



Agency Financial Report



A collage of four images representing different aspects of healthcare: a man and woman smiling, a woman holding a plate of food, a person getting a vaccine, and a person in a lab coat.

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MESSAGE FROM THE SECRETARY

**Kathleen Sebelius**

I am pleased to present the *FY 2013 Agency Financial Report* for the Department of Health and Human Services.

Our Department's mission is to improve the health and well-being of all Americans through effective health and human services and by fostering sound, sustained advances in care, research, public health, and social services.

We manage one of the largest budgets in the world and improve the health and lives of Americans every day. We administer more grant dollars than all other federal agencies combined. Our initiatives are as diverse as the people whom we serve. It is our obligation to make the investments that will reach the most people, build most effectively on our partners' efforts, and lead to the biggest gains in health and opportunity for the American people.

One of our most notable initiatives is our work to implement the *Affordable Care Act*. Today, health care cost growth has been driven down to the lowest levels in 50 years, and millions of Americans are already benefitting from new rights and consumer protections. With the new Health Insurance Marketplace, choice and competition among private market plans is now available to millions of uninsured and underinsured Americans. We are committed to improving the consumer experience with the Marketplace and our work will not be done until every eligible American has the opportunity to access affordable, quality health coverage.

As Secretary of HHS, I recognize that we are accountable, above all, to the American public. Our departmental financial statement audit is one of the best tools the American people have to assess our financial information. This year, we obtained a clean opinion on our Consolidated Balance Sheet, Statement of Net Cost, Statement of Changes in Net Position, and the Combined Statement of Budgetary Resources. The auditors did not audit nor express an opinion on the FY 2013 Statement of Social Insurance and Statement of Changes in Social Insurance Amounts that reflect current law as presented in the *2013 Medicare Trustees Report*.

As required by the *Federal Managers' Financial Integrity Act of 1982* (FMFIA) and the Office of Management and Budget's Circular A-123, *Management's Responsibility for Internal Control*, we also evaluated our internal controls and financial management systems. We found one material weakness in the Department related to Information Systems Controls and Security and one material noncompliance with the *Improper Payments Information Act* related to error rate measurement. We have already begun taking actions to improve our financial reports and systems. Further details may be found in the Management's Discussion and Analysis section of our report.

None of our accomplishments would be possible without the dedication and commitment of our employees and the strong support of our state, local, and nonprofit partners. I am proud of the work we do and the progress we have made. We are delivering on our promise of providing better care, helping Americans achieve better health, and lowering the costs of health care for all Americans.

/Kathleen Sebelius/
Kathleen Sebelius
Secretary
December 16, 2013

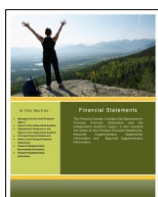
ABOUT THE AGENCY FINANCIAL REPORT

The Department of Health and Human Services (HHS or the Department) Fiscal Year (FY) 2013 *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 beginning October 1, 2012 and ending September 30, 2013. Challenges and accomplishments arising after September 30, 2013 will be addressed in the FY 2014 AFR. 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:



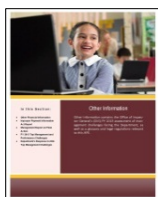
Management's Discussion and Analysis

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 2013. It also discusses HHS' compliance with legal and regulatory requirements, a summary of audit and management assurances and gives a brief look ahead to FY 2014.



Financial Section

The Financial Section includes the Department's Principal Financial Statements and the Report of the Independent Auditors. It also contains the Notes to the Principal Financial Statements, Required Supplementary Stewardship Information (RSSI) and Required Supplementary Information (RSI).



Other Information

The Other Information (OI) section contains additional financial information including the Schedule of Spending, the Office of Inspector General's (OIG) FY 2013 assessment of management challenges facing the Department, a Management Report on Final Action and the Improper Payments Information Act Report, as well as a glossary and legal regulations relevant to this AFR.

Agency Financial Report Availability

We present our FY 2013 AFR, which conforms to OMB Circular A-136, *Financial Reporting Requirements*. The FY 2013 AFR will be available December 16 and the FY 2014 *Congressional Budget Justification* will be available in February 2014, as will the *Summary of Performance and Financial Information*. These reports will be available on our website at <http://www.hhs.gov> at that time. This suite of reports provides readers and decision-makers with enhanced and more transparent financial and performance information.

We Welcome Your Comments

Thank you for your interest in the Department of Health and Human Services. The FY 2013 AFR is available at <http://www.hhs.gov>. We welcome your comments and questions regarding this AFR and appreciate any suggestions. Please contact us at hhsdeputycfo@hhs.gov or at:

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



In this Section:

- About the Department of Health and Human Services
- Performance Goals, Objectives and Results
- Analysis of Financial Statements and Stewardship Information
- Systems, Legal Compliance and Internal Controls
- Statement of Assurance
- Summary of Financial Statement Audit
- Summary of Management Assurances
- Looking Ahead to 2014

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 2013. It also discusses HHS' compliance with legal and regulatory requirements, a summary of audit and management assurances and gives a brief look ahead to FY 2014.

ABOUT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

Mission Statement

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

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

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

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

The Administration for Children and Families (ACF) is responsible for federal programs that promote the economic and social well-being of families, children, individuals and communities. For more information, please visit: <http://www.acf.hhs.gov>.

The Administration for Community Living (ACL) is responsible for providing national leadership and direction to plan, manage, develop and raise awareness of comprehensive and coordinated systems of long-term services and support that enable older Americans and individuals with disabilities to maintain their health and independence in their homes and communities. For more information, please visit: <http://www.hhs.gov/acl>.

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



ACL serves as the Federal agency responsible for increasing access to community supports, while focusing attention and resources on the unique needs of older Americans and people with disabilities across the lifespan.

The Agency for Toxic Substances and Disease Registry (ATSDR) serves the public by using the best science, taking responsive public health actions and providing trusted health information to prevent harmful exposures or disease-related exposures to toxic substances. For more information, please visit: <http://www.atsdr.cdc.gov>.



The Norton Sound Regional Hospital in Nome, Alaska operates under the umbrella of the Indian Health Service.

The Centers for Medicare and Medicaid Services (CMS) administers public insurance programs which serve as the primary sources of health care coverage for seniors and a large population of medically vulnerable individuals and 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 also is responsible for helping to implement many provisions of the *Affordable Care Act* (ACA). For more information, please visit: <http://www.cms.gov>.

The Centers for Disease Control and Prevention (CDC) collaborates to create the expertise, information and tools that people and communities need to protect their health – through health promotion; prevention of disease, injury and disability; and preparedness for new health threats. For more information, please visit: <http://www.cdc.gov>.

The Food and Drug Administration (FDA) is responsible for protecting the public health by assuring the safety, efficacy and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics and products that emit radiation. FDA is also responsible for advancing the public health by helping to speed innovations that make medicines and foods effective, affordable and safe. Additionally, it helps the public get the most accurate, science-based information it needs to use medicines and foods to improve its health. For more information, please visit: <http://www.fda.gov>.



An FDA field inspector checks imported food for contaminants and prepares samples for laboratory analysis.

The Health Resources and Services Administration (HRSA) is responsible for improving health care and achieving health care equity through access to quality services, a skilled health workforce and innovative programs. HRSA focuses on uninsured, underserved and special needs populations in its goals and program activities. For more information, please visit: <http://www.hrsa.gov>.



The Indian Health Service (IHS) is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally recognized tribes grew out of the special government-to-government relationship between the Federal Government and Indian tribes. This relationship, established in 1787, is based on Article I, Section 8, of the U.S. Constitution and has been given form and substance by numerous treaties, laws, Supreme Court decisions and Executive Orders. IHS is the principal federal health care provider and health advocate for Indian people, with the goal of raising Indian health status to the highest possible level. The IHS

provides a comprehensive health service delivery system for approximately 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>.

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

The Substance Abuse and Mental Health Services Administration (SAMHSA) is responsible for reducing the impact of substance abuse and mental illness on America's communities. SAMHSA accomplishes its mission by providing leadership, developing service capacity, communicating with the public, setting standards and improving practice in communities, primary and specialty care settings. For more information, please visit: <http://www.samhsa.gov>.

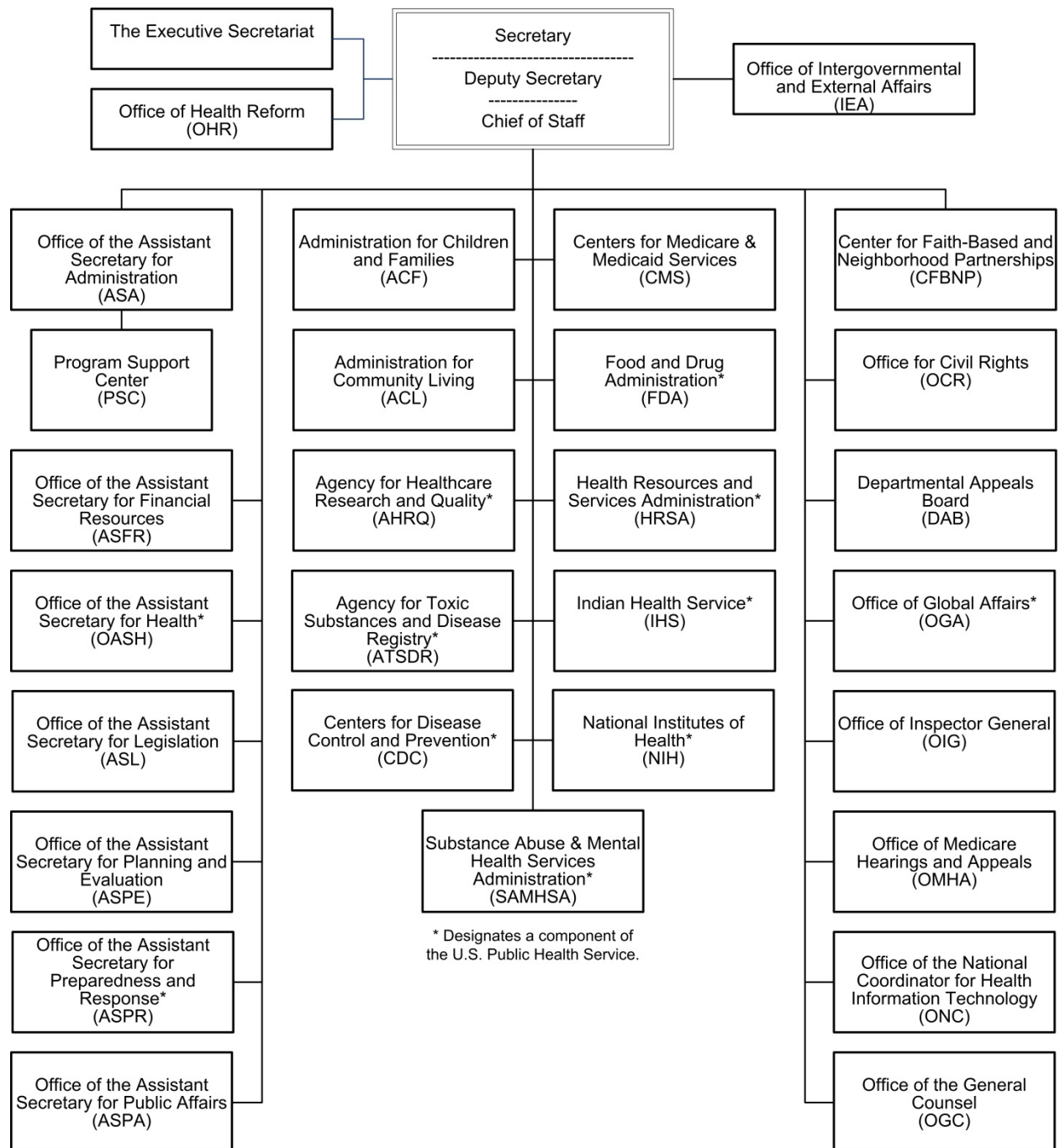


NIH scientists prepare equipment for research at the National Eye Institute.

The Office of the Secretary (OS), with our Secretary, leads HHS and its eleven OPDIVs, listed above, 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. They are:

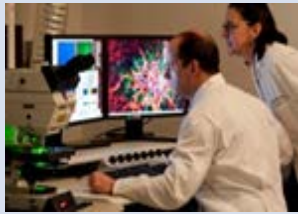
- Office of the Assistant Secretary for Administration (ASA) <http://www.hhs.gov/asa/>
- Office of the Assistant Secretary for Financial Resources (ASFR) <http://www.hhs.gov/asfr/>
- Office of the Assistant Secretary for Health (OASH) <http://www.hhs.gov/ash/>
- Office of the Assistant Secretary for 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 the National Coordinator for Health Information Technology (ONC) <http://www.healthit.hhs.gov/>

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



PERFORMANCE GOALS, OBJECTIVES AND RESULTS

Health and Human Services Performance Results



Scientists at NIH

Throughout FY 2013, HHS continued to improve its performance management processes in alignment with the *Government Performance and Results Modernization Act*. This activity supports HHS' mission to enhance the health and well-being of Americans. HHS' performance management efforts during this period have reinforced progress while finding new efficiencies.

Performance Management Process Milestones

In FY 2013, HHS ensured the prominence of program performance to support the Department's mission of protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. These efforts are shown through the successes of the 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 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 HHS infrastructure and workforce

With collaboration from stakeholders throughout the Department, HHS has continued to pursue six Priority Goals for FY 2012-2013. These efforts have supported significant improvements in near-term outcomes and advanced progress toward longer-term, outcome-focused strategic objectives. These goals include efforts to:

- Increase the number of health centers certified as Patient Centered Medical Homes
- Improve patient safety
- Improve health care through meaningful use of Health Information Technology
- Improve the quality of early childhood education
- Reduce cigarette smoking
- Reduce food-borne illness in the population



An FDA shellfish specialist (left) and a New Jersey state inspector look at a map of the waters where clams were harvested. The risks associated with eating raw or partially cooked shellfish are often related to the quality of water from which they are harvested.

The performance results reported in the AFR represent key measures and performance highlights demonstrating progress toward each HHS Strategic Goal. Additional performance measures and trends are available in the FY 2014 HHS Annual Performance Plan and Report which was published in April 2013 and is located at www.hhs.gov/budget/fy2014/opa_040513.pdf. Detailed FY 2013 performance results will be available in February

2014 in the HHS FY 2015 *Annual Performance Report* (APR) and the FY 2015 *Congressional Budget Justification*. These reports can be located at www.hhs.gov upon approval and issuance. A synopsis of FY 2013 performance information will also be contained in the FY 2014 *Summary of Performance and Financial Information*.

The accomplishments and performance trends below, including progress on HHS Priority Goals, underscore HHS' dedication to sustained performance improvement and emphasis on working to meet the Departments' five Strategic Goals. Targets presented within the tables 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 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 data collection requirements. The target is displayed to show planned progress, with results expected in FY 2014.



A CDC researcher inspects equipment.

Strategic Goal One: Strengthen Health Care

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' efforts in patient safety as well as health care quality are reflected in Improve Patient Safety Priority Goal, 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. Of these hospital-acquired events, central line-associated bloodstream infections (CLABSI) have a strong potential to cause serious illness or death and catheter-associated urinary tract infections (CAUTI) are among the most common, and reduction of these two HAIs in hospitals is the target of the Priority Goal.



Indiana University–Purdue University Fort Wayne received a grant that will help better prepare its nursing students for the rapid changes in today's health care industry.

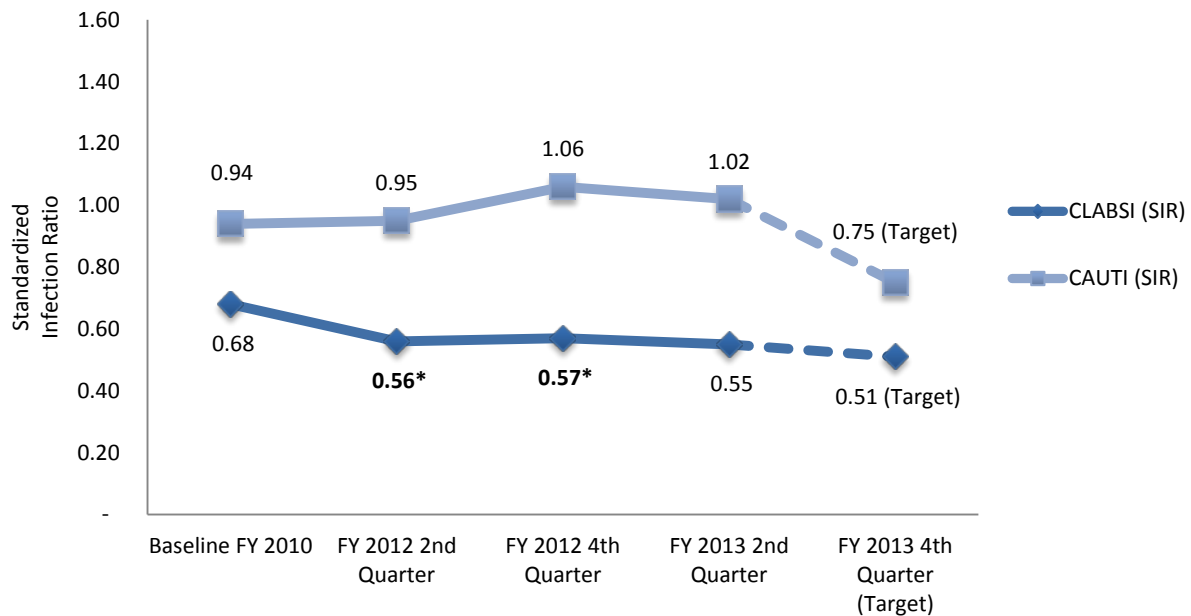
Leveraging the combined programmatic efforts within HHS, including AHRQ, CDC, CMS and OASH, the Improve Patient Safety Priority Goal worked to reduce CLABSI by 25 percent and CAUTI by 20 percent in hospitals nationwide by the end of FY 2013. This is measured over the FY 2010 Standardized Infection Ratios (SIRs) of 0.68 and 0.94, respectively (SIR is calculated by dividing the actual (observed) infections by the expected infections using data gathered through the CDC National Healthcare Safety Network (NHSN)). As of August 2013, NHSN has over 12,000 health care facilities participating for local quality improvement and the success of this capacity building effort to measure quality of care more effectively has had the intended effect of supporting a whole host of quality improvement initiatives, including this priority goal.

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

The FY 2013 Q2 CLABSI NHSN data was calculated at 0.55 SIR, or a 19 percent reduction in the SIR over the baseline of 0.68, significantly contributing to reduced central line-associated bloodstream infections, which saves lives and provides better patient outcomes. The FY 2013 Q2 CAUTI NHSN data was calculated at 1.02 SIR or a 9 percent increase in the SIR over the baseline of 0.94. The plan is to focus on efforts to continue and sustain the successes seen in CLABSI reduction while intensifying work to improve progress toward reducing CAUTIs through maximizing collaboration, ensuring accuracy in reporting, and identifying regional focus area through data.

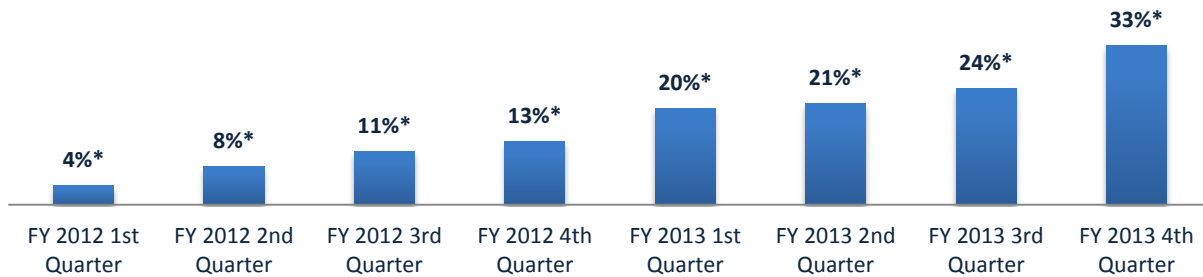


Standardized Infection Ratio of Hospital-Acquired Infection
HHS Priority Goal- Improve Patient Safety
 (* result exceeded target)



The Patient Centered Medical Home (PCMH) Initiative was established to enhance the quality of care in health centers and support health center efforts to achieve national PCMH certification under the medical home program. As of Q4 of FY 2013, 978 health center grantees have initiated certification surveys (far exceeding the FY13 target of 460) demonstrating their desire to participate in the program's service delivery model designed to improve the quality of care through enhanced access, planning, management, and monitoring of patient care. Most importantly, 33 percent of health centers now have at least one site recognized as a PCMH also exceeding the quarterly target.

Percentage of Health Centers with at least One Site Recognized as a PCMH
HHS Priority Goal- Increase the Number of Health Centers Certified as PCMH
 (* result exceeded target)



Using 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 is critical to HHS's strategy to strengthen and modernize health care. This focus on utilizing data is also facilitating new means of improving the quality, efficiency, and patient-centeredness of care. 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. Progress on this

step has exceeded expectations as the annual goal of 230,000 providers was met in Q2 and has been exceeded by over 90,000 providers as of Q4. Concurrently, IHS tracking of Meaningful Use payments indicates that, as of July 2013, 1,819 eligible providers from IHS, tribal, and urban Indian health programs have registered with CMS, and 931 eligible providers have received CMS EHR incentive payments contributing to health care modernization.

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 exceeded target)



Strategic Goal Two: Advance Scientific Knowledge and Innovation

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.

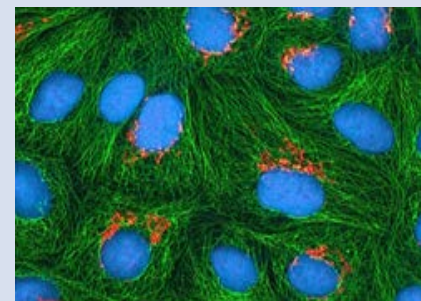
The *Guide to Community Preventive Services* is a compilation of the recommendations from the nonfederal, independent Community Preventive Services Task Force (Task Force) and the systematic reviews on which the recommendations are based. Task Force recommendations provide evidence-based options for programs, services, and policies from which decision makers, practitioners, and researchers can choose those that best meet the needs, preferences, available resources, and constraints of their constituents. To achieve their maximum health impact, Task Force recommendations must be disseminated, adopted, and used. Fiscal year trends through August 2013 show increased page views above FY 2012 levels. These results serve as a proxy measure indicating increased awareness and use of the *Community Guide*.

Number of Page Views of the "Guide to Community Preventive Services"

(* result exceeded target)



NIH's Genotype-Tissue Expression (GTEx) program provides data on how human DNA variation correlates with variation in gene expression levels, which strengthens the power of genome-wide association studies to identify potential new gene targets for therapies. Following an initial two-year pilot, GTEx underwent an expansion in FY 2013 to build a comprehensive data and sample resource of genetic variation and gene expression profiles in multiple tissues. The GTEx program has been highly successful in procuring samples, extracting high-quality RNA from tissues, and obtaining data from gene expression array and RNA sequencing experiments. Additionally, data and biospecimens made available to the research community to support additional molecular analyses of GTEx samples have added scientific value to the resource as a whole.



Cultured HeLa cells counterstained for DNA (cyan).

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

HHS is striving 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 Quality of Early Childhood Education Priority Goal calls for actions to improve the quality of programs for low-income children. 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 the HHS, in coordination with the Department of Education. QRIS is a mechanism by which 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 technical assistance and other support from ACF, an additional seven states have demonstrated significant progress by meeting at least six (of the seven) quality benchmarks toward the overall target of 25 states shown below.



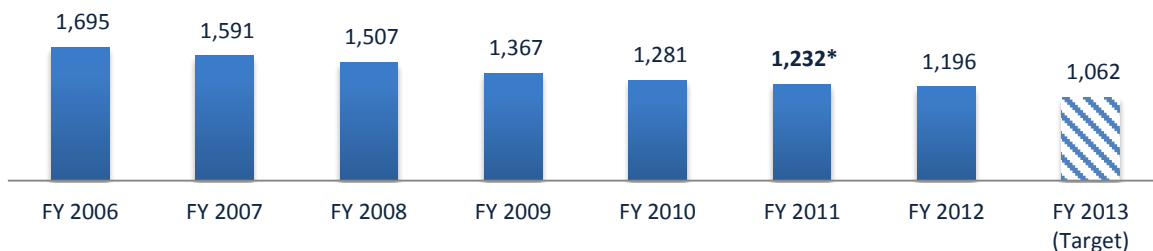
Secretary of Health and Human Services, Kathleen Sebelius, met with students at Lowry Elementary School in Denver, CO.

*Number of States Implementing QRIS that are Meeting the QRIS High-Quality Benchmarks
HHS Priority Goal- Improve the Quality of Early Childhood Education*



Smoking, and secondhand smoke, kills an estimated 443,000 people in the United States each year. For every smoker who dies from a smoking-attributable disease, another 20 live with a serious smoking-related disease. Smoking costs the U.S. \$96 billion in medical costs and \$97 billion in lost productivity each year. While smoking among adults in the United States is down significantly from a decade ago, the decline in adult smoking rates has slowed, concurrent with reductions in state investments in tobacco control programs. However, the coordinated efforts of this Priority Goal have continued reductions in adult cigarette consumption based on FY 2012 results (reported in June 2013).

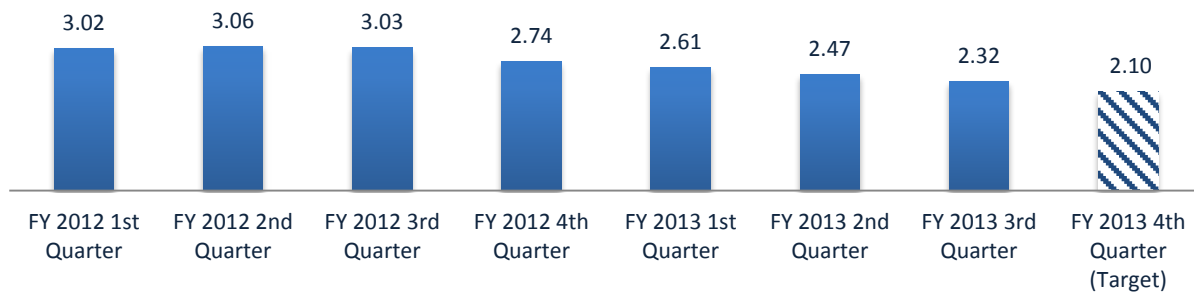
*Annual Per Capita Cigarette Consumption by Adults in the United States
HHS Priority Goal- Reduce Cigarette Smoking
(* result exceeded target)*



Salmonella is the leading known cause of bacterial foodborne illness and death in the United States. Salmonella serotype enteritidis (SE), a subtype of Salmonella, is now the most common type of salmonella in the United States and accounts for approximately 20 percent of all salmonella cases in humans. 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, as part of a shared vision to reduce foodborne illness, is working to improve data to better estimate sources of illness. Efforts throughout FY 2013 have produced a reduction in the SE rate each quarter through 3rd Quarter.

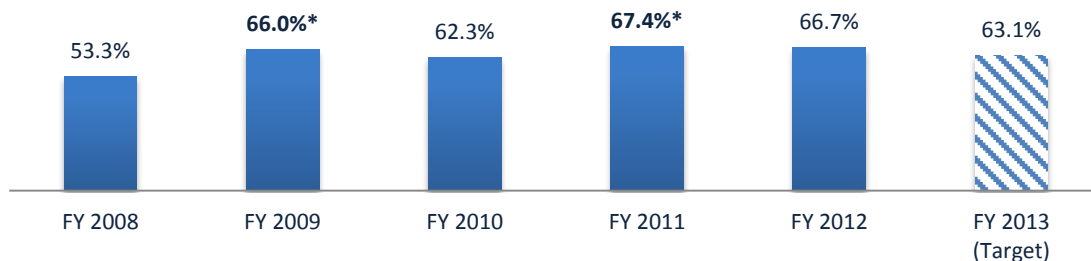


Rate of Salmonella Enteritidis Illness in the Population
HHS Priority Goal- Reduce Food-Borne Illness in the Population



One of the goals of SAMHSA's 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 mental health, from the consumer's perception of his or her recent functioning. Questions are asked specifically about how the consumer was able to deal with everyday life and how frequently the consumer experienced psychological distress within the past 30 days. Following the initial 13 percent increase from FY 2008 to FY 2009, the percentage has been maintained over 60 percent since, and FY 2013 progress supports continued sustained performance.

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





A woman participates in an AoA exercise program in Juneau, AK.

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 relative 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.

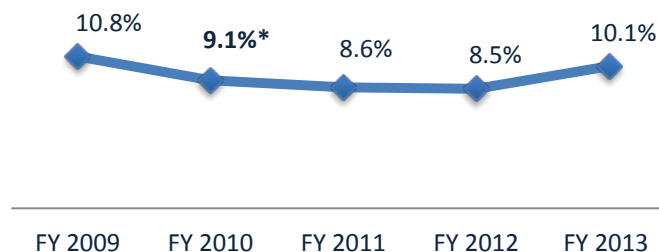
Strategic Goal Four: Increase Efficiency, Transparency and Accountability of HHS Programs

As the largest grant-awarding agency in the Federal Government and the nation's largest health insurer, HHS places a high priority on ensuring the integrity of its 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' 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 Medicare Trust Fund dollars. The Medicare Fee-for-Service (FFS) improper payment estimate is calculated under the Comprehensive Error Rate Testing (CERT) Program. Between FY 2009 and FY 2012, the improper payment rate consistently improved. Recent data from FY 2013 indicates an increase in this rate and efforts are currently in progress to investigate and resolve the drivers causing this increase.

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



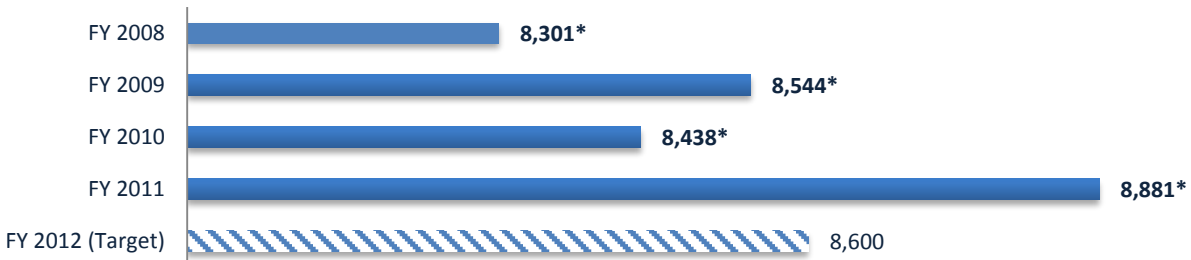


An older man receives a home-delivered meal from a volunteer in Baltimore, MD as part of an ACL program.

Access to and quality of home and community-based services is foundational to the success of ACL's programs. According to the most recent data reported in early FY 2013, the Aging Services Network served 8,881 clients per million dollars of *Title III Older Americans Act* (OAA) funding in FY 2011 continuing to demonstrate the success of the Aging Services Network in employing available tools to enhance the use of OAA funds as this indicator has achieved its efficiency performance targets for the past seven years. This also serves to address performance efficiency at all levels of ACL's AoA in the provision of home and community-based services, including caregiver services.

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 exceeded target)



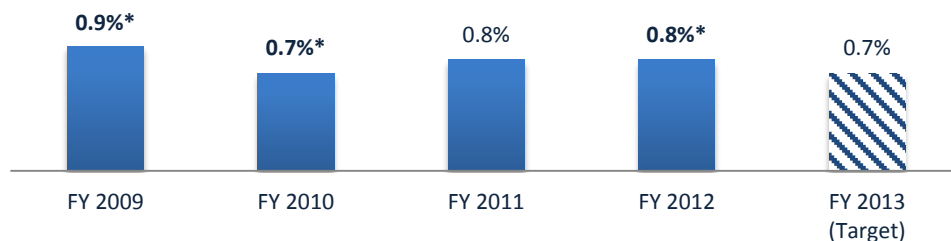
ACF's Head Start program works to ensure that the maximum number of children are served and that federal funds are used appropriately and efficiently by measuring under-enrollment across programs. Since Head Start grantees range in size from super-grantees with multiple delegate agencies serving up to 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.



The most recent data available indicate that, during the FY 2011-2012 program year, Head Start grantees had, on average, not enrolled 0.8 percent of the children they were funded to serve, continuing steady improvement in this area. Further improvements are expected in FY 2013 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 exceeded target)





As part of its program assessment, the OMHA is evaluating its customer service through an independent evaluation. This will assure appellants and related parties are satisfied with their Administrative Law Judge Medicare Level III appeals experience based on beneficiary survey results. The data shows that, on a scale of 1 to 5, where 5 equals "very satisfied," evaluations have consistently been over 4, which exceeds the yearly targets for this measure since FY 2008.

Strategic Goal Five: Strengthen the Nation's HHS Infrastructure and Workforce

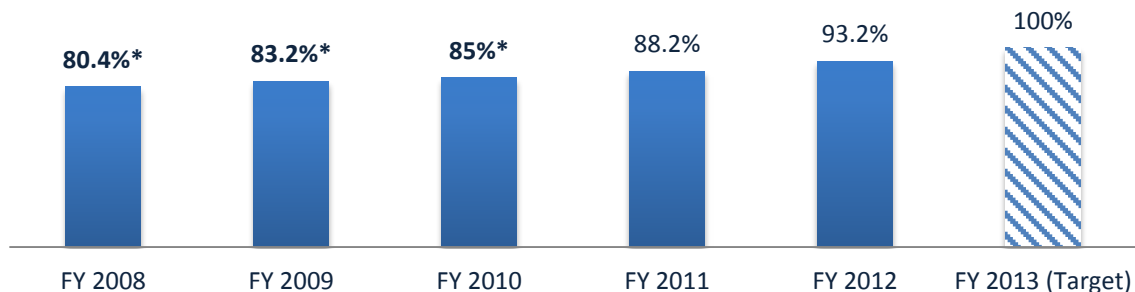
The nation faces shortages of critical health care workers, including primary care physicians, nurses, behavioral health and long-term care workers, as well as public health and human service professionals. More than 64 million people currently live in an area that has a shortage of primary care health professionals. HHS programs seek to address these shortages, and ensure that there is an able health care workforce in the other areas that fall under the Department's purview, such as biomedical research.

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 2013, 93.2 percent of Head Start teachers had an AA degree or higher, missing the target of 100 percent but improving significantly over the previous result. The total FY 2012 figure represents an increase of 2,227 degreed teachers over the previous year demonstrating Head Start teachers are better equipped to deliver quality instruction to Head Start children.

DID YOU KNOW

Officially coming into existence on April 11, 1953, the Cabinet-level Department of Health, Education and Welfare (HEW) was created under President Eisenhower. In 1979, the Department of Education Organization Act was signed into law, providing for a separate Department of Education. HEW became the Department of Health and Human Services, officially arriving on May 4, 1980.

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



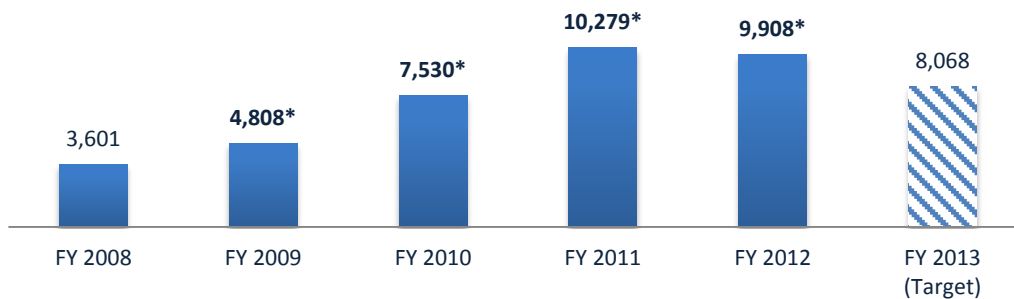
The National Health Service Corps (NHSC) addresses the nationwide shortage of health care providers in health professional shortage areas by providing recruitment and retention incentives in the form of scholarship and loan repayment support to health professionals committed to a career in primary care and service to underserved communities. The NHSC field strength indicates the number of providers fulfilling active service obligations with the NHSC in underserved areas in exchange for scholarship or loan repayment support. As funding is available, the program will continue to maximize this funding to build the primary care workforce. In FY 2012, the NHSC field strength was 9,908 representing almost triple the field strength of FY 2008.



Absentee Shawnee Little Axe Health Center in Norman, OK.

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 exceeded target)



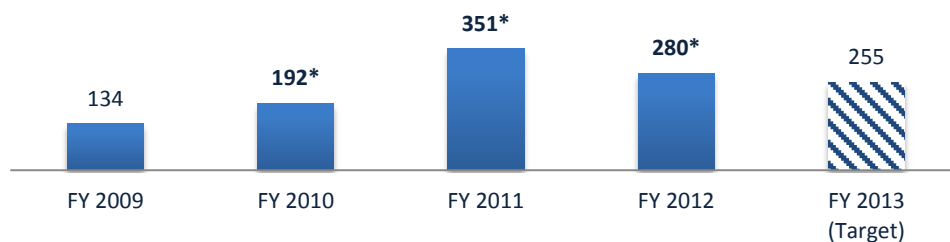
CDC Researcher

The CDC has over 30 years of international experience training public health leaders through its Field Epidemiology Training Programs (FETPs), a two-year applied capacity development program, modeled on the U.S. Epidemic Intelligence Service. 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. Since 1980, CDC has developed 50 international FETPs serving 94 countries and graduated over 2,800 epidemiologists, in addition to continuing to add capacity as shown below by the number of new residents to the program.

Capacity of Epidemiology and Laboratory within Global Health Ministries through FETP

As measured by the Number of New Residents

(* result exceeded target)



ANALYSIS OF FINANCIAL STATEMENTS AND STEWARDSHIP INFORMATION

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

Financial Condition: What is Our Financial Picture?

The table below summarizes trend information concerning components of our financial condition as of September 30 each year. The Consolidated Balance Sheet, found in the Financial Section of this report, presents our financial condition as of September 30, 2013, compared to September 30, 2012, and displays assets, liabilities and net position.

Another presentation of our financial picture is our Consolidated Statement of Net Cost, also found in the Financial Section, with further detailed presentations, which can be found in the Other 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)

	2009	2010	2011	2012	2013	\$ Change (2012-13)	% Change (2012-13)
Total Assets	\$ 562.8	\$ 563.7	\$ 532.9	\$ 530.7	\$ 470.2	\$ (60.5)	(11.4)
Fund Balance with Treasury	162.0	182.2	166.9	197.3	159.2	(38.1)	(19.3)
Investments, Net	381.1	359.9	325.4	306.4	281.7	(24.7)	(8.1)
Other Assets	19.7	21.6	40.6	27.0	29.3	2.3	8.5
Total Liabilities	\$ 94.4	\$ 99.2	\$ 104.9	\$ 99.5	\$ 107.5	\$ 8.0	8.0
Accounts Payable	1.1	1.6	1.2	1.1	1.2	0.1	9.1
Entitlement Benefits Due and Payable	72.2	72.7	80.9	72.5	77.3	4.8	6.6
Accrued Grant Liability	4.0	4.2	4.5	3.7	3.9	0.2	5.4
Federal Employee and Veterans' Benefits	9.7	10.0	10.2	11.0	11.6	0.6	5.5
Other Liabilities	7.4	10.7	8.1	11.2	13.5	2.3	20.5
Net Position	\$ 468.4	\$ 464.5	\$ 428.0	\$ 431.2	\$ 362.7	\$ (68.5)	(15.9)
Total Liabilities and Net Position	\$ 562.8	\$ 563.7	\$ 532.9	\$ 530.7	\$ 470.2	\$ (60.5)	(11.4)

Assets: What Do We Own and Manage?

Assets represent the value of what we own and manage. Our total assets were \$470.2 billion on September 30, 2013. This amount represents a decrease of \$60.5 billion or 11.4 percent less than last year's assets. This \$60.5 billion decrease in assets is primarily attributable to a decrease in Net Investments of \$24.6 billion for the Medicare Trust Funds. In addition, the assets included a decrease in Fund Balance with Treasury in FY 2013 compared to FY 2012 of \$38.1 billion (\$159.2 billion and \$197.3 billion, respectively). The decrease is primarily attributable to a decrease in Supplementary Medical Insurance (SMI) of \$14.3 billion and a decrease by Medicaid in the amount of \$15.8 billion. The decrease was also offset by an increase in the Hospital Insurance (HI) program in the amount of \$0.5 billion.

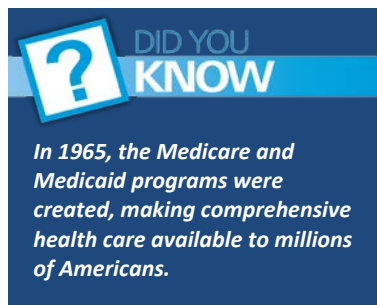
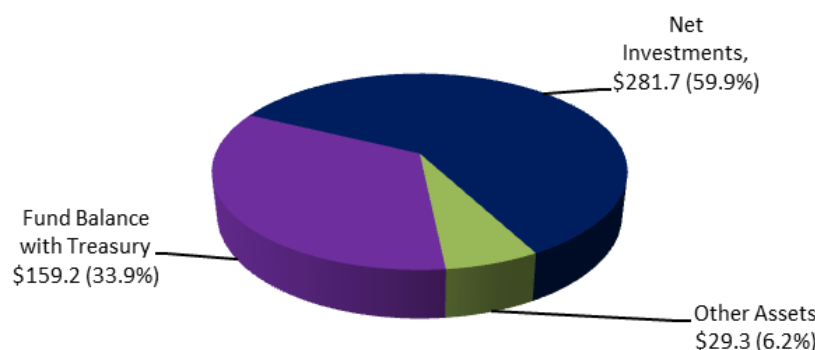


Figure 1: FY 2013 Assets by Type
(In Billions)



The Federal Government does not set aside assets to pay future benefits associated with Medicare. Treasury securities (our Net Investments) are the funds from dedicated collections for the Medicare program. Trust fund holdings not necessary to meet current expenditures are invested in interest-bearing U.S. Treasury securities. The securities held by the Medicare Trust Fund provide the authority to make expenditures. As a result, our Net Investments declined by \$24.6 billion in FY 2013 for Medicare. The investment decreased to meet the cash requirements related to Medicare, primarily for the HI program in the amount of \$22.6 billion and the SMI program in the amount of \$2.0 billion. Although *Federal Insurance Contributions Act* (FICA) and *Self Employment Contributions Act* (SECA) contributions, or revenues, are beginning to grow following the national recession, the HI investments continue to decrease as expenses exceed revenues.

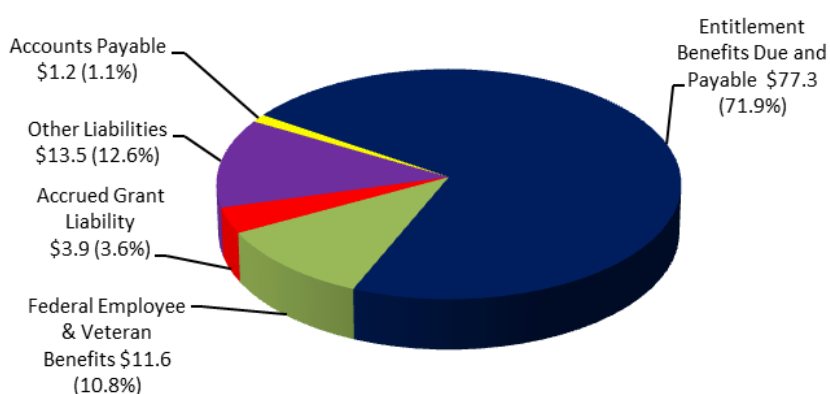
We have experienced a slight change in the overall composition of our assets in FY 2013 compared to FY 2012. The Fund Balance with Treasury and Net Investments together currently comprise 93.8 percent of our total assets compared to 94.9 percent at the end of FY 2012. The remaining FY 2013 assets, totaling \$29.3 billion or 6.2 percent, consists of: Accounts Receivable; Inventory and Related Property; General Property, Plant and Equipment; Advances; and Other Assets, compared to FY 2012, which represented 5.1 percent of our total assets. This change in asset composition is directly related to a decrease in advance payments by CMS for the Medicare Advantage and Prescription Drug plans for services provided in October 2012.

Liabilities: What Do We Owe?

Our liabilities, or amounts that we owe from past transactions or events, were \$107.5 billion on September 30, 2013. This represents an increase of \$8.0 billion, or 8.0 percent more than the FY 2012 liabilities, primarily due to Entitlement Benefits Due and Payable and Other Liabilities. Entitlement Benefits Due and Payable increased by \$4.8 billion, or a 6.6 percent change from FY 2012, due to the Medicare and Medicaid programs. This represents 71.9 percent and 72.9 percent of our total liabilities in FY 2013 and FY 2012, respectively. Additionally, Other Liabilities increased by \$2.3 billion, or a 20.5 percent change from FY 2012, primarily due to contingencies related to the Medicaid audit and program disallowances and reimbursements of State Plan Amendments for program audit deferrals.

Figure 2: FY 2013 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 (SOSI) 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 \$68.5 billion (15.9 percent), from \$431.2 billion in FY 2012 to \$362.7 billion in FY 2013. The \$362.7 billion includes \$248.5 billion for funds from dedicated collections (compared to \$287.5 billion in FY 2012) and \$114.2 billion for FY 2013 for all other funds (compared to the FY 2012 ending balance of \$143.7 billion).

The FY 2013 decrease of \$68.5 billion includes a decrease of \$16.0 billion in funds from dedicated collections unexpended appropriations, \$30.1 billion in unexpended appropriations for all other funds and \$23.0 billion in funds from dedicated collections cumulative results of operation. The decrease was offset by an increase of \$0.6 billion in cumulative results of operations 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.

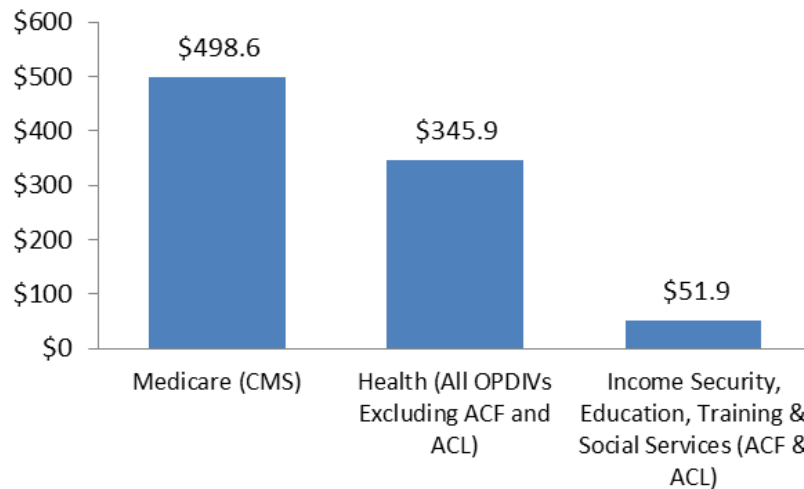
Net Cost of Operations: What Are Our Sources and Uses of Funds?

Our net cost of operations represents the difference between the costs incurred by our programs less associated revenues. We receive the majority of our funding through Congressional appropriations and reimbursement for the provision of goods or services to other federal agencies. Our Net Cost of Operations for the year ended September 30, 2013, totalled \$896.3 billion.

Figure 3 depicts our FY 2013 Combined Net Cost of Operations by major budget function and significant components. The majority of FY 2013 net costs relate to Medicare (\$498.6 billion) and Health (\$345.9 billion) programs, or more than 94.2 percent of our annual net costs. During FY 2013, the Medicare budget function experienced growth of 4.4 percent (\$20.9 billion) and Health increased 5.7 percent (\$18.5 billion).

The growth in the Medicare budget function is primarily attributable to benefit expenses increases in SMI of \$9.8 billion and HI of \$11.0 billion.

Figure 3: FY 2013 Combined Net Cost of Operations by Budget Function
(in Billions)



The FY 2013 Net Cost represents an increase of \$40.7 billion or 4.8 percent more than the FY 2012 Net Cost of Operations. Approximately 86.9 percent of the Net Cost of Operations (\$779.2 billion) relates to Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and other health programs managed CMS. The Table on the next page depicts our Net Cost of Operations by major component for the last five years.

Net Cost of Operations

(in Billions)

	2009	2010	2011	2012	2013	\$ Change (2012-13)	% Change (2012-13)
Responsibility Segments							
CMS Gross Cost	\$ 749.0	\$ 789.7	\$ 817.4	\$ 802.3	\$ 848.9	\$ 46.6	5.8
CMS Exchange Revenue	(57.3)	(60.7)	(63.7)	(65.1)	(69.7)	(4.6)	7.1
CMS Net Cost of Operations	\$ 691.7	\$ 729.0	\$ 753.7	\$ 737.2	\$ 779.2	\$ 42.0	5.7
Other Segments:							
Other Segments Gross Cost of Operations	\$ 116.0	\$ 130.9	\$ 128.2	\$ 121.5	\$ 121.0	\$ (0.5)	(0.4)
Other Segment Exchange Revenue	(3.8)	(3.2)	(3.8)	(3.2)	(3.9)	(0.7)	21.9
Other Segments Net Cost of Operations	\$ 112.2	\$ 127.7	\$ 124.4	\$ 118.3	\$ 117.1	\$ (1.2)	(1.0)
Net Cost of Operations	\$ 803.9	\$ 856.7	\$ 878.1	\$ 855.5	\$ 896.3	\$ 40.8	4.8

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 2013 total resources were \$1.3 trillion, representing an increase of \$33.9 billion, or 2.6 percent, over FY 2012. FY 2013 total obligations of \$1.3 trillion increased by \$76.2 billion, or 6.3 percent, compared to FY 2012. Our year-end resources were \$41.7 billion, of which \$9.6 billion are not yet available for expenditure as of September 30, 2013. Total net outlays (cash disbursed for HHS' obligations) of \$888.2 billion increased by \$40.0 billion or 4.7 percent from FY 2012 net outlays of \$848.2 billion.

Statement of Social Insurance

The SOSI presents the 75-year actuarial present value of the income and expenditures of the HI and SMI Trust Funds. Future expenditures are expected to arise from the formulas specified in current law for current and future program participants. This projection is considered to be important information regarding the potential future cost of the program. These projected potential future obligations under current law are not included in the Consolidated Balance Sheet, Statements of Net Cost and Changes in Net Position, or Combined Statement of Budgetary Resources.

The SOSI presents the following estimates:

- The present value of future income (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;

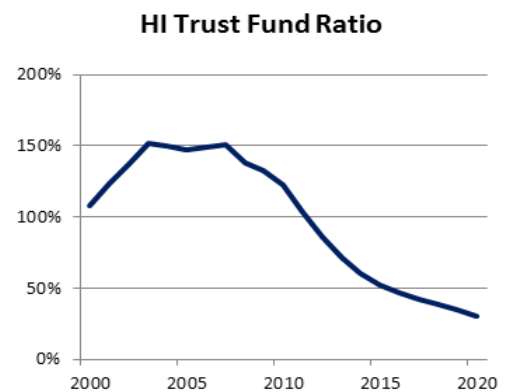
- The present value of future income less future cost for the closed group, which represents all current participants who attain age 15 or older in the first year of the projection period, plus the assets in the combined HI and SMI Trust Funds as of the beginning of the valuation period;
- The present 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 \$(5.6) trillion, determined as of January 1, 2012, to \$(4.8) trillion, determined as of January 1, 2013.

Including the combined HI and SMI Trust Fund assets increases the present value, as of January 1, 2013, of future cash flow for all current and future participants to \$(4.5) trillion for the 75-year valuation period. The comparable closed group of participants, including the combined HI and SMI Trust Fund assets, is \$(9.4) trillion.

HI 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 134 percent at the beginning of FY 2009 to 85 percent at the beginning of FY 2013.



**Trust Fund Ratio¹
Beginning of Fiscal Year**

	2009	2010	2011	2012	2013
HI	134.0%	124.0%	106.0%	94.0%	85.0%

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

Short-Term Financing

The HI Trust Fund is deemed adequately financed for the short term when actuarial estimates of Trust Fund assets for the beginning of each calendar year are at least as large as program obligations for the year. Estimates in the *2013 Trustees Report* indicate that the HI Trust Fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the *2013 Trustees Report*, the HI Trust Fund ratio is estimated to steadily decline to about 48 percent by the beginning of calendar year 2022. From the end of 2012 to the end of 2022, assets are expected to decline by 13 percent, from \$220 billion to \$192 billion.

Long-Term Financing

HI financing is not projected to be sustainable over the long term with the tax rates and expenditure levels projected in current law. Program cost will exceed total income in all years of the 75-year projection period. In 2026, the HI Trust Fund will be exhausted according to the projections by the CMS Office of the Actuary. Under current law, when the HI Trust Fund is exhausted, full benefits cannot be paid on a timely basis. Tax revenues are projected to be sufficient to support 87 percent of projected expenditures after the HI Trust Fund exhaustion in 2026, declining to 73 percent of projected expenditures in 2087.

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 3.43 in 2012 to about 2.1 by 2087. 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 \$4.6 trillion, which is 1.1 percent of taxable payroll and 0.5 percent of Gross Domestic Product (GDP) over the same period.

Significant uncertainty surrounds the estimates for the SOSI. In particular, the actual future values of demographic, economic, and programmatic factors are likely to be different from the near-term and ultimate assumptions used in the projections. For more information, please refer to the *Required Supplementary Information: Social Insurance* disclosures required by the Federal Accounting Standards Advisory Board (FASAB).

SMI Trust Fund Solvency

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

While differences between the two accounts exist, the financing mechanism for each part is similar in that the financing is determined on a yearly basis. The Part B account is generally financed by premiums and general revenue matching appropriations determined annually to cover projected program expenditures and to provide a contingency for unexpected program variation. The Part D account is financed by premiums, general revenues, and transfers from state governments. Unlike the Part B account, Part D has a flexible general revenue appropriation, which means that general revenues cover the remaining cost of providing Part D benefits, thereby eliminating the need to maintain a normal contingency reserve.

Since both the Part B and Part D programs are financed on a yearly basis, from a program perspective, there is no unfunded liability in the short or long-range. Therefore, in this financial statement the present value of estimated future excess of income over expenditures for current and future participants over the next 75 years is \$0. However, from a government-wide perspective, general fund transfers as well as interest payments to the Medicare Trust Funds and asset redemption, represent a draw on other Federal resources for which there is no earmarked source of revenue from the public. Hence, from a government-wide perspective, the corresponding estimate of future expenditures less income for the 75-year projection period is \$(22.5) 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 2012, SMI expenditures were 1.99 percent of GDP. By 2087, SMI expenditures are projected to grow to 4.01 percent of the GDP.

The following table presents key amounts from our basic financial statements for FY 2011 through FY 2013.

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

	2013	2012	2011
<i>Net Position (end of fiscal year)</i>			
Assets	\$ 370.2	\$ 424.8	\$ 424.2
Less Total Liabilities	88.3	80.5	87.5
Net Position (assets net of liabilities)	<u>\$ 281.9</u>	<u>\$ 344.3</u>	<u>\$ 336.7</u>
<i>Change in Net Position (end of fiscal year)</i>			
Net Costs	\$ 779.7	\$ 737.8	\$ 754.1
Total Financing Sources	756.1	710.8	730.4
Change in Net Position	<u>\$ (23.6)</u>	<u>\$ (27.0)</u>	<u>\$ (23.7)</u>
<i>Statement of Social Insurance (calendar year basis)</i>			
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), current year valuation	\$ (4,772)	\$ (5,581)	\$ (3,252)
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), prior year valuation	(5,581)	(3,252)	(2,683)
Change in present value	<u>\$ 809</u>	<u>\$ (2,329)</u>	<u>\$ (569)</u>

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>.

Statement of Changes in Social Insurance Amounts (SCSIA)

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

The present value as of January 1, 2013, would have decreased by \$285 billion due to advancing the valuation date by one year and including the additional year 2087. However, changes in the projection base, demographic assumptions, economic and health care assumptions, and legislation changes increased the present value of future cash flows by \$308 billion, \$724 billion, \$31 billion, and \$31 billion, respectively.

Required Supplementary Information (RSI)

As required by Statement of Federal Financial Accounting Standards (SFFAS) 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 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 *2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare Trust Funds.

Limitations of the Principal Financial Statements

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

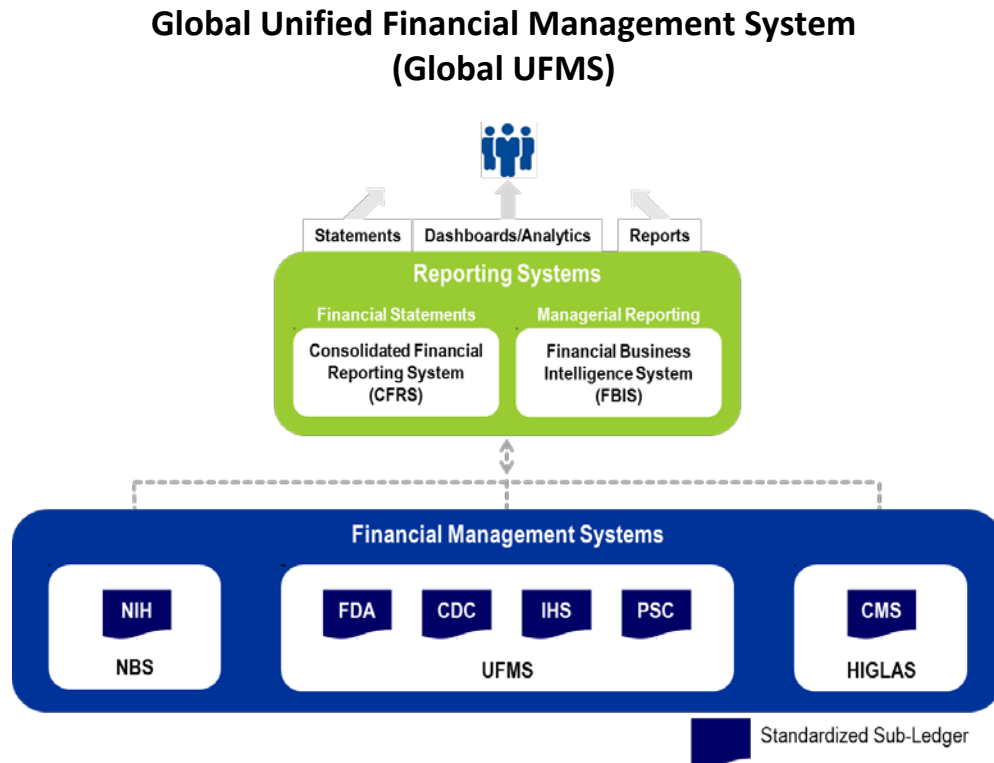
The statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation providing HHS with resources and budget authority.

The RSI section is unique to Federal financial reporting. This section is required under OMB Circular A-136, *Financial Reporting Requirements*, and is unaudited.

SYSTEMS, LEGAL COMPLIANCE AND INTERNAL CONTROLS

SYSTEMS

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



Global UFMS and its major components are described below.

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

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

2. The reporting systems component of Global UFMS (shown above in the Reporting Systems layer) consists of two reporting solutions that accept data from the financial management systems and facilitate reconciliation, financial analysis and management reporting. The specific systems are described below:

- The Consolidated Financial Reporting System (CFRS), implemented during FY 2011, enables HHS to systematically consolidate information from the three financial management systems. It generates the formal, HHS-wide consolidated financial statements and other managerial reports on a consistent, timely and reliable basis.
- The Enterprise Financial Business Intelligence System (FBIS), which HHS is implementing in phases, with the second phase rolled out during FY 2013, currently gathers information from core financial systems into a sustainable business intelligence platform for integrated, timely, and accurate reporting and analysis. This system facilitates the delivery of actionable data to the appropriate users across all financial systems. HHS leadership primarily accesses this data using executive dashboards and scorecards for strategic decision-making. Management employees primarily rely on financial reports and alerts for making tactical decisions and managing operations. Staff employees throughout the Department utilize operational reports, ad hoc queries and drill-down capabilities 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 Global UFMS are to consistently strengthen internal controls, to maintain data integrity and transparency and to report reliable financial information on a timely basis. In addition, it is one of HHS priorities to ensure continual systems improvement that is accomplished by addressing weaknesses identified in audits and by performing self-evaluations and 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*
- *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 Regulations related to these laws.



In line with the goals described above and, anticipating the need to meet new business and reporting demands, HHS has developed a Department-wide financial systems improvement strategy and is executing it incrementally over time based on a high-level roadmap. The most critical component of this multi-year initiative addresses the need to upgrade the three financial management systems since the software vendor will end its support for the current version of the software in December 2014. By upgrading, HHS will maintain a secure and reliable systems

environment while protecting its investment. Through this strategy, HHS will also implement data standards that will improve data integrity, enhance the accuracy of financial reporting and reduce the need for burdensome and manual reconciliations. Another key component of this strategy is the pursuit of sharing initiatives, ranging from the standardization of accounting treatment across systems to the transitioning of financial management systems environment to managed cloud / hosting providers. At the same time, HHS will expand the use of business intelligence incrementally to further enhance financial management information and reporting, strengthen internal controls and facilitate effective decision-making.

To support the financial systems improvement strategy, HHS is also establishing a Department-wide governance structure to provide oversight of the financial management systems portfolio as well as manage the integration and alignment of the related core financial projects. This governance structure will ensure efficient execution of project responsibilities and Department-wide coordination of project activities.

LEGAL COMPLIANCE

Anti-Deficiency Act

As noted in our FY 2012 AFR, HHS investigated potential reportable violations. As required by the *Anti-Deficiency Act*, we are in the process of notifying all appropriate authorities of such violations. HHS notifications may be found at <http://www.gao.gov/legal/lawresources/antideficiencyrpts.html>

HHS management has taken and continues to take, all necessary steps to prevent future violations. With respect to other possible issues, we are working through investigations and further assessment where necessary. We remain fully committed to resolving these matters appropriately and complying with all aspects of the law.

Federal Managers' Financial Integrity and Federal Financial Management Improvement Acts

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

In 1996, Congress enacted the Federal Financial Management Improvement Act (FFMIA). As described in OMB Circular No. A-127, *Financial Management Systems*, FFMIA expanded upon FMFIA by requiring that agencies implement and maintain financial management systems that comply substantially with federal financial management systems requirements, applicable federal accounting standards and the U.S. Standard General Ledger at the transaction level.

The material weakness that resulted in the non-compliance with FFMIA is related to system security controls that are described in the Statement of Assurance section of the AFR. This section also describes the corrective action plan that HHS will execute to resolve this weakness as it continues working towards its goal of making Global UFMS fully compliant with FFMIA. This multi-faceted effort also encompasses improvements to all HHS financial management and reporting systems, as well as enhanced policies and procedures.

The following briefly describes our accomplishments during FY 2013.

UFMS and its Related Reporting Systems

HHS carefully reviewed the weaknesses related to UFMS and its related reporting systems and has developed corrective action plans. HHS also significantly strengthened its FFMIA compliance process by updating its A-127-related system inventory, formalizing the review/approval procedures that the business owner and OPDIVs utilize throughout the year, and providing additional FFMIA training. In addition, HHS is committed to its corrective action plans through active management engagement in its compliance process to remove the identified system weaknesses.

HHS recently implemented Financial Business Intelligence System (FBIS) which has been of particular assistance during the process. FBIS provides users with integrated financial reporting and business analytics capabilities using data from HHS' distinct financial management systems and other data sources. Among the many benefits that this system offers, those shown below are especially helpful for attaining and then maintaining compliance with FFMIA:

- Improves data integrity and reduces manual review efforts;
- Consolidates and reconciles data sourced from different systems;
- Strengthens internal controls to ensure that errors and irregularities are detected in a timely manner; and
- Provides tools for verifying accounting data and for analyzing reported account balances in a timely fashion.

HIGLAS

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

Following the guidance of the OMB Circular A-130, *Management of Federal Information Resources*, CMS acquired a COTS product. As a result, in FY 2012 CMS became substantially compliant with the FFMIA and considers its financial systems to be integrated in accordance with OMB Circular A-127. Through the implementation of HIGLAS among the Medicare Administrative Contractors (MACs) and the implementation of the administrative program accounting functions at the CMS Central office, CMS core program dollars (i.e., Medicare, Medicaid and CHIP) are accounted for in HIGLAS. Since going "live" in May 2005, HIGLAS has processed more than 4.75 billion financial transactions and over 181.8 million payments worth \$1.71 trillion, as of June 2013.

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

NBS

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

is undergoing review for potential closure in FY 2013, while the segregation of duties finding is targeted for closure during FY 2014.

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

Improper Payments Reporting

The *Improper Payments Elimination and Recovery Act* (IPERA; signed into law on July 22, 2010) and the *Improper Payments Elimination and Recovery Improvement Act* (IPERIA; signed into law on January 10, 2013), amended the *Improper Payments Information Act* (IPIA; signed into law on November 26, 2002). The IPIA, as amended, requires each federal agency to review all programs and activities that it administers and identify all such programs and activities that may be susceptible to significant improper payments. For programs that are identified as susceptible to significant improper payments (known as high-risk programs), it also requires that each agency report improper payment estimates and various other related information. In addition, the IPIA as amended by IPERA significantly increases our recovery auditing efforts by expanding the definition of payments recovered to include program payments. More recently, the IPIA as amended by IPERIA requires federal agencies to utilize the Do Not Pay solution to identify, prevent, and reduce improper payments. The Other Information section of this report contains detailed information on our improper payment activities.

HHS has shown tremendous leadership in the improper payments arena. HHS has published an error rate for Medicare FFS since FY 1996 and reported Foster Care error rates since FY 2004. Between FY 2004 and FY 2012, the Head Start error rate declined from 3.9 percent to 0.6 percent. In FY 2013, based on Head Start's strong internal controls, monitoring systems, and low reported error rates, the Office of Management and Budget (OMB) granted HHS relief from reporting annual error rate estimates for Head Start. In lieu of an annual error rate measurement, HHS will oversee Head Start's performance through existing internal controls and monitoring systems, and incorporate the program into the improper payment risk assessment cycle. In addition, beginning in September 2014, HHS will submit an annual report to OMB that describes Head Start's policies, controls, and corrective actions to prevent and mitigate improper payments in the program, as well as any control deficiencies, risks, and trends that are identified.

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

Table 1 in the Improper Payments Reporting section (found in the Other Information section of this report) displays HHS specific error rate results and associated notes for the current year (CY) 2013, the prior year (PY) 2012, as well as the targets for the years 2014 through 2016. In FY 2013, HHS is reporting improper payment estimates for seven high-risk programs, of which five are reporting lower error rate estimates in FY 2013 than were reported in FY 2012. Two programs – Medicare Fee-For-Service (FFS) and Medicare Part D –reported an increase in the FY 2013 error rates compared to the FY 2012 error rates. While HHS strives to decrease its error rates, sometimes an increase occurs. However, an increase in an error rate does not necessarily indicate a breakdown in the program's internal control structure. For example, one reason for the increase in the reported FY 2013 Medicare FFS error rate is that the program issued new policies (e.g., a policy requiring documentation of face-to-face encounters with physicians prior to providing home health services). Although this policy change will

ultimately strengthen the integrity of the program, there is a change management aspect to implementing new policies. Since it takes time for providers and suppliers to fully implement new policies, especially those with new documentation requirements, it is not unusual to see increases in error rates following the implementation of new policies. As a result, increases in error rates may not necessarily indicate increases in internal control risk.

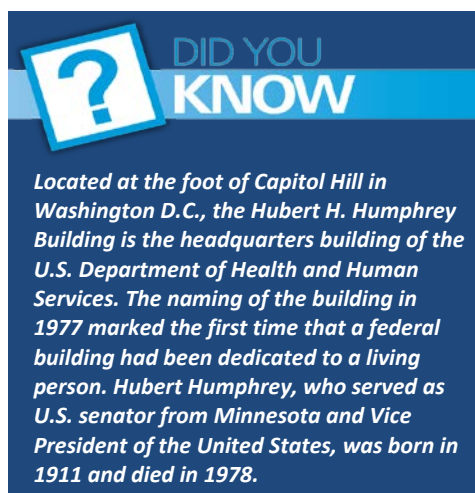
INTERNAL CONTROLS

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

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

HHS continues to strengthen our internal control assessment process to be more effective and inclusive so that management can identify risks and implement timely corrective actions. The HHS FY 2013 self-assessment, as well as the financial statement audit, 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.

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



STATEMENT OF ASSURANCE



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

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

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

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

Internal Control over Financial Reporting

HHS conducted its assessment of the effectiveness of internal control over financial reporting, which includes safeguarding of assets and compliance with applicable laws and regulations, in accordance with the requirements of Appendix A, OMB Circular A-123, *Management's Responsibility for Internal Control*. Based on the results of this assessment, HHS identified one material weakness in its internal control over financial reporting relating 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, 2013, 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, *Management's Responsibility for Internal Control*. Based on the results of this evaluation, HHS identified one material weakness in its internal control over the effectiveness and efficiency of operations under Section 2 of FMFIA relating to the Department's information system controls and security, which also constitutes a non-conformance under Section 4 of FMFIA, and one material noncompliance with IPIA related to error rate measurement, as of September 30, 2013. Other than these exceptions, the Department provides reasonable assurance that internal controls over operations and compliance with applicable laws and regulations as of September 30, 2013, were operating effectively and no other material weaknesses were found in the design or execution of the internal controls over operations and compliance.

/Kathleen Sebelius/
 Kathleen Sebelius
 Secretary
 December 16, 2013

Summary of Material Weaknesses, Non-Compliance and System Non-Conformances

Control Areas	FMFIA Section 2			FMFIA Section 4
	Operations (As of 9/30/2013)	Compliance (As of 9/30/2013)	Financial Reporting (As of 6/30/2013)	System Non-Conformance (9/30/2013)
1. Information System Controls and Security	1	0	1	1
2. Error Rate Measurement	0	1	0	0

1. Information System Controls and Security

HHS acknowledges an internal control weakness related to system security, including general and application controls in our financial management systems, and other information security weaknesses identified through the *Federal Information Security Management Act* (FISMA) annual review process. Although no one financial management system had a material weakness, the pervasive nature of the findings across our organization leads management to conclude that these findings warrant classification as a material weakness. While the Department has made progress in the remediation of the financial management systems' finding, our systems are not yet in substantial conformance with the *Federal Financial Management Improvement Act* (FFMIA) of 1996 and its associated regulatory guidelines, as established by the appropriate governing bodies with respect to overall system security, as of September 30, 2013.

2. Error Rate Measurement

HHS did not identify any material weaknesses in our controls over compliance; however, we did identify one process limitation relating to the Temporary Assistance for Needy Families (TANF) program that led to a material noncompliance with IPIA. The TANF program is not reporting an error rate for Fiscal Year (FY) 2013 as statutory limitations prohibit HHS from requiring States to participate in a TANF improper payment measurement. When legislation is considered to reauthorize TANF, HHS plans to encourage Congress to include changes that would facilitate reliable error rate measurement.

Corrective Action Plans and Impact of Material Weakness, Non-Compliance and System Non-Conformance

The following table lists the corrective action dates for the material weakness, noncompliance and system non-conformance and their impact on the Department's financial statements.

Control Areas	Corrective Action Date	Impact on Financial Statements
1. Information System Controls and Security	FY 2015	Compensating controls exist through manual efforts that partially mitigate the risk of misstating the financial statements.
2. Error Rate Measurement	Ongoing	While error rate measurements do not directly impact HHS' financial statements, we are unable to report in our Agency Financial Report (AFR) an estimate of improper payments for TANF, as required by IPIA.

1. Information System Controls and Security

The range of challenges resulting in HHS' Information Technology (IT) material weakness and system non-conformance will require additional work beyond FY 2013 to address. In FY 2014, we will continue our efforts to remediate this IT material weakness by continuing to work 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' 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 Risk Management and Financial Oversight Board 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; however, when legislation is considered to reauthorize TANF, HHS plans to encourage Congress to include changes that would allow for a reliable error rate measurement.

SUMMARY OF FINANCIAL STATEMENT AUDIT
TABLE 1

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

Definition of Terms – Tables 1 and 2

Beginning Balance: The beginning balance shall agree with the ending balance of material weaknesses from the prior year.

Resolved: The total number of material weaknesses that have dropped below the level of materiality in the current year.

Consolidated: The combining of two or more findings.

Reassessed: The removal of any finding not attributable to corrective actions (e.g., management has re-evaluated and determined a material weakness does not meet the criteria for materiality or is redefined as more correctly classified under another heading (e.g., Section 2 to a Section 4 and vice versa).

Ending: The agency's year-end balance.

SUMMARY OF MANAGEMENT ASSURANCES

TABLE 2

Effectiveness of Internal Control over Financial Reporting (FMFIA #2)						
Statement of Assurance	Qualified					
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
Information System Controls and Security	-	-	-	-	1	1
Total Material Weaknesses	0	0	0	0	1	1

Effectiveness of Internal Control over Operations (FMFIA #2)						
Statement of Assurance	Qualified					
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
Information System Controls and Security	1	-	-	-	-	1
Error Rate Measure	1	-	-	-	-	1
Total Material Weaknesses	2	0	0	0	0	2

Conformance with Financial Management System Requirements (FMFIA #4)						
Statement of Assurance	Do not conform to financial management system requirements					
Non-Conformances	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
Information System Controls and Security	1	-	-	-	-	1
Total Non-Conformances	1	0	0	0	0	1

Compliance with Federal Financial Management Improvement Act (FFMIA)		
	Agency	Auditor
Overall Substantial Compliance	No	No
1. System Requirements	Noncompliance Noted	
2. Accounting Standards	No Noncompliance Noted	
3. USSGL at Transaction Level	Noncompliance Noted	

LOOKING AHEAD TO 2014

Management Challenges and High-Risk Areas

HHS is the United States Government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. Guided by the *HHS Strategic Plan*, 2014 will be a critical year in enabling the Health Insurance Marketplaces to begin operations as well as many other efforts in a number of exciting and challenging areas.

Strengthen Health Care

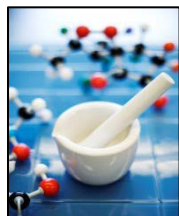
HHS is responsible for implementing many of the provisions included in the *Affordable Care Act* which makes health insurance coverage more secure and reliable for Americans, makes coverage more affordable and accessible for families and small business owners, and helps bring down health care costs. The *Affordable Care Act* also expands consumer choice and supports informed decision-making and increases health insurance coverage for low-income populations, partly through the advent of Health Insurance Marketplaces, which launched on October 1, 2013. Efforts in FY 2014 will include enrolling individuals in the Marketplace and continued improvements to the Healthcare.gov portal to enhance the customer experience. HHS is also committed to offering alternative enrollment options to facilitate the application process and ensure that every American who wants to enroll in a health insurance plan can access these new options for care.



HHS is also providing technical assistance to states that are transitioning to state-based Marketplaces. The expansion of health insurance to individuals with behavioral health needs will require action to strengthen state behavioral health systems, to disseminate the most effective evidence-based practices and provide quality training to existing providers.

Efforts will continue to ensure 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.

Advance Scientific Knowledge and Innovation



HHS is working to advance scientific knowledge and innovation to prevent, diagnose, and 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 in substance use and abuse, research toward the treatment and prevention of Alzheimer's disease and related dementias, as well as HIV, and reverse the national epidemic of obesity and diabetes.

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

Over the next several years, HHS' focus will align 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.

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.



FDA's Emergency Operations Center monitoring Hurricane Sandy

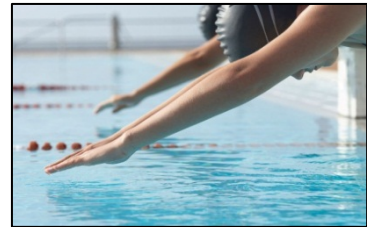


Response teams moving supplies during Hurricane Sandy

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 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. 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.

Ensure Efficiency, Transparency, Accountability, and Effectiveness

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 to towards its goal of improved health and well-being among Americans. Specifically, HHS will continue its evaluation efforts, including program integrity reviews to ensure compliance with federal program integrity regulations, provide technical assistance 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.



Recruiting, developing, retaining, and supporting a skilled and diverse workforce to provide effective and efficient services and promote responsible stewardship will remain a priority. Currently, there are areas in the nation that face shortages of critical health care workers, including primary care physicians, nurses, behavioral health and long-term care workers, as well as public health and human service professionals. To address this, HHS will continue to foster a 21st century workforce to deliver high-quality care, improve population health, and maximize limited resources.