial data, and system technologies. In addition, the FGB provides executive-level oversight of financial management-related areas and promotes collaboration among stakeholders from the different disciplines within the financial management environment.

As it executes both programs, HHS is prepared to address the challenges that are inherent in programs of this scale, including those listed below:

- Finding the right resources as part of an effective strategic workforce planning effort – The successful completion of FSIP and FBIP hinges to a large degree on having the resources with the necessary skills and experience working on the project. For the upgrade of our financial management systems, HHS has sought internal resources as subject matter experts where possible, because they would be most familiar with HHS's business processes and unique requirements. Although program leadership has been successful to date finding a sufficient number of high-quality, internal resources, challenges are certain to arise in the future as additional needs surface and/or as resources currently on the project return to their previous roles.
- Acquiring a steady flow of long term funding to ensure successful completion of new programs – Although currently focused on the upgrade of our financial management systems, FSIP's roadmap envisions other important projects that, together with FBIP, would move HHS towards a state of operational excellence. These multi-year initiatives will require funding through FY 2018. Any interruption of the required funding could adversely affect HHS's ability to fully achieve the benefits that these programs offer.
- Complying with mandates from Congress and central agencies with diminishing resources – HHS is subject to many mandates from Congress and central agencies (e.g. Treasury and OMB) that impact our financial management systems. These mandates, such as the recent *Digital Accountability and Transparency Act of 2014* (DATA Act), require that HHS initiate new projects to research their requirements, devise appropriate solutions for meeting the requirements and then implement the solutions. In many cases, these solutions have both significant system and non-system impacts. The cost to maintain currency with,

and respond to, the current and future mandates is significant. HHS, like other agencies, faces the challenge of seeking funding for these efforts in a fiscal landscape where each is asked to do more with diminishing resources.

Legal Compliance

Anti-Deficiency Act (ADA)

The *Anti-Deficiency Act* prohibits federal employees from obligating in excess of an appropriation, or before funds are available, or from accepting voluntary services. As required by the *Anti-Deficiency Act*, HHS notifies all appropriate authorities of any ADA violations. HHS notifications may be found at <http://www.gao.gov/legal/lawresources/antideficiencyrpts.html>.

HHS management has taken and continues to take necessary steps to prevent future violations. With respect to two 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.

Digital Accountability and Transparency Act of 2014 (DATA Act)

The recently-passed DATA Act expands the *Federal Funding Accountability and Transparency Act of 2006* to increase accountability and transparency in federal spending, making federal expenditure information more accessible to the public. It directs the federal government to use government-wide data standards for developing and publishing reports, and to make more information, including award-related data, available on the USASpending.gov website. The standards and website allow stakeholders to track federal spending more effectively. Among other goals, the DATA Act aims to improve the quality of the information on USASpending.gov, as verified through regular audits of the posted data, and to streamline and simplify reporting requirements through clear data standards. Additionally, the DATA Act accelerated the referral of delinquent debt owed to the federal government to Treasury's administrative offset program after 120 days of delinquency.

HHS is preparing now for implementation of the DATA Act starting in 2015. We reduced our delinquent debt referral window from 180 days to 120 days, and we established processes to audit the information on the USASpending.gov website. Furthermore, HHS is in the midst of revamping our accounting treatment manual to facilitate data standards throughout the Department.

Improper Payments Information Act (IPIA) of 2002, Improper Payments Elimination and Recovery Act (IPERA) of 2010 and the Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012

An improper payment occurs when federal funds go to the wrong recipient, the recipient receives an incorrect amount of funds, or the recipient uses the funds in an improper manner. *The Improper Payments Information Act* (IPIA) of 2002, as amended by the *Improper Payments Elimination and Recovery Act* (IPERA) of 2010 and the *Improper Payments Elimination and Recovery Improvement Act* (IPERIA) of 2012, requires federal agencies to review their programs and activities, identify programs that may be susceptible to significant improper payments, perform testing of programs considered high risk, and develop and implement corrective action plans for high risk programs. HHS is striving to better detect and prevent improper payments through close review of our programs and activities using sound risk models, statistical estimates and internal controls.

Patient Protection and Affordable Care Act (Affordable Care Act)

The *Affordable Care Act* is monumental legislation that implements comprehensive health care reform over the next several years to make quality health care more affordable and accessible. The *Affordable Care Act* includes provisions for a patient's bill of rights, a Health Insurance Marketplace, tax credits for low-income Americans, and expansion of the Medicaid program, helping to provide access to affordable health insurance options for all Americans.

The *Affordable Care Act* also aims to reduce health care fraud, waste and abuse by toughening the sentences for perpetrators of fraud; employing enhanced screening procedures; improving the monitoring of providers; and using predictive modeling technology to target suspect behaviors. These efforts have enabled the government to recover over \$19.2 billion in related improper payments over the last five years.

A key aspect of the *Affordable Care Act* allows eligible Americans to receive a premium tax credit when purchasing their health insurance coverage through the Health Insurance Marketplace. The amount of the credit can be paid in advance directly to the consumer's health insurer. Consumers then claim the premium tax credit on their federal tax returns, reconciling the credit allowed with any advance payments made throughout the tax year. HHS coordinates closely with the Internal Revenue Service (IRS) on this process.

HHS has already implemented many provisions of the *Affordable Care Act*. For more information about implementation of the many *Affordable Care Act* provisions, visit the "Key Features" page at <http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html>.

Federal Managers' Financial Integrity Act (FMFIA) and Federal Financial Management Improvement Act (FFMIA)

The *Federal Managers' Financial Integrity Act* (FMFIA) requires federal agencies to annually evaluate and assert on the effectiveness and efficiency of their internal control and financial management systems. Agency heads must annually provide a statement on whether there is reasonable assurance that the agency's internal controls are achieving their intended objectives and the agency's financial management systems conform to government-wide requirements. Section 2 of FMFIA outlines compliance with internal control requirements, while Section 4 dictates conformance with systems requirements. Additionally, agencies must report on any material weaknesses identified and provide a plan and schedule for correcting the weaknesses.

The *Federal Financial Management Improvement Act* (FFMIA) requires federal agency heads to assess the conformance of their financial management information systems to mandated requirements. FFMIA expanded upon FMFIA by requiring that agencies implement and maintain financial management systems that substantially comply with federal financial management systems requirements, applicable federal accounting standards and the U.S. Standard General Ledger at the transaction level. Guidance for determining compliance with FFMIA is provided in OMB Circular A-123, Appendix D, *Compliance with the FFMIA of 1996*.

HHS is fully focused on the requirements of FMFIA and FFMIA through its internal control program and annual risk-based assessment cycle. Based on thorough, ongoing internal assessments and FY 2014 audit findings, HHS provides a qualified statement of reasonable assurance that controls are operating effectively and financial systems conform to federal requirements. We are actively engaged with our OpDivs to correct the identified weakness. More information on the internal control program and the HHS Statement of Assurance follows.

Internal Control

FMFIA requires agency heads to regularly evaluate and report on the internal control and financial systems that protect the integrity of federal programs. This evaluation aims to provide reasonable assurance that internal controls are achieving the objectives of effective and efficient operations, reliable financial reporting, and compliance with applicable laws and regulations. The safeguarding of assets is a subset of these objectives. HHS has performed rigorous evaluations of its internal controls in compliance with OMB Circular A-123, *Management's Responsibility for Internal Control*, since FY 2006.

HHS management is directly responsible for establishing and maintaining effective internal controls in its respective areas of responsibility. As part of this responsibility, management regularly evaluates internal controls and HHS executive leadership provides annual assurance statements reporting on the effectiveness of internal controls at meeting objectives. The HHS Risk Management and Financial Oversight Board (RMFOB) evaluates all senior management assurances and provides a recommended Department assurance to the Secretary for consideration. The Secretary's annual Statement of Assurance is included on the following page.

HHS aims to strengthen its internal control assessment and reporting process to be more effective at identifying key risks, developing effective risk responses, and implementing timely corrective actions. The HHS FY 2014 OMB Circular A-123 assessment and the financial statement audit reported one material weakness in information system controls and security, which also constitutes a non-conformance under Section 4 of FMFIA. Additionally, HHS recognizes one material noncompliance with IPIA regarding Error Rate Measurement. These material deficiencies were also reported in FY 2013.

Maintaining integrity and accountability in all programs and operations is critical to HHS's mission and demonstrates responsible stewardship over assets and resources. It also promotes responsible leadership, ensures the effective delivery of high quality services to the American people and maximizes desired program outcomes.

MANAGEMENT ASSURANCES

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 *Federal Managers' Financial Integrity Act* (FMFIA) and Office of Management and Budget (OMB) Circular A-123, *Management's Responsibility for Internal Control*. These objectives are to ensure (1) effective and efficient operations; (2) compliance with applicable laws and regulations; and (3) reliable financial reporting. The safeguarding of assets is a subset of these objectives.

As required by OMB Circular A-123, 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 one material weakness under Section 2 of FMFIA, 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 OMB Circular A-123, Appendix A. The assessment identified one material weakness in internal control over financial reporting related to the Department's Information System Controls and Security. Other than this exception, the Department provides reasonable assurance that internal controls were operating effectively as of June 30, 2014, and no other 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. The assessment identified one material weakness in internal control over the effectiveness and efficiency of operations under Section 2 of FMFIA related to the Department's Information System Controls and Security, which also constitutes a non-conformance under Section 4 of FMFIA. The assessment also identified one material noncompliance with IPIA related to error rate measurement. Other than these exceptions, the Department provides reasonable assurance that internal control over operations and compliance with applicable laws and regulations was operating effectively as of September 30, 2014, and no other material weaknesses were found in the design or execution of the internal control over operations and compliance.

Federal Financial Management Improvement Act of 1996

The *Federal Financial Management Improvement Act of 1996* (FFMIA) requires agencies to implement and maintain financial management systems that substantially comply with Federal Financial Management System Requirements, Federal accounting standards, and the United States Standard General Ledger at the transaction level. HHS conducted its assessment of financial management systems for compliance with FFMIA in accordance with OMB Circular A-123, Appendix D. The results of this evaluation identified one material noncompliance, which constitutes a non-conformance under Section 4 of FMFIA, relating to the Department's Information System Controls and Security. Other than this exception, the Department substantially complies with FFMIA as of September 30, 2014.

/Sylvia M. Burwell/

Sylvia M. Burwell
Secretary
November 13, 2014

Summary of Material Weaknesses

Control Areas	FMFIA Section 2			FMFIA Section 4
	Financial Reporting (As of 6/30/2014)	Operations (As of 9/30/2014)	Compliance (As of 9/30/2014)	System Conformance (As of 9/30/2014)
1. Information System Controls and Security	1	1	0	1
2. Error Rate Measurement	0	0	1	0

1. Information System Controls and Security

HHS acknowledges an internal control weakness related to information system security, including general and application controls in our financial management systems, and other information system security weaknesses identified through the annual *Federal Information Security Management Act* (FISMA) review. Although no one financial management system had a material weakness, the pervasive nature of the deficiencies across the organization leads management to conclude that these deficiencies in aggregate warrant classification as a material weakness under Section 2 of FMFIA and a non-conformance under Section 4 of FMFIA. While the Department has made progress in the remediation of this material deficiency, our information systems are not yet in substantial compliance with the *Federal Financial Management Improvement Act* (FFMIA) of 1996 and its associated regulatory guidelines.

2. Error Rate Measurement

HHS did not identify any material weaknesses in our internal controls over compliance with applicable laws and regulations; however, HHS recognizes a process limitation relating to the Temporary Assistance for Needy Families (TANF) program that results in one material noncompliance with IPIA. The TANF program is not reporting an error rate, as required by IPIA, for Fiscal Year (FY) 2014 as statutory limitations currently prohibit HHS from requiring states to participate in reporting a TANF improper payment measurement.

Summary of Corrective Action Plans for Material Deficiencies

1. Information System Controls and Security

The range of challenges resulting in HHS's Information System Controls and Security material weakness and system non-conformance will require additional work beyond FY 2014 to address. In FY 2015, we will continue our efforts to remediate this IT material weakness by coordinating with the established joint Chief Financial Officer (CFO) and Chief Information Officer (CIO) partnership to meet corrective action plan milestones and objectives. This partnership expands ongoing efforts of the CFO, CIO and Chief Information Security Officer (CISO) to address the issues underlying the IT material weakness and system non-conformance. We will continue to identify high risk areas and key drivers of HHS's financial systems, mixed financial systems and associated IT infrastructure and collaborate with the various executive sponsor-led cross-cutting teams. The executive sponsors of each of these teams are accountable to the RMFOB to drive results and establish effective operational controls to reduce risk.

2. Error Rate Measurement

HHS is limited with respect to corrective actions it can take to develop an error rate for TANF due to current statutory limitations. When legislation is considered to reauthorize TANF, HHS plans to encourage Congress to consider statutory modifications that would allow for a reliable error rate measurement.

For summary information related to HHS internal control, refer to the tables on the financial statement audit material weakness findings and related management assurances in the Other Information section.

LOOKING AHEAD TO 2015

HHS is the United States Government's principal agency for protecting the health of all Americans, providing essential human services, and promoting economic and social well-being for individuals, families, and communities, including seniors and individuals with disabilities. Guided by the *HHS Strategic Plan, 2015* will be crucial in supporting continuing Health Insurance Marketplace operations as well as many other efforts in a number of exciting and challenging areas.

Strengthen Health Care

HHS is responsible for implementing many of the provisions included in the *Affordable Care Act*, which makes health insurance coverage more secure and reliable for Americans, makes coverage more affordable and accessible for families and small business owners, and helps bring down health care costs. The *Affordable Care Act* also expands consumer choice, supports informed decision making and increases health insurance coverage for low-income populations, partly through the expansion of Medicaid eligibility and the advent of the Health Insurance Marketplace, which launched on October 1, 2013. More than 7.3 million people signed up for Marketplace plans, paid their premiums, and accessed quality, affordable coverage. Another 8.7 million enrolled in Medicaid or CHIP since the beginning of Open Enrollment (as of August 2014) – an increase of 15 percent compared to average monthly signups before October 1, 2013. Beginning in January 2015, a new provision enacted in the *Affordable Care Act* will increasingly tie Medicare physician payments to the quality and efficiency of care they provide through the application of the Value-based Payment Modifier. As this modifier is phased in, physicians who provide higher value care will receive higher payments than those who provide lower value care.

Efforts continue to emphasize access to quality, culturally-competent care for vulnerable populations, and the population at large in many areas. This will include investments in health centers to provide increased access to quality care in underserved areas, both rural and urban, with access to comprehensive primary and preventive health care services. In addition, implementation of best practices to reduce health care associated infections and investment to encourage and expand the meaningful use of health information technology will contribute to overall efforts to ensure patient safety, promote efficiency and accountability, and reduce health care costs.



NIH's lab technician pipetting substrate at the Biopharmaceutical Development Laboratory at the National Cancer Institute's Frederick National Laboratory for Cancer Research in Frederick, Maryland.



IHS Ribbon cutting ceremony celebrating the opening of the new Samuel Simmonds Memorial Hospital in Barrow, Alaska.

Advance Scientific Knowledge and Innovation

HHS is working to advance scientific knowledge and innovation to prevent, diagnose, treat diseases and disorders, address emerging health threats, and sustain a vital and cutting edge workforce and scientific infrastructure. Future HHS plans include accelerating the development of opportunities for the prevention and treatment of substance use and abuse, research Alzheimer's disease and related dementias, as well as human immunodeficiency virus (HIV), and reverse the national epidemic of obesity and diabetes. Research will also address health disparities, multiple chronic conditions, and cardiovascular disease, critical health priorities facing America. HHS is also sparking innovation in various ways, including the NIH's "Follow

that Cell” challenge. NIH is challenging science innovators to compete for prizes totaling up to \$500,000, by developing new ways to track the health status of a single cell in complex tissue over time. This could lead to a tool that would, for example, monitor a cell in the process of becoming cancerous, detect changes due to a disease-causing virus, or track how a cell responds to treatment.

Advance the Health, Safety, and Well-Being of the American People

HHS’s focus will continue aligning with the *National Prevention Strategy*, which will create environments that promote healthy behaviors such as preventing and reducing tobacco use, and implementing a 21st century food safety system to reduce foodborne illness in the population. HHS will also help Americans achieve and maintain healthy weight through school-based, workplace-based, and community-based strategies.

Global health security is an area in which HHS plays a crucial role. Through the Biomedical Advanced Research and Development Authority (BARDA) the Department provides an integrated, systematic approach to the advanced development and purchase of the necessary vaccines, drugs, therapies, and diagnostic tools. Beyond developing, manufacturing, and storing medical countermeasures for chemical, radiological, biological, and nuclear threats, pandemic influenza, and emerging infectious threats, BARDA, along with HHS and industry partners, is also working to provide new options to treat antibiotic-resistant infections. The Department will also continue its effort to promote global well-being and health diplomacy, as well as creating a nimble system better able to respond to unanticipated demands.



A mother and daughter outside an accessible home provided by ACL funded Georgia Developmental Disability Council's Universal Home Design project.

HHS plans to continue investing in efforts to prevent and manage chronic diseases and conditions, enhancing clinical efforts including childhood and adult immunizations, threat detection and response, and supporting behavioral and primary health integration. This will serve to support overall public health as well as protect Americans’ health and safety during emergencies, and foster resilience in response to emergencies. Health at all ages is a priority for the Department. Continued partnering between HHS and state, local, tribal, urban Indian, and other service providers will sustain an essential safety net of services that protect children and youth, promote their emotional health and resilience in the face of adversity, and ensure their healthy development from birth through the transition to adulthood. Health and early intervention services ensure children get off to a good start



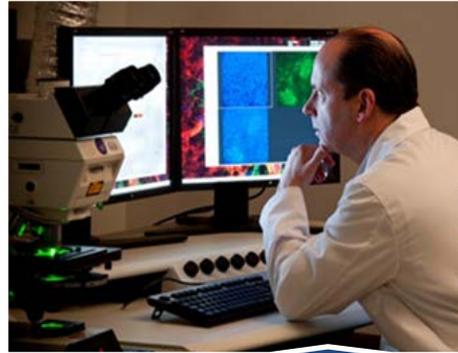
NIH's senior investigator works with a student investigator in the NIAID Laboratory of Malaria and Vector Research.

from infancy. In support of this, HHS will maintain efforts to improve the quality of early childhood education for all children, and other efforts that will put children and youth on the path to successful futures, such as improving access to care, treatment, and services for children and youth exposed to traumatic events. Furthermore, by implementing evidence-based strategies in home visiting, foster care, and teen pregnancy prevention, HHS will ensure that this population is given the chance to succeed in adulthood and can contribute to America’s success. Community living for older adults and people with disabilities will continue to be an area of focus as the U.S. population over the age of 65 is projected to increase by 29 percent between 2012 and 2020.

Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs

HHS will stay committed to developing effective systems, workforce, and infrastructure that can address complicated and emerging challenges. These efforts will allow HHS to continue towards its goal of improved health and well-being among Americans. Specifically, HHS will continue its evaluation efforts, including program integrity reviews that ensure compliance with federal program integrity regulations and identify areas to improve efficiency and effectiveness. Also, HHS will further integrate strategic planning, program performance and integrity, and budget management efforts to provide better and more efficient public service.

One area identified to ensure effective and efficient services are provided is recruiting, developing, retaining, and supporting a skilled and diverse workforce. Supporting this, the Department is making it a priority to fill STEMM (Scientific, Technical, Engineering, Mathematics, and Medicine) positions. This effort strengthens agency strategic workforce management architecture and capability for mission critical occupations.



Robert Fariss, Ph.D., chief of the Biological Imaging Core at the National Eye Institute (NEI) under NIH, examines tissue samples illuminated under a laser scanning microscope.

ANALYSIS OF FINANCIAL STATEMENTS AND STEWARDSHIP INFORMATION

The Principal Financial Statements (statements) have been prepared to report the financial position, results of operations, and budgetary resources of the HHS, as required by the *Chief Financial Officers Act*. The statements are the Consolidated Balance Sheet, Statement of Changes in Net Position, Statement of Net Cost, and Combined Statement of Budgetary Resources. In addition, HHS is also responsible for producing the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts. The format presentations are in accordance with the OMB Circular A-136. The statements found in the Financial Section of this report present our financial condition as of September 30, 2014 and 2013.

The statements are prepared in conformity with U.S. generally accepted accounting principles (GAAP) established by the Federal Accounting Standards Advisory Board (FASAB), and audited by the independent accounting firm of Ernst & Young LLP, under the direction of our Inspector General. Accurate, timely, and reliable financial information is necessary for making sound decisions, assessing performance, and allocating resources. The Financial Section of this report presents our audited financial statements and notes.

Financial Condition: What is Our Financial Picture?

The Consolidated Balance Sheet presents resources owned or managed by HHS (assets), amounts owed by HHS that will require payments from resources or future resources (liabilities), and the residual amounts retained by HHS comprising the difference (net position). The table, on the next page, summarizes trend information concerning components of our financial condition as of September 30 each year.

Another presentation of our financial picture is our Consolidated Statement of Net Cost, also found in the Financial Section, with further detailed presentations located in the Other 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 Notes to the Principal Financial Statement found in the Financial Section of this report.

Summary of Financial Condition Trends

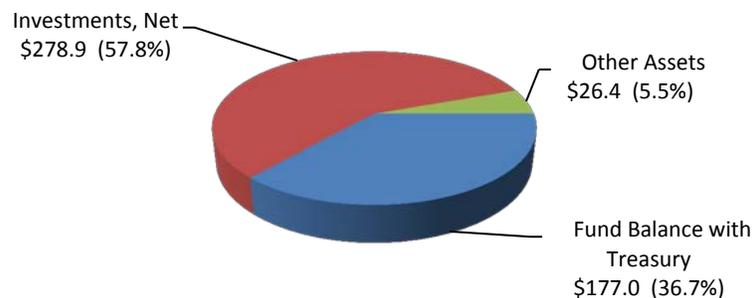
(in Billions)

	2010	2011	2012	2013	2014	\$ Change (2013-14)	% Change (2013-14)
Fund Balance with Treasury	\$ 182.2	\$ 166.9	\$ 197.3	\$ 159.2	\$ 177.0	\$ 17.8	11.2
Investments, Net	359.9	325.4	306.4	281.7	278.9	(2.8)	(1.0)
Other Assets	21.6	40.6	27.0	29.3	26.4	(2.9)	(9.9)
Total Assets	\$ 563.7	\$ 532.9	\$ 530.7	\$ 470.2	\$ 482.3	\$ 12.1	2.6
Accounts Payable	\$ 1.6	\$ 1.2	\$ 1.1	\$ 1.2	\$ 1.0	\$ (0.2)	(16.7)
Entitlement Benefits Due and Payable	72.7	80.9	72.5	77.3	91.0	13.7	17.7
Accrued Grant Liability	4.2	4.5	3.7	3.9	3.3	(0.6)	(15.4)
Federal Employee and Veterans' Benefits	10.0	10.2	11.0	11.6	12.0	0.4	3.4
Other Liabilities	10.7	8.1	11.2	13.5	16.8	3.3	24.4
Total Liabilities	\$ 99.2	\$ 104.9	\$ 99.5	\$ 107.5	\$ 124.1	\$ 16.6	15.4
Net Position	\$ 464.5	\$ 428.0	\$ 431.2	\$ 362.7	\$ 358.2	\$ (4.5)	(1.2)
Total Liabilities & Net Position	\$ 563.7	\$ 532.9	\$ 530.7	\$ 470.2	\$ 482.3	\$ 12.1	2.6

Assets: What Do We Own and Manage?

Assets represent the value of what we own and manage. Our total assets were \$482.3 billion on September 30, 2014. This amount represents an increase of \$12.1 billion (2.6 percent) over last year's assets. The increase in assets is primarily attributable to an increase in CMS's Fund Balance with Treasury (FBWT) of \$15.7 billion related to increased appropriations for Payments to Trust Fund and Medicaid. This increase in FBWT was offset by a decrease in CMS's Investments of \$2.9 billion and a decrease in HHS's Other Assets of \$2.9 billion. The decrease in Investments is primarily attributable to a decrease in the Medicare Hospital Insurance (HI) Trust Fund investments.

Figure 1: FY 2014 Assets by Type
(in Billions)



Medicare Trust Funds are classified as Dedicated Collections in the financial statements and reported separately in many of the financial statements and notes. Medicare Trust Fund holdings that are not needed to meet current expenditures are invested in interest-bearing U.S. Treasury securities and reported on the Balance Sheet as Investments, Net. This year the payments from the Medicare HI Trust Fund exceeded revenue collected from

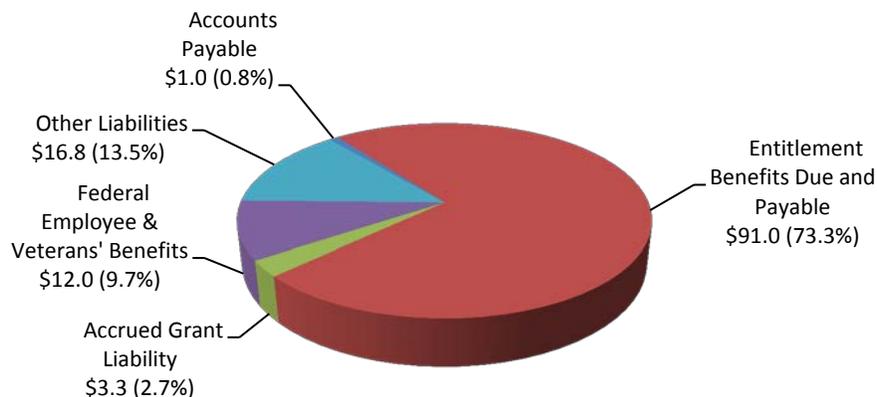
Federal Insurance Contributions Act (FICA) and Self Employment Contributions Act (SECA) withholding taxes; therefore, CMS's Trust Fund investments decreased by \$2.9 billion.

Securities held by the Medicare Trust Fund are debts to the U.S. Government. While the Federal Government does not set aside assets to pay future benefits associated with Medicare, the Medicare Investments shown on the Balance Sheet present accounting balances of amounts that have been collected and not yet expended as benefit payments. Although FICA and SECA revenue are beginning to grow following the national recession, the HI investments continue to decrease as expenses exceed revenues.

Liabilities: What Do We Owe?

Our liabilities, or amounts that we owe from past transactions or events, were \$124.1 billion on September 30, 2014. This represents an increase of \$16.6 billion (15.4 percent) more than the FY 2013 liabilities, primarily due to Entitlement Benefits Due and Payable and Other Liabilities. Entitlement Benefits Due and Payable increased by \$13.7 billion (17.7 percent) from FY 2013, due to the Medicare, and the *Affordable Care Act* expanding eligibility for Medicaid programs. This represents 73.3 percent and 71.9 percent of our total liabilities in FY 2014 and FY 2013, respectively. Additionally, Other Liabilities increased by \$3.3 billion (24.4 percent) from FY 2013, primarily due to contingencies related to the Medicaid audit and program disallowances and reimbursements of State Plan Amendments.

Figure 2: FY 2014 Liabilities by Type
(in Billions)



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 and discussed later in this analysis. A more extensive discussion is provided in the Notes to the Principal Financial Statements located 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 decreased by \$4.5 billion (1.2 percent), from \$362.7 billion in FY 2013 to \$358.2 billion in FY 2014. The \$358.2

billion includes \$243.8 billion for funds from dedicated collections (compared to \$248.5 billion in FY 2013) and \$114.4 billion for FY 2014 for all other funds (compared to the FY 2013 ending balance of \$114.2 billion).

The FY 2014 decrease of \$4.5 billion includes a decrease of \$16.4 billion in funds from dedicated collections cumulative results of operation, and \$1.5 billion in Cumulative Results of Operations for all other funds. The decrease was offset by an increase of \$11.7 billion in funds from dedicated collections Unexpended Appropriations and, \$1.7 billion in Unexpended Appropriations for all other funds. Net position is the sum of the Cumulative Results of Operations since inception and Unexpended Appropriations that represent those appropriations provided to HHS that remain unused at the end of the fiscal year.

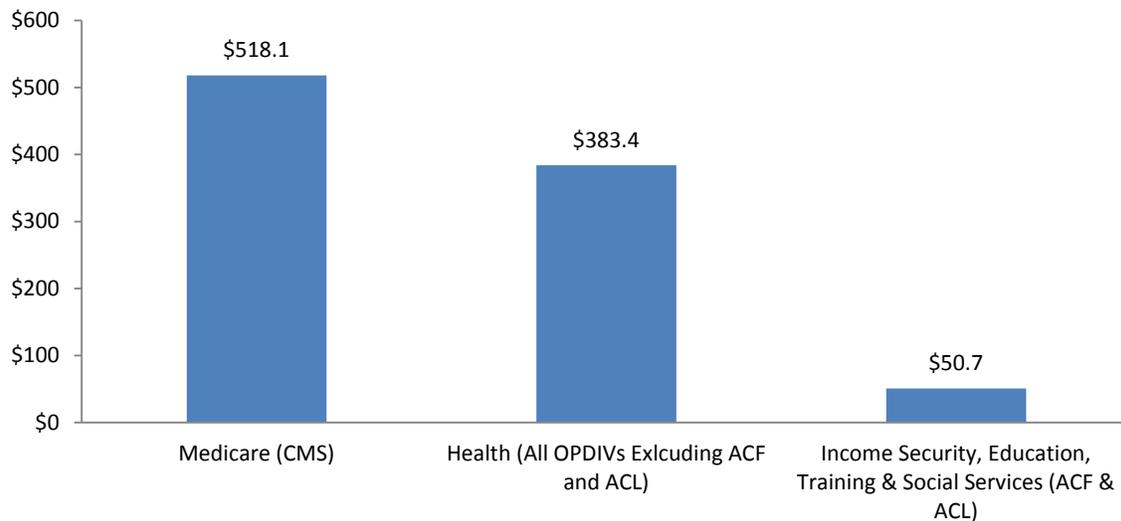
Net Cost of Operations: What Are Our Sources and Uses of Funds?

Our Consolidated 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 Consolidated Net Cost of Operations for the year ended September 30, 2014, totaled \$952.0 billion.

Figure 3 depicts our FY 2014 Combined Net Cost of Operations by major budget function and significant components. 94.7 percent of our annual net costs relate to Medicare (\$518.1 billion) and the Health budget function (\$383.4 billion) which includes Medicaid. During FY 2014, the Medicare budget function experienced growth of \$19.5 billion (3.9 percent) and Health increased \$37.5 billion (10.8 percent).

The growth in the Medicare budget function is primarily attributable to benefit expense increases in Supplementary Medical Insurance (SMI) of \$17.4 billion and HI of \$5.3 billion, offset by SMI premium increases (decrease to net cost) of \$3.5 billion.

Figure 3: FY 2014 Combined Net Cost of Operations by Budget Function
(in Billions)



The FY 2014 Consolidated Net Cost of Operations represents an increase of \$55.7 billion (6.2 percent) over FY 2013. Approximately 87.9 percent of Net Cost of Operations (\$837.2 billion) relates to Medicare, Medicaid, CHIP and other health programs managed by CMS. The Table, on the next page, depicts our Consolidated Net Cost of Operations by major responsibility segment for the last five years.

Consolidated Net Cost of Operations
(in Billions)

	2010	2011	2012	2013	2014	\$ Change (2013-14)	% Change (2013-14)
Responsibility Segments:							
CMS Gross Cost	\$ 789.7	\$ 817.4	\$ 802.3	\$ 848.9	\$ 910.5	\$ 61.6	7.3
CMS Exchange Revenue	(60.7)	(63.7)	(65.1)	(69.7)	(73.3)	(3.6)	5.2
CMS Net Cost of Operations	\$ 729.0	\$ 753.7	\$ 737.2	\$ 779.2	\$ 837.2	\$ 58.0	7.4
Other Segments:							
Other Segments Gross Cost	\$ 130.9	\$ 128.2	\$ 121.5	\$ 121.0	\$ 120.5	\$ (0.5)	(0.4)
Other Segments Exchange Revenue	(3.2)	(3.8)	(3.2)	(3.9)	(5.7)	(1.8)	46.2
Other Segments Net Cost of Operations	\$ 127.7	\$ 124.4	\$ 118.3	\$ 117.1	\$ 114.8	\$ (2.3)	(2.0)
Net Cost of Operations	\$ 856.7	\$ 878.1	\$ 855.5	\$ 896.3	\$ 952.0	\$ 55.7	6.2

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 2014 total resources were \$1.4 trillion, representing an increase of \$88.5 billion (6.7 percent) over FY 2013. FY 2014 total obligations of \$1.4 trillion increased by \$92.3 billion (7.2 percent) compared to FY 2013. Our year-end resources were \$37.9 billion, of which \$8.5 billion are not yet available for expenditure as of September 30, 2014. Total net outlays (cash disbursed for HHS's obligations) of \$937.4 billion increased by \$49.2 billion (5.5 percent) from FY 2013 net outlays of \$888.2 billion.

Statement of Social Insurance

The Statement of Social Insurance 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 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 are not included in the Consolidated Balance Sheet, Statements of Net Cost and Changes in Net Position, or Combined Statement of Budgetary Resources.

Actuarial present values are computed under the intermediate set of assumptions specified in the *Annual Report of the Medicare Board of Trustees*. As noted in the Trustees Report, the basis for the Part B projections has changed since last year (for more information, see footnotes 20 and 21).

The Statement of Social Insurance 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;

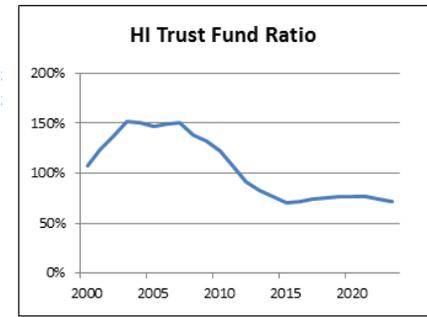
- The present value of future income to be received from or on behalf of current participants who have not yet attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income less future cost for the closed group, which represents all 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;
- 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 cash flows for all current and future participants over the next 75 years (open group measure) increased from \$(4.8) trillion, determined as of January 1, 2013, to \$(3.8) trillion, determined as of January 1, 2014.

Including the combined HI and SMI Trust Fund assets increases the present value, as of January 1, 2014, of future cash flow for all current and future participants to \$(3.5) trillion for the 75-year valuation period. The comparable closed group of participants, including the combined HI and SMI Trust Fund assets, is \$(8.8) 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 124.0 percent at the beginning of FY 2010 to 77.0 percent at the beginning of FY 2014.



		Trust Fund Ratio ¹				
		Beginning of Fiscal Year				
		2010	2011	2012	2013	2014
HI		124.0%	107.0%	95.0%	86.0%	77.0%

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 2014 Trustees Report indicate that the HI Trust Fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the 2014 Trustees Report, the HI Trust Fund ratio is estimated to continue to decline

¹ Assets at the beginning of the year to expenditures during the year.

through 2015 and remain at approximately that level through 2023. From the end of 2013 to the end of 2023, assets are expected to increase, from \$205.0 billion to \$320.0 billion.

Long-Term Financing

The short-range outlook for the HI Trust Fund is somewhat better than projected last year, and the estimated depletion is 4 years later. After 2023, the trust fund ratio starts to decline quickly until the fund is depleted in 2030. HI financing is not projected to be sustainable over the long term with the tax rates and expenditure levels projected. Program cost is expected to exceed total income in 2014, and thereafter, income is projected to exceed costs for several years before falling below it in 2022 and later. 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 85.0 percent of projected expenditures after the HI Trust Fund exhaustion in 2030, declining to 75.0 percent of projected expenditures in 2045, and to stabilize at about this level thereafter.

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 3.2 in 2013 to about 2.1 by 2088. 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 \$3.6 trillion, which is 0.8 percent of taxable payroll over the same period.

Significant uncertainty surrounds the estimates for the Statement of Social Insurance. 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 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, and their program benefits are quite different in nature.

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 generally included an indefinite authority provision allowing for amounts to be transferred to the Part D account on an as-needed basis. This provision allows previously apportioned amounts to change without additional Congressional action if those amounts are later determined to be insufficient. Consequently, once an appropriation with this provision has been made, no deficit will occur in the Part D account, and no contingency fund will be necessary to cover deficits.

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 \$(24.7) 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 2013, SMI expenditures were 1.92 percent of GDP. By 2088, SMI expenditures are projected to grow to 4.54 percent of the GDP.

The following table presents key amounts from our basic financial statements for fiscal year 2012 through 2014.

Table of Key Measures²
Based on the CMS Financial Statements³
(in Billions)

	2014	2013	2012
<i>Net Position (end of fiscal year)</i>			
Assets	\$ 380.0	\$ 370.2	\$ 424.8
Less Total Liabilities	104.7	88.3	80.5
Net Position (assets net of liabilities)	<u>\$ 275.3</u>	<u>\$ 281.9</u>	<u>\$ 344.3</u>
<i>Change in Net Position (end of fiscal year)</i>			
Net Costs	\$ 837.8	\$ 779.8	\$ 737.8
Total Financing Sources	820.4	756.1	710.8
Change in Net Position	<u>\$ (17.4)</u>	<u>\$ (23.7)</u>	<u>\$ (27.0)</u>
<i>Statement of Social Insurances (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 evaluation	\$ (3,823.0)	\$ (4,772.0)	\$ (5,581.0)
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), prior year evaluation	(4,772.0)	(5,581.0)	(3,252.0)
Change in present value	<u>\$ 949.0</u>	<u>\$ 809.0</u>	<u>\$ (2,329.0)</u>

Statement of Changes in Social Insurance Amounts

The Statement of Changes in Social Insurance Amount 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, 2014, would have decreased by \$239.0 billion due to advancing the valuation date by one year and including the additional year 2088, and by \$139.0 billion due to the change in demographic assumptions. However, changes in the projection base, economic and health care assumptions, and legislation changes increased the present value of future cash flows by \$447.0 billion, \$772.0 billion, and \$108.0 billion, respectively.

Required Supplementary Information (RSI)

As required by Statement of Federal Financial Accounting Standards (SSFAS) Number 17, *Accounting for Social Insurance* (as amended by SFFAS Number 37, *Social Insurance: Additional Requirements for Management Discussion and Analysis and Basic Financial Statements*), CMS has included information about the Medicare trust funds – HI and SMI. The RSI 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

² 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.

³ Available at <http://www.cms.gov>.

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 cash flow 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 2014 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.

Limitation of the Principal Financial Statements

The principal financial statements have been prepared to report our financial position and results of operations, pursuant to the requirements of 31 U.S.C. 3515(b). While the financial statements have been prepared from our books and records in accordance with GAAP for federal entities and the formats prescribed by OMB, the statements are in addition to the financial reports used to monitor and control budgetary resources that are prepared from the same books and records.

The statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation that provides resources to do so.

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

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